shall be increased by 1 percent for each month occurring after the expiration of such period and prior to the month in which the primary plans makes the reimbursement.".

SEC. 8306. IMPOSITION OF 20 PERCENT COINSURANCE ON HOME HEALTH SERVICES UNDER MEDICARE.

(a) PART A.—Section 1813(a) (42 U.S.C. 1395e(a)) is amended by adding at the end the following new paragraph:

"(5) The amount payable for a home health service furnished to an individual under this part shall be reduced by a copayment amount equal to 20 percent of the average of all the per visit costs for such service furnished under this title determined under section 1861(v)(1)(L) (as determined by the Secretary on a prospective basis for services furnished during a calendar year).".

(b) PART B.—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)), as amended by section 2106(c)(1), is amended—

(1) in subparagraph (A), by striking "to home health services," and by striking the comma after "opinion)";

(2) in subparagraph (E), by striking "and" at the end;

(3) in subparagraph (F), by striking the semicolon at the end and inserting "; and"; and

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

"(G) with respect to any home health service—

"(i) the lesser of —

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

"(II) the customary charges with respect to such service,

less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), or

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

less a copayment amount equal to 20 percent of the average of all per visit costs for such service furnished under this title determined under section 1861(v)(1)(L) (as determined by the Secretary on a prospective basis for services furnished during a calendar year);".

(c) PROVIDER CHARGES.—Section 1866(a)(2)(A)(i) (42 U.S.C. 1395cc(a)(2)(A)(i)) is amended—

(1) by striking "deduction or coinsurance" and inserting "deduction, coinsurance, or copayment"; and

(2) by striking "or (a)(4)" and inserting "(a)(4), or (a)(5)".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1998.

SEC. 8307. HOME HEALTH COST LIMITS.

(a) REDUCTION IN UPDATE TO ROUTINE COST LIMITS.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) in subclause (II), by striking "or" at the end;

(2) in subclause (III), by striking "112 percent," and inserting "and before July 1, 1996, 112 percent, or"; and

(3) by inserting after subclause (III) the following new subclause:

"(IV) July 1, 1996, 100 percent (adjusted by such amount as the Secretary determines to be necessary to preserve the savings resulting from the enactment of section 13564(a)(1) of the Omnibus Budget Reconciliation Act of 1993),".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to cost reporting periods beginning on or after July 1, 1996.

PART 2—PROVISIONS RELATING TO PAYMENTS FOR MEDICAL EDUCATION

SEC. 8311. LIMITING MEDICARE MEDICAL EDUCATION PAYMENTS TO APPROVED RESIDENCY POSITIONS.

(a) PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended by adding at the end the following new subparagraph:

"(F) REQUIRING RESIDENTS TO MEET APPROVAL UNDER WORKFORCE PROGRAM.—Such rules shall provide that, with respect to a resident whose initial residency period begins on or after July 1, 1998—

"(i) an individual shall be counted only if the individual is in a residency position that, under section 7013 of the Guaranteed Health Insurance Act of 1994, has been allocated to an approved medical residency training program; and

"(ii) the Secretary may not make any payments under this subsection to a hospital unless the number of residents in each of the approved medical residency training programs of the hospital is in accordance with allocations under such section 7013.".

(b) PAYMENT FOR INDIRECT GRADUATE MEDICAL EDUCATION.—Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clause:

"(v) On and after July 1, 1998—

"(I) the Secretary, in determining such adjustment, may count a resident in the calculation of a hospital's ratio of full-time equivalent interns and residents to beds only if the resident is in a residency position that, under section 7013 of the Guaranteed Health Insurance Act of 1994, has been allocated to an approved medical residency training program; and

"(II) the Secretary may not make any payments under this subparagraph to the hospital unless the number of residents in each of the approved medical residency training programs of the hospital is in accordance with allocations under such section 7013.".

SEC. 8312. DETERMINATION OF NUMBER OF FULL-TIME EQUIVALENT RESIDENTS.

(a) DETERMINATION OF FULL-TIME EQUIVALENT RESIDENTS DURING INITIAL RESIDENCY PERIOD.—

(1) EMPHASIS ON PRIMARY CARE.—Paragraph (4)(C)(ii) of section 1886(h) (42 U.S.C. 1395ww(h)) is amended by striking "is 1.00," and inserting the following: "is—

"(I) 1.1, in the case of a resident who is a primary care resident (as defined in paragraph (5)(H)),

"(II) .8, in the case of a resident not described in subclause (I),".

(2) TREATING OBSTETRICS AND GYNECOLOGY RESIDENTS AS PRIMARY CARE RESIDENTS.—Paragraph (5) of such section is amended—

(A) by striking "or"; and

(B) by striking the period and inserting ", or obstetrics and gynecology.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to portions of cost reporting periods beginning on or after January 1, 1996.

SEC. 8313. PAYMENTS FOR HOSPITALS LOSING SPECIALTY POSITIONS.

Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following subsection:

"(j) PAYMENTS FOR HOSPITALS LOSING SPECIALTY POSITIONS UNDER ALLOCATION SYSTEM.—

"(1) IN GENERAL.—

"(A) PAYMENTS.—In the case of each hospital that in accordance with paragraph (3) submits to the Secretary an application for calendar year 1998 or any subsequent calendar year (in this subsection referred to as an 'eligible hospital' for the year involved), the Secretary shall make payments for the year to the hospital in an amount determined in accordance with paragraph (4).

"(B) SOURCE OF FUNDS FOR PAYMENTS.—Payments under paragraph (1) shall be made from amounts in the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, and from amounts in the Medicare Part C Trust Fund under title XXI (in the proportions described in subsection (h)(1), taking into account the proportions of direct medical education costs associated with the provision of services under title XXI).

"(2) HOSPITALS LOSING SPECIALTY POSITIONS; OTHER CONDITIONS.—

"(A) LOSS OF POSITIONS.—

"(i) IN GENERAL.—The Secretary may make payments under paragraph (1) to a hospital for a calendar year only if, as a result of allocations under 7013 of the Guaranteed Health Insurance Act of 1994, the aggregate number of full-time-equivalent specialty positions for the hospital for the academic year in which the calendar year begins (as estimated by the Secretary) is below the aggregate number of such positions for the hospital for academic year 1993.

"(ii) AGGREGATE NUMBER OF SPECIALTY POSITIONS LOST.—For purposes of this subsection:

"(I) The term 'aggregate number of specialty positions lost', with respect to a hospital and an academic year, means the difference between the 2 aggregate numbers determined by the Secretary under clause (i) for the hospital.

"(II) The term 'lost position', with respect to an academic year, means a full-time-equivalent specialty position counted in the determination under subclause (I) of the aggregate number of specialty positions lost for the year.

"(B) COMPLIANCE WITH ALLOCATION SYSTEM.—With respect to the approved physician training programs of a hospital, the Secretary may make payments under paragraph (1) only if the hospital agrees to ensure that the numbers of individuals enrolled in the programs is in accordance with allocations made under section 7013 of the Guaranteed Health Insurance Act of 1994 for the programs.

"(3) APPLICATION FOR PAYMENTS.—For purposes of paragraph (1), an application for payments under such paragraph for a hospital is in accordance with this paragraph if—

"(A) the hospital submits the application not later than the date specified by the Secretary;

"(B) the application demonstrates that the hospital meets the condition described in paragraph (2)(A)(i);

"(C) the application contains each agreement required in this subsection; and

"(D) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary.

"(4) AMOUNT OF PAYMENTS.—The amount of payments required in paragraph (1) to be made to an eligible hospital for a calendar year is an amount equal to the product of—

"(A) the aggregate lost position amount, as defined in paragraph (5) or (6) for the year, as applicable; and

"(B) the medicare patient load of the hospital under subsection (h)(3)(C) for the cost reporting period involved, except that the determination of the medicare patient load for purposes of this subparagraph shall include (in addition to the patients included under such subsection) patients enrolled in the medicare part C program under part A of title XXI.

"(5) AGGREGATE LOST POSITION AMOUNT; FIRST YEAR OF PAYMENTS.—For purposes of paragraph (4)(A), the term 'aggregate lost position amount', with respect to the first calendar year for which an eligible hospital receives payments under paragraph (1), means an amount equal to the product of—

"(A) the aggregate number of specialty positions lost (as defined in paragraph (2)(A)(ii)(I)); and

"(B) an amount equal to 100 percent of the national average FTE training amount in effect for the year under section 7024(c)(3) of the Guaranteed Health Insurance Act of 1994 (or, as the case may be, 100 percent of the alternative amount that applies to the hospital under section 7024(c)(3)(D) or section 7025 of such Act).

"(6) AGGREGATE LOST POSITION AMOUNT; SUBSEQUENT YEARS OF PAYMENTS.—For purposes of paragraph (4)(A), the term 'aggregate lost position amount', with respect to the second or subsequent calendar year for which an eligible hospital receives payments under paragraph (1), means an amount equal to the sum of subparagraphs (A) through (D), as follows:

"(A) An amount equal to the product of—

"(i) the aggregate number of specialty positions lost, less an amount equal to the sum of—

"(I) the number of lost positions for which payments are being made for the calendar year pursuant to subparagraphs (B) through (D); and

"(II) the total number of lost positions for which, in determinations under this paragraph for the hospital for prior calendar years, the percentage applicable to the national average or alternative amount referred to in paragraph (5)(B) was 25 percent; and

"(ii) 100 percent of such national average or alternative amount applicable for the year involved.

"(B) An amount equal to the product of—

"(i) the number of lost positions for which, in the determination under this paragraph for the hospital for the preceding calendar year, the percentage applicable to the national average or alternative amount was 100 percent, subject to paragraph (7) (relating to decreases in aggregate numbers); and

"(ii) 75 percent of the national average or alternative amount applicable for the year involved.

"(C) An amount equal to the product of—

"(i) the number of lost positions for which, in the determination under this paragraph for the hospital for the preceding calendar year, the percentage applicable to the national average or alternative amount was 75 percent, subject to paragraph (7); and

"(ii) 50 percent of the national average or alternative amount applicable for the year involved.

"(D) An amount equal to the product of—

"(i) the number of lost positions for which, in the determination under this paragraph for the hospital for the preceding calendar year, the percentage applicable to the national average or alternative amount was 50 percent, subject to paragraph (7); and

"(ii) 25 percent of the national average or alternative amount applicable for the year involved.

"(7) RULE REGARDING DECREASE IN AGGREGATE NUMBER OF SPECIALTY POSITIONS LOST.—With respect to payments under paragraph (1) for an eligible hospital for a calendar year, if the aggregate number of specialty positions lost for the academic year involved is less than such number for the preceding academic year (which difference between the 2 aggregate numbers is referred to in this paragraph as the "decrease in the number of lost positions"), the following applies:

"(A) The Secretary shall identify the number of lost positions for which, as determined under paragraph (6) without regard to this paragraph, the percentage applicable to payments for the calendar year is 75 percent, the number of such positions for which such percentage is 50 percent, and the number of such positions for which such percentage is 25 percent.

"(B) In the case of the lost positions so identified, the Secretary shall apply the decrease in the number of lost positions as follows:

"(i) First, as a reduction in the number of positions for which the percentage applicable is 75 percent.

"(ii) Second (for any remaining portions of the decrease after compliance with clause (i)), as a reduction in the number of positions for which such percentage is 50 percent.

"(iii) Third (for any remaining portions of the decrease after compliance with clause (ii)), as a reduction in the number of positions for which such percentage is 25 percent.

"(8) DEFINITIONS.—For purposes of this subsection, the terms 'academic year', 'approved physician training program', 'full-time-equivalent specialty position', and 'specialty position', each has the meaning given the term under section 7081 of the Guaranteed Health Insurance Act of 1994.".

SEC. 8314. MEDICARE DEMONSTRATION REGARDING CONSORTIA OF HOSPITALS.

(a) IN GENERAL.—The Secretary shall establish and conduct not more than 10 demonstration projects to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice under which the Secretary shall make payments in accordance with subsection (c) to participating health care training consortia.

(b) APPLICATIONS.—Each consortium desiring to participate in a demonstration project under this section shall prepare and submit to the Secretary an application at such time and in such manner as the Secretary may require, and containing—

(1) assurances that not less than 55 percent of all residents participating in approved residency training programs conducted by members of the consortium are primary care residents (as defined in section 1886(h)(5)(H) of the Social Security Act); and

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

(c) PAYMENTS TO PARTICIPANTS.—

(1) IN GENERAL.—Notwithstanding any provision of title XVIII of the Social Security Act—

(A) in the case of a consortium participating in a demonstration project under this subtitle, the Secretary shall make payments under such title for the direct and indirect costs of graduate medical education of members of the consortium to the consortium (or through any entity identified by such a consortium as appropriate for receiving payments on behalf of the consortium), except that the amount paid to the consortium shall be based on the designations described in paragraph (2); and

(B) the Secretary may not make any payment under such title to a member of a consortium for the direct and indirect costs of graduate medical education during the period of the consortium's participation in the demonstration project.

(2) DESIGNATION OF RESIDENTS BY CONSORTIUM.—Each consortium participating in a demonstration project shall designate for each resident assigned to the consortium a hospital operating an approved medical residency training program for purposes of enabling the Secretary to calculate the amount paid to the consortium under paragraph (1)(A). Such hospital shall be the hospital where the resident receives the majority of the resident's hospital-based, nonambulatory training experience.

(3) LIMIT ON PAYMENT.—The amount paid to a consortium under paragraph (1)(A) during a year may not exceed the Secretary's estimate of the sum of the payments that would have been made under title XVIII to each member of the consortium during the year but for the application of this section, determined as if such payments were based on—

(A) the number of full-time-equivalent residents in approved medical residency training programs of the member calculated under section 1886(h)(4) of the Social Security Act during the academic year beginning July 1, 1993; and

(B) the ratio of the member's full-time equivalent interns and residents to beds applicable under section 1886(d)(5)(B)(ii) of such Act for discharges occurring during the 12-month cost reporting period beginning or after July 1, 1993.

(d) DURATION.—A demonstration project under this section shall be conducted for a period not to exceed 10 years. The Secretary may terminate a project if the Secretary determines that the consortium participating in the project is not in substantial compliance with the terms of the application approved by the Secretary.

(e) EVALUATIONS AND REPORTS.—

(1) EVALUATIONS.—Each consortium participating in a demonstration project shall submit to the Secretary a final evaluation within 360 days of the termination of the consortium's participation and such interim evaluations as the Secretary may require.

(2) REPORTS TO CONGRESS.—Not later than 360 days after the first demonstration project under this section begins, and annually thereafter for each year in which such a project is conducted, the Secretary shall submit a report to Congress which evaluates the effectiveness of the consortium activities conducted under such projects and includes any legislative recommendations determined appropriate by the Secretary.

(f) DEFINITIONS.—In this section:

(1) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—The term "approved medical residency training program" has the meaning given such term in section 1886(h)(5)(A) of the Social Security Act.

(2) HEALTH CARE TRAINING CONSORTIUM.—The term "health care training consortium" means a State, regional, or local entity consisting of at least 2 hospitals operating approved medical residency training programs.

(3) RESIDENT.—The term "resident" has the meaning given such term in section 1886(h)(5)(H) of the Social Security Act.

SEC. 8315. STUDY OF PAYMENTS FOR MEDICAL EDUCATION AT SITES OTHER THAN HOSPITALS.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the feasibility and desirability of making payments to facilities, from sources including the Health Care Workforce Trust Fund under title VII and the Trust Funds established under title XVIII of the Social Security Act, that are not hospitals for the direct and indirect costs of graduate medical edu-

cation attributable to residents trained at such facilities. In conducting the study, the Secretary shall evaluate new payment methodologies—

(1) under which each entity which incurs costs of graduate medical education shall receive reimbursement for such costs; and

(2) which would encourage the training of primary care physicians.

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

PART 3—ASSISTANCE FOR PROVIDERS SERVING LOW-INCOME AND UNDERSERVED POPULATIONS

SEC. 8321. INCREASE IN PAYMENTS FOR FEDERALLY QUALIFIED HEALTH CENTERS.

(a) IN GENERAL.—Section 1833(a)(3) (42 U.S.C. 1395l(a)(3)) is amended by inserting after "1861(v)(1)(A)," the following: "and, in the case of services described in subparagraph (D)(ii) of such section, which include any costs associated with participation in an approved medical residency training program (as defined in section 1886(h)(5)(A)) as determined based on the portion of time spent by a resident or intern at the center and adjusted by a factor reflecting the relative indirect and direct costs of such participation,".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to costs incurred on or after January 1, 1996.

SEC. 8322. CHANGES IN UNDERSERVED AREA BONUS PAYMENTS.

(a) INCREASE IN AMOUNT OF PAYMENT FOR PRIMARY CARE SERVICES.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended—

(A) by striking "10 percent" and inserting "a percent",

(B) by striking "service" the last place it appears and inserting "services", and

(C) by adding the following new sentence: "The percent referred to in the previous sentence is 20 percent in the case of primary care services, as defined in section 1842(i)(4), and 10 percent for services other than primary care services furnished in health professional shortage areas located in rural areas as defined in section 1886(d)(2)(D).".

(b) EXTENSION TO SERVICES FURNISHED IN AREAS LOSING DESIGNATION.—Section 1833(m) of such Act (42 U.S.C. 1395l(m)) is amended by striking "area," and inserting "area (or was designated as such an area at any time during the 36-month period ending on the date the services are furnished),".

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to services furnished on or after January 1, 1998.

SEC. 8323. ESSENTIAL ACCESS COMMUNITY HOSPITALS.

(a) INCREASING NUMBER OF PARTICIPATING STATES.—Section 1820(a)(1) of the Social Security Act (42 U.S.C. 1395i–4(a)(1)) is amended by striking "not more than 7".

(b) TREATMENT OF INPATIENT HOSPITAL SERVICES PROVIDED IN RURAL PRIMARY CARE HOSPITALS.—

(1) IN GENERAL.—Section 1820(f)(1)(F) of such Act (42 U.S.C. 1395i–4(f)(1)(F)) is amended to read as follows:

"(F) subject to paragraph (4), provides not more than 6 inpatient beds (meeting such conditions as the Secretary may establish) for providing inpatient care to patients requiring stabilization before discharge or transfer to a hos-

pital, except that the facility may not provide any inpatient hospital services—

"(i) to any patient whose attending physician does not certify that the patient may reasonably be expected to be discharged or transferred to a hospital within 72 hours of admission to the facility; or

"(ii) consisting of surgery or any other service requiring the use of general anesthesia (other than surgical procedures specified by the Secretary under section 1833(i)(1)(A)), unless the attending physician certifies that the risk associated with transferring the patient to a hospital for such services outweighs the benefits of transferring the patient to a hospital for such services.".

(2) LIMITATION ON AVERAGE LENGTH OF STAY.—Section 1820(f) of such Act (42 U.S.C. 1395i–4(f)) is amended by adding at the end the following new paragraph:

"(4) LIMITATION ON AVERAGE LENGTH OF INPATIENT STAYS.—The Secretary may terminate a designation of a rural primary care hospital under paragraph (1) if the Secretary finds that the average length of stay for inpatients at the facility during the previous year in which the designation was in effect exceeded 72 hours. In determining the compliance of a facility with the requirement of the previous sentence, there shall not be taken into account periods of stay of inpatients in excess of 72 hours to the extent such periods exceed 72 hours because transfer to a hospital is precluded because of inclement weather or other emergency conditions.".

(3) CONFORMING AMENDMENT.—Section 1814(a)(8) of such Act (42 U.S.C. 1395f(a)(8)) is amended by striking "such services" and all that follows and inserting "the individual may reasonably be expected to be discharged or transferred to a hospital within 72 hours after admission to the rural primary care hospital.".

(4) GAO REPORTS.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General shall submit reports to Congress on—

(A) the application of the requirements under section 1820(f) of the Social Security Act (as amended by this subsection) that rural primary care hospitals provide inpatient care only to those individuals whose attending physicians certify may reasonably be expected to be discharged within 72 hours after admission and maintain an average length of inpatient stay during a year that does not exceed 72 hours; and

(B) the extent to which such requirements have resulted in such hospitals providing inpatient care beyond their capabilities or have limited the ability of such hospitals to provide needed services.

(c) DESIGNATION OF HOSPITALS.—

(1) PERMITTING DESIGNATION OF HOSPITALS LOCATED IN URBAN AREAS.—

(A) IN GENERAL.—Section 1820 of such Act (42 U.S.C. 1395i–4) is amended—

(i) by amending paragraph (1) of subsection (e) to read as follows:

"(1) is participating in a rural health network that includes at least one rural primary care hospital designated by the State under subsection (f);";

(ii) in subsection (e)(2)(A)—

(I) by striking "is located" and inserting "except in the case of a hospital located in an urban area, is located",

(II) by striking ", (ii)" and inserting "or (ii)", and

(III) by striking "or (iii)" and all that follows through "section."; and

(iii) in subsection (i)(1)(B), by striking "paragraph (3)" and inserting "paragraph (2)".

(B) NO CHANGE IN MEDICARE PROSPECTIVE PAYMENT.—Section 1886(d)(5)(D) of such Act (42 U.S.C. 1395ww(d)(5)(D)) is amended—

(i) in clause (iii)(III), by inserting "located in a rural area and" after "that is", and

(ii) in clause (v), by inserting "located in a rural area and" after "in the case of a hospital".

(2) PERMITTING HOSPITALS LOCATED IN ADJOINING STATES TO PARTICIPATE IN STATE PROGRAM.—

(A) IN GENERAL.—Section 1820 of such Act (42 U.S.C. 1395i–4) is amended—

(i) by redesignating subsection (k) as subsection (l); and

(ii) by inserting after subsection (j) the following new subsection:

"(k) ELIGIBILITY OF HOSPITALS NOT LOCATED IN PARTICIPATING STATES.—Notwithstanding any other provision of this section—

"(1) for purposes of including a hospital or facility as a member institution of a rural health network, a State may designate a hospital or facility that is not located in the State as an essential access community hospital or a rural primary care hospital if the hospital or facility is located in an adjoining State and is otherwise eligible for designation as such a hospital;

"(2) the Secretary may designate a hospital or facility that is not located in a State receiving a grant under subsection (a)(1) as an essential access community hospital or a rural primary care hospital if the hospital or facility is a member institution of a rural health network of a State receiving a grant under such subsection; and

"(3) a hospital or facility designated pursuant to this subsection shall be eligible to receive a grant under subsection (a)(2).".

(B) CONFORMING AMENDMENTS.—(i) Section 1820(c)(1) of such Act (42 U.S.C. 1395i–4(c)(1)) is amended by striking "paragraph (3)" and inserting "paragraph (3) or subsection (k)".

(ii) Paragraphs (1)(A) and (2)(A) of section 1820(i) of such Act (42 U.S.C. 1395i–4(i)) are each amended—

(I) in clause (i), by striking "(a)(1)" and inserting "(a)(1) (except as provided in subsection (k))", and

(II) in clause (ii), by striking "subparagraph (B)" and inserting "subparagraph (B) or subsection (k)".

[*New*] (3) ELIGIBILITY OF INDIAN HEALTH SERVICE FACILITIES FOR DESIGNATION AS RURAL PRIMARY CARE HOSPITALS.—Section 1820(i)(2) (42 U.S.C. 1395i–4(i)(2)) is amended by adding at the end the following new subparagraph:

"(D) The Secretary may designate a [facility of the Indian Health Service] as a rural primary care hospital under this section if the facility meets the requirements applicable to a hospital described in subparagraph (C) and elects to be treated as such a hospital under this title. No facility designated by the Secretary under this subparagraph shall be taken into account under subparagraph (C) in determining the number of hospitals designated by the Secretary under this paragraph.".

(d) SKILLED NURSING SERVICES IN RURAL PRIMARY CARE HOSPITALS.—Section 1820(f)(3) (42 U.S.C. 1395i–4(f)(3)) is amended by striking "because the facility" and all that follows and inserting the following: "because, at the time the facility applies to the State for designation as a rural primary care hospital, there is in effect an agreement between the facility and the Secretary under section

1883 under which the facility's inpatient hospital facilities are used for the furnishing of extended care services, except that the number of beds used for the furnishing of such services may not exceed the total number of licensed inpatient beds at the time the facility applies to the State for such designation (minus the number of inpatient beds used for providing inpatient care pursuant to paragraph (1)(F)). For purposes of the previous sentence, the number of beds of the facility used for the furnishing of extended care services shall not include any beds of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the State for designation as a rural primary care hospital.".

(e) DEADLINE FOR DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—Section 1814(l)(2) of such Act (42 U.S.C. 1395f(l)(2)) is amended by striking "January 1, 1993" and inserting "January 1, 1996".

(f) PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(1) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Section 1834(g) of such Act (42 U.S.C. 1395m(g)) is amended—

(A) in paragraph (1), by striking "during a year before 1993" and inserting "during a year before the prospective payment system described in paragraph (2) is in effect"; and

(B) in paragraph (2), by striking "January 1, 1993," and inserting "January 1, 1996,".

(2) NO USE OF CUSTOMARY CHARGE IN DETERMINING PAYMENT.—Section 1834(g)(1) of such Act (42 U.S.C. 1395m(g)(1)) is amended by adding at the end the following new flush sentence:

"The amount of payment shall be determined under either method without regard to the amount of the customary or other charge.".

(g) REQUIREMENTS RELATING TO RURAL HEALTH CARE PLAN.—

(1) IN GENERAL.—Section 1820(b)(1)(A) of such Act (42 U.S.C. 1395i-4(b)(1)(A)) is amended—

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

(B) by striking the semicolon at the end of clause (iv) and inserting ", and"; and

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

"(v) meets such other requirements as the Secretary may establish regarding the quality and effectiveness of such plans;".

(2) TECHNICAL ASSISTANCE.—At the request of a State submitting an application for a grant under section 1820 of the Social Security Act, the Secretary of Health and Human Services shall provide technical assistance to the State for the development of the State's rural health care plan described in section 1820(b)(1) of such Act.

(h) SERVICE AREA OF FACILITIES INCLUDED IN RURAL HEALTH NETWORKS.—Section 1820(g) of such Act (42 U.S.C. 1395i-4(g)) is amended—

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

(2) by striking the period at the end of paragraph (2) and inserting ", and"; and

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

"(3) the members of which provide services in the same general geographic area (in accordance with criteria established by the Secretary).".

(i) PAYMENT FOR SERVICES OF ESSENTIAL ACCESS COMMUNITY HOSPITALS.—

(1) REPEAL OF CATEGORICAL TREATMENT AS SOLE COMMUNITY HOSPITAL.—Section 1886(d)(5)(D)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(D)(iii)) is amended—

(A) by adding "or" at the end of subclause (I);

(B) by striking "or" at the end of subclause (II); and

(C) by striking subclause (III).

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to discharges occurring on or after October 1, 1996.

(3) REPORT ON APPROPRIATE PAYMENT METHODOLOGY.—Not later than September 1, 1995, the Prospective Payment Assessment Commission shall submit a report to Congress recommending appropriate adjustments in the methodology used to determine the amounts paid to essential access community hospitals for the operating costs of inpatient hospital services under part A of the medicare program to take into account the special needs of such hospitals.

(j) CLARIFICATION OF PHYSICIAN STAFFING REQUIREMENT FOR RURAL PRIMARY CARE HOSPITALS.—Section 1820(f)(1)(H) of such Act (42 U.S.C. 1395i–4(f)(1)(H)) is amended by striking the period and inserting the following: ", except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).".

(k) TECHNICAL AMENDMENTS RELATING TO PART A DEDUCTIBLE, COINSURANCE, AND SPELL OF ILLNESS.—(1) Section 1812(a)(1) of such Act (42 U.S.C. 1395d(a)(1)) is amended—

(A) by striking "inpatient hospital services" the first place it appears and inserting "inpatient hospital services or inpatient rural primary care hospital services";

(B) by striking "inpatient hospital services" the second place it appears and inserting "such services"; and

(C) by striking "and inpatient rural primary care hospital services".

(2) Sections 1813(a) and 1813(b)(3)(A) of such Act (42 U.S.C. 1395e(a), 1395e(b)(3)(A)) are each amended by striking "inpatient hospital services" each place it appears and inserting "inpatient hospital services or inpatient rural primary care hospital services".

(3) Section 1813(b)(3)(B) of such Act (42 U.S.C. 1395e(b)(3)(B)) is amended by striking "inpatient hospital services" and inserting "inpatient hospital services, inpatient rural primary care hospital services".

(4) Section 1861(a) of such Act (42 U.S.C. 1395x(a)) is amended—

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

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

(l) AUTHORIZATION OF APPROPRIATIONS.—Section 1820(l) of such Act (42 U.S.C. 1395i–4(l)), as redesignated by subsection (c)(2)(A), is amended by striking "Trust Fund" and all that follows and inserting the following: "Trust Fund—

"(1) for each of the fiscal years 1990 through 1994—

"(A) $10,000,000 for grants to States under subsection (a)(1), and

"(B) $15,000,000 for grants to hospitals, facilities, and consortia under subsection (a)(2); and

"(2) for each of the fiscal years 1995 through 1999—

"(A) $50,000,000 for grants to States under subsection (a)(1), and

"(B) $40,000,000 for grants to hospitals, facilities, and consortia under subsection (a)(2).".

(m) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 8324. MEDICARE TELEMEDICINE PILOT PROJECTS.

(a) ESTABLISHMENT OF PROJECT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall establish not more than 10 pilot projects to in-

vestigate over a 3-year period the effectiveness of the use of rural health care provider telemedicine networks to provide coverage of physician consultative services provided with respect to the provision of other services under part B of the medicare program in rural areas.

(2) NETWORKS DEFINED.—In this section, the term "rural health care provider telemedicine network" (hereafter referred to as a "network") means a network of providers that meets the following requirements:

(A) The network serves physicians, clinics (including rural health clinics described in section 1861(aa)(2) of the Social Security Act), and other non-tertiary care providers in a rural area who have entered into agreements with a multi-specialty tertiary care provider who has agreed to provide physician consultative services (without regard to whether or not such tertiary care provider is in the rural area) regarding patient referral and transfer, the use of joint communications systems, and the provision of emergency and non-emergency transportation among the network members.

(B) The area in which the network operates is a rural area designated as a health professional shortage area (under section 332(a) of the Public Health Service Act) or is an underserved rural area in accordance with such other criteria as the Secretary may specify.

(b) MEDICARE PAYMENT FOR PARTICIPANTS.—

(1) IN GENERAL.—Under the projects established under this section, the Secretary shall make payments from the Federal Supplementary Medical Insurance Trust Fund under part B of title XVIII of the Social Security Act in accordance with the methodology described in paragraph (2) for physicians' consultation services provided by the tertiary care services consisting of a professional consultation to an individual or entity in the network furnishing a service for which payment may be made under such part to a medicare beneficiary in a rural area, notwithstanding that the individual providing the professional consultation is not at the same location as the individual furnishing the service to the medicare beneficiary.

(2) METHODOLOGY FOR DETERMINING AMOUNT OF PAYMENTS.—Taking into account the amount of funds available for payments under the project, the Secretary shall establish a methodology for determining the amount of payments made under paragraph (1), and shall include in the methodology a method for making payment for reasonable costs incurred in the usage of signal transmission facilities suitable for the conduct of physician consultative services.

(c) ELIGIBILITY OF NETWORKS.—

(1) IN GENERAL.—A network is eligible to participate in a pilot project under this section if—

(A) the network submits to the Secretary (at such time and in such form as the Secretary may require) an application containing—

(i) information and assurances that the members of the network have entered into such agreements as are necessary to operate the network,

(ii) information and assurances that the network has available the appropriate technology for providing remote consultations, and

(iii) such other information and assurances as the Secretary may require; and

(B) the network agrees to submit to the Secretary such information as the Secretary may require to determine the amount of payments described in subsection (b)(2), to prepare reports under subsection (e), and to otherwise carry out the project.

(2) RURAL AREA DEFINED.—In this section, the term "rural area" has the meaning given such term in section 1886(d)(2)(D) of the Social Security Act.

(d) CRITERIA FOR SELECTING PARTICIPANTS.—

(1) TECHNOLOGY APPLIED.—In selecting among eligible networks for participation in pilot projects under this section, the Secretary shall give priority to networks that provide for consultations between patients and medical specialists involving transmission of detailed data on the patient in a manner that serves as a reasonable substitute for in-person interaction between the patients and the specialists.

(2) PERMITTING EXISTING NETWORKS TO PARTICIPATE.—Nothing in this section may be construed to prohibit the Secretary from selecting a network operating at the time of the establishment of the pilot projects for participation in the project.

(e) REPORTS.—

(1) INTERIM REPORT ON PARTICIPATING SITES.—Not later than 24 months after the Secretary first makes payment under subsection (b) for services under a pilot project, the Secretary shall submit a report to Congress describing the projects and the networks participating in the projects under this section, including a description of the amounts expended and the number of patients served under the projects;

(2) FINAL.—Not later than 1 year after the termination of the projects, the Secretary shall submit a final report to Congress describing the operation of the projects and containing—

(A) the Secretary's analysis of the projects' cost-effectiveness and success in promoting the access of providers of health care services in rural areas to consultation services of specialist physicians;

(B) the Secretary's analysis of the impact of the projects on the ability of patients to obtain a higher quality and greater range of care; and

(C) such recommendations as the Secretary considers appropriate for changes in the medicare program relating to telemedicine, including estimates of the costs associated with any such changes.

(f) LIMITATION ON AMOUNT EXPENDED UNDER PROJECTS.—The total amount expended from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act for services under the demonstration project under this section may not exceed $25,000,000.

SEC. 8325. TREATMENT OF OTHER INDIAN FACILITIES AS INDIAN HEALTH SERVICE FACILITIES.

(a) IN GENERAL.—Section 1880(a) (42 U.S.C. 1395qq(a)) is amended by striking "facility of the Indian Health Service, whether operated by such service" and inserting "facility operated by the Indian Health Service".

(b) CLARIFICATION OF COVERAGE OF HOSPITAL OUTPATIENT SERVICES.—Section 1880(a) (42 U.S.C. 1395qq(a)) is amended by inserting "(including payments for services described in section 1832(a)(2)(B))" after "under this title".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to portions of cost reporting periods beginning on or after January 1, 1999.

PART 4—APPLICATION OF QUALITY MANAGEMENT AND ADMINISTRATIVE REFORM UNDER GUARANTEED HEALTH INSURANCE ACT OF 1994

SEC. 8331. INTEGRATION OF MEDICARE INTO NATIONAL QUALITY MANAGEMENT PROGRAM.

Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a detailed proposal for

legislation to provide for the integration of the medicare program into the National Quality Management Program through—

(1) the incorporation of information provided by medicare beneficiaries into the consumer surveys described in section 9002;

(2) the incorporation of information on the quality of services provided under the medicare program, as measured by the national measures of quality performance established under section 9003, into the performance reports described in section 9003(g);

(3) the transfer to approved quality improvement organizations, on a State-by-State basis over a 5-year period, of functions being performed by both approved quality improvement organizations and utilization and quality control peer review organizations entering into contracts with the Secretary under part B of title XI of the Social Security Act (without regard to whether the organizations with contracts under such part perform such functions on a multi-State basis); and

(4) the retention by such peer review organizations of functions the organizations are required to perform under such Act that do not overlap with functions that are required to be performed by approved quality improvement organizations under this part.

SEC. 8332. COORDINATION OF MEDICARE CARDS WITH HEALTH SECURITY CARDS.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1804 the following new section:

"COORDINATION OF CARDS

"SEC. 1805. In issuing identification cards for individuals entitled to benefits under this title, the Secretary shall assure that such cards conform to the standards established for health security cards under section 9101(c) of the Guaranteed Health Insurance Act of 1994."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect January 1, 1997.

SEC. 8333. ELIMINATION OF MEDICARE AND MEDICAID COVERAGE DATA BANK.

Effective upon full implementation of the national enrollment verification system under section 9102—

(1) no employer is required to make any reports under section 1144(c) of the Social Security Act; and

(2) information and functions previously in or performed by the Medicare and Medicaid Coverage Data Bank under section 1144 of such Act shall be subsumed by the enrollment verification system.

SEC. 8334. REQUIREMENT FOR UNIFORM HOSPITAL COST REPORTING.

(a) IN GENERAL.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (P), by striking "and" at the end;

(2) by striking the period at the end of subparagraph (Q) and inserting ", and"; and

(3) by inserting after subparagraph (Q) the following:

"(R) in the case of a hospital or a rural primary care hospital, to report information in a uniform manner consistent with standards established by the Secretary to carry out section 4007(c) of the Omnibus Budget Reconciliation Act of 1987 and in an electronic form, consistent with standards established by the Secretary.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to cost reporting periods beginning on or after October 1, 1994.

SEC. 8335. APPLICATION OF HEALTH INFORMATION AND INFORMATION TRANSACTION REQUIREMENTS TO FISCAL INTERMEDIARIES AND CARRIERS.

(a) FISCAL INTERMEDIARIES UNDER PART A.—Section 1816(f) (42 U.S.C. 1395h(f)) is amended by adding at the end the following new paragraph:

"(3) The standards and criteria under paragraph (1) shall include requirements that the agency or organization meet the following requirements applicable under subtitle B of title IX of the Guaranteed Health Insurance Act of 1994 to a sponsor of an administered health plan:

"(A) Health information standards under section 9103 of such Act.

"(B) Standards relating to transactions and information under section 9104 of such Act.

"(C) Standards relating to the acceptance of claims and attachments and limitations on other transactions under section 9105 of such Act.".

(b) CARRIERS UNDER PART B.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended by adding at the end the following new paragraph:

"(4) Each contract under this section shall include requirements that the carrier meet the following requirements applicable under subtitle B of title IX of the Guaranteed Health Insurance Act of 1994 to a sponsor of an administered health plan:

"(A) Health information standards under section 9103 of such Act.

"(B) Standards relating to transactions and information under section 9104 of such Act.

"(C) Standards relating to the acceptance of claims and attachments and limitations on other transactions under section 9105 of such Act.".

SEC. 8336. APPLICATION OF RESTRICTIONS ON DISCLOSURE AND USE OF HEALTH INFORMATION.

Part A of title XI (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new section:

"RESTRICTIONS ON DISCLOSURE OF HEALTH INFORMATION

"SEC. 1145. The provisions of subtitle C of title IX of the Guaranteed Health Insurance Act of 1994 shall apply with respect to health information relating to individuals entitled to benefits under part A of title XVIII in the same manner as such provisions apply with respect to health information relating to other individuals under such subtitle.".

PART 5—AMENDMENTS TO ANTI-FRAUD AND ABUSE PROVISIONS

SEC. 8341. ANTI-KICKBACK STATUTORY PROVISIONS.

(a) REVISION TO PENALTIES.—

(1) PERMITTING SECRETARY TO IMPOSE CIVIL MONETARY PENALTY.—Section 1128A(a) (42 U.S.C. 1320a-7a(a)) is amended—

(A) by striking "or" at the end of paragraphs (1) and (2);

(B) by striking the semicolon at the end of paragraph (3) and inserting "; or"; and

(C) by inserting after paragraph (3) the following new paragraph:

"(4) carries out any activity in violation of paragraph (1) or (2) of section 1128B(b);".

(2) DESCRIPTION OF CIVIL MONETARY PENALTY APPLICABLE.—Section 1128A(a) (42 U.S.C. 1320a-7a(a)) is amended—

(A) by striking "given)." at the end of the first sentence and inserting the following: "given or, in cases under paragraph (4), $50,000 for each such violation)."; and

(B) by striking "claim." at the end of the second sentence and inserting the following: "claim (or, in cases under paragraph (4), damages of not more than three times the total amount of remuneration offered, paid, solicited, or received.".

(3) INCREASE IN CRIMINAL PENALTY.—Paragraphs (1) and (2) of section 1128B(b) (42 U.S.C. 1320a-7b(b)) are each amended—

(A) by striking "$25,000" and inserting "$50,000"; and

(B) by striking the period at the end and inserting the following: ", and shall be subject to damages of not more than three times the total remuneration offered, paid, solicited, or received.".

(b) REVISIONS TO EXCEPTIONS.—

(1) EXCEPTION FOR DISCOUNTS.—Section 1128B(b)(3)(A) (42 U.S.C. 1320a-7b(b)(3)(A)) is amended by striking "program;" and inserting "program and is not in the form of a cash payment;".

(2) EXCEPTION FOR PAYMENTS TO EMPLOYEES.—Section 1128B(b)(3)(B) (42 U.S.C. 1320a-7b(b)(3)(B)) is amended by inserting at the end "if the amount of remuneration under the arrangement is consistent with the fair market value of the services and is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals, except that such employee can be paid remuneration in the form of a productivity bonus based on services personally performed by the employee.".

(3) EXCEPTION FOR WAIVER OF COINSURANCE BY CERTAIN PROVIDERS.—Section 1128B(b)(3)(D) (42 U.S.C. 1320a-7b(b)(3)(D)) is amended to read as follows:

"(D) a waiver or reduction of any coinsurance or other copayment if—

"(i) the waiver or reduction is made pursuant to a public schedule of discounts which the person is obligated as a matter of law to apply to certain individuals,

"(ii) the waiver or reduction is made pursuant to an established program and applies to a defined group of individuals whose incomes do not exceed 150 percent (or such higher percentage as the Secretary may permit) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved,

"(iii) the waiver or reduction of coinsurance is not offered as part of any advertisement or solicitation and the person offering the waiver or reduction determines in good faith that the individual is in financial need,

"(iv) the person offering the waiver or reduction fails to collect the coinsurance or other payment after making reasonable collection efforts, or

"(v) the waiver or reduction of coinsurance is in accordance with a cost sharing schedule or a supplemental benefit package which may be offered by a managed care plan under title XXII; and".

(4) NEW EXCEPTION FOR CAPITATED PAYMENTS.—Section 1128B(b)(3) (42 U.S.C. 1320a-7b(b)(3)) is amended—

(A) by striking "and" at the end of subparagraph (D);

(B) by striking the period at the end of subparagraph (E) and inserting "; and"; and

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

"(F) any reduction in cost sharing or increased benefits given to an individual, any amounts paid to a provider for an item or service furnished to an individual, or any discount or reduction in price given by the provider for such an item or

service, if the individual is enrolled with and such item or service is covered under any of the following:

"(i) A health plan which is furnishing items or services under a risk-sharing contract under section 1876 or section 1903(m).

"(ii) A health plan receiving payments on a prepaid basis, under a demonstration project under section 402(a) of the Social Security Amendments of 1967 or under section 222(a) of the Social Security Amendments of 1972; and

"(G) any amounts paid to a provider for an item or service furnished to an individual or any discount or reduction in price given by the provider for such an item or service, if the individual is enrolled with and such item or service is covered under a health plan under which the provider furnishing the item or service is paid by the health plan for furnishing the item or service only on a capitated basis pursuant to a written arrangement between the plan and the provider in which the provider assumes financial risk for furnishing the item or service.".

(c) AUTHORIZATION FOR THE SECRETARY TO ISSUE REGULATIONS.—Section 1128B(b) (42 U.S.C. 1320a–7b(b)) is amended by adding at the end the following new paragraph:

"(4) The Secretary is authorized to impose by regulation such other requirements as needed to protect against program or patient abuse with respect to any of the exceptions described in paragraph (3).".

(d) CLARIFICATION OF OTHER ELEMENTS OF OFFENSE.—Section 1128B(b) (42 U.S.C. 1320a–7b(b)) is amended—

(1) in paragraph (1)(A), by striking "in return for referring" and inserting "to refer";

(2) in paragraph (1)(B), by striking "in return for purchasing, leasing, ordering, or arranging for or recommending" and inserting "to purchase, lease, order, or arrange for or recommend"; and

(3) by adding at the end of paragraphs (1) and (2) the following sentence: "A violation exists under this paragraph if one or more purposes of the remuneration is unlawful under this paragraph.".

SEC. 8342. CIVIL MONEY PENALTIES.

(a) PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER PLANS.—

(1) OFFER OF REMUNERATION.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by section 8341(a)(1), is amended—

(A) by striking "; or" at the end of paragraph (3) and inserting a semicolon;

(B) by striking the semicolon at the end of paragraph (4) and inserting "; or"; and

(C) by inserting after paragraph (4) the following new paragraph:

"(5) offers, pays, or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program, other than to influence an individual enrolled in a managed care plan or a point-of-service plan (as defined in section 2204) to receive benefits under the plan in accordance with established practice patterns for the delivery of medically necessary services;".

(2) REMUNERATION DEFINED.—Section 1128A(i) of such Act (42 U.S.C. 1320a–7a(i)) is amended by adding at the end the following new paragraph:

"(6) The term 'remuneration' includes the waiver or reduction of coinsurance amounts, and transfers of items or services for free or for other than fair market value, except that such term does not include the waiver or reduction of coinsurance amounts by a person or entity, if—

"(A) the waiver or reduction is made pursuant to a public schedule of discounts which the person is obligated as a matter of law to apply to certain individuals,

"(B) the waiver or reduction is made pursuant to an established program and applies to a defined group of individuals whose incomes do not exceed 150 percent (or such higher percentage as the Secretary may permit) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved,

"(C) the waiver or reduction of coinsurance is not offered as part of any advertisement or solicitation and the person offering the waiver or reduction determines in good faith that the individual is in financial need,

"(D) the person offering the waiver or reduction fails to collect the coinsurance or other payment after making reasonable collection efforts, or

"(E) the waiver or reduction of coinsurance is in accordance with a cost sharing schedule or a supplemental benefit package which may be offered by a managed care plan under title XXII.".

(b) ADDITIONAL OFFENSES.—Section 1128A(a) of such Act, as amended by section 8341(a)(1) and subsection (a)(1), is further amended—

(1) by striking "or" at the end of paragraph (4);

(2) by striking the semicolon at the end of paragraph (5) and inserting "; or"; and

(3) by inserting after paragraph (5) the following new paragraphs:

"(6) engages in a practice which has the effect of limiting or discouraging (as compared to other plan enrollees) the utilization of medically necessary health care services covered by law or under the service contract by title XIX or other publicly subsidized patients, including but not limited to differential standards for the location and hours of service offered by providers participating in the plan;

"(7) substantially fails to cooperate with a quality assurance program or a utilization review activity;

"(8) engaging in a pattern of failing substantially to provide or authorize medically necessary items and services that are required to be provided to an individual covered under a health plan under the Guaranteed Health Insurance Act of 1994 or public program for the delivery of or payment for health care items or services, if the failure has adversely affected (or had a substantial likelihood of adversely affecting) the individual; or

"(9) submits false or fraudulent statements, data or information on claims to the Secretary, a State health care agency, or any other Federal, State or local agency charged with implementation or oversight of a health plan or a public program that the person knows or should know is fraudulent;".

(c) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) (42 U.S.C. 1320a-7a(a)), as amended by section 8341(a), subsection (a)(1), and subsection (b), is amended in the matter following paragraph (9)—

(1) by striking "$2,000" and inserting "$10,000";

(2) by inserting after "under paragraph (4), $50,000 for each such violation" the following: "; in cases under paragraph (5), $10,000 for each such offer, payment, or transfer; in cases

under paragraphs (6) through (9), an amount not to exceed $10,000 for each such determination by the Secretary"; and

(3) by striking "twice the amount" and inserting "three times the amount".

(d) INTEREST ON PENALTIES.—Section 1128A(f) (42 U.S.C. 1320a–7a(f)) is amended by adding after the first sentence the following: "Interest shall accrue on the penalties and assessments imposed by a final determination of the Secretary in accordance with an annual rate established by the Secretary under the Federal Claims Collection Act. The rate of interest charged shall be the rate in effect on the date the determination becomes final and shall remain fixed at that rate until the entire amount due is paid. In addition, the Secretary is authorized to recover the costs of collection in any case where the penalties and assessments are not paid within 30 days after the determination becomes final, or in the case of a compromised amount, where payments are more than 90 days past due. In lieu of actual costs, the Secretary is authorized to impose a charge of up to 10 percent of the amount of penalties and assessments owed to cover the costs of collection.".

(e) AUTHORIZATION TO ACT.—

(1) IN GENERAL.—The first sentence of section 1128A(c)(1) (42 U.S.C. 1320a–7a(c)(1)) is amended by striking all that follows "(b)" and inserting the following: "unless, within one year after the date the Secretary presents a case to the Attorney General for consideration, the Attorney General brings an action in a district court of the United States.".

(2) EFFECTIVE DATE.—The amendment made by this paragraph (1) shall apply to cases presented by the Secretary of Health and Human Services for consideration on or after the date of the enactment of this Act.

(f) DEPOSIT OF PENALTIES COLLECTED INTO ALL-PAYER ACCOUNT.—Section 1128A(f)(3) (42 U.S.C. 1320a–7a(f)(3)) is amended by striking "as miscellaneous receipts of the Treasury of the United States" and inserting "in the All-Payer Health Care Fraud and Abuse Control Account established under section [9212] of Guaranteed Health Insurance Act of 1994".

(g) CLARIFICATION OF PENALTY IMPOSED ON EXCLUDED PROVIDER FURNISHING SERVICES.—Section 1128A(a)(1)(D) (42 U.S.C. 1320a–7a(a)(1)(D)) is amended by inserting "who furnished the service" after "in which the person".

SEC. 8343. AMENDMENTS TO EXCLUSIONARY PROVISIONS IN FRAUD AND ABUSE PROGRAM.

(a) MANDATORY EXCLUSION OF INDIVIDUAL CONVICTED OF CRIMINAL OFFENSE RELATED TO HEALTH CARE FRAUD.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a–7(a)) is amended by adding at the end the following new paragraph:

"(3) FELONY CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted under Federal or State law, in connection with the delivery of a health care item or service on or after January 1, 1996, or with respect to any act or omission on or after such date in a program operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.".

(2) CONFORMING AMENDMENT.—Section 1128(b)(1) (42 U.S.C. 1320a–7(b)(1)) is amended—

(A) in the heading, by striking "CONVICTION" and inserting "MISDEMEANOR CONVICTION"; and

(B) by striking "criminal offense" and inserting "criminal offense consisting of a misdemeanor".

(b) ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.—

(1) IN GENERAL.—Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

"(D) In the case of an exclusion of an individual or entity under paragraphs (1), (2), or (3) of subsection (b), the period of exclusion shall be a minimum of 3 years, unless the Secretary determines that an alternative period is appropriate because of aggravating or mitigating circumstances.

"(E) In the case of an exclusion of an individual or entity under paragraph (4) or (5) of subsection (b), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

"(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.".

(2) CONFORMING AMENDMENT.—Section 1128(c)(3)(A) (42 U.S.C. 1320a–7(c)(3)(A)) is amended by striking "subsection (b)(12)" and inserting "paragraph (1), (2), (3), (4), (6)(B), or (12) of subsection (b)".

(c) FAILURE TO PROVIDE INFORMATION AS GROUNDS FOR PERMISSIVE EXCLUSION UNDER MEDICARE AND MEDICAID.—Section 1128(b)(9) (42 U.S.C. 1320a–7(b)(9)) is amended by striking the period at the end and inserting ", or provide any information requested by the Attorney General or the Inspector General of the Department of Health and Human Services to carry out the All-Payer Health Care Fraud and Abuse Control Program established under section [9211] of the Guaranteed Health Insurance Act of 1994.";

SEC. 8344. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS RELATING TO QUALITY OF CARE.

(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) (42 U.S.C. 1320c-5(b)(1)) is amended by striking "may prescribe)" and inserting "may prescribe, except that such period may not be less than one year)".

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) (42 U.S.C. 1320c-5(b)(2)) is amended by striking "shall remain" and inserting "shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain".

(b) AMOUNT OF CIVIL MONEY PENALTY.—Section 1156(b)(3) (42 U.S.C. 1320c-5(b)(3)) is amended by striking "the actual or estimated cost" and inserting the following: "$10,000 for each instance".

(c) REPEAL OF "UNWILLING OR UNABLE" CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) (42 U.S.C. 1320c-5(b)(1)) is amended—

(1) in the second sentence, by striking "and determines" and all that follows through "such obligations," and

(2) by striking the third sentence.

SEC. 8345. REVISIONS TO CRIMINAL PENALTIES.

(a) TREBLE DAMAGES FOR CRIMINAL SANCTIONS.—Section 1128B (42 U.S.C. 1320a–7b) is amended by adding at the end the following new subsection:

"(f) In addition to the fines that may be imposed under subsection (a) or (c) any individual found to have violated the provisions of any of such subsections may be subject to treble damages.".

(b) IDENTIFICATION OF COMMUNITY SERVICE OPPORTUNITIES.—Section 1128B (42 U.S.C. 1320a–7b), as amended by subsection (a), is further amended by adding at the end the following new subsection:

"(g) The Secretary shall—

"(1) in consultation with State and local health care officials, identify opportunities for the satisfaction of community service obligations that a court may impose upon the conviction of an offense under this section, and

"(2) make information concerning such opportunities available to Federal and State law enforcement officers and State and local health care officials.".

SEC. 8346. EFFECTIVE DATE.

The amendments made by this part shall take effect January 1, [1996].

PART 6—REVISIONS TO LIMITATIONS ON PHYSICIAN SELF-REFERRALS

SEC. 8351. APPLICATION OF BAN ON SELF-REFERRALS TO CLAIMS SUBMITTED BY PHYSICIANS.

Section 1877(a)(1)(B) (42 U.S.C. 1395nn(a)(1)(B)) is amended to read as follows:

"(B) no physician or entity may present or cause to be presented a claim under this title or bill to any individual, third party payor, or other entity for designated health services furnished pursuant to a referral prohibited under subparagraph (A).".

SEC. 8352. EXPANSION OF SELF-REFERRAL BAN TO ADDITIONAL SERVICES.

Section 1877(h)(6) (42 U.S.C. 1395nn(h)(6)) is amended—

(1) in subparagraph (D), by striking "or other diagnostic"; and

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

"(L) Home infusion drug therapy services (other than services consisting of the furnishing of infusion pumps).

"(M) Any other item or service not rendered by the physician personally or by a person under the physician's direct supervision.".

SEC. 8353. EXCEPTIONS FOR BOTH OWNERSHIP AND COMPENSATION ARRANGEMENTS.

(a) REPEAL OF EXCEPTION FOR PHYSICIANS' SERVICES.—Section 1877(b) (42 U.S.C. 1395nn(b)) is amended by striking paragraph (1).

(b) REVISION TO IN-OFFICE ANCILLARY SERVICES EXCEPTION.—

(1) IN GENERAL.—Section 1877(b) (42 U.S.C. 1395nn(b)(1)), as amended by subsection (a), is amended by striking "Subsection (a)(1) shall not apply in the following cases" and all that follows through paragraph (2) and inserting the following:

"(1) IN-OFFICE ANCILLARY SERVICES OF SOLE PRACTITIONERS.—Subsection (a)(1) shall not apply in the case of designated health services—

"(A) that are furnished—

"(i) personally by the referring physician or personally by individuals who are directly supervised by the physician,

"(ii) in an office location in which the referring physician furnishes physicians' services unrelated to the furnishing of designated health services, and

"(iii) using equipment that is wholly owned or leased exclusively by the referring physician; and

"(B) that are billed by the physician performing or supervising the services or by an entity that is wholly owned by such physician,

if the ownership or investment interest in such services meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

"(2) IN-OFFICE ANCILLARY SERVICES OF PHYSICIANS IN GROUP PRACTICE.—Subject to subsection (h)(4)(C), subsection

(a)(1) shall not apply in the case of designated health services—

"(A) that are furnished personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are directly supervised by any physician who is a member of such group practice;

"(B) that are furnished in a building in which a physician who is a member of the group practice furnishes physicians' services unrelated to the furnishing of designated health services;

"(C) that are furnished using equipment that is owned or leased exclusively by the physician group; and

"(D) that are billed by the group practice of which the physician is a member under a billing number assigned to the group practice, or by an entity that is wholly owned by such group practice,

unless the Secretary determines other terms and conditions under which the provision of such services does not present a risk of program or patient abuse.".

(2) REQUIREMENTS FOR GROUP PRACTICE.—Section 1877(h)(4) (42 U.S.C. 1395nn(h)(4)) is amended by adding at the end the following new subparagraph:

"(C) REQUIREMENTS FOR GROUP PRACTICE.—For purposes of subsection (b)(2), a group practice meets the requirements of this subparagraph only if—

"(i) no member of the group is permitted to personally employ any individual to participate in the furnishing of services to patients of the group;

"(ii) no member of the group is permitted to enter separately on the member's own behalf into arrangements with any type of managed care entity (including health maintenance organizations and preferred provider organizations), third party payer, or other health benefit plan for the provision of services to patients of the group, except that nothing in this clause may be construed to prohibit the group from entering into an arrangement with a managed care entity that does not apply to services furnished by all the members of the group; and

"(iii) the group has a governing body or persons with responsibility for the conduct of the group practice, including making decisions relating to retention of all physician and nonphysician personnel, promulgating and enforcing personnel policies which apply to all employees of the group, developing salary, bonus, and benefits applicable to physicians and nonphysician personnel, and establishing fees for all services furnished by the group, except that nothing in this clause may be construed to prohibit the delegation of authority within a group practice or to require the personnel policies to be documented in writing.".

(c) NEW EXCEPTION FOR CAPITATED PAYMENTS.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by subsection (a), is amended—

(1) by redesignating paragraph (3) as paragraph (4); and

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

"(3) OTHER CAPITATED PAYMENTS.—Subsection (a)(1) shall not apply in the case of a designated health service, if the designated health service is included in the services for which a physician or physician group is paid only on a capitated basis by a health plan or insurer pursuant to a written arrangement between the plan or insurer and the physician or physician group in which the physician or physician group assumes financial risk for the furnishing of the service.".

(d) NEW EXCEPTION FOR SHARED FACILITY SERVICES.—

(1) IN GENERAL.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by subsections (a) and (c), is amended—

(A) by redesignating paragraph (4) as paragraph (3); and

(B) by inserting after paragraph (3) the following new paragraph:

"(4) SHARED FACILITY SERVICES.—

"(A) IN GENERAL.—Subsection (a)(1) shall not apply in the case of a designated health service consisting of a shared facility service of a shared facility—

"(i) that is furnished—

"(I) personally by the referring physician who is a shared facility physician or personally by an individual directly employed by such a physician,

"(II) by a shared facility in a building in which the referring physician furnishes substantially all of the services of the physician that are unrelated to the furnishing of shared facility services, and

"(III) to a patient of a shared facility physician; and

"(ii) that is billed by the referring physician.

"(B) SHARED FACILITY RELATED DEFINITIONS.—

"(i) SHARED FACILITY SERVICE.—The term 'shared facility service' means, with respect to a shared facility, a designated health service furnished by the facility to patients of shared facility physicians.

"(ii) SHARED FACILITY.—The term 'shared facility' means an entity that furnishes shared facility services under a shared facility arrangement.

"(iii) SHARED FACILITY PHYSICIAN.—The term 'shared facility physician' means, with respect to a shared facility, a physician who has a financial relationship under a shared facility arrangement with the facility.

"(iv) SHARED FACILITY ARRANGEMENT.—The term 'shared facility arrangement' means, with respect to the provision of shared facility services in a building, a financial arrangement—

"(I) which is only between physicians who are providing services (unrelated to shared facility services) in the same building,

"(II) in which the overhead expenses of the facility are shared, in accordance with methods previously determined by the physicians in the arrangement, among the physicians in the arrangement, and

"(III) which, in the case of a corporation, is wholly owned and controlled by shared facility physicians."

SEC. 8354. EXCEPTIONS RELATED ONLY TO OWNERSHIP OR INVESTMENT.

(a) REVISION TO PUBLICLY TRADED SECURITIES EXCEPTION.—Section 1877(c)(1) (42 U.S.C. 1395nn(c)(1)) is amended by inserting "at the time acquired by the physician" after "which may be purchased on terms generally available to the public".

(b) REVISION TO RURAL PROVIDER EXCEPTION.—Section 1877(d)(2) of such Act (42 U.S.C. 1395nn(d)(2)) is amended by striking "substantially all" and inserting "not less than 75 percent (as determined in accordance with regulations of the Secretary)".

SEC. 8355. REPEAL OF EXCEPTION FOR REMUNERATION UNRELATED TO PROVISION OF DESIGNATED HEALTH SERVICES.

Section 1877(e) (42 U.S.C. 1395nn(e)) is amended—

(1) by striking paragraph (4); and

(2) by redesignating paragraphs (5), (6), (7), and (8) as paragraphs (4), (5), (6), and (7).

SEC. 8356. REFERRING PHYSICIANS.

Section 1877(h)(5)(C) (42 U.S.C. 1395nn(H)(5)(C)) is amended—

(1) by striking "and a request" and inserting "a request";

(2) by inserting after "radiation therapy," the following: "and a request by a nephrologist for items or services related to renal dialysis,"; and

(3) by striking "or radiation oncologist" and inserting "radiation oncologist, or nephrologist".

SEC. 8357. MISCELLANEOUS AND TECHNICAL PROVISIONS.

(a) CLARIFICATION OF COVERAGE OF INDIRECTLY HELD FINANCIAL INTERESTS.—The last sentence of section 1877(a)(2) (42 U.S.C. 1395nn(a)(2)) is amended by striking "an interest in an entity that holds an ownership or investment interest in any entity providing the designated health service" and inserting the following: "an interest held indirectly through means such as (but not limited to) holding a legal or beneficial interest in another entity (such as a trust) that holds such investment interest".

(b) CLARIFICATION OF EXCEPTION FOR PAYMENTS BY A PHYSICIAN.—Section 1877(e)(7) (42 U.S.C. 1395nn(e)(7)), as redesignated by section 9305, is amended to read as follows:

"(7) PAYMENTS BY A PHYSICIAN FOR ITEMS AND SERVICES.—Payments made by a physician to an individual or entity as compensation for items or services if the items or services are furnished at a price that is consistent with fair market value.".

(c) REPORTING REQUIREMENTS.—Section 1877(f) (42 U.S.C. 1395nn) is amended—

(1) in the matter before paragraph (1), by inserting ", investment, and compensation" after "ownership";

(2) in paragraph (2), by inserting ", or with a compensation arrangement (as described in subsection (a)(2)(B))," after "investment interest (as described in subsection (a)(2)(A))";

(3) in paragraph (2), by inserting "interest or who have such a compensation relationship with the entity" before the period at the end;

(4) in the fourth sentence, by striking "covered items and" and inserting "designated health"; and

(5) by striking the third and fifth sentences.

(d) REVISION OF EFFECTIVE DATE EXCEPTION PROVISION.—Section 13562(b)(2) of the Omnibus Budget Reconciliation Act of 1993 is amended by striking subparagraphs (A) and (B) and inserting the following:

"(A) the second sentence of subsection (a)(2), and subsections (b)(2)(B) and (d)(2), of section 1877 of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply instead of the corresponding provisions in section 1877 (as amended by this Act);

"(B) section 1877(b)(4) of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply;

"(C) the requirements of section 1877(c)(2) of the Social Security Act (as amended by this Act) shall not apply to any securities of a corporation that meets the requirements of section 1877(c)(2) of the Social Security Act (as in effect on the day before the date of the enactment of this Act);

"(D) section 1877(e)(3) of the Social Security Act (as amended by this Act) shall apply, except that it shall not apply to any arrangement that meets the requirements of subsection (e)(2) or subsection (e)(3) of section 1877 of the Social Security Act (as in effect on the day before the date of the enactment of this Act);

"(E) the requirements of clauses (iv) and (v) of section 1877(h)(4)(A), and of clause (i) of section 1877(h)(4)(B), of

the Social Security Act (as amended by this Act) shall not apply; and

"(F) section 1877(h)(4)(B) of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply instead of section 1877(h)(4)(A)(ii) of such Act (as amended by this Act).".

(e) CLARIFICATION OF SANCTION AUTHORITY.—Section 1877(g)(4) (42 U.S.C. 1395nn(g)(4)) is amended by striking "Any physician" and all that follows through "to such entity," and inserting the following: "Any physician or other entity that enters into an arrangement or scheme (such as a cross-referral arrangement or an arrangement with multiple leases overlapping in time for the same or similar rental space or equipment) which the physician or entity knows or should know has a principal purpose of inducing referrals to another entity, which referrals, if made directly by the physician or entity to such other entity,".

(f) AUTHORIZATION FOR SECRETARY TO ISSUE REGULATIONS.—Section 1877 (42 U.S.C. 1395nn) is amended by adding at the end the following new subsection:

"(i) ADDITIONAL REQUIREMENTS.—The Secretary is authorized to impose by regulation such other requirements as needed to protect against program or patient abuse with respect to any of the exceptions under this section.".

SEC. 8358. EFFECTIVE DATE.

The amendments made by this part shall apply to referrals made on or after January 1, 1996, except that the amendments made by section 8356(2) and section 8357(d) shall apply as if included in the enactment of OBRA–1993.

PART 7—OTHER MEDICARE PROVISIONS

SEC. 8361. TREATMENT OF BENEFICIARIES RESIDING IN STATES WITH APPROVED SINGLE-PAYER SYSTEMS.

Title XVIII, as amended by section 3116(f), is further amended by adding at the end the following new section:

"TREATMENT OF BENEFICIARIES UNDER STATE SINGLE-PAYER SYSTEMS

"SEC. 1894. (a) IN GENERAL.—In the case of individual entitled to benefits under this title who is covered under a State single-payer system approved under subtitle A of title IV of the Guaranteed Health Insurance Act of 1994—

"(1) the benefits covered under such system shall be instead of the payments which would otherwise be made to the individual or on the individual's behalf under this title; and

"(2) the Secretary shall make a payment to the State in the amount specified under subsection (b), on such periodic basis that will permit the State to make timely payment for items and services furnished under the State single-payer system to such individuals.

"(b) AMOUNT OF PAYMENTS TO STATES.—

"(1) IN GENERAL.—The amount specified in this subsection with respect to a State is the Secretary's estimate of the sum of the following products:

"(A) The product of—

"(i) the part A per enrollee payment described in paragraph (2) for the month; and

"(ii) the number of individuals who are entitled to benefits under part A during the month and (as estimated prior to the month based on information provided by the State) who are covered under the State system described in subsection (a).

"(B) The product of—

"(i) the part B per enrollee payment described in paragraph (2) for the month; and

"(ii) the number of individuals who are enrolled under part B during the month and (as estimated

prior to the month based on information provided by the State) who are covered under the State system described in subsection (a).

"(2) PER ENROLLEE PAYMENTS.—In paragraph (1)—

"(A) the 'part A per enrollee payment' for a month is an amount equal to the Secretary's estimate of the amount of payment which would be made under part A for the month on behalf of individuals covered under the State system described in subsection (a) during the month if the individuals were not covered under the State system during the month; and

"(B) the 'part B per enrollee payment' for a month is an amount equal to the Secretary's estimate of the amount of payment which would be made under part B for the month on behalf of individuals covered under the State system described in subsection (a) during the month if the individuals were not covered under the State system during the month.

"(3) ADJUSTMENTS.—The Secretary shall adjust the amount of payment otherwise made to a State under this subsection for a month to take into account overpayments or underpayments made under this subsection in previous months.

"(c) PAYMENTS FROM TRUST FUNDS.—Of the total amount of payment made to a State under subsection (b)—

"(1) the portion attributable to the amount described in subsection (b)(1)(A) shall be paid from the Federal Hospital Insurance Trust Fund; and

"(2) the portion attributable to the amount described in subsection (b)(1)(B) shall be paid from the Federal Supplementary Medical Insurance Trust Fund.".

SEC. 8362. DEVELOPMENT AND IMPLEMENTATION OF PROSPECTIVE PAYMENT METHODOLOGIES.

(a) IN GENERAL.—Subject to subsection (b), the Secretary shall, not later than January 1, 1997, develop and implement prospective payment methodologies for setting payment rates for services for which a prospective payment methodology is not used under the medicare program. In developing such methodologies, the Secretary shall ensure that the amount of payments under such methodologies under the medicare program would not exceed the amount of payments that would be paid under the methodologies otherwise applicable.

(b) PAYMENT METHODOLOGIES FOR PPS-EXEMPT HOSPITALS.—The Secretary shall develop and implement such a payment methodology for services of classes of hospitals (including children's hospitals) that are not subsection (d) hospitals (within the meaning of section 1886(d)(1)(B) of the Social Security Act) where appropriate. Any such payment methodology shall provide for hospital-specific payment rates based on resource requirements of such hospitals, determined using data specific to the different classes of such hospitals.

(c) APPLICATION OF METHODOLOGIES.—In the case of any service within a class of services for which a prospective payment methodology is implemented under subsection (a), notwithstanding any other provision of law, such methodology shall be applied under the medicare program and medicare part C and under subtitle D of title VI instead of the methodology otherwise provided.

(d) DEVELOPMENT OF METHODOLOGY FOR ESTABLISHING LIMITS ON PAYMENTS FOR SERVICES PROVIDED IN HOSPITAL OUTPATIENT DEPARTMENTS.—The Secretary shall revise the payment methodology established under the medicare program for payment for services provided in hospital outpatient departments in order to provide for a hospital-specific limit on the rate of growth in payments for such services. Such revision shall first be applied to payments to hospitals for portions of cost reporting periods occurring on or after January 1, 1997.

SEC. 8363. MEDICARE SUPPLEMENTAL INSURANCE POLICY AMENDMENTS.

(a) CONFORMING CHANGES IN MEDICARE BENEFITS.—Not later than July 1, 1995, the Secretary shall, in accordance with section 1882(p)(1) of the Social Security Act, promulgate standards for medicare supplemental policies to reflect the changes in benefits provided under parts A and B of title XVIII of such Act for purposes of the NAIC or Federal Standards applicable under such section. The provisions of section 1882(p)(1) of the Social Security Act shall apply to such standards in the same manner as such provisions apply to "Federal standards" described in subparagraph (B) of such section, except that any reference in such section to "the date specified in subparagraph" shall be deemed to be a reference to "January 1, 1998".

(b) REQUIRING OPEN ENROLLMENT.—

(1) IN GENERAL.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(A) in paragraph (3), by striking "paragraphs (1) and (2)" and inserting "paragraphs (1), (2), and (3)";

(B) by redesignating paragraph (3) as paragraph (4); and

(C) by inserting after paragraph (2) the following new paragraph:

"(3) Notwithstanding paragraph (2), the issuer of a medicare supplemental policy may not deny the issuance of a medicare supplemental policy during an annual open enrollment period of at least 30 days established by the Secretary for medicare supplemental policies.".

(2) ISSUANCE OF REGULATIONS.—Not later than July 1, 1995, the Secretary shall issue regulations to carry out the amendments made by paragraph (1).

(c) EFFECTIVE DATE.—

(1) CONFORMING CHANGES.—The changes in the NAIC or Federal standards made pursuant to subsection (a) shall apply to medicare supplemental policies issued on or after January 1, 1998.

(2) OPEN ENROLLMENT.—(A) Except as provided in subparagraph (B), the amendments made by subsection (b) shall apply to medicare supplemental policies issued on or after January 1, 1997.

(B) In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the amendments made by subsection (b), but

(ii) having a legislature which is not scheduled to meet in 1996 in a legislative session in which such legislation may be considered,

the amendment made by subsection (b) shall apply to medicare supplemental policies issued in the State on or after the earlier of January 1, 1998, or the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 8364. REQUIRING HOSPITALS TO PARTICIPATE IN MEDICARE PART C.

(a) IN GENERAL.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)), as amended by section 8334(a), is amended—

(1) in subparagraph (Q), by striking "and" at the end;

(2) by striking the period at the end of subparagraph (R) and inserting ", and"; and

(3) by inserting after subparagraph (R) the following:

"(S) in the case of a hospital or a rural primary care hospital, to file a participation agreement with respect to the medicare part C program (in accordance with [section 2131])."

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to cost reporting periods beginning on or after January 1, 1999.

SEC. 8365. CONFORMING AMENDMENTS RELATING TO PROGRAM OF COST-SHARING FOR QUALIFIED MEDICARE BENEFICIARIES.

(a) IN GENERAL.—(1) Section 1818(g)(1) (42 U.S.C. 1395i–2(g)(1)) is amended by striking "1905(p)(1)" and inserting "2223(a)".

(2) Section 1843(h) (42 U.S.C. 1395v(h)) is amended by striking "1905(p)(1)" each place it appears in paragraph (1)(B) and paragraph (2) and inserting "2223(a)"

(3) Section 1848(g)(3)(A) (42 U.S.C. 1395w–4(g)(3)) is amended—

(A) by striking "(including as a qualified medicare beneficiary, as described in section 1905(p)(1))", and

(B) by inserting "or who is eligible for benefits under part C of title XXII" after "title XIX".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to items or services furnished in a State on or after January 1, 1999.

SEC. 8366. ADJUSTING CAPITAL PAYMENTS FOR AMOUNTS RECEIVED UNDER CAPITAL FINANCING ASSISTANCE PROGRAM.

Section 1886(g)(1)(B) (42 U.S.C. 1395ww(g)(1)(B)) is amended—

(1) by striking "and" at the end of clause (iii);

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

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

"(v) shall provide for adjustments to assure that payment is not made to a hospital for capital-related costs to the extent that such costs were reduced or eliminated as a result of the receipt of financial assistance under title XXVIII of the Public Health Service Act.".

SEC. 8367. STUDY OF PHYSICIAN SUPERVISION OF NURSE ANESTHETIST SERVICES.

(a) STUDY.—The Secretary of Health and Human Services, acting through the Administrator of the Health Care Financing Administration, shall conduct a study to determine the appropriate requirements for and amount of—

(1) payments under part B of the medicare program for services of a certified registered nurse anesthetist who does not provide such services under the medical supervision or medical direction of a physician, and

(2) payments under such part for the medical direction of such certified registered nurse anesthetist by a physician.

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

PART 8—EXPANSION OF FRAIL ELDERLY DEMONSTRATIONS

SEC. 8371. EXPANSION OF NUMBER OF SITES FOR DEMONSTRATION PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE).

Section 9412(b)(1) of OBRA–1986 is amended by striking "not more than 15" and inserting "not more than 50".

Subtitle E—Minor and Technical Medicare Amendments

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PART 1—PROVISIONS RELATING TO PART A

SEC. 8401. PROVISIONS RELATING TO ADJUSTMENTS TO STANDARDIZED AMOUNTS FOR WAGES AND WAGE-RELATED COSTS.

(a) USE OF OCCUPATIONAL MIX IN GUIDELINES FOR DETERMINATION OF AREA WAGE INDEX.—

(1) IN GENERAL.—Section 1886(d)(10)(D)(i)(I) (42 U.S.C. 1395ww(d)(10)(D)(i)(I)) is amended by inserting "(to the extent the Secretary determines appropriate)" after "taking into account".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect as if included in the enactment of OBRA–1989.

(b) CONFORMING AMENDMENTS RELATING TO GEOGRAPHIC AREA USED TO DETERMINE WAGE INDEX APPLICABLE TO HOSPITAL.—(1) Section 1886(d)(8)(C) (42 U.S.C. 1395ww(d)(8)(C)), as amended by section 13501(b)(1) of OBRA–1993, is amended—

(A) in clause (iv), by striking "paragraph (1)" and inserting "paragraph (10)"; and

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

"(v) This subparagraph shall apply with respect to discharges occurring in a fiscal year only if the Secretary uses a method for making adjustments to the DRG prospective payment rate for area differences in hospital wage levels under paragraph (3)(E) for the fiscal year that is based on the use of Metropolitan Statistical Area classifications.".

(2) Section 1886(d)(10) (42 U.S.C. 1395ww(d)(10)) is amended—

(A) in subparagraph (C)(i)(II), by striking "the area wage index applicable" and inserting "the factor used to adjust the DRG prospective payment rate for area differences in hospital wage levels that applies"; and

(B) in subparagraph (D)—

(i) by redesignating clause (ii) as clause (iii), and

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

"(ii) Notwithstanding clause (i), if the Secretary uses a method for making adjustments to the DRG prospective payment rate for area differences in hospital wage levels under paragraph (3)(E) that is not based on the use of Metropolitan Statistical Area classifications, the Secretary may revise the guidelines published under clause (i) to the extent such guidelines are used to determine the appropriateness of the geographic area in which the hospital is determined to be located for purposes of making such adjustments.".

(c) ADJUSTMENT OF LABOR AND NON-LABOR PORTIONS OF STANDARDIZED AMOUNTS.—Section 1886(d)(3)(A)(iii) (42 U.S.C. 1395ww(d)(3)(A)(iii)) is amended by adding at the end the following: "For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.".

SEC. 8402. PROVISIONS RELATING TO RURAL HEALTH TRANSITION GRANT PROGRAM.

(a) ELIGIBILITY OF RURAL PRIMARY CARE HOSPITALS FOR GRANTS.—

(1) IN GENERAL.—Section 4005(e)(2) of OBRA–1987 is amended in the matter preceding subparagraph (A) by inserting "any rural primary care hospital designated by the Secretary under section 1820(i)(2) of the Social Security Act, or" after "means".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to grants made on or after October 1, 1993.

(b) EXTENSION OF AUTHORIZATION OF APPROPRIATIONS.—Section 4005(e)(9) of OBRA–1987 is amended—

(1) by striking "1989 and" and inserting "1989,"; and

(2) by striking "1992" and inserting "1992 and $30,000,000 for each of fiscal years 1993 through 1997".

(c) FREQUENCY OF REQUIRED REPORTS.—Section 4008(e)(8)(B) of OBRA–1987 is amended by striking "every 6 months" and inserting "every 12 months".

(d) USE OF GRANTS FOR TELECOMMUNICATIONS PROJECTS.—

(1) IN GENERAL.—Section 4005(e)(7) of OBRA–1987 is amended by adding at the end the following new subparagraph:

"(E) A hospital may use a grant received under this subsection to participate in a project established by the Secretary to establish telecommunications linkages between the hospital and other medical facilities in order to permit the hospital to use the medical expertise or equipment of the other facility through telecommunications techniques. In awarding grants to hospitals for this purpose, the Secretary shall take into account the need to demonstrate alternative telecommunications techniques for rural hospitals, including interactive video telecommunications, static video imaging transmitted through the telephone system, and facsimile reproductions transmitted through the telephone system.".

(2) SET-ASIDE OF AUTHORIZATION.—Section 4005(e)(9) of OBRA–1987 is amended by adding at the end the following: "Of the amounts authorized to be appropriated during each of the fiscal years 1996 and 1997, $2,000,000 shall be available solely for projects described in paragraph (7)(E).".

SEC. 8403. PSYCHOLOGY SERVICES IN HOSPITALS.

Section 1861(e)(4) (42 U.S.C. 1395x(e)(4)) is amended by striking "physician;" and inserting "physician, except that a patient receiving qualified psychologist services (as defined in subsection (ii)) may be under the care of a clinical psychologist with respect to such services to the extent permitted under State law;".

SEC. 8404. SKILLED NURSING FACILITIES.

(a) CONSTRUCTION OF WAGE INDEX.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall begin to collect data on employee compensation and paid hours of employment in skilled nursing facilities for the purpose of constructing a skilled nursing facility wage index adjustment to the routine service cost limits required under section 1888(a)(4) of the Social Security Act.

(b) CLARIFICATION OF REPEAL OF UTILIZATION REVIEW REQUIREMENTS.—

(1) IN GENERAL.—(A) Section 1814(a)(5) (42 U.S.C. 1395f(a)(5)) is amended—

(i) by striking "and with respect" and all that follows through "regulations";

(ii) by striking "or skilled nursing facility, as the case may be"; and

(iii) by striking "or facility".

(B) Section 1866(d) (42 U.S.C. 1395cc(d)) is amended—

(i) by striking "or skilled nursing facility";

(ii) by striking "or facility" each place it appears;

(iii) by striking "or for post-hospital" and all that follows through "the case may be"; and

(iv) by striking ", or (in the case of" and all that follows through "transfer agreement,".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect as if included in the enactment of OBRA–1987.

(c) REIMBURSEMENT FOR ATYPICAL SERVICES.—Section 1888(c) (42 U.S.C. 1395yy(c)) is amended—

(1) by striking "(c)" and inserting "(c)(1)"; and

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

"(2) The Secretary shall establish an expedited review process under which the Secretary shall respond to the request of a skilled nursing facility received on or after October 1, 1994, for an adjustment under this subsection, based on the furnishing of atypical services by the facility during any cost reporting period (including

the furnishing of atypical services based on the facility's case mix) not later than 30 days after receiving the facility's request. If the Secretary approves a facility's request under the process, the Secretary shall adjust the amount of the payments made under this title (on a timely basis) with respect to routine service costs of extended care services furnished by the facility for each cost reporting period for which the facility demonstrates that it furnishes (or will furnish) such atypical services.".

(d) PAYMENT FOR SERVICES OF INDEPENDENT LABORATORIES FURNISHED TO RESIDENTS.—

(1) INCLUSION AS ROUTINE SERVICE COSTS OF EXTENDED CARE SERVICES.—Section 1861(h)(6) (42 U.S.C. 1395x(h)(6)) is amended by inserting "or an independent clinical laboratory" after "by a hospital".

(2) REQUIRING FACILITIES TO FURNISH LABORATORY SERVICES.—Section 1819(b)(4)(A) (42 U.S.C. 1395i-3(b)(4)(A)) is amended—

(A) by striking "and" at the end of clause (vi);

(B) by striking the period at the end of clause (vii) and inserting "; and"; and

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

"(viii) clinical laboratory services necessary to meet the needs of each resident.".

(e) CONFORMING AMENDMENTS TO NURSING HOME REFORM.—

(1) SUSPENSION OF DECERTIFICATION OF NURSES AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS BASED ON EXTENDED SURVEYS.—

(A) IN GENERAL.—Section 1819(f)(2)(B)(iii)(I)(b) (42 U.S.C. 1395i-3(f)(2)(B)(iii)(I)(b)) is amended by striking the semicolon and inserting the following: ", unless the survey shows that the facility is in compliance with the requirements of subsections (b), (c), and (d) of this section;".

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect as if included in the enactment of OBRA-1990.

(2) REQUIREMENTS FOR CONSULTANTS CONDUCTING REVIEWS ON USE OF DRUGS.—

(A) IN GENERAL.—Section 1819(c)(1)(D) (42 U.S.C. 1395i-3(c)(1)(D)) is amended by adding at the end the following sentence: "In determining whether such a consultant is qualified to conduct reviews under the preceding sentence, the Secretary shall take into account the needs of nursing facilities under this title to have access to the services of such a consultant on a timely basis.".

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect as if included in the enactment of OBRA-1987.

(3) INCREASE IN MINIMUM AMOUNT REQUIRED FOR SEPARATE DEPOSIT OF PERSONAL FUNDS.—

(A) IN GENERAL.—Section 1819(c)(6)(B)(i) (42 U.S.C. 1395i-3(c)(6)(B)(i)) is amended by striking "$50" and inserting "$100".

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect January 1, 1995.

(4) DUE PROCESS PROTECTIONS FOR NURSE AIDES.—

(A) PROHIBITING STATE FROM INCLUDING UNDOCUMENTED ALLEGATIONS IN NURSES AIDE REGISTRY.—Section 1819(e)(2)(B) (42 U.S.C. 1395i-3(e)(2)(B)) is amended by striking the period at the end of the first sentence and inserting the following: ", but shall not include any allegations of resident abuse or neglect or misappropriation of resident property that are not specifically documented by the State under such subsection.".

(B) DUE PROCESS REQUIREMENTS FOR REBUTTING ALLEGATIONS.—Section 1819(g)(1)(C) (42 U.S.C. 1395i-

3(g)(1)(C)) is amended by striking the second sentence and inserting the following: "The State shall, after providing the individual involved with a written notice of the allegations (including a statement of the availability of a hearing for the individual to rebut the allegations) and the opportunity for a hearing on the record, make a written finding as to the accuracy of the allegations.".

(C) EFFECTIVE DATE.—The amendments made by this paragraph shall take effect January 1, 1995.

(f) CORRECTIONS RELATING TO SECTION 4008.—

(1) Section 1819(b)(5)(D) (42 U.S.C. 1395i-3(b)(5)(D)), as amended by section 4008(h)(1)(D) of OBRA-1990, is amended by striking the comma before "or a new competency evaluation program.".

(2) Section 1819(b)(5)(G) (42 U.S.C. 1395i-3(b)(5)(G)) is amended by striking "or licensed or certified social worker" and inserting "licensed or certified social worker, registered respiratory therapist, or certified respiratory therapy technician".

(3) Section 1819(f)(2)(B)(i) (42 U.S.C. 1395i-3(f)(2)(B)(i)) is amended by striking "facilities," and inserting "facilities (subject to clause (iii)),".

(4) Section 1819(f)(2)(B)(iii)(I)(c) (42 U.S.C. 1395i-3(f)(2)(B)(iii)(I)(c)) is amended by striking "clauses" each place it appears and inserting "clause".

(5) Section 1819(g)(5)(B) (42 U.S.C. 1395i-3(g)(5)(B)) is amended by striking "paragraphs" and inserting "paragraph".

(6) Section 4008(h)(1)(F)(ii) of OBRA-1990 is amended—

(A) by striking "The amendments" and inserting "(I) The amendments";

(B) by striking "nursing facility" each place it appears and inserting "skilled nursing facility";

(C) by redesignating subclauses (I) through (V) as items (aa) through (ee); and

(D) by adding at the end the following new subclause:

"(II) Notwithstanding subclause (I) and subject to section 1819(f)(2)(B)(iii)(I) of the Social Security Act (as amended by clause (i)), a State may approve a training and competency evaluation program or a competency evaluation program offered by or in a skilled nursing facility described in subclause (I) if, during the previous 2 years, item (aa), (bb), (cc), (dd), or (ee) of subclause (I) did not apply to the facility.".

(7) EFFECTIVE DATE.—The amendments made by this subsection shall take effect as if included in the enactment of OBRA-1990.

SEC. 8405. NOTIFICATION OF AVAILABILITY OF HOSPICE BENEFIT.

(a) IN GENERAL.—Section 1861(ee)(2)(D) (42 U.S.C. 1395x(ee)(2)(D)) is amended by inserting ", including hospice services," after "post-hospital services".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after the first day of the first month beginning more than one year after the date of the enactment of this Act.

SEC. 8406. CLARIFYING EXPERTISE OF INDIVIDUALS TO SERVE ON THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION.

Section 1886(e)(6)(B) (42 U.S.C. 1395ww(e)(6)(B)) is amended by striking "hospital reimbursement, hospital financial management" and inserting "health facility management, reimbursement of health facilities or other providers of services which reflect the scope of the Commission's responsibilities".

SEC. 8407. AUTHORITY FOR BUDGET NEUTRAL ADJUSTMENTS FOR CHANGES IN PAYMENT AMOUNTS FOR TRANSFER CASES.

Section 1886(d)(5)(I) (42 U.S.C. 1395ww(d)(5)) is amended—

(1) by inserting "(i)" after "(I)"; and

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

"(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater or lesser than those that would have otherwise been made in such fiscal year.".

SEC. 8408. HEMOPHILIA PASS-THROUGH EXTENSION.

Effective as if included in the enactment of OBRA–1993, section 6011(d) of OBRA–1989 (as amended by section 13505 of OBRA–1993) is amended by striking "September 30, 1994" and inserting "September 30, 1999".

SEC. 8409. SUB-ACUTE CARE SERVICES DEMONSTRATION PROJECT.

(a) DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project during fiscal years 1996 and 1997 on the provision of sub-acute care services under part A of the medicare program in freestanding skilled nursing facilities and hospitals.

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $10,000,000 for each of the fiscal years 1996 and 1997 to conduct the demonstration project under paragraph (1).

(b) REPORT.—Not later than 6 months after the conclusion of the demonstration project conducted under subsection (a), the Secretary shall submit a report to Congress on the demonstration project, and shall include in the report an evaluation of the demonstration project together with any recommendations considered appropriate by the Secretary for changes to title XVIII of the Social Security Act relating to the provision of sub-acute care services under part A of the medicare program.

SEC. 8410. CLARIFICATION OF DRG PAYMENT WINDOW EXPANSION; MISCELLANEOUS AND TECHNICAL CORRECTIONS.

(a) CLARIFICATION OF DRG PAYMENT WINDOW EXPANSION.—The first sentence of section 1886(a)(4) (42 U.S.C. 1395ww(a)(4)) is amended by inserting "(or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day)" after "3 days".

(b) TECHNICAL CORRECTION RELATING TO RESIDENT ASSESSMENT IN NURSING HOMES.—Section 1819(b)(3)(C)(i)(I) (42 U.S.C. 1395i–3(b)(3)(C)(i)(I)) is amended by striking "not later than" before "14 days".

(c) TECHNICAL CORRECTION RELATING TO APPLICABLE ADJUSTMENT FACTOR FOR INDIRECT MEDICAL EDUCATION ADJUSTMENT.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended by striking "May 1, 1986," and inserting "October 1, 1988,".

(d) MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS AND SOLE COMMUNITY HOSPITALS.—

(1) MEDICARE DEPENDENT, SMALL RURAL HOSPITALS.—

(A) CLARIFICATION OF ADDITIONAL PAYMENT.—Section 1886(d)(5)(G)(ii)(I), (42 U.S.C. 1395ww(d)(5)(G)(ii)(I)), as amended by section 13501(e)(1) of OBRA–1993, is amended by striking "the first 3 12-month cost reporting periods that begin" and inserting "the 36-month period beginning with the first day of the cost reporting period that begins".

(B) CONFORMING TARGET AMOUNTS TO EXTENSION OF ADDITIONAL PAYMENTS.—Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)) is amended in the matter preceding clause (i) by striking "March 31, 1993" and inserting "September 30, 1994".

(2) CLARIFICATION OF UPDATES.—Section 1886(b)(3)(B)(iv)(II) (42 U.S.C. 1395ww(b)(3)(B)(iv)(II)), as added by section 13501(a)(2) of OBRA–1993, is amended by striking "(taking into account" and all that follows through "1994)" and inserting "(adjusted to exclude any portion of a cost reporting period beginning during fiscal year 1993 for

which the applicable percentage increase is determined under subparagraph (I)".

(e) CLERICAL CORRECTIONS.—(1) Section 1814(i)(1)(C)(i) (42 U.S.C. 1395f(i)(1)(C)(i)) is amended by striking "1990" and inserting "1990,".

(2) Section 1816(f)(2)(A)(ii) (42 U.S.C. 1396h(f)(2)(A)(ii)) is amended by striking "such agency" and inserting "such agency's".

PART 2—PROVISIONS RELATING TO PART B

Subpart A—Physicians' Services

SEC. 8411. DEVELOPMENT AND IMPLEMENTATION OF RESOURCE-BASED METHODOLOGY FOR PRACTICE EXPENSES.

(a) DEVELOPMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a methodology for implementing in 1997 a resource-based system for determining practice expense relative value units for each physicians' service. The methodology utilized shall recognize the staff, equipment, and supplies used in the provision of various medical and surgical services in various settings.

(2) REPORT.—The Secretary shall transmit a report by July 1, 1995, on the methodology developed under paragraph (1) to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate. The report shall include a presentation of data utilized in developing the methodology and an explanation of the methodology.

(b) IMPLEMENTATION.—

(1) IN GENERAL.—Section 1848(c)(2)(C)(ii) (42 U.S.C. 1395w-4(c)(2)(C)(ii)) is amended—

(A) by inserting "for the service for years before 1997" before "equal to",

(B) by striking the period at the end of subclause (II) and inserting a comma, and

(C) by adding after and below subclause (II) the following:

"and for years beginning with 1997 based on the relative practice expense resources involved in furnishing the service (in accordance with the transition provided in subparagraph (G)).".

(2) TRANSITION.—Section 1848(c)(2) (42 U.S.C. 1395w-4(c)(2)) is amended by adding at the end the following new subparagraph:

"(G) TRANSITION TO RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUE UNITS.—With respect to physicians' services furnished in years beginning with 1997, the number of practice expense relative value units applicable under subparagraph (C)(ii) shall be equal to the following:

"(i) For services furnished in 1997, the sum of—

"(I) 75 percent of the units determined under the methodology applicable under such subparagraph for years prior to 1997; and

"(II) 25 percent of the units determined under the methodology developed by the Secretary under section 8411(a)(1) of the Guaranteed Health Insurance Act of 1994.

"(ii) For services furnished in 1998, the sum of—

"(I) 50 percent of the units determined under the methodology applicable under such subparagraph for years prior to 1997; and

"(II) 50 percent of the units determined under the methodology developed by the Secretary under section 8411(a)(1) of the Guaranteed Health Insurance Act of 1994.

"(iii) For services furnished in 1999, the sum of—

"(I) 25 percent of the units determined under the methodology applicable under such subparagraph for years prior to 1997; and

"(II) 75 percent of the units determined under the methodology developed by the Secretary under section 8411(a)(1) of the Guaranteed Health Insurance Act of 1994.

"(iv) For services furnished in years beginning with 2000, 100 percent of the units determined under the methodology developed by the Secretary under section 8411(a)(1) of the Guaranteed Health Insurance Act of 1994.".

(3) CONFORMING AMENDMENT.—Section 1848(c)(3)(C)(ii) (42 U.S.C. 1395w-4(c)(3)(C)(ii)) is amended by striking "The practice" and inserting "For years before 2000, the practice".

(4) APPLICATION OF CERTAIN PROVISIONS.—In implementing the amendment made by paragraph (1)(C), the provisions of clauses (ii)(II) and (iii) of section 1848(c)(2)(B) of the Social Security Act shall apply in the same manner as they apply to adjustments under clause (ii)(I) of such section.

SEC. 8412. GEOGRAPHIC COST OF PRACTICE INDEX REFINEMENTS.

(a) REQUIRING CONSULTATION WITH REPRESENTATIVES OF PHYSICIANS IN REVIEWING GEOGRAPHIC ADJUSTMENT FACTORS.—Section 1848(e)(1)(C) (42 U.S.C. 1395w-4(e)(1)(C)) is amended by striking "shall review" and inserting "shall, in consultation with appropriate representatives of physicians, review".

(b) USE OF MOST RECENT DATA IN GEOGRAPHIC ADJUSTMENT.—Section 1848(e)(1) (42 U.S.C. 1395w-4(e)(1)) is amended by adding at the end the following new subparagraph:

"(D) USE OF RECENT DATA.—In establishing indices and index values under this paragraph, the Secretary shall use the most recent data available relating to practice expenses, malpractice expenses, and physician work effort in different fee schedule areas.".

(c) REPORT ON REVIEW PROCESS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall study and report to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives on—

(1) the data necessary to review and revise the indices established under section 1848(e)(1)(A) of the Social Security Act, including—

(A) the shares allocated to physicians' work effort, practice expenses (other than malpractice expenses), and malpractice expenses;

(B) the weights assigned to the input components of such shares; and

(C) the index values assigned to such components;

(2) any limitations on the availability of data necessary to review and revise such indices at least every three years;

(3) ways of addressing such limitations, with particular attention to the development of alternative data sources for input components for which current index values are based on data collected less frequently than every three years; and

(4) the costs of developing more accurate and timely data.

SEC. 8413. EXTRA-BILLING LIMITS.

(a) ENFORCEMENT OF LIMITS.—Section 1848(g) (42 U.S.C. 1395w-4(g)), as amended by section 13517(a) of OBRA-1993, is amended—

(1) by amending paragraph (1) to read as follows:

"(1) LIMITATION ON ACTUAL CHARGES.—

"(A) IN GENERAL.—In the case of a nonparticipating physician or nonparticipating supplier or other person (as defined in section 1842(i)(2)) who does not accept payment on an assignment-related basis for a physician's service

furnished with respect to an individual enrolled under this part, the following rules apply:

"(i) APPLICATION OF LIMITING CHARGE.—No person may bill or collect an actual charge for the service in excess of the limiting charge described in paragraph (2) for such service.

"(ii) NO LIABILITY FOR EXCESS CHARGES.—No person is liable for payment of any amounts billed for the service in excess of such limiting charge.

"(iii) CORRECTION OF EXCESS CHARGES.—If such a physician, supplier, or other person bills, but does not collect, an actual charge for a service in violation of clause (i), the physician, supplier, or other person shall reduce on a timely basis the actual charge billed for the service to an amount not to exceed the limiting charge for the service.

"(iv) REFUND OF EXCESS COLLECTIONS.—If such a physician, supplier, or other person collects an actual charge for a service in violation of clause (i), the physician, supplier, or other person shall provide on a timely basis a refund to the individual charged in the amount by which the amount collected exceeded the limiting charge for the service. The amount of such a refund shall be reduced to the extent the individual has an outstanding balance owed by the individual to the physician.

"(B) SANCTIONS.—If a physician, supplier, or other person—

"(i) knowingly and willfully bills or collects for services in violation of subparagraph (A)(i) on a repeated basis, or

"(ii) fails to comply with clause (iii) or (iv) of subparagraph (A) on a timely basis,

the Secretary may apply sanctions against the physician, supplier, or other person in accordance with paragraph (2) of section 1842(j). In applying this subparagraph, paragraph (4) of such section applies in the same manner as such paragraph applies to such section and any reference in such section to a physician is deemed also to include a reference to a supplier or other person under this subparagraph.

"(C) TIMELY BASIS.—For purposes of this paragraph, a correction of a bill for an excess charge or refund of an amount with respect to a violation of subparagraph (A)(i) in the case of a service is considered to be provided on a timely basis if the reduction or refund is made not later than 30 days after the date the physician, supplier, or other person is notified by the carrier under this part of such violation and of the requirements of subparagraph (A).";

(2) in paragraph (3)(B)—

(A) by inserting after the first sentence the following: "No person is liable for payment of any amounts billed for such a service in violation of the previous sentence.", and

(B) in the last sentence, by striking "previous sentence" and inserting "first sentence".

(b) CLARIFICATION OF MANDATORY ASSIGNMENT RULES FOR CERTAIN PRACTITIONERS.—

(1) IN GENERAL.—Section 1842(b) (42 U.S.C. 1395u(b)), as amended by section 8416(e), is amended by adding at the end the following new paragraph:

"(18)(A) Payment for any service furnished by a practitioner described in subparagraph (C) and for which payment may be made under this part on a reasonable charge or fee schedule basis may only be made under this part on an assignment-related basis.

"(B) A practitioner described in subparagraph (C) or other person may not bill (or collect any amount from) the individual or another person for any service described in subparagraph (A), except for deductible and coinsurance amounts applicable under this part. No person is liable for payment of any amounts billed for such a service in violation of the previous sentence. If a practitioner or other person knowingly and willfully bills (or collects an amount) for such a service in violation of such sentence, the Secretary may apply sanctions against the practitioner or other person in the same manner as the Secretary may apply sanctions against a physician in accordance with subsection (j)(2) in the same manner as such section applies with respect to a physician. Paragraph (4) of subsection (j) shall apply in this subparagraph in the same manner as such paragraph applies to such section.

"(C) A practitioner described in this subparagraph is any of the following:

"(i) A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5)).

"(ii) A certified registered nurse anesthetist (as defined in section 1861(bb)(2)).

"(iii) A certified nurse-midwife (as defined in section 1861(gg)(2)).

"(iv) A clinical social worker (as defined in section 1861(hh)(1)).

"(v) A clinical psychologist (as defined by the Secretary for purposes of section 1861(ii)).

"(D) For purposes of this paragraph, a service furnished by a practitioner described in subparagraph (C) includes any services and supplies furnished as incident to the service as would otherwise be covered under this part if furnished by a physician or as incident to a physician's service.".

(2) CONFORMING AMENDMENTS.—

(A) Section 1833 (42 U.S.C. 1395l) is amended—

(i) in subsection (l)(5), by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B);

(ii) by striking subsection (p); and

(iii) in subsection (r), by striking paragraph (3) and redesignating paragraph (4) as paragraph (3).

(B) Section 1842(b)(12) (42 U.S.C. 1395u(b)(12)) is amended by striking subparagraph (C).

(c) INFORMATION ON EXTRA-BILLING LIMITS.—

(1) PART OF EXPLANATION OF MEDICARE BENEFITS.—Section 1842(h)(7) (42 U.S.C. 1395u(h)(7)) is amended—

(A) by striking "and" at the end of subparagraph (B),

(B) in subparagraph (C), by striking "shall include",

(C) in subparagraph (C), by striking the period at the end and inserting ", and", and

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

"(D) in the case of services for which the billed amount exceeds the limiting charge imposed under section 1848(g), information regarding such applicable limiting charge (including information concerning the right to a refund under section 1848(g)(1)(A)(iv)).".

(2) DETERMINATIONS BY CARRIERS.—Subparagraph (G) of section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended to read as follows:

"(G) will, for a service that is furnished with respect to an individual enrolled under this part, that is not paid on an assignment-related basis, and that is subject to a limiting charge under section 1848(g)—

"(i) determine, prior to making payment, whether the amount billed for such service exceeds the limiting charge applicable under section 1848(g)(2);

"(ii) notify the physician, supplier, or other person periodically (but not less often than once every 30 days) of determinations that amounts billed exceeded such applicable limiting charges; and

"(iii) provide for prompt response to inquiries of physicians, suppliers, and other persons concerning the accuracy of such limiting charges for their services;".

(d) REPORT ON CHARGES IN EXCESS OF LIMITING CHARGE.—Section 1848(g)(6)(B) (42 U.S.C. 1395w–4(g)(6)(B)) is amended by inserting "information on the extent to which actual charges exceed limiting charges, the number and types of services involved, and the average amount of excess charges and information" after "report to the Congress".

(e) MISCELLANEOUS AND TECHNICAL AMENDMENTS.—Section 1833(h)(5)(D) (42 U.S.C. 1395l(h)(5)(D)) is amended—

(1) by striking "paragraphs (2) and (3)" and by inserting "paragraph (2)"; and

(2) by adding at the end the following: "Paragraph (4) of such section shall apply in this subparagraph in the same manner as such paragraph applies to such section.".

(f) EFFECTIVE DATES.—

(1) ENFORCEMENT; MISCELLANEOUS AND TECHNICAL AMENDMENTS.—The amendments made by subsections (a) and (e) shall apply to services furnished on or after the date of the enactment of this Act; except that the amendments made by subsection (a) shall not apply to services of a nonparticipating supplier or other person furnished before January 1, 1995.

(2) PRACTITIONERS.—The amendments made by subsection (b) shall apply to services furnished on or after January 1, 1995.

(3) EOMBS.—The amendments made by subsection (c)(1) shall apply to explanations of benefits provided on or after January 1, 1995.

(4) CARRIER DETERMINATIONS.—The amendments made by subsection (c)(2) shall apply to contracts as of January 1, 1995.

(5) REPORT.—The amendment made by subsection (d) shall apply to reports for years beginning with 1995.

SEC. 8414. RELATIVE VALUES FOR PEDIATRIC SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall fully develop, by not later than January 1, 1995, relative values for the full range of pediatric physicians' services which are consistent with the relative values developed for other physicians' services under section 1848(c) of the Social Security Act. In developing such values, the Secretary shall conduct such refinements as may be necessary to produce appropriate estimates for such relative values.

(b) STUDY.—

(1) IN GENERAL.—The Secretary shall conduct a study of the relative values for pediatric and other services to determine whether there are significant variations in the resources used in providing similar services to different populations. In conducting such study, the Secretary shall consult with appropriate organizations representing pediatricians and other physicians and physical and occupational therapists.

(2) REPORT.—Not later than July 1, 1995, the Secretary shall submit to Congress a report on the study conducted under paragraph (1). Such report shall include any appropriate recommendations regarding needed changes in coding or other payment policies to ensure that payments for pediatric services appropriately reflect the resources required to provide these services.

SEC. 8415. ADMINISTRATION OF CLAIMS RELATING TO PHYSICIANS' SERVICES.

(a) LIMITATION ON CARRIER USER FEES.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended by adding at the end the following new paragraph:

"(4) Neither a carrier nor the Secretary may impose a fee under this title—

"(A) for the filing of claims related to physicians' services,

"(B) for an error in filing a claim relating to physicians' services or for such a claim which is denied,

"(C) for any appeal under this title with respect to physicians' services,

"(D) for applying for (or obtaining) a unique identifier under subsection (r), or

"(E) for responding to inquiries respecting physicians' services or for providing information with respect to medical review of such services.".

(b) CLARIFICATION OF PERMISSIBLE SUBSTITUTE BILLING ARRANGEMENTS.—

(1) IN GENERAL.—Clause (D) of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended to read as follows: "(D) payment may be made to a physician for physicians' services (and services furnished incident to such services) furnished by a second physician to patients of the first physician if (i) the first physician is unavailable to provide the services; (ii) the services are furnished pursuant to an arrangement between the two physicians that (I) is informal and reciprocal, or (II) involves per diem or other fee-for-time compensation for such services; (iii) the services are not provided by the second physician over a continuous period of more than 60 days; and (iv) the claim form submitted to the carrier for such services includes the second physician's unique identifier (provided under the system established under subsection (r)) and indicates that the claim meets the requirements of this subparagraph for payment to the first physician".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after the first day of the first month beginning more than 60 days after the date of the enactment of this Act.

SEC. 8416. MISCELLANEOUS AND TECHNICAL CORRECTIONS.

(a) OVERVALUED PROCEDURES.—(1) Section 1842(b)(16)(B)(iii) (42 U.S.C. 1395u(b)(16)(B)(iii)) is amended—

(A) by striking ", simple and subcutaneous",

(B) by striking "; small" and inserting "and small",

(C) by striking "treatments;" the first place it appears and inserting "and",

(D) by striking "lobectomy;",

(E) by striking "enterectomy; colectomy; cholecystectomy;",

(F) by striking "; transurerethral resection" and inserting "and resection", and

(G) by striking "sacral laminectomy;".

(2) Section 4101(b)(2) of OBRA-1990 is amended—

(A) in the matter before subparagraph (A), by striking "1842(b)(16)" and inserting "1842(b)(16)(B)", and

(B) in subparagraph (B)—

(i) by striking ", simple and subcutaneous",

(ii) by striking "(HCPCS codes 19160 and 19162)" and inserting "(HCPCS code 19160)", and

(iii) by striking all that follows "(HCPCS codes 92250" and inserting "and 92260).".

(b) RADIOLOGY SERVICES.—(1) Section 1834(b)(4) (42 U.S.C. 1395m(b)(4)) is amended by redesignating the subparagraphs (E) and (F) redesignated by section 4102(a)(1) of OBRA-1990 as subparagraphs (F) and (G), respectively.

(2) Section 1834(b)(4)(D) (42 U.S.C. 1395m(b)(4)(D)) is amended—

(A) in the matter before clause (i), by striking "shall be determined as follows:" and inserting "shall, subject to clause (vii), be reduced to the adjusted conversion factor for the locality determined as follows:",

(B) in clause (iv), by striking "LOCAL ADJUSTMENT.—Subject to clause (vii), the conversion factor to be applied to" and inserting "ADJUSTED CONVERSION FACTOR.—The adjusted conversion factor for",

(C) in clause (vii), by striking "under this subparagraph", and

(D) in clause (vii), by inserting "reduced under this subparagraph by" after "shall not be".

(3) Section 4102(c)(2) of OBRA-1990 is amended by striking "radiology services" and all that follows and inserting "nuclear medicine services.".

(4) Section 4102(d) of OBRA-1990 is amended by striking "new paragraph" and inserting "new subparagraph".

(5) Section 1834(b)(4)(E) (42 U.S.C. 1395m(b)(4)(E)) is amended by inserting "RULE FOR CERTAIN SCANNING SERVICES.—" after "(E)".

(6) Section 1848(a)(2)(D)(iii) (42 U.S.C. 1395w-4(a)(2)(D)(iii)) is amended by striking "that are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989" and by striking "provided under such section" and inserting "provided under section 6105(b) of the Omnibus Budget Reconciliation Act of 1989".

(c) ANESTHESIA SERVICES.—(1) Section 4103(a) of OBRA-1990 is amended by striking "REDUCTION IN FEE SCHEDULE" and inserting "REDUCTION IN PREVAILING CHARGES".

(2) Section 1842(q)(1)(B) (42 U.S.C. 1395u(q)(1)(B)) is amended—

(A) in the matter before clause (i), by striking "shall be determined as follows:" and inserting "shall, subject to clause (iv), be reduced to the adjusted prevailing charge conversion factor for the locality determined as follows:", and

(B) in clause (iii), by striking "Subject to clause (iv), the prevailing charge conversion factor to be applied in" and inserting "The adjusted prevailing charge conversion factor for".

(d) ASSISTANTS AT SURGERY.—(1) Section 4107(c) of OBRA-1990 is amended by inserting "(a)(1)" after "subsection".

(2) Section 4107(a)(2) of OBRA-1990 is amended by adding at the end the following: "In applying section 1848(g)(2)(D) of the Social Security Act for services of an assistant-at-surgery furnished during 1991, the recognized payment amount shall not exceed the maximum amount specified under section 1848(i)(2)(A) of such Act (as applied under this paragraph in such year).".

(e) TECHNICAL COMPONENTS OF DIAGNOSTIC SERVICES.—Section 1842(b) (42 U.S.C. 1395u(b)) is amended by redesignating paragraph (18), as added by section 4108(a) of OBRA-1990, as paragraph (17) and, in such paragraph, by inserting ", tests specified in paragraph (14)(C)(i)," after "diagnostic laboratory tests".

(f) STATEWIDE FEE SCHEDULES.—Section 4117 of OBRA-1990 is amended—

(1) in subsection (a)—

(A) by striking "(a) IN GENERAL.—", and

(B) by striking ", if the" and all that follows through "1991,"; and

(2) by striking subsections (b), (c), and (d).

(g) STUDY OF AGGREGATION RULE FOR CLAIMS OF SIMILAR PHYSICIAN SERVICES.—Section 4113 of OBRA-1990 is amended—

(1) by inserting "of the Social Security Act" after "1869(b)(2)"; and

(2) by striking "December 31, 1992" and inserting "December 31, 1993".

(h) OTHER MISCELLANEOUS AND TECHNICAL AMENDMENTS.—(1) The heading of section 1834(f) (42 U.S.C. 1395m(f)) is amended by striking "FISCAL YEAR".

(2)(A) Section 4105(b) of OBRA-1990 is amended—

(i) in paragraph (2), by striking "amendments" and inserting "amendment", and

(ii) in paragraph (3), by striking "amendments made by paragraphs (1) and (2)" and inserting "amendment made by paragraph (1)".

(B) Section 1848(f)(2)(C) (42 U.S.C. 1395w-4(f)(2)(C)) is amended by inserting "PERFORMANCE STANDARD RATES OF INCREASE FOR FISCAL YEAR 1991.—" after "(C)".

(C) Section 4105(d) of OBRA-1990 is amended by inserting "PUBLICATION OF PERFORMANCE STANDARD RATES.—" after "(d)".

(3) Section 4106(c) of OBRA-1990 is amended by inserting "of the Social Security Act" after "1848(d)(1)(B)".

(4) Section 4114 of OBRA-1990 is amended by striking "patients" the second place it appears.

(5) Section 1848(e)(1)(C) (42 U.S.C. 1395w-4(e)(1)(C)) is amended by inserting "date of the" after "since the".

(6) Section 4118(f)(1)(D) of OBRA-1990 is amended by striking "is amended".

(7) Section 4118(f)(1)(N)(ii) of OBRA-1990 is amended by striking "subsection (f)(5)(A)" and inserting "subsection (f)(5)(A))".

(8) Section 1845(e) (42 U.S.C. 1395w-1(e)) is amended—

(A) by striking paragraph (2); and

(B) by redesignating paragraphs (3), (4), and (5) as paragraphs (2), (3), and (4).

(9) Section 4118(j)(2) of OBRA-1990 is amended by striking "In section" and inserting "Section".

(10)(A) Section 1848(i)(3) (42 U.S.C. 1395w-4(i)(3)) is amended by striking the space before the period at the end.

(B) Section 1834(a)(10)(B) (42 U.S.C. 1395m(a)(10)(B)) is amended—

(i) by striking "apply to" and inserting "would otherwise apply to", and

(ii) by inserting before the period at the end "but for the application of section 1848(i)(3)".

(i) OTHER CORRECTIONS.—(1) Effective on the date of the enactment of this Act, section 6102(d)(4) of OBRA-1989 is amended by striking all that follows the first sentence.

(2) Effective for payments for fiscal years beginning with fiscal year 1994, section 1842(c)(1) (42 U.S.C. 1395u(c)(1)) is amended—

(A) in subparagraph (A), by striking "(A) Any contract" and inserting "Any contract"; and

(B) by striking subparagraph (B).

(j) EFFECTIVE DATE.—Except as provided in subsection (i), the amendments made by this section and the provisions of this section shall take effect as if included in the enactment of OBRA-1990.

Subpart B—Durable Medical Equipment

SEC. 8421. CERTIFICATION OF SUPPLIERS.

(a) REQUIREMENTS.—

(1) IN GENERAL.—Section 1834 (42 U.S.C. 1395m), as amended by section 13544(b)(1) of OBRA-1993, is amended by adding at the end the following new subsection:

"(j) REQUIREMENTS FOR SUPPLIERS OF MEDICAL EQUIPMENT AND SUPPLIES.—

"(1) ISSUANCE AND RENEWAL OF SUPPLIER NUMBER.—

"(A) PAYMENT.—Except as provided in subparagraph (C), no payment may be made under this part after the expiration of the 60-day period that begins on the date of the enactment of the Guaranteed Health Insurance Act of 1994, for items furnished by a supplier of medical equipment and supplies unless such supplier obtains (and renews at such intervals as the Secretary may require) a supplier number.

"(B) STANDARDS FOR POSSESSING A SUPPLIER NUMBER.—A supplier may not obtain a supplier number unless—

"(i) for medical equipment and supplies furnished on or after the expiration of the 60-day period that begins on the date of the enactment of the Guaranteed Health Insurance Act of 1994, and before January 1, 1996, the supplier meets standards prescribed by the Secretary in regulations issued on June 18, 1992; and

"(ii) for medical equipment and supplies furnished on or after January 1, 1996, the supplier meets revised standards prescribed by the Secretary (in consultation with representatives of suppliers of medical equipment and supplies, carriers, and consumers) that shall include requirements that the supplier—

"(I) comply with all applicable State and Federal licensure and regulatory requirements;

"(II) maintain a physical facility on an appropriate site;

"(III) have proof of appropriate liability insurance; and

"(IV) meet such other requirements as the Secretary may specify.

"(C) EXCEPTION FOR ITEMS FURNISHED AS INCIDENT TO A PHYSICIAN'S SERVICE.—Subparagraph (A) shall not apply with respect to medical equipment and supplies furnished incident to a physician's service.

"(D) PROHIBITION AGAINST MULTIPLE SUPPLIER NUMBERS.—The Secretary may not issue more than one supplier number to any supplier of medical equipment and supplies unless the issuance of more than one number is appropriate to identify subsidiary or regional entities under the supplier's ownership or control.

"(E) PROHIBITION AGAINST DELEGATION OF SUPPLIER DETERMINATIONS.—The Secretary may not delegate (other than by contract under section 1842) the responsibility to determine whether suppliers meet the standards necessary to obtain a supplier number.

"(2) CERTIFICATES OF MEDICAL NECESSITY.—

"(A) LIMITATION ON INFORMATION PROVIDED BY SUPPLIERS ON CERTIFICATES OF MEDICAL NECESSITY.—

"(i) IN GENERAL.—Effective upon the expiration of the 60-day period that begins on the date of the enactment of the Guaranteed Health Insurance Act of 1994, a supplier of medical equipment and supplies may distribute to physicians, or to individuals entitled to benefits under this part, a certificate of medical necessity for commercial purposes which contains no more than the following information completed by the supplier:

"(I) An identification of the supplier and the beneficiary to whom such medical equipment and supplies are furnished.

"(II) A description of such medical equipment and supplies.

"(III) Any product code identifying such medical equipment and supplies.

"(IV) Any other administrative information (other than information relating to the beneficiary's medical condition) identified by the Secretary.

"(ii) INFORMATION ON PAYMENT AMOUNT AND CHARGES.—If a supplier distributes a certificate of medical necessity containing any of the information permitted to be supplied under clause (i), the supplier shall also list on the certificate of medical necessity the fee schedule amount and the supplier's charge for the medical equipment or supplies being furnished prior to distribution of such certificate to the physician.

"(iii) PENALTY.—Any supplier of medical equipment and supplies who knowingly and willfully distributes a certificate of medical necessity in violation of clause (i) or fails to provide the information required under clause (ii) is subject to a civil money penalty in an amount not to exceed $1,000 for each such certificate of medical necessity so distributed. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under section 1128A(a).

"(B) DEFINITION.—For purposes of this paragraph, the term 'certificate of medical necessity' means a form or other document containing information required by the carrier to be submitted to show that an item is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

"(3) DEFINITION.—The term 'medical equipment and supplies' means—

"(A) durable medical equipment (as defined in section 1861(n));

"(B) prosthetic devices (as described in section 1861(s)(8));

"(C) orthotics and prosthetics (as described in section 1861(s)(9));

"(D) surgical dressings (as described in section 1861(s)(5));

"(E) such other items as the Secretary may determine; and

"(F) for purposes of paragraph (1)—

"(i) home dialysis supplies and equipment (as described in section 1861(s)(2)(F)),

"(ii) immunosuppressive drugs (as described in section 1861(s)(2)(J)),

"(iii) therapeutic shoes for diabetics (as described in section 1861(s)(12)),

"(iv) oral drugs prescribed for use as an anticancer therapeutic agent (as described in section 1861(s)(2)(Q)), and

"(v) self-administered erythropoetin (as described in section 1861(s)(2)(P)).".

(2) CONFORMING AMENDMENT.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by striking paragraph (16).

(b) USE OF COVERED ITEMS BY DISABLED BENEFICIARIES.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with representatives of suppliers of durable medical equipment under part B of the medicare program and individuals entitled to benefits under such program on the basis of disability, shall conduct a study of the effects of the methodology for determining payments for items of such equipment under such part on the ability of such individuals to obtain items of such equipment, including customized items.

(2) REPORT.—Not later than one year after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the study conducted under paragraph (1), and shall include in the report such recommendations as the Secretary considers appropriate to assure that disabled medicare beneficiaries have access to items of durable medical equipment.

(c) CRITERIA FOR TREATMENT OF ITEMS AS PROSTHETIC DEVICES OR ORTHOTICS AND PROSTHETICS.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit a report to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate describing pros-

thetic devices or orthotics and prosthetics covered under part B of the medicare program that do not require individualized or custom fitting and adjustment to be used by a patient. Such report shall include recommendations for an appropriate methodology for determining the amount of payment for such items under such program.

SEC. 8422. RESTRICTIONS ON CERTAIN MARKETING AND SALES ACTIVITIES.

(a) PROHIBITING UNSOLICITED TELEPHONE CONTACTS FROM SUPPLIERS OF DURABLE MEDICAL EQUIPMENT TO MEDICARE BENEFICIARIES.—

(1) IN GENERAL.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by adding at the end the following new paragraph:

"(17) PROHIBITION AGAINST UNSOLICITED TELEPHONE CONTACTS BY SUPPLIERS.—

"(A) IN GENERAL.—A supplier of a covered item under this subsection may not contact an individual enrolled under this part by telephone regarding the furnishing of a covered item to the individual unless 1 of the following applies:

"(i) The individual has given written permission to the supplier to make contact by telephone regarding the furnishing of a covered item.

"(ii) The supplier has furnished a covered item to the individual and the supplier is contacting the individual only regarding the furnishing of such covered item.

"(iii) If the contact is regarding the furnishing of a covered item other than a covered item already furnished to the individual, the supplier has furnished at least 1 covered item to the individual during the 15-month period preceding the date on which the supplier makes such contact.

"(B) PROHIBITING PAYMENT FOR ITEMS FURNISHED SUBSEQUENT TO UNSOLICITED CONTACTS.—If a supplier knowingly contacts an individual in violation of subparagraph (A), no payment may be made under this part for any item subsequently furnished to the individual by the supplier.

"(C) EXCLUSION FROM PROGRAM FOR SUPPLIERS ENGAGING IN PATTERN OF UNSOLICITED CONTACTS.—If a supplier knowingly contacts individuals in violation of subparagraph (A) to such an extent that the supplier's conduct establishes a pattern of contacts in violation of such subparagraph, the Secretary shall exclude the supplier from participation in the programs under this Act, in accordance with the procedures set forth in subsections (c), (f), and (g) of section 1128.".

(2) REQUIRING REFUND OF AMOUNTS COLLECTED FOR DISALLOWED ITEMS.—Section 1834(a) (42 U.S.C. 1395m(a)), as amended by paragraph (1), is amended by adding at the end the following new paragraph:

"(18) REFUND OF AMOUNTS COLLECTED FOR CERTAIN DISALLOWED ITEMS.—

"(A) IN GENERAL.—If a nonparticipating supplier furnishes to an individual enrolled under this part a covered item for which no payment may be made under this part by reason of paragraph (17)(B), the supplier shall refund on a timely basis to the patient (and shall be liable to the patient for) any amounts collected from the patient for the item, unless—

"(i) the supplier establishes that the supplier did not know and could not reasonably have been expected to know that payment may not be made for the item by reason of paragraph (17)(B), or

"(ii) before the item was furnished, the patient was informed that payment under this part may not

be made for that item and the patient has agreed to pay for that item.

"(B) SANCTIONS.—If a supplier knowingly and willfully fails to make refunds in violation of subparagraph (A), the Secretary may apply sanctions against the supplier in accordance with section 1842(j)(2).

"(C) NOTICE.—Each carrier with a contract in effect under this part with respect to suppliers of covered items shall send any notice of denial of payment for covered items by reason of paragraph (17)(B) and for which payment is not requested on an assignment-related basis to the supplier and the patient involved.

"(D) TIMELY BASIS DEFINED.—A refund under subparagraph (A) is considered to be on a timely basis only if—

"(i) in the case of a supplier who does not request reconsideration or seek appeal on a timely basis, the refund is made within 30 days after the date the supplier receives a denial notice under subparagraph (C), or

"(ii) in the case in which such a reconsideration or appeal is taken, the refund is made within 15 days after the date the supplier receives notice of an adverse determination on reconsideration or appeal.".

(b) CONFORMING AMENDMENT.—Section 1834(h)(3) (42 U.S.C. 1395m(h)(3)) is amended by striking "Paragraph (12)" and inserting "Paragraphs (12) and (17)".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to items furnished after the expiration of the 60-day period that begins on the date of the enactment of this Act.

SEC. 8423. BENEFICIARY LIABILITY FOR NONCOVERED SERVICES.

(a) UNASSIGNED CLAIMS.—Section 1834(j) (42 U.S.C. 1395m(i)), as added by section 8421(a)(1), is amended—

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

(B) by inserting after paragraph (2) the following new paragraph:

"(3) LIMITATION ON PATIENT LIABILITY.—If a supplier of medical equipment and supplies (as defined in paragraph (4))—

"(A) furnishes an item or service to a beneficiary for which no payment may be made by reason of paragraph (1);

"(B) furnishes an item or service to a beneficiary for which payment is denied in advance under subsection (a)(15); or

"(C) furnishes an item or service to a beneficiary for which payment is denied under section 1862(a)(1);

any expenses incurred for items and services furnished to an individual by such a supplier not on an assigned basis shall be the responsibility of such supplier. The individual shall have no financial responsibility for such expenses and the supplier shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected from the individual for such items or services. The provisions of subsection (a)(18) shall apply to refunds required under the previous sentence in the same manner as such provisions apply to refunds under such subsection.".

(b) ASSIGNED CLAIMS.—Section 1879 (42 U.S.C. 1395pp) is amended by adding at the end the following new subsection:

"(h) If a supplier of medical equipment and supplies (as defined in section 1834(j)(4))—

"(1) furnishes an item or service to a beneficiary for which no payment may be made by reason of section 1834(j)(1);

"(2) furnishes an item or service to a beneficiary for which payment is denied in advance under section 1834(a)(15); or

"(3) furnishes an item or service to a beneficiary for which no payment may be made by reason of section 1834(a)(17)(B),

any expenses incurred for items and services furnished to an individual by such a supplier on an assignment-related basis shall be the responsibility of such supplier. The individual shall have no financial responsibility for such expenses and the supplier shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected from the individual for such items or services. The provisions of section 1834(a)(18) shall apply to refunds required under the previous sentence in the same manner as such provisions apply to refunds under such section.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items or services furnished on or after the expiration of the 60-day period that begins on the date of the enactment of this Act.

SEC. 8424. ADJUSTMENTS FOR INHERENT REASONABLENESS.

(a) ADJUSTMENTS MADE TO FINAL PAYMENT AMOUNTS.—

(1) IN GENERAL.—Section 1834(a)(10)(B) (42 U.S.C. 1395m(a)(10)(B)) is amended by adding at the end the following: "In applying such provisions to payments for an item under this subsection, the Secretary shall make adjustments to the payment basis for the item described in paragraph (1)(B) if the Secretary determines (in accordance with such provisions and on the basis of prices and costs applicable at the time the item is furnished) that such payment basis is not inherently reasonable.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(b) ADJUSTMENT REQUIRED FOR CERTAIN ITEMS.—

(1) IN GENERAL.—In accordance with section 1834(a)(10)(B) of the Social Security Act (as amended by subsection (a)), the Secretary of Health and Human Services shall determine whether the payment amounts for the items described in paragraph (2) are not inherently reasonable, and shall adjust such amounts in accordance with such section if the amounts are not inherently reasonable.

(2) ITEMS DESCRIBED.—The items referred to in paragraph (1) are decubitus care equipment, transcutaneous electrical nerve stimulators, and any other items considered appropriate by the Secretary.

SEC. 8425. MISCELLANEOUS AND TECHNICAL CORRECTIONS.

(a) UPDATES TO PAYMENT AMOUNTS.—(1) Subparagraph (A) of section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended to read as follows:

"(A) for 1991 and 1992, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced by 1 percentage point; and".

(2) The amendment made by paragraph (1) shall be effective on the date of the enactment of this Act.

(b) ADVANCE DETERMINATIONS OF COVERAGE.—(1) Effective on the expiration of the 60-day period that begins on date of the enactment of this Act, section 1834(a)(15) (42 U.S.C. 1395m(a)(15)) is amended to read as follows:

"(15) ADVANCE DETERMINATIONS OF COVERAGE FOR CERTAIN ITEMS.—

"(A) DEVELOPMENT OF LISTS OF ITEMS BY SECRETARY.—The Secretary may develop and periodically update a list of items for which payment may be made under this subsection that the Secretary determines, on the basis of prior payment experience, are frequently subject to unnecessary utilization throughout a carrier's entire service area or a portion of such area.

"(B) DEVELOPMENT OF LISTS OF SUPPLIERS BY SECRETARY.—The Secretary may develop and periodically up-

date a list of suppliers of items for which payment may be made under this subsection with respect to whom—

"(i) the Secretary has found that a substantial number of claims for payment under this part for items furnished by the supplier have been denied on the basis of the application of section 1862(a)(1); or

"(ii) the Secretary has identified a pattern of overutilization resulting from the business practice of the supplier.

"(C) DETERMINATIONS OF COVERAGE IN ADVANCE.—A carrier shall determine in advance of delivery of an item whether payment for the item may not be made because the item is not covered or because of the application of section 1862(a)(1) if—

"(i) the item is included on the list developed by the Secretary under subparagraph (A);

"(ii) the item is furnished by a supplier included on the list developed by the Secretary under subparagraph (B); or

"(iii) the item is a customized item (other than inexpensive items specified by the Secretary) and the patient to whom the item is to be furnished or the supplier requests that such advance determination be made.".

(2) Effective for standards applied for contract years beginning after the date of the enactment of this Act, section 1842(c) (42 U.S.C. 1395u(c)), as amended by section 8415(a), is amended by adding at the end the following new paragraph:

"(5) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall require the carrier to meet criteria developed by the Secretary to measure the timeliness of carrier responses to requests for payment of items described in section 1834(a)(15)(C).".

(3) Effective on the date of the enactment of this Act, section 1834(h)(3) (42 U.S.C. 1395m(h)(3)), as amended by section 8423(b), is amended by striking "(12) and (17)" and inserting "(12), (15), and (17)".

(c) STUDY OF VARIATIONS IN DURABLE MEDICAL EQUIPMENT SUPPLIER COSTS.—

(1) COLLECTION AND ANALYSIS OF SUPPLIER COST DATA.—The Administrator of the Health Care Financing Administration shall, in consultation with appropriate organizations, collect data on supplier costs of durable medical equipment for which payment may be made under part B of the medicare program, and shall analyze such data to determine the proportions of such costs attributable to the service and product components of furnishing such equipment and the extent to which such proportions vary by type of equipment and by the geographic region in which the supplier is located.

(2) DEVELOPMENT OF GEOGRAPHIC ADJUSTMENT INDEX; REPORTS.—Not later than 6 months after collecting and analyzing the data described in paragraph (1)—

(A) the Administrator shall submit a report to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the data collected and the analysis conducted under paragraph (1), and shall include in such report the Administrator's recommendations for a geographic cost adjustment index for suppliers of durable medical equipment under the medicare program and an analysis of the impact of such proposed index on payments under the medicare program; and

(B) the Comptroller General shall submit a report to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate analyzing on a geographic basis

the supplier costs of durable medical equipment under the medicare program.

(d) OXYGEN RETESTING.—(1) Section 1834(a)(5)(E) (42 U.S.C. 1395m(a)(5)(E)) is amended by striking "55" and inserting "56".

(2) The amendment made by paragraph (1) shall be effective on the date of the enactment of this Act.

(e) OTHER MISCELLANEOUS AND TECHNICAL AMENDMENTS.—(1) Section 4152(a)(3) of OBRA–1990 is amended by striking "amendment made by subsection (a)" and inserting "amendments made by this subsection".

(2) Section 4152(c)(2) of OBRA–1990 is amended by striking "1395m(a)(7)(A)" and inserting "1395m(a)(7)".

(3) Section 1834(a)(7)(A)(iii)(II) (42 U.S.C. 1395m(a)(7)(A)(iii)(II)) is amended by striking "clause (v)" and inserting "clause (vi)".

(4) Section 1834(a)(7)(C)(i) (42 U.S.C. 1395m(a)(7)(C)(i)) is amended by striking "or paragraph (3)".

(5) Section 1834(a)(3) (42 U.S.C. 1395m(a)(3)) is amended by striking subparagraph (D).

(6) Section 4153(c)(1) of OBRA–1990 is amended by striking "1834(a)" and inserting "1834(h)".

(7) Section 4153(d)(2) of OBRA–1990 is amended by striking "Reconiliation" and inserting "Reconciliation".

(8) The amendments made by this subsection shall take effect as if included in the enactment of OBRA–1990.

Subpart C—Other Items and Services

SEC. 8431. AMBULATORY SURGICAL CENTER SERVICES.

(a) PAYMENT AMOUNTS FOR SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.—

(1) USE OF SURVEY TO DETERMINE INCURRED COSTS.—Section 1833(i)(2)(A)(i) (42 U.S.C. 1395l(i)(2)(A)(i)) is amended by striking the comma at the end and inserting the following: ", as determined in accordance with a survey (based upon a representative sample of procedures and facilities) taken not later than January 1, 1995, and every 5 years thereafter, of the actual audited costs incurred by such centers in providing such services,".

(2) AUTOMATIC APPLICATION OF INFLATION ADJUSTMENT.—Section 1833(i)(2) (42 U.S.C. 1395l(i)(2)) is amended—

(A) in the second sentence of subparagraph (A) and the second sentence of subparagraph (B), by striking "and may be adjusted by the Secretary, when appropriate,"; and

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

"(C) Notwithstanding the second sentence of subparagraph (A) or the second sentence of subparagraph (B), if the Secretary has not updated amounts established under such subparagraphs with respect to facility services furnished during a fiscal year (beginning with fiscal year 1996), such amounts shall be increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.".

(3) CONSULTATION REQUIREMENT.—The second sentence of section 1833(i)(1) (42 U.S.C. 1395l(i)(1)) is amended by striking the period and inserting the following: ", in consultation with appropriate trade and professional organizations.".

(b) ADJUSTMENTS TO PAYMENT AMOUNTS FOR NEW TECHNOLOGY INTRAOCULAR LENSES.—

(1) ESTABLISHMENT OF PROCESS FOR REVIEW OF AMOUNTS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall develop and implement a process under which interested parties may request review by the Secretary of the appropriateness of the

reimbursement amount provided under section 1833(i)(2)(A)(iii) of the Social Security Act with respect to a class of new technology intraocular lenses. For purposes of the preceding sentence, an intraocular lens may not be treated as a new technology lens unless it has been approved by the Food and Drug Administration.

(2) FACTORS CONSIDERED.—In determining whether to provide an adjustment of payment with respect to a particular lens under paragraph (1), the Secretary shall take into account whether use of the lens is likely to result in reduced risk of intraoperative or postoperative complication or trauma, accelerated postoperative recovery, reduced induced astigmatism, improved postoperative visual acuity, more stable postoperative vision, or other comparable clinical advantages.

(3) NOTICE AND COMMENT.—The Secretary shall publish notice in the Federal Register from time to time (but no less often than once each year) of a list of the requests that the Secretary has received for review under this subsection, and shall provide for a 30-day comment period on the lenses that are the subjects of the requests contained in such notice. The Secretary shall publish a notice of the Secretary's determinations with respect to intraocular lenses listed in the notice within 90 days after the close of the comment period.

(4) EFFECTIVE DATE OF ADJUSTMENT.—Any adjustment of a payment amount (or payment limit) made under this subsection shall become effective not later than 30 days after the date on which the notice with respect to the adjustment is published under paragraph (3).

(c) TECHNICAL CORRECTION RELATING TO BLEND AMOUNTS FOR AMBULATORY SURGICAL CENTER PAYMENTS.—

(1) IN GENERAL.—Subclauses (I) and (II) of section 1833(i)(3)(B)(ii) (42 U.S.C. 1395l(i)(3)(B)(ii)) are each amended—

(A) by striking "for reporting" and inserting "for portions of cost reporting"; and

(B) by striking "and on or before" and inserting "and ending on or before".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect as if included in the enactment of OBRA–1990.

(d) TECHNICAL CORRECTION RELATED TO CATARACT SURGERY.—Effective as if included in the enactment of OBRA–1990, section 4151(c)(3) of such Act is amended by striking "for the insertion of an intraocular lens" and inserting "for an intraocular lens inserted".

SEC. 8432. STUDY OF MEDICARE COVERAGE OF PATIENT CARE COSTS ASSOCIATED WITH CLINICAL TRIALS OF NEW CANCER THERAPIES.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the effects of expressly covering under the medicare program the patient care costs for beneficiaries enrolled in clinical trials of new cancer therapies, where the protocol for the trial has been approved by the National Cancer Institute or meets similar scientific and ethical standards, including approval by an institutional review board. The study shall include—

(1) an estimate of the cost of such coverage, taking into account the extent to which medicare currently pays for such patient care costs in practice;

(2) an assessment of the extent to which such clinical trials represent the best available treatment for the patients involved and of the effects of participation in the trials on the health of such patients;

(3) an assessment of whether progress in developing new anticancer therapies would be assisted by medicare coverage of such patient care costs; and

(4) an evaluation of whether there should be special criteria for the admission of medicare beneficiaries (on account of their age or physical condition) to clinical trials for which medicare would pay the patient care costs.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit a report on the study conducted under subsection (a) to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate. Such report shall include recommendations as to the coverage under the medicare program of patient care costs of beneficiaries enrolled in clinical trials of new cancer therapies.

SEC. 8433. STUDY OF ANNUAL CAP ON AMOUNT OF MEDICARE PAYMENT FOR OUTPATIENT PHYSICAL THERAPY AND OCCUPATIONAL THERAPY SERVICES.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the appropriateness of continuing an annual limitation on the amount of payment for outpatient services of independently practicing physical and occupational therapists under the medicare program.

(b) REPORT.—By not later than January 1, 1996, the Secretary shall submit to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the study conducted under subsection (a). Such report shall include such recommendations for changes in such annual limitation as the Secretary finds appropriate.

SEC. 8434. PAYMENT OF PART B PREMIUM LATE ENROLLMENT PENALTIES BY STATES.

Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following new subsection:

"(g)(1) Upon the request of a State, the Secretary may enter into an agreement with the State under which the State agrees to pay on a quarterly or other periodic basis to the Secretary (to be deposited in the Treasury to the credit of the Federal Supplementary Medical Insurance Trust Fund) an amount equal to the amount of the part B late enrollment premium increases with respect to the premiums for eligible individuals (as defined in paragraph (3)(A)).

"(2) No part B late enrollment premium increase shall apply to an eligible individual for premiums for months for which the amount of such an increase is payable under an agreement under paragraph (1).

"(3) In this subsection:

"(A) The term 'eligible individual' means an individual who is enrolled under this part B and who is within a class of individuals specified in the agreement under paragraph (1).

"(B) The term 'part B late enrollment premium increase' means any increase in a premium as a result of the application of subsection (b).".

SEC. 8435. TREATMENT OF INPATIENTS AND PROVISION OF DIAGNOSTIC X-RAY SERVICES BY RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.

(a) TREATMENT OF INPATIENTS.—Section 1861(aa) (42 U.S.C. 1395x(aa)) is amended—

(1) in paragraph (1), in the matter following subparagraph (C), by striking "as an outpatient" and inserting "as a patient";

(2) in paragraph (2)(A), by striking "furnishing to outpatients" and inserting "furnishing to patients"; and

(3) in paragraph (3), in the matter following subparagraph (B), by striking "as an outpatient" and inserting "as a patient".

(b) TREATMENT OF DIAGNOSTIC X-RAY SERVICES.—Section 1861(aa) (42 U.S.C. 1395x(aa)) is further amended—