Omnibus Budget Reconciliation Act of 1989, Titles VI, VIII, X, XI

One Hundred First Congress of the United States of America
AT THE FIRST SESSION

Begun and held at the City of Washington on Tuesday, the third day of January,

one thousand nine hundred and eighty-nine

An Act

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

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

SECTION 1. SHORT TITLE.

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PART 1--PROVISIONS RELATING TO PART A

Subpart A--General Provisions

SEC. 6001. EXTENSION OF REDUCTIONS UNDER ORIGINAL SEQUESTER ORDER AND APPLICABILITY OF NEW SEQUESTER ORDER.

Notwithstanding any other provision of law (including section 11002 or any other provision of this Act, other than section 6201), the
reductions in the amount of payments required under title XVIII of the Social Security Act made by the final sequester order issued by the President on October 16, 1989, pursuant to section 252(b) of the Balanced Budget and Emergency Deficit Control Act of 1985 shall continue to be effective (as provided by sections 252(a)(4)(B) and 256(d)(2) of such Act) through December 31, 1989, with respect to payments for items and services under part A of such title (including payments under section 1886 of such title attributable or allocated to such part). Each such payment made for items and services provided during fiscal year 1990 after such date shall be increased by 1.42 percent above what it would otherwise be under this Act.

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

Section 1886(g)(3)(A) of the Social Security Act (42 U.S.C. 1395ww(g)(3)(A)) is amended--
(1) in clause (iii), by striking `and';
(2) in clause (iv), by striking the period at the end and inserting `, and'; and
(3) by adding at the end the following new clause:
` (v) 15 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during the period beginning January 1, 1990, and ending September 30, 1990.'.

SEC. 6003. PROSPECTIVE PAYMENT HOSPITALS.

(a) CHANGES IN HOSPITAL UPDATE FACTORS-
(1) IN GENERAL- Section 1886(b)(3)(B)(i) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended--
(A) by striking `and' at the end of subclause (IV),
(B) in subclause (V), by striking `1990' and inserting `1991' and redesignating such subclause as subclause (VI), and
(C) by inserting after subclause (IV) the following new subclause:
` (V) for fiscal year 1990, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas, and'.

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

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

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

(1) by striking `\(C\)' and inserting `\(C\)(i)'; and

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

`\(\text{ii}\)' For discharges in fiscal year 1990, the Secretary shall reduce the weighting factor for each diagnosis-related group by 1.22 percent.

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

`\(\text{iv}\)' The Secretary shall include recommendations with respect to adjustments to weighting factors under clause (i) in the annual report to Congress required under subsection (e)(3)(B).

(c) **INCREASE IN DISPROPORTIONATE SHARE ADJUSTMENT**-

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

(A) in clause (iv)(I), by striking `\(\text{the following formula}' and all that follows through `\(\text{as defined in clause (vi))}';' and inserting `\(\text{the applicable formula described in clause (vii))}';' and

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

`\(\text{vii}\)' The formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(I) is--

`\(\text{i}\) in the case of such a hospital with a disproportionate patient percentage (as defined in clause (vi)) greater than 20.2, \((P-20.2)(.65)+5.62\), or

`\(\text{ii}\) in the case of any other such hospital, \((P-15)(.6)+2.5\), where \(P\) is the hospital's disproportionate patient percentage (as defined in clause (vi)).'.
(2) TREATMENT OF RURAL HOSPITALS FOR DISPROPORTIONATE SHARE CALCULATION- Section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)), as amended by paragraph (1), is amended--

(A) in clause (iv)--

(i) in subclause (II), by striking `or',
(ii) in subclause (III), by inserting `in subclause (IV) or (V) or' after `described',
(iii) by striking the period at the end of subclause (III) and inserting a semicolon, and
(iv) by adding at the end the following new subclauses:

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

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

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

(B) in clause (v)--

(i) in subclause (III), by striking `area' and inserting `area and is not described in subclause (II)',
(ii) by redesignating subclauses (II) and (III) as subclauses (III) and (IV), and
(iii) by inserting after subclause (I) the following new subclause:

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

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

`(viii) The formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(IV) or (iv)(V) is the percentage determined in accordance with the following formula: (P-30)(.6)+4.0, where `P' is the hospital's disproportionate patient percentage (as defined in clause (vi)).'.
Act (42 U.S.C. 1395ww(d)(5)(F)(iii)) is amended by striking `25 percent' and inserting `30 percent'.

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

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

(e) CRITERIA AND PAYMENT FOR SOLE COMMUNITY HOSPITALS-

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

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

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

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

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

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

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

`(II) the amount determined under paragraph (1)(A)(iii), whichever results in greater payment to the hospital.

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

`(iii) The term `sole community hospital' means any hospital--

`(I) that the Secretary determines is located more than 35 road miles from another hospital, or
`(II) that, by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (in accordance with standards promulgated by the Secretary), location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under part A.

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

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

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

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

`(C) In the case of a hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii)), the term `target amount' means-

`(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital--

`'(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the `base cost reporting period') preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by--

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

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

There shall be substituted for the base cost reporting period described in clause (i) a hospital’s cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.'.
(2) CONFORMING AMENDMENTS- Such Act is further amended--
(A) in section 1833(h)(1)(D), by striking `the last sentence of section 1886(d)(5)(C)(ii)' and inserting `section 1886(d)(5)(D)(iii)';
(B) in section 1886(d)(5)(C)(i)--
   (i) by striking `(C)(i)(I)' and inserting `(C)(i)', and
   (ii) by redesignating subclause (II) as clause (ii) and
       by striking `subclause (I)' each place it appears in
       such clause and inserting `clause (i)';
(C) in section 1886(d)(9)(B)(ii)(IV), by striking `(D)(v)' and inserting `(D)(iii)';
(D) in section 1886(d)(9)(D)--
   (i) by striking clause (iv),
   (ii) by transferring clause (iii) to the end and
       redesignating it as clause (iv), and by striking
       `(C)(iii)' and inserting `(H)', and
   (iii) by redesignating clause (v) as clause (iii); and
(E) in section 1886(g)(3)(B), by striking `(d)(5)(C)(ii)' and inserting `(d)(5)(D)(iii)'.

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

(f) CRITERIA AND PAYMENT FOR MEDICARE-DEPENDENT, SMALL
RURAL HOSPITALS-
(1) CRITERIA- Section 1886(d)(5) of the Social Security Act (42
U.S.C. 1395ww(d)(5)), as amended by subsection (e)(1)(A), is
further amended by inserting after subparagraph (F) the
following new subparagraph:
   `(G)(i) For any cost reporting period beginning on or after April 1,
       1990, and ending on or before March 31, 1993, with respect to a
       subsection (d) hospital which is a medicare-dependent, small rural
       hospital, payment under paragraph (1)(A) shall be--
       `(I) an amount based on 100 percent of the hospital's target
           amount for the cost reporting period, as defined in subsection
           (b)(3)(D), or
       `(II) the amount determined under paragraph (1)(A)(iii),
           whichever results in the greater payment to the hospital.
`(ii) In the case of a medicare dependent, small rural hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

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

`(I) located in a rural area,
`(II) that has not more than 100 beds,
`(III) that is not classified as a sole community hospital under subparagraph (D), and
`(IV) for which not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987 were attributable to inpatients entitled to benefits under part A'.

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

(i) in subparagraph (A), by striking `subparagraph (C)' and inserting `subparagraphs (C) and (D)', and
(ii) by adding at the end the following new subparagraph:

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

`(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital--

`(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the `base cost reporting period') preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by--
`(II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or
(ii) with respect to a later cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(i) for discharges occurring in the fiscal year in which that later cost reporting period begins.

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

(g) ESSENTIAL ACCESS COMMUNITY HOSPITAL PROGRAM-

(1) ESTABLISHMENT OF PROGRAM-

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

`ESSENTIAL ACCESS COMMUNITY HOSPITAL PROGRAM

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

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

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

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

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

(1) assurances that the State--

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

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

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

(iii) improves access to hospital and other health services for rural residents of the State, and
enhances the provision of emergency and other transportation services related to health care;
(B) has developed the rural health care plan described in subparagraph (A) in consultation with the hospital association of the State and rural hospitals located in the State (or, in the case of a State in the process of developing such plan, that assures the Secretary that it will consult with its State hospital association and rural hospitals located in the State in developing such plan); and
(C) has designated, or is in the process of designating, rural non-profit or public hospitals or facilities located in the State as essential access community hospitals or rural primary care hospitals within such networks; and
(2) such other information and assurances as the Secretary may require.
(c) ELIGIBILITY OF HOSPITALS AND CONSORTIA FOR GRANTS-
(1) IN GENERAL- Except as provided in paragraph (3), a hospital or facility is eligible to receive a grant under subsection (a)(2) only if the hospital or facility--
(A) is located in a State receiving a grant under subsection (a)(1);
(B) is designated as an essential access community hospital or a rural primary care hospital by the State in which it is located or is a member of a rural health network (as defined in subsection (g));
(C) submits to the State in which it is located and to the Secretary, at such time and in such form as the Secretary may require, an application containing such information and assurances as the Secretary may require; and
(D) the State in which the hospital or facility is located certifies to the Secretary that--
(i) the receiving of such a grant by the hospital or facility is consistent with the State's rural health care plan (described in subsection (b)(1)(A)), and
(ii) the State has approved the application submitted under subparagraph (C).
(2) TREATMENT OF CONSORTIA- A consortium of hospitals or facilities each of which is part of the same rural health network is eligible to receive a grant under subsection (a)(2) if each of its members would individually be eligible to receive such a grant.
(3) ELIGIBILITY OF RPC HOSPITALS NOT LOCATED IN A STATE RECEIVING GRANT- A facility designated as a rural primary care hospital by the Secretary under subsection (i)(2)(C) shall be eligible to receive a grant under subsection (a)(2).
(d) ACTIVITIES FOR WHICH GRANTS MAY BE USED-

(1) GRANTS TO STATES- A State shall use a grant received under subsection (a)(1) to carry out the demonstration program established under this section in the State. Such grant may be used for engaging in activities relating to planning and implementing a rural health care plan and rural health networks, designating hospitals or facilities in the State as essential access community hospitals or rural primary care hospitals, and developing and supporting communication and emergency transportation systems.

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

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

(1) is located in a rural area (as defined in section 1886(d)(2)(D));
(2)(A) is located more than 35 miles from any hospital that either (i) has been designated as an essential access community hospital, (ii) is classified by the Secretary as a rural referral center under section 1886(d)(5)(C), or (iii) is located in an urban area that meets the criteria for classification as a regional referral center under such section, or (B) meets such other criteria relating to geographic location as the State may impose with the approval of the Secretary;
(3) has at least 75 inpatient beds or is located more than 35 miles from any other hospital;
(4) has in effect an agreement to provide emergency and medical backup services to rural primary care hospitals.
participating in the rural health network of which it is a member and throughout its service area;
`(5) has in effect an agreement, with each rural primary care hospital participating in the rural health network of which it is a member, to accept patients transferred from such primary care hospital, to receive data from and transmit data to such primary care hospital, and to provide staff privileges to physicians providing care at such primary care hospital; and
`(6) meets any other requirements imposed by the State with the approval of the Secretary.
`(f) DESIGNATION BY STATE OF RURAL PRIMARY CARE HOSPITALS-
`(1) CRITERIA FOR DESIGNATION- A State may designate a facility as a rural primary care hospital only if the facility--
`(A) is located in a rural area (as defined in section 1886(d)(2)(D));
`(B) at the time such facility applies to the State for designation as a rural primary care hospital, is a hospital with a participation agreement in effect under section 1866(a) and had not been found, on the basis of a survey under section 1864, to be in violation of any requirement to participate as a hospital under this title;
`(C) has ceased, or agrees (upon the approval of such application) to cease, providing inpatient care (except as required under subparagraph (F));
`(D) in the case of a facility that is a member of a rural health network, has in effect an agreement to participate with other hospitals and facilities in the communications system of such network, including the network’s system for the electronic sharing of patient data, including telemetry and medical records, if the network has in operation such a system;
`(E) makes available 24-hour emergency care;
`(F) provides not more than 6 inpatient beds (meeting such conditions as the Secretary may establish) for providing inpatient care for a period not to exceed 72 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions) to patients requiring stabilization before discharge or transfer to a hospital;
`(G) meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that--
`(i) the facility need not meet hospital standards relating to the number of hours during a day, or days
during a week, in which the facility must be open, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraph (E), (ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietician, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, off-site basis, and (iii) the inpatient care described in subparagraph (F) may be provided by a physician's assistant or nurse practitioner, subject to the oversight of a physician; and 
(H) meets the requirements of subparagraphs (C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of that paragraph.
(2) PREFERENCE GIVEN TO HOSPITALS OR FACILITIES PARTICIPATING IN RURAL HEALTH NETWORK- In designating facilities as rural primary care hospitals under paragraph (1), the State shall give preference to hospitals or facilities participating in a rural health network.
(3) PERMITTING RURAL PRIMARY CARE HOSPITALS TO MAINTAIN SWING BEDS- Nothing in this subsection shall be construed to prohibit a State from designating a facility as a rural primary care hospital solely because the facility has entered into an agreement with the Secretary under section 1883 under which the facility's inpatient hospital facilities may be used for the furnishing of extended care services.
(g) RURAL HEALTH NETWORK DEFINED- For purposes of this section, the term 'rural health network' means, with respect to a State, an organization--
(1) consisting of--
(A) at least 1 hospital that--
(i) the State has designated or plans to designate as an essential access community hospital under subsection (b)(1)(C),
(ii) is classified by the Secretary as rural a referral center under section 1886(d)(5)(C), or
(iii) is located in an urban area and meets the criteria for classification as a regional referral center under such section, and
(B) at least 1 facility that the State has designated or plans to designate as a rural primary care hospital, and
(2) the members of which have entered into agreements regarding--

(A) patient referral and transfer,

(B) the development and use of communications systems, including (where feasible) telemetry systems and systems for electronic sharing of patient data, and

(C) the provision of emergency and non-emergency transportation among the members.

(h) LIMIT ON AMOUNT OF GRANT TO HOSPITAL OR FACILITY- A grant made to a hospital or facility under subsection (a)(2) may not exceed $200,000.

(i) ELIGIBILITY OF HOSPITALS OR FACILITIES FOR DESIGNATION BY SECRETARY-

(1) ESSENTIAL ACCESS COMMUNITY HOSPITAL- (A) The Secretary shall designate a hospital as an essential access community hospital if the hospital--

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

(ii) is designated as an essential access community hospital by the State in which it is located (except as provided in subparagraph (B)); and

(iii) meets such other criteria as the Secretary may require.

(B) In the case of a hospital that is not eligible for designation as an essential access community hospital under this paragraph solely because it is not designated as an essential access community hospital by the State in which it is located, the Secretary may designate such hospital as an essential access community hospital under this paragraph if the hospital is not so designated by the State in which it is located solely because of its failure to meet the criteria described in paragraph (3) of subsection (e).

(2) RURAL PRIMARY CARE HOSPITAL- (A) The Secretary shall designate a facility as a rural primary care hospital if the facility--

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

(ii) is designated as a rural primary care hospital by the State in which it is located (except as provided in subparagraph (B)); and

(iii) meets such other criteria as the Secretary may require.

(B) In the case of a facility that is not eligible for designation as a rural primary care hospital under this paragraph solely because
it is not designated as a rural primary care hospital by the State in which it is located, the Secretary may designate such facility as a rural primary care hospital under this paragraph if the facility is not so designated by the State in which it is located solely because of its failure to meet the criteria described in subparagraphs (C), (F), or (G) of subsection (f)(1).

`(C) The Secretary may designate not more than 15 facilities as rural primary care hospitals under this paragraph that do not meet the requirements of clauses (i) and (ii) of subparagraph (A) if such a facility meets the criteria described in subparagraphs (A), (B), and (E) of subsection (f)(1), except that nothing in this subparagraph shall be construed to prohibit the Secretary from designating a facility as a rural primary care hospital solely because the facility has entered into an agreement with the Secretary under section 1883 under which the facility's inpatient hospital facilities may be used for the furnishing of extended care services.

`(j) WAIVER OF CONFLICTING PART A PROVISIONS- The Secretary is authorized to waive such provisions of this part as are necessary to conduct the program established under this section.

`(k) AUTHORIZATION OF APPROPRIATIONS- There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for each of the fiscal years 1990, 1991, and 1992--

`(1) $10,000,000 for grants to States under subsection (a)(1); and

`(2) $15,000,000 for grants to hospitals, facilities, and consortia under subsection (a)(2).'

(B) MODIFICATION OF RURAL HEALTH CARE TRANSITION GRANT PROGRAM- (i) Section 4005(e) of the Omnibus Budget Reconciliation Act of 1987 is amended--

`(I) in paragraph (1), by adding at the end the following new sentence: `Grants under this paragraph may be used to provide instruction and consultation (and such other services as the Administrator determines appropriate) via telecommunications to physicians in such rural areas (within the meaning of section 1886(d)(2)(D) of the Social Security Act) as are designated either class 1 or class 2 health manpower shortage areas under section 332(a)(1)(A) of the Public Health Service Act.',

`(II) in paragraph (3)(A), by striking `an application to the Governor' and inserting `an application to the
Administrator and a copy of such application to the Governor',
(III) in paragraph (3)(B), by striking `any application' and all that follows through `accompanied by' and inserting `to the Administrator, within a reasonable time after receiving a copy of an application pursuant to subparagraph (A)',
(IV) in paragraph (6), by striking `2 years' and inserting `3 years',
(V) in paragraph (7)(A), by striking `(D)' and inserting `(B)',
(VI) in paragraph (7)(C), by striking the period at the end and inserting the following: `, except that this limitation shall not apply with respect to a grant used for the purposes described in subparagraph (D).',
(VII) by adding at the end of paragraph (7) the following new subparagraph:
`(D) A hospital may use a grant received under this subsection to develop a plan for converting itself to a rural primary care hospital (as described in section 1820 of the Social Security Act) or to develop a rural health network (as defined in section 1820(g) of such Act) in the State in which it is located if the State is receiving a grant under section 1820(a)(1).', and
(VIII) in paragraph (9), by striking `each of the fiscal years 1989 and 1990' and inserting `fiscal year 1989 and $25,000,000 for each of the fiscal years 1990, 1991, and 1992'.

(ii) The amendments made by clause (i) shall apply with respect to applications for grants under the Rural Health Care Transition Grant Program described in section 4005(e) of the Omnibus Budget Reconciliation Act of 1987 submitted on or after October 1, 1989, except that the amendments made by subclauses (V) and (VII) of such clause shall take effect on the date of the enactment of this Act.

(2) TREATMENT OF ESSENTIAL ACCESS COMMUNITY HOSPITALS AS SOLE COMMUNITY HOSPITALS - Section 1886(d)(5)(D) of such Act (42 U.S.C. 1395ww(d)(5)(D)) (as redesignated and amended by subsection (e)(1)(A)) is further amended--
(A) in clause (iii)--
(i) in subclause (I), by striking `or',
(ii) in subclause (II), by striking the period at the end and inserting `; or', and
(iii) by adding at the end the following new subclause:

 `(III) that is designated by the Secretary as an essential access community hospital under section 1820(i)(1).', and

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

 `(v) If the Secretary determines that, in the case of a hospital designated by the Secretary as an essential access community hospital under section 1820(i)(1), the hospital has incurred increases in reasonable costs during a cost reporting period as a result of becoming a member of a rural health network (as defined in section 1820(g)) in the State in which it is located, and in incurring such increases, the hospital will increase its costs for subsequent cost reporting periods, the Secretary shall increase the hospital's target amount under subsection (b)(3)(C) to account for such incurred increases.'.

(3) COVERAGE OF, AND PAYMENT FOR, INPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES-

(A) DEFINITIONS- Section 1861 of such Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

 `Rural Primary Care Hospital; Rural Primary Care Hospital Services

 `(mm)(1) The term `rural primary care hospital' means a facility designated by the Secretary as a rural primary care hospital under section 1820(i)(2).
 `(2) The term `inpatient rural primary care hospital services' means items and services, furnished to an inpatient of a rural primary care hospital by such a hospital, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.'.

(B) COVERAGE AND PAYMENT- (i) Section 1812(a)(1) of such Act (42 U.S.C. 1395d(a)(1)), as restored by the Medicare Catastrophic Coverage Repeal Act of 1989, is amended by inserting `and inpatient rural primary care hospital services' before the semicolon.

(ii) Section 1814(a) of such Act (42 U.S.C. 1395f(a)) is amended--

(I) by striking `and' at the end of paragraph (6),

(II) by striking the period at the end of paragraph (7) and inserting `; and', and

(III) by inserting after paragraph (7) the following new paragraph:
(8) in the case of inpatient rural primary care hospital services, a physician certifies that such services were required to be immediately furnished on a temporary, inpatient basis.

(iii) Section 1814 of such Act is further amended--
(I) in subsection (b), by inserting `, other than a rural primary care hospital providing inpatient rural primary care hospital services,' after `providing hospice care', and
(II) by adding at the end the following new subsection:

`Payment for Inpatient Rural Primary Care Hospital Services`

`(l)(1) The amount of payment under this part for inpatient rural primary care hospital services--
`(A) in the case of the first 12-month cost reporting period for which the facility operates as such a hospital, is the reasonable costs of the facility in providing inpatient rural primary care hospital services during such period, as such costs are determined on a per diem basis, and
` (B) in the case of a later reporting period, is the per diem payment amount established under this paragraph for the preceding 12-month cost reporting period, increased by the applicable percentage increase under section 1886(b)(3)(B)(i) for that particular cost reporting period applicable to hospitals located in a rural area.

The payment amounts otherwise determined under this paragraph shall be reduced, to the extent necessary, to avoid duplication of any payment made under section 1820(a)(2) (or under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987) to cover the provision of inpatient rural primary care hospital services.

` (2) The Secretary shall develop a prospective payment system for determining payment amounts for inpatient rural primary care hospital services under this part furnished on or after January 1, 1993.'.

(C) TREATMENT OF RURAL PRIMARY CARE HOSPITALS AS PROVIDERS OF SERVICES- (i) Section 1861(u) of such Act (42 U.S.C. 1395x(u)) is amended by inserting `rural primary care hospital,' after `hospital,'.
(ii) Section 1863 of such Act (42 U.S.C. 1395z) is amended by striking `and (jj)(3)' and inserting `(jj)(3), and (mm)(1)'.
(iii) The first sentence of section 1864(a) of such Act (42 U.S.C. 1395aa(a)) is amended by inserting `, a rural
primary care hospital, as defined in section 1861(mm)(1), after `1861(aa)(2)'.
(iv) The third sentence of section 1865(a) of such Act (42 U.S.C. 1395bb(a)) is amended by striking `or 1861(dd)(2)' and inserting `1861(dd)(2), or 1861(mm)(1)'.
(D) CONFORMING AMENDMENTS- (i) Section 1128A(b)(1) of such Act (42 U.S.C. 1320a-7a(b)(1)) is amended by striking `hospital' each place it appears and inserting `hospital or a rural primary care hospital'.
(ii) Section 1128B(c) of such Act (42 U.S.C. 1320a-7b(c)) is amended by inserting `rural primary care hospital,' after `hospital,'.
(iii) Section 1134 of such Act (42 U.S.C. 1320b-4) is amended by striking `hospitals' each place it appears and inserting `hospitals or rural primary care hospitals'.
(iv) Section 1138(a)(1) of such Act (42 U.S.C. 1320b-8(a)(1)) is amended by striking `hospital' each place it appears in the matter preceding clause (i) of subparagraph (A) and inserting `hospital or rural primary care hospital'.
(v) Section 1164(e) of such Act (42 U.S.C. 1320c-13(e)) is amended by inserting `rural primary care hospitals,' after `hospitals,'.
(vi) Section 1816(c)(2)(C) of such Act (42 U.S.C. 1395h(c)(2)(C)) is amended by inserting `rural primary care hospital,' after `hospital,'.
(vii) Section 1833 of such Act (42 U.S.C. 1395l) is amended--
(I) in subsection (h)(5)(A)(iii), by striking `hospital,' each place it appears and inserting `hospital or rural primary care hospital,';
(II) in subsection (i)(1)(A), by inserting `, rural primary care hospital,' after `1832(a)(2)(F)(i))';
(III) in subsection (i)(3)(A), by inserting `or rural primary care hospital services' after `facility services';
(IV) in subsection (l)(5)(A), by inserting `rural primary care hospital,' after `hospital,' each place it appears; and
(V) in subsection (l)(5)(C), by striking `hospital' each place it appears and inserting `hospital or rural primary care hospital'.
(viii) Section 1835(c) of such Act (42 U.S.C. 1395n(c)) is amended by adding at the end the following: `A rural
primary care hospital shall be considered a hospital for purposes of this subsection.'.
(ix) Section 1842(b)(6)(A)(ii) of such Act (42 U.S.C. 1395u(b)(6)(A)(ii)) is amended by inserting `rural primary care hospital,' after `hospital,'.
(x) Section 1861 of such Act (42 U.S.C. 1395x) is amended--

(I) in subsection (e), by adding at the end the following:

`The term `hospital' does not include, unless the context otherwise requires, a rural primary care hospital (as defined in section 1861(mm)(1)).',

(II) in subsection (w)(1), by inserting `rural primary care hospital,' after `hospital,', and

(III) in subsection (w)(2), by striking `hospital' each place it appears and inserting `hospital or rural primary care hospital'.

(xi) Section 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)) is amended by striking `hospital' each place it appears and inserting `hospital or rural primary care hospital'.

(xii) Section 1866(a)(1) of such Act (42 U.S.C. 1395cc(a)(1)) is amended--

(I) in subparagraph (F)(ii), by inserting `rural primary care hospitals,' after `hospitals';

(II) in subparagraph (H), by inserting after `this title' the first place it appears the following: `and in the case of rural primary care hospitals which provide rural primary care hospital services';

(III) in subparagraph (I), by inserting `and in the case of a rural primary care hospital' after `hospital'; and

(IV) in subparagraph (N), by striking `hospitals' and `hospital,' and inserting `hospitals and rural primary care hospitals' and `hospital or rural primary care hospital', respectively.

(xiii) Section 1866(a)(3) of such Act (42 U.S.C. 1395cc(a)(3)) is amended--

(I) by striking `hospital,' each place it appears in subparagraphs (A) and (B) and inserting `hospital, rural primary care hospital,', and

(II) in subparagraph (C)(ii)(II), by striking `facilities' each place it appears and inserting `facilities, rural primary care hospitals,'.
Section 1867(e) of such Act (42 U.S.C. 1395dd(e)) is amended by adding at the end the following new paragraph:

' (6) The term `hospital' includes a rural primary care hospital (as defined in section 1861(mm)(1)).'

(4) AVOIDING DUPLICATIVE PAYMENTS TO HOSPITALS PARTICIPATING IN RURAL HEALTH CARE TRANSITION GRANTS-
Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

' (i) AVOIDING DUPLICATIVE PAYMENTS TO HOSPITALS PARTICIPATING IN RURAL DEMONSTRATION PROGRAMS- The Secretary shall reduce any payment amounts otherwise determined under this section to the extent necessary to avoid duplication of any payment made under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987.'.

(h) GEOGRAPHIC CLASSIFICATION OF HOSPITALS- 
(1) ESTABLISHMENT OF MEDICARE GEOGRAPHICAL CLASSIFICATION BOARD- Section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) is amended by adding at the end the following new paragraph:

' (10)(A) There is hereby established the Medicare Geographical Classification Review Board (hereinafter in this paragraph referred to as the `Board').

(B)(i) The Board shall be composed of 5 members appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. Two of such members shall be representatives of subsection (d) hospitals located in a rural area under paragraph (2)(D). At least 1 member shall be a member of the Prospective Payment Assessment Commission, and at least 1 member shall be knowledgeable in the field of analyzing costs with respect to the provision of inpatient hospital services.

(ii) The Secretary shall make all appointments to the Board as provided in this paragraph within 180 days after the date of the enactment of this paragraph.

(C)(i) The Board shall consider the application of any subsection (d) hospital requesting that the Secretary change the hospital's geographic classification for purposes of determining for a fiscal year---

(I) the hospital's average standardized amount under paragraph (2)(D), or

(II) the area wage index applicable to such hospital under paragraph (3)(E).

(ii) A hospital requesting a change in geographic classification under clause (i) for a fiscal year shall submit its application to the Board not later than the first day of the preceding fiscal year.
`(iii)(I) The Board shall render a decision on an application submitted
under clause (i) not later than 180 days after the deadline referred to
in clause (ii).
`(II) A decision of the Board shall be final unless the unsuccessful
applicant appeals such decision to the Secretary by not later than 15
days after the Board renders its decision. The Secretary in considering
the appeal of an applicant shall receive no new evidence but shall
consider the record as a whole as such record appeared before the
Board. The Secretary shall issue a decision on such an appeal not later
than 90 days after the appeal is filed. The decision of the Secretary
shall be final and shall not be subject to judicial review.
`(D)(i) The Secretary shall publish guidelines to be utilized by the
Board in rendering decisions on applications submitted under this
paragraph, and shall include in such guidelines the following:
` (I) Guidelines for comparing wages, taking into account
occupational mix, in the area in which the hospital is classified
and the area in which the hospital is applying to be classified.
` (II) Guidelines for determining whether the county in which the
hospital is located should be treated as being a part of a
particular Metropolitan Statistical Area.
` (III) Guidelines for considering information provided by an
applicant with respect to the effects of the hospital's geographic
classification on access to inpatient hospital services by medicare
beneficiaries.
` (IV) Guidelines for considering the appropriateness of the
criteria used to define New England County Metropolitan Areas.
`(ii) The Secretary shall publish the guidelines described in clause (i)
by July 1, 1990.
`(E)(i) The Board shall have full power and authority to make rules
and establish procedures, not inconsistent with the provisions of this
title or regulations of the Secretary, which are necessary or
appropriate to carry out the provisions of this paragraph. In the course
of any hearing the Board may administer oaths and affirmations. The
provisions of subsections (d) and (e) of section 205 with respect to
subpoenas shall apply to the Board to the same extent as such
provisions apply to the Secretary with respect to title II.
`(ii) The Board is authorized to engage such technical assistance and
to receive such information as may be required to carry out its
functions, and the Secretary shall, in addition, make available to the
Board such secretarial, clerical, and other assistance as the Board may
require to carry out its functions.
`(F)(i) Each member of the Board who is not an officer or employee of
the Federal Government shall be compensated at a rate equal to the
daily equivalent of the annual rate of basic pay prescribed for grade
GS-18 of the General Schedule under section 5332 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Board. Each member of the Board who is an officer or employee of the United States shall serve without compensation in addition to that received for service as an officer or employee of the United States.

 `(ii) Members of the Board shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

(2) EFFECT OF DECISIONS OF BOARD ON PAYMENTS TO HOSPITALS- Section 1886(d)(8) of such Act (42 U.S.C. 1395ww(d)(8)) is amended--

(A) in subparagraph (C)(i), by striking `subparagraph (B)' each place it appears and inserting `subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10)', and

(B) in subparagraph (D), by striking `(B) and (C)' each place it appears and inserting `(B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10)'.

(3) REVISION OF RULES FOR TREATMENT OF RECLASSIFIED HOSPITALS- Section 1886(d)(8)(C) of such Act is amended to read as follows:

 `(C)(i) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by treating hospitals located in a rural county or counties as being located in an urban area--

 `(I) reduces the wage index for that urban area (as applied under this subsection) by 1 percentage point or less, the Secretary, in calculating such wage index under this subsection, shall exclude those hospitals so treated, or

 `(II) reduces the wage index for that urban area by more than 1 percentage point (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such urban area (excluding all the hospitals so treated) and to the hospitals so treated (as if each affected rural county were a separate urban area).

 `(ii) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by reclassifying a county from a rural to an
urban area or by reclassifying an urban county from one urban area to another urban area--

`(I) reduces the wage index for the urban area within which the county or counties is reclassified by 1 percentage point or less (as applied under this subsection), the Secretary, in calculating such wage index under this subsection, shall exclude those counties so reclassified, or

`(II) reduces the wage index for the urban area within which the county or counties is reclassified by more than 1 percentage point (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such urban area (excluding all the hospitals so reclassified) and to hospitals located in the counties so reclassified (as if each affected county were a separate area).

`(iii) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by treating hospitals located in a rural county or counties as not being located in the rural area in a State, reduces the wage index for that rural area (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection as if the hospitals so treated had not been excluded from calculation of the wage index for that rural area.'.

(4) FLOOR FOR AREA WAGE INDICES- Section 1886(d)(8)(C) of such Act (as amended by paragraph (3)) is further amended by adding at the end the following new clause:

`(iv) The application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) may not result in the reduction of any county's wage index to a level below the wage index for rural areas in the State in which the county is located.'.

(5) ADDITIONAL PAYMENT RESULTING FROM CORRECTIONS OF ERRONEOUSLY DETERMINED WAGE INDEX-

(A) IN GENERAL- If the Secretary of Health and Human Services (hereinafter referred to as the `Secretary') discovers an error with respect to the determination, adjustment, or computation of the area wage index described in section 1886(d)(3)(E) of the Social Security Act and subsequently corrects such error, the Secretary shall make an additional payment under title XVIII of such Act to a hospital affected by such error for inpatient hospital discharges occurring during the period when the erroneously determined, adjusted, or computed wage index was in effect.
(B) CONDITIONS FOR ADDITIONAL PAYMENT- A hospital is eligible for an additional payment under subparagraph (A) only if--

(i) the error resulted from the submission of erroneous data, except that a hospital is not eligible for such additional payment if it submitted such erroneous data;
(ii) the error was made with respect to the survey of the 1984 wages and wage-related costs of hospitals in the United States conducted under section 1886(d)(3)(E) of the Social Security Act; and
(iii) the correction of the error resulted in an adjustment to the area wage index of not less than 3 percentage points.

(C) PERIOD OF APPLICABILITY- A hospital may not receive an additional payment under subparagraph (A) for discharges occurring after October 1, 1990.

(6) UPDATES TO WAGE INDEX SURVEY- Section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) is amended--

(A) by striking ´October 1, 1990 (and at least every 36 months thereafter)´ and inserting ´October 1, 1990, and October 1, 1993 (and at least every 12 months thereafter)´, and
(B) by adding at the end the following new sentence: ´Any adjustments or updates made under this subparagraph for a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.´.

(7) EFFECTIVE DATE- The amendments made by paragraphs (3) and (4) shall apply to discharges occurring on or after April 1, 1990.

(i) LEGISLATIVE PROPOSAL ELIMINATING SEPARATE AVERAGE STANDARDIZED AMOUNTS-

(1) IN GENERAL- The Secretary of Health and Human Services (hereinafter referred to as the ´Secretary´) shall design a legislative proposal eliminating the system of determining separate average standardized amounts for subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act) classified as being located in large urban, other urban, or rural areas under section 1886(d)(2)(D) of such Act, and shall include in such proposal the following:
(A) A transition period beginning in fiscal year 1992 during which a single rate for determining payment to hospitals in all areas shall be phased in with such single rate to be completely in effect by fiscal year 1995.
(B) Recommendations, where appropriate, for modifying or maintaining additional payments or adjustments made under title XVIII of the Social Security Act for teaching hospitals, rural referral centers, sole community hospitals, disproportionate share hospitals, and outlier cases, and for creating additional payments or adjustments where deemed appropriate by the Secretary.
(C) Recommendations with respect to recalculating standardized amounts to reflect information from more recent cost reporting periods.
(D) Recommendations, where appropriate, for modifying reimbursement for hospitals that are not subsection (d) hospitals under title XVIII of such Act.
(E) A recommendation for a methodology to reflect the severity of illness of different patients within the same diagnosis-related group (as determined in section 1886(d)(4)(B) of such Act).

(2) REPORT TO CONGRESS AND PROPAC- (A) Not later than October 1, 1990, the Secretary shall submit the proposal described in paragraph (1) and an accompanying analysis of the impact of the proposed elimination of separate average standardized amounts on various categories of hospitals to Congress and the Prospective Payment Assessment Commission. (B) Not later than February 1, 1991, the Prospective Payment Assessment Commission and the Director of the Congressional Budget Office shall each prepare and submit to Congress a report analyzing the legislative proposal submitted under subparagraph (A), and shall include in such report an analysis of the probable impact of such legislation on hospitals participating in the medicare program.

(j) PROPAC STUDY OF PAYMENTS TO RURAL SOLE COMMUNITY HOSPITALS AND SMALL RURAL HOSPITALS-
(1) STUDY- The Prospective Payment Assessment Commission (hereinafter referred to as the `Commission') shall conduct a study of the feasibility and desirability of--
(A) using a cost-based reimbursement system to determine the amount of payments to be made under the medicare program to small rural hospitals and rural sole community hospitals for the operating costs of inpatient hospital services;
(B) developing and applying alternative definitions of market share for use in determining the eligibility of hospitals for classification as sole community hospitals under section 1886(d)(5) of the Social Security Act; and
(C) developing and applying a method for accounting for decreases in the number of inpatients served in determining payment to small rural hospitals under section 1886(d) of the Social Security Act for the operating costs of inpatient hospital services.

(2) REPORT- By not later than May 1, 1990, the Commission shall submit a report to Congress on the study conducted under paragraph (1).

SEC. 6004. PPS-EXEMPT HOSPITALS.

(a) EXEMPTION OF CANCER HOSPITALS FROM PROSPECTIVE PAYMENT SYSTEM-

(1) IN GENERAL- Section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) is amended--
(A) in clause (iii), by striking `or';
(B) in clause (iv), by striking the semicolon at the end and inserting `, or'; and
(C) by inserting after clause (iv) the following new clause:
`(v) a hospital that the Secretary has classified, at any time on or before December 31, 1990, (or, in the case of a hospital that, as of the date of the enactment of this clause, is located in a State operating a demonstration project under section 1814(b), on or before December 31, 1991) for purposes of applying exceptions and adjustments to payment amounts under this subsection, as a hospital involved extensively in treatment for or research on cancer;'.

(2) CONFORMING AMENDMENT- Section 1886(d)(5)(I) of such Act (as redesignated by section 6003(e)(1)(A)) is amended by striking `(including' and all that follows through `cancer)'.

(3) EFFECTIVE DATE- The amendments made by this subsection shall apply with respect to cost reporting periods beginning on or after October 1, 1989, except that--
(A) in the case of a hospital classified by the Secretary of Health and Human Services as a hospital involved extensively in treatment for or research on cancer under section 1886(d)(5)(I) of the Social Security Act (as redesignated by section 6003(e)(1)(A)) after the date of the enactment of this Act, such amendments shall apply...
with respect to cost reporting periods beginning on or after the date of such classification,
(B) in the case of a hospital that is not described in subparagraph (A), such amendments shall apply with respect to portions of cost reporting periods or discharges occurring during and after fiscal year 1987 for purposes of section 1886(g) of the Social Security Act, and
(C) such amendments shall take effect 30 days after the date of the enactment of this Act for purposes of determining the eligibility of a hospital to receive periodic interim payments under section 1815(e)(2) of the Social Security Act.

(b) REBASING FOR CANCER HOSPITALS-
(1) IN GENERAL- Section 1886(b)(3) of such Act (42 U.S.C. 1395ww(b)(3)), as amended by subsections (e)(1)(B) and (f)(2) of section 6003, is further amended--
(A) in subparagraph (A), by striking `(C) and (D)' and inserting `(C), (D), and (E)',
(B) in subparagraph (B)(ii), by striking `For purposes of subparagraph (A)' and inserting `For purposes of subparagraphs (A) and (E)', and
(C) by adding at the end the following new subparagraph:

` (E) In the case of a hospital described in clause (v) of subsection (d)(1)(B), the term `target amount' means--

` (i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital--

` (I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the `base cost reporting period') preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by--

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

` (ii) with respect to a later cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(ii) for that later cost reporting period.

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

(2) EFFECTIVE DATE- The amendments made by paragraph (1) shall apply with respect to cost reporting periods beginning on or after April 1, 1989.

SEC. 6005. PAYMENTS FOR HOSPICE CARE.

(a) INCREASE IN CURRENT RATES- Section 1814(i)(1) of the Social Security Act (42 U.S.C. 1395f(i)(1)) is amended--

(1) in subparagraph (A), by inserting `and except as otherwise provided in this paragraph' after `1813(a)(4)', and

(2) by striking subparagraph (C) and inserting the following:

`\(\text{(C)(i)}\) With respect to routine home care and other services included in hospice care furnished during fiscal year 1990, the payment rates for such care and services shall be 120 percent of such rates in effect as of September 30, 1989.

\(\text{(ii)}\) With respect to routine home care and other services included in hospice care furnished during a subsequent fiscal year, the payment rates for such care and services shall be the payment rates in effect under this subparagraph during the previous fiscal year increased by the market basket percentage increase (as defined in section 1886(b)(3)(B)(iii)) otherwise applicable to discharges occurring in the fiscal year.'.

(b) REQUIREMENT OF CERTIFICATION OF TERMINAL ILLNESS FOR HOSPICE CARE MODIFIED- Section 1814(a)(7)(A)(i) of the Social Security Act (42 U.S.C. 1395f(a)(7)(A)(i)) is amended by striking `certify,' and all that follows through `initiated,' and inserting the following: `\(\text{certify in writing, not later than 2 days after hospice care is initiated (or, if each certify verbally not later than 2 days after hospice care is initiated, not later than 8 days after such care is initiated)},\)'.

(c) EFFECTIVE DATE- The amendments made by subsection (a) shall become effective with respect to care and services furnished on or after January 1, 1990.

Subpart B--Technical and Miscellaneous Provisions

SEC. 6011. PASS THROUGH PAYMENT FOR HEMOPHILIA INPATIENTS.
(a) PASS THROUGH PAYMENT FOR HEMOPHILIA INPATIENTS- The second sentence of section 1886(a)(4) of the Social Security Act (42 U.S.C. 1395ww(d)(4)) is amended--

(1) by striking `or,'; and
(2) by striking `October 1, 1987)' and inserting `October 1, 1987), or costs with respect to administering blood clotting factors to individuals with hemophilia'.

(b) DETERMINING PAYMENT AMOUNT- The Secretary of Health and Human Services shall determine the amount of payment made to hospitals under part A of title XVIII of the Social Security Act for the costs of administering blood clotting factors to individuals with hemophilia by multiplying a predetermined price per unit of blood clotting factor (determined in consultation with the Prospective Payment Assessment Commission) by the number of units provided to the individual.

(c) RECOMMENDATIONS ON PAYMENTS- The Prospective Payment Assessment Commission and the Health Care Financing Administration shall develop recommendations with respect to payments to hospitals under part A of title XVIII of the Social Security Act for the costs of administering blood clotting factors to individuals with hemophilia, and shall submit such recommendations to Congress not later than 18 months after the date of enactment of this Act.

(d) EFFECTIVE DATE- The amendments made by subsection (a) shall apply with respect to items furnished 6 months after the date of enactment of this Act and shall expire 2 years after the date of enactment of this Act.

SEC. 6012. MEDICARE BUY-IN FOR CONTINUED BENEFITS FOR DISABLED INDIVIDUALS.

(a) IN GENERAL- Title XVIII of the Social Security Act is amended--

(1) in the heading of section 1818, by inserting `ELDERLY' after `UNINSURED'; and
(2) by inserting after section 1818 the following new section:

`HOSPITAL INSURANCE BENEFITS FOR DISABLED INDIVIDUALS WHO HAVE EXHAUSTED OTHER ENTITLEMENT

`SEC. 1818A. (a) Every individual who--

`(1) has not attained the age of 65;
`(2)(A) has been entitled to benefits under this part under section 226(b), and
`(B)(i) continues to have the disabling physical or mental impairment on the basis of which the individual was found to be under a disability or to be a disabled qualified railroad retirement beneficiary, or (ii) is blind (within the meaning of section 216(i)(1)), but
`(C) whose entitlement under section 226(b) ends due solely to the individual having earnings that exceed the substantial gainful activity amount (as defined in section 223(d)(4)); and
`(3) is not otherwise entitled to benefits under this part,
shall be eligible to enroll in the insurance program established by this part.
`(b)(1) An individual may enroll under this section only in such manner and form as may be prescribed in regulations, and only during an enrollment period prescribed in or under this section.
`(2) The individual's initial enrollment period shall begin with the month in which the individual receives notice that the individual's entitlement to benefits under section 226(b) will end due solely to the individual having earnings that exceed the substantial gainful activity amount (as defined in section 223(d)(4) and shall end 7 months later.
`(3) There shall be a general enrollment period during the period beginning on January 1 and ending on March 31 of each year (beginning with 1990).
`(c)(1) The period (in this subsection referred to as a `coverage period') during which an individual is entitled to benefits under the insurance program under this part shall begin on whichever of the following is the latest:
`(A) In the case of an individual who enrolls under subsection (b)(2) before the month in which the individual first satisfies subsection (a), the first day of such month.
`(B) In the case of an individual who enrolls under subsection (b)(2) in the month in which the individual first satisfies subsection (a), the first day of the month following the month in which the individual so enrolls.
`(C) In the case of an individual who enrolls under subsection (b)(2) in the month following the month in which the individual first satisfies subsection (a), the first day of the second month following the month in which the individual so enrolls.
`(D) In the case of an individual who enrolls under subsection (b)(2) more than one month following the month in which the individual first satisfies subsection (a), the first day of the third month following the month in which the individual so enrolls.
`(E) In the case of an individual who enrolls under subsection (b)(3), the July 1 following the month in which the individual so enrolls.
(2) An individual's coverage period under this section shall continue until the individual's enrollment is terminated as follows:

  (A) As of the month following the month in which the Secretary provides notice to the individual that the individual no longer meets the condition described in subsection (a)(2)(B).

  (B) As of the month following the month in which the individual files notice that the individual no longer wishes to participate in the insurance program established by this part.

  (C) As of the month before the first month in which the individual becomes eligible for hospital insurance benefits under section 226(a) or 226A.

  (D) As of a date, determined under regulations of the Secretary, for nonpayment of premiums.

The regulations under subparagraph (D) may provide a grace period of not longer than 90 days, which may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90-day period. Termination of coverage under this section shall result in simultaneous termination of any coverage affected under any other part of this title.

(3) The provisions of subsections (h) and (i) of section 1837 apply to enrollment and nonenrollment under this section in the same manner as they apply to enrollment and nonenrollment and special enrollment periods under section 1818.

(d)(1)(A) Premiums shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulations prescribe, and shall be deposited in the Treasury to the credit of the Federal Hospital Insurance Trust Fund.

  (B)(i) Subject to clause (ii), such premiums shall be payable for the period commencing with the first month of an individual's coverage period and ending with the month in which the individual dies or, if earlier, in which the individual's coverage period terminates.

  (ii) Such premiums shall not be payable for any month in which the individual is eligible for benefits under this part pursuant to section 226(b).

  (C) For purposes of applying section 1839(g) of this title and section 59B(f)(1)(B)(i) of the Internal Revenue Code of 1986, any reference to section 1818 shall be deemed to include a reference to this section.

  (2) The provisions of subsections (d) through (f) of section 1818 (relating to premiums) shall apply to individuals enrolled under this section in the same manner as they apply to individuals enrolled under that section.

(b) EFFECTIVE DATE- The amendments made by this section shall take effect on the date of the enactment of this Act, but shall not apply so
as to provide for coverage under part A of title XVIII of the Social Security Act for any month before July 1990.

SEC. 6013. BUY-IN UNDER PART A FOR QUALIFIED MEDICARE BENEFICIARIES.

(a) IN GENERAL- Section 1818 of the Social Security Act (42 U.S.C. 1395i-2) is amended by adding at the end the following:
`(g)(1) The Secretary shall, at the request of a State made after 1989, enter into a modification of an agreement entered into with the State pursuant to section 1843(a) under which the agreement provides for enrollment in the program established by this part of qualified medicare beneficiaries (as defined in section 1905(p)(1)).
`(2)(A) Except as provided in subparagraph (B), the provisions of subsections (c), (d), (e), and (f) of section 1843 shall apply to qualified medicare beneficiaries enrolled, pursuant to such agreement, in the program established by this part in the same manner and to the same extent as they apply to qualified medicare beneficiaries enrolled, pursuant to such agreement, in part B.
`(B) For purposes of this subsection, section 1843(d)(1) shall be applied by substituting `section 1818' for `section 1839' and `subsection (c) (with reference to subsection (b) of section 1839)' for `subsection (b).'.'.
(b) CONFORMING AMENDMENT- Section 1843 of such Act (42 U.S.C. 1395v) is amended by adding at the end the following:
`(i) For provisions relating to enrollment of qualified medicare beneficiaries under part A, see section 1818(g).'.
(c) EFFECTIVE DATE- The amendments made by this section shall become effective January 1, 1990.

SEC. 6014. PROPAC STUDY ON MEDICARE-DEPENDENT HOSPITALS.

(a) STUDY- The Prospective Payment Assessment Commission shall conduct a study of the appropriateness of making an adjustment to the methodology for determining the amount of payment to hospitals for which individuals entitled to benefits under part A of title XVIII of the Social Security Act represent a high proportion of discharges.
(b) REPORT- Not later than June 1, 1990, the Commission shall include a report on the study conducted under subsection (a) in its annual report submitted to Congress.

SEC. 6015. PROVISIONS RELATING TO TARGET AMOUNT ADJUSTMENTS.
(a) INCLUDING NEW BASE PERIOD IN TARGET ADJUSTMENTS- Section 1886(b)(4)(A) of the Social Security Act (42 U.S.C. 1395ww(b)(4)(A)) is amended by striking `deems appropriate,' and inserting `deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services and'.

(b) PUBLICATION OF INSTRUCTIONS RELATING TO EXCEPTIONS AND ADJUSTMENTS IN TARGET AMOUNTS- By not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services shall publish instructions specifying the application process to be used in providing exceptions and adjustments under section 1886(b)(4)(A) of the Social Security Act.

(c) EFFECTIVE DATE- The amendment made by subsection (a) shall become effective with respect to cost reporting periods beginning on or after April 1, 1990.

SEC. 6016. STUDY OF METHODS TO COMPENSATE HOSPICES FOR HIGH-COST CARE.

(a) STUDY- The Secretary of Health and Human Services shall--
(1) conduct a study of high-cost hospice care provided to medicare beneficiaries under the medicare program, and evaluate the ability of hospice programs participating in the medicare program to provide such high-cost care to such patients; and
(2) based on such study, develop methods to compensate such programs for providing such high-cost care.

(b) REPORT TO CONGRESS- Not later than April 1, 1991, the Secretary shall submit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the study conducted under subsection (a) and shall include in the report any recommendations developed by the Secretary to compensate hospice programs for providing high-cost hospice care to medicare beneficiaries.

SEC. 6017. PROHIBITION ON NURSING HOME BALANCE BILLING.

Section 1866(a)(2)(B) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(B)) is amended--
(1) in clause (i), by striking `(i)'; and
(2) by striking clause (ii).

SEC. 6018. HOSPITAL ANTI-DUMPING PROVISIONS.
(a) HOSPITAL OBLIGATIONS WITH RESPECT TO TREATMENT OF EMERGENCY MEDICAL CONDITIONS AND INDIGENT CARE- Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended--

(1) by amending subparagraph (I) to read as follows:
`(I) in the case of a hospital or rural primary care hospital--
  `(i) to adopt and enforce a policy to ensure compliance with the requirements of section 1867,
  `(ii) to maintain medical and other records related to individuals transferred to or from the hospital for a period of five years from the date of the transfer, and
  `(iii) to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition;'; and

(2) in subparagraph (N)--
(A) by striking `and' at the end of clause (i),
(B) by striking `and' at the end of clause (ii), and
(C) by adding at the end the following new clauses:
  `(iii) to post conspicuously in any emergency department a sign (in a form specified by the Secretary) specifying rights of individuals under section 1867 with respect to examination and treatment for emergency medical conditions and women in labor, and
  `(iv) to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital participates in the medicaid program under a State plan approved under title XIX, and'.

(b) EFFECTIVE DATE- The amendments made by subsection (a) shall take effect on the first day of the first month that begins more than 180 days after the date of the enactment of this Act, without regard to whether regulations to carry out such amendments have been promulgated by such date.

SEC. 6019. RELEASE AND USE OF HOSPITAL ACCREDITATION SURVEYS.

(a) REQUIRING ALL INSTITUTIONS AND JCAHO TO RELEASE SURVEYS TO SECRETARY- Section 1865(a)(2) of the Social Security Act (42 U.S.C. 1395bb(a)(2)) is amended--

(1) by striking `(2) such institution' and inserting `(2)(A) such institution';
(2) by striking `(if it is included within a survey described in section 1864(c))';
(3) by striking the comma at the end and inserting the following: ‘, together with any other information directly related to the survey as the Secretary may require (including corrective action plans),’; and
(4) by adding at the end the following new subparagraph:
`(B) such Commission releases such a copy and any such information to the Secretary,‘.
(b) AUTHORIZING SECRETARY TO RELEASE CERTAIN INFORMATION—
Section 1865(a) of such Act is further amended by striking the period at the end of the last sentence and inserting the following: ‘, except that the Secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the Secretary.’.
(c) PERMITTING SECRETARY TO WITHDRAW HOSPITAL’S STATUS BASED UPON INFORMATION OTHER THAN SURVEYS—Section 1865(b) of such Act is amended by striking ‘following a survey made pursuant to section 1864(c)’.
(d) EFFECTIVE DATE— (1) Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act.
(2) The amendments made by subsection (a) shall take effect 6 months after the date of the enactment of this Act.

SEC. 6020. INTERMEDIATE SANCTIONS FOR PSYCHIATRIC HOSPITALS.

Section 1866 of the Social Security Act (42 U.S.C. 1395cc) is amended by adding at the end the following new subsection:
`(i)(1) If the Secretary determines that a psychiatric hospital which has an agreement in effect under this section no longer meets the requirements for a psychiatric hospital under this title and further finds that the hospital’s deficiencies—
` (A) immediately jeopardize the health and safety of its patients, the Secretary shall terminate such agreement; or
` (B) do not immediately jeopardize the health and safety of its patients, the Secretary may terminate such agreement, or provide that no payment will be made under this title with respect to any individual admitted to such hospital after the effective date of the finding, or both.
`(2) If a psychiatric hospital, found to have deficiencies described in paragraph (1)(B), has not complied with the requirements of this title—
` (A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the Secretary shall
provide that no payment will be made under this title with respect to any individual admitted to such hospital after the end of such 3-month period, or
` (B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no payment may be made under this title with respect to any individual in the hospital until the Secretary finds that the hospital is in compliance with the requirements of this title.'.

SEC. 6021. ELIGIBILITY OF MERGED OR CONSOLIDATED HOSPITALS FOR PERIODIC INTERIM PAYMENTS.

(a) IN GENERAL- Section 1815(e) of the Social Security Act (42 U.S.C. 1395g(e)) is amended by adding at the end the following new paragraph:
` (4) A hospital created by the merger or consolidation of 2 or more hospitals or hospital campuses shall be eligible to receive periodic interim payment on the basis described in paragraph (1)(B) if-
` (A) at least one of the hospitals or campuses received periodic interim payment on such basis prior to the merger or consolidation; and
` (B) the merging or consolidating hospitals or campuses would each meet the requirement of paragraph (1)(B)(i) if such hospitals or campuses were treated as independent hospitals for purposes of this title.'.

(b) EFFECTIVE DATE- The amendment made by subsection (a) shall apply to payments made for discharges occurring on or after the expiration of the 30-day period that begins on the date of the enactment of this Act, regardless of the date of the merger or consolidation involved.

SEC. 6022. EXTENSION OF WAIVER FOR FINGER LAKES AREA HOSPITAL CORPORATION.

Section 1886(c)(4) of the Social Security Act (42 U.S.C. 1395ww(c)(4)) is amended in the second sentence by striking `the aggregate payment or payments' and all that follows and inserting `the aggregate rate of increase from October 1, 1984, to the most recent date for which annual data are available.'.

SEC. 6023. CLARIFICATION OF CONTINUATION OF AUGUST 1987 HOSPITAL BAD DEBT RECOGNITION POLICY.
(a) IN GENERAL- Section 4008(c) of the Omnibus Budget Reconciliation Act of 1987 is amended by adding at the end the following: `The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.'.

(b) EFFECTIVE DATE- The amendment made by subsection (a) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

SEC. 6024. USE OF MORE RECENT DATA REGARDING ROUTINE SERVICE COSTS OF SKILLED NURSING FACILITIES.

The Secretary of Health and Human Services shall determine mean per diem routine service costs for freestanding and hospital based skilled nursing facilities under section 1888(a) of the Social Security Act for cost reporting periods beginning on or after October 1, 1989, in accordance with regulations published by the Secretary that require the use of cost reports submitted by skilled nursing facilities for cost reporting periods beginning not earlier than October 1, 1985.

SEC. 6025. PERMITTING DENTIST TO SERVE AS HOSPITAL MEDICAL DIRECTOR.

Notwithstanding the requirement that the responsibility for organization and conduct of the medical staff of an institution be assigned only to a doctor of medicine or osteopathy in order for the institution to participate as a hospital under the medicare program, an institution that has a doctor of dental surgery or of dental medicine serving as its medical director shall be considered to meet such requirement if the laws of the State in which the institution is located permit a doctor of dental surgery or of dental medicine to serve as the medical staff director of a hospital.

SEC. 6026. GAO STUDY OF HOSPITAL-BASED AND FREESTANDING SKILLED NURSING FACILITIES.

(a) STUDY- The Comptroller General shall conduct a study to assess the differences in costs and case-mix between hospital-based
freestanding skilled nursing facilities participating in the medicare program.

(b) REPORT- By not later than June 1, 1990, the Comptroller General shall submit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the study conducted under paragraph (1) and shall include in the report any recommendations, including recommendations regarding the payment differential between hospital-based and freestanding skilled nursing facilities, the Comptroller General considers appropriate.

SEC. 6027. MASSACHUSETTS MEDICARE REPAYMENT.

The Secretary of Health and Human Services may not, on or after the date of the enactment of this Act and before May 1, 1990, recoup from, or otherwise reduce payments to, hospitals in the State of Massachusetts because of alleged overpayments to such hospitals under part A of title XVIII of the Social Security Act which occurred during the period of the statewide hospital reimbursement demonstration project conducted in that State between October 1, 1982, and June 30, 1986, under section 402 of the Social Security Amendments of 1967 and section 222 of the Social Security Amendments of 1972. Interest shall not accrue on any such alleged overpayments during the period beginning on the date of the enactment of this Act and ending on May 1, 1990.

SEC. 6028. ALLOWING CERTIFICATIONS AND RECERTIFICATIONS BY NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS FOR CERTAIN SERVICES.

Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) is amended--

(1) in paragraph (2) by striking `(2) a physician' and inserting `(2) a physician, or, in the case of services described in subparagraph (B), a physician, or a nurse practitioner or clinical nurse specialist who does not have a direct or indirect employment relationship with the facility but is working in collaboration with a physician,'; and

(2) in the matter following the final paragraph by striking `a physician makes' and inserting `a physician, nurse practitioner, or clinical nurse specialist (as the case may be) makes'.

PART 2--PROVISIONS RELATING TO PART B
Subpart A--General Provisions

SEC. 6101. EXTENSION OF REDUCTIONS UNDER SEQUESTER ORDER.

Notwithstanding any other provision of law (including any other provision of this Act, other than section 6201), the reductions in the amount of payments required under title XVIII of the Social Security Act made by the final sequester order issued by the President on October 16, 1989, pursuant to section 252(b) of the Balanced Budget and Emergency Deficit Control Act of 1985 shall continue to be effective (as provided by sections 252(a)(4)(B) and 256(d)(2) of such Act) through March 31, 1990, with respect to payments for items and services under part B of such title.

SEC. 6102. PHYSICIAN PAYMENT REFORM.

(a) IN GENERAL- Part B of title XVIII of the Social Security Act is amended by adding at the end the following new section:

`PAYMENT FOR PHYSICIANS' SERVICES

`SEC. 1848. (a) PAYMENT BASED ON FEE SCHEDULE-
` (1) IN GENERAL- Effective for all physicians' services (as defined in subsection (j)(3)) furnished under this part during a year (beginning with 1992) for which payment is otherwise made on the basis of a reasonable charge or on the basis of a fee schedule under section 1834(b) or 1834(f), payment under this part shall instead be based on the lesser of--
` (A) the actual charge for the service, or
` (B) subject to the succeeding provisions of this subsection, the amount determined under the fee schedule established under subsection (b) for services furnished during that year (in this subsection referred to as the `fee schedule amount').
` (2) TRANSITION TO FULL FEE SCHEDULE-
` (A) LIMITING REDUCTIONS AND INCREASES TO 15 PERCENT IN 1992-
` (i) LIMIT ON INCREASE- In the case of a service in a fee schedule area (as defined in subsection (j)(2)) for which the adjusted historical payment basis (as defined in subparagraph (D)) is less than 85 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount for services furnished during such year a new fee schedule amount determined by applying to the fee schedule amount for services furnished during such year a reduction that

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amount an amount equal to the adjusted historical payment basis plus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

(ii) LIMIT IN REDUCTION- In the case of a service in a fee schedule area for which the adjusted historical payment basis exceeds 115 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis minus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

(B) SPECIAL RULE FOR 1993, 1994, AND 1995- If a physicians' service in a fee schedule area is subject to the provisions of subparagraph (A) in 1992, for physicians' services furnished in the area--

(i) during 1993, there shall be substituted for the fee schedule amount an amount equal to the sum of-

(I) 75 percent of the fee schedule amount determined under subparagraph (A), adjusted by the update established under subsection (d)(3) for 1993, and

(II) 25 percent of the fee schedule amount determined under paragraph (1) for 1993 without regard to this paragraph;

(ii) during 1994, there shall be substituted for the fee schedule amount an amount equal to the sum of-

(I) 67 percent of the fee schedule amount determined under clause (i), adjusted by the update established under subsection (d)(3) for 1994, and

(II) 33 percent of the fee schedule amount determined under paragraph (1) for 1994 without regard to this paragraph; and

(iii) during 1995, there shall be substituted for the fee schedule amount an amount equal to the sum of-

(I) 50 percent of the fee schedule amount determined under clause (ii) adjusted by the update established under subsection (d)(3) for 1995, and
`(II) 50 percent of the fee schedule amount determined under paragraph (1) for 1995 without regard to this paragraph.

`(C) SPECIAL RULE FOR ANESTHESIA SERVICES- With respect to physicians' services which are anesthesia services, the Secretary shall provide for a transition in the same manner as a transition is provided for other services under subparagraph (B).

`(D) ADJUSTED HISTORICAL PAYMENT BASIS DEFINED-

`(i) IN GENERAL- In this paragraph, the term 'adjusted historical payment basis' means, with respect to a physicians' service furnished in a fee schedule area, the weighted average prevailing charge applied in the area for the service in 1991 (as determined by the Secretary without regard to physician specialty and as adjusted to reflect payments for services with customary charges below the prevailing charge or other payment limitations imposed by law or regulation) adjusted by the update established under subsection (d)(3) for 1992.

`(ii) APPLICATION TO RADIOLOGY SERVICES- In applying clause (i) in the case of physicians' services which are radiology services (including radiologist services, as defined in section 1834(b)(6)), there shall be substituted for the weighted average prevailing charge the amount provided under the fee schedule established for the service for the fee schedule area under section 1834(b).

`(3) INCENTIVES FOR PARTICIPATING PHYSICIANS- In applying paragraph (1)(B) in the case of a nonparticipating physician, the fee schedule amount shall be 95 percent of such amount otherwise applied under this subsection (without regard to this paragraph).

`(b) ESTABLISHMENT OF FEE SCHEDULES-

`(1) IN GENERAL- Before January 1 of each year beginning with 1992, the Secretary shall establish, by regulation, fee schedules that establish payment amounts for all physicians' services furnished in all fee schedule areas (as defined in subsection (j)(2)) for the year. Except as provided in paragraph (2), each such payment amount for a service shall be equal to the product of--

`(A) the relative value for the service (as determined in subsection (c)(2)),
(B) the conversion factor (established under subsection (d)) for the year, and
(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area.

(2) TREATMENT OF RADIOLOGY SERVICES AND ANESTHESIA SERVICES-
(A) RADIOLOGY SERVICES- With respect to radiology services (including radiologist services, as defined in section 1834(b)(6)), the Secretary shall base the relative values on the relative value scale developed under section 1834(b)(1)(A), with appropriate modifications of the relative values to assure that the relative values established for radiology services which are similar or related to other physicians' services are consistent with the relative values established for those similar or related services.

(B) ANESTHESIA SERVICES- In establishing the fee schedule for anesthesia services for which a relative value guide has been established under section 4048(b) of the Omnibus Budget Reconciliation Act of 1987, the Secretary shall use, to the extent practicable, such relative value guide, with appropriate adjustment of the conversion factor, in a manner to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined by the Secretary to be of comparable value. In applying the previous sentence, the Secretary shall adjust the conversion factor by geographic adjustment factors in the same manner as such adjustment is made under paragraph (1)(C).

(C) CONSULTATION- The Secretary shall consult with the Physician Payment Review Commission and organizations representing physicians or suppliers who furnish radiology services and anesthesia services in applying subparagraphs (A) and (B).

(c) DETERMINATION OF RELATIVE VALUES FOR PHYSICIANS' SERVICES-
(1) DIVISION OF PHYSICIANS' SERVICES INTO COMPONENTS- In this section, with respect to a physicians' service:
(A) WORK COMPONENT DEFINED- The term `work component' means the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service. Such portion shall--
(i) include activities before and after direct patient contact, and
(ii) be defined, with respect to surgical procedures, to reflect a global definition including pre-operative and post-operative physicians' services.

(B) PRACTICE EXPENSE COMPONENT DEFINED - The term 'practice expense component' means the portion of the resources used in furnishing the service that reflects the general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising practice expenses. In this subparagraph, the term 'practice expenses' includes all expenses for furnishing physicians' services, excluding malpractice expenses, physician compensation, and other physician fringe benefits.

(C) MALPRACTICE COMPONENT DEFINED - The term 'malpractice component' means the portion of the resources used in furnishing the service that reflects malpractice expenses in furnishing the service.

(2) DETERMINATION OF RELATIVE VALUES -
(A) In general-
(i) COMBINATION OF UNITS FOR COMPONENTS - The Secretary shall develop a methodology for combining the work, practice expense, and malpractice relative value units, determined under subparagraph (C), for each service in a manner to produce a single relative value for that service.
(ii) EXTRAPOLATION - The Secretary may use extrapolation and other techniques to determine the number of relative value units for physicians' services for which specific data are not available and shall take into account recommendations of the Physician Payment Review Commission and the results of consultations with organizations representing physicians who provide such services.

(B) PERIODIC REVIEW AND ADJUSTMENTS IN RELATIVE VALUES -
(i) PERIODIC REVIEW - The Secretary, not less often than every 5 years, shall review the relative values established under this paragraph for all physicians' services.
(ii) ADJUSTMENTS -
(I) IN GENERAL - The Secretary shall, to the extent the Secretary determines to be
necessary and subject to subclause (II), adjust the number of such units to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. The Secretary shall publish an explanation of the basis for such adjustments.

`(II) LIMITATION ON ANNUAL ADJUSTMENTS-
The adjustments under subclause (I) for a year may not cause the amount of expenditures under this part for the year to differ by more than $20,000,000 from the amount of expenditures under this part that would have been made if such adjustments had not been made.

`(iii) CONSULTATION- The Secretary, in making adjustments under clause (ii), shall consult with the Physician Payment Review Commission and organizations representing physicians.

`(C) COMPUTATION OF RELATIVE VALUE UNITS FOR COMPONENTS- For purposes of this section for each physician's service--

`(i) WORK RELATIVE VALUE UNITS- The Secretary shall determine a number of work relative value units for the service based on the relative resources incorporating physician time and intensity required in furnishing the service.

`(ii) PRACTICE EXPENSE RELATIVE VALUE UNITS- The Secretary shall determine a number of practice expense relative value units equal to the product of--

` `(I) the base allowed charges (as defined in subparagraph (D)) for the service, and
` `(II) the practice expense percentage for the service (as determined under paragraph (3)(C)(ii)).

`(iii) MALPRACTICE RELATIVE VALUE UNITS- The Secretary shall determine a number of malpractice relative value units equal to the product of--

` `(I) the base allowed charges (as defined in subparagraph (D)) for the service, and
` `(II) the malpractice percentage for the service (as determined under paragraph (3)(C)(iii)).
(D) BASE ALLOWED CHARGES DEFINED- In this paragraph, the term "base allowed charges" means, with respect to a physician's service, the national average allowed charges for the service under this part for services furnished during 1991, as estimated by the Secretary using the most recent data available.

(3) COMPONENT PERCENTAGES- For purposes of paragraph (2), the Secretary shall determine a work percentage, a practice expense percentage, and a malpractice percentage for each physician's service as follows:

(A) DIVISION OF SERVICES BY SPECIALTY- For each physician's service or class of physicians' services, the Secretary shall determine the average percentage of each such service or class of services that is performed, nationwide, under this part by physicians in each of the different physician specialties (as identified by the Secretary).

(B) DIVISION OF SPECIALTY BY COMPONENT- The Secretary shall determine the average percentage division of resources, among the work component, the practice expense component, and the malpractice component, used by physicians in each of such specialties in furnishing physicians' services. Such percentages shall be based on national data that describe the elements of physician practice costs and revenues, by physician specialty. The Secretary may use extrapolation and other techniques to determine practice costs and revenues for specialties for which adequate data are not available.

(C) DETERMINATION OF COMPONENT PERCENTAGES-

(i) WORK PERCENTAGE- The work percentage for a service (or class of services) is equal to the sum (for all physician specialties) of--

(I) the average percentage division for the work component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(ii) PRACTICE EXPENSE PERCENTAGE- The practice expense percentage for a service (or class of services) is equal to the sum (for all physician specialties) of--
`(I) the average percentage division for the practice expense component for each physician specialty (determined under subparagraph (B)), multiplied by
`(II) by the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.
`(iii) MALPRACTICE PERCENTAGE- The malpractice percentage for a service (or class of services) is equal to the sum (for all physician specialties) of--
`(I) the average percentage division for the malpractice component for each physician specialty (determined under subparagraph (B)), multiplied by
`(II) by the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.
`(D) PERIODIC RECOMPUTATION- The Secretary may, from time to time, provide for the recomputation of work percentages, practice expense percentages, and malpractice percentages determined under this paragraph.
`(3) ANCILLARY POLICIES- The Secretary may establish ancillary policies (with respect to the use of modifiers, local codes, and other matters) as may be necessary to implement this subsection.
`(4) CODING- The Secretary shall establish a uniform procedure coding system for the coding of all physicians' services. The Secretary shall provide for an appropriate coding structure for visits and consultations. The Secretary may incorporate the use of time in the coding for visits and consultations only for services furnished on or after January 1, 1993. The Secretary, in establishing such coding system, shall consult with the Physician Payment Review Commission and other organizations representing physicians.
`(5) NO VARIATION FOR SPECIALISTS- The Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.
`(d) CONVERSION FACTORS-
`(1) ESTABLISHMENT-
`(A) IN GENERAL- The conversion factor for each year shall be the conversion factor established under this subsection for the previous year (or, in the case of 1992,
specified in subparagraph (B)) adjusted by the update (established under subparagraph (C)) for the year involved.

\'(B) SPECIAL PROVISION FOR 1992- For purposes of subparagraph (A), the conversion factor specified in this subparagraph is a conversion factor (determined by the Secretary) which, if this section were to apply during 1991 using such conversion factor, would result in the same aggregate amount of payments under this part for physicians' services as the estimated aggregate amount of the payments under this part for such services in 1991.

\'(C) PUBLICATION- The Secretary shall cause to have published in the Federal Register, during the last 15 days of October of--

\'(i) 1991, the conversion factor (or factors) which will apply to physicians' services for 1992, and the update (or updates) determined under paragraph (3) for 1992; and

\'(ii) each succeeding year, the update (or updates) determined under paragraph (3) for the following year.

\'(2) RECOMMENDATION OF UPDATE-

\'(A) IN GENERAL- Not later than April 15 of each year (beginning with 1991), the Secretary shall transmit to the Congress a report that includes a recommendation on the appropriate update (or updates) in the conversion factor (or factors) for all physicians' services in the following year. The Secretary may recommend a uniform update or different updates for different categories or groups of services. In making the recommendation, the Secretary shall consider--

\'(i) the percentage change in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for that year;

\'(ii) the percentage by which actual expenditures for all physicians' services (as defined in subsection (f)(5)(A)) under this part for the fiscal year ending in the year preceding the year in which such recommendation is made were greater or less than actual expenditures for all such physicians' services in the fiscal year ending in the second preceding year;

\'(iii) the relationship between the percentage determined under clause (ii) for a fiscal year and the
performance standard rate of increase (established under subsection (f)(2)) for that fiscal year;
\`(iv) changes in volume or intensity of services;
\`(v) access to services; and
\`(vi) other factors that may contribute to changes in volume or intensity of services or access to services.

For purposes of making the comparison under clause (iii), the Secretary shall adjust the performance standard rate of increase for a fiscal year to reflect changes in the actual proportion of HMO enrollees (as defined in subsection (f)(5)(B)) in that fiscal year compared with such proportion for the previous fiscal year.

\`(B) ADDITIONAL CONSIDERATIONS- In making recommendations under subparagraph (A), the Secretary may also consider--
\`(i) unexpected changes by physicians in response to the implementation of the fee schedule;
\`(ii) unexpected changes in outlay projections;
\`(iii) changes in the quality or appropriateness of care; and
\`(iv) any other relevant factors not measured in the resource-based payment methodology.

\`(C) SPECIAL RULE FOR 1992 UPDATE- In considering the update for 1992, the Secretary shall make a separate determination of the percentage and relationship described in clauses (ii) and (iii) of subparagraph (A) with respect to the category of surgical services (as defined by the Secretary pursuant to subsection (j)(1)).

\`(D) EXPLANATION OF UPDATE- The Secretary shall include in each report under subparagraph (A)--
\`(i) the update recommended for each category of physicians' services (established by the Secretary under subsection (j)(1)) and for each of the following groups of physicians' services: nonsurgical services, visits, consultations, and emergency room services;
\`(ii) the rationale for the recommended update (or updates) for each category and group of services described in clause (i); and
\`(iii) the data and analyses underlying the update (or updates) recommended.

\`(E) COMPUTATION OF BUDGET-NEUTRAL ADJUSTMENT-
\`(i) IN GENERAL- The Secretary shall include in the report made under subparagraph (A) in a year a statement of the percentage by which (I) the actual
expenditures for physicians' services under this part (during the fiscal year ending in the preceding year, as set forth in most recent annual report made pursuant to section 1841(b)(2)), exceeded, or was less than (II) the expenditures projected for the fiscal year under clause (iii).

(ii) PROJECTED EXPENDITURES- For purposes of clause (i), the expenditures projected under this clause for a fiscal year is the actual expenditures for physicians' services made under this part in the second preceding fiscal year--

(I) increased by the weighted average percentage increase permitted under this part for physicians' services in the preceding fiscal year;

(II) adjusted to reflect the percentage change in the average number of individuals enrolled under this part (who are not enrolled with a risk-sharing contract under section 1876) for the preceding fiscal year compared with the second preceding fiscal year;

(III) adjusted to reflect the average annual percentage growth in the volume and intensity of physicians' services under this part for the five-fiscal-year period ending with the second preceding fiscal year; and

(IV) adjusted to reflect the percentage change in expenditures for physicians' services under this part in the preceding fiscal year (compared with the second preceding fiscal year) which result from changes in law or regulations.

(F) COMMISSION REVIEW- The Physician Payment Review Commission shall review the report submitted under subparagraph (A) in a year and shall submit to the Congress, by not later than May 15 of the year, a report including its recommendations respecting the update (or updates) in the conversion factor (or factors) for the following year.

(3) UPDATE-

(A) BASED ON INDEX-

(i) IN GENERAL- Unless Congress otherwise provides, subject to subparagraph (B), for purposes of this section the update for a year is equal to the
Secretary's estimate of the percentage increase in the appropriate update index (as defined in clause (ii)) for the year.

(ii) APPROPRIATE UPDATE INDEX DEFINED- In clause (i), the term `appropriate update index’ means--

(I) for services for which prevailing charges in 1989 were subject to a limit under the fourth sentence of section 1842(b)(3), the medicare economic index (referred to in that sentence), and

(II) for other services, such index (such as the consumer price index) that was applicable under this part in 1989 to increases in the payment amounts recognized under this part with respect to such services.

(B) ADJUSTMENT IN UPDATE-

(i) IN GENERAL- The update for a year provided under subparagraph (A) shall, subject to clause (ii), be increased or decreased by the same percentage by which (I) the percentage increase in the actual expenditures for physicians' services (as defined in section (f)(5)(A)) in the second previous fiscal year over the third previous fiscal year, was less or greater, respectively, than (II) the performance standard rate of increase (established under subsection (f)) for such category of services for the second previous fiscal year.

(ii) RESTRICTIONS ON ADJUSTMENT- The adjustment made under clause (i) for a year may not result in a decrease of--

(I) more than 2 percentage points for the update for 1992 or 1993,

(II) 2 1/2 percentage points for the update for 1994 or 1995, and

(III) 3 percentage points for the update for any succeeding year.

(e) GEOGRAPHIC ADJUSTMENT FACTORS-

(1) ESTABLISHMENT OF GEOGRAPHIC INDICES-

(A) IN GENERAL- Subject to subparagraph (B), the Secretary shall establish--

(i) an index which reflects the relative costs of the mix of goods and services comprising practice expenses (other than malpractice expenses) in the
different fee schedule areas compared to the national average of such costs,
(ii) an index which reflects the relative costs of malpractice expenses in the different fee schedule areas compared to the national average of such costs, and
(iii) an index which reflects 1/4 of the difference between the relative value of physicians' work effort in each of the different fee schedule areas and the national average of such work effort.

(B) CLASS-SPECIFIC GEOGRAPHIC COST-OF-PRACTICE INDICES- The Secretary may establish more than one index under subparagraph (A)(i) in the case of classes of physicians' services, if, because of differences in the mix of goods and services comprising practice expenses for the different classes of services, the application of a single index under such clause to different classes of such services would be substantially inequitable.

(2) COMPUTATION OF GEOGRAPHIC ADJUSTMENT FACTOR- For purposes of subsection (b)(1)(C), for all physicians' services for each fee schedule area the Secretary shall establish a geographic adjustment factor equal to the sum of the geographic cost-of-practice adjustment factor (specified in paragraph (3)), the geographic malpractice adjustment factor (specified in paragraph (4)), and the geographic physician work adjustment factor (specified in paragraph (5)) for the service and the area.

(3) GEOGRAPHIC COST-OF-PRACTICE ADJUSTMENT FACTOR- For purposes of paragraph (2), the 'geographic cost-of-practice adjustment factor', for a service for a fee schedule area, is the product of--

(A) the proportion of the total relative value for the service that reflects the relative value units for the practice expense component, and
(B) the geographic cost-of-practice index value for the area for the service, based on the index established under paragraph (1)(A)(i) or (1)(B) (as the case may be).

(4) GEOGRAPHIC MALPRACTICE ADJUSTMENT FACTOR- For purposes of paragraph (2), the 'geographic malpractice adjustment factor', for a service for a fee schedule area, is the product of--

(A) the proportion of the total relative value for the service that reflects the relative value units for the malpractice component, and
'(B) the geographic malpractice index value for the area, based on the index established under paragraph (1)(A)(ii).

'(5) GEOGRAPHIC PHYSICIAN WORK ADJUSTMENT FACTOR- For purposes of paragraph (2), the 'geographic physician work adjustment factor', for a service for a fee schedule area, is the product of--

'(A) the proportion of the total relative value for the service that reflects the relative value units for the work component, and

'(B) the geographic physician work index value for the area, based on the index established under paragraph (1)(A)(iii).

'(f) MEDICARE VOLUME PERFORMANCE STANDARD RATES OF INCREASE-

'(1) PROCESS FOR ESTABLISHING MEDICARE VOLUME PERFORMANCE STANDARD RATES OF INCREASE-

'(A) SECRETARY'S RECOMMENDATION- By not later than April 15 of each year (beginning with 1990), the Secretary shall transmit to the Congress a recommendation on performance standard rates of increase for all physicians' services and for each category of such services for the fiscal year beginning in such year. In making the recommendation, the Secretary shall confer with organizations representing physicians and shall consider--

'(i) inflation,

'(ii) changes in numbers of enrollees (other than HMO enrollees) under this part,

'(iii) changes in the age composition of enrollees (other than HMO enrollees) under this part,

'(iv) changes in technology,

'(v) evidence of inappropriate utilization of services,

'(vi) evidence of lack of access to necessary physicians' services, and

'(vii) such other factors as the Secretary considers appropriate.

'(B) COMMISSION REVIEW- The Physician Payment Review Commission shall review the recommendation transmitted during a year under subparagraph (A) and shall make its recommendation to Congress, by not later than May 15 of the year, respecting the performance standard rates of increase for the fiscal year beginning in that year.

'(C) PUBLICATION OF PERFORMANCE STANDARD RATES OF INCREASE- The Secretary shall cause to have published
in the Federal Register, in the last 15 days of October of each year (beginning with 1990), the performance standard rates of increase for all physicians' services and for each category of physicians' services for the fiscal year beginning in that year. The Secretary shall cause to have published in the Federal Register, by not later than January 1, 1990, the performance standard rate of increase under subparagraph (D) for fiscal year 1990.

(D) PERFORMANCE STANDARD RATE OF INCREASE FOR FISCAL YEAR 1990- The performance standard rate of increase for fiscal year 1990 is equal to the sum of--

(i) the Secretary's estimate of the weighted average percentage increase in the reasonable charges for physicians' services (as defined in subsection (f)(5)(A)) under this part for calendar years included in fiscal year 1990,

(ii) the Secretary's estimate of the percentage increase or decrease in the average number of individuals enrolled under this part (other than HMO enrollees) from fiscal year 1989 to fiscal year 1990,

(iii) the Secretary's estimate of the average annual percentage growth in volume and intensity of physicians' services under this part for the 5-fiscal-year period ending with fiscal year 1989 (based upon information contained in the most recent annual report made pursuant to section 1841(b)(2)), and

(iv) the Secretary's estimate of the percentage increase or decrease in expenditures for physicians' services (as defined in subsection (f)(5)(A)) in fiscal year 1990 (compared with fiscal year 1989) which will result from changes in law or regulations and which is not taken into account in the percentage increase described in clause (i), reduced by 1/2 percent.

(2) Specification of performance standard rates of increase for subsequent fiscal years-

(A) IN GENERAL- Unless Congress otherwise provides, subject to paragraph (4), each performance standard rate of increase for a fiscal year (beginning with fiscal year 1991) shall be equal to the sum of--

(i) the Secretary's estimate of the weighted average percentage increase in the fees for physicians' services (as defined in subsection
(f)(5)(A)) under this part for calendar years included in the fiscal year involved,

(ii) the Secretary’s estimate of the percentage increase or decrease in the average number of individuals enrolled under this part (other than HMO enrollees) from the previous fiscal year to the fiscal year involved,

(iii) the Secretary's estimate of the average annual percentage growth in volume and intensity of physicians' services under this part for the 5-fiscal-year period ending with the preceding fiscal year (based upon information contained in the most recent annual report made pursuant to section 1841(b)(2)), and

(iv) the Secretary's estimate of the percentage increase or decrease in expenditures for physicians' services (as defined in subsection (f)(5)(A)) in the fiscal year (compared with the preceding fiscal year) which will result from changes in law or regulations and which is not taken into account in the percentage increase described in clause (i), reduced by the performance standard factor (specified in subparagraph (B)). In clause (i), the term 'fees' means, with respect to 1991, reasonable charges and, with respect to any succeeding year, fee schedule amounts.

(B) PERFORMANCE STANDARD FACTOR- For purposes of subparagraph (A), the performance standard factor--

(i) for 1991 is 1 percentage point,

(ii) for 1992 is 1 1/2 percentage points, and

(iii) for each succeeding year is 2 percentage points.

(3) QUARTERLY REPORTING- The Secretary shall establish procedures for providing, on a quarterly basis to the Physician Payment Review Commission, the Congressional Budget Office, the Congressional Research Service, the Committees on Ways and Means and Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate, information on compliance with performance standard rates of increase established under this subsection.

(4) Separate group-specific performance standard rates of increase-

(A) IMPLEMENTATION OF PLAN- Subject to paragraph (B), the Secretary shall, after completion of the study required under section 6102(e)(3) of the Omnibus Budget
Reconciliation Act of 1989, but not before October 1, 1991, implement a plan under which qualified physician groups could elect annually separate performance standard rates of increase other than the performance standard rate of increase established for the year under paragraph (2) for such physicians. The Secretary shall develop criteria to determine which physician groups are eligible to elect to have applied to such groups separate performance standard rates of increase and the methods by which such group-specific performance standard rates of increase would be accomplished. The Secretary shall report to the Congress on the criteria and methods by April 15, 1991. The Physician Payment Review Commission shall review and comment on such recommendations by May 15, 1991. Before implementing group-specific performance standard rates of increase, the Secretary shall provide for notice and comment in the Federal Register and consult with organizations representing physicians.

` (B) APPROVAL- The Secretary may not implement the plan described in subparagraph (A), unless Congress specifically approves the plan.

` (5) DEFINITIONS- In this subsection:

` (A) SERVICES INCLUDED IN PHYSICIANS' SERVICES- The term `physicians' services' includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to an HMO enrollee under a risk-sharing contract under section 1876.

` (B) HMO ENROLLEE- The term `HMO enrollee' means, with respect to a fiscal year, an individual enrolled under this part who is enrolled with an entity under a risk-sharing contract under section 1876 in the fiscal year.

` (g) LIMITATION ON BENEFICIARY LIABILITY-

` (1) LIMITATION ON ACTUAL CHARGES FOR UNASSIGNED CLAIMS- If a nonparticipating physician knowingly and willfully bills on a repeated basis for physicians' services (furnished with respect to an individual enrolled under this part on or after January 1, 1991) an actual charge in excess of the limiting charge described in paragraph (2) and for which payment is not made on an assignment-related basis under this part, the Secretary may apply sanctions against such physician in accordance with section 1842(j)(2).
(2) LIMITING CHARGE DEFINED-

(A) FOR 1991- For physicians' services of a physician furnished during 1991, the `limiting charge' shall be the same percentage (or, if less, 25 percent) above the recognized payment amount under this part with respect to the physician (as a nonparticipating physician) as the percentage by which--

(i) the maximum allowable actual charge (as determined under section 1842(j)(1)(C) as of December 31, 1990, or, if less, the maximum actual charge otherwise permitted for the service under this part as of such date) for the service of the physician, exceeds

(ii) the recognized payment amount for the service of the physician (as a nonparticipating physician) as of such date.

(B) FOR 1992- For physicians' services furnished during 1992, the `limiting charge' shall be the same percentage (or, if less, 20 percent) above the recognized payment amount under this part for nonparticipating physicians as the percentage by which--

(i) the limiting charge (as determined under subparagraph (A) as of December 31, 1991) for the service, exceeds

(ii) the recognized payment amount for the service for nonparticipating physicians as of such date.

(C) AFTER 1992- For physicians' services furnished in a year after 1992, the `limiting charge' shall be 115 percent of the recognized payment amount under this part for nonparticipating physicians.

(D) RECOGNIZED PAYMENT AMOUNT- In this section, the term `recognized payment amount' means, for services furnished on or after January 1, 1992, the fee schedule amount determined under subsection (a), and, for services furnished during 1991, the applicable percentage (as defined in section 1842(b)(4)(A)(iv)) of the prevailing charge (or fee schedule amount) for nonparticipating physicians for that year.

(3) LIMITATION ON CHARGES FOR MEDICARE BENEFICIARIES ELIGIBLE FOR MEDICAID BENEFITS-

(A) IN GENERAL- Payment for physicians' services furnished on or after April 1, 1990, to an individual who is enrolled under this part and eligible for any medical assistance (including as a qualified medicare beneficiary,
as defined in section 1905(p)(1)) with respect to such services under a State plan approved under title XIX may only be made on an assignment-related basis.

`(B) PENALTY- A person may not bill for physicians' services subject to subparagraph (A) other than on an assignment-related basis. If a person knowingly and willfully bills for physicians' services in violation of the previous sentence, the Secretary may apply sanctions against the person in accordance with section 1842(j)(2).

`(4) PHYSICIAN SUBMISSION OF CLAIMS-

`(A) IN GENERAL- For services furnished on or after September 1, 1990, within 1 year after the date of providing a service for which payment is made under this part on a reasonable charge or fee schedule basis, a physician, supplier, or other person (or an employer or facility in the cases described in section 1842(b)(6)(A))--

`(i) shall complete and submit a claim for such service on a standard claim form specified by the Secretary to the carrier on behalf of a beneficiary, and

`(ii) may not impose any charge relating to completing and submitting such a form.

`(B) PENALTY- (i) With respect to an assigned claim wherever a physician, provider, supplier or other person (or an employer or facility in the cases described in section 1842(b)(6)(A)) fails to submit such a claim as required in subparagraph (A), the Secretary shall reduce by 10 percent the amount that would otherwise be paid for such claim under this part.

`(ii) If a physician, supplier, or other person (or an employer or facility in the cases described in section 1842(b)(6)(A)) fails to submit a claim required to be submitted under subparagraph (A) or imposes a charge in violation of such subparagraph, the Secretary shall apply the sanction with respect to such a violation in the same manner as a sanction may be imposed under section 1842(p)(3) for a violation of section 1842(p)(1).

`(5) ELECTRONIC BILLING; DIRECT DEPOSIT- The Secretary shall encourage and develop a system providing for expedited payment for claims submitted electronically. The Secretary shall also encourage and provide incentives allowing for direct deposit as payments for services furnished by participating physicians. The Secretary shall provide physicians with such technical information as necessary to enable such physicians to submit
claims electronically. The Secretary shall submit a plan to Congress on this paragraph by May 1, 1990.

` (6) MONITORING OF CHARGES-
  `(A) IN GENERAL- The Secretary shall monitor--
    `(i) the actual charges of nonparticipating physicians for physicians' services furnished on or after January 1, 1991, to individuals enrolled under this part, and
    `(ii) changes (by specialty, type of service, and geographic area) in (I) the proportion of expenditures for physicians' services provided under this part by participating physicians, (II) the proportion of expenditures for such services for which payment is made under this part on an assignment-related basis, and (III) the amounts charged above the recognized payment amounts under this part.
  `(B) REPORT- The Secretary shall, by not later than April 15 of each year (beginning in 1992), report to the Congress regarding the changes described in subparagraph (A)(ii).
  `(C) PLAN- If the Secretary finds that there has been a significant decrease in the proportions described in subclauses (I) and (II) of subparagraph (A)(ii) or an increase in the amounts described in subclause (III) of that subparagraph, the Secretary shall develop a plan to address such a problem and transmit to Congress recommendations regarding the plan. The Physician Payment Review Commission shall review the Secretary's plan and recommendations and transmit to Congress its comments regarding such plan and recommendations.

` (7) MONITORING OF UTILIZATION AND ACCESS-
  `(A) IN GENERAL- The Secretary shall monitor--
    `(i) changes in the utilization of and access to services furnished under this part within geographic, population, and service related categories,
    `(ii) possible sources of inappropriate utilization of services furnished under this part which contribute to the overall level of expenditures under this part, and
    `(iii) factors underlying these changes and their interrelationships.
  `(B) REPORT- The Secretary shall by not later than April 15, of each year (beginning with 1991) report to the Congress on the changes described in subparagraph (A)(i) and shall include in the report an examination of the
factors (including factors relating to different services and specific categories and groups of services and geographic and demographic variations in utilization) which may contribute to such changes.

(C) RECOMMENDATIONS- The Secretary shall include in each annual report under subparagraph (B) recommendations--

(i) addressing any identified patterns of inappropriate utilization,
(ii) on utilization review,
(iii) on physician education or patient education,
(iv) addressing any problems of beneficiary access to care made evident by the monitoring process, and
(v) on such other matters as the Secretary deems appropriate.

The Physician Payment Review Commission shall comment on the Secretary’s recommendations and in developing its comments, the Commission shall convene and consult a panel of physician experts to evaluate the implications of medical utilization patterns for the quality of and access to patient care.

(h) SENDING INFORMATION TO PHYSICIANS- Before the beginning of each year (beginning with 1992), the Secretary shall send to each physician furnishing physicians' services under this part, for services commonly performed by the physician, information on fee schedule amounts that apply for the year in the fee schedule area for participating and non-participating physicians, and the maximum amount that may be charged consistent with subsection (g)(2). Such information shall be transmitted in conjunction with notices to physicians under section 1842(h) (relating to the participating physician program) for a year.

(i) MISCELLANEOUS PROVISIONS-

(1) RESTRICTION ON ADMINISTRATIVE AND JUDICIAL REVIEW- There shall be no administrative or judicial review under section 1869 or otherwise of--

(A) the determination of the historical payment basis (as defined in subsection (a)(2)(C)(i)),
(B) the determination of relative values and relative value units under subsection (c),
(C) the determination of conversion factors under subsection (d),
(D) the establishment of geographic adjustment factors under subsection (e), and
(E) the establishment of the system for the coding of physicians' services under this section.

(j) DEFINITIONS- In this section:

(1) CATEGORY- The term 'category' means, with respect to physicians' services, surgical services, and all physicians' services other than surgical services, and such other category or categories of physicians' services as the Secretary, from time to time, defines in regulation. The Secretary shall define surgical services and publish such definition in the Federal Register no later than May 1, 1990, after consultation with organizations representing physicians.

(2) FEE SCHEDULE AREA- The term 'fee schedule area' means a locality used under section 1842(b) for purposes of computing payment amounts for physicians' services.

(3) PHYSICIANS' SERVICES- The term 'physicians' services' includes items and services described in paragraphs (1), (2)(A), (2)(D), (3), and (4) of section 1861(s) (other than clinical diagnostic laboratory tests and such other items and services as the Secretary may specify).

(4) PRACTICE EXPENSES- The term 'practice expenses' includes all expenses for furnishing physicians' services, excluding malpractice expenses, physician compensation, and other physician fringe benefits.'.

(b) REQUIREMENTS FOR CARRIERS TO PROFILE PHYSICIANS- Section 1842(b)(3) of such Act (42 U.S.C. 1395u(b)(3)) is amended--

(1) by striking `and' at the end of subparagraph (J),
(2) by inserting `and' at the end of subparagraph (K), and
(3) by inserting after subparagraph (K) the following new subparagraph:

(L) will monitor and profile physicians' billing patterns within each area or locality and provide comparative data to physicians whose utilization patterns vary significantly from other physicians in the same payment area or locality;'.

(c) Rural and Inner-City Access Adjustments-

(1) ADJUSTMENTS- Section 1833(m) of such Act (42 U.S.C. 1395I(m)) is amended--

(A) by striking `class 1 or class 2', and
(B) by striking `5 percent' and inserting `10 percent'.

(2) EFFECTIVE DATE- The amendments made by paragraph (1) shall apply to services furnished on or after January 1, 1991.

(d) STUDIES-

(1) GAO STUDY OF ALTERNATIVE PAYMENT METHODOLOGY FOR MALPRACTICE COMPONENT- The Comptroller General shall provide for--
(A) a study of alternative ways of paying, under section 1848 of the Social Security Act, for the malpractice component for physicians' services, in a manner that would assure, to the extent practicable, payment for medicare's share of malpractice insurance premiums, and (B) a study to examine alternative resolution procedures for malpractice claims respecting professional services furnished under the medicare program.

The examination under subparagraph (B) shall include review of the feasibility of establishing procedures that involve no-fault payment or that involve mandatory arbitration. By not later than April 1, 1991, the Comptroller General shall submit a report to Congress on the results of the studies.

(2) STUDY OF PAYMENTS TO RISK-CONTRACTING PLANS- The Secretary of Health and Human Services (in this subsection referred to as the `Secretary') shall conduct a study of how payments under section 1848 of the Social Security Act may affect payments to eligible organizations with risk-sharing contracts under section 1876 of such Act. By not later than April 1, 1990, the Secretary shall submit a report to Congress on such study and shall include in the report such recommendations for such changes in the methodology for payment under such risk-sharing contracts as the Secretary deems appropriate.

(3) STUDY OF VOLUME PERFORMANCE STANDARD RATES OF INCREASE BY GEOGRAPHY, SPECIALTY, AND TYPE OF SERVICE- The Secretary shall conduct a study of the feasibility of establishing, under section 1848(f) of the Social Security Act, separate performance standard rates of increase for services furnished by or within each of the following (including combinations of the following):

(A) Geographic area (such as a region, State, or other area).

(B) Specialty or group of specialties of physicians.

(C) Type of services (such as primary care, services of hospital-based physicians, and other inpatient services).

Such study shall also include the scope of services included within, or excluded from, the rate of increase in expenditure system. By not later than July 1, 1990, the Secretary shall submit a report to Congress on such study and shall include in the report such recommendations respecting the feasibility of establishing separate performance standards rates of increase in expenditures as the Secretary deems appropriate.

(4) HHS VISIT CODE MODIFICATION STUDY- The Secretary shall conduct a study of the desirability of including time as a factor in
establishing visit codes. By not later than July 1, 1991, the Secretary shall consult with the Physician Payment Review Commission, and submit a report to Congress on such study and shall include in the report recommendations respecting the desirability of modifying the number of visit codes, whether greater coding uniformity would result from including time in visit codes when compared with clarifying the clinical descriptions of existing codes, and the ability to audit physician time accurately.

(5) COMMISSION STUDY OF PAYMENT FOR PRACTICE EXPENSES- The Physician Payment Review Commission shall conduct a study of--

(A) the extent to which practice costs and malpractice costs vary by geographic locality (including region, State, Metropolitan Statistical Areas, or other areas and by specialty),
(B) the extent to which available geographic practice-cost indices accurately reflect practice costs and malpractice costs in rural areas,
(C) which geographic units would be most appropriate to use in measuring and adjusting practice costs and malpractice costs,
(D) appropriate methods for allocating malpractice expenses to particular procedures which could be incorporated into the determination of relative values for particular procedures using a consensus panel and other appropriate methodologies,
(E) the effect of alternative methods of allocating malpractice expenses on medicare expenditures by specialty, type of service, and by geographic area, and
(F) the special circumstances of rural independent laboratories in determining the geographic cost-of-practice index.

By not later than July 1, 1991, the Commission shall submit a report to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on the study and shall include in the report such recommendations as it deems appropriate.

(6) COMMISSION STUDY OF GEOGRAPHIC PAYMENT AREAS- The Physician Payment Review Commission shall conduct a study of the feasibility and desirability of using Metropolitan Statistical Areas or other payment areas for purposes of payment for physicians’ services under part B of title XVIII of the Social Security Act. By not later than July 1, 1991, the Commission
shall submit a report to Congress on such study and shall include in the report recommendations on the desirability of retaining current carrier-wide localities, changing to a system of statewide localities, or adopting Metropolitan Statistical Areas or other payment areas for purposes of payment under such part B.

(7) COMMISSION STUDY OF PAYMENT FOR NON-PHYSICIAN PROVIDERS OF MEDICARE SERVICES- The Physician Payment Review Commission shall conduct a study of the implications of a resource-based fee schedule for physicians' services for non-physician practitioners, such as physician assistants, clinical psychologists, nurse midwives, and other health practitioners whose services can be billed under the medicare program on a fee-for-service basis. The study shall address (A) what the proper level of payment should be for these practitioners, (B) whether or not adjustments to their payments should be subject to the medicare volume performance standard process, and (C) what update to use for services outside the medicare volume performance standard process. The Commission shall submit a report to Congress on such study by not later than July 1, 1991.

(8) COMMISSION STUDY OF PHYSICIAN FEES UNDER MEDICAID- The Physician Payment Review Commission shall conduct a study on physician fees under State medicaid programs established under title XIX of the Social Security Act. The Commission shall specifically examine in such study the adequacy of physician reimbursement under such programs, physician participation in such programs, and access to care by medicaid beneficiaries. By no later than July 1, 1991, the Commission shall submit a report to Congress on such study and shall include such recommendations as the Commission deems appropriate.

(9) GAO STUDY ON PHYSICIAN ANTI-TRUST ISSUES- The Comptroller General shall conduct a study of the effect of anti-trust laws on the ability of physicians to act in groups to educate and discipline peers of such physicians in order to reduce and eliminate ineffective practice patterns and inappropriate utilization. The study shall further address anti-trust issues as they relate to the adoption of practice guidelines by third-party payers and the role that practice guidelines might play as a defense in malpractice cases. By no later than July 1, 1991, the Comptroller General shall submit a report to Congress on such study and shall make such recommendations as the Comptroller General deems appropriate.

(e) MISCELLANEOUS CONFORMING AMENDMENTS-
(1) REFERENCE TO NEW PAYMENT RULES- Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended--
(A) by striking `and' before clause (M), and
(B) by inserting before the semicolon the following new clause: `and (N) with respect to expenses incurred for physicians' services (as defined in section 1848(j)(3)), the amounts paid shall be 80 percent of the payment basis determined under section 1848(a)(1)'.

(2) CHANGING REFERENCE TO MAXIMUM ALLOWABLE ACTUAL CHARGES- Section 1842(b)(3)(G) of such Act (42 U.S.C. 1395u(b)(3)(G)) is amended by striking `maximum allowable actual charges (established under subsection (j)(1)(C))' and inserting `limiting charges established under subsection (j)(1)(C)'.

(3) DIFFERENTIAL FOR PARTICIPATING PHYSICIANS- Effective for physicians' services furnished on or after January 1, 1992, the first sentence of section 1842(b)(4)(A)(iv) of such Act (42 U.S.C. 1395u(b)(4)(A)(iv)) is amended by inserting `and before January 1, 1992,' after `January 1, 1987,'.

(4) PAYMENT FOR PHYSICIAN ASSISTANTS- Section 1842(b)(12)(A)(ii)(II) of such Act (42 U.S.C. 1395u(b)(12)(A)(ii)(II)) is amended by inserting `(or, for services furnished on or after January 1, 1992, the fee schedule amount specified in section 1848, as the case may be)' after `prevailing charge rate for such services'.

(5) PAYMENT FOR CERTIFIED REGISTERED NURSE ANESTHETISTS- Section 1833(a)(1)(H) of such Act (42 U.S.C. 1395l(a)(1)(H)) is amended by inserting `(or, for services furnished on or after January 1, 1992, 65 percent of the fee schedule amount provided under section 1848, as the case may be)' after `prevailing charge that would be recognized'.

(6) PAYMENT FOR RADIOLOGIST SERVICES- (A) Section 1833(a)(1)(J) of such Act (42 U.S.C. 1395l(a)(1)(J)) is amended by inserting `subject to section 1848,' before `the amounts'.
(B) Section 4049(b)(2) of the Omnibus Budget Reconciliation Act of 1987 is amended by striking ``, and until' and all that follows through `Social Security Act'.

(7) PAYMENT FOR NURSE MIDWIVES- Section 1833(a)(1)(K) of the Social Security Act (42 U.S.C. 1395l(a)(1)(K)) is amended by inserting `, or, for services furnished on or after January 1, 1992, 65 percent of the fee schedule amount provided under section 1848 for the same service performed by a physician' after `for the same service performed by a physician'.
(8) PHYSICIANS' SERVICES FOR INDIVIDUALS WITH END STAGE RENAL DISEASE- Section 1881(b)(3)(A) of such Act (42 U.S.C. 1395rr(b)(3)(A)) is amended by inserting `or, for services furnished on or after January 1, 1992, on the basis described in section 1848' after `comparable services'.

(9) EXTENSION OF MAXIMUM ALLOWABLE ACTUAL CHARGE LIMITS- Subparagraphs (B)(ii) and (D)(v) of section 1842(j)(1) of such Act (42 U.S.C. 1395u(j)(1)) are each amended by striking all that follows `after' the first place it appears and inserting `December 31, 1990.'.

(10) TREATMENT OF CERTAIN EYE EXAMINATION VISITS AS PRIMARY CARE SERVICES- In applying section 1842(i)(4) of the Social Security Act for services furnished on or after January 1, 1990, intermediate and comprehensive office visits for eye examinations and treatments (codes 92002 and 92004) shall be considered to be primary care services.

(11) DISTRIBUTION OF MODEL FEE SCHEDULE- By September 1, 1990, the Secretary shall develop a Model Fee Schedule, using the methodology set forth in section 1848 of the Social Security Act. The Model Fee Schedule shall include as many services as the Secretary concludes can be assigned valid relative values. The Secretary shall submit the Model Fee Schedule to the appropriate committees of Congress and make it generally available to the public.

(f) PAYMENT FOR PATHOLOGY SERVICES-

(1) FEE SCHEDULE- Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

`(f) FEE SCHEDULE FOR PHYSICIAN PATHOLOGY SERVICES-

` (1) APPLICATION- Subject to section 1848, the Secretary shall provide for application of a fee schedule with respect to physician pathology services. Subject to paragraph (2), such fee schedule shall be based on relative values developed by the Secretary, in consultation with organizations representing physicians performing such services. Such fee schedule shall be designed so as to result in expenditures under this part for services covered under the schedule in an amount that would not exceed the amount of such expenditures which would otherwise occur. In developing such fee schedule the Secretary shall take into account the special circumstances of rural independent laboratories.

` (2) GEOGRAPHIC AREA ADJUSTMENT- The Secretary shall provide for a geographic area adjustment of the conversion factors in a manner comparable to the geographic area
adjustment applied to physicians’ services under section 1848
during the year in which the services are furnished.’.
(2) PAYMENT ON BASIS OF FEE SCHEDULE- Section
1833(a)(1)(J) of such Act (42 U.S.C. 1395l(a)(1)(J)) is
amended--
(A) by inserting ‘or physician pathology services’ after
‘1834(b)(6))’, and
(B) by inserting ‘or section 1834(f), respectively’ after
‘1834(b)’.
(3) EFFECTIVE DATE- The amendments made by this subsection
shall apply to services furnished on or after January 1, 1991.
(g) EFFECTIVE DATE- Except as otherwise provided in this section, this
section, and the amendments made by this section, shall take effect
on the date of the enactment of this Act.

SEC. 6103. ESTABLISHMENT OF AGENCY FOR HEALTH CARE POLICY AND
RESEARCH.

(a) IN GENERAL- The Public Health Service Act (42 U.S.C. 201 et seq.)
is amended by inserting after title VIII the following new title:

`TITLE IX--AGENCY FOR HEALTH CARE POLICY AND
RESEARCH

`Part A--Establishment and General Duties

`SEC. 901. ESTABLISHMENT.

` (a) IN GENERAL- There is established within the Service an agency to
be known as the Agency for Health Care Policy and Research.
` (b) PURPOSE- The purpose of the Agency is to enhance the quality,
appropriateness, and effectiveness of health care services, and access
to such services, through the establishment of a broad base of
scientific research and through the promotion of improvements in
clinical practice and in the organization, financing, and delivery of
health care services.
` (c) APPOINTMENT OF ADMINISTRATOR- There shall be at the head of
the Agency an official to be known as the Administrator for Health
Care Policy and Research. The Administrator shall be appointed by the
Secretary. The Secretary, acting through the Administrator, shall carry
out the authorities and duties established in this title.

`SEC. 902. GENERAL AUTHORITIES AND DUTIES.
`(a) IN GENERAL- In carrying out section 901(b), the Administrator shall conduct and support research, demonstration projects, evaluations, training, guideline development, and the dissemination of information, on health care services and on systems for the delivery of such services, including activities with respect to--

 `(1) the effectiveness, efficiency, and quality of health care services;
 `(2) subject to subsection (d), the outcomes of health care services and procedures;
 `(3) clinical practice, including primary care and practice-oriented research;
 `(4) health care technologies, facilities, and equipment;
 `(5) health care costs, productivity, and market forces;
 `(6) health promotion and disease prevention;
 `(7) health statistics and epidemiology; and
 `(8) medical liability.

`(b) REQUIREMENTS WITH RESPECT TO RURAL AREAS AND UNDERSERVED POPULATIONS- In carrying out subsection (a), the Administrator shall undertake and support research, demonstration projects, and evaluations with respect to--

 `(1) the delivery of health care services in rural areas (including frontier areas); and
 `(2) the health of low-income groups, minority groups, and the elderly.

`(c) MULTIDISCIPLINARY CENTERS- The Administrator may provide financial assistance to public or nonprofit private entities for meeting the costs of planning and establishing new centers, and operating existing and new centers, for multidisciplinary health services research, demonstration projects, evaluations, training, policy analysis, and demonstrations respecting the matters referred to in subsection (b).

`(d) RELATION TO CERTAIN AUTHORITIES REGARDING SOCIAL SECURITY- Activities authorized in this section may include, and shall be appropriately coordinated with, experiments, demonstration projects, and other related activities authorized by the Social Security Act and the Social Security Amendments of 1967. Activities under subsection (a)(2) of this section that affect the programs under titles XVIII and XIX of the Social Security Act shall be carried out consistent with section 1142 of such Act.

`SEC. 903. DISSEMINATION.

`(a) IN GENERAL- The Administrator shall--
(1) promptly publish, make available, and otherwise disseminate, in a form understandable and on as broad a basis as practicable so as to maximize its use, the results of research, demonstration projects, and evaluations conducted or supported under this title and the guidelines, standards, and review criteria developed under this title;
(2) promptly make available to the public data developed in such research, demonstration projects, and evaluations;
(3) provide indexing, abstracting, translating, publishing, and other services leading to a more effective and timely dissemination of information on research, demonstration projects, and evaluations with respect to health care to public and private entities and individuals engaged in the improvement of health care delivery and the general public, and undertake programs to develop new or improved methods for making such information available; and
(4) as appropriate, provide technical assistance to State and local government and health agencies and conduct liaison activities to such agencies to foster dissemination.

(b) PROHIBITION AGAINST RESTRICTIONS- Except as provided in subsection (c), the Administrator may not restrict the publication or dissemination of data from, or the results of, projects conducted or supported under this title.

(c) LIMITATION ON USE OF CERTAIN INFORMATION- No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under this title may be used for any purpose other than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Secretary) to its use for such other purpose. Such information may not be published or released in other form if the person who supplied the information or who is described in it is identifiable unless such person has consented (as determined under regulations of the Secretary) to its publication or release in other form.

(d) CERTAIN INTERAGENCY AGREEMENT- The Administrator and the Director of the National Library of Medicine shall enter into an agreement providing for the implementation of subsection (a)(3).

SEC. 904. HEALTH CARE TECHNOLOGY AND TECHNOLOGY ASSESSMENT.

(a) IN GENERAL- In carrying out section 901(b), the Administrator shall promote the development and application of appropriate health care technology assessments--
(1) by identifying needs in, and establishing priorities for, the assessment of specific health care technologies;
(2) by developing and evaluating criteria and methodologies for health care technology assessment;
(3) by conducting and supporting research on the development and diffusion of health care technology;
(4) by conducting and supporting research on assessment methodologies; and
(5) by promoting education, training, and technical assistance in the use of health care technology assessment methodologies and results.

(b) SPECIFIC ASSESSMENTS-
(1) IN GENERAL- In carrying out section 901(b), the Administrator shall conduct and support specific assessments of health care technologies.
(2) CONSIDERATION OF CERTAIN FACTORS- In carrying out paragraph (1), the Administrator shall consider the safety, efficacy, and effectiveness, and, as appropriate, the cost-effectiveness, legal, social, and ethical implications, and appropriate uses of such technologies, including consideration of geographic factors.

(c) INFORMATION CENTER-
(1) IN GENERAL- There shall be established at the National Library of Medicine an information center on health care technologies and health care technology assessment.
(2) INTERAGENCY AGREEMENT- The Administrator and the Director of the National Library of Medicine shall enter into an agreement providing for the implementation of paragraph (1).

(d) RECOMMENDATIONS WITH RESPECT TO HEALTH CARE TECHNOLOGY-
(1) IN GENERAL- The Administrator shall make recommendations to the Secretary with respect to whether specific health care technologies should be reimbursable under federally financed health programs, including recommendations with respect to any conditions and requirements under which any such reimbursements should be made.
(2) CONSIDERATION OF CERTAIN FACTORS- In making recommendations respecting health care technologies, the Administrator shall consider the safety, efficacy, and effectiveness, and, as appropriate, the cost-effectiveness and appropriate uses of such technologies.
(3) CONSULTATIONS- In carrying out this subsection, the Administrator shall cooperate and consult with the Director of the National Institutes of Health, the Commissioner of Food and
Drugs, and the heads of any other interested Federal department or agency.

`Part B--Forum for Quality and Effectiveness in Health Care

`SEC. 911. ESTABLISHMENT OF OFFICE.

`There is established within the Agency an office to be known as the Office of the Forum for Quality and Effectiveness in Health Care. The office shall be headed by a director, who shall be appointed by the Administrator.

`SEC. 912. DUTIES.

` (a) ESTABLISHMENT OF FORUM PROGRAM- The Administrator, acting through the Director, shall establish a program to be known as the Forum for Quality and Effectiveness in Health Care. For the purpose of promoting the quality, appropriateness, and effectiveness of health care, the Director, using the process set forth in section 913, shall arrange for the development and periodic review and updating of--
` (1) clinically relevant guidelines that may be used by physicians, educators, and health care practitioners to assist in determining how diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically; and
` (2) standards of quality, performance measures, and medical review criteria through which health care providers and other appropriate entities may assess or review the provision of health care and assure the quality of such care.

` (b) CERTAIN REQUIREMENTS- Guidelines, standards, performance measures, and review criteria under subsection (a) shall--
` (1) be based on the best available research and professional judgment regarding the effectiveness and appropriateness of health care services and procedures;
` (2) be presented in formats appropriate for use by physicians, health care practitioners, providers, medical educators, and medical review organizations and in formats appropriate for use by consumers of health care; and
` (3) include treatment-specific or condition-specific practice guidelines for clinical treatments and conditions in forms appropriate for use in clinical practice, for use in educational programs, and for use in reviewing quality and appropriateness of medical care.
(c) AUTHORITY FOR CONTRACTS- In carrying out this part, the Director may enter into contracts with public or nonprofit private entities.

(d) DATE CERTAIN FOR INITIAL GUIDELINES AND STANDARDS- The Administrator, by not later than January 1, 1991, shall assure the development of an initial set of guidelines, standards, performance measures, and review criteria under subsection (a) that includes not less than 3 clinical treatments or conditions described in section 1142(a)(3) of the Social Security Act.

(e) RELATIONSHIP WITH MEDICARE PROGRAM- To assure an appropriate reflection of the needs and priorities of the program under title XVIII of the Social Security Act, activities under this part that affect such program shall be conducted consistent with section 1142 of such Act.

SEC. 913. PROCESS FOR DEVELOPMENT OF GUIDELINES AND STANDARDS.

(a) DEVELOPMENT THROUGH CONTRACTS AND PANELS- The Director shall--

(1) enter into contracts with public and nonprofit private entities for the purpose of developing and periodically reviewing and updating the guidelines, standards, performance measures, and review criteria described in section 912(a); and

(2) convene panels of appropriately qualified experts (including practicing physicians with appropriate expertise) and health care consumers for the purpose of--

(A) developing and periodically reviewing and updating the guidelines, standards, performance measures, and review criteria described in section 912(a); and

(B) reviewing the guidelines, standards, performance measures, and review criteria developed under contracts under paragraph (1).

(b) AUTHORITY FOR ADDITIONAL PANELS- The Director may convene panels of appropriately qualified experts (including practicing physicians with appropriate expertise) and health care consumers for the purpose of--

(1) developing the standards and criteria described in section 914(b); and

(2) providing advice to the Administrator and the Director with respect to any other activities carried out under this part or under section 902(a)(2).

(c) SELECTION OF PANEL MEMBERS- In selecting individuals to serve on panels convened under this section, the Director shall consult with
a broad range of interested individuals and organizations, including organizations representing physicians in the general practice of medicine and organizations representing physicians in specialties and subspecialties pertinent to the purposes of the panel involved. The Director shall seek to appoint physicians reflecting a variety of practice settings.

`SEC. 914. ADDITIONAL REQUIREMENTS.

`(a) PROGRAM AGENDA-
   `(1) IN GENERAL- The Administrator shall provide for an agenda for the development of the guidelines, standards, performance measures, and review criteria described in section 912(a), including--
      `(A) with respect to the guidelines, identifying specific diseases, disorders, and other health conditions for which the guidelines are to be developed and those that are to be given priority in the development of the guidelines; and
      `(B) with respect to the standards, performance measures, and review criteria, identifying specific aspects of health care for which the standards, performance measures, and review criteria are to be developed and those that are to be given priority in the development of the standards, performance measures, and review criteria.
   `(2) CONSIDERATION OF CERTAIN FACTORS IN ESTABLISHING PRIORITIES-
      `(A) Factors considered by the Administrator in establishing priorities for purposes of paragraph (1) shall include consideration of the extent to which the guidelines, standards, performance measures, and review criteria involved can be expected--
         `(i) to improve methods of prevention, diagnosis, treatment, and clinical management for the benefit of a significant number of individuals;`
         `(ii) to reduce clinically significant variations among physicians in the particular services and procedures utilized in making diagnoses and providing treatments; and`
         `(iii) to reduce clinically significant variations in the outcomes of health care services and procedures.
      `(B) In providing for the agenda required in paragraph (1), including the priorities, the Administrator shall consult with the Administrator of the Health Care Financing
Administration and otherwise act consistent with section 1142(b)(3) of the Social Security Act.

`(b) STANDARDS AND CRITERIA-
` `(1) PROCESS FOR DEVELOPMENT, REVIEW, AND UPDATING-
The Director shall establish standards and criteria to be utilized by the recipients of contracts under section 913, and by the expert panels convened under such section, with respect to the development and periodic review and updating of the guidelines, standards, performance measures, and review criteria described in section 912(a).
` `(2) AWARD OF CONTRACTS- The Director shall establish standards and criteria to be utilized for the purpose of ensuring that contracts entered into for the development or periodic review or updating of the guidelines, standards, performance measures, and review criteria described in section 912(a) will be entered into only with appropriately qualified entities.
` `(3) CERTAIN REQUIREMENTS FOR STANDARDS AND CRITERIA-
The Director shall ensure that the standards and criteria established under paragraphs (1) and (2) specify that--
` `(A) appropriate consultations with interested individuals and organizations are to be conducted in the development of the guidelines, standards, performance measures, and review criteria described in section 912(a); and
` `(B) such development may be accomplished through the adoption, with or without modification, of guidelines, standards, performance measures, and review criteria that--
` `(i) meet the requirements of this part; and
` `(ii) are developed by entities independently of the program established in this part.
` `(4) IMPROVEMENTS OF STANDARDS AND CRITERIA- The Director shall conduct and support research with respect to improving the standards and criteria developed under this subsection.
` `(c) DISSEMINATION- The Director shall promote and support the dissemination of the guidelines, standards, performance measures, and review criteria described in section 912(a). Such dissemination shall be carried out through organizations representing health care providers, organizations representing health care consumers, peer review organizations, accrediting bodies, and other appropriate entities.
` `(d) PILOT TESTING- The Director may conduct or support pilot testing of the guidelines, standards, performance measures, and review criteria developed under section 912(a). Any such pilot testing
may be conducted prior to, or concurrently with, their dissemination under subsection (c).

`(e) EVALUATIONS- The Director shall conduct and support evaluations of the extent to which the guidelines, standards, performance standards, and review criteria developed under section 912 have had an effect on the clinical practice of medicine.

` (f) RECOMMENDATIONS TO ADMINISTRATOR- The Director shall make recommendations to the Administrator on activities that should be carried out under section 902(a)(2) and under section 1142 of the Social Security Act, including recommendations of particular research projects that should be carried out with respect to--

` (1) evaluating the outcomes of health care services and procedures; 
` (2) developing the standards and criteria required in subsection (b); and
` (3) promoting the utilization of the guidelines, standards, performance standards, and review criteria developed under section 912(a).

(b) OUTCOMES OF HEALTH CARE SERVICES AND PROCEDURES-

` (1) ESTABLISHMENT OF PROGRAM OF RESEARCH- Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new section:

`RESEARCH ON OUTCOMES OF HEALTH CARE SERVICES AND PROCEDURES

`SEC. 1142. (a) ESTABLISHMENT OF PROGRAM-

` (1) IN GENERAL- The Secretary, acting through the Administrator for Health Care Policy and Research, shall--

` (A) conduct and support research with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically; and

` (B) assure that the needs and priorities of the program under title XVIII are appropriately reflected in the development and periodic review and updating (through the process set forth in section 913 of the Public Health Service Act) of treatment-specific or condition-specific practice guidelines for clinical treatments and conditions in forms appropriate for use in clinical practice, for use in
(2) EVALUATIONS OF ALTERNATIVE SERVICES AND PROCEDURES- In carrying out paragraph (1), the Secretary shall conduct or support evaluations of the comparative effects, on health and functional capacity, of alternative services and procedures utilized in preventing, diagnosing, treating, and clinically managing diseases, disorders, and other health conditions.

(3) INITIAL GUIDELINES-

(A) In carrying out paragraph (1)(B) of this subsection, and section 912(d) of the Public Health Service Act, the Secretary shall, by not later than January 1, 1991, assure the development of an initial set of the guidelines specified in paragraph (1)(B) that shall include not less than 3 clinical treatments or conditions that--

(I) account for a significant portion of expenditures under title XVIII; and

(II) have a significant variation in the frequency or the type of treatment provided; or

(ii) otherwise meet the needs and priorities of the program under title XVIII, as set forth under subsection (b)(3).

(B)(i) The Secretary shall provide for the use of guidelines developed under subparagraph (A) to improve the quality, effectiveness, and appropriateness of care provided under title XVIII. The Secretary shall determine the impact of such use on the quality, appropriateness, effectiveness, and cost of medical care provided under such title and shall report to the Congress on such determination by not later than January 1, 1993.

(ii) For the purpose of carrying out clause (i), the Secretary shall expend, from the amounts specified in clause (iii), $1,000,000 for fiscal year 1990 and $1,500,000 for each of the fiscal years 1991 and 1992.

(iii) For each fiscal year, for purposes of expenditures required in clause (ii)--

(I) 60 percent of an amount equal to the expenditure involved is appropriated from the Federal Hospital Insurance Trust Fund (established under section 1817); and

(II) 40 percent of an amount equal to the expenditure involved is appropriated from the
Federal Supplementary Medical Insurance Trust Fund (established under section 1841).

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(b) PRIORITIES-
  (1) IN GENERAL- The Secretary shall establish priorities with respect to the diseases, disorders, and other health conditions for which research and evaluations are to be conducted or supported under subsection (a). In establishing such priorities, the Secretary shall, with respect to a disease, disorder, or other health condition, consider the extent to which--
    (A) improved methods of prevention, diagnosis, treatment, and clinical management can benefit a significant number of individuals;
    (B) there is significant variation among physicians in the particular services and procedures utilized in making diagnoses and providing treatments or there is significant variation in the outcomes of health care services or procedures due to different patterns of diagnosis or treatment;
    (C) the services and procedures utilized for diagnosis and treatment result in relatively substantial expenditures; and
    (D) the data necessary for such evaluations are readily available or can readily be developed.

  (2) PRELIMINARY ASSESSMENTS- For the purpose of establishing priorities under paragraph (1), the Secretary may, with respect to services and procedures utilized in preventing, diagnosing, treating, and clinically managing diseases, disorders, and other health conditions, conduct or support assessments of the extent to which--
    (A) rates of utilization vary among similar populations for particular diseases, disorders, and other health conditions;
    (B) uncertainties exist on the effect of utilizing a particular service or procedure; or
    (C) inappropriate services and procedures are provided.

  (3) RELATIONSHIP WITH MEDICARE PROGRAM- In establishing priorities under paragraph (1) for research and evaluation, and under section 914(a) of the Public Health Service Act for the agenda under such section, the Secretary shall assure that such priorities appropriately reflect the needs and priorities of the program under title XVIII, as set forth by the Administrator of the Health Care Financing Administration.
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(c) METHODOLOGIES AND CRITERIA FOR EVALUATIONS- For the purpose of facilitating research under subsection (a), the Secretary shall--
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(1) conduct and support research with respect to the improvement of methodologies and criteria utilized in conducting research with respect to outcomes of health care services and procedures;
(2) conduct and support reviews and evaluations of existing research findings with respect to such treatment or conditions;
(3) conduct and support reviews and evaluations of the existing methodologies that use large data bases in conducting such research and shall develop new research methodologies, including data-based methods of advancing knowledge and methodologies that measure clinical and functional status of patients, with respect to such research;
(4) provide grants and contracts to research centers, and contracts to other entities, to conduct such research on such treatment or conditions, including research on the appropriate use of prescription drugs;
(5) conduct and support research and demonstrations on the use of claims data and data on clinical and functional status of patients in determining the outcomes, effectiveness, and appropriateness of such treatment; and
(6) conduct and support supplementation of existing data bases, including the collection of new information, to enhance data bases for research purposes, and the design and development of new data bases that would be used in outcomes and effectiveness research.

(d) STANDARDS FOR DATA BASES- In carrying out this section, the Secretary shall develop--
(1) uniform definitions of data to be collected and used in describing a patient's clinical and functional status;
(2) common reporting formats and linkages for such data; and
(3) standards to assure the security, confidentiality, accuracy, and appropriate maintenance of such data.

(e) DISSEMINATION OF RESEARCH FINDINGS AND GUIDELINES-
(1) IN GENERAL- The Secretary shall provide for the dissemination of the findings of research and the guidelines described in subsection (a), and for the education of providers and others in the application of such research findings and guidelines.
(2) COOPERATIVE EDUCATIONAL ACTIVITIES- In disseminating findings and guidelines under paragraph (1), and in providing for education under such paragraph, the Secretary shall work with professional associations, medical specialty and subspecialty organizations, and other relevant groups to identify and implement effective means to educate physicians, other
providers, consumers, and others in using such findings and guidelines, including training for physician managers within provider organizations.

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(f) EVALUATIONS- The Secretary shall conduct and support evaluations of the activities carried out under this section to determine the extent to which such activities have had an effect on the practices of physicians in providing medical treatment, the delivery of health care, and the outcomes of health care services and procedures.
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(g) RESEARCH WITH RESPECT TO DISSEMINATION- The Secretary may conduct or support research with respect to improving methods of disseminating information on the effectiveness and appropriateness of health care services and procedures.
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h) REPORT TO CONGRESS- Not later than February 1 of each of the years 1991 and 1992, and of each second year thereafter, the Secretary shall report to the Congress on the progress of the activities under this section during the preceding fiscal year (or preceding 2 fiscal years, as appropriate), including the impact of such activities on medical care (particularly medical care for individuals receiving benefits under title XVIII).
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i) AUTHORIZATION OF APPROPRIATIONS-

(1) IN GENERAL- There are authorized to be appropriated to carry out this section--

` (A) $50,000,000 for fiscal year 1990;
` (B) $75,000,000 for fiscal year 1991;
` (C) $110,000,000 for fiscal year 1992;
` (D) $148,000,000 for fiscal year 1993; and
` (E) $185,000,000 for fiscal year 1994.
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(2) SPECIFICATIONS- For the purpose of carrying out this section, for each of the fiscal years 1990 through 1992 an amount equal to two-thirds of the amounts authorized to be appropriated under paragraph (1), and for each of the fiscal years 1993 and 1994 an amount equal to 70 percent of such amounts, are to be appropriated in the following proportions from the following trust funds:

` (A) 60 percent from the Federal Hospital Insurance Trust Fund (established under section 1817).
` (B) 40 percent from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841).
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(3) ALLOCATIONS-

` (A) For each fiscal year, of the amounts transferred or otherwise appropriated to carry out this section, the Secretary shall reserve appropriate amounts for each of the purposes specified in clauses (i) through (iv) of subparagraph (B).
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(B) The purposes referred to in subparagraph (A) are--
(ii) the development of guidelines, standards, performance measures, and review criteria;
(iii) data-base standards and development; and
(iv) education and information dissemination.'.

(2) REPORT ON LINKAGE OF PUBLIC AND PRIVATE RESEARCH-RELATED DATA- Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall report to the Congress on the feasibility of linking research-related data described in section 1142(d) of the Social Security Act (as added by paragraph (1) of this subsection) with similar data collected or maintained by non-Federal entities and by Federal agencies other than the Department of Health and Human Services (including the Departments of Defense and Veterans Affairs and the Office of Personnel Management).

(3) TECHNICAL AND CONFORMING PROVISIONS-
(A) Effective for fiscal years beginning after fiscal year 1990, subsection (c) of section 1875 of the Social Security Act (42 U.S.C. 1395ll) is repealed.
(B) Section 1862(a)(1)(E) of the Social Security Act (42 U.S.C. 1395y(a)(1)(E)) is amended by striking `section 1875(c)' and inserting `section 1142'.

(c) ADDITIONAL AUTHORITIES AND DUTIES WITH RESPECT TO AGENCY FOR HEALTH CARE POLICY AND RESEARCH- Title IX of the Public Health Service Act, as added by subsection (a) of this section, is amended by adding at the end the following new part:

`Part C--General Provisions

SEC. 921. ADVISORY COUNCIL FOR HEALTH CARE POLICY, RESEARCH, AND EVALUATION.

(a) ESTABLISHMENT- There is established an advisory council to be known as the National Advisory Council for Health Care Policy, Research, and Evaluation.
(b) DUTIES-
(1) IN GENERAL- The Council shall advise the Secretary and the Administrator with respect to activities to carry out the purpose of the Agency under section 901(b).
(2) CERTAIN RECOMMENDATIONS- Activities of the Council under paragraph (1) shall include making recommendations to the Administrator regarding priorities for a national agenda and strategy for--
(A) the conduct of research, demonstration projects, and evaluations with respect to health care, including clinical practice and primary care;
(B) the development and application of appropriate health care technology assessments;
(C) the development and periodic review and updating of guidelines for clinical practice, standards of quality, performance measures, and medical review criteria with respect to health care; and
(D) the conduct of research on outcomes of health care services and procedures.

(c) MEMBERSHIP-
(1) IN GENERAL- The Council shall, in accordance with this subsection, be composed of appointed members and ex officio members. All members of the Council shall be voting members, other than officials designated under paragraph (3)(B) as ex officio members of the Council.
(2) APPOINTED MEMBERS- The Secretary shall appoint to the Council 17 appropriately qualified representatives of the public who are not officers or employees of the United States. The Secretary shall ensure that the appointed members of the Council, as a group, are representative of professions and entities concerned with, or affected by, activities under this title and under section 1142 of the Social Security Act. Of such members--
(A) 8 shall be individuals distinguished in the conduct of research, demonstration projects, and evaluations with respect to health care;
(B) 3 shall be individuals distinguished in the practice of medicine;
(C) 2 shall be individuals distinguished in the health professions;
(D) 2 shall be individuals distinguished in the fields of business, law, ethics, economics, and public policy; and
(E) 2 shall be individuals representing the interests of consumers of health care.
(3) EX OFFICIO MEMBERS- The Secretary shall designate as ex officio members of the Council--
(A) the Director of the National Institutes of Health, the Director of the Centers for Disease Control, the Administrator of the Health Care Financing Administration, the Assistant Secretary of Defense (Health Affairs), the Chief Medical Officer of the Department of Veterans Affairs; and
(B) such other Federal officials as the Secretary may consider appropriate.

(d) SUBCOUNCIL ON OUTCOMES AND GUIDELINES-
   (1) ESTABLISHMENT- For the purpose of carrying out the duties specified in subparagraphs (C) and (D) of subsection (b)(2), the Secretary shall establish a subcouncil of the Council and shall designate the membership of the subcouncil in accordance with paragraph (2).
   (2) MEMBERSHIP- The subcouncil established pursuant to paragraph (1) shall consist of--
      (A) 6 individuals from among the individuals appointed to the Council under subparagraphs (A) through (C) of subsection (c)(2);
      (B) 2 individuals from among the individuals appointed to the Council under subparagraphs (D) and (E) of such subsection; and
      (C) each of the officials designated as ex officio members of the Council under subsection (c)(3)(A).

(e) TERMS-
   (1) IN GENERAL- Except as provided in paragraph (2), members of the Council appointed under subsection (c)(2) shall serve for a term of 3 years.
   (2) STAGGERED ROTATION- Of the members first appointed to the Council under subsection (c)(2), the Secretary shall appoint 6 members to serve for a term of 3 years, 6 members to serve for a term of 2 years, and 5 members to serve for a term of 1 year.
   (3) SERVICE BEYOND TERM- A member of the Council appointed under subsection (c)(2) may continue to serve after the expiration of the term of the member until a successor is appointed.

(f) VACANCIES- If a member of the Council appointed under subsection (c)(2) does not serve the full term applicable under subsection (e), the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

(g) CHAIR- The Administrator shall, from among the members of the Council appointed under subsection (c)(2), designate an individual to serve as the chair of the Council.

(h) MEETINGS- The Council shall meet not less than once during each discrete 4-month period and shall otherwise meet at the call of the Administrator or the chair.

(i) COMPENSATION AND REIMBURSEMENT OF EXPENSES-
(1) APPOINTED MEMBERS- Members of the Council appointed under subsection (c)(2) shall receive compensation for each day (including traveltime) engaged in carrying out the duties of the Council. Such compensation may not be in an amount in excess of the maximum rate of basic pay payable for GS-18 of the General Schedule.

(2) EX OFFICIO MEMBERS- Officials designated under subsection (c)(3) as ex officio members of the Council may not receive compensation for service on the Council in addition to the compensation otherwise received for duties carried out as officers of the United States.

(j) STAFF- The Administrator shall provide to the Council such staff, information, and other assistance as may be necessary to carry out the duties of the Council.

(k) DURATION- Notwithstanding section 14(a) of the Federal Advisory Committee Act, the Council shall continue in existence until otherwise provided by law.

SEC. 922. PEER REVIEW WITH RESPECT TO GRANTS AND CONTRACTS.

(a) REQUIREMENT OF REVIEW-
(1) IN GENERAL- Appropriate technical and scientific peer review shall be conducted with respect to each application for a grant, cooperative agreement, or contract under this title.

(2) REPORTS TO ADMINISTRATOR- Each peer review group to which an application is submitted pursuant to paragraph (1) shall report its finding and recommendations respecting the application to the Administrator in such form and in such manner as the Administrator shall require.

(b) APPROVAL AS PRECONDITION OF AWARDS- The Administrator may not approve an application described in subsection (a)(1) unless the application is recommended for approval by a peer review group established under subsection (c).

(c) ESTABLISHMENT OF PEER REVIEW GROUPS-
(1) IN GENERAL- The Administrator shall establish such technical and scientific peer review groups as may be necessary to carry out this section. Such groups shall be established without regard to the provisions of title 5, United States Code, that govern appointments in the competitive service, and without regard to the provisions of chapter 51, and subchapter III of chapter 53, of such title that relate to classification and pay rates under the General Schedule.

(2) MEMBERSHIP- The members of any peer review group established under this section shall be appointed from among
individuals who are not officers or employees of the United States and who by virtue of their training or experience are eminently qualified to carry out the duties of such peer review group.

`(3) DURATION- Notwithstanding section 14(a) of the Federal Advisory Committee Act, peer review groups established under this section shall continue in existence until otherwise provided by law.

`(d) CATEGORIES OF REVIEW-
  `(1) IN GENERAL- With respect to technical and scientific peer review under this section, such review of applications with respect to research, demonstration projects, or evaluations shall be conducted by different peer review groups than the peer review groups that conduct such review of applications with respect to dissemination activities or the development of research agendas (including conferences, workshops, and meetings).

  `(2) AUTHORITY FOR PROCEDURAL ADJUSTMENTS IN CERTAIN CASES- In the case of applications described in subsection (a)(1) for financial assistance whose direct costs will not exceed $50,000, the Administrator may make appropriate adjustments in the procedures otherwise established by the Administrator for the conduct of peer review under this section. Such adjustments may be made for the purpose of encouraging the entry of individuals into the field of research, for the purpose of encouraging clinical practice-oriented research, and for such other purposes as the Administrator may determine to be appropriate.

`(e) REGULATIONS- The Secretary shall issue regulations for the conduct of peer review under this section.

`SEC. 923. CERTAIN PROVISIONS WITH RESPECT TO DEVELOPMENT, COLLECTION, AND DISSEMINATION OF DATA.

`(a) STANDARDS WITH RESPECT TO UTILITY OF DATA-
  `(1) IN GENERAL- With respect to data developed or collected by any entity for the purpose described in section 901(b), the Administrator shall, in order to assure the utility, accuracy, and sufficiency of such data for all interested entities, establish guidelines for uniform methods of developing and collecting such data. Such guidelines shall include specifications for the development and collection of data on the outcomes of health care services and procedures.
(2) RELATIONSHIP WITH MEDICARE PROGRAM- In any case where guidelines under paragraph (1) may affect the administration of the program under title XVIII of the Social Security Act, the guidelines shall be in the form of recommendations to the Secretary for such program.

(b) STATISTICS- The Administrator shall--

(1) take such action as may be necessary to assure that statistics developed under this title are of high quality, timely, and comprehensive, as well as specific, standardized, and adequately analyzed and indexed; and

(2) publish, make available, and disseminate such statistics on as wide a basis as is practicable.

SEC. 924. ADDITIONAL PROVISIONS WITH RESPECT TO GRANTS AND CONTRACTS.

(a) REQUIREMENT OF APPLICATION- The Administrator may not, with respect to any program under this title authorizing the provision of grants, cooperative agreements, or contracts, provide any such financial assistance unless an application for the assistance is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Administrator determines to be necessary to carry out the program involved.

(b) PROVISION OF SUPPLIES AND SERVICES IN LIEU OF FUNDS-

(1) IN GENERAL- Upon the request of an entity receiving a grant, cooperative agreement, or contract under this title, the Secretary may, subject to paragraph (2), provide supplies, equipment, and services for the purpose of aiding the entity in carrying out the project involved and, for such purpose, may detail to the entity any officer or employee of the Department of Health and Human Services.

(2) CORRESPONDING REDUCTION IN FUNDS- With respect to a request described in paragraph (1), the Secretary shall reduce the amount of the financial assistance involved by an amount equal to the costs of detailing personnel and the fair market value of any supplies, equipment, or services provided by the Administrator. The Secretary shall, for the payment of expenses incurred in complying with such request, expend the amounts withheld.

(c) APPLICABILITY OF CERTAIN PROVISIONS WITH RESPECT TO CONTRACTS- Contracts may be entered into under this part without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).
SEC. 925. CERTAIN ADMINISTRATIVE AUTHORITIES.

(a) DEPUTY ADMINISTRATOR AND OTHER OFFICERS AND EMPLOYEES-
   (1) DEPUTY ADMINISTRATOR- The Administrator may appoint a
deputy administrator for the Agency.
   (2) OTHER OFFICERS AND EMPLOYEES- The Administrator may
   appoint and fix the compensation of such officers and employees
   as may be necessary to carry out this title. Except as otherwise
   provided by law, such officers and employees shall be appointed
   in accordance with the civil service laws and their compensation
   fixed in accordance with title 5, United States Code.

(b) FACILITIES- The Secretary, in carrying out this title--
   (1) may acquire, without regard to the Act of March 3, 1877
   (40 U.S.C. 34), by lease or otherwise through the Administrator
   of General Services, buildings or portions of buildings in the
   District of Columbia or communities located adjacent to the
   District of Columbia for use for a period not to exceed 10 years;
   and
   (2) may acquire, construct, improve, repair, operate, and
   maintain laboratory, research, and other necessary facilities and
   equipment, and such other real or personal property (including
   patents) as the Secretary deems necessary.

(c) PROVISION OF FINANCIAL ASSISTANCE- The Administrator, in
    carrying out this title, may make grants to, and enter into cooperative
    agreements with, public and nonprofit private entities and individuals,
    and when appropriate, may enter into contracts with public and private
    entities and individuals.

(d) UTILIZATION OF CERTAIN PERSONNEL AND RESOURCES-
    (1) DEPARTMENT OF HEALTH AND HUMAN SERVICES- The
    Administrator, in carrying out this title, may utilize personnel
    and equipment, facilities, and other physical resources of the
    Department of Health and Human Services, permit appropriate
    (as determined by the Secretary) entities and individuals to
    utilize the physical resources of such Department, and provide
    technical assistance and advice.
    (2) OTHER AGENCIES- The Administrator, in carrying out this
    title, may use, with their consent, the services, equipment,
    personnel, information, and facilities of other Federal, State, or
    local public agencies, or of any foreign government, with or
    without reimbursement of such agencies.

(e) CONSULTANTS- The Secretary, in carrying out this title, may
    secure, from time to time and for such periods as the Administrator
    deems advisable but in accordance with section 3109 of title 5, United
States Code, the assistance and advice of consultants from the United States or abroad.

`(f) EXPERTS-

  `(1) IN GENERAL- The Secretary may, in carrying out this title, obtain the services of not more than 50 experts or consultants who have appropriate scientific or professional qualifications. Such experts or consultants shall be obtained in accordance with section 3109 of title 5, United States Code, except that the limitation in such section on the duration of service shall not apply.

  `(2) TRAVEL EXPENSES-

    `(A) Experts and consultants whose services are obtained under paragraph (1) shall be paid or reimbursed for their expenses associated with traveling to and from their assignment location in accordance with sections 5724, 5724a(a)(1), 5724a(a)(3), and 5726(c) of title 5, United States Code.

    `(B) Expenses specified in subparagraph (A) may not be allowed in connection with the assignment of an expert or consultant whose services are obtained under paragraph (1) unless and until the expert agrees in writing to complete the entire period of assignment, or one year, whichever is shorter, unless separated or reassigned for reasons that are beyond the control of the expert or consultant and that are acceptable to the Secretary. If the expert or consultant violates the agreement, the money spent by the United States for the expenses specified in subparagraph (A) is recoverable from the expert or consultant as a debt of the United States. The Secretary may waive in whole or in part a right of recovery under this subparagraph.

`(g) VOLUNTARY AND UNCOMPENSATED SERVICES- The Administrator, in carrying out this title, may accept voluntary and uncompensated services.

`SEC. 926. FUNDING.

`(a) AUTHORIZATION OF APPROPRIATIONS- For the purpose of carrying out this title, there are authorized to be appropriated $35,000,000 for fiscal year 1990, $50,000,000 for fiscal year 1991, and $70,000,000 for fiscal year 1992.

`(b) EVALUATIONS- In addition to amounts available pursuant to subsection (a) for carrying out this title, there shall be made available for such purpose, from the amounts made available pursuant to
section 2611 of this Act (relating to evaluations), an amount equal to 40 percent of the maximum amount authorized in such section 2611 to be made available.

`SEC. 927. DEFINITIONS.

For purposes of this title:

(1) The term `Administrator' means the Administrator for Health Care Policy and Research.

(2) The term `Agency' means the Agency for Health Care Policy and Research.

(3) The term `Council' means the National Advisory Council on Health Care Policy, Research, and Evaluation.

(4) The term `Director' means the Director of the Office of the Forum for Quality and Effectiveness in Health Care.'.

(d) GENERAL PROVISIONS-

(1) TERMINATIONS-

(A) The National Center for Health Services Research and Health Care Technology Assessment is terminated, and part A of title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by striking section 305.

(B) The council on health care technology established under section 309 of the Public Health Service Act is terminated, and part A of title III of such Act is amended by striking section 309.

(2) CONTRACT FOR TEMPORARY ASSISTANCE TO SECRETARY WITH RESPECT TO HEALTH CARE TECHNOLOGY ASSESSMENT-

(A) The Secretary of Health and Human Services shall request the Institute of Medicine of the National Academy of Sciences to enter into a contract--

(i) to develop and recommend to the Secretary priorities for the assessment of specific health care technologies under section 904 of the Public Health Service Act (as added by subsection (a) of this section); and

(ii) to assist the Administrator for Health Care Policy and Research, and the Director of the National Library of Medicine, in establishing the information center required under subsection (c)(1) of such section 904.

(B) In carrying out section 904(c)(1) of the Public Health Service Act (as added by subsection (a) of this section), the Secretary of Health and Human Services shall, as appropriate, provide for the transfer to the Secretary of
any information and materials developed by the council on health care technology under section 309(c)(1)(A) of the Public Health Service Act (as such section was in effect on the day before the effective date of this section). (C) The Secretary of Health and Human Services shall ensure that the contract under subparagraph (A) specifies that the activities described in clauses (i) and (ii) of such subparagraph shall be completed not later than 1 year after the date on which the Secretary enters into the contract. (D) For the purpose of carrying out the contract under subparagraph (A), there is authorized to be appropriated $300,000 for fiscal year 1990. (e) TECHNICAL AND CONFORMING AMENDMENTS- (1) SECTION 304- Section 304 of the Public Health Service Act (42 U.S.C. 242b) is amended-- (A) in subsection (a)-- (i) by striking paragraphs (1) and (2); and (ii) by striking the paragraph designation in paragraph (3); (B) in subsection (a) (as amended by subparagraph (A) of this paragraph)-- (i) by striking `the National Center for Health Services Research and Health Care Technology Assessment' and inserting `the Agency for Health Care Policy and Research'; and (ii) by striking `in sections 305, 306, and 309' and inserting `in section 306 and in title IX'; (C) in subsection (b), in the matter preceding paragraph (1), by striking `subsection (a),' and inserting `subsection (a) and section 306,'; and (D) in subsection (c)-- (i) in paragraph (1), in the second sentence, by striking `the National Center for Health Services Research and Health Care Technology Assessment' and inserting `the Agency for Health Care Policy and Research'; and (ii) in paragraph (2), by striking `the National Center for Health Services Research and Health Care Technology Assessment' and inserting `the Agency for Health Care Policy and Research'. (2) SECTION 306- Section 306 of the Public Health Service Act (42 U.S.C. 242k) is amended--
(A) in subsection (a), by adding at the end the following new sentence: `The Secretary, acting through the Center, shall conduct and support statistical and epidemiological activities for the purpose of improving the effectiveness, efficiency, and quality of health services in the United States.';
(B) in subsection (b), in the matter preceding paragraph (1), by striking `section 304(a),' and inserting `subsection (a),' and
(C) by adding at the end the following new subsection:
`(m) For health statistical and epidemiological activities undertaken or supported under this section, there are authorized to be appropriated $55,000,000 for fiscal year 1988 and such sums as may be necessary for each of the fiscal years 1989 and 1990.'.

(3) SECTION 307- Section 307(a) of the Public Health Service Act (42 U.S.C. 242l(a)) is amended by striking `sections 304, 305, 306, and 309' and inserting `section 306 and by title IX'.

(4) SECTION 308- Section 308 of the Public Health Service Act (42 U.S.C. 242m) is amended--
(A) in the section heading, by striking `SECTIONS' and all that follows and inserting the following: `EFFECTIVENESS, EFFICIENCY, AND QUALITY OF HEALTH SERVICES';
(B) in subsection (a)--
(i) in paragraph (1)(A)(i), by striking `sections 304 through 307 and section 309' and inserting `sections 304, 306, and 307 and title IX'; and
(ii) in paragraph (2), by striking `the National Center for Health Services Research and Health Care Technology Assessment' and inserting `the Agency for Health Care Policy and Research';
(C) in subsection (b)--
(i) in paragraph (1), by striking `sections 304, 305, 306, 307, and 309' and inserting `section 304, 306, or 307';
(ii) in subparagraph (A) of paragraph (2)--
(I) in the first sentence, by striking `under section 304 or 305,' and inserting `under section 306';
(II) by striking the second sentence; and
(III) by amending the last sentence to read as follows: `The Director of the National Center for Health Statistics shall establish such peer review groups as may be necessary to provide
for such an evaluation of each such application.

(iii) in subparagraph (B) of paragraph (2), by striking `the Director involved,' and inserting `the Director of the National Center for Health Statistics,';

(iv) in subparagraph (C) of paragraph (2), by striking `the Directors,' and inserting `the Director of the National Center for Health Statistics,'; and

(v) in paragraph (3), in the first sentence--

(I) by striking `section 304, 305, or 306' the first place such term appears and inserting `section 306'; and

(II) by striking `section 304, 305, or 306' the second place such term appears and inserting `any of such sections';

(D) in subsection (d)--

(i) in the matter preceding paragraph (1), by striking `section 304, 305, 306, 307, or 309' and inserting `section 304, 306, or 307';

(ii) in paragraph (1), by striking `in other form, and' and inserting `in other form.' and by striking the paragraph designation; and

(iii) by striking paragraph (2);

(E) in subsection (e)--

(i) in paragraph (1), by striking `section 304, 305, 306, 307, or 309' and inserting `section 304, 306, or 307'; and

(ii) in paragraph (2), in the matter preceding subparagraph (A), by striking `section 304, 305, 306, 307, or 309' and inserting `section 304, 306, or 307';

(F) in subsection (f), by striking `section 304, 305, 306, or 309' and inserting `section 304 or 306';

(G) in subsection (g)--

(i) in paragraph (1), by striking the matter after and below subparagraph (C); and

(ii) in paragraph (2), by striking `sections 304, 305, 306, and 309' and inserting `sections 304 and 306';

(H) in subsection (h)(1)--

(i) by striking `section 304, 305, 306, or 309' the first place such term appears and inserting `section 306'; and
(ii) by striking `section 304, 305, 306, or 309' the second place such term appears and inserting `any of such sections'; and

(I) by striking subsection (i).

(5) SECTION 330- Section 330(e)(3)(G)(i) of the Public Health Service Act (42 U.S.C. 254c(e)(3)(G)(i)) is amended by inserting after ` (i)' the following: `except in the case of an entity operated by an Indian tribe or tribal or Indian organization under the Indian Self-Determination Act,.'.

(6) SECTION 402- Section 402 of the Public Health Service Amendments of 1987 is amended--

(A) by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

`(c) Such Act is amended in section 411(c)(2) by striking subparagraph (B), by striking `subparagraphs (A) and (B)' in subparagraph (C), and by redesignating subparagraph (C) as subparagraph (B). Such Act is amended in section 415(a) by inserting before the period at the end the following: `or as preempting or overriding any State law which provides incentives, immunities, or protection for those engaged in a professional review action that is in addition to or greater than that provided by this part'; and

(B) in subsection (d)(1) (as so redesignated), by striking `subsection (a)' and inserting `subsections (a) and (c)'.

(7) SECTION 487- Section 487(d)(3)(B) of the Public Health Service Act (42 U.S.C. 288(d)(3)(B)) is amended by striking `National Center' and all that follows through `Assessment' and inserting `Agency for Health Care Policy and Research'.

(f) TRANSITIONAL AND SAVINGS PROVISIONS-

(1) TRANSFER OF PERSONNEL, ASSETS, AND LIABILITIES-

Personnel of the Department of Health and Human Services employed on the date of the enactment of this Act in connection with the functions vested in the Administrator for Health Care Policy and Research pursuant to the amendments made by this section, and assets, property, contracts, liabilities, records, unexpended balances of appropriations, authorizations, allocations, and other funds, of such Department arising from or employed, held, used, or available on such date, or to be made available after such date, in connection with such functions shall be transferred to the Administrator for appropriate allocation. Unexpended funds transferred under this paragraph shall be used only for the purposes for which the funds were originally authorized and appropriated.
(2) SAVINGS PROVISIONS - With respect to functions vested in the Administrator for Health Care Policy and Research pursuant to the amendments made by this section, all orders, rules, regulations, grants, contracts, certificates, licenses, privileges, and other determinations, actions, or official documents, of the Department of Health and Human Services that have been issued, made, granted, or allowed to become effective in the performance of such functions, and that are effective on the date of the enactment of this Act, shall continue in effect according to their terms unless changed pursuant to law.

SEC. 6104. REDUCTION IN PAYMENTS FOR CERTAIN PROCEDURES.

(a) IN GENERAL - Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)) is amended by adding at the end the following new paragraph:

`(14)(A) In determining the reasonable charge for a physicians' service specified in subparagraph (C)(i) and furnished during the 9-month period beginning on April 1, 1990, the prevailing charge for such service shall be the prevailing charge otherwise recognized for such service for 1989 reduced by 15 percent or, if less, 1/3 of the percent (if any) by which the prevailing charge otherwise applied in the locality in 1989 exceeds the locally-adjusted reduced prevailing amount (as determined under subparagraph (B)(i)) for the service.

`(B) For purposes of this paragraph:

`(i) The `locally-adjusted reduced prevailing amount' for a locality for a physicians' service is equal to the product of--

` (I) the reduced national weighted average prevailing charge for the service (specified under clause (ii)), and

` (II) the adjustment factor (specified under clause (iii)) for the locality.

`(ii) The `reduced national weighted average prevailing charge' for a physicians' service is equal to the national weighted average prevailing charge for the service (specified in subparagraph (C)(ii)) reduced by the percentage change (specified in subparagraph (C)(iii)) for the service.

`(iii) The `adjustment factor', for a physicians' service for a locality, is the sum of--

` (I) the practice expense ratio for the service (specified in Table #1 in the Joint Explanatory Statement referred to in subparagraph (C)(i)), multiplied by the geographic practice cost index value (specified in subparagraph (C)(iv)) for the locality, and

` (II) 1 minus the practice expense ratio.
'(C) For purposes of this paragraph:

`(i) The physicians' services specified in this clause are the physicians' services specified in Table #2 in the Joint Explanatory Statement of the Committee of Conference submitted with the Conference Report to accompany H.R. 3299 (the `Omnibus Budget Reconciliation Act of 1989'), 101st Congress, which specification is of physicians' services that have been identified as overvalued by at least 10 percent based on a comparison of payments for such services under a resource-based relative value scale and of the national average prevailing charges under this part.

`(ii) The `national weighted average prevailing charge' specified in this clause, for a physicians' service specified in clause (i), is the national weighted average prevailing charge for the service in 1989 as determined by the Secretary using the best data available.

`(iii) The `percent change' specified in this clause, for a physicians' service specified in clause (i), is the percent change specified for the service in Table #2 in the Joint Explanatory Statement referred to in clause (i).

`(iv) The geographic practice cost index value specified in this clause for a locality is such value specified for the locality in Table #3 in the Joint Explanatory Statement referred to in clause (i).

'(D) In the case of a reduction in the prevailing charge for a physicians' service under subparagraph (A), if a nonparticipating physician furnishes the service to an individual entitled to benefits under this part, after the effective date of such reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).

(b) SPECIAL LIMITS ON ACTUAL CHARGES- Section 1842(j)(1)(D) of such Act is amended--

(1) in clause (ii)(II), by inserting `or (b)(14)(A)' after `(b)(10)(A)', and

(2) in clause (iii)(II), by striking `or (b)(11)(C)(i)' and inserting `(b)(11)(C)(i), or (b)(14)(A)'.

SEC. 6105. REDUCTION IN PAYMENTS FOR RADIOLOGY SERVICES.

(a) FEE SCHEDULES FOR RADIOLOGIST SERVICES REDUCED- Section 1834(b)(4) of the Social Security Act (42 U.S.C. 1395m(b)(4)) is amended--

(1) by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), and
(2) by inserting after subparagraph (B) the following new subparagraph:

'(C) 1990 FEE SCHEDULES- For radiologist services (other than portable X-ray services) furnished under this part during 1990, after March 31 of such year, the conversion factors used under this subsection shall be 96 percent of the conversion factors that applied under this subsection as of December 31, 1989.'.

(b) SPECIAL RULE FOR NUCLEAR MEDICINE PHYSICIANS- In applying section 1834(b) of the Social Security Act with respect to nuclear medicine services furnished by a physician for whom nuclear medicine services account for at least 80 percent of the total amount of charges made under part B of title XVIII of the Social Security Act--

(1) during 1990, after April 1, 1990, there shall be substituted for the fee schedule otherwise applicable a fee schedule based 1/3 on the fee schedule computed under such section (without regard to this subsection) and 2/3 on 101 percent of the 1988 prevailing charge for such services; and

(2) during 1991, there shall be substituted for the fee schedule otherwise applicable a fee schedule based 2/3 on the fee schedule computed under such section (without regard to this subsection) and 1/3 on 101 percent of the 1988 prevailing charge for such services.

(c) INTERVENTIONAL RADIOLOGISTS- In applying section 1834(b) of the Social Security Act to radiologist services furnished in 1990, the exception for `split billing' set forth at section 5262J of the Medicare Carriers Manual shall apply to services furnished in 1990 in the same manner and to the same extent as the exception applied to services furnished in 1989.

SEC. 6106. ANESTHESIA SERVICES.

(a) COUNTING ACTUAL TIME UNITS FOR ANESTHESIA SERVICES AND CODIFICATION OF PREVIOUS AUTHORITY- Section 1842 of the Social Security Act (42 U.S.C. 1395u) is amended by adding at the end the following new subsection:

`(q)(1) The Secretary, in consultation with groups representing physicians who furnish anesthesia services, shall establish by regulation a relative value guide for use in all carrier localities in making payment for physician anesthesia services furnished under this part. Such guide shall be designed so as to result in expenditures under this title for such services in an amount that would not exceed the amount of such expenditures which would otherwise occur.
(2) For purposes of payment for anesthesia services (whether furnished by physicians or by certified registered nurse anesthetists) under this part, the time units shall be counted based on actual time rather than rounded to full time units.’.

(b) EFFECTIVE DATE- The amendment made by subsection (a) shall apply to services furnished on or after April 1, 1990.

SEC. 6107. DELAY IN UPDATE AND REDUCTION IN PERCENTAGE INCREASE IN THE MEDICARE ECONOMIC INDEX.

(a) DELAYING UPDATES UNTIL APRIL 1-
   (1) IN GENERAL- Subject to the amendments made by this section, any increase or adjustment in customary, prevailing, or reasonable charges, fee schedule amounts, maximum allowable actual charges, and other limits on actual charges with respect to physicians' services and other items and services described in paragraph (2) under part B of title XVIII of the Social Security Act which would otherwise occur as of January 1, 1990, shall be delayed so as to occur as of April 1, 1990, and, notwithstanding any other provision of law, the amount of payment under such part for such items and services which are furnished during the period beginning on January 1, 1990, and ending on March 31, 1990, shall be determined on the same basis as the amount of payment for such services furnished on December 31, 1989.
   (2) ITEMS AND SERVICES COVERED- The items and services described in this paragraph are items and services (other than ambulance services and clinical diagnostic laboratory services) for which payment is made under part B of title XVIII of the Social Security Act on the basis of a reasonable charge or a fee schedule.
   (3) EXTENSION OF PARTICIPATION AGREEMENTS AND RELATED PROVISIONS- Notwithstanding any other provision of law--
      (A) subject to the last sentence of this paragraph, each participation agreement in effect on December 31, 1989, under section 1842(h)(1) of the Social Security Act shall remain in effect for the 3-month period beginning on January 1, 1990;
      (B) the effective period for such agreements under such section entered into for 1990 shall be the 9-month period beginning on April 1, 1990, and the Secretary of Health and Human Services shall provide an opportunity for physicians and suppliers to enroll as participating physicians and suppliers before April 1, 1990;
(C) instead of publishing, under section 1842(h)(4) of the Social Security Act, at the beginning of 1990, directories of participating physicians and suppliers for 1990, the Secretary shall provide for such publication, at the beginning of the 9-month period beginning on April 1, 1990, of such directories of participating physicians and suppliers for such period; and
(D) instead of providing to nonparticipating physicians under section 1842(b)(3)(G) of the Social Security Act at the beginning of 1990, a list of maximum allowable actual charges for 1990, the Secretary shall provide, at the beginning of the 9-month period beginning on April 1, 1990, such physicians such a list for such 9-month period.

An agreement with a participating physician or supplier described in subparagraph (A) in effect on December 31, 1989, under section 1842(h)(1) of the Social Security Act shall not remain in effect for the period described in subparagraph (A) if the participating physician or supplier requests on or before December 31, 1989, that the agreement be terminated.

(b) PERCENTAGE INCREASE IN MEI FOR 1990- Section 1842(b)(4)(E) of the Social Security Act (42 U.S.C. 1395u(b)(4)(E)) is amended by adding at the end the following new clause:
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(iv) For purposes of this part for items and services furnished in 1990, after March 31, 1990, the percentage increase in the MEI is--
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(I) 0 percent for radiology services, for anesthesia services, and for other services specified in Table #2 in the Joint Explanatory Statement of the Committee of Conference submitted with the Conference Report to accompany H.R. 3299 (the `Omnibus Budget Reconciliation Act of 1989'), 101st Congress,
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(II) 2 percent for other services (other than primary care services), and
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(III) such percentage increase in the MEI (as defined in subsection (i)(3)) as would be otherwise determined for primary care services (as defined in subsection (i)(4)).
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SEC. 6108. MISCELLANEOUS PROVISIONS RELATING TO PAYMENT FOR PHYSICIANS' SERVICES.

(a) CUSTOMARY CHARGE FOR NEW PHYSICIANS-
(1) PHASE-IN TO PREVAILING CHARGE LEVEL- Section 1842(b)(4)(F) of the Social Security Act (42 U.S.C. 1395u(b)(4)(F)) is amended--
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(A) by inserting `furnished during a calendar year' after `physicians' services', and
(B) by adding at the end the following: `For the first calendar year during which the preceding sentence no longer applies, the Secretary shall set the customary charge at a level no higher than 85 percent of the prevailing charge for the service.'.

(2) EFFECTIVE DATE- (A) Subject to subparagraph (B), the amendments made by paragraph (1) apply to services furnished in 1990 which were subject to the first sentence of section 1842(b)(4)(F) of the Social Security Act in 1989.

(B) The amendments made by paragraph (1) shall not apply to services furnished in 1990 before April 1, 1990. With respect to physicians' services furnished during 1990 on and after April 1, such amendments shall be applied as though any reference, in the matter inserted by such amendments, to the `first calendar year during which the preceding sentence no longer applies' were deemed a reference to the remainder of 1990.

(b) LIMITATION ON AMOUNTS FOR CERTAIN SERVICES FURNISHED BY MORE THAN ONE SPECIALTY-

(1) IN GENERAL- Section 1842(b) of such Act (42 U.S.C. 1395u(b)), as amended by section 6104(a) of this subtitle, is amended by adding at the end the following:

`(15)(A) In determining the reasonable charge for surgery, radiology, and diagnostic physicians' services which the Secretary shall designate (based on their high volume of expenditures under this part) and for which the prevailing charge (but for this paragraph) differs by physician specialty, the prevailing charge for such a service may not exceed the prevailing charge or fee schedule amount for that specialty of physicians that furnish the service most frequently nationally.

`(B) In the case of a reduction in the prevailing charge for a physician's service under subparagraph (A), if a nonparticipating physician furnishes the service to an individual entitled to benefits under this part, after the effective date of the reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).'.

(2) SPECIAL LIMITS ON ACTUAL CHARGES- Section 1842(j)(1)(D) of such Act (42 U.S.C. 1395u(j)(1)(D)) is amended--

(A) in clause (ii)(IV), by inserting `or (b)(15)(A)' before the comma at the end, and

(B) in clause (iii)(II), by striking `or (b)(14)(A)' and inserting `(b)(14)(A), or (b)(15)(A)'.

(3) EFFECTIVE DATE- The amendments made by this subsection apply to procedures performed after March 31, 1990.
SEC. 6109. WAIVER OF LIABILITY LIMITING RECOUPMENT IN CERTAIN CASES.

In the case where more than the correct amount may have been paid to a physician or individual under part B of title XVIII of the Social Security Act with respect to services furnished during the period beginning on July 1, 1985, and ending on March 31, 1986, as a result of a carrier's establishing statewide fees for certain procedure codes while the carrier was in the process of implementing the national common procedure coding system of the Health Care Financing Administration, the provisions of section 1870(c) of the Social Security Act shall apply, without the need for affirmative action by such a physician or individual, so as to prevent any recoupment, or other decrease in subsequent payments, to the physician or individual. The previous sentence shall apply to claims for items and services which were reopened by carriers on or after July 31, 1987.

SEC. 6110. REDUCTION IN CAPITAL PAYMENTS FOR OUTPATIENT HOSPITAL SERVICES.

Section 1861(v)(1)(S) of the Social Security Act (42 U.S.C. 1395x(v)(1)(S)) is amended--

(1) by inserting `'(i)' after `(S)', and

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

`'(ii)(I) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of outpatient hospital services, the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1990.

'(II) Subclause (I) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in section 1886(d)(5)(D)(iii)).

'(III) In applying subclause (I) to services for which payment is made on the basis of a blend amount under section 1833(i)(3)(A)(ii) or 1833(n)(1)(A)(ii), capital-related costs reflected in the amounts described in sections 1833(i)(3)(B)(i)(I) and 1833(n)(1)(B)(i)(I), respectively, shall be reduced in accordance with such subclause.'.

SEC. 6111. CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) REDUCTION OF LIMITATION AMOUNT ON PAYMENT AMOUNT-

Section 1833(h) of the Social Security Act (42 U.S.C. 1395l(h)) is amended--
(1) in subparagraphs (B) and (C) of paragraph (1), by striking `during the period' and all that follows through `established on a nationwide basis' and inserting `on or after July 1, 1984';
(2) in paragraph (4)(B)(i), by striking `or' at the end;
(3) in paragraph (4)(B)(ii)--
   (A) by striking `and so long as a fee schedule for the test has not been established on a nationwide basis,'
   (B) by inserting `and before January 1, 1990,' after `March 31, 1988,', and
   (C) by striking the period at the end and inserting `, and'; and
(4) by adding at the end of paragraph (4)(B) the following new clause:
   `(iii) after December 31, 1989, is equal to 93 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1).'

(b) RESTRICTION ON PAYMENT TO REFERRING LABORATORY-
(1) IN GENERAL- Section 1833(h)(5)(A)(ii) of such Act (42 U.S.C. 1395l(h)(5)(A)(ii)) is amended by striking `referring laboratory, and' and inserting `referring laboratory but only if--
   `(I) the referring laboratory is located in, or is part of, a rural hospital,
   `(II) the referring laboratory is a wholly-owned subsidiary of the entity performing such test, the referring laboratory wholly owns the entity performing such test, or both the referring laboratory and the entity performing such test are wholly-owned by a third entity, or
   `(III) not more than 30 percent of the clinical diagnostic laboratory tests for which such referring laboratory submits bills or requests for payment in any year are performed by another laboratory, and'.
(2) EFFECTIVE DATE- The amendment made by paragraph (1) shall apply with respect to clinical diagnostic laboratory tests performed on or after January 1, 1990.

SEC. 6112. DURABLE MEDICAL EQUIPMENT.

(a) DELAY IN AND REDUCTION OF UPDATE FOR 1990-
(1) INEXPENSIVE AND ROUTINELY PURCHASED DURABLE MEDICAL EQUIPMENT AND ITEMS REQUIRING FREQUENT AND SUBSTANTIAL SERVICING- Paragraphs (2)(B)(i) and (3)(B)(i) of section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)) are each amended by striking `in 1989' and inserting `in 1989 and in 1990'.
(2) MISCELLANEOUS DEVICES AND ITEMS AND OTHER COVERED ITEMS- Paragraph (8)(A)(ii) of such section is amended--

(A) in subclause (I), by striking `1989' and inserting `1989 and 1990', and
(B) in subclause (II), by striking `1990, 1991,' and inserting `1991'.

(3) OXYGEN AND OXYGEN EQUIPMENT- Paragraph (9)(A)(ii) of such section is amended--

(A) in subclause (I), by striking `1989' and inserting `1989 and 1990', and
(B) in subclause (II), by striking `1990, 1991,' and inserting `1991'.

(4) CONFORMING AMENDMENTS- Such section is further amended--

(A) in paragraph (7)(A)(i), by striking `this subparagraph' and inserting `this clause';
(B) in paragraph (7)(B)(i), by inserting `in' after `rental of the item'; and
(C) in paragraph (7)(B)(ii), by striking `the payment amount' and all that follows and inserting `clause (i) shall apply in the same manner as it applies to items furnished during 1989.'.

(b) RENTAL PAYMENTS FOR ENTERAL AND PARENTERAL PUMPS- (1) IN GENERAL- Except as provided in paragraph (2), the amount of any monthly rental payment under part B of title XVIII of the Social Security Act for an enteral or parenteral pump furnished on or after April 1, 1990, shall be determined in accordance with the methodology under which monthly rental payments for such pumps were determined during 1989.

(2) CAP ON RENTAL PAYMENTS, SERVICING, AND REPAIRS- In the case of an enteral or parenteral pump described in paragraph (1) that is furnished on a rental basis during a period of medical need--

(A) monthly rental payments shall not be made under part B of title XVIII of the Social Security Act for more than 15 months during such period, and
(B) after monthly rental payments have been made for 15 months during such period, payment under such part shall be made for maintenance and servicing of the pump in such amounts as the Secretary of Health and Human Services determines to be reasonable and necessary to ensure the proper operation of the pump.
(c) REDUCTION IN FEE SCHEDULES FOR SEAT-LIFT CHAIRS AND TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS- Paragraph (1) of such section 1834(a) is amended by adding at the end the following new subparagraph:

`'(D) REDUCTION IN FEE SCHEDULES FOR CERTAIN ITEMS- With respect to a seat-lift chair or transcutaneous electrical nerve stimulator furnished on or after April 1, 1990, the Secretary shall reduce the payment amount applied under subparagraph (B)(ii) for such an item by 15 percent.'.

(d) TREATMENT OF POWER DRIVEN WHEELCHAIRS-
(1) AS ROUTINELY PURCHASED- Section 1834(a)(2)(A) of the Social Security Act (42 U.S.C. 1395m(a)(2)(A)) is amended--
(A) by striking `or' at the end of clause (i),
(B) by adding `or' at the end of clause (ii), and
(C) by inserting after clause (ii) the following new clause:
`'(iii) which is a power-driven wheelchair (other than a customized wheelchair that is classified as a customized item under paragraph (4) pursuant to criteria specified by the Secretary),'.

(2) AS CUSTOMIZED ITEM- The Secretary of Health and Human Services shall by regulation specify criteria to be used by carriers in making determinations on a case-by-case basis as whether to classify power-driven wheelchairs as a customized item (as described in section 1834(a)(4) of the Social Security Act) for purposes of reimbursement under title XVIII of such Act.

(e) OSTOMY SUPPLIES AS PART OF HOME HEALTH SERVICES-
(1) SPECIFIC INCLUSION IN HOME HEALTH SERVICES- Section 1861(m)(5) of the Social Security Act (42 U.S.C. 1395x(m)(5)) is amended to read as follows:
`'(5) medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care, but excluding drugs and biologicals) and durable medical equipment while under such a plan;'.

(2) EXCLUSION FROM COVERED ITEMS- Section 1834(a)(13) of such Act (42 U.S.C. 1395m(a)(13)) is amended by inserting after `intraocular lenses' the following: `or medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care) furnished by a home health agency under section 1861(m)(5)'.

(3) REQUIRING PROVISION AS PART OF HOME HEALTH SERVICES- Section 1866(a)(1) of such Act (42 U.S.C. 1395cc(a)(1)) is amended--
(A) by striking `and' at the end of subparagraph (N),
(B) by striking the period at the end of subparagraph (O) and inserting `; and',
(C) and by inserting after subparagraph (O) the following new subparagraph:
`(P) in the case of home health agencies which provide home health services to individuals entitled to benefits under this title who require ostomy supplies (described in section 1861(m)(5)), to offer to furnish such supplies to such an individual as part of their furnishing of home health services.'.
(4) EFFECTIVE DATE- The amendments made by this subsection shall apply with respect to items furnished on or after January 1, 1990.

SEC. 6113. MENTAL HEALTH SERVICES.

(a) ELIMINATING RESTRICTION ON PSYCHOLOGISTS' SERVICES TO SERVICES FURNISHED AT COMMUNITY MENTAL HEALTH CENTERS-Section 1861(ii) of the Social Security Act (42 U.S.C. 1395x(ii)) is amended by striking `on-site at a community mental health center' and all that follows through `because of similar circumstances of the individual,'.
(b) CLINICAL SOCIAL WORKERS-
(1) COVERAGE OF SERVICES- Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended--
(A) by striking `and' at the end of subparagraph (L);
(B) by adding `and' at the end of subparagraph (M); and
(C) by adding at the end the following new subparagraph:
`(N) clinical social worker services (as defined in subsection (hh)(2));'.
(2) DEFINITIONS- Section 1861 of such Act (42 U.S.C. 1395x) is amended--
(A) in subsection (s)(2)(H)(ii), by striking `(hh)' and inserting `(hh)(2)', and
(B) in subsection (hh)--
(i) by amending the heading to read as follows:
`Clinical Social Worker; Clinical Social Worker Services',
(ii) by redesignating clauses (i) and (ii) of paragraph (3)(B) as subclauses (I) and (II), respectively,
(iii) by redesignating subparagraphs (A) and (B) of paragraph (3) as clauses (i) and (ii), respectively,
(iv) by redesignating paragraphs (1), (2), and (3) as subparagraphs (A), (B), and (C), respectively,
(v) by striking `(hh)' and inserting `(hh)(1)', and
(vi) by adding at the end the following new paragraph:

`(2) The term `clinical social worker services' means services performed by a clinical social worker (as defined in paragraph (1)) for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation) which the clinical social worker is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.'.

(3) PAYMENT BASIS- Section 1833 of such Act (42 U.S.C. 1395l) is amended--
(A) by inserting after clause (E) of subsection (a)(1) the following new clause: `(F) with respect to clinical social worker services under section 1861(s)(2)(N), the amounts paid shall be 80 percent of the lesser of (i) the actual charge for the services or (ii) 75 percent of the amount determined for payment of a psychologist under clause (L)',; and
(B) in subsection (p)--
(i) by striking `1861(s)(2)(L) and' and by inserting `1861(s)(2)(L),', and
(ii) by inserting `and in the case of clinical social worker services for which payment may be made under this part only pursuant to section 1861(s)(2)(N), after `1861(s)(2)(M),'.

(c) DEVELOPMENT OF CRITERIA REGARDING CONSULTATION WITH A PHYSICIAN- The Secretary of Health and Human Services shall, taking into consideration concerns for patient confidentiality, develop criteria with respect to payment for qualified psychologist services for which payment may be made directly to the psychologist under part B of title XVIII of the Social Security Act under which such a psychologist must agree to consult with a patient's attending physician in accordance with such criteria.

(d) ELIMINATING DOLLAR LIMITATION ON MENTAL HEALTH SERVICES- Section 1833(d)(1) of the Social Security Act (42 U.S.C. 1395l(d)(1)) is amended by striking `whichever' and all that follows in the first sentence and inserting `62 1/2 percent of such expenses.'.

(e) EFFECTIVE DATE- The amendments made by this section, and the provisions of subsection (c), shall apply to services furnished on or
after July 1, 1990, and the amendments made by subsection (d) shall apply to expenses incurred in a year beginning with 1990.

SEC. 6114. COVERAGE OF NURSE PRACTITIONER SERVICES IN NURSING FACILITIES.

(a) SERVICES COVERED- Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended--
(1) by striking `and' at the end of subparagraph (J), and
(2) in subparagraph (K)--
(A) in clause (i), by striking `and' at the end,
(B) in clause (ii), by striking `to such services' and inserting `to services described in clause (i) or (ii)',
(C) by redesignating clause (ii) as clause (iii), and
(D) by inserting after clause (i) the following new clause:
`(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner (as defined in subsection (aa)(3)) working in collaboration (as defined in subsection (aa)(4)) with a physician (as defined in subsection (r)(1)) in a skilled nursing facility or nursing facility (as defined in section 1919(a)) which the nurse practitioner is legally authorized to perform by the State in which the services are performed, and'.

(b) DETERMINATION OF PAYMENT AMOUNT- Section 1842(b)(12)(A) of such Act (42 U.S.C. 1395u(b)(12)(A)) is amended by striking `physician assistant acting under the supervision of a physician' and inserting `physician assistants and nurse practitioners'.

(c) PAYMENT TO EMPLOYER; PAYMENT FOR ROUTINE VISITS BY MEMBERS OF A TEAM- Section 1842(b) of such Act (42 U.S.C. 1395u(b)) is amended--
(1) in clause (C) of the first sentence of paragraph (6), by inserting `or nurse practitioner' after `physician assistant', and
(2) by adding at the end of paragraph (2), the following new subparagraph:
`(C) In the case of residents of nursing facilities who receive services described in clause (i) or (ii) of section 1861(s)(2)(K) performed by a member of a team, the Secretary shall instruct carriers to develop mechanisms which permit routine payment under this part for up to 1.5 visits per month per resident. In the previous sentence, the term `team' refers to a physician and includes a physician assistant acting under the supervision of the physician or a nurse practitioner working in collaboration with that physician, or both.'.
(d) DEFINITION OF COLLABORATION- Section 1861(aa) of such Act (42 U.S.C. 1395x(aa)) is amended by adding at the end the following new paragraph:

`(4) The term `collaboration' means a process in which a nurse practitioner works with a physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as defined by the law of the State in which the services are performed.'.

(e) STATE DEMONSTRATION PROJECTS ON APPLICATION OF LIMITATION ON VISITS PER MONTH PER RESIDENT ON AGGREGATE BASIS FOR A TEAM- The Secretary of Health and Human Services shall provide for at least 1 demonstration project under which, in the application of section 1842(b)(2)(C) of the Social Security Act (as added by subsection (c)(2) of this section) in one or more States, the limitation on the number of visits per month per resident would be applied on an average basis over the aggregate total of residents receiving services from members of the team.

(f) EFFECTIVE DATE- The amendments made by this section shall apply to services furnished on or after April 1, 1990.

SEC. 6115. COVERAGE OF SCREENING PAP SMEARS.

(a) IN GENERAL- Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 6003(g)(3)(A) of this subtitle, is amended--

(1) in subsection (s)--

(A) by striking `and' at the end of paragraph (12),
(B) by striking the period at the end of paragraph (13) and inserting `; and',
(C) by redesignating paragraphs (14) and (15) as paragraphs (15) and (16), respectively, and
(D) by inserting after paragraph (13) the following new paragraph;

`(14) screening pap smear.'; and

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

`Screening Pap Smear

`(nn) The term `screening pap smear' means a diagnostic laboratory test consisting of a routine exfoliative cytology test (Papanicolaou test) provided to a woman for the purpose of early detection of cervical cancer and includes a physician's interpretation of the results of the test, if the individual involved has not had such a test during the
preceding 3 years (or such shorter period as the Secretary may specify in the case of a woman who is at high risk of developing cervical cancer (as determined pursuant to factors identified by the Secretary)).

(b) REVISION OF EXCLUSION GROUNDS- Section 1862(a)(1)(F) of such Act (42 U.S.C. 1395y(a)(1)(F)) is amended by inserting before the semicolon at the end the following: `and, in the case of screening pap smear, which is performed more frequently than is provided under 1861(nn)`.

(c) CONFORMING AMENDMENTS- Sections 1864(a), 1865(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) of such Act (42 U.S.C. 1395aa(a), 1395bb(a), 1396(a)(9)(C), 1396n(a)(1)(B)(ii)(I)) are each amended by striking `paragraphs (14) and (15)' and inserting `paragraphs (15) and (16)`.

(d) EFFECTIVE DATE- The amendments made by this section shall apply to screening pap smears performed on or after July 1, 1990.

SEC. 6116. COVERAGE UNDER, AND PAYMENT FOR, OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES UNDER PART B.

(a) COVERAGE-
(1) Section 1861(mm) of the Social Security Act (42 U.S.C. 1395x(mm)), as added by section 6003(g)(3)(A) of this subtitle, is amended by adding at the end the following:
`The term `outpatient rural primary care hospital services' means medical and other health services furnished by a rural primary care hospital.'.

(2) Section 1832(a)(2) of such Act (42 U.S.C. 1395k(a)(2)) is amended--
(A) in subparagraph (F), by striking `and' at the end,
(B) in subparagraph (G) by striking the period at the end and inserting `; and', and
(C) by inserting after subparagraph (G) the following new subparagraph:
`outpatient rural primary care hospital services (as defined in section 1861(mm)(3)).'

(b) PAYMENT-
(1) Section 1833(a) of such Act (42 U.S.C. 1395l(a)) is amended--
(A) in paragraph (2), in the matter before subparagraph (A), by striking `and (G)' and inserting `(G), and (H)',
(B) in paragraph (4), by striking `and' at the end,
(C) in paragraph (5), by striking the period at the end and inserting `; and', and
(D) by inserting after paragraph (5) the following new paragraph:

`(6) in the case of outpatient rural primary care hospital services, the amounts described in section 1834(g)`.

(2) Section 1834 of such Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

` `(g) PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES-

`(1) IN GENERAL- The amount of payment for outpatient rural primary care hospital services provided during a year before 1993 in a rural primary care hospital under this part shall be determined by one of the 2 following methods, as elected by the rural primary care hospital:

`(A) COST-BASED FACILITY FEE PLUS PROFESSIONAL CHARGES-

`(i) FACILITY FEE- With respect to facility services, not including any services for which payment may be made under clause (ii), there shall be paid amounts equal to the amounts described in section 1833(a)(2)(B) (describing amounts paid for hospital outpatient services).

`(ii) REASONABLE CHARGES FOR PROFESSIONAL SERVICES- In electing treatment under this subparagraph, payment for professional medical services otherwise included within outpatient rural primary care hospital services shall be made under such other provisions of this part as would apply to payment for such services if they were not included in outpatient rural primary care hospital services.

`(B) ALL-INCLUSIVE RATE- With respect to both facility services and professional medical services, there shall be paid amounts equal to the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, less the amount the hospital may charge as described in clause (i) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A) and for items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion was in disagreement with the first opinion) exceed 80 percent of such costs.`
(2) DEVELOPMENT AND IMPLEMENTATION OF ALL INCLUSIVE, PROSPECTIVE PAYMENT SYSTEM- Not later than January 1, 1993, the Secretary shall develop and implement a prospective payment system for determining payments under this part for outpatient rural primary care hospital services using a methodology that includes all costs in providing all such services (including related professional medical services) and that determines the payment amount for such services on a prospective basis.'.

Subpart B--Technical and Miscellaneous Provisions

SEC. 6131. MODIFICATION OF PAYMENT FOR THERAPEUTIC SHOES FOR INDIVIDUALS WITH SEVERE DIABETIC FOOT DISEASE.

(a) PERMITTING ADDITIONAL INSERTS-
(1) IN GENERAL- Section 1833(o) of the Social Security Act (42 U.S.C. 1395l(o)) is amended--
(A) by amending subparagraph (A) of paragraph (1) to read as follows:
`(A) no payment may be made under this part, with respect to any individual for any year, for the furnishing of--
(i) more than one pair of custom molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts for such shoes, or
(ii) more than one pair of extra-depth shoes (not including inserts provided with such shoes) and 3 pairs of inserts for such shoes, and';
(B) in paragraphs (1)(B) and (2)(A), by striking `limit' and inserting `limits';
(C) in the second sentence of paragraph (1), by inserting `(or inserts)' after `shoes' each place it appears;
(D) by amending clause (i) of paragraph (2)(A) to read as follows:
`(i) for the furnishing of--
(I) one pair of custom molded shoes (including any inserts that are provided initially with the shoes) is $300, and
(II) any additional pair of inserts with respect to such shoes is $50; and'; and
(E) in paragraph (2)(A)(ii)(II), by inserting `any pairs of' after `$50 for'.


(2) CONFORMING AMENDMENT- Section 1861(s)(12) of such Act (42 U.S.C. 1395x(s)(12)) is amended by inserting ‘with inserts' after ‘custom molded shoes'.

(b) PERMITTING SUBSTITUTION OF SHOE MODIFICATIONS FOR INSERTS- Section 1833(o)(2) of such Act is amended by adding at the end the following new subparagraph:

‘(D) In accordance with procedures established by the Secretary, an individual entitled to benefits with respect to shoes described in section 1861(s)(12) may substitute modification of such shoes instead of obtaining one (or more, as specified by the Secretary) pairs of inserts (other than the original pair of inserts with respect to such shoes). In such case, the Secretary shall substitute, for the limits established under subparagraph (A), such limits as the Secretary estimates will assure that there is no net increase in expenditures under this subsection as a result of this subparagraph.'.

(c) EFFECTIVE DATE-

(1) The amendments made by this section shall apply with respect to therapeutic shoes and inserts furnished on or after July 1, 1989.

(2) In applying the amendments made by this section, the increase under subparagraph (C) of section 1833(o)(2) of the Social Security Act shall apply to the dollar amounts specified under subparagraph (A) of such section (as amended by this section) in the same manner as the increase would have applied to the dollar amounts specified under subparagraph (A) of such section (as in effect before the date of the enactment of this Act).

SEC. 6132. PAYMENTS TO CERTIFIED REGISTERED ANESTHETISTS.

(a) EXTENSION AND EXPANSION OF CRNA PASS-THROUGH- Section 9320(k) of the Omnibus Budget Reconciliation Act of 1986, as added by section 608(c)(2) of the Family Support Act of 1988, is amended--

(1) by striking ‘250' each place it appears and inserting ‘500';

(2) in paragraph (1)--

(A) by striking ‘1989, 1990, and 1991' and inserting ‘a year (beginning with 1989)', and

(B) by striking ‘before April 1, 1989,' and inserting ‘at any time before the year';

(3) in paragraph (2)--

(A) by striking ‘1990 or 1991' and inserting ‘in a year (after 1989)', and
(B) by striking `each respective year' and inserting `the year'; and
(4) by striking paragraph (3).
(b) EFFECTIVE DATE- The amendments made by this section shall apply to services furnished on or after January 1, 1990.

SEC. 6133. INCREASE IN PAYMENT LIMIT FOR PHYSICAL AND OCCUPATIONAL THERAPY SERVICES.

(a) IN GENERAL- Section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) is amended by striking `$500' each place it appears and inserting `$750'.
(b) EFFECTIVE DATE- The amendment made by subsection (a) shall apply to services furnished on or after January 1, 1990.

SEC. 6134. STUDY OF PAYMENT FOR PORTABLE X-RAY SERVICES.

The Secretary of Health and Human Services shall conduct a study of the costs of furnishing, and payments for, portable x-ray services under part B of title XVIII of the Social Security Act. Not later than 1 year after the date of the enactment of this Act, the Secretary shall report to Congress on the results of such study and shall include a recommendation respecting whether payment for such services should be made in the same manner as for radiologists' services or on the basis of a separate fee schedule.

SEC. 6135. EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

Section 9215 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended--
(1) by striking `, for a period of three additional years,' and inserting `through December 31, 1993,'; and
(2) by adding at the end the following: `The Secretary shall submit a report to Congress on the waiver program with respect to the quality of health care, beneficiary costs, and such other factors as may be appropriate.'.

SEC. 6136. STUDY OF REIMBURSEMENT FOR AMBULANCE SERVICES.

(a) IN GENERAL- The Secretary of Health and Human Services shall conduct a study to determine the adequacy and appropriateness of payment amounts under title XVIII of the Social Security Act for ambulance services. Such study shall examine at least the following:
(1) The effect of payment amounts on the provision of ambulance services in rural areas.
(2) The relationship of such payment amounts to the direct and indirect costs of providing ambulance services. Such relationship shall be examined separately--
   (A)(i) for tax-subsidized, municipally-owned and operated services, (ii) for volunteer services, (iii) for private, for-profit services, and (iv) for hospital-owned services, and (B) for different levels (such as basic life support and advanced life support) of such services.
(3) How such payment amounts compare to the payment amounts made for ambulance services under medicaid plans under title XIX of such Act.

(b) REPORT- By not later than one year after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the results of the study conducted under subsection (a) and shall include in the report such recommendations for changes in medicare payment policy with respect to ambulance services as may be needed to ensure access by medicare beneficiaries to quality ambulance services in metropolitan and rural areas.

SEC. 6137. PROPAC STUDY OF PAYMENTS FOR SERVICES IN HOSPITAL OUTPATIENT DEPARTMENTS.

(a) IN GENERAL- The Prospective Payment Assessment Commission shall conduct a study on payment under title XVIII of the Social Security Act for hospital outpatient services. Such study shall include an examination of--
   (1) the sources of growth in spending for hospital outpatient services;
   (2) the differences between the costs of delivering services in a hospital outpatient department as opposed to providing similar services in other appropriate settings (including ambulatory surgery centers and physician offices);
   (3) the effects on outpatient hospital costs of the step-down method used to allocate hospital capital between inpatient and outpatient departments and the extent to which hospital outpatient costs were affected by the implementation of the prospective payment system of payment for inpatient hospital services and by increased review of such services by peer review organizations; and
   (4) alternative methods for reimbursing hospitals for services in outpatient departments under the medicare program, including
prospective payment methods, fee schedules, and such other methods as the Commission may consider appropriate.

(b) REPORTS- (1) By not later than July 1, 1990, the Commission shall submit a report to Congress on the study conducted under subsection (a) with respect to the portions of the study described in paragraphs (1), (2), and (3) of such subsection, and shall include in the report such recommendations as the Commission deems appropriate.

(2) By not later than March 1, 1991, the Commission shall submit a report to Congress on the study conducted under subsection (a) with respect to the portion of the study described in paragraph (4) of such subsection, and shall include in the report such recommendations as the Commission deems appropriate.

SEC. 6138. PHYSPRC STUDY OF PAYMENTS FOR ASSISTANTS AT SURGERY.

(a) STUDY; CONTENTS- The Physician Payment Review Commission shall conduct a study of the payments made under title XVIII of the Social Security Act for assistants at surgery. Such study shall examine-

(1) the necessity and appropriateness of using an assistant at surgery;
(2) the use of physician and non-physician assistants at surgery;
(3) the appropriateness of providing for payments, and the appropriate level of payment, under title XVIII of the Social Security Act for assistants at surgery; and

(4) the effect of the amendments made by section 9338 of the Omnibus Budget Reconciliation Act of 1986 on the employment of registered nurses as assistants at surgery, and whether or not the reductions described in subsection (d) of such section have been implemented.

(b) REPORT- By not later than April 1, 1991, the Commission shall submit a report to Congress on the study conducted under subsection (a), and shall include in the report such recommendations as it deems appropriate.

SEC. 6139. GAO STUDY OF STANDARDS FOR USE OF AND PAYMENT FOR ITEMS OF DURABLE MEDICAL EQUIPMENT.

(a) STUDY- The Comptroller General shall conduct a study of the appropriate uses of items of durable medical equipment and of the appropriate criteria for making determinations of medical necessity under title XVIII of the Social Security Act for such items, with particular emphasis on items (including seat-lift chairs) that may be
subject to abusive billing practices. Such study shall include an analysis of--

(1) the appropriate use of forms in making medical necessity determinations for items of durable medical equipment under such title; and

(2) procedures for identifying items of durable medical equipment that should no longer be covered under such title.

(b) USE OF PANEL IN CONDUCTING STUDY- The Comptroller General shall conduct such study with a panel convened by the Comptroller General consisting of--

(1) specialists in the disciplines of orthopedic medicine, rehabilitation, arthritis, and geriatric medicine;

(2) representatives of consumer organizations; and

(3) representatives of carriers under the medicare program.

(c) REPORT- Not later than April 1, 1991, the Comptroller General shall submit a report to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on the study conducted under subsection (a), and shall include in such report such recommendations as the Comptroller General deems appropriate.

SEC. 6140. NARROWING OF RANGE OF AMOUNTS RECOGNIZED FOR ITEMS OF DURABLE MEDICAL EQUIPMENT.

Paragraphs (8) and (9) of section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)) are each amended in subparagraph (D)--

(1) in clause (i), by striking `1991' and all that follows through `80 percent' and inserting `1991, may not exceed 125 percent, and may not be lower than 85 percent'; and

(2) in clause (ii), by striking `125 percent' and all that follows through `85 percent' and inserting `120 percent, and may not be lower than 90 percent'.

SEC. 6141. PHYSICIAN OFFICE LABS.

(a) IN GENERAL- Section 1861(s) of the Social Security Act (42 U.S.C. 1395x(s)) is amended--

(1) in the matter following paragraph (14), by striking `which is independent' and all that follows through `per year,' and inserting the following: `, including a laboratory that is part of';

(2) by redesignating paragraph (16) as subparagraph (B); and

(3) by inserting immediately after paragraph (15) the following: `(16)(A) meets the certification requirements under section 353 of the Public Health Service Act; and'.

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(b) EFFECTIVE DATE- The amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 6142. STUDY OF REIMBURSEMENT FOR BLOOD CLOTTING FACTOR FOR HEMOPHILIA PATIENTS.

The Secretary of Health and Human Services shall review the current methodology for reimbursing for blood clotting factor for hemophilia patients under part B of title XVIII of the Social Security Act and shall evaluate the effect of such methodology on the accessibility and affordability of such factor to medicare beneficiaries. By not later than 6 months after the date of the enactment of this Act, the Secretary shall report to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate on such review and shall include in such report such recommendations as the Secretary deems appropriate.

PART 3--PROVISIONS RELATING TO PARTS A AND B

Subpart A--General Provisions

SEC. 6201. REDUCTIONS UNDER ORIGINAL SEQUESTER ORDER AND APPLICABILITY OF NEW SEQUESTER ORDER FOR HEALTH MAINTENANCE ORGANIZATIONS.

Notwithstanding any other provision of law (including section 11002 or any other provision of this Act), the reductions in the amount of payments required under title XVIII of the Social Security Act made by the final sequester order issued by the President on October 16, 1989, pursuant to section 252(b) of the Balanced Budget and Emergency Deficit Control Act of 1985 shall continue to be effective (as provided by sections 252(a)(4)(B) and 256(d)(2) of such Act) through December 31, 1989, with respect to payments under section 1833(a)(1)(A) or 1876 of the Social Security Act, section 402 of the Social Security Amendments of 1967, or section 222 of the Social Security Amendments of 1972. Each such payment made during fiscal year 1990 after such date shall be increased by 1.42 percent above what it would otherwise be under this Act.

SEC. 6202. MEDICARE AS SECONDARY PAYER.

(a) IDENTIFICATION OF MEDICARE SECONDARY PAYER SITUATIONS-
(1) DISCLOSURE OF CERTAIN TAXPAYER IDENTITY INFORMATION FOR VERIFICATION OF EMPLOYMENT STATUS OF MEDICARE BENEFICIARY AND SPOUSE OF MEDICARE BENEFICIARY-

(A) IN GENERAL- Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to disclosure of returns and return information for purposes other than tax administration) is amended by adding at the end thereof the following new paragraph:

` (12) DISCLOSURE OF CERTAIN TAXPAYER IDENTITY INFORMATION FOR VERIFICATION OF EMPLOYMENT STATUS OF MEDICARE BENEFICIARY AND SPOUSE OF MEDICARE BENEFICIARY-

` (A) RETURN INFORMATION FROM INTERNAL REVENUE SERVICE- The Secretary shall, upon written request from the Commissioner of Social Security, disclose to the Commissioner available filing status and taxpayer identity information from the individual master files of the Internal Revenue Service relating to whether any medicare beneficiary identified by the Commissioner was a married individual (as defined in section 7703) for any specified year after 1986, and, if so, the name of the spouse of such individual and such spouse's TIN.

` (B) RETURN INFORMATION FROM SOCIAL SECURITY ADMINISTRATION- The Commissioner of Social Security shall, upon written request from the Administrator of the Health Care Financing Administration, disclose to the Administrator the following information:

` (i) The name and TIN of each medicare beneficiary who is identified as having received wages (as defined in section 3401(a)) from a qualified employer in a previous year.

` (ii) For each medicare beneficiary who was identified as married under subparagraph (A) and whose spouse is identified as having received wages from a qualified employer in a previous year--

` (I) the name and TIN of the medicare beneficiary, and

` (II) the name and TIN of the spouse.

` (iii) With respect to each such qualified employer, the name, address, and TIN of the employer and the number of individuals with respect to whom written statements were furnished under section 6051 by the employer with respect to such previous year.
(C) DISCLOSURE BY HEALTH CARE FINANCING ADMINISTRATION- With respect to the information disclosed under subparagraph (B), the Administrator of the Health Care Financing Administration may disclose--

(i) to the qualified employer referred to in such subparagraph the name and TIN of each individual identified under such subparagraph as having received wages from the employer (hereinafter in this subparagraph referred to as the 'employee') for purposes of determining during what period such employee or the employee's spouse may be (or have been) covered under a group health plan of the employer and what benefits are or were covered under the plan (including the name, address, and identifying number of the plan),

(ii) to any group health plan which provides or provided coverage to such an employee or spouse, the name of such employee and the employee's spouse (if the spouse is a medicare beneficiary) and the name and address of the employer, and, for the purpose of presenting a claim to the plan--

(I) the TIN of such employee if benefits were paid under title XVIII of the Social Security Act with respect to the employee during a period in which the plan was a primary plan (as defined in section 1862(b)(2)(A) of the Social Security Act), and

(II) the TIN of such spouse if benefits were paid under such title with respect to the spouse during such period, and

(iii) to any agent of such Administrator the information referred to in subparagraph (B) for purposes of carrying out clauses (i) and (ii) on behalf of such Administrator.

(D) SPECIAL RULES-

(i) RESTRICTIONS ON DISCLOSURE- Information may be disclosed under this paragraph only for purposes of, and to the extent necessary in, determining the extent to which any medicare beneficiary is covered under any group health plan.

(ii) TIMELY RESPONSE TO REQUESTS- Any request made under subparagraph (A) or (B) shall be complied with as soon as possible but in no event
later than 120 days after the date the request was made.

`(E) DEFINITIONS- For purposes of this paragraph--

`(i) MEDICARE BENEFICIARY- The term `medicare beneficiary' means an individual entitled to benefits under part A, or enrolled under part B, of title XVIII of the Social Security Act, but does not include such an individual enrolled in part A under section 1818.

`(ii) GROUP HEALTH PLAN- The term `group health plan' means--

`(I) any group health plan (as defined in section 5000(b)(1)), and
`(II) any large group health plan (as defined in section 5000(b)(2)).

`(iii) QUALIFIED EMPLOYER- The term `qualified employer' means, for a calendar year, an employer which has furnished written statements under section 6051 with respect to at least 20 individuals for wages paid in the year.

`(F) TERMINATION- Subparagraphs (A) and (B) shall not apply to--

`(i) any request made after September 30, 1991, and
`(ii) any request made before such date for information relating to--

`(I) 1990 or thereafter in the case of subparagraph (A), or
`(II) 1991 or thereafter in the case of subparagraph (B).'

(B) SAFEGUARDS-

(i) Paragraph (3) of section 6103(a) of such Code is amended by inserting `((12),' after `(1)(D)(iii),'.
(ii) Subparagraph (A) of section 6103(p)(3) of such Code is amended by striking `or (11)' and inserting `(11), or (12)'.
(iii) Paragraph (4) of section 6103(p) of such Code is amended in the material preceding subparagraph (A) by striking `or (9) shall' and inserting `(9), or (12) shall'.
(iv) Clause (ii) of section 6103(p)(4)(F) of such Code is amended by striking `or (11)' and inserting `(11), or (12)'.

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(v) The next to the last sentence of paragraph (4) of section 6103(p) of such Code is amended by inserting `or which receives any information under subsection (l)(12)(B) and which discloses any such information to any agent' before `, this paragraph'.

(C) PENALTY- Paragraph (2) of section 7213(a) of such Code is amended by striking `or (10)' and inserting `(10), or (12)'.

(D) EFFECTIVE DATE- The amendments made by this paragraph shall take effect on the date of the enactment of this Act.

(2) RESPONSIBILITIES OF HCFA-

(A) IN GENERAL- Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)), as amended by subsection (b)(1) of this section, is amended by inserting after paragraph (4) the following new paragraph:

`5 IDENTIFICATION OF SECONDARY PAYER SITUATIONS-

(A) REQUESTING MATCHING INFORMATION-

(i) COMMISSIONER OF SOCIAL SECURITY- The Commissioner of Social Security shall, not less often than annually, transmit to the Secretary of the Treasury a list of the names and TINs of medicare beneficiaries (as defined in section 6103(l)(12) of the Internal Revenue Code of 1986) and request that the Secretary disclose to the Commissioner the information described in subparagraph (A) of such section.

(ii) ADMINISTRATOR- The Administrator of the Health Care Financing Administration shall request, not less often than annually, the Commissioner of the Social Security Administration to disclose to the Administrator the information described in subparagraph (B) of section 6103(l)(12) of the Internal Revenue Code of 1986.

(B) DISCLOSURE TO FISCAL INTERMEDIARIES AND CARRIERS- In addition to any other information provided under this title to fiscal intermediaries and carriers, the Administrator shall disclose to such intermediaries and carriers (or to such a single intermediary or carrier as the Secretary may designate) the information received under subparagraph (A) for the purposes of carrying out this subsection.

(C) CONTACTING EMPLOYERS-
`(i) IN GENERAL- With respect to each individual (in this subparagraph referred to as an `employee') who was furnished a written statement under section 6051 of the Internal Revenue Code of 1986 by a qualified employer (as defined in section 6103(l)(12)(D)(iii) of such Code), as disclosed under subparagraph (B), the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee's spouse may be (or have been) covered under a group health plan of the employer and the nature of the coverage that is or was provided under the plan (including the name, address, and identifying number of the plan).

`(ii) EMPLOYER RESPONSE- Within 30 days of the date of receipt of the inquiry, the employer shall notify the intermediary or carrier making the inquiry as to the determinations described in clause (i). An employer (other than a Federal or other governmental entity) who willfully or repeatedly fails to provide timely and accurate notice in accordance with the previous sentence shall be subject to a civil money penalty of not to exceed $1,000 for each individual with respect to which such an inquiry is made. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

`(iii) SUNSET ON REQUIREMENT- Clause (ii) shall not apply to inquiries made after September 30, 1991.'

(B) DEADLINE FOR FIRST REQUEST- The Commissioner of Social Security shall first--

(i) transmit to the Secretary of the Treasury information under paragraph (5)(A)(i) of section 1862(b) of the Social Security Act (as inserted by subparagraph (A)), and

(ii) request from the Secretary disclosure of information described in section 6013(l)(12)(A) of the Internal Revenue Code of 1986,

by not later than 14 days after the date of the enactment of this Act.

(b) UNIFORM ENFORCEMENT AND COORDINATION OF BENEFITS-
(1) IN GENERAL- Section 1862 of the Social Security Act (42 U.S.C. 1395y) is amended--

(A) in the heading, by adding at the end the following:

`AND MEDICARE AS SECONDARY PAYER'; and

(B) by amending subsection (b) to read as follows:

`(b) MEDICARE AS SECONDARY PAYER-

  `(1) REQUIREMENTS OF GROUP HEALTH PLANS-

  `(A) WORKING AGED UNDER GROUP HEALTH PLANS-

  `(i) IN GENERAL- A group health plan--

  `(I) may not take into account, for any item or

  service furnished to an individual 65 years of

  age or older at the time the individual is

  covered under the plan by reason of the

  current employment of the individual (or the

  individual's spouse), that the individual is

  entitled to benefits under this title under

  section 226(a), and

  `(II) shall provide that any employee age 65

  or older, and any employee's spouse age 65 or

  older, shall be entitled to the same benefits

  under the plan under the same conditions as

  any employee, and the spouse of such

  employee, under age 65.

  `(ii) EXCLUSION OF GROUP HEALTH PLAN OF

  A SMALL EMPLOYER- Clause (i) shall not apply

  to a group health plan unless the plan is

  sponsored by or contributed to by an employer

  that has 20 or more employees for each

  working day in each of 20 or more calendar

  weeks in the current calendar year or the

  preceding calendar year.

  `(iii) EXCEPTION FOR SMALL EMPLOYERS IN

  MULTIEMPLOYER OR MULTIPLE EMPLOYER

  GROUP HEALTH PLANS- Clause (i) also shall

  not apply with respect to individuals enrolled in

  a multiemployer or multiple employer group

  health plan if the coverage of the individuals

  under the plan is by virtue of employment with

  an employer that does not have 20 or more

  employees for each working day in each of 20

  or more calendar weeks in the current calendar

  year or the preceding calendar year; except

  that the exception provided in this clause shall
only apply if the plan elects treatment under this clause.

(iv) EXCEPTION FOR INDIVIDUALS WITH END STAGE RENAL DISEASE- Clause (i) shall not apply to an item or service furnished in a month to an individual if for the month the individual is, or would upon application be, entitled to benefits under section 226A.

(v) GROUP HEALTH PLAN DEFINED- In this subparagraph, and subparagraph (C), the term `group health plan' has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986.

(B) DISABLED ACTIVE INDIVIDUALS IN LARGE GROUP HEALTH PLANS-

(i) IN GENERAL- A large group health plan (as defined in clause (iv)(II)) may not take into account that an active individual (as defined in clause (iv)(I)) is entitled to benefits under this title under section 226(b).

(ii) EXCEPTION FOR INDIVIDUALS WITH END STAGE RENAL DISEASE- Clause (i) shall not apply to an item or service furnished in a month to an individual if for the month the individual is, or would upon application be, entitled to benefits under section 226A.

(iii) SUNSET- Clause (i) shall only apply to items and services furnished on or after January 1, 1987, and before January 1, 1992.

(iv) DEFINITIONS- In this subparagraph:

(I) ACTIVE INDIVIDUAL- The term `active individual' means an employee (as may be defined in regulations), the employer, self-employed individual (such as the employer), an individual associated with the employer in a business relationship, or a member of the family of any of such persons.

(II) LARGE GROUP HEALTH PLAN- The term `large group health plan' has the meaning given such term in section 5000(b)(2) of the Internal Revenue Code of 1986.

(C) INDIVIDUALS WITH END STAGE RENAL DISEASE- A group health plan (as defined in subparagraph (A)(v))--
(i) may not take into account that an individual is entitled to benefits under this title solely by reason of section 226A during the 12-month period which begins with the earlier of--

(I) the month in which a regular course of renal dialysis is initiated, or
(II) in the case of an individual who receives a kidney transplant, the first month in which he would be eligible for benefits under part A (if he had filed an application for such benefits) under the provisions of section 226A(b)(1)(B); and

(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner; except that clause (ii) shall not prohibit a plan from taking into account that an individual is entitled to benefits under this title solely by reason of section 226A after the end of the 12-month period described in clause (i).

(2) MEDICARE SECONDARY PAYER-

(A) IN GENERAL- Payment under this title may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that--

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or
(ii) payment has been made, or can reasonably be expected to be made promptly (as determined in accordance with regulations) under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In this subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies.

(B) CONDITIONAL PAYMENT-

(i) PRIMARY PLANS- Any payment under this title with respect to any item or service to which
subparagraph (A) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been or could be made under such subparagraph.

(ii) ACTION BY UNITED STATES- In order to recover payment under this title for such an item or service, the United States may bring an action against any entity which is required or responsible under this subsection to pay with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph (3)(A) collect double damages against that entity), or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service.

(iii) SUBROGATION RIGHTS- The United States shall be subrogated (to the extent of payment made under this title for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(iv) WAIVER OF RIGHTS- The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this title.

(3) ENFORCEMENT-

(A) PRIVATE CAUSE OF ACTION- There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with such paragraphs (1) and (2)(A).

(B) REFERENCE TO EXCISE TAX WITH RESPECT TO NONCONFORMING GROUP HEALTH PLANS- For provision imposing an excise tax with respect to nonconforming group health plans, see section 5000 of the Internal Revenue Code of 1986.

(4) COORDINATION OF BENEFITS- Where payment for an item or service by a primary plan is less than the amount of the
charge for such item or service and is not payment in full, payment may be made under this title (without regard to deductibles and coinsurance under this title) for the remainder of such charge, but--

`(A) payment under this title may not exceed an amount which would be payable under this title for such item or service if paragraph (2)(A) did not apply; and

`(B) payment under this title, when combined with the amount payable under the primary plan, may not exceed--

`(i) in the case of an item or service payment for which is determined under this title on the basis of reasonable cost (or other cost-related basis) or under section 1886, the amount which would be payable under this title on such basis, and

`(ii) in the case of an item or service for which payment is authorized under this title on another basis--

`(I) the amount which would be payable under the primary plan (without regard to deductibles and coinsurance under such plan), or

`(II) the reasonable charge or other amount which would be payable under this title (without regard to deductibles and coinsurance under this title),

whichever is greater.'.

(2) ENFORCEMENT THROUGH EXCISE TAX- Section 5000 of the Internal Revenue Code of 1986 is amended--

(A) by striking `LARGE' in the heading;

(B) in subsection (a), by striking `large' each place it appears; and

(C) by amending subsections (b) and (c) to read as follows:

`(b) GROUP HEALTH PLAN AND LARGE GROUP HEALTH PLAN- For purposes of this section--

`(1) GROUP HEALTH PLAN- The term `group health plan' means any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of such employees or former employees.

`(2) LARGE GROUP HEALTH PLAN- The term `large group health plan' means a plan of, or contributed to by, an employer or employee organization (including a self-insured plan) to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly
associated with the employer in a business relationship, or their families, that covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year.

(c) NONCONFORMING GROUP HEALTH PLAN- For purposes of this section, the term "nonconforming group health plan" means a group health plan or large group health plan that at any time during a calendar year does not comply with the requirements of subparagraphs (A) and (C) or subparagraph (B), respectively, of section 1862(b)(1) of the Social Security Act.'.

(3) REPEAL OF CERTAIN ALTERNATIVE ENFORCEMENT PROVISIONS-

(A) DENIAL OF DEDUCTION FOR GROUP HEALTH PLANS- Subsection (i) of section 162 of such Code (relating to group health plans) is repealed.

(B) CONFORMING AMENDMENT- Section 4980B(g)(2) of such Code is amended by striking `162(i)' and inserting `5000(b)(1)'.

(C) AGE DISCRIMINATION IN EMPLOYMENT ACT- The Age Discrimination in Employment Act of 1967 is amended--

(i) by striking subsection (g) of section 4,

(ii) in section 12(a), by striking `(except the provisions of section 4(g))'.

(4) CLERICAL AND CONFORMING AMENDMENTS-

(A) Chapter 47 of the Internal Revenue Code of 1986 is amended--

(i) in the heading, by striking `LARGE', and

(ii) in the table of sections, by striking `large'.

(B) The item in the table of chapters of subtitle D of such Code relating to chapter 47 is amended by striking `large'.

(C) Sections 1837(i) and 1839(b) of the Social Security Act (42 U.S.C. 1395p(i), 1395r(b)) are each amended by striking `1862(b)(3)(A)(iv)' and `1862(b)(4)(B)' each place each appears and inserting `1862(b)(1)(A)(v)' and `1862(b)(1)(B)(iv)', respectively.

(5) EFFECTIVE DATE- The amendments made by this subsection shall apply to items and services furnished after the date of the enactment of this Act.

(c) SPECIAL ENROLLMENT PERIOD FOR DISABLED EMPLOYEES-

(1) IN GENERAL- Section 1837(i) of the Social Security Act (42 U.S.C. 1395p(i)) is amended--

(A) in paragraph (1)--

(i) by striking subparagraph (A),
(ii) by redesignating subparagraphs (B) and (C) as subparagraphs (A) and (B), respectively, and
(iii) in the second sentence, by inserting `not described in the previous sentence' after `In the case of an individual'; and
(B) in paragraph (2)--
(i) in subparagraph (B)(i), by striking `(1)(B)' and inserting `(1)(A)',
(ii) by striking subparagraph (A),
(iii) by redesignating subparagraphs (B) through (D) as subparagraphs (A) through (C), respectively, and
(iv) in the second sentence, by inserting `not described in the previous sentence' after `In the case of an individual'.

(2) CONFORMING AMENDMENT- The second sentence of section 1839(b) of such Act (42 U.S.C. 1395r(b)) is amended by striking `during which the individual has attained the age of 65 and'.

(3) EFFECTIVE DATE- The amendments made by this subsection shall apply to enrollments occurring after, and premiums for months after, the second calendar quarter beginning after the date of the enactment of this Act.

(d) NO MATCHING BASED ON PRIVATE ACTIVITIES REQUIRED IN FISCAL INTERMEDIARY AGREEMENTS AND CARRIER CONTRACTS-
(1) FISCAL INTERMEDIARY AGREEMENTS- Section 1816(c)(1) of the Social Security Act (42 U.S.C. 1395h(c)(1)) is amended by adding at the end the following: `The Secretary may not require, as a condition of entering into or renewing an agreement under this section or under section 1871, that a fiscal intermediary match data obtained other than in its activities under this part with data used in the administration of this part for purposes of identifying situations in which the provisions of section 1862(b) may apply.'.

(2) CARRIER CONTRACTS- Section 1842(b)(2)(A) of such Act (42 U.S.C. 1395u(b)(2)(A)) is amended by adding at the end the following: `The Secretary may not require, as a condition of entering into or renewing a contract under this section or under section 1871, that a carrier match data obtained other than in its activities under this part with data used in the administration of this part for purposes of identifying situations in which section 1862(b) may apply.'.

(3) EFFECTIVE DATE- The amendments made by this subsection shall apply to agreements and contracts entered into or renewed on or after the date of the enactment of this Act.
(e) TREATMENT OF EMPLOYMENT AS A MEMBER OF A RELIGIOUS ORDER-
(1) IN GENERAL- Section 1862(b)(1) of the Social Security Act (42 U.S.C. 1395y(b)(1)), as amended by subsection (b)(1) of this section, is amended by adding at the end the following new subparagraph:
`(D) TREATMENT OF CERTAIN MEMBERS OF RELIGIOUS ORDERS- In this subsection, an individual shall not be considered to be employed, or an employee, with respect to the performance of services as a member of a religious order which are considered employment only by virtue of an election made by the religious order under section 3121(r) of the Internal Revenue Code of 1986.'.
(2) EFFECTIVE DATE- The amendment made by paragraph (1) shall apply to items and services furnished on or after October 1, 1989.

SEC. 6203. PAYMENT FOR END STAGE RENAL DISEASE SERVICES.

(a) MAINTENANCE OF CURRENT COMPOSITE RATE-
(1) IN GENERAL- Section 9335(a)(1) of the Omnibus Budget Reconciliation Act of 1986 is amended--
(A) by striking `and before October 1, 1988' and inserting `and before October 1, 1990', and
(B) by adding at the end the following: `No change may be made in the base rate in effect as of September 30, 1990, unless the Secretary makes such change in accordance with notice and comment requirements set forth in section 1871(b)(1) of such Act.'.
(2) EFFECTIVE DATE- The amendment made by paragraph (1) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986.

(b) REQUIREMENTS FOR PATIENTS DEALING DIRECTLY WITH MEDICARE-
(1) LIMITATION ON AMOUNT OF PAYMENT GENERALLY- Section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)) is amended by inserting after the second sentence the following new sentence: `The amount of a payment made under any method other than a method based on a single composite weighted formula may not exceed the amount (or, in the case of continuous cycling peritoneal dialysis, 130 percent of the amount) of the median payment that would have been made under the formula for hospital-based facilities.'.
(2) AGREEMENTS WITH PROVIDERS OF SERVICES- Section 1881(b)(4) of such Act (42 U.S.C. 1395rr(b)(4)) is amended--

(A) by striking `(4)' and inserting ``(4)(A)', and

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

`(B) The Secretary shall make payments to a supplier of home dialysis supplies and equipment furnished to a patient whose self-care home dialysis is not under the direct supervision of an approved provider of services or renal dialysis facility only in accordance with a written agreement under which--

`(i) the patient certifies that the supplier is the sole provider of such supplies and equipment to the patient,

`(ii) the supplier agrees to receive payment for the cost of such supplies and equipment only on an assignment-related basis, and

`(iii) the supplier certifies that it has entered into a written agreement with an approved provider of services or renal dialysis facility under which such provider or facility agrees to furnish to such patient all self-care home dialysis support services and all other necessary dialysis services and supplies, including institutional dialysis services and supplies and emergency services.'.

(3) EFFECTIVE DATE- The amendments made by this subsection shall apply with respect to dialysis services, supplies, and equipment furnished on or after February 1, 1990.

SEC. 6204. PHYSICIAN OWNERSHIP OF, AND REFERRAL TO, HEALTH CARE ENTITIES.

(a) PROHIBITION OF CERTAIN FINANCIAL ARRANGEMENTS BETWEEN REFERRING PHYSICIANS AND CLINICAL LABORATORIES- Title XVIII of the Social Security Act is amended by inserting after section 1876 the following new section:

`LIMITATION ON CERTAIN PHYSICIAN REFERRALS`

`SEC. 1877. (a) PROHIBITION OF CERTAIN REFERRALS-`

`(1) IN GENERAL- Except as provided in subsection (b), if a physician (or immediate family member of such physician) has a financial relationship with an entity specified in paragraph (2), then--`
(A) the physician may not make a referral to the entity for the furnishing of clinical laboratory services for which payment otherwise may be made under this title, and

(B) the entity may not present or cause to be presented a claim under this title or bill to any individual, third party payor, or other entity for clinical laboratory services furnished pursuant to a referral prohibited under subparagraph (A).

(2) FINANCIAL RELATIONSHIP SPECIFIED- For purposes of this section, a financial relationship of a physician (or immediate family member) with an entity specified in this paragraph is--

(A) except as provided in subsections (c) and (d), an ownership or investment interest in the entity; or

(B) except as provided in subsection (e), a compensation arrangement (as defined in subsection (h)(1)(A)) between the physician (or immediate family member) and the entity.

An ownership or investment interest described in subparagraph (A) may be through equity, debt, or other means.

(b) GENERAL EXCEPTIONS TO BOTH OWNERSHIP AND COMPENSATION ARRANGEMENT PROHIBITIONS- Subsection (a)(1) shall not apply in the following cases:

(1) PHYSICIANS' SERVICES- In the case of physicians' services (as defined in section 1861(q)) provided personally by (or under the personal supervision of) another physician in the same group practice (as defined in subsection (h)(4)) as the referring physician.

(2) IN-OFFICE ANCILLARY SERVICES- In the case of services--

(A) that are furnished--

(i) personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are employed by such physician or group practice and who are personally supervised by the physician or by another physician in the group practice, and

(ii)(I) in a building in which the referring physician (or another physician who is a member of the same group practice) furnishes physicians' services unrelated to the furnishing of clinical laboratory services, or

(II) in the case of a referring physician who is a member of a group practice, in another building which is used by the group practice for the
centralized provision of the group's clinical laboratory services, and

`\( (B) \) that are billed by the physician performing or supervising the services, by a group practice of which such physician is a member, or by an entity that is wholly owned by such physician or such group practice, if the ownership or investment interest in such services meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

`\( (3) \) PREPAID PLANS- In the case of services furnished--

`\( \text{\textbackslash \textquoteleft} (A) \text{\textbackslash \textquoteleft} \) by an organization with a contract under section 1876 to an individual enrolled with the organization,
`\( \text{\textbackslash \textquoteleft} (B) \text{\textbackslash \textquoteleft} \) by an organization described in section 1833(a)(1)(A) to an individual enrolled with the organization, or
`\( \text{\textbackslash \textquoteleft} (C) \text{\textbackslash \textquoteleft} \) by an organization receiving payments on a prepaid basis, under a demonstration project under section 402(a) of the Social Security Amendments of 1967 or under section 222(a) of the Social Security Amendments of 1972, to an individual enrolled with the organization.

`\( (4) \) OTHER PERMISSIBLE EXCEPTIONS- In the case of any other financial relationship which the Secretary determines, and specifies in regulations, does not pose a risk of program or patient abuse.

`\( (c) \) GENERAL EXCEPTION RELATED ONLY TO OWNERSHIP OR INVESTMENT PROHIBITION FOR OWNERSHIP IN PUBLICLY-TRADED SECURITIES- Ownership of investment securities (including shares or bonds, debentures, notes, or other debt instruments) which were purchased on terms generally available to the public and which are in a corporation that--

`\( \text{\textbackslash \textquoteleft} (1) \text{\textbackslash \textquoteleft} \) is listed for trading on the New York Stock Exchange or on the American Stock Exchange, or is a national market system security traded under an automated interdealer quotation system operated by the National Association of Securities Dealers, and
`\( \text{\textbackslash \textquoteleft} (2) \text{\textbackslash \textquoteleft} \) had, at the end of the corporation's most recent fiscal year, total assets exceeding $100,000,000,

shall not be considered to be an ownership or investment interest described in subsection (a)(2)(A).

`\( (d) \) ADDITIONAL EXCEPTIONS RELATED ONLY TO OWNERSHIP OR INVESTMENT PROHIBITION- The following, if not otherwise excepted under subsection (b), shall not be considered to be an ownership or investment interest described in subsection (a)(2)(A):
 `(1) HOSPITALS IN PUERTO RICO- In the case of clinical laboratory services provided by a hospital located in Puerto Rico.

 `(2) RURAL PROVIDER- In the case of clinical laboratory services if the laboratory furnishing the services is in a rural area (as defined in section 1886(d)(2)(D)).

 `(3) HOSPITAL OWNERSHIP- In the case of clinical laboratory services provided by a hospital (other than a hospital described in paragraph (1)) if--

 `(A) the referring physician is authorized to perform services at the hospital, and

 `(B) the ownership or investment interest is in the hospital itself (and not merely in a subdivision thereof).

 `(e) EXCEPTIONS RELATING TO OTHER COMPENSATION ARRANGEMENTS- The following shall not be considered to be a compensation arrangement described in subsection (a)(2)(B):

 `(1) RENTAL OF OFFICE SPACE- Payments made for the rental or lease of office space if--

 `(A) there is a written agreement, signed by the parties, for the rental or lease of the space, which agreement--

 `(i) specifies the space covered by the agreement and dedicated for the use of the lessee,

 `(ii) provides for a term of rental or lease of at least one year;

 `(iii) provides for payment on a periodic basis of an amount that is consistent with fair market value;

 `(iv) provides for an amount of aggregate payments that does not vary (directly or indirectly) based on the volume or value of any referrals of business between the parties; and

 `(v) would be considered to be commercially reasonable even if no referrals were made between the parties;

 `(B) in the case of rental or lease of office space in which a physician who is an interested investor (or an interested investor who is an immediate family member of the physician) has an ownership or investment interest, the office space is in the same building as the building in which the physician (or group practice of which the physician is a member) has a practice; and

 `(C) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

 `(2) EMPLOYMENT AND SERVICE ARRANGEMENTS WITH HOSPITALS- An arrangement between a hospital and a physician
(or immediate family member) for the employment of the physician (or family member) or for the provision of administrative services, if--

(A) the arrangement is for identifiable services;
(B) the amount of the remuneration under the arrangement--
(i) is consistent with the fair market value of the services, and
(ii) is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician;
(C) the remuneration is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the hospital; and
(D) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(3) OTHER SERVICE ARRANGEMENTS- Remuneration from an entity (other than a hospital) under an arrangement if--
(A) the arrangement is--
(i) for specific identifiable services as the medical director or as a member of a medical advisory board at the entity pursuant to a requirement of this title,
(ii) for specific identifiable physicians' services to be furnished to an individual receiving hospice care if payment for such services may only be made under this title as hospice care,
(iii) for specific physicians' services furnished to a nonprofit blood center, or
(iv) for specific identifiable administrative services (other than direct patient care services), but only under exceptional circumstances specified by the Secretary in regulations;
(B) the requirements described in subparagraphs (B) and (C) of paragraph (2) are met with respect to the entity in the same manner as they apply to a hospital; and
(C) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(4) PHYSICIAN RECRUITMENT- In the case of remuneration which is provided by a hospital to a physician to induce the physician to relocate to the geographic area served by the hospital in order to be a member of the medical staff of the hospital, if--
(A) the physician is not required to refer patients to the hospital,
(B) the amount of the remuneration under the arrangement is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician, and
(C) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(5) ISOLATED TRANSACTIONS- In the case of an isolated financial transaction, such as a one-time sale of property, if--
(A) the requirements described in subparagraphs (B) and (C) of paragraph (2) are met with respect to the entity in the same manner as they apply to a hospital, and
(B) the transaction meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(6) SALARIED PHYSICIANS IN A GROUP PRACTICE- A compensation arrangement involving payment by a group practice of the salary of a physician member of the group practice.

(f) REPORTING REQUIREMENTS- Each entity providing covered items or services for which payment may be made under this title shall provide the Secretary with the information concerning the entity's ownership arrangements, including--
(1) the covered items and services provided by the entity, and
(2) the names and all of the medicare provider numbers of the physicians who are interested investors or who are immediate relatives of interested investors.

Such information shall be provided in such form, manner, and at such times as the Secretary shall specify. Such information shall first be provided not later than 1 year after the date of the enactment of this section.

(g) SANCTIONS-
(1) DENIAL OF PAYMENT- No payment may be made under this title for a clinical laboratory service which is provided in violation of subsection (a)(1).
(2) REQUIRING REFUNDS FOR CERTAIN CLAIMS- If a person collects any amounts that were billed in violation of subsection (a)(1), the person shall be liable to the individual for, and shall refund on a timely basis to the individual, any amounts so collected.
(3) CIVIL MONEY PENALTY AND EXCLUSION FOR IMPROPER CLAIMS- Any person that presents or causes to be presented a bill or a claim for a service that such person knows or should know is for a service for which payment may not be made under paragraph (1) or for which a refund has not been made under paragraph (2) shall be subject to a civil money penalty of not more than $15,000 for each such service. The provisions of section 1128A
other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(4) CIVIL MONEY PENALTY AND EXCLUSION FOR CIRCUMVENTION SCHEMES- Any physician or other entity that enters into an arrangement or scheme (such as a cross-referral arrangement) which the physician or entity knows or should know has a principal purpose of assuring referrals by the physician to a particular entity which, if the physician directly made referrals to such entity, would be in violation of this section, shall be subject to a civil money penalty of not more than $100,000 for each such arrangement or scheme. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(5) FAILURE TO REPORT INFORMATION- Any person who is required, but fails, to meet a reporting requirement of subsection (f) is subject to a civil money penalty of not more than $10,000 for each day for which reporting is required to have been made.

(h) DEFINITIONS- For purposes of this section:

(1) COMPENSATION ARRANGEMENT; REMUNERATION- (A) The term `compensation arrangement' means any arrangement involving any remuneration between a physician (or immediate family member) and an entity.

(B) The term `remuneration' includes any remuneration, directly or indirectly, overtly or covertly, in cash or in kind.

(2) EMPLOYEE- An individual is considered to be `employed by' or an `employee' of an entity if the individual would be considered to be an employee of the entity under the usual common law rules applicable in determining the employer-employee relationship (as applied for purposes of section 3121(d)(2) of the Internal Revenue Code of 1986).

(3) FAIR MARKET VALUE- The term `fair market value' means the value in arms length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes (not taking into account its intended use) and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.

(4) GROUP PRACTICE- The term `group practice' means a group of two or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association--
(A) in which each physician who is a member of the group provides substantially the full range of services which the physician routinely provides (including medical care, consultation, diagnosis, or treatment) through the joint use of shared office space, facilities, equipment, and personnel;
(B) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group;
(C) in which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by members of the group; and
(D) which meets such other standards as the Secretary may impose by regulation.

In the case of a faculty practice plan associated with a hospital with an approved medical residency training program in which physician members may provide a variety of different specialty services and provide professional services both within and outside the group (as well as perform other tasks such as research), the previous sentence shall be applied only with respect to the services provided within the faculty practice plan.

(5) INTERESTED INVESTOR; DISINTERESTED INVESTOR- The term `interested investor' means, with respect to an entity, an investor who is a physician in a position to make or to influence referrals or business to the entity (or who is an immediate family member of such an investor), and the term `disinterested investor' means an investor other than an interested investor.

(6) REFERRAL; REFERRING PHYSICIAN-
(A) PHYSICIANS' SERVICES- Except as provided in subparagraph (C), in the case of a clinical laboratory service which under law is required to be provided by (or under the supervision of) a physician, the request by a physician for the service, including the request by a physician for a consultation with another physician (and any test or procedure ordered by, or to be performed by (or under the supervision of) that other physician), constitutes a `referral' by a `referring physician'.
(B) OTHER ITEMS- Except as provided in subparagraph (C), in the case of another clinical laboratory service, the request or establishment of a plan of care by a physician which includes the provision of the clinical laboratory service constitutes a `referral' by a `referring physician'.
(C) CLARIFICATION RESPECTING CERTAIN SERVICES INTEGRAL TO A CONSULTATION BY CERTAIN SPECIALISTS- A request by a pathologist for clinical diagnostic laboratory tests and pathological examination services, if such services are furnished by (or under the supervision of) such pathologist pursuant to a consultation requested by another physician does not constitute a `referral' by a `referring physician'.
(b) REQUIRING REQUESTS FOR PAYMENT TO INCLUDE INFORMATION ON REFERRING PHYSICIAN- Section 1833 of such Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

`(q)(1) Each request for payment, or bill submitted, for an item or service furnished by an entity for which payment may be made under this part and for which the entity knows or has reason to believe there has been a referral by a referring physician (within the meaning of section 1877) shall include the name and provider number for the referring physician and indicate whether or not the referring physician is an interested investor (within the meaning of section 1877(h)(5)).

`(2)(A) In the case of a request for payment for an item or service furnished by an entity under this part on an assignment-related basis and for which information is required to be provided under paragraph (1) but not included, payment may be denied under this part.

`(B) In the case of a request for payment for an item or service furnished by an entity under this part not submitted on an assignment-related basis and for which information is required to be provided under paragraph (1) but not included--

`(i) if the entity knowingly and willfully fails to provide such information promptly upon request of the Secretary or a carrier, the entity may be subject to a civil money penalty in an amount not to exceed $2,000, and

`(ii) if the entity knowingly, willfully, and in repeated cases fails, after being notified by the Secretary of the obligations and requirements of this subsection to provide the information required under paragraph (1), the entity may be subject to exclusion from participation in the programs under this Act for a period not to exceed 5 years, in accordance with the procedures of subsections (c), (f), and (g) of section 1128.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under clause (i) in the same manner as they apply to a penalty or proceeding under section 1128A(a).'

(c) EFFECTIVE DATES-

(1) Except as provided in paragraph (2), the amendments made by this section shall become effective with respect to referrals made on or after January 1, 1992.

(2) The reporting requirement of section 1877(f) of the Social Security Act shall take effect on October 1, 1990.

(d) DEADLINE FOR CERTAIN REGULATIONS- The Secretary of Health and Human Services shall publish final regulations to carry out section 1877 of the Social Security Act by not later than October 1, 1990.

(e) GAO STUDY OF OWNERSHIP BY REFERRING PHYSICIANS- The Comptroller General shall conduct a study of the ownership of hospitals and other providers of medicare services by referring physicians. Such study shall investigate--
(1) the types of such ownership arrangements and types of services offered under such arrangements,
(2) the returns generally earned by physician investors in such arrangements,
(3) the effect of such arrangements on (A) the utilization of items and services by medicare beneficiaries, (B) medicare expenditures, and (C) other entities providing items and services in the communities served,
(4) the effect of such arrangements on independent providers of similar services, and
(5) the effect on the provision of in-office clinical laboratory services of the limitation on payment for certain referrals contained in section 1877 of the Social Security Act.

By not later than February 1, 1991, the Comptroller General shall report to Congress on the results of such study.

(f) QUARTERLY REPORTS TO CONGRESS ON COMPARATIVE UTILIZATION-
The Secretary of Health and Human Services shall submit to the Congress and the Comptroller General, not later than 90 days after the end of each calendar quarter, a report which provides a statistical profile (by State and type of item or service) comparing utilization of items and services by medicare beneficiaries served by entities in which the referring physician has a direct or indirect financial interest and by medicare beneficiaries served by other entities.

SEC. 6205. COSTS OF NURSING AND ALLIED HEALTH EDUCATION.

(a) RECOGNITION OF COSTS OF CERTAIN HOSPITAL-BASED NURSING SCHOOLS-
(1) IN GENERAL- (A) The reasonable costs incurred by a hospital in training students of a hospital-based nursing school shall be allowable as reasonable costs under title XVIII of the Social Security Act and reimbursed under such title on the same basis as if they were allowable direct costs of a hospital-operated educational program (other than an approved graduate medical education program) if, before June 15, 1989, and thereafter, the hospital demonstrates that for each year, it incurs at least 50 percent of the costs of training nursing students at such school, the nursing school and the hospital share some common board members, and all instruction is provided at the hospital or, if in another building, a building on the immediate grounds of the hospital.

(B) Section 8411(b) of the Technical and Miscellaneous Revenue Act of 1988 is amended by striking `1989, 1990, and' and inserting `1986 through'.

(2) EFFECTIVE DATE- Paragraph (1)(A) shall apply with respect to cost reporting periods beginning on or after the date of the enactment of this Act.
and on or before the date on which the Secretary issues regulations pursuant to subsection (b)(2)(A).

(b) DELAY IN RECOUPMENT OF CERTAIN NURSING AND ALLIED EDUCATION COSTS-

(1) The Secretary of Health and Human Services (in this subsection referred to as the `Secretary') shall not, before October 1, 1990, recoup from, or otherwise reduce or adjust payments under title XVIII of the Social Security Act to, hospitals because of alleged overpayments to such hospitals under such title due to a determination that costs which were reported by a hospital on its medicare cost reports relating to approved nursing and allied health education programs were allowable costs and are included in the definition of `operating costs of inpatient hospital services' pursuant to section 1886(a)(4) of such Act, so that no pass-through of such costs was permitted under that section.

(2)(A) Before July 1, 1990, the Secretary shall issue regulations respecting payment of costs described in paragraph (1).

(B) In issuing such regulations--

(i) the Secretary shall allow a comment period of not less than 60 days,

(ii) the Secretary shall consult with the Prospective Payment Assessment Commission, and

(iii) any final rule shall not be effective prior to October 1, 1990, or 30 days after publication of the final rule in the Federal Register, whichever is later.

(C) Such regulations shall specify--

(i) the relationship required between an approved nursing or allied health education program and a hospital for the program's costs to be attributed to the hospital;

(ii) the types of costs related to nursing or allied health education programs that are allowable by medicare;

(iii) the distinction between costs of approved educational activities as recognized under section 1886(a)(3) of the Social Security Act and educational costs treated as operating costs of inpatient hospital services; and

(iv) the treatment of other funding sources for the program.

SEC. 6206. DISCLOSURE OF ASSUMPTIONS IN ESTABLISHING AAPCC; ELIMINATION OF COORDINATED OPEN ENROLLMENT REQUIREMENT.

(a) DISCLOSURE OF ASSUMPTIONS IN ESTABLISHING AAPCC-

(1) IN GENERAL- Section 1876(a)(1) of the Social Security Act (42 U.S.C. 1395mm(a)(1)) is amended by adding at the end the following new subparagraph:

`\( F(i) \) At least 45 days before making the announcement under subparagraph (A) for a year (beginning with the announcement for 1991), the Secretary shall provide for notice to eligible organizations of proposed
changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

(ii) In each announcement made under subparagraph (A) for a year (beginning with the announcement for 1991), the Secretary shall include an explanation of the assumptions (including any benefit coverage assumptions) and changes in methodology used in the announcement in sufficient detail so that eligible organizations can compute per capita rates of payment for classes of individuals located in each county (or equivalent area) which is in whole or in part within the service area of such an organization.'.

(2) NOTICE- Before July 1, 1990, the Secretary of Health and Human Services shall provide for notice to eligible organizations of the methodology used in making the announcement under section 1876(a)(1)(A) of the Social Security Act for 1990.

(b) ELIMINATION OF COORDINATED OPEN ENROLLMENT REQUIREMENT-
(1) IN GENERAL- Section 1876(c)(3)(A) of such Act (42 U.S.C. 1395mm(c)(3)(A)) is amended--
(A) in clause (i), by striking `30-day period' and inserting `period or periods', and
(B) by striking clause (ii) and inserting the following:
`(ii)(I) If a risk-sharing contract under this section is not renewed or is otherwise terminated, eligible organizations with risk-sharing contracts under this section and serving a part of the same service area as under the terminated contract are required to have an open enrollment period for individuals who were enrolled under the terminated contract as of the date of notice of such termination. If a risk-sharing contract under this section is renewed in a manner that discontinues coverage for individuals residing in part of the service area, eligible organizations with risk-sharing contracts under this section and enrolling individuals residing in that part of the service area are required to have an open enrollment period for individuals residing in the part of the service area who were enrolled under the contract as of the date of notice of such discontinued coverage.
`(II) The open enrollment periods required under subclause (I) shall be for 30 days and shall begin 30 days after the date that the Secretary provides notice of such requirement.
`(III) Enrollment under this clause shall be effective 30 days after the end of the open enrollment period, or, if the Secretary determines that such date is not feasible, such other date as the Secretary specifies.'.

(2) EFFECTIVE DATE- The amendments made by paragraph (1) shall take effect 60 days after the date of the enactment of this Act.

SEC. 6207. EXTENSION OF EXPIRING AUTHORITIES.
(a) DELAY IN EFFECTIVE DATE IN PHYSICIAN INCENTIVE RULES- Section 9313(c)(2)(B) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 4016 of the Omnibus Budget Reconciliation Act of 1987, is amended by striking `April 1, 1990' and inserting `April 1, 1991'.
(b) EXTENSION OF PROHIBITION ON COST SAVINGS POLICIES BEFORE BEGINNING OF FISCAL YEAR- Section 4039(d) of the Omnibus Budget Reconciliation Act of 1987, as amended by section 426(e) of the Medicare Catastrophic Coverage Act of 1988, is amended--
(1) by striking `October 15, 1989' and inserting `October 15, 1990', and
(2) by inserting `or in fiscal year 1991' after `fiscal year 1990'.

Subpart B--Technical and Miscellaneous Provisions

SEC. 6211. MEDICARE HOSPITAL PATIENT PROTECTION AMENDMENTS.

(a) SCOPE OF HOSPITAL RESPONSIBILITY FOR SCREENING- Subsection (a) of section 1867 of the Social Security Act (42 U.S.C. 1395dd) is amended by striking `department' the third place it appears and inserting the following: `department, including ancillary services routinely available to the emergency department,'.
(b) INFORMED REFUSALS OF TREATMENT OR TRANSFERS- Subsection (b) of such section is amended--
(1) in paragraph (2)--
(A) by inserting `and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment,' after `in that paragraph',
(B) by striking `or treatment' and inserting `and treatment', and
(C) by adding at the end the following new sentence: `The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.'; and
(2) in paragraph (3)--
(A) by inserting `and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer,' after `with subsection (c)', and
(B) by adding at the end the following new sentence: `The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.'.
(c) AUTHORIZATION FOR TRANSFERS-
(1) INFORMED CONSENT FOR TRANSFERS AT INDIVIDUAL REQUEST- Subsection (c)(1)(A)(i) of such section is amended by striking `requests that the transfer be effected' and inserting `after being informed of the hospital's
obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility'.

(2) **CLARIFYING PHYSICIAN AUTHORIZATION FOR TRANSFERS**- Subsection (c)(1)(A) of such section is amended--
(A) by striking `or' at the end of clause (i);
(B) in clause (ii)--
(i) by striking `, or other qualified medical personnel when a physician is not readily available in the emergency department,', and
(ii) by inserting `of transfer' after `information available at the time';
(C) by striking `; and' at the end of clause (ii) and inserting `, or', and
(D) by adding at the end the following new clause:
`if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1861(r)(1)), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and'.

(3) **STANDARD FOR AUTHORIZING TRANSFER**- Subsection (c)(1)(A)(ii) of such section is amended--
(A) by striking `, based upon the reasonable risks and benefits to the patient, and', and
(B) by striking `individual's medical condition' and inserting `individual and, in the case of labor, to the unborn child'.

(4) **INCLUSION OF SUMMARY OF RISKS AND BENEFITS IN CERTIFICATE OF TRANSFER**- Subsection (c)(1) of such section is amended by adding at the end the following:
`A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.'.

(5) **PROVISION OF SERVICES PENDING TRANSFER**- Subsection (c)(2) of such section is amended--
(A) by redesignating subparagraphs (A) through (D) as subparagraphs (B) through (E), respectively, and
(B) by inserting before subparagraph (B), as so redesignated, the following new subparagraph:
`in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child';

(d) **REQUIRING MAINTENANCE OF RECORDS OF TRANSFERS**- Subsection (c)(2)(C) of such section, as redesignated by subsection (c)(5)(A) of this section, is amended--
(1) by striking `provides' and inserting `sends to', and
(2) by striking `with appropriate medical records' and all that follows through `transferring hospital' and inserting `all medical records (or copies
thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(2)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment'.

(e) PHYSICIAN LIABILITY- Subsection (d)(2) of such subsection is amended-

(1) by amending subparagraph (B) to read as follows:

` (B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who knowingly violates a requirement of this section, including a physician who--

` (i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

` (ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is knowing and willful or negligent, to exclusion from participation in this title and State health care programs. The provisions of section 1128A (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1128A(a).';

and

(2) by striking subparagraph (C) and inserting the following:

` (C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1866(a)(1)(I)) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.'.

(f) ADDITIONAL OBLIGATIONS- Such section is amended by adding at the end the following new subsections:
(g) NONDISCRIMINATION—A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) NO DELAY IN EXAMINATION OR TREATMENT—A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) or further medical examination and treatment required under subsection (b) in order to inquire about the individual's method of payment or insurance status.

(i) WHISTLEBLOWER PROTECTIONS—A participating hospital may not penalize or take adverse action against a physician because the physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized.

(g) CHANGE IN `PATIENT' TERMINOLOGY—
(1) Subsection (c) of such section is amended—
(A) by striking `PATIENT' and inserting `INDIVIDUAL', and
(B) by striking `a patient' `the patient', `patient's', and `patients' each place each appears and inserting `an individual', `the individual', `individual's', and `individuals', respectively.

(2) Subsection (e)(5) of such section is amended by striking `a patient' each place it appears and inserting `an individual'.

(h) CLARIFICATION OF `EMERGENCY MEDICAL CONDITION' DEFINITION—
(1) IN GENERAL—Subsection (e) of such section (as amended by section 6003(g)(3)(D)(xiv)) is amended—
(A) in paragraph (1), by striking `means' and all that follows and inserting the following:
`means--

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in--

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant women who is having contractions--

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery,

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.';
(B) by striking paragraph (2);
(C) in paragraph (4)(A)--
(i) by inserting `described in paragraph (1)(A)' after `emergency medical condition',
(ii) by inserting `or occur during' after `likely to result from',
(iii) by inserting before the period at the end the following: `, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta)';
(D) in paragraph (4)(B)--
(i) by inserting `described in paragraph (1)(A)' after `emergency medical condition',
(ii) by inserting `or occur during' after `to result from', and
(iii) by inserting before the period at the end the following: `, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta)'; and
(E) by redesignating paragraphs (3) through (6) as paragraphs (2) through (5), respectively.
(2) CONFORMING AMENDMENTS- Such section is further amended--
(A) in the heading, by striking `ACTIVE';
(B) in subsection (a), by striking `or to determine if the individual is in active labor (within the meaning of section (e)(2))';
(C) in the heading of subsection (b), by striking `ACTIVE';
(D) in subsection (b)(1)--
(i) by striking `or is in active labor', and
(ii) in subparagraph (A), by striking `or to provide for treatment of the labor'; and
(E) in subsection (c)(1), by striking `(e)(4)(B)) or is in active labor' and inserting `(e)(3)(B))'.
(i) EFFECTIVE DATE- The amendments made by this section shall take effect on the first day of the first month that begins more than 180 days after the date of the enactment of this Act, without regard to whether regulations to carry out such amendments have been promulgated by such date.

SEC. 6212. HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.

(a) TEMPORARY WAIVER FOR WATTS HEALTH FOUNDATION- Section 9312(c)(3)(D) of the Omnibus Budget Reconciliation Act of 1986, as added by section 4018(d) of the Omnibus Budget Reconciliation Act of 1987, is amended--
(1) in clause (i), by striking `January 1, 1990' and inserting `January 1, 1994'; and
(2) by amending clauses (ii) and (iii) to read as follows:
`(ii) beginning on January 1, 1990, the Secretary of Health and Human Services shall conduct an annual review of the organization to determine the
organization's compliance with the quality assurance requirements of section 1876(c)(6) of such Act; and

` (iii) after January 1, 1990, if the organization receives an unfavorable review under clause (ii), the Secretary, after notice to the organization of the unfavorable review and an opportunity to correct any deficiencies identified during the review, may provide for the sanction described in section 1876(f)(3) of such Act effective with respect to individuals enrolling with the organization after the date the Secretary notifies the organization that the organization is not in compliance with the requirements of section 1876(c)(6) of such Act.'.

(b) LIMIT ON CHARGES FOR EMERGENCY SERVICES AND OUT-OF-AREA COVERAGE-

(1) IN GENERAL- Section 1876 of the Social Security Act (42 U.S.C. 1395mm) is amended by adding at the end the following new subsection:

` (j)(1)(A) In the case of physicians' services described in paragraph (2) which are furnished by a participating physician to an individual enrolled with an eligible organization under this section and enrolled under part B, the participation agreement under section 1842(h)(1) is deemed to provide that the physician will accept as payment in full from the eligible organization the amount that would be payable to the physician under part B and from the individual under such part, if the individual were not enrolled with an eligible organization under this section.

(B) In the case of physicians' services described in paragraph (2) which are furnished by a nonparticipating physician, the limitations on actual charges for such services otherwise applicable under part B (to services furnished by individuals not enrolled with an eligible organization under this section) shall apply in the same manner as such limitations apply to services furnished to individuals not enrolled with such an organization.

(2) The physicians' services described in this paragraph are physicians' services which--

(A) are emergency services or out-of-area coverage (described in clauses (iii) and (iv) of subsection (b)(2)(A)), and

(B) are furnished to an enrollee of an eligible organization under this section by a person who is not under a contract with the organization.'.

(2) EFFECTIVE DATE- The amendment made by paragraph (1) shall apply to services furnished on or after April 1, 1990.

(c) MAKING AUTHORITY FOR BENEFIT STABILIZATION FUND PERMANENT-

(1) REPEAL ON LIMITATION ON ESTABLISHMENT OF A FUND- Section 2350(b) of the Deficit Reduction Act of 1984 (Public Law 98-369) is amended by striking paragraphs (3) and (4).

(2) REPEAL ON LIMITING PERIOD OF USE- Section 1876(g)(5) of the Social Security Act (42 U.S.C. 1395mm(g)(5)) is amended by striking `and during a period of not longer than four years'.
SEC. 6213. RURAL HEALTH CLINIC SERVICES.

(a) STAFFING REQUIREMENTS; INCLUSION OF NURSE-MIDWIFE SERVICES-
Section 1861(aa)(2) of the Social Security Act (42 U.S.C. 1395x(aa)(2)) is
amended--
(1) by striking `; and' at the end of subparagraph (I) and inserting a
semicolon;
(2) by redesignating subparagraph (J) as subparagraph (K); and
(3) by inserting after subparagraph (I) the following new subparagraph:
`(J) has a nurse practitioner, a physician assistant, or a certified nurse-
midwife (as defined in subsection (gg)) available to furnish patient care
services not less than 50 percent of the time the clinic operates; and'.
(b) COVERAGE OF SOCIAL WORKER SERVICES- Section 1861(aa)(1)(B) of
such Act (42 U.S.C. 1395x(aa)(1)(B)) is amended--
(1) by striking `or' before `by'; and
(2) by inserting `or by a clinical social worker (as defined in subsection
(hh)(1)), after `Secretary').
(c) EXPANSION OF ELIGIBLE AREAS- The second sentence of section
1861(aa)(2) of such Act is amended--
(1) by striking `designated by the Secretary' and inserting `designated by
the chief executive officer of the State and certified by the Secretary as an
area with a shortage of personal health services, or that is designated by the
Secretary';
(2) by striking `section 1302(7) of the Public Health Service Act or' and
inserting `section 330(b)(3) or 1302(7) of the Public Health Service Act,';
and
(3) by striking `medical care manpower,' and inserting the following:
`medical care manpower, (III) as a high impact area described in section
329(a)(5) of that Act, or (IV) as an area which includes a population group
which the Secretary determines has a health manpower shortage under
section 332(a)(1)(B) of that Act,.'.
(d) EFFECTIVE DATE- The amendments made by subsections (a) through (c)
of this section shall take effect October 1, 1989.
(e) DISSEMINATION OF RURAL HEALTH CLINIC INFORMATION-
(1) IN GENERAL- Not later than 60 days after the date of the enactment of
this Act, the Secretary of Health and Human Services, in consultation with
the Director of the Office of Rural Health Policy, shall disseminate to health
care facilities and to the chief executive officer, chief health officer, and chief
human services officer of each State, applications and other necessary
information to enable such a facility to apply for designation as a rural health
clinic for the purposes of titles XVIII and XIX of the Social Security Act.
(2) DEFINITIONS- For purposes of this subsection:
(A) The term `health care facility' means a community health center or a migrant health center, or a hospital, home health agency, or skilled nursing facility participating in a program established under title XVIII or title XIX of the Social Security Act.
(B) The term `State' includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

(f) TREATMENT OF CERTAIN FACILITIES AS RURAL HEALTH CLINICS- The Secretary of Health and Human Services shall not deny certification of a facility as a rural health clinic under section 1861(aa)(2) of the Social Security Act if the facility is located on an island and would otherwise be qualified to be certified as such a facility but for the requirement that the services of a physician assistant or nurse practitioner be provided in the facility.

(g) EXPANSION OF FUNCTIONS OF OFFICE OF RURAL HEALTH POLICY- Section 711(b) of the Social Security Act (42 U.S.C. 912(b)) is amended--
(1) in paragraph (2)(A), by striking `health care issues' and inserting `health care issues, including rural mental health, rural infant mortality prevention, and rural occupational safety and preventive health promotion';
(2) in paragraph (2)(C), by striking `rural areas' and inserting `rural areas, including programs providing community-based mental health services, prenatal and infant care services, and rural occupational safety and preventive health education and promotion'; and
(3) in paragraph (4), by striking `rural health care' and inserting `rural health care, including activities relating to rural mental health, rural infant mortality, and rural occupational safety and preventive health promotion'.

SEC. 6214. DETERMINING ELIGIBILITY OF HOME HEALTH AGENCIES FOR WAIVER OF LIABILITY FOR DENIED CLAIMS.

(a) SCOPE OF WAIVER AND DETERMINATION OF DENIED CLAIM- Section 1879(f) of the Social Security Act (42 U.S.C. 1395pp(f)) is amended--
(1) in paragraph (1), by striking `with respect to' and all that follows and inserting a period; and
(2) in paragraph (4), by striking `(4) The requirement' and inserting `(4)(A) The requirement'; and by adding at the end the following new subparagraph:
'(B) For purposes of determining the rate of denial of bills for a home health agency under subparagraph (A), a bill shall not be considered to be denied until the expiration of the 60-day period that begins on the date such bill is denied by the fiscal intermediary, or, with respect to such a denial for which the agency requests reconsideration, until the fiscal intermediary issues a decision denying payment for such bill.'.
(b) MONITORING OF DENIED CLAIMS- Section 1879(f) of such Act (42 U.S.C. 1395pp(f)) is amended by adding at the end the following new paragraph:

 `(6) The Secretary shall monitor the proportion of denied bills submitted by home health agencies for which reconsideration is requested, and shall notify Congress if the proportion of denials reversed upon reconsideration increases significantly.'.

(c) EFFECTIVE DATE- The amendments made by subsection (a) shall apply to determinations for quarters beginning on or after the date of the enactment of this Act.

SEC. 6215. EXTENSION OF AUTHORITY TO CONTRACT WITH FISCAL INTERMEDIARIES AND CARRIERS ON OTHER THAN A COST BASIS.

(a) IN GENERAL- Section 2326(a) of the Deficit Reduction Act of 1984 is amended--

(1) in the first sentence, by striking `fiscal year 1989' and inserting `fiscal year 1993',

(2) in the second sentence, by striking `over a period of time' and inserting `over a 2-year period of time', and

(3) by inserting after the second sentence the following: `In addition, during such period the Secretary may enter into such additional agreements and contracts without regard to such cost reimbursement provisions if the fiscal intermediary or carrier involved and the Secretary agree to waive such provisions, but the Secretary may not take any action that has the effect of requiring that the intermediary or carrier agree to waive such provisions, including requiring such a waiver as a condition for entering into or renewing such an agreement or contract.'.

(b) EFFECTIVE DATE- The amendments made by subsection (a) shall apply beginning with fiscal year 1990.

SEC. 6216. EXPANSION OF RURAL HEALTH MEDICAL EDUCATION DEMONSTRATION PROJECT.

(a) NUMBER OF PROJECTS- Section 4038(a) of the Omnibus Budget Reconciliation Act of 1987 is amended by striking `four sponsoring hospitals' and inserting `10 sponsoring hospitals'.

(b) SELECTION OF NEW PROJECTS- Section 4038(c) of such Act is amended--

(1) by striking `In selecting' and inserting `(1) In selecting';

(2) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B); and

(3) by adding at the end the following new paragraph:
\`(2) The provisions of paragraph (1) shall not apply with respect to applications submitted as a result of amendments made by section 6216 of the Omnibus Budget Reconciliation Act of 1989.'.

(c) COMMENCEMENT OF NEW PROJECTS- Section 4038(e) of such Act is amended by inserting `\(or the date of the enactment of the Omnibus Budget Reconciliation Act of 1989, in the case of a project conducted as a result of the amendments made by section 6216 of such Act)\)' after `this Act'.

SEC. 6217. INNER-CITY HOSPITAL TRIAGE DEMONSTRATION PROJECT.

(a) ESTABLISHMENT- The Secretary of Health and Human Services shall establish a demonstration project in a public hospital that is located in a large urban area and that has established a triage system, under which the Secretary shall make payments for 3 years to reimburse the hospital for the reasonable costs of operating the system, including costs--

(1) to train hospital personnel to operate and participate in the system; and

(2) to provide services to patients who might otherwise be denied appropriate and prompt care.

(b) LIMITATIONS ON PAYMENT- (1) The Secretary may not make payment under the demonstration project established under subsection (a) for costs that the Secretary determines are not reasonable.

(2) The amount of payment made under the demonstration project during a single year may not exceed $500,000.

SEC. 6218. GAO STUDY OF ADMINISTRATIVE COSTS OF MEDICARE PROGRAM.

(a) STUDY- The Comptroller General shall conduct a study of the administrative burden of medicare regulations and program requirements on providers of services, fiscal intermediaries, and carriers, and shall include in such study--

(1) an assessment of current administrative costs to such entities and of trends in such administrative costs since 1982; and

(2) a comparison of the administrative burden to such entities in providing services to individuals who are not medicare beneficiaries.

For purposes of such assessment, administrative costs shall include personnel costs, training costs, the costs of data and communications systems as affected by changes in requirements of the medicare program, and costs to such entities of non-compliance with such requirements resulting from the failure of the Secretary of Health and Human Services to provide entities with adequate notice of changes in program requirements.

(b) REPORT- Not later than March 31, 1990, the Comptroller General shall submit a report to the Committees on Ways and Means and Energy and
Commerce of the House of Representatives and the Committee on Finance of the Senate on the study conducted under subsection (a).

SEC. 6219. PROVISIONS RELATING TO END STAGE RENAL DISEASE SERVICES.

(a) FLEXIBILITY IN FUNDING ESRD NETWORK ORGANIZATIONS- The last sentence of section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)) is amended by striking `network administrative' and all that follows and inserting the following: `organizations (designated under subsection (c)(1)(A)) for such organizations' necessary and proper administrative costs incurred in carrying out the responsibilities described in subsection (c)(2). The Secretary shall provide that amounts paid under the previous sentence shall be distributed to the organizations described in subsection (c)(1)(A) to ensure equitable treatment of all such network organizations. The Secretary in distributing any such payments to network organizations shall take into account--
  `(A) the geographic size of the network area;
  `(B) the number of providers of end stage renal disease services in the network area;
  `(C) the number of individuals who are entitled to end stage renal disease services in the network area; and
  `(D) the proportion of the aggregate administrative funds collected in the network area.'.

(b) LIABILITY PROTECTION FOR ESRD NETWORK ORGANIZATIONS AND PROHIBITION AGAINST DISCLOSURE OF INFORMATION- Section 1881(c) of such Act (42 U.S.C. 1395rr(c)) is amended by adding at the end the following new paragraph:
  `(8) The provisions of sections 1157 and 1160 shall apply with respect to network administrative organizations (including such organizations as medical review boards) with which the Secretary has entered into agreements under this subsection.'.

(c) REPORT ON PAYMENT FOR ERYTHROPOIETIN (EPO)- Not later than April 1, 1990, the Secretary of Health and Human Services shall submit a report to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate and to the Comptroller General on the methodology and rationale used to establish a payment rate for the drug erythropoietin (EPO) under title XVIII of the Social Security Act and shall include in the report (1) a summary of information provided to the Secretary by the manufacturer of EPO and used by the Secretary to establish such rate and (2) a plan for ensuring the appropriateness of such rate in the future.
SEC. 6220. AMENDMENTS RELATING TO THE UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE.

(a) COMMISSION NAME- Section 401 of the Medicare Catastrophic Coverage Act of 1988 is amended by inserting before the period at the end the following: `and also to be known as the `Claude Pepper Commission' or the `Pepper Commission'.

(b) 4 VICE CHAIRMEN- Section 403(b) of such Act is amended--
(1) by striking `VICE CHAIRMAN' and inserting `VICE CHAIRMEN'; and
(2) by striking `vice chairman' and inserting `4 vice chairmen'.

(c) ADDITIONAL MAILING PRIVILEGE- Section 405(f) of such Act is amended by inserting before the period at the end the following: `, and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code'.

(d) PRINTING OF REPORTS- Section 405 of such Act is further amended by adding at the end the following new subsection:

`(j) PRINTING- For purposes of costs relating to printing and binding, including the costs of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of the Congress.'.

(e) REPORT DEADLINES- Section 406 of such Act is amended--
(1) in each of subsections (a) and (b), by striking `, not later than' and all that follows through `for the Commission,'; and
(2) by adding at the end the following new subsection:

` (c) DEADLINES- The two reports required under this section shall be submitted concurrently by not later than November 9, 1989.'.

SEC. 6221. NATIONAL COMMISSION ON CHILDREN.

Section 1139 of the Social Security Act (42 U.S.C. 1320b-9) is amended--
(1) in subsection (d)--
(A) by striking `September 30, 1988' and inserting `March 31, 1990'; and
(B) by striking `March 31, 1990' and inserting `March 31, 1991';

(2) in subsection (e), by striking `September 30, 1990' and inserting `March 31, 1991';

(3) in subsection (j), by striking `such sums' and inserting `through fiscal year 1991, such sums'; and

(4) by adding at the end thereof the following new subsections:

`(k) (1) The Commission is authorized to accept donations of money, property, or personal services. Funds received from donations shall be deposited in the Treasury in a separate fund created for this purpose. Funds appropriated for the Commission and donated funds may be expended for such purposes as official reception and representation expenses, public surveys, public service announcements, preparation of special papers,
analyses, and documentaries, and for such other purposes as determined by
the Commission to be in furtherance of its mission to review national issues
affecting children.
``(2) For purposes of Federal income, estate, and gift taxation, money and
other property accepted under paragraph (1) of this subsection shall be
considered as a gift or bequest to or for the use of the United States.
``(3) Expenditure of appropriated and donated funds shall be subject to such
rules and regulations as may be adopted by the Commission and shall not be
subject to Federal procurement requirements.
``(l) The Commission is authorized to conduct such public surveys as it
deems necessary in support of its review of national issues affecting children
and, in conducting such surveys, the Commission shall not be deemed to be
an `agency' for the purpose of section 3502 of title 44, United States Code.'.

SEC. 6222. CONTINUED USE OF HOME HEALTH WAGE INDEX IN EFFECT
PRIOR TO JULY 1, 1989, UNTIL AFTER JULY 1, 1991.

Notwithstanding the requirement of section 1861(v)(1)(L)(iii) of the Social
Security Act, the Secretary of Health and Human Services shall, in
determining the limits of reasonable costs under title XVIII of the Social
Security Act with respect to services furnished by home health agencies,
continue to utilize the wage index that was in effect for cost reporting
periods beginning before July 1, 1989, until cost reporting periods beginning
on or after July 1, 1991.

SEC. 6223. HCFA PERSONNEL STUDY.

(a) IN GENERAL- The Secretary of Health and Human Services shall (subject
to subsection (c)) enter into an agreement with the National Academy of
Public Administration (hereafter in this section referred to as the `Academy')
to--
(1) study personnel administration at the Health Care Financing
Administration (hereafter in this section referred to as `HCFA');
(2) assess the adequacy of HCFA staffing; and
(3) recommend any needed changes with respect to HCFA staffing to the
Secretary of Health and Human Services and the Congress.
(b) REQUIREMENTS OF STUDY- In conducting the study, the Academy shall
interview management officials at HCFA and other appropriate agencies. The
study shall include consideration of--
(1) the average years in service, years to retirement and average age of
various categories of HCFA personnel;
(2) the adequacy of HCFA practices to recruit personnel to replace persons
who retire or resign and train new employees in the intricacies of HCFA
programs;
(3) the grade structure of various categories of HCFA personnel, and the need for additional nonsupervisory positions at the GS-13, GS-14, and GS-15 levels for particularly skilled and expert personnel needed for HCFA to carry out its missions;
(4) the grade structure at HCFA with Federal agencies of similar size and responsibilities;
(5) whether bonus payments or other incentives are needed for HCFA to recruit and retain specialized personnel;
(6) particular problems in hiring personnel that may prevent recruitment and retention of qualified staff;
(7) Office of Personnel Management rules that may be burdensome to the hiring process; and
(8) how HCFA can more appropriately address the priorities of both Congress and the executive branch of Government.
(c) ARRANGEMENTS FOR STUDY- The Secretary shall request the Academy, acting through appropriate units, to submit an application to conduct the study described in this section. If the Academy submits an acceptable application, the Secretary shall enter into an appropriate arrangement with the Academy for the conduct of the study. If the Academy does not submit an acceptable application to conduct the study, the Secretary may request one or more appropriate nonprofit private entities to submit an application to conduct the study and may enter into an appropriate arrangement for the conduct of the study by the entity which submits the best acceptable application.
(d) DATE OF REPORT- The results of the study shall be reported to Congress and the Secretary of Health and Human Services no later than December 31, 1990.

SEC. 6224. PEER REVIEW ORGANIZATIONS.

(a) PEER REVIEW OF NON-PHYSICIAN SERVICES-
(1) IN GENERAL- Section 1154(a)(1) of the Social Security Act (42 U.S.C. 1320c-3(a)(1)) is amended by adding at the end the following:
`If the organization performs such reviews with respect to a type of health care practitioner other than medical doctors, the organization shall establish procedures for the involvement of health care practitioners of that type in such reviews.'.
(2) EFFECTIVE DATE- The amendment made by paragraph (1) shall apply to contracts entered into after the date of the enactment of this Act.
(b) PROVIDER AND PRACTITIONER RIGHT TO RECONSIDERATION OF PRO
DETERMINATION BEFORE NOTICE TO BENEFICIARY-
(1) IN GENERAL- Section 1154(a)(3) of the Social Security Act (42 U.S.C. 1320c-3(a)(3)) is amended--
(A) in subparagraph (A), by striking `subparagraph (B)' and inserting `subparagraphs (B) and (D)',
(B) in subparagraph (B), by inserting `with respect to services or items disapproved by reason of subparagraph (A) or (C) of paragraph (1)' after `under subparagraph (A)', and
(C) by adding at the end the following new subparagraphs:
  `(D) The notification under subparagraph (A) with respect to services or items disapproved by reason of paragraph (1)(B) shall not occur until after--
    `(i) the organization has notified the practitioner or provider involved of the determination and of the practitioner's or provider's right to a formal reconsideration of the determination under section 1155, and
    `(ii) if the provider or practitioner requests such a reconsideration, the organization has made such a reconsideration.
If a provider or practitioner is provided a reconsideration, such reconsideration shall be in lieu of any subsequent reconsideration to which the provider or practitioner may be otherwise entitled under section 1155, but shall not affect the right of a beneficiary from seeking reconsideration under such section of the organization's determination (after any reconsideration requested by the provider or physician under clause (ii)).
  `(E) In the case of services and items disapproved by reason of paragraph (1)(B), the notice to the patient shall state the following: `In the judgment of the peer review organization, the medical care received was not acceptable under the medicare program. The reasons for the denial have been discussed with your physician and hospital.'.
(2) CONFORMING AMENDMENT- Section 1155 of such Act (42 U.S.C. 1320c-5) is amended by inserting `, subject to section 1154(a)(3)(D),' before `any practitioner or provider'.
(3) EFFECTIVE DATE- The amendments made by this subsection shall apply to determinations by utilization and quality control peer review organizations with respect to which preliminary notifications were made under section 1154(a)(3)(B) of the Social Security Act more than 30 days after the date of the enactment of this Act.

PART 4--PART B PREMIUM

SEC. 6301. PART B PREMIUM.

Section 1839(e) of the Social Security Act (42 U.S.C. 1395r(e)) is amended by striking `1990' each place it appears and inserting `1991'.

Subtitle B--Medicaid

PART 1--GENERAL PROVISIONS
SEC. 6401. MANDATORY COVERAGE OF CERTAIN LOW-INCOME PREGNANT WOMEN AND CHILDREN.

(a) IN GENERAL- Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended--

(1) in subsection (a)(10)(A)(i)--

(A) by striking `or' at the end of subclause (IV),

(B) by striking the semicolon at the end of subclause (V) and inserting `, or', and

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

`(VI) who are described in subparagraph (C) of subsection (l)(1) and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(B) for such a family;'

(2) in subsection (a)(10)(A)(ii)(IX), by inserting `or clause (i)(VI)' after `clause (i)(IV)';

(3) in subsection (l)(1)--

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

(B) by striking subparagraph (C) and inserting the following:

`(C) children who have attained one year of age but have not attained 6 years of age, and

(D) at the option of the State, children born after September 30, 1983, who have attained 6 years of age but have not attained 7 or 8 years of age (as selected by the State),';

(4) in subsection (l)(2)(A)--

(A) in clause (ii), by amending subclause (II) to read as follows:

`April 1, 1990, 133 percent, or, if greater, the percentage provided under clause (iv).'; and

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

`In the case of a State which, as of the date of the enactment of this clause, has established under clause (i), or has enacted legislation authorizing, or appropriating funds, to provide for, a percentage (of the official poverty line) that is greater than 133 percent, the percentage provided under clause (ii) for medical assistance on or after April 1, 1990, shall not be less than--

(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of the date of the enactment of this clause, or

(II) if no such percentage is specified as of the date of the enactment of this clause, the percentage established under the State's authorizing legislation or provided for under the State's appropriations.');

(5) in subparagraph (B) of subsection (l)(2)--

(A) by striking `or, if less, the percentage established under subparagraph (A)', and

(B) by redesignating such subparagraph as subparagraph (C);
(6) in subsection (l)(2), by inserting after subparagraph (A) the following new subparagraph:

`(B) For purposes of paragraph (1) with respect to individuals described in subparagraph (C) of such paragraph, the State shall establish an income level which is equal to 133 percent of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.';

(6) in subsection (l)(3)--
(A) by inserting `,(a)(10)(A)(i)(VI),', after `(a)(10)(A)(i)(IV)', and
(B) in subparagraph (C), by striking `or (C)' and inserting `, (C), or (D)';

(7) in subsection (l)(4)--
(A) in subparagraph (A), by inserting `and for children described in subsection (a)(10)(A)(i)(VI)' after `(a)(10)(A)(i)(IV)', and
(B) in subparagraph (B), by inserting `or (a)(10)(A)(i)(VI)' after `(a)(10)(A)(i)(IV)';

(8) in subsection (e)(7), by striking `or (C)' and inserting `, (C), or (D)'; and


(b) CONFORMING AMENDMENT- Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting `1902(a)(10)(A)(i)(VI),', after `1902(a)(10)(A)(i)(IV),'.

(c) EFFECTIVE DATE-
(1) Except as provided in paragraph (2), the amendments made by this section shall apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after April 1, 1990, with respect to eligibility for medical assistance on or after such date, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 6402. PAYMENT FOR OBSTETRICAL AND PEDIATRIC SERVICES.
(a) CODIFICATION OF ADEQUATE PAYMENT LEVEL PROVISIONS- Section 1902(a)(30)(A) of the Social Security Act (42 U.S.C. 1396a(a)(30)(A)) is amended by inserting before the semicolon at the end the following: ‘and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area’.

(b) ASSURING ADEQUATE PAYMENT LEVELS FOR OBSTETRICAL AND PEDIATRIC SERVICES- Title XIX of such Act, as amended by section 303 of the Family Support Act of 1988, is amended by redesignating section 1926 as section 1927 and by inserting after section 1925 the following new section:

`ASSURING ADEQUATE PAYMENT LEVELS FOR OBSTETRICAL AND PEDIATRIC SERVICES`

`SEC. 1926. (a)(1) A State plan under this title shall not be considered to meet the requirement of section 1902(a)(30)(A) with respect to obstetrical services (as defined in paragraph (4)(A)), as of July 1 of each year (beginning with 1990), unless, by not later than April 1 of such year, the State submits to the Secretary an amendment to the plan that specifies the payment rates to be used for such services under the plan in the succeeding period and includes in such submission such additional data as will assist the Secretary in evaluating the State's compliance with such requirement, including data relating to how rates established for payments to health maintenance organizations under section 1903(m) take into account such payment rates.

`(2) A State plan under this title shall not be considered to meet the requirement of section 1902(a)(30)(A) with respect to pediatric services (as defined in paragraph (4)(B)), as of July 1 of each year (beginning with 1990), unless, by not later than April 1 of such year, the State submits to the Secretary an amendment to the plan that specifies, by pediatric procedure, the payment rates to be used for such services under the plan in the succeeding period and includes in such submission such additional data as will assist the Secretary in evaluating the State's compliance with such requirement, including data relating to how rates established for payments to health maintenance organizations under section 1903(m) take into account such payment rates.

`(3) The Secretary, by not later than 90 days after the date of submission of a plan amendment under paragraph (1) or (2), shall--

`A) review each such amendment for compliance with the requirement of section 1902(a)(30)(A), and

`B) approve or disapprove each such amendment.
If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement.

(4) In this section:

(A) The term ‘obstetrical services' means services relating to pregnancy covered under the State plan provided by an obstetrician, obstetrician-gynecologist, family practitioner, certified nurse midwife, or certified family nurse practitioner and does not include inpatient or outpatient hospital services or other institutional services.

(B) The term ‘pediatric services' means services covered under the State plan provided by a pediatrician, family practitioner, or certified pediatric nurse practitioner to children under 18 years of age and does not include inpatient or outpatient hospital services or other institutional services.

(b) For amendments submitted under subsection (a)(1) in 1992 and thereafter, the data submitted under such subsection must include, for the second previous year, at least the statewide average payment rates under the State plan for obstetrical services furnished by obstetricians, obstetrician-gynecologists, family practitioners, certified family nurse practitioners, and certified nurse midwives, by procedure. Such information shall be provided separately for providers located in each metropolitan statistical area (or similar area) in the State and in the remainder of the State.

(c) For amendments submitted under subsection (a)(2) in 1992 and thereafter, the data submitted under such subsection must include, for the second previous year, at least the statewide average payment rates under the State plan for pediatric services furnished by pediatricians, family practitioners, and certified pediatric nurse practitioners by procedure. Such information shall be provided separately for providers located in each metropolitan statistical area (or similar area) in the State and in the remainder of the State.

(d) Nothing in this title (including section 1902(a)(30)(A)) shall be construed as preventing a State from establishing payment levels for obstetrical or pediatric services that are higher for those services furnished in rural areas than those furnished in metropolitan statistical areas.'.

(c) PAYMENT FOR CERTAIN SERVICES IN CERTAIN FEDERALLY-FUNDED HEALTH CENTERS-

(1) COVERAGE- Section 1905(a)(2) of the Social Security Act (42 U.S.C. 1396d(a)(2)) is amended by striking ‘and' before ‘(B)' and by inserting before the semicolon at the end the following: ‘, and (C) ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age'.

(2) PAYMENT AMOUNTS- Section 1902(a)(13)(E) of such Act (42 U.S.C. 1396a(a)(13)(E)) is amended by inserting ‘, and for payment for services
described in section 1905(a)(2)(C) under the plan,' after `provided by a rural health clinic under the plan'.

(d) EFFECTIVE DATE- (1) The amendments made by subsections (a) and (b) (except as otherwise provided in such amendments) shall take effect on the date of the enactment of this Act.

(2)(A) The amendments made by subsection (c) apply (except as provided under subparagraph (B)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsection (c), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 6403. EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES DEFINED.

(a) IN GENERAL- Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

`\(r\) The term `early and periodic screening, diagnostic, and treatment services' means the following items and services:

\(1\) Screening services--

\(A\) which are provided--

\(i\) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care, and

\(ii\) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and

\(B\) which shall at a minimum include--

\(i\) a comprehensive health and developmental history (including assessment of both physical and mental health development),

\(ii\) a comprehensive unclothed physical exam,

\(iii\) appropriate immunizations according to age and health history,

\(iv\) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and
(v) health education (including anticipatory guidance).

(2) Vision services--
  (A) which are provided--
  (i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
  (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
  (B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

(3) Dental services--
  (A) which are provided--
  (i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and
  (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
  (B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

(4) Hearing services--
  (A) which are provided--
  (i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
  (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
  (B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

(5) Such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan. Nothing in this title shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services.

(b) REPORT ON PROVISION OF EPSDT- Section 1902(a)(43) of such Act (42 U.S.C. 1396a(a)(43)) is amended--
(1) by striking `and' at the end of subparagraph (B),
(2) by striking the semicolon at the end of subparagraph (C) and inserting `and', and
(3) by inserting `and' at the end of subparagraph (D).
(3) by adding at the end the following new subparagraph:
`
(D) reporting to the Secretary (in a uniform form and manner established by the Secretary, by age group and by basis of eligibility for medical assistance, and by not later than April 1 after the end of each fiscal year, beginning with fiscal year 1990) the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year:
  `(i) the number of children provided child health screening services,
  `(ii) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services),
  `(iii) the number of children receiving dental services, and
  `(iv) the State's results in attaining the participation goals set for the State under section 1905(r);`
```
(c) ANNUAL PARTICIPATION GOALS- Section 1905(r) of such Act, as added by subsection (a), is amended by adding at the end the following: `The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this title in early and periodic screening, diagnostic, and treatment services.'.
(d) CONFORMING AMENDMENTS- (1) Section 1902(a)(43)(A) of such Act (42 U.S.C. 1396a(a)(43)(A)) is amended by striking `and treatment services as described in section 1905(a)(4)(B)' and inserting `and treatment services as described in section 1905(r)'.
(2) Section 1905(a)(4) of such Act (42 U.S.C. 1396d(a)(4)) is amended by amending clause (B) to read as follows: `early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)) for individuals who are eligible under the plan and are under the age of 21;`
(e) EFFECTIVE DATE- The amendments made by this section shall take effect on April 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 6404. PAYMENT FOR FEDERALLY-QUALIFIED HEALTH CENTER SERVICES.

(a) COVERAGE- Section 1905(a)(2) of the Social Security Act (42 U.S.C. 1396d(a)(2)) is amended--
(1) by striking `and' before `(B)',
(2) by striking `subsection (l)' and inserting `subsection (l)(1)', and
(3) by inserting before the semicolon at the end the following: `Federally-qualified health center services (as defined in subsection (l)(2)) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan'.
(b) TERMS DEFINED- Section 1905(l) of such Act is amended--
(1) by redesignating clauses (1) and (2) as clauses (A) and (B),
(2) by inserting `(1)' after `(l)', and
(3) by adding at the end the following new paragraph:

`(2)(A) The term `Federally-qualified health center services' means services
of the type described in subparagraphs (A) through (C) of section
1861(aa)(1) when furnished to an individual as an outpatient of a Federally-
qualified health center and, for this purpose, any reference to a rural health
clinic or a physician described in section 1861(aa)(2)(B) is deemed a
reference to a Federally-qualified health center or a physician at the center,
respectively.

`(B) The term `Federally-qualified health center' means a facility which--
`(i) is receiving a grant under section 329, 330, or 340 of the Public Health
Service Act, or
`(ii) based on the recommendation of the Health Resources and Services
Administration within the Public Health Service, is determined by the
Secretary to meet the requirements for receiving such a grant.
In applying clause (ii), the Secretary may waive any requirement referred to
in such clause for up to 2 years for good cause shown.'.

(c) PAYMENT AMOUNTS- Section 1902(a)(13)(E) of such Act (42 U.S.C.
1396a(a)(13)(E)) is amended by striking `section 1905(a)(2)(B) provided by
a rural health clinic' and inserting `clause (B) or (C) of section 1905(a)(2)'.

(d) EFFECTIVE DATE- (1) The amendments made by this section apply
(except as provided under paragraph (2)) to payments under title XIX of the
Social Security Act for calendar quarters beginning on or after April 1, 1990,
without regard to whether or not final regulations to carry out such
amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the
Social Security Act which the Secretary of Health and Human Services
determines requires State legislation (other than legislation appropriating
funds) in order for the plan to meet the additional requirements imposed by
the amendments made by this section, the State plan shall not be regarded
as failing to comply with the requirements of such title solely on the basis of
its failure to meet these additional requirements before the first day of the
first calendar quarter beginning after the close of the first regular session of
the State legislature that begins after the date of the enactment of this Act.
For purposes of the previous sentence, in the case of a State that has a 2-
year legislative session, each year of such session shall be deemed to be a
separate regular session of the State legislature.

SEC. 6405. REQUIRED COVERAGE OF NURSE PRACTITIONER SERVICES.

(a) IN GENERAL- Section 1905(a) of the Social Security Act (42 U.S.C.
1396d(a)) is amended--
(1) in paragraph (20), by striking `and';
(2) by redesignating paragraph (21) as paragraph (22); and
(3) by inserting after paragraph (20) the following new paragraph:
"(21) services furnished by a certified pediatric nurse practitioner or certified
family nurse practitioner (as defined by the Secretary) which the certified
pediatric nurse practitioner or certified family nurse practitioner is legally
authorized to perform under State law (or the State regulatory mechanism
provided by State law), whether or not the certified pediatric nurse
practitioner or certified family nurse practitioner is under the supervision of,
or associated with, a physician or other health care provider; and'.
(b) CONFORMING AMENDMENT- Section 1902(a)(10)(A) of such Act (42
U.S.C. 1396a(a)(10)(A)) is amended by striking `(1) through (5) and (17)' and
by inserting `(1) through (5), (17) and (21)'.
(c) EFFECTIVE DATE- The amendments made by this section shall become
effective with respect to services furnished by a certified pediatric nurse
practitioner or certified family nurse practitioner on or after July 1, 1990.

SEC. 6406. REQUIRED MEDICAID NOTICE AND COORDINATION WITH
SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND
CHILDREN (WIC).

(a) STATE PLAN REQUIREMENTS OF NOTICE AND COORDINATION- Section
1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended--
(1) in paragraph (11), by striking `and' before `(B)' and by inserting before
the semicolon at the end the following: `, and (C) provide for coordination of
the operations under this title with the State's operations under the special
supplemental food program for women, infants, and children under section
17 of the Child Nutrition Act of 1966';
(2) by striking `and' at the end of paragraph (51);
(3) by striking the period at the end of paragraph (52) and inserting `; and';
and
(4) by inserting after paragraph (52) the following new paragraph:
`(53) provide--
(A) for notifying in a timely manner all individuals in the State who are
determined to be eligible for medical assistance and who are pregnant
women, breastfeeding or postpartum women (as defined in section 17 of the
Child Nutrition Act of 1966), or children below the age of 5, of the
availability of benefits furnished by the special supplemental food program
under such section, and
(B) for referring any such individual to the State agency responsible for
administering such program.'.
(b) EFFECTIVE DATE- The amendments made by subsection (a) shall take
effect on July 1, 1990, without regard to whether regulations to carry out
such amendments have been promulgated by such date.
SEC. 6407. DEMONSTRATION PROJECTS TO STUDY THE EFFECT OF ALLOWING STATES TO EXTEND MEDICAID TO PREGNANT WOMEN AND CHILDREN NOT OTHERWISE QUALIFIED TO RECEIVE MEDICAID BENEFITS.

(a) IN GENERAL- In order to allow States to develop and carry out innovative programs to extend health insurance coverage to pregnant women and children under age 20 who lack insurance and to encourage workers to obtain health insurance for themselves and their children, the Secretary of Health and Human Services (in this section referred to as the `Secretary') shall enter into agreements with several States submitting applications in accordance with subsection (b) for the purpose of conducting demonstration projects to study the effect on access to health care, private insurance coverage, and costs of health care when such States are allowed to extend benefits under title XIX of the Social Security Act, either directly, in the same manner, or otherwise as alternative assistance authorized in section 1925(b)(4)(D) of such Act, to pregnant women and children under 20 years of age who are not otherwise qualified to receive benefits under such section.

(b) PROJECT REQUIREMENTS- (1) Each State applying to participate in the demonstration project under subsection (a) shall assure the Secretary that eligibility shall be limited to pregnant women and children who have not attained 20 years of age who are in families with income below 185 percent of the income official poverty line (referred to in subsection (c)(1)).

(2) The Secretary shall further provide in conducting demonstration projects under this section that, if one or more of such demonstration projects utilizes employer coverage as allowed under section 1925(b)(4)(D) of the Social Security Act, such project shall require an employer contribution.

(c) PREMIUMS- In the case of pregnant women and children eligible to participate in such demonstration projects whose family income level is--

(1) below 100 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved, there shall be no premium charged; and

(2) between 100 and 185 percent of such income official poverty line, there shall be a premium equal to--

(A) an amount based on a sliding scale relating to income, or

(B) 3 percent of the family's average gross monthly earnings, whichever is less.

(d) DURATION- Each demonstration project under this section shall be conducted for a period not to exceed 3 years.

(e) WAIVER- The Secretary where he deems appropriate may waive the statewideness requirement described in section 1902(a)(1) of the Social Security Act.
(f) LIMIT ON EXPENDITURES- The Secretary in conducting the demonstration projects described in this section shall limit the amount of the Federal share of benefits paid and expenses incurred under title XIX of the Social Security Act to $10,000,000 in each of fiscal years 1990, 1991, and 1992.

(g) EVALUATION AND REPORT- (1) For each demonstration project conducted under this section, the Secretary shall assure that an evaluation is conducted on the effect of the project with respect to--
(A) access to health care;
(B) private health care insurance coverage;
(C) costs with respect to health care; and
(D) developing feasible premium and cost-sharing policies.
(2) The Secretary shall submit to Congress an interim report containing a summary of the evaluations conducted under paragraph (1) not later than January 1, 1992, and a final report containing such summary together with such further recommendations as the Secretary may determine appropriate not later than January 1, 1994.

SEC. 6408. OTHER MEDICAID PROVISIONS.

(a) INSTITUTIONS FOR MENTAL DISEASES-
(1) STUDY- The Secretary of Health and Human Services shall conduct a study of--
(A) the implementation, under current provisions, regulations, guidelines, and regulatory practices under title XIX of the Social Security Act, of the exclusion of coverage of services to certain individuals residing in institutions for mental diseases, and
(B) the costs and benefits of providing services under title XIX of the Social Security Act in public subacute psychiatric facilities which provide services to psychiatric patients who would otherwise require acute hospitalization.
(2) REPORT- By not later than October 1, 1990, the Secretary shall submit a report to Congress on the study and shall include in the report recommendations respecting--
(A) modifications in such provisions, regulations, guidelines, and practices, if any, that may be appropriate to accommodate changes that may have occurred since 1972 in the delivery of psychiatric and other mental health services on an inpatient basis to such individuals, and
(B) the continued coverage of services provided in subacute psychiatric facilities under title XIX of the Social Security Act.
(3) MORATORIUM ON TREATMENT OF CERTAIN FACILITIES- Any determination by the Secretary that Kent Community Hospital Complex in Michigan or Saginaw Community Hospital in Michigan is an institution for mental diseases, for purposes of title XIX of the Social Security Act shall not
take effect until 180 days after the date the Congress receives the report required under paragraph (2).

(b) EXTENSION OF TEXAS PERSONAL CARE SERVICES WAIVER- Section 9523(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended by section 4115(d) of the Omnibus Budget Reconciliation Act of 1987 (added by section 411(k)(9)(C) of the Medicare Catastrophic Coverage Act of 1988), is amended by striking `January 1, 1990' and inserting `July 1, 1990'.

(c) HOSPICE PAYMENT FOR ROOM AND BOARD-
(1) IN GENERAL- Section 1902(a)(13)(D) of the Social Security Act (42 U.S.C. 1396a(a)(13)(D)) is amended--
(A) by striking `in the same amounts, and using the same methodology, as used' and inserting `in amounts no lower than the amounts, using the same methodology, used', and
(B) by striking `a separate rate may be paid for' and inserting `in the case of', and
(C) by striking `to take into account the room and board furnished by such facility' and inserting `there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual'.
(2) EFFECTIVE DATE- The amendments made by paragraph (1) shall apply to services furnished on or after April 1, 1990, without regard to whether or not final regulations have been promulgated by such date to implement such amendments.

(d) MEDICARE BUY-IN FOR PREMIUMS OF CERTAIN WORKING DISABLED-
(1) IN GENERAL- Section 1902(a)(10)(E) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)) is amended--
(A) by inserting `(i)' after `(E)',
(B) by striking the semicolon at the end and inserting `, and', and
(C) by adding at the end the following new clause:
`(ii) for making medical assistance available for payment of medicare cost-sharing described in section 1905(p)(3)(A)(i) for qualified disabled and working individuals described in section 1905(s);';
(2) ELIGIBILITY- Section 1905 of such Act (42 U.S.C. 1396d), as amended by section 6403(a) of this subtitle, is amended by adding at the end the following new subsection:
`(s) The term `qualified disabled and working individual' means an individual--
`(1) who is entitled to enroll for hospital insurance benefits under part A of title XVIII under section 1818A (as added by 6012 of the Omnibus Budget Reconciliation Act of 1989);
`(2) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed 200 percent of the
official poverty line (as defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;

(3) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual or a couple (in the case of an individual with a spouse) may have and obtain benefits for supplemental security income benefits under title XVI; and

(4) who is not otherwise eligible for medical assistance under this title.'.

(3) PREMIUM PAYMENTS REQUIRED FOR CERTAIN INDIVIDUALS- Section 1916 of such Act (42 U.S.C. 1396o) is amended--
(A) in subsection (a), by striking `(E)' and inserting `(E)(i)',
(B) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively, and
(C) by inserting after subsection (c) the following new subsection:
`(d) With respect to a qualified disabled and working individual described in section 1905(s) whose income (as determined under paragraph (3) of that section) exceeds 150 percent of the official poverty line referred to in that paragraph, the State plan of a State may provide for the charging of a premium (expressed as a percentage of the medicare cost-sharing described in section 1905(p)(3)(A)(i) provided with respect to the individual) according to a sliding scale under which such percentage increases from 0 percent to 100 percent, in reasonable increments (as determined by the Secretary), as the individual's income increases from 150 percent of such poverty line to 200 percent of such poverty line.'.

(4) CONFORMING AMENDMENTS-
(A) Section 1905(p)(3) of such Act (42 U.S.C. 1396d(p)(3)) is amended--
(i) by amending subparagraph (A) to read as follows:
`(A)(i) premiums under section 1818, and
`(ii) premiums under section 1839,'; and
(ii) in subparagraph (A) as so amended, by striking `section 1818' and inserting `section 1818 or 1818A'.
(B) Section 1905(p)(1)(A) of such Act is amended by inserting `, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1818A' after `1818'.
(C) Section 1902(f) of such Act (42 U.S.C. 1396a(f)) is amended by inserting `; except with respect to qualified disabled and working individuals (described in section 1905(s)), after `1619(b)(3)'.

(5) EFFECTIVE DATE-
(A) The amendments made by this subsection apply (except as provided under subparagraph (B)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.
(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this subsection, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

**PART 2--TECHNICAL AND MISCELLANEOUS PROVISIONS**

SEC. 6411. MISCELLANEOUS MEDICAID TECHNICAL AMENDMENTS.

(a) TECHNICAL CORRECTION TO MEDICARE BUY-IN FOR THE ELDERLY-
(1) CLARIFICATION WITH RESPECT TO `SECTION 209(B)' STATES- The first sentence of section 1902(f) of the Social Security Act (42 U.S.C. 1396a(f)) is amended by inserting `and except with respect to qualified medicare beneficiaries, qualified severely impaired individuals, and individuals described in subsection (m)(1)' before `, no State'.
(2) EFFECTIVE DATE- The amendment made by paragraph (1) shall apply as if it had been included in the enactment of the Medicare Catastrophic Coverage Act of 1988.

(b) EXTENSION OF DELAY IN ISSUANCE OF CERTAIN FINAL REGULATIONS- Section 8431 of the Technical and Miscellaneous Revenue Act of 1988 is amended by striking `May 1, 1989' and inserting `December 31, 1990'.

(c) DISPROPORTIONATE SHARE HOSPITALS-
(1) SPECIAL RULE FOR NEW JERSEY UNCOMPENSATED CARE TRUST FUND- Section 1923(e)(1) of the Social Security Act (42 U.S.C. 1396r-4(e)(1)) is amended--
(A) by inserting `(A)(i)' after `without regard to the requirement of subsection (a) if', and
(B) by striking `and if' and inserting `or (ii) the plan as of January 1, 1987, provided for payment adjustments based on a statewide pooling arrangement involving all acute care hospitals and the arrangement provides for reimbursement of the total amount of uncompensated care provided by each participating hospital, and (B)'.

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(2) CONFORMING AMENDMENT- Section 1915(b)(4) of such Act (42 U.S.C. 1396n(b)(4)) is amended by inserting `shall be consistent with the requirements of section 1923 and' after `which standards'.

(3) TRANSITION RULE- The State of Missouri shall be treated as having met the requirement of section 1902(a)(13)(A) of the Social Security Act (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs) for the period beginning with July 1, 1988, and ending with (and including) June 30, 1990, if the total amount of such payments for such period is not less than the total of such payments otherwise required by law for such period.

(4) EFFECTIVE DATE- The amendment made by paragraph (2) shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

(d) FRAUD AND ABUSE TECHNICAL AMENDMENTS-

(1) TREATMENT OF LOSS OF RIGHT TO RENEW LICENSE- Section 1128(b)(4)(A) of the Social Security Act (42 U.S.C. 1396a-7(b)(4)(A)) is amended by inserting `or the right to apply for or renew such a license' after `lost such a license'.

(2) CLARIFICATION WITH RESPECT TO EMERGENCY TREATMENT- Sections 1862(e)(1) and 1903(i)(2) of such Act (42 U.S.C. 1395y(e)(1), 1396b(i)(2)) are each amended by inserting `, not including items or services furnished in an emergency room of a hospital' after `emergency item or service'.

(3) CLARIFICATION OF EXCLUSION WITH RESPECT TO EMPLOYMENT BY HEALTH MAINTENANCE ORGANIZATIONS- (A) Section 1876(i)(6)(A) of the Social Security Act (42 U.S.C. 1395mm(i)(6)(A)) is amended--

(i) by striking `or' at the end of clause (v),

(ii) by adding `or' at the end of clause (vi), and

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

`(vii) in the case of a risk-sharing contract, employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services;'.

(B) Section 1902(p)(2) of such Act (42 U.S.C. 1396a(p)(2)) is amended--

(i) by striking `or' at the end of subparagraph (A),

(ii) by striking the period at the end of subparagraph (B) and inserting `or', and

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

`(C) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative
services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services.

(4) EFFECTIVE DATES- The amendments made by paragraphs (1) and (2) shall take effect on the date of the enactment of this Act. The amendments made by paragraph (3) shall apply to employment and contracts as of 90 days after the date of the enactment of this Act.

(e) SPOUSAL IMPOVERISHMENT-

(1) EQUAL TREATMENT OF TRANSFERS BY COMMUNITY SPOUSE BEFORE INSTITUTIONALIZATION- Section 1917(c) of the Social Security Act (42 U.S.C. 1396p(c)) is amended--

(A) in paragraph (1), by inserting `or whose spouse,' after `an institutionalized individual (as defined in paragraph (3)) who,', and

(B) in paragraph (2)(B)--

(i) by amending clause (i) to read as follows: `(i) to or from (or to another for the sole benefit of) the individual's spouse, or', and

(ii) by striking `, or (iii)' and all that follows through `fair market value'.

(2) CLARIFYING APPLICATION TO `SECTION 209(B)' STATES- Section 1902(f) of such Act (42 U.S.C. 1396a(f)) is amended by inserting `and section 1924' after `1619(b)(3)'.

(3) CLARIFICATION OF APPLICATION OF INCOME RULES TO REDETERMINATIONS- Subsections (b)(2) and (d)(1) of section 1924 of such Act (42 U.S.C. 1396r-5) are amended by inserting `or redetermined' after `determined'.

(4) EFFECTIVE DATES-

(A) SPOUSAL TRANSFERS- The amendments made by paragraph (1) shall apply to transfers occurring after the date of the enactment of this Act.

(B) OTHER AMENDMENTS- Except as provided in subparagraph (A), the amendments made by this subsection shall apply as if included in the enactment of section 303 of the Medicare Catastrophic Coverage Act of 1988.

(f) EXTENSION OF WAIVER FOR HEALTH INSURING ORGANIZATION- The Secretary of Health and Human Services shall continue to waive, through June 30, 1992, the application of section 1903(m)(2)(A)(ii) of the Social Security Act to the Tennessee Primary Care Network, Inc., under the same terms and conditions as applied to such waiver as of July 1, 1989.

(g) DAY HABILITATION AND RELATED SERVICES-

(1) PROHIBITION OF DISALLOWANCE PENDING ISSUANCE OF REGULATIONS- Except as specifically permitted under paragraph (3), the Secretary of Health and Human Services may not--

(A) withhold, suspend, disallow, or deny Federal financial participation under section 1903(a) of the Social Security Act for day habilitation and related services under paragraph (9) or (13) of section 1905(a) of such Act on behalf of persons with mental retardation or with related conditions pursuant to a provision of its State plan as approved on or before June 30, 1989, or
(B) withdraw Federal approval of any such State plan provision.

(2) REQUIREMENTS FOR REGULATION- A final regulation described in this paragraph is a regulation, promulgated after a notice of proposed rule-making and a period of at least 60 days for public comment, that--

(A) specifies the types of day habilitation and related services that a State may cover under paragraph (9) or (13) of section 1905(a) of the Social Security Act on behalf of persons with mental retardation or with related conditions, and

(B) any requirements respecting such coverage.

(3) PROSPECTIVE APPLICATION OF REGULATION- If the Secretary promulgates a final regulation described in paragraph (2) and the Secretary determines that a State plan under title XIX of the Social Security Act does not comply with such regulation, the Secretary shall notify the State of the determination and its basis, and such determination shall not apply to day habilitation and related services furnished before the first day of the first calendar quarter beginning after the date of the notice to the State.

(h) MORATORIUM ON ISSUANCE OF FINAL REGULATION ON MEDICALLY NEEDY INCOME LEVELS FOR CERTAIN 1-MEMBER FAMILIES- The Secretary of Health and Human Services may not issue in final form, before December 31, 1990, any regulation implementing the proposed regulation published on September 26, 1989 (54 Federal Register 39421) insofar as such regulation changes the method for establishing the medically needy income level for single individuals in any State (including the proposed change to section 435.1007(a)(1) of title 42, Code of Federal Regulations).

(i) TECHNICAL CORRECTIONS CONCERNING TRANSITIONAL COVERAGE-

(1) CLARIFICATION OF TERMINATION WHEN NO CHILD IN HOUSEHOLD- Subsections (a)(3)(A) and (b)(3)(A)(i) of section 1925 of the Social Security Act (42 U.S.C. 1396r-6) are each amended by striking `who is' and inserting `whether or not the child is'.

(2) EFFECTIVE DATE FOR TERMINATION OF CURRENT 9-MONTH EXTENSION- Section 303(f)(2)(A) of the Family Support Act of 1988 is amended by inserting before the period at the end the following: `but such amendment shall not apply with respect to families that cease to be eligible for aid under part A of title IV of the Social Security Act before such date'.

(3) CORRECTION OF REFERENCES- Subsections (a)(3)(C) and (b)(3)(C)(i) of section 1925 of the Social Security Act (42 U.S.C. 1396r-6) are each amended by striking `or (v) of section 1905(a)' and inserting `of section 1905(a) or clause (i)(IV), (i)(VI), or (ii)(IX) of section 1902(a)(10)(A)'.

(4) EFFECTIVE DATE- The amendments made by this subsection shall be effective as if included in the enactment of the Family Support Act of 1988.

(j) MINNESOTA PREPAID MEDICAID DEMONSTRATION PROJECT EXTENSION- Section 507 of the Family Support Act of 1988 is amended by striking `1990' and inserting `1991'.

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Subtitle C--Maternal and Child Health Block Grant Program

SEC. 6501. INCREASE IN AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL- Section 501 of the Social Security Act (42 U.S.C. 701) is amended--
(1) by amending subsection (a) to read as follows:
`'(a) To improve the health of all mothers and children consistent with the applicable health status goals and national health objectives established by the Secretary under the Public Health Service Act for the year 2000, there are authorized to be appropriated $686,000,000 for fiscal year 1990 and each fiscal year thereafter--
'(1) for the purpose of enabling each State--
'(A) to provide and to assure mothers and children (in particular those with low income or with limited availability of health services) access to quality maternal and child health services;
'(B) to reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, to reduce the need for inpatient and long-term care services, to increase the number of children (especially preschool children) appropriately immunized against disease and the number of low income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise to promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low income, at-risk pregnant women, and to promote the health of children by providing preventive and primary care services for low income children;
'(C) to provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under title XVI, to the extent medical assistance for such services is not provided under title XIX; and
'(D) to provide and to promote family-centered, community-based, coordinated care (including care coordination services, as defined in subsection (b)(3)) for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families;
'(2) for the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for special projects of regional and national significance, research, and training with respect to maternal and child health and children with special health care needs (including early intervention training and services development), for genetic disease testing, counseling, and information development and dissemination programs, for grants (including funding for comprehensive hemophilia diagnostic treatment centers) relating to hemophilia without regard to age, and for the screening
of newborns for sickle cell anemia, and other genetic disorders and follow-up services; and

`(3) subject to section 502(b) for the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for developing and expanding the following--

`(A) maternal and infant health home visiting programs in which case management services as defined in subparagraphs (A) and (B) of subsection (b)(4), health education services, and related social support services are provided in the home to pregnant women or families with an infant up to the age one by an appropriate health professional or by a qualified nonprofessional acting under the supervision of a health care professional,

`(B) projects designed to increase the participation of obstetricians and pediatricians under the program under this title and under state plans approved under title XIX,

`(C) integrated maternal and child health service delivery systems (of the type described in section 1136 and using, once developed, the model application form developed under section 6506(a) of the Omnibus Budget Reconciliation Act of 1989),

`(D) maternal and child health centers which (i) provide prenatal, delivery, and postpartum care for pregnant women and preventive and primary care services for infants up to age one, and (ii) operate under the direction of a not-for-profit hospital,

`(E) maternal and child health projects to serve rural populations, and

`(F) outpatient and community based services programs (including day care services) for children with special health care needs whose medical services are provided primarily through inpatient institutional care.', and

(2) by adding at the end of subsection (b) the following new paragraphs:

`(3) The term `care coordination services' means services to promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families.

`(4) The term `case management services' means--

`(A) with respect to pregnant women, services to assure access to quality prenatal, delivery, and postpartum care; and

`(B) with respect to infants up to age one, services to assure access to quality preventive and primary care services.'.

(b) CONFORMING AMENDMENT- Section 505(2)(C)(ii) of such Act (42 U.S.C. 705(2)(C)(ii)) is amended by striking `paragraphs (1) through (3) of section 501(a)' and inserting `subparagraphs (A) through (D) of section 501(a)(1)'.

SEC. 6502. ALLOTMENTS TO STATE AND FEDERAL SET-ASIDES.
(a) IN GENERAL- Section 502 of the Social Security Act (42 U.S.C. 702) is amended--

(1) by amending the first sentence of paragraph (1) of subsection (a) to read as follows: `Of the amounts appropriated under section 501(a) for a fiscal year that are not in excess of $600,000,000, the Secretary shall retain an amount equal to 15 percent for the purpose of carrying out activities described in section 501(a)(2).';

(2) in subsection (a)(3), by inserting `or subsection (b)'' after `this subsection'';

(3) by striking subsection (c), by redesignating subsection (b) as subsection (c), and by inserting after subsection (a) the following new subsection:

`(b)(1)(A) Of the amounts appropriated under section 501(a) for a fiscal year in excess of $600,000,000 the Secretary shall retain an amount equal to 12 3/4 percent thereof for the projects described in subparagraphs (A) through (F) of section 501(a)(3).

`(B) Any amount appropriated under section 501(a) for a fiscal year in excess of $600,000,000 that remains after the Secretary has retained the applicable amount (if any) under subparagraph (A) shall be retained by the Secretary in accordance with subsection (a) and allocated to the States in accordance with subsection (c).

`(2)(A) Of the amounts retained for the purpose of carrying out activities described in section 501(a)(3)(A), (B), (C), (D) and (E), the Secretary shall provide preference to qualified applicants which demonstrate that the activities to be carried out with such amounts shall be in areas with a high infant mortality rate (relative to the average infant mortality rate in the United States or in the State in which the area is located).

`(B) In carrying out activities described in section 501(a)(3)(D), the Secretary shall not provide for developing or expanding a maternal and child health center unless the Secretary has received satisfactory assurances that there will be applied, towards the costs of such development or expansion, non-Federal funds in an amount at least equal to the amount of funds provided under this title toward such development or expansion.'; and

(4) in subsection (c), as redesignated by paragraph (2)--

(A) by striking `$478,000,000' and inserting `$600,000,000', and

(B) by amending paragraph (2) to read as follows:

`(2) Each such State shall be allotted for each fiscal year an amount equal to the sum of--

`(A) the amount of the allotment to the State under this subsection in fiscal year 1983, and

`(B) the State's proportion (determined under paragraph (1)(B)(ii)) of the amount by which the allotment available under this subsection for all the States for that fiscal year exceeds the amount that was available under this subsection for allotment for all the States for fiscal year 1983.'.
(b) CONFORMING AMENDMENTS- Sections 503(a) and 508(b) of such Act (42 U.S.C. 703(a), 708(b)) are amended by striking `502(b)' each place it appears and inserting `502(c)'.

SEC. 6503. USE OF ALLOTMENT FUNDS AND APPLICATION FOR BLOCK GRANT FUNDS.

(a) EXPANDING USE OF FUNDS AND LIMITATION ON USE OF FUNDS FOR ADMINISTRATIVE COSTS- Section 504 of the Social Security Act (42 U.S.C. 704) is amended--
(1) in subsection (a), by inserting `and including payment of salaries and other related expenses of National Health Service Corps personnel' after `education, and evaluation', and
(2) by adding at the end the following new subsection:
`(d) Of the amounts paid to a State under section 503 from an allotment for a fiscal year under section 502(c), not more than 10 percent may be used for administering the funds paid under such section.'.

(b) APPLICATION- Section 505 of such Act (42 U.S.C. 705) is amended--
(1) by amending the heading to read as follows:
`APPLICATION FOR BLOCK GRANT FUNDS';
(2) by inserting `(a)' after `SEC. 505.';
(3) in the matter before paragraph (1), by inserting `an application (in a standardized form specified by the Secretary) that' after `must prepare and transmit to the Secretary';
(4) by striking paragraph (1) and redesignating paragraph (2) as paragraph (5) and by inserting before paragraph (5), as redesignated, the following new paragraphs:
`(1) contains a statewide needs assessment (to be conducted every 5 years) that shall identify (consistent with the health status goals and national health objectives referred to in section 501(a)) the need for--
`(A) preventive and primary care services for pregnant women, mothers, and infants up to age one; 
`(B) preventive and primary care services for children; and
`(C) services for children with special health care needs (as specified in section 501(a)(1)(D));
`(2) includes for each fiscal year--
`(A) a plan for meeting the needs identified by the statewide needs assessment under paragraph (1); and
`(B) a description of how the funds allotted to the State under section 502(c) will be used for the provision and coordination of services to carry out such plan that shall include--
`(i) subject to paragraph (3), a statement of the goals and objectives consistent with the health status goals and national health objectives referred to in section 501(a) for meeting the needs specified in the State plan described in subparagraph (A);

` (ii) an identification of the areas and localities in the State in which services are to be provided and coordinated;

` (iii) an identification of the types of services to be provided and the categories or characteristics of individuals to be served; and

` (iv) information the State will collect in order to prepare reports required under section 506(a);

` (3) except as provided under subsection (b), provides that the State will use--

` (A) at least 30 percent of such payment amounts for preventive and primary care services for children, and

` (B) at least 30 percent of such payment amounts for services for children with special health care needs (as specified in section 501(a)(1)(D));

` (4) provides that a State receiving funds for maternal and child health services under this title shall maintain the level of funds being provided solely by such State for maternal and child health programs at a level at least equal to the level that such State provided for such programs in fiscal year 1989; and'; and

` (5) in paragraph (5), as redesignated by paragraph (4) of this subsection--

` (A) by striking `a statement of assurances that represents to the Secretary' and inserting `provides';

` (B) in subparagraph (A), by striking `will provide' and inserting `will establish';

` (C) by amending subparagraph (C)(i) to read as follows:

` (i) special consideration (where appropriate) for the continuation of the funding of special projects in the State previously funded under this title (as in effect before August 31, 1981), and';

` (D) in subparagraph (D), by striking `and' at the end;

` (E) by redesignating subparagraph (E) as subparagraph (F) and by inserting after subparagraph (D) the following new subparagraph:

` (E) the State agency (or agencies) administering the State's program under this title will provide for a toll-free telephone number (and other appropriate methods) for the use of parents to access information about health care providers and practitioners who provide health care services under this title and title XIX and about other relevant health and health-related providers and practitioners; and'; and

` (F) in subparagraph (F) (as redesignated by subparagraph (E))--

` (i) by striking `participate' before clause (i),

` (ii) in clause (i), by striking `diagnosis' and inserting `diagnostic',
(iii) in clause (i), by striking `title XIX' and inserting `section 1905(a)(4)(B) (including the establishment of periodicity and content standards for early and periodic screening, diagnostic, and treatment services)',
(iv) by inserting `participate' after `(i)', after `(ii)', and after `(iii)',
(v) by striking `and' at the end of clause (ii),
(vi) by striking the period at the end of clause (iii) and inserting `, and', and
(vii) by inserting after clause (iii) the following new clause:
`(iv) provide, directly and through their providers and institutional contractors, for services to identify pregnant women and infants who are eligible for medical assistance under subparagraph (A) or (B) of section 1902(l)(1) and, once identified, to assist them in applying for such assistance.';
(6) by striking the last 2 sentences and inserting the following:
`The application shall be developed by, or in consultation with, the State maternal and child health agency and shall be made public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during its development and after its transmittal.'; and
(7) by adding at the end the following new subsection:
`(b) The Secretary may waive the requirement under subsection (a)(3) that a State's application for a fiscal year provide for the use of funds for specific activities if for that fiscal year--
`(1) the Secretary determines--
`(A) on the basis of information provided in the State's most recent annual report submitted under section 506(a)(1), that the State has demonstrated an extraordinary unmet need for one of the activities described in subsection (a)(3), and
`(B) that the granting of the waiver is justified and will assist in carrying out the purposes of this title; and
`(2) the State provides assurances to the Secretary that the State will provide for the use of some amounts paid to it under section 503 for the activities described in subparagraphs (A) and (B) of subsection (a)(3) and specifies the percentages to be substituted in each of such subparagraphs.'.
(c) CONFORMING AMENDMENTS- (1) Section 502(c) of such Act (42 U.S.C. 702(c)), as redesignated by section 6502(a)(3) of this subtitle, is amended by striking `a description of intended activities and statement of assurances' and inserting `an application'.
(2) Section 504(a) of such Act (42 U.S.C. 704(a)) is amended by striking `its description of intended expenditures and statement of assurances' and insert `its application'.
(3) Section 506(a)(1)(C) of such Act (42 U.S.C. 706(a)(1)(C)) is amended by striking `description and statement' and inserting `application'.
(4) Sections 502(b), 502(d)(1), 503(c), 504(a), 506(a)(1)(C), and 509(a)(6) of such Act (42 U.S.C. 702(b), 702(d)(1), 703(c), 704(a), 706(a)(1)(C),
are each amended by striking `505' each place it appears and inserting `505(a)'.

SEC. 6504. REPORTS.

(a) STATE REPORTS- Subsection (a) of section 506 of the Social Security Act (42 U.S.C. 706) is amended--
(1) in paragraph (1)--
(A) by inserting after the first sentence the following: `Each such report shall be prepared by, or in consultation with, the State maternal and child health agency.',
(B) by striking `be in such form and contain such information' and inserting `be in such standardized form and contain such information (including information described in paragraph (2))', and
(C) by striking `and of the progress made toward achieving the purposes of this title, and (C)' and inserting `, (C) to describe the extent to which the State has met the goals and objectives it set forth under section 505(a)(2)(B)(i) and the national health objectives referred to in section 501(a), and (D)';
(2) by redesignating paragraph (2) as paragraph (3); and
(3) by inserting after paragraph (1) the following new paragraph:
`(2) Each annual report under paragraph (1) shall include the following information:
(A)(i) The number of individuals served by the State under this title (by class of individuals).
(iii) The types (as defined by the Secretary) of services provided under this title to individuals within each such class.
(iv) The amounts spent under this title on each type of services, by class of individuals served.
(B) Information on the status of maternal and child health in the State, including--
(i) information (by county and by racial and ethnic group) on--
(I) the rate of infant mortality, and
(II) the rate of low-birth-weight births;
(ii) information (on a State-wide basis) on--
(I) the rate of maternal mortality,
(II) the rate of neonatal death,
(III) the rate of perinatal death,
(IV) the number of children with chronic illness and the type of illness,
(V) the proportion of infants born with fetal alcohol syndrome,
(VI) the proportion of infants born with drug dependency,
(VII) the proportion of women who deliver who do not receive prenatal care during the first trimester of pregnancy, and
(VIII) the proportion of children, who at their second birthday, have been vaccinated against each of measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Hib meningitis, and hepatitis B; and
(iii) information on such other indicators of maternal, infant, and child health care status as the Secretary may specify.
(C) Information (by racial and ethnic group) on--
(i) the number of deliveries in the State in the year, and
(ii) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under the State plan under title XIX in the year.
(B) Information (by racial and ethnic group) on--
(i) the number of infants under one year of age who were in the State in the year, and
(ii) the number of such infants who were provided services under this title or were entitled to benefits under the State plan under title XIX at any time during the year.
(E) Information on the number of--
(i) obstetricians,
(ii) family practitioners,
(iii) certified family nurse practitioners,
(iv) certified nurse midwives,
(v) pediatricians, and
(vi) certified pediatric nurse practitioners,
who were licensed in the State in the year.
For purposes of subparagraph (A), each of the following shall be considered to be a separate class of individuals: pregnant women, infants up to age one, children with special health care needs, other children under age 22, and other individuals.'.
(b) SECRETARIAL REPORT- Paragraph (3) of subsection (a) of such section, as redesignated by subsection (a)(2) of this section, is amended to read as follows:
(3) The Secretary shall annually transmit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report that includes--
(A) a description of each project receiving funding under paragraph (2) or (3) of section 502(a), including the amount of Federal funds provided, the number of individuals served or trained, as appropriate, under the project, and a summary of any formal evaluation conducted with respect to the project;
(B) a summary of the information described in paragraph (2)(A) reported by States;
(C) based on information described in paragraph (2)(B) supplied by the States under paragraph (1), a compilation of the following measures of maternal and child health in the United States and in each State:

(i) Information on--
(I) the rate of infant mortality, and
(II) the rate of low-birth-weight births.
Information under this clause shall also be compiled by racial and ethnic group.

(ii) Information on--
(I) the rate of maternal mortality,
(II) the rate of neonatal death,
(III) the rate of perinatal death,
(IV) the proportion of infants born with fetal alcohol syndrome,
(V) the proportion of infants born with drug dependency,
(VI) the proportion of women who deliver who do not receive prenatal care during the first trimester of pregnancy, and
(VII) the proportion of children, who at their second birthday, have been vaccinated against each of measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Hib meningitis, and hepatitis B.

(iii) Information on such other indicators of maternal, infant, and child health care status as the Secretary has specified under paragraph (2)(B)(iii).

(iv) Information (by racial and ethnic group) on--
(I) the number of deliveries in the State in the year, and
(II) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under the State plan under title XIX in the year;

(D) based on information described in subparagraphs (C), (D), and (E) of paragraph (2) supplied by the States under paragraph (1), a compilation of the following information in the United States and in each State:

(i) Information on--
(I) the number of deliveries in the year, and
(II) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under a State plan under title XIX in the year.
Information under this clause shall also be compiled by racial and ethnic group.

(ii) Information on--
(I) the number of infants under one year of age in the year, and
(II) the number of such infants who were provided services under this title or were entitled to benefits under a State plan under title XIX at any time during the year.
Information under this clause shall also be compiled by racial and ethnic group.

(iii) Information on the number of--
(I) obstetricians,
(II) family practitioners,
(III) certified family nurse practitioners,
(IV) certified nurse midwives,
(V) pediatricians, and
(VI) certified pediatric nurse practitioners,
who were licensed in a State in the year; and
(E) an assessment of the progress being made to meet the health status goals and national health objectives referred to in section 501(a).

SEC. 6505. FEDERAL ADMINISTRATION AND ASSISTANCE.

Section 509(a) of the Social Security Act (42 U.S.C. 709(a)) is amended--
(1) in paragraph (4) by inserting before the semicolon at the end the following: `and in developing consistent and accurate data collection mechanisms in order to report the information required under section 506(a)(2)';
(2) in paragraph (5) by striking `and' at the end thereof;
(3) in paragraph (6) by striking the period and inserting `; and'; and
(4) by adding at the end thereof the following new paragraphs:
(7) assisting States in the development of care coordination services (as defined in section 501(b)(3)); and
(8) developing and making available to the State agency (or agencies) administering the State's program under this title a national directory listing by State the toll-free numbers described in section 505(a)(5)(E).

SEC. 6506. DEVELOPMENT OF MODEL APPLICATIONS.

(a) FOR MATERNAL AND CHILD ASSISTANCE PROGRAMS-
(1) IN GENERAL- The Secretary of Health and Human Services shall develop, by not later than one year after the date of the enactment of this Act and in consultation with the Secretary of Agriculture, a model application form for use in applying, simultaneously, for assistance for a pregnant woman or a child less than 6 years of age under maternal and child assistance programs (as defined in paragraph (3)). In developing such form, the Secretary is not authorized to change any requirement with respect to eligibility under any maternal and child assistance program.
(2) DISSEMINATION OF MODEL FORM- The Secretary shall provide for publication in the Federal Register of the model application form developed under paragraph (1) and shall send a copy of such form to each State.
agency responsible for administering a maternal and child assistance
program.
(3) MATERNAL AND CHILD ASSISTANCE PROGRAM DEFINED- In this
subsection, the term `maternal and child assistance program' means any of
the following programs:
(A) The maternal and child health services block grant program under title V
of the Social Security Act.
(B) The medicaid program under title XIX of the Social Security Act.
(C) The migrant and community health centers programs under sections 329
and 330 of the Public Health Service Act.
(D) The grant program for the homeless under section 340 of the Public
Health Service Act.
(F) The head start program under the Head Start Act.
(b) FOR MEDICAID PROGRAM-
(1) IN GENERAL- The Secretary of Health and Human Services shall, by not
later than 1 year after the date of the enactment of this Act, develop a
model application form for use in applying for benefits under title XIX of the
Social Security Act for individuals who are not receiving cash assistance
under part A of title IV of the Social Security Act, and who are not
institutionalized. In developing such model application form, the Secretary is
not authorized to require that such form be adopted by States as part of
their State medicaid plan.
(2) DISSEMINATION OF MODEL FORM- The Secretary shall provide for
publication in the Federal Register of the model application form developed
under paragraph (1), and shall send a copy of such form to each State
agency responsible for administering a State medicaid plan.

SEC. 6507. RESEARCH ON INFANT MORTALITY AND
MEDICAID SERVICES.

The Secretary of Health and Human Services shall develop a national data
system for linking, for any infant up to age one--
(1) the infant's birth record,
(2) any death record for the infant, and
(3) information on any claims submitted under title XIX of the Social
Security Act for health care furnished to the infant or with respect to the
birth of the infant.

SEC. 6508. DEMONSTRATION PROJECT ON HEALTH INSURANCE FOR
MEDICALLY UNINSURABLE CHILDREN.

(a) IN GENERAL- The Secretary of Health and Human Services (in this
section referred to as the `Secretary') may conduct not more than 4
demonstration projects to provide health insurance coverage (as defined by the Secretary) through an eligible plan (as defined in subsection (b)) to medically uninsurable children (as defined by the Secretary) under 19 years of age.

(b) ELIGIBILITY- In this section, the term `eligible plan' means--
(1) a school-based plan;
(2) a plan operated under the direction of a not-for-profit entity offering health insurance; and
(3) a plan operated by a not-for-profit hospital.

c) REQUIREMENTS- A demonstration project conducted under subsection (a) may only be conducted under an agreement between the Secretary and an eligible plan which provides that--
(1) health insurance coverage will be made available under the project for at least 2 years, and, if the eligible plan fails to provide such coverage during such period, the Secretary will guarantee the provision of such coverage;
(2) non-Federal funds will be made available to fund the project at a level not less than--
(A) 50 percent in the first year of such agreement,
(B) 65 percent in the second year of such agreement, and
(C) 80 percent in the third or subsequent year of such agreement;
(3) the plan may not--
(A) restrict health insurance coverage on the basis of a child's medical condition, or
(B) impose waiting periods or exclusions for preexisting conditions;
(4) any premium imposed under the project shall be disclosed in advance of enrollment and shall be varied by the income of individuals; and
(5) with respect to a plan which at the time of entering into such agreement is conducting a project similar to the one described in this subsection such plan must maintain its current level of non-Federal funding at its current level unless such level is less than the applicable level described in paragraph (2).

(d) APPLICATION- No funds may be made available by the Secretary under this section unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, be submitted in such manner, and contain and be accompanied by such information, as the Secretary may specify. No such application may be approved unless it contains assurances that the applicant will use the funds provided only for the purposes specified in the approved application and will establish such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement and accounting of Federal funds paid to the applicant under this section.

(e) EVALUATION AND REPORT-
(1) EVALUATION- The Secretary shall provide for an evaluation of the effects of the demonstration projects conducted under subsection (a) on--
(A) access to health services by previously medically uninsurable children,
(B) the availability of insurance coverage to participating medically
uninsurable children,
(C) the demographic characteristics and health status of participating
medically uninsurable children and their families, and
(D) out-of-pocket health care costs for such families.
(2) REPORT- The Secretary shall submit a report on the demonstration
projects conducted under subsection (a) to the Committee on Energy and
Commerce of the House of Representatives and the Committee on Finance of
the Senate, and shall include in such report a summary of the evaluation
described in paragraph (1).
(f) AUTHORIZATION OF APPROPRIATIONS- There are authorized to be
appropriated to carry out this section $5,000,000, for each of fiscal years

SEC. 6509. MATERNAL AND CHILD HEALTH HANDBOOK.

(a) IN GENERAL-
(1) DEVELOPMENT- The Secretary of Health and Human Services shall
develop a maternal and child health handbook in consultation with the
National Commission to Prevent Infant Mortality and public and private
organizations interested in the health and welfare of mothers and children.
(2) FIELD TESTING AND EVALUATION- The Secretary shall complete
publication of the handbook for field testing by July 1, 1990, and shall
complete field testing and evaluation by June 1, 1991.
(3) AVAILABILITY AND DISTRIBUTION- The Secretary shall make the
handbook available to pregnant women and families with young children,
and shall provide copies of the handbook to maternal and child health
programs (including maternal and child health clinics supported through
either title V or title XIX of the Social Security Act, community and migrant
health centers under sections 329 and 330 of the Public Health Service Act,
the grant program for the homeless under section 340 of the Public Health
Service Act, the 'WIC' program under section 17 of the Child Nutrition Act of
1966, and the head start program under the Head Start Act) that serve
high-risk women. The Secretary shall coordinate the distribution of the
handbook with State maternal and child health departments, State and local
public health clinics, private providers of obstetric and pediatric care, and
community groups where applicable. The Secretary shall make efforts to
involve private entities in the distribution of the handbook under this
paragraph.
(b) AUTHORIZATION OF APPROPRIATIONS- There are authorized to be
appropriated $1,000,000 for each of fiscal years 1991, 1992, and 1993, for
carrying out the purposes of this section.
SEC. 6510. EFFECTIVE DATES.

(a) IN GENERAL- Except as provided in subsection (b), the amendments made by this subtitle shall apply to appropriations for fiscal years beginning with fiscal year 1990.

(b) APPLICATION AND REPORT- The amendments made--
(1) by subsections (b) and (c) of section 6503 shall apply to payments for allotments for fiscal years beginning with fiscal year 1991, and
(2) by section 6504 shall apply to annual reports for fiscal years beginning with fiscal year 1991.

Subtitle D--Vaccine Compensation Technicals

SEC. 6601. VACCINE INJURY COMPENSATION TECHNICALS.

(a) REFERENCE- Whenever in this section an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

(b) PUBLICATION OF PROGRAM- Section 2110 (42 U.S.C. 300aa-10) is amended by adding at the end thereof the following:
`(c) PUBLICITY- The Secretary shall undertake reasonable efforts to inform the public of the availability of the Program.'.

(c) PETITIONS-
(1) Section 2111(a)(1) (42 U.S.C. 300aa-11(a)(1)) is amended--
(A) by striking out `filing of a petition' and inserting in lieu thereof `filing of a petition containing the matter prescribed by subsection (c)', and
(B) by inserting at the end of paragraph (1) `The clerk of the United States Claims Court shall immediately forward the filed petition to the chief special master for assignment to a special master under section 2112(d)(1).'.

(2) Section 2111(a)(2)(A)(i) (42 U.S.C. 300aa-11(a)(2)(A)(i)) is amended by striking out `under subsection (b)'.

(3) Section 2111(a)(5) (42 U.S.C. 300aa-11(a)(5)) is amended--
(A) in subparagraph (A), by striking out `elect to withdraw such action' and inserting in lieu thereof `petition to have such action dismissed without prejudice or costs', and
(B) in subparagraph (B), by striking out `on the effective date of this part had pending' and inserting in lieu thereof `has pending' and by striking out `does not withdraw the action under subparagraph (A)'.

(4) Section 2111(a)(6) (42 U.S.C. 300aa-11(a)(6)) is amended by striking out `the effective date of this part' each place it occurs and inserting in lieu thereof `November 15, 1988'.
(5) Section 2111(a) (42 U.S.C. 300aa-11(a)) is amended by redesignating paragraph (8) as paragraph (9) and by inserting after paragraph (7) the following:

`If on the effective date of this part there was pending an appeal or rehearing with respect to a civil action brought against a vaccine administrator or manufacturer and if the outcome of the last appellate review of such action or the last rehearing of such action is the denial of damages for a vaccine-related injury or death, the person who brought such action may file a petition under subsection (b) for such injury or death.'.

(6) Section 2111(c) (42 U.S.C. 300aa-11(c)) is amended--

(A) in paragraph (1), by inserting `except as provided in paragraph (3)', after `(1)' and in paragraph (2), by inserting `except as provided in paragraph (3)', after `(2)',

(B) by redesignating paragraph (2) as subsection (d), by expanding the margin of the paragraph to full measure, and by striking out `all available' and inserting in lieu thereof `(d) ADDITIONAL INFORMATION- A petition may also include other available', by striking out `(including autopsy reports, if any)', and by striking out `and an identification' and all that follows and inserting in lieu thereof a period,

(C) by adding after paragraph (1) the following new paragraphs:

`except as provided in paragraph (3), maternal prenatal and delivery records, newborn hospital records (including all physicians' and nurses' notes and test results), vaccination records associated with the vaccine allegedly causing the injury, pre- and post-injury physician or clinic records (including all relevant growth charts and test results), all post-injury inpatient and outpatient records (including all provider notes, test results, and medication records), if applicable, a death certificate, and if applicable, autopsy results, and

(3) an identification of any records of the type described in paragraph (1) or (2) which are unavailable to the petitioner and the reasons for their unavailability.', and

(D) by redesignating paragraph (3), as in effect on the date of the enactment, as subsection (e), by expanding the margin of the paragraph to full measure, and by striking out `appropriate' and inserting in lieu thereof `(e) SCHEDULE- The petitioner shall submit in accordance with a schedule set by the special master assigned to the petition'.

(7) The margin on paragraph (9) of section 2111(a) (as so redesignated) is indented two ems.

(8) Section 2115(e)(2) (42 U.S.C. 300aa-15(e)(2)) is amended--

(A) by striking out `and elected under section 2111(a)(4) to withdraw such action' and inserting in lieu thereof `and petitioned under section 2111(a)(5) to have such action dismissed', and
(B) by striking out `the judgment of the court on such petition may include' and inserting in lieu thereof `in awarding compensation on such petition the special master or court may include'.

(d) JURISDICTION- Section 2112(a) (42 U.S.C. 300aa-12(a)) is amended--
(1) by striking out `shall have jurisdiction (1)' and inserting in lieu thereof `and the United States Claims Court special masters shall, in accordance with this section, have jurisdiction',
(2) by striking out `, and (2) to issue' and inserting in lieu thereof a period and the following: `The United States Claims Court may issue', and
(3) by striking out `deem' and inserting in lieu thereof `deems'.

(e) SPECIAL MASTERS ESTABLISHED- Section 2112 (42 U.S.C. 300aa-12) is amended--
(1) by redesignating subsections (c), (d), and (e) as subsections (d), (e), and (f), respectively, and
(2) by inserting after subsection (b) the following new subsection:
`c) UNITED STATES CLAIMS COURT SPECIAL MASTERS-
`(1) There is established within the United States Claims Court an office of special masters which shall consist of not more than 8 special masters. The judges of the United States Claims Court shall appoint the special masters, 1 of whom, by designation of the judges of the United States Claims Court, shall serve as chief special master. The appointment and reappointment of the special masters shall be by the concurrence of a majority of the judges of the court.
`(2) The chief special master and other special masters shall be subject to removal by the judges of the United States Claims Court for incompetency, misconduct, or neglect of duty or for physical or mental disability or for other good cause shown.
`(3) A special master's office shall be terminated if the judges of the United States Claims Court determine, upon advice of the chief special master, that the services performed by that office are no longer needed.
`(4) The appointment of any individual as a special master shall be for a term of 4 years, subject to termination under paragraphs (2) and (3). Individuals serving as special masters upon the date of the enactment of this subsection shall serve for 4 years from the date of their original appointment, subject to termination under paragraphs (2) and (3). The chief special master in office on the date of the enactment of this subsection shall continue to serve as chief special master for the balance of the master's term, subject to termination under paragraphs (2) and (3).
`(5) The compensation of the special masters shall be determined by the judges of the United States Claims Court, upon advice of the chief special master. The salary of the chief special master shall be the annual rate of basic pay for level IV of the Executive Schedule, as prescribed by section 5315, title 5, United States Code. The salaries of the other special masters
shall not exceed the annual rate of basic pay of level V of the Executive Schedule, as prescribed by section 5316, title 5, United States Code.

` (6) The chief special master shall be responsible for the following:
` (A) Administering the office of special masters and their staff, providing for the efficient, expeditious, and effective handling of petitions, and performing such other duties related to the Program as may be assigned to the chief special master by a concurrence of a majority of the United States Claims Courts judges.
` (B) Appointing and fixing the salary and duties of such administrative staff as are necessary. Such staff shall be subject to removal for good cause by the chief special master.
` (C) Managing and executing all aspects of budgetary and administrative affairs affecting the special masters and their staff, subject to the rules and regulations of the Judicial Conference of the United States. The Conference rules and regulations pertaining to United States magistrates shall be applied to the special masters.
` (D) Coordinating with the United States Claims Court the use of services, equipment, personnel, information, and facilities of the United States Claims Court without reimbursement.
` (E) Reporting annually to the Congress and the judges of the United States Claims Court on the number of petitions filed under section 2111 and their disposition, the dates on which the vaccine-related injuries and deaths for which the petitions were filed occurred, the types and amounts of awards, the length of time for the disposition of petitions, the cost of administering the Program, and recommendations for changes in the Program.'.

(f) PARTIES- Section 2112(b) (42 U.S.C. 300aa-12(b)) is amended--

(1) by amending the first sentence to read as follows: `In all proceedings brought by the filing of a petition under section 2111(b), the Secretary shall be named as the respondent, shall participate, and shall be represented in accordance with section 518(a) of title 28, United States Code.', and

(2) by striking out the second sentence.

(g) SPECIAL MASTER FUNCTIONS- Section 2112(d) (42 U.S.C. 300aa-12(d)) (as so redesignated by subsection (e)) is amended--

(1) by amending paragraph (1) to read as follows:
` (1) Following the receipt and filing of a petition under section 2111, the clerk of the United States Claims Court shall forward the petition to the chief special master who shall designate a special master to carry out the functions authorized by paragraph (3).', and

(2) by striking out paragraph (2) and inserting in lieu thereof the following:
` (2) The special masters shall recommend rules to the Claims Court and, taking into account such recommended rules, the Claims Court shall promulgate rules pursuant to section 2071 of title 28, United States Code. Such rules shall--
(A) provide for a less-adversarial, expeditious, and informal proceeding for the resolution of petitions,
(B) include flexible and informal standards of admissibility of evidence,
(C) include the opportunity for summary judgment,
(D) include the opportunity for parties to submit arguments and evidence on the record without requiring routine use of oral presentations, cross examinations, or hearings, and
(E) provide for limitations on discovery and allow the special masters to replace the usual rules of discovery in civil actions in the United States Claims Court.

(3)(A) A special master to whom a petition has been assigned shall issue a decision on such petition with respect to whether compensation is to be provided under the Program and the amount of such compensation. The decision of the special master shall--
(i) include findings of fact and conclusions of law, and
(ii) be issued as expeditiously as practicable but not later than 240 days, exclusive of suspended time under subparagraph (C), after the date the petition was filed.

The decision of the special master may be reviewed by the United States Claims Court in accordance with subsection (e).

(4)(A) Except as provided in subparagraph (B), information submitted to a special master or the court in a proceeding on a petition may not be
disclosed to a person who is not a party to the proceeding without the express written consent of the person who submitted the information.

` (B) A decision of a special master or the court in a proceeding shall be disclosed, except that if the decision is to include information--

` (i) which is trade secret or commercial or financial information which is privileged and confidential, or

` (ii) which are medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of privacy,

and if the person who submitted such information objects to the inclusion of such information in the decision, the decision shall be disclosed without such information.'.

(h) ACTION BY THE UNITED STATES CLAIMS COURT- Section 2112(e) (42 U.S.C. 300aa-12(e)) (as so redesignated by subsection (e)) is amended to read as follows:

` (e) ACTION BY THE UNITED STATES CLAIMS COURT-

` (1) Upon issuance of the special master's decision, the parties shall have 30 days to file with the clerk of the United States Claims Court a motion to have the court review the decision. If such a motion is filed, the other party shall file a response with the clerk of the United States Claims Court no later than 30 days after the filing of such motion.

` (2) Upon the filing of a motion under paragraph (1) with respect to a petition, the United States Claims Court shall have jurisdiction to undertake a review of the record of the proceedings and may thereafter--

` (A) uphold the findings of fact and conclusions of law of the special master and sustain the special master's decision,

` (B) set aside any findings of fact or conclusion of law of the special master found to be arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law and issue its own findings of fact and conclusions of law, or

` (C) remand the petition to the special master for further action in accordance with the court's direction.

The court shall complete its action on a petition within 120 days of the filing of a response under paragraph (1) excluding any days the petition is before a special master as a result of a remand under subparagraph (C). The court may allow not more than 90 days for remands under subparagraph (C).

` (3) In the absence of a motion under paragraph (1) respecting the special master's decision or if the United States Claims Court takes the action described in paragraph (2)(A) with respect to the special master's decision, the clerk of the United States Claims Court shall immediately enter judgment in accordance with the special master's decision.'.

(i) APPEALS- Section 2112(f) (42 U.S.C. 300aa-12(f)) (as so redesignated by subsection (e)) is amended by inserting before the period the following:

` within 60 days of the date of entry of the United States Claims Court's judgment with such court of appeals'.


(j) DETERMINATION OF ELIGIBILITY AND COMPENSATION- Section 2113 (42 U.S.C. 300aa-13) is amended--
(1) by striking `court' each place it appears and inserting in lieu thereof `special master or court', and
(2) by inserting before `United States Claims Court' in subsection (c) `special masters of'.
(k) TABLE-
(1) The table contained in section 2114(a) (42 U.S.C. 300aa-14(a)) is amended by striking out `(c)(2)' each place it appears and inserting in lieu thereof `(b)(2)'.
(2) Section 2114(b)(3)(B) (42 U.S.C. 300aa-14(b)(3)(B)) is amended by striking out `2111(b)' and inserting in lieu thereof `2111'.
(l) Compensation-
(1) Section 2115(b) (42 U.S.C. 300aa-15(b)) is amended by striking out `may not include' and all that follows and inserting in lieu thereof `may include the compensation described in paragraphs (1)(A) and (2) of subsection (a) and may also include an amount, not to exceed a combined total of $30,000, for--
  `(1) lost earnings (as provided in paragraph (3) of subsection (a)),
  `(2) pain and suffering (as provided in paragraph (4) of subsection (a)), and
  `(3) reasonable attorneys' fees and costs (as provided in subsection (e)).'.
(2) Section 2115(e) (42 U.S.C. 300aa-15(b)) is amended--
(A) in the first sentence of paragraph (1), by striking out `The judgment of the United States Claims Court on a petition filed under section 2111 awarding compensation shall include an amount to cover' and inserting in lieu thereof `In awarding compensation on a petition filed under section 2111 the special master or court shall also award as part of such compensation an amount to cover',
(B) in the second sentence of paragraph (1), by striking out `civil action' each place it appears and inserting in lieu thereof `petition',
(C) in the second sentence of paragraph (1), by striking out `may include in the judgment an amount to cover' and inserting in lieu thereof `may award an amount of compensation to cover' and by striking out `court' each place it appears and inserting in lieu thereof `special master or court',
(D) in paragraph (2), by striking out `the judgment of the court on such petition may include an amount' and inserting in lieu thereof `the special master or court may also award an amount of compensation', and
(E) in paragraph (3), by striking out `included under paragraph (1) in a judgment on such petition' and inserting in lieu thereof `awarded as compensation by the special master or court under paragraph (1)'.
(3) Section 2115(f) (42 U.S.C. 300aa-15(f)) is amended--
(A) in paragraph (3), by inserting after `Payments of compensation' the following: `under the Program and the costs of carrying out the Program',
(B) in paragraph (4)(A), by striking out `made in a lump sum' and by adding after `compensation' the second time it appears the following: `...and shall be paid from the trust fund in a lump sum of which all or a portion of the proceeds may be used as ordered by the special master to purchase an annuity or otherwise be used, with the consent of the petitioner, in a manner determined by the special master to be in the best interests of the petitioner', and

(C) in paragraph (4)(B), by striking out `paid in 4 equal annual installments.' and inserting in lieu thereof `...determined on the basis of the net present value of the elements of compensation and paid in 4 equal annual installments of which all or a portion of the proceeds may be used as ordered by the special master to purchase an annuity or otherwise be used, with the consent of the petitioner, in a manner determined by the special master to be in the best interests of the petitioner. Any reasonable attorneys’ fees and costs shall be paid in a lump sum.'.

(4) Section 2115 (42 U.S.C. 300aa-15) is amended--
(A) in subsection (g), by inserting `(other than under title XIX of the Social Security Act)' after `State health benefits program', and
(B) in subsection (h), by inserting before the period at the end the following: `...except that this subsection shall not apply to the provision of services or benefits under title XIX of the Social Security Act'.

(5) Section 2115(i)(1) (42 U.S.C. 300aa-15(i)(1)) is amended by striking out `(i)' and inserting in lieu thereof `(j)'.

(6) The first sentence of section 2115(j) (42 U.S.C. 300aa-15(j)) is amended by striking out `...and' after `1991,' and by inserting before the period a comma and `$80,000,000 for fiscal year 1993'.

(m) TECHNICALS-
(1) Section 2116(c) (42 U.S.C. 300aa-16(c)) is amended by striking out `2111(b)' and inserting in lieu thereof `2111'.
(2) Section 2117(b) (42 U.S.C. 300aa-17(b)) is amended by striking out `the trust fund which has been established to provide compensation under the Program' and inserting in lieu thereof `the Vaccine Injury Compensation Trust Fund established under section 9510 of the Internal Revenue Code of 1986'.

(n) ELECTION-
(1) Section 2121(a) (42 U.S.C. 300aa-21(a)) is amended--
(A) in the first sentence, by striking out `After the judgment of the United States Claims Court under section 2111 on a petition filed for compensation under the Program for a vaccine-related injury or death has become final, the person who filed the petition shall file with the court' and inserting in lieu thereof: `After judgment has been entered by the United States Claims Court or, if an appeal is taken under section 2112(f), after the appellate court's mandate is issued, the petitioner who filed the petition under section 2111 shall file with the clerk of the United States Claims Court', and
(B) by amending the last sentence to read as follows: 'For limitations on the bringing of civil actions, see section 2111(a)(2)'.

(2) Section 2121(b) (42 U.S.C. 300aa-21(b)) is amended--
   (A) in the first sentence, by striking out `within 365 days' and inserting in lieu thereof `within 420 days (excluding any period of suspension under section 2112(d) and excluding any days the petition is before a special master as a result of a remand under section 2112(e)(2)(C))', and
   (B) by amending the second sentence to read as follows: `An election shall be filed under this subsection not later than 90 days after the date of the entry of the Claims Court's judgment or the appellate court's mandate with respect to which the election is to be made.'.

(o) TRIAL- Section 2123(e) (42 U.S.C. 300aa-23(e)) is amended--
   (1) by striking out `finding' and inserting in lieu thereof `finding of fact or conclusion of law',
   (2) by striking out `master appointed by such court' and inserting in lieu thereof `special master', and
   (3) by striking out `a district court of the United States' and inserting in lieu thereof `the United States Claims Court and subsequent appellate review'.

(p) VACCINE INFORMATION- Section 2126(c)(9) (42 U.S.C. 300aa-26(c)(9)) is amended to read as follows:
   `(9) a summary of--
      `(A) relevant Federal recommendations concerning a complete schedule of childhood immunizations, and
      `(B) the availability of the Program, and'.

(q) SAFER VACCINES- Section 2127 (42 U.S.C. 300aa-27) is amended by redesignating subsection (b) as subsection (c) and by adding after subsection (a) the following:
   `(b) TASK FORCE-
      `(1) The Secretary shall establish a task force on safer childhood vaccines which shall consist of the Director of the National Institutes of Health, the Commissioner of the Food and Drug Administration, and the Director of the Centers for Disease Control.
      `(2) The Director of the National Institutes of Health shall serve as chairman of the task force.
      `(3) In consultation with the Advisory Commission on Childhood Vaccines, the task force shall prepare recommendations to the Secretary concerning implementation of the requirements of subsection (a)'.'.

(r) AUTHORIZATIONS- 
   (1) For administering part A of subtitle 2 of title XXI of the Public Health Service Act there is authorized to be appropriated from the Vaccine Injury Compensation Trust Fund established under section 9510(c) of the Internal Revenue Code of 1986 to the Secretary of Health and Human Services $1,500,000 for each of the fiscal years 1990 and 1991.
(2) For administering part A of subtitle 2 of title XXI of the Public Health Service Act there is authorized to be appropriated from the Vaccine Injury Compensation Trust Fund to the Attorney General $1,500,000 for each of the fiscal years 1990 and 1991.
(3) For administering part A of subtitle 2 of title XXI of the Public Health Service Act there is authorized to be appropriated from the Vaccine Injury Compensation Trust Fund to the United States Claims Court $1,500,000 for each of the fiscal years 1990 and 1991.

(s) APPLICABILITY AND EFFECTIVE DATE-
(1) Except as provided in paragraph (2), the amendments made by this section shall apply as follows:
(A) Petitions filed after the date of enactment of this section shall proceed under the National Vaccine Injury Compensation Program under title XXI of the Public Health Service Act as amended by this section.
(B) Petitions currently pending in which the evidentiary record is closed shall continue to proceed under the Program in accordance with the law in effect before the date of the enactment of this section, except that if the United States Claims Court is to review the findings of fact and conclusions of law of a special master on such a petition, the court may receive further evidence in conducting such review.
(C) Petitions currently pending in which the evidentiary record is not closed shall proceed under the Program in accordance with the law as amended by this section.

All pending cases which will proceed under the Program as amended by this section shall be immediately suspended for 30 days to enable the special masters and parties to prepare for proceeding under the Program as amended by this section. In determining the 240-day period prescribed by section 2112(d) of the Public Health Service Act, as amended by this section, or the 420-day period prescribed by section 2121(b) of such Act, as so amended, any period of suspension under the preceding sentence shall be excluded.
(2) The amendments to section 2115 of the Public Health Service Act shall apply to all pending and subsequently filed petitions.
(t) STUDY- The Secretary of Health and Human Services shall evaluate the National Vaccine Injury Compensation Program under title XXI of the Public Health Service Act and shall report the results of such study to the Committee on Energy and Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate not later than January 1, 1992.

SEC. 6602. SEVERABILITY.

Section 322 of the National Childhood Vaccine Injury Act of 1986 (42 U.S.C. 300aa-1 note) is amended to read as follows:
`SEC. 322. SEVERABILITY.

(a) IN GENERAL- Except as provided in subsection (b), if any provision of title XXI of the Public Health Service Act, as added by section 311(a), or the application of such a provision to any person or circumstance is held invalid by reason of a violation of the Constitution, such title XXI shall be considered invalid.

(b) SPECIAL RULE- If any amendment made by section 6601 of the Omnibus Budget Reconciliation Act of 1989 to title XXI of the Public Health Service Act or the application of such a provision to any person or circumstance is held invalid by reason of the Constitution, subsection (a) shall not apply and such title XXI of the Public Health Service Act without such amendment shall continue in effect.'.

Subtitle E--Provisions With Respect to COBRA Continuation Coverage

PART 1--EXTENSION OF COVERAGE FOR DISABLED EMPLOYEES

SEC. 6701. EXTENSION, UNDER INTERNAL REVENUE CODE, OF COVERAGE FROM 18 TO 29 MONTHS FOR THOSE WITH A DISABILITY AT TIME OF TERMINATION OF EMPLOYMENT.

(a) IN GENERAL- Paragraph (2)(B) of section 4980B(f) of the Internal Revenue Code of 1986, as added by section 3011(a) of the Technical and Miscellaneous Revenue Act of 1988 (Public Law 100-647), (relating to maximum required period of continuation coverage), is amended--

(1) in clause (i) by adding after and below subclause (IV) the following new sentence:
`In the case of a qualified beneficiary who is determined, under title II or XVI of the Social Security Act, to have been disabled at the time of a qualifying event described in paragraph (3)(B), any reference in subclause (I) or (II) to 18 months with respect to such event is deemed a reference to 29 months, but only if the qualified beneficiary has provided notice of such determination under paragraph (6)(C) before the end of such 18 months.';

and

(2) by adding at the end the following new clause:
`(v) TERMINATION OF EXTENDED COVERAGE FOR DISABILITY- In the case of a qualified beneficiary who is disabled at the time of a qualifying event described in paragraph (3)(B), the month that begins more than 30 days after the date of the final determination under title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled.'.
(b) INCREASED PREMIUM PERMITTED- Paragraph (2)(C) of such section (relating to premium requirements) is amended by adding at the end the following new sentence: `In the case of an individual described in the last sentence of subparagraph (B)(i), any reference in clause (i) of this subparagraph to `102 percent' is deemed a reference to `150 percent' for any month after the 18th month of continuation coverage described in subclause (I) or (II) of subparagraph (B)(i).'.

(c) NOTICES REQUIRED- Paragraph (6)(C) of such section (relating to certain notices to plan administrator) is amended by inserting before the period at the end the following: `and each qualified beneficiary who is determined, under title II or XVI of the Social Security Act, to have been disabled at the time of a qualifying event described in paragraph (3)(B) is responsible for notifying the plan administrator of such determination within 60 days after the date of the determination and for notifying the plan administrator within 30 days of the date of any final determination under such title or titles that the qualified beneficiary is no longer disabled'.

(d) EFFECTIVE DATE- The amendments made by this section shall apply to plan years beginning on or after the date of the enactment of this Act, regardless of whether the qualifying event occurred before, on, or after such date.

SEC. 6702. EXTENSION, UNDER PUBLIC HEALTH SERVICE ACT, OF COVERAGE FROM 18 TO 29 MONTHS FOR THOSE WITH A DISABILITY AT TIME OF TERMINATION OF EMPLOYMENT.

(a) IN GENERAL- Section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb-2) is amended--
(1) in subparagraph (A), by adding after and below clause (iii) the following new sentence: `In the case of an individual who is determined, under title II or XVI of the Social Security Act, to have been disabled at the time of a qualifying event described in section 2203(2), any reference in clause (i) or (ii) to 18 months with respect to such event is deemed a reference to 29 months, but only if the qualified beneficiary has provided notice of such determination under section 2206(3) before the end of such 18 months.'; and
(2) by adding at the end the following new subparagraph:
`(E) TERMINATION OF EXTENDED COVERAGE FOR DISABILITY- In the case of a qualified beneficiary who is disabled at the time of a qualifying event described in section 2203(2), the month that begins more than 30 days after the date of the final determination under title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled.'.

(b) INCREASED PREMIUM PERMITTED- Section 2202(3) of the Public Health Service Act (42 U.S.C. 300bb-3) is amended in the matter after and below subparagraph (B) by adding at the end the following new sentence: `In the
case of an individual described in the last sentence of paragraph (2)(A), any reference in subparagraph (A) of this paragraph to `102 percent' is deemed a reference to `150 percent' for any month after the 18th month of continuation coverage described in clause (i) or (ii) of paragraph (2)(A)'.

(c) NOTICES REQUIRED- Section 2206(3) of such Act (42 U.S.C. 300bb-6(3)) (relating to certain notices to plan administrator) is amended by inserting before the comma the following: `...each qualified beneficiary who is determined, under title II or XVI of the Social Security Act, to have been disabled at the time of a qualifying event described in section 2203(2) is responsible for notifying the plan administrator of such determination within 60 days after the date of the determination and for notifying the plan administrator within 30 days after the date of any final determination under such title or titles that the qualified beneficiary is no longer disabled'.

(d) EFFECTIVE DATE- The amendments made by this section shall apply to plan years beginning on or after the date of the enactment of this Act, regardless of whether the qualifying event occurred before, on, or after such date.

SEC. 6703. EXTENSION, UNDER ERISA, OF COVERAGE FROM 18 TO 29 MONTHS FOR THOSE WITH A DISABILITY AT TIME OF TERMINATION OF EMPLOYMENT.

(a) IN GENERAL- Section 602(2) of the Employee Retirement Income Security Act of 1974 (42 U.S.C. 1162(2)) is amended--

(1) in subparagraph (A), by adding after and below clause (iv) the following new sentence: `In the case of an individual who is determined, under title II or XVI of the Social Security Act, to have been disabled at the time of a qualifying event described in section 603(2), any reference in clause (i) or (ii) to 18 months with respect to such event is deemed a reference to 29 months, but only if the qualified beneficiary has provided notice of such determination under section 606(3) before the end of such 18 months.'; and

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

`(E) TERMINATION OF EXTENDED COVERAGE FOR DISABILITY- In the case of a qualified beneficiary who is disabled at the time of a qualifying event described in section 603(2), the month that begins more than 30 days after the date of the final determination under title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled.'.

(b) INCREASED PREMIUM PERMITTED- Section 602(3) of such Act (42 U.S.C. 1162(3)) is amended in the matter after and below subparagraph (B) by adding at the end the following new sentence: `In the case of an individual described in the last sentence of paragraph (2)(A), any reference in subparagraph (A) of this paragraph to `102 percent' is deemed a
reference to `150 percent' for any month after the 18th month of continuation coverage described in clause (i) or (ii) of paragraph (2)(A).'.

(c) NOTICES REQUIRED- Section 606(3) of such Act (42 U.S.C. 1166(3)) (relating to certain notices to plan administrator) is amended by inserting before the comma the following: `and each qualified beneficiary who is determined, under title II or XVI of the Social Security Act, to have been disabled at the time of a qualifying event described in section 603(2) is responsible for notifying the plan administrator of such determination within 60 days after the date of the determination and for notifying the plan administrator within 30 days after the date of any final determination under such title or titles that the qualified beneficiary is no longer disabled'.

(d) EFFECTIVE DATE- The amendments made by this section shall apply to plan years beginning on or after the date of the enactment of this Act, regardless of whether the qualifying event occurred before, on, or after such date.

**PART 2--MISCELLANEOUS AMENDMENTS**

**SEC. 6801. PUBLIC HEALTH SERVICE ACT.**

(a) SECTION 2201-
(1) SUBSECTION (B)- Section 2201(b) of the Public Health Service Act (42 U.S.C. 300bb-1(b)) is amended by striking the matter after and below paragraph (2).
(2) EFFECTIVE DATE- The amendment made by paragraph (1) shall apply to years beginning after December 31, 1986.

(b) SECTION 2202-
(1) PARAGRAPH (2)(A)-
(A) IN GENERAL- Section 2202(2)(A) of the Public Health Service Act (42 U.S.C. 300bb-2(2)(A)) is amended by adding at the end the following new clause:
`(iv) QUALIFYING EVENT INVOLVING MEDICARE ENTITLEMENT- In the case of an event described in section 2203(4) (without regard to whether such event is a qualifying event), the period of coverage for qualified beneficiaries other than the covered employee for such event or any subsequent qualifying event shall not terminate before the close of the 36-month period beginning on the date the covered employee becomes entitled to benefits under title XVIII of the Social Security Act.'
(B) EFFECTIVE DATE- The amendments made by this paragraph shall apply to plan years beginning after December 31, 1989.

(2) PARAGRAPH (2)(D)-
(A) IN GENERAL- Section 2202(2)(D) of the Public Health Service Act (42 U.S.C. 300bb-2(2)(D)) is amended--
(i) in the heading for such paragraph, by striking `ELIGIBILITY' and inserting `ENTITLEMENT'; and
(ii) in clause (i), by inserting before the comma the following: `which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary'.

(B) EFFECTIVE DATE- The amendments made by subparagraph (A) shall apply to--
(i) qualifying events occurring after December 31, 1989, and
(ii) in the case of qualified beneficiaries who elected continuation coverage after December 31, 1988, the period for which the required premium was paid (or was attempted to be paid but was rejected as such).

(3) PARAGRAPH (3)-
(A) IN GENERAL- Section 2202(3) of the Public Health Service Act (42 U.S.C. 300bb-2(3)) is amended by amending the matter after and below subparagraph (B) to read as follows:
`In no event may the plan require the payment of any premium before the day which is 45 days after the day on which the qualified beneficiary made the initial election for continuation coverage.'.

(B) EFFECTIVE DATE- The amendment made by subparagraph (A) shall apply to plan years beginning after December 31, 1989.

(c) SECTION 2208-
(1) PARAGRAPH (2)- Section 2208(2) of the Public Health Service Act (42 U.S.C. 300bb-8(2)) is amended by striking `the individual's employment or previous employment with an employer' and inserting `the performance of services by the individual for 1 or more persons maintaining the plan (including as an employee defined in section 401(c)(1) of the Internal Revenue Code of 1986)'.

(2) EFFECTIVE DATE- The amendment made by paragraph (1) shall apply to plan years beginning after December 31, 1989.

Subtitle F--Technical and Miscellaneous Provisions Relating to Nursing Home Reform

SEC. 6901. MEDICARE AND MEDICAID TECHNICAL CORRECTIONS RELATING TO NURSING HOME REFORM.

(a) MORATORIUM ON IMPLEMENTATION OF FEBRUARY 2, 1989 REGULATION- The regulations promulgated by the Secretary of Health and Human Services on February 2, 1989 (54 Federal Register 5315 et seq., relating to requirements for long-term care facilities) shall not be effective before October 1, 1990, insofar as such regulations apply to skilled nursing facilities and intermediate care facilities under title XVIII or XIX of the Social Security Act.

(b) NURSE AIDE TRAINING-
(1) DELAY IN REQUIREMENT- Sections 1819(b)(5) and 1919(b)(5) of the Social Security Act (42 U.S.C. 1395i-3(b)(5), 1396r(b)(5)) are each amended--
(A) in subparagraph (A), by striking `January 1, 1990' and inserting `October 1, 1990', and
(B) in subparagraph (B), by striking `July 1, 1989' and `January 1, 1990' and inserting `January 1, 1990' and `October 1, 1990', respectively.
(2) PUBLICATION OF PROPOSED REGULATIONS- The Secretary of Health and Human Services shall issue proposed regulations to establish the requirements described in sections 1819(f)(2) and 1919(f)(2) of the Social Security Act by not later than 90 days after the date of the enactment of this Act.
(3) REQUIREMENTS FOR TRAINING AND EVALUATION PROGRAMS- Sections 1819(f)(2)(A) and 1919(f)(2)(A) of the Social Security Act (42 U.S.C. 1395i-3(f)(2)(A), 1396r(f)(2)(A)) are each amended--
(A) in clause (i)(I), by inserting `care of cognitively impaired residents,' after `social service needs,';
(B) in clause (ii), by striking `cognitive, behavioral and social care' and inserting `recognition of mental health and social service needs, care of cognitively impaired residents';
(C) by striking the period at the end of clause (iii) and inserting `; and'; and
(D) by adding at the end the following new clause:
`(iv) requirements, under both such programs, that--
(I) provide procedures for determining competency that permit a nurse aide, at the nurse aide's option, to establish competency through procedures or methods other than the passing of a written examination and to have the competency evaluation conducted at the nursing facility at which the aide is (or will be) employed (unless the facility is described in subparagraph (B)(iii)(I)), and
(II) prohibit the imposition on a nurse aide of any charges (including any charges for textbooks and other required course materials and any charges for the competency evaluation) for either such program.'.
(4) DELAY AND TRANSITION IN 75-HOUR TRAINING PROGRAM REQUIREMENT-
(B) A nurse aide shall be considered to satisfy the requirement of sections 1819(b)(5)(A) and 1919(b)(5)(A) of the Social Security Act (of having completed a training and competency evaluation program approved by a State under section 1819(e)(1)(A) or 1919(e)(1)(A) of such Act), if such aide would have satisfied such requirement as of July 1, 1989, if a number of hours (not less than 60 hours) were substituted for `75 hours' in sections 1819(f)(2) and 1919(f)(2) of such Act, respectively, and if such aide had received, before July 1, 1989, at least the difference in the number of such
hours in supervised practical nurse aide training or in regular in-service nurse aide education.

(C) A nurse aide shall be considered to satisfy the requirement of sections 1819(b)(5)(A) and 1919(b)(5)(A) of the Social Security Act (of having completed a training and competency evaluation program approved by a State under section 1819(e)(1)(A) or 1919(e)(1)(A) of such Act), if such aide was found competent (whether or not by the State), before July 1, 1989, after the completion of a course of nurse aide training of at least 100 hours duration.

(D) With respect to the nurse aide competency evaluation requirements described in sections 1819(b)(5)(A) and 1919(b)(5)(A) of the Social Security Act, a State may waive such requirements with respect to an individual who can demonstrate to the satisfaction of the State that such individual has served as a nurse aide at one or more facilities of the same employer in the State for at least 24 consecutive months before the date of the enactment of this Act.

(5) CLARIFICATION OF TEMPORARY ENHANCED FEDERAL FINANCIAL PARTICIPATION FOR NURSE AIDE TRAINING BY NURSING FACILITIES-(A) IN GENERAL- Section 1903(a)(2)(B) of such Act (42 U.S.C. 1396b(a)(2)(B)) is amended--

(i) by inserting `(including the costs for nurse aides to complete such competency evaluation programs)' after `1919(e)(1)', and

(ii) by inserting `(or, for calendar quarters beginning on or after July 1, 1988, and before July 1, 1990, the lesser of 90 percent or the Federal medical assistance percentage plus 25 percentage points)' after `50 percent'.

(B) NO ALLOCATION OF COSTS BEFORE OCTOBER 1, 1990- In making payments under section 1903(a)(2)(B) of the Social Security Act for amounts expended for nurse aide training and competency evaluation programs, and competency evaluation programs, described in section 1919(e)(1) of such Act, in the case of activities conducted before October 1, 1990, the Secretary of Health and Human Services shall not take into account, or allocate amounts on the basis of, the proportion of residents of nursing facilities that is entitled to benefits under title XVIII or XIX of such Act.

(6) EFFECTIVE DATES-

(A) IN GENERAL- Except as provided in subparagraph (B), the amendments made by this subsection shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

(B) EXCEPTION- The amendments made by paragraph (3) shall apply to nurse aide training and competency evaluation programs, and nurse aide competency evaluation programs, offered on or after the end of the 90-day period beginning on the date of the enactment of this Act, but shall not
affect competency evaluations conducted under programs offered before the end of such period.

(c) PUBLICATION OF PROPOSED REGULATIONS RESPECTING PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW- The Secretary of Health and Human Services shall issue proposed regulations to establish the criteria described in section 1919(f)(8)(A) of the Social Security Act by not later than 90 days after the date of the enactment of this Act.

(d) OTHER AMENDMENTS-

(1) CLARIFICATION OF APPLICABILITY OF ENFORCEMENT RULES TO DUALLY-CERTIFIED FACILITIES- Section 1919(h)(8) of the Social Security Act (42 U.S.C. 1396r(h)(8)) is amended by adding at the end the following: ‘The provisions of this subsection shall apply to a nursing facility (or portion thereof) notwithstanding that the facility (or portion thereof) also is a skilled nursing facility for purposes of title XVIII.’.

(2) CLARIFICATION OF FEDERAL MATCHING RATE FOR SURVEY AND CERTIFICATION ACTIVITIES- During the period before October 1, 1990, the Federal percentage matching payment rate under section 1903(a) of the Social Security Act for so much of the sums expended under a State plan under title XIX of such Act as are attributable to compensation or training of personnel responsible for inspecting public or private skilled nursing or intermediate care facilities to individuals receiving medical assistance to determine compliance with health or safety standards shall be 75 percent.

(3) MEDICARE WAIVER AUTHORITY FOR CERTAIN DEMONSTRATION PROJECTS- (A) The Secretary of Health and Human Services may waive the survey and certification requirements of sections 1819(g) and 1864(a) of the Social Security Act to the extent the Secretary determines is required to carry out a demonstration project in New York (relating to testing an approved alternative survey and certification process), which has been approved as of the date of the enactment of this Act. Such waiver shall apply only during the period beginning on November 1, 1988, and ending on October 31, 1991.

(B) The Secretary also may waive the survey and certification requirements described in subparagraph (A) to the extent the Secretary determines is required to carry out a pilot demonstration project in Wisconsin (relating to testing an approved alternative survey and certification process). Such waiver shall apply only during the one-year period beginning on the date of implementation of the project.

(4) MISCELLANEOUS TECHNICAL CORRECTIONS- Sections 1819 and 1919 of the Social Security Act are each further amended--

(A) in subsection (c)(1)(A)(ii)(II), by striking the closing parenthesis after ‘Secretary’ and inserting a closing parenthesis after ‘obtained’,

(B) in subsection (c)(1)(A)(v)(I), by striking ‘accommodations’ and inserting ‘accommodation’,
(C) in subsection (f)(2)(A)(i), by striking `content of the curriculum' and inserting `and content of the curriculum', and (D) in subsection (h)(2)(C) (of section 1819) and in subsection (h)(3)(D) (of section 1919), by inserting `after the effective date of the findings' after `6 months'.

(5) ADDITIONAL MISCELLANEOUS TECHNICAL CORRECTIONS- Section 1910 of such Act (42 U.S.C. 1396i) is amended--
(A) by inserting `AND INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED' after `RURAL HEALTH CLINICS',
(B) in subsection (b)(1), by striking `skilled nursing or intermediate care facility' and inserting `intermediate care facility for the mentally retarded',
(C) in subsection (b)(1), as amended by section 411(l)(6)(F) of the Medicare Catastrophic Coverage Act of 1988, by striking `1902(a)(28) or section 1919 or section 1905(c)' and inserting `1902(a)(31) or section 1905(d)', and (D) in subsections (b)(1) and (b)(2), by striking `skilled nursing facility or intermediate care facility' each place it appears and inserting `intermediate care facility for the mentally retarded'.

(6) EFFECTIVE DATE-
(A) IN GENERAL- Except as provided in subparagraph (B), the amendments made by this subsection shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987.
(B) EXCEPTION- The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

Subtitle G--Public Health Service Act

SEC. 6911. ESTABLISHMENT OF AGENCY FOR HEALTH CARE POLICY AND RESEARCH.

For amendments establishing the Agency for Health Care Policy and Research and creating a new title IX in the Public Health Service Act, see section 6103 of this Act.
TITLE VIII--HUMAN RESOURCE AND INCOME SECURITY PROVISIONS

SEC. 8000. TABLE OF CONTENTS; AMENDMENT OF SOCIAL SECURITY ACT.

(a) TABLE OF CONTENTS-

Sec. 8000. Table of contents; amendment of Social Security Act.

Sec. 8001. Extension of authority to transfer foster care funds to child welfare services.

Sec. 8002. Extension of independent living initiatives program.

Sec. 8003. Permanent extension of medicaid eligibility extension due to collection of child or spousal support.

Sec. 8004. New AFDC quality control system.

Sec. 8005. Emergency assistance and AFDC special needs.

Sec. 8006. Increase in reimbursement for foster and adoptive parent training.

Sec. 8007. Case plans to include health and education records and to be reviewed and updated at the time of each placement.

Sec. 8008. Establishment and conduct of outreach program for children.

Sec. 8009. Eligibility for benefits of children of Armed Forces personnel residing overseas.

Sec. 8010. Rule for deeming to children the income and resources of their parents waived for certain disabled children.

Sec. 8011. Exclusion from income of domestic commercial transportation tickets received as gifts.

Sec. 8012. Reduction in time during which income and resources of separated couples must be treated as jointly available.

Sec. 8013. Exclusion of accrued income with respect to purchase of certain burial spaces.
Sec. 8014. Exclusion from resources of all income-producing property.

Sec. 8015. Demonstration of effectiveness of Minnesota Family Investment Plan.

Sec. 8016. Increase in funding for title XX social services block grant.

(b) AMENDMENT OF SOCIAL SECURITY ACT- Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Social Security Act.

SEC. 8001. EXTENSION OF AUTHORITY TO TRANSFER FOSTER CARE FUNDS TO CHILD WELFARE SERVICES.

(a) 3-YEAR EXTENSION- Subsections (b)(1), (b)(2)(B), (b)(4)(B), (b)(5)(A), (b)(5)(A)(ii), (c)(1), and (c)(2) of section 474 (42 U.S.C. 674) are each amended by striking `1989' and inserting `1992'.

(b) EFFECTIVE DATE- The amendments made by subsection (a) shall take effect on October 1, 1989.

SEC. 8002. EXTENSION OF INDEPENDENT LIVING INITIATIVES PROGRAM.

(a) PROGRAM EXTENDED FOR 3 YEARS- Section 477 (42 U.S.C. 677) is amended--

(1) in each of subsections (a)(1) and (e)(1), by striking `, 1988, and 1989' and inserting `through 1992'; and

(2) in subsection (c), by striking `the fiscal year 1988 or 1989' and inserting `any of the fiscal years 1988 through 1992'.

(b) ENTITLEMENT INCREASED- Section 477(e)(1) (42 U.S.C. 677(e)(1)) is amended--

(1) by inserting `(A)' after `(1)';

(2) by striking `The amount' and inserting `The basic amount';


(4) by striking `$45,000,000' and inserting `the basic ceiling for such fiscal year'; and

(5) by adding after and below such provision the following:

`(B) The maximum additional amount to which a State shall be entitled under section 474(a)(4) for fiscal years 1991 and 1992 shall be an amount which bears the same ratio to the additional ceiling for such fiscal year as the basic amount of such State bears to $45,000,000.'; and

`(C) As used in this section:

`(i) The term `basic ceiling' means--
(I) for fiscal year 1990, $50,000,000; and
(II) for each fiscal year other than fiscal year 1990, $45,000,000.
(ii) The term `additional ceiling' means--
(I) for fiscal year 1991, $15,000,000; and
(II) for fiscal year 1992, $25,000,000.'.
(c) MATCHING PAYMENTS TO STATES- Section 474(a)(4) (42 U.S.C. 674(a)(4)) is amended to read as follows:
(4) an amount equal to the sum of--
(A) so much of the amounts expended by such State to carry out programs under section 477 as do not exceed the basic amount for such State determined under section 477(e)(1); and
(B) the lesser of--
(i) one-half of any additional amounts expended by such State for such programs; or
(ii) the maximum additional amount for such State under such section 477(e)(1).'.
(d) STUDY BY THE SECRETARY OF HHS; REPORT-
(1) STUDY- The Secretary of Health and Human Services shall study the programs authorized under section 477 of the Social Security Act for the purposes of evaluating the effectiveness of the programs. The study shall include a comparison of outcomes of children who participated in the programs and a comparable group of children who did not participate in the programs.
(2) REPORT- Upon completion of the study, the Secretary shall issue a report to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.
(e) EFFECTIVE DATE- The amendments made by subsections (a), (b) and (c) shall take effect October 1, 1989.

SEC. 8003. PERMANENT EXTENSION OF MEDICAID ELIGIBILITY EXTENSION DUE TO COLLECTION OF CHILD OR SPOUSAL SUPPORT.

(a) ELIMINATION OF SUNSET ON APPLICABILITY OF MEDICAID ELIGIBILITY EXTENSION- Section 20(b) of the Child Support Enforcement Amendments of 1984 (Public Law 98-378) is amended by striking `and before October 1, 1989'.
(b) EFFECTIVE DATE- The amendment made by subsection (a) shall take effect on October 1, 1989.

SEC. 8004. NEW AFDC QUALITY CONTROL SYSTEM.

(a) IN GENERAL- Part A of title IV (42 U.S.C. 601 et seq.) is amended by inserting after section 407 the following:
SEC. 408. AFDC QUALITY CONTROL SYSTEM.

(a) IN GENERAL- In order to improve the accuracy of payments of aid to families with dependent children, the Secretary shall establish and operate a quality control system under which the Secretary shall determine, with respect to each State, the amount (if any) of the disallowance required to be repaid to the Secretary due to erroneous payments made by the State in carrying out the State plan approved under this part.

(b) REVIEW OF CASES-

(1) STATE REVIEW-

(A) IN GENERAL- Each State with a plan approved under this part shall for each fiscal year, in accordance with the time schedule and methodology prescribed in regulations issued under paragraphs (1) and (2) of subsection (h)--

(i) review a sample of cases in the State with respect to which a payment has been made under such plan during the fiscal year; and

(ii) determine the level of erroneous payments for the State for the fiscal year.

(B) EFFECTS OF FAILURE TO COMPLETE REVIEW IN A TIMELY MANNER-

(i) SECRETARY CONDUCTS REVIEW- If a State fails to conduct and complete, on a timely basis, a review required by subparagraph (A), or otherwise fails to cooperate with the Secretary in implementing this subsection, the Secretary, directly or through contractual or such other arrangements as the Secretary may find appropriate, shall conduct the review and establish the error rate for the State for the fiscal year on the basis of the best data reasonably available to the Secretary, in accordance with the statistical methods that would apply if the review were conducted by the State.

(ii) STATE INCURS COSTS OF REVIEW- The amount that would otherwise be payable under this part to a State for which the Secretary conducts a review under clause (i) shall be reduced by the costs incurred by the Secretary in conducting the review.

(2) REVIEW BY THE SECRETARY- The Secretary shall review a subsample of the cases reviewed by the State, or by the Secretary with respect to the State, under paragraph (1).

(3) NOTIFICATION OF DIFFERENCE CASES- Upon completion of the review under paragraph (2), the Secretary shall notify the State of any case in the subsample which the Secretary finds involves erroneous payments, and which the State’s review determined to be correct (in this section referred to as a ‘difference case’).

(4) ESTABLISHMENT OF QUALITY CONTROL REVIEW PANEL- The Secretary shall by regulation establish a Quality Control Review Panel to review difference cases.

(5) RESOLUTION OF DIFFERENCE CASES-
(A) IN GENERAL- The State may seek review by the Panel of any difference case, within the time period prescribed in regulations issued under subsection (h)(3).

(B) PROCEDURAL RULES- The State and the Secretary may submit such documentation to the Panel as the State or the Secretary finds appropriate to substantiate its position. The findings of the Panel shall be made on the record, within the time period prescribed in regulations issued under subsection (h)(4).

(C) STATUS OF DECISIONS OF THE QUALITY CONTROL REVIEW PANEL- The decisions of the Panel shall constitute the decisions of the Secretary for purposes of establishing the State's error rate for the fiscal year.

(D) APPEALABILITY OF DECISIONS OF THE QUALITY CONTROL REVIEW PANEL- The decisions of the Panel shall not be appealable, except as provided in subsection (k).

(c) IDENTIFICATION OF ERRONEOUS PAYMENTS-

(1) APPLY PROVISIONS OF STATE PLAN- Except as provided in paragraph (2), in determining whether a payment is an erroneous payment, the State and the Secretary shall apply all relevant provisions of the State plan approved under this part.

(2) TREATMENT OF PROVISIONS OF STATE PLAN THAT ARE INCONSISTENT WITH FEDERAL LAW-

(A) IN GENERAL- If a provision of a State plan approved under this part is inconsistent with a provision of Federal law or regulations, and the Secretary has notified the State of the inconsistency, the provision of Federal law or regulations shall control.

(B) EXCEPTION- Subparagraph (A) shall not apply with respect to a payment of the State if-

(i) it is necessary for the State to enact a law in order to remove an inconsistency described in subparagraph (A), the Secretary has advised the State that the State will be allowed a reasonable period in which to enact such a law, and the payment was made during such period; or

(ii) the State agency made the payment in compliance with a court order.

(3) CERTAIN PAYMENTS NOT CONSIDERED ERRONEOUS- For purposes of this section, a payment by a State shall not be considered an erroneous payment if the payment is in error solely by reason of-

(A) the State's failure to implement properly changes in Federal statute within 6 months after the effective date of such changes or, if later, 6 months after the issuance of final regulations (including regulations in interim final form) if such regulations are reasonably necessary to construe or apply the Federal statutory change;

(B) the State's reliance upon and correct use of erroneous information provided by the Secretary about matters of fact;

(C) the State's reliance upon and correct use of written statements of Federal policy provided to the State by the Secretary;
(D) the occurrence of an event in the State that--
  (i) results in the declaration by the President or the Governor of the State of a state of emergency or major disaster; and
  (ii) directly affects the State agency's ability to make correct payments under the State plan approved under this part; or
(E) the failure of a family to submit monthly reports to the State pursuant to section 402(a)(14), if the failure did not affect the amount of the payment.

(4) CERTAIN PAYMENTS CONSIDERED ERRONEOUS- Notwithstanding any other provision of this section, a payment shall be considered an erroneous payment if the payment is made to a family--
  (A) which has failed without good cause to assign support rights as required by section 402(a)(26); or
  (B) any member of which is a recipient of aid under a State plan approved under this part and does not have a social security account number (unless an application for a social security account number for the family member has been filed within 30 days after the date of application for such aid).

(d) DETERMINATION OF ERROR RATES-
  (1) IN GENERAL- The Secretary shall, in accordance with this subsection, determine an error rate for each State for the fiscal year involved, based on the reviews under paragraphs (1) and (2) of subsection (b) and the decisions of the Quality Control Review Panel under subsection (b)(5).
  (2) ERROR RATE FORMULA- Except as provided in paragraph (3), the State's error rate for a fiscal year is--
    (A) the ratio of--
      (i) the erroneous payments of the State for the fiscal year; to
      (ii) the total payments of aid under the State plan approved under this part for the fiscal year; reduced by
    (B) the amount by which--
      (i) the national average underpayment rate for the fiscal year; exceeds
      (ii) the underpayment rate of the State for the fiscal year.
  (3) APPLICATION OF REDUCTION TO SUBSEQUENT FISCAL YEAR- At the request of a State, the Secretary shall apply the reduction described in paragraph (2)(B) in determining the State's error rate for either of the 2 following fiscal years instead of in determining the State's error rate for the fiscal year to which the reduction would otherwise apply.
  (e) NOTIFICATION TO STATES OF ERROR RATES- The Secretary shall notify each State of the error rate of the State determined under subsection (d), within the time period prescribed in regulations issued under subsection (h)(5).
  (f) IMPOSITION OF DISALLOWANCES- If a State's error rate for a fiscal year exceeds the national average error rate for the fiscal year, the Secretary shall impose a disallowance on the State for the fiscal year in an amount equal to--
(1) the product of--
  (A) the State's total payments of aid to families with dependent children for the fiscal year;
  (B) the Federal medical assistance percentage applicable to the State for purposes of section 1118;
  (C) the lesser of--
    (i) the ratio of--
      (I) the amount by which the State's error rate for the fiscal year exceeds the national average error rate for the fiscal year; to
      (II) the national average error rate for the fiscal year; or
    (ii) 1; and
  (D) the amount by which the State's error rate for the fiscal year exceeds the national average error rate for the fiscal year;
reduced by
(2) the product of--
  (A) the ratio of--
    (i) the amount by which the State's error rate for the fiscal year exceeds the national average error rate for the fiscal year; and
    (ii) the State's error rate for the fiscal year;
  (B) the overpayments recovered by the State in the fiscal year; and
  (C) the Federal medical assistance percentage applicable to the State for purposes of section 1118;
and further reduced by
(3) the product of--
  (A) the calculation described in paragraphs (1) and (2); and
  (B) the percentage by which--
    (i) the State's rate of child support collections for the fiscal year; exceeds
    (ii) the lesser of--
      (I) the national average rate of child support collections for the fiscal year; or
      (II) the average of the State's child support collection rates for each of the 3 fiscal years preceding the fiscal year.
(g) NOTIFICATION TO STATES OF AMOUNTS OF DISALLOWANCES- The Secretary shall notify each State on which the Secretary imposes a disallowance the amount of the disallowance, within the time period prescribed in regulations issued under subsection (h)(6).
(h) REGULATIONS- The Secretary, after consultation with the chief executives of the States, shall by regulation prescribe--
(1) the periods within which--
  (A) the reviews required by paragraphs (1) and (2) of subsection (b) are to begin and be completed; and
  (B) the results of the review required by subsection (b)(1) are to be reported to the Secretary;
(2) matters relating to the selection and size of the samples to be reviewed under paragraphs (1) and (2) of subsection (b), and the methodology for making statistically valid estimates of each State’s error rate;

(3) the period within which a State may seek review by the Quality Control Review Panel of a difference case;

(4) the period within which a difference case appealed by a State is to be resolved by the Quality Control Review Panel;

(5) the period, after the completion of the reviews required by paragraphs (1) and (2) of subsection (b) and the resolution by the Quality Control Review Panel of any difference cases appealed by a State, within which the Secretary is to notify the State of the error rate of the State for the fiscal year involved; and

(6) the period within which the Secretary is to notify a State of any disallowance.

(i) PAYMENT OF DISALLOWANCES-

(1) PAYMENT OPTIONS- Within 45 days after the date a State is notified of a disallowance pursuant to subsection (g), the State shall, at the option of the State--

(A) pay the Secretary the amount of the disallowance; or

(B) enter into an agreement with the Secretary under which the State will make quarterly payments to the Secretary over a period not to exceed 30 months beginning not later than the first quarter beginning after the date the State receives the notice, in amounts sufficient to repay the disallowance with interest by the end of such period.

(2) AUTHORITY TO ADJUST STATE MATCHING PAYMENTS- If a State fails to pay the amount of a disallowance imposed on the State, in the manner required by the applicable subparagraph of paragraph (1), the Secretary shall reduce the amount to be paid to the State under section 403(a) by amounts sufficient to recover the amount of the disallowance with interest.

(3) INTEREST ON UNPAID DISALLOWANCES-

(A) RATE OF INTEREST- Interest on the unpaid amount of a disallowance shall accrue at the overpayment rate established under section 6621(a)(1) of the Internal Revenue Code of 1986.

(B) ACCRUAL OF INTEREST-

(i) IN GENERAL- Except as provided in clause (ii), interest on the unpaid amount of a State’s disallowance shall accrue beginning 45 days after the date the State receives notice of the disallowance.

(ii) EXCEPTION- If the State appeals the imposition of a disallowance under this section to the Departmental Appeals Board and the Board does not decide the appeal within 90 days after the date of the State’s notice of appeal, interest shall not accrue on the unpaid amount of the disallowance during the period beginning on such 90th day and ending on the date of the Board’s final decision on the appeal, except to the extent that the Board finds that the State caused or requested the delay.
(j) ADMINISTRATIVE REVIEW OF DISALLOWANCES-
(1) IN GENERAL- Within 60 days after the date a State receives notice of a disallowance imposed under this section, the State may appeal the imposition of the disallowance, in whole or in part, to the Departmental Appeals Board established in the Department of Health and Human Services, by filing an appeal with the Board.
(2) PROCEDURAL RULES- The Board shall consider a State's appeal on the basis of such documentation as the State may submit and as the Board may require to support the final decision of the Board. In deciding whether to uphold a disallowance or any portion thereof, the Board shall conduct a thorough review of the issues and take into account all relevant evidence. In rendering its final decision, the Board shall incorporate by reference any findings of the Quality Control Review Panel that were made in connection with the determination of the error rate and the amount of the disallowance, and such findings shall not be reviewable by the Board.

(k) JUDICIAL REVIEW OF DISALLOWANCES-
(1) IN GENERAL- Within 90 days after the date of a final decision by the Departmental Appeals Board with respect to the imposition of a disallowance on a State under this section, the State may obtain judicial review of the final decision (and the findings of the Quality Control Review Panel incorporated into the final decision) by filing an action in--
(A) the district court of the United States for the judicial district in which the principal or headquarters office of the State agency is located; or
(B) the United States District Court for the District of Columbia.
(2) PROCEDURAL RULES- The district court in which an action is filed shall review the final decision of the Board on the record established in the administrative proceeding, in accordance with the standards of review prescribed by subparagraphs (A) through (E) of section 706(2) of title 5, United States Code. The review shall be on the basis of the documents and supporting data submitted to the Board (or to the Quality Control Review Panel, in the case of any finding by the Panel which is at issue in the appeal).

(l) REFUND OF DISALLOWANCES IMPOSED IN ERROR- If the Secretary, directly or indirectly, receives from a State part or all of the amount of a disallowance imposed on the State under this section, and part or all of the disallowance is finally determined to have been imposed in error, the Secretary shall refund to the State the amount received by reason of the error, with interest which shall accrue from the date of receipt at the rate described in subsection (i)(3)(A).

(m) DEFINITIONS- As used in this section:
(1) NATIONAL AVERAGE ERROR RATE- The term `national average error rate' for a fiscal year means the greater of--
(A) the ratio of--
(i) the total amount of erroneous payments made by all States for the fiscal year; to
(ii) the total amount of aid paid by all the States for the fiscal year under plans approved under this part; or
(B) 4 percent.
(2) UNDERPAYMENT RATE- The term `underpayment rate', with respect to a State for a fiscal year, means the ratio of--
(A) the total amounts of aid that should have been but were erroneously not paid for a fiscal year to recipients of aid under the State plan approved under this part; to
(B) the total amount of aid paid under such plan for the fiscal year.
(3) NATIONAL AVERAGE UNDERPAYMENT RATE- The term `national average underpayment rate' for a fiscal year means the ratio of--
(A) the total amounts of aid that should have been but were erroneously not paid for a fiscal year to all recipients of aid under State plans approved under this part; to
(B) the total amount of aid paid for the fiscal year under all State plans approved under this part.
(4) CHILD SUPPORT COLLECTION RATE- The term `child support collection rate', with respect to a State for a fiscal year, means the ratio of--
(A) the sum of the number of cases reported by the agency administering the State plan approved under part D for each quarter in the fiscal year for which--
(i) an assignment was made under section 402(a)(26); and
(ii) a collection was made under the State's plan approved under part D; to
(B) the sum of the number of cases reported by such agency for each quarter in the fiscal year under which an assignment was made under section 402(a)(26).
(5) NATIONAL CHILD SUPPORT COLLECTION RATE- The term `national child support collection rate' for a fiscal year means the ratio of--
(A) the sum of the number of cases described in paragraph (4)(A) reported by all States for quarters in the fiscal year; to
(B) the sum of the number of cases described in paragraph (4)(B) reported by all States for quarters in the fiscal year.
(6) ERRONEOUS PAYMENTS- The term `erroneous payments' means the sum of overpayments to eligible families and payments to ineligible families made in carrying out a plan approved under this part.'.
(b) CONFORMING REPEALS- Effective October 1, 1990, subsections (i) and (j) of section 403 are hereby repealed.
(c) APPLICABILITY OF NEW QUALITY CONTROL SYSTEM- The amendment made by subsection (a) shall apply to erroneous payments made in any fiscal year after fiscal year 1990.
(d) NO SANCTIONS WITH RESPECT TO DISALLOWANCES BEFORE FISCAL YEAR 1991- No disallowance or other similar sanction shall be applied to a
State for any fiscal year before fiscal year 1991 under section 403(i) of the Social Security Act or any predecessor statutory or regulatory provision relating to disallowances for erroneous payments made in carrying out a State plan approved under part A of title IV of such Act.

(e) IMPLEMENTATION- The Secretary of Health and Human Services shall take all actions necessary to assure that adequate numbers of staff are available to perform the functions required by the amendments made by this section.

(f) ANNUAL REPORTS- The Secretary of Health and Human Services shall annually submit to the Committee on Finance of the Senate, and to the Committee on Ways and Means of the House of Representatives a report on whether the time periods contained in the regulations prescribed pursuant to section 408 of the Social Security Act (as added by subsection (a)) have been or will be met. The first such report shall be submitted not later than January 1, 1992.

(g) STUDY OF NEGATIVE CASE ACTIONS-
(1) IN GENERAL- Not later than October 1, 1992, the Secretary of Health and Human Services shall report and make recommendations to the Congress on the results of a study of negative case actions under the program of aid to families with dependent children under State plans approved under part A of title IV of the Social Security Act.

(2) NEGATIVE CASE ACTIONS DEFINED- As used in paragraph (1), the term ‘negative case actions’ means termination of assistance under part A of title IV of the Social Security Act, denial of an application for assistance under such part, or other action with respect to an application under such part without a determination of eligibility for assistance under such part.

SEC. 8005. EMERGENCY ASSISTANCE AND AFDC SPECIAL NEEDS.

(a) IMPLEMENTATION OF PROPOSED REGULATIONS PROHIBITED- Except as provided in subsection (b), the Secretary of Health and Human Services (in this section referred to as the ‘Secretary’) shall not--

(1) implement in whole or in part the proposed regulation published in the Federal Register on December 14, 1987, (52 F.R. 47420) with respect to emergency assistance and the need for and amount of assistance under the program of aid to families with dependent children; or

(2) before October 1, 1990, change any policy in effect immediately before the date of the enactment of this Act with respect to any of the matters addressed in the proposed regulation.

(b) REVISED PROPOSED REGULATION- Notwithstanding subsection (a), the Secretary may issue a revised proposed regulation concerning the use of emergency assistance under the program of aid to families with dependent children under title IV of the Social Security Act that incorporates the recommendations included in the report entitled ‘Use of the Emergency
(c) ESTABLISHMENT OF EFFECTIVE DATES FOR PROPOSED RULES- Any final regulation which would change any policy in effect immediately before the date of the enactment of this Act with respect to the use of emergency assistance or special needs funds under the program of aid to families with dependent children under part A of title IV of the Social Security Act shall not take effect before October 1, 1990.

(d) REPORTING REQUIREMENTS- With respect to any calendar quarter beginning on or after January 1, 1990, a financial report by a State submitted to the Secretary to fulfill reporting requirements under the program of aid to families with dependent children under part A of title IV of the Social Security Act shall identify any emergency assistance and special needs funds expended by the State under the program and used to pay for housing in hotels or similar temporary living arrangements (as defined by the Secretary) that house recipients of such aid.

SEC. 8006. INCREASE IN REIMBURSEMENT FOR FOSTER AND ADOPTIVE PARENT TRAINING.

(a) IN GENERAL- Section 474(a)(3) (42 U.S.C. 674(a)(3)) is amended--
(1) by striking `and' at the end of subparagraph (A);
(2) by redesignating subparagraph (B) as subparagraph (C); and
(3) by inserting after subparagraph (A) the following:
`(B) 75 percent of so much of such expenditures (including travel and per diem expenses) as are for the short-term training of current or prospective foster or adoptive parents and the members of the staff of State-licensed or State-approved child care institutions providing care to foster and adopted children receiving assistance under this part, in ways that increase the ability of such current or prospective parents, staff members, and institutions to provide support and assistance to foster and adopted children, whether incurred directly by the State or by contract, and'.

(b) EFFECTIVE DATE- The amendments made by subsection (a) shall apply to expenditures made on or after October 1, 1989, and before October 1, 1992.

SEC. 8007. CASE PLANS TO INCLUDE HEALTH AND EDUCATION RECORDS AND TO BE REVIEWED AND UPDATED AT THE TIME OF EACH PLACEMENT.

(a) INCLUSION OF HEALTH AND EDUCATION RECORDS- Section 475(1) (42 U.S.C. 675(1)) is amended--
(1) by inserting `(A)' before `A description';
(2) by striking `472(a)(1); and a' and inserting `472(a)(1). (B) A';
(3) by indenting subparagraphs (A) and (B) (as so amended by paragraphs (1) and (2) of this subsection) 4 ems to the right of the left margin; (4) by inserting after and below subparagraph (B) (as so amended and indented) the following:

'(C) To the extent available and accessible, the health and education records of the child, including--

'(i) the names and addresses of the child's health and educational providers;
'(ii) the child's grade level performance;
'(iii) the child's school record;
'(iv) assurances that the child's placement in foster care takes into account proximity to the school in which the child is enrolled at the time of placement;
'(v) a record of the child's immunizations;
'(vi) the child's known medical problems;
'(vii) the child's medications; and
'(viii) any other relevant health and education information concerning the child determined to be appropriate by the State agency.'; and

(5) by setting the last sentence flush with the left margin of the paragraph.

(b) REVIEW AND UPDATE OF HEALTH AND EDUCATION RECORD AT TIME OF PLACEMENT- Section 475(5) (42 U.S.C. 675(5)) is amended--

(1) by striking `and' at the end of subparagraph (B);
(2) by striking the period at the end of subparagraph (C) and inserting `; and'
(3) by adding at the end the following new subparagraph:

'(D) a child's health and education record (as described in paragraph (1)(A)) is reviewed and updated, and supplied to the foster parent or foster care provider with whom the child is placed, at the time of each placement of the child in foster care.'.

(c) EFFECTIVE DATE- The amendments made by subsections (a) and (b) shall take effect on April 1, 1990.

SEC. 8008. ESTABLISHMENT AND CONDUCT OF OUTREACH PROGRAM FOR CHILDREN.

(a) IN GENERAL- Part B of title XVI (42 U.S.C. 1383 et seq.) is amended by adding at the end the following:

'SEC. 1635. OUTREACH PROGRAM FOR CHILDREN.

'(a) ESTABLISHMENT- The Secretary shall establish and conduct an ongoing program of outreach to children who are potentially eligible for benefits under this title by reason of disability or blindness.
'(b) REQUIREMENTS- Under this program, the Secretary shall--
(1) aim outreach efforts at populations for whom such efforts would be most effective; and
(2) work in cooperation with other Federal, State, and private agencies, and nonprofit organizations, which serve blind or disabled individuals and have knowledge of potential recipients of supplemental security income benefits, and with agencies and organizations (including school systems and public and private social service agencies) which focus on the needs of children.'.
(b) EFFECTIVE DATE- The amendment made by subsection (a) shall take effect 3 months after the date of the enactment of this Act.

SEC. 8009. ELIGIBILITY FOR BENEFITS OF CHILDREN OF ARMED FORCES PERSONNEL RESIDING OVERSEAS.

(a) IN GENERAL- Section 1611(f) (42 U.S.C. 1382(f)) is amended by inserting `(other than a child described in section 1614(a)(1)(B)(ii))' after `no individual'.
(b) CONFORMING AMENDMENT- Section 1614(a)(1) (42 U.S.C. 1382c(a)(1)) is amended--
(1) in subparagraph (B)--
(A) by redesignating clauses (i) and (ii) as subclauses (I) and (II), respectively;
(B) by inserting `(i)' after `(B)'; and
(C) by striking the period and inserting `, or'; and
(2) by adding after and below subparagraph (B) the following:
`(ii) is a child who is a citizen of the United States, who is living with a parent of the child who is a member of the Armed Forces of the United States assigned to permanent duty ashore outside the United States, the District of Columbia, Puerto Rico, and the territories and possessions of the United States, and who, during the month before the parent reported for such assignment, was receiving benefits under this title.'.
(c) EFFECTIVE DATE- The amendments made by subsections (a) and (b) shall apply with respect to benefits for months after March 1990.

SEC. 8010. RULE FOR DEEMING TO CHILDREN THE INCOME AND RESOURCES OF THEIR PARENTS WAIVED FOR CERTAIN DISABLED CHILDREN.

(a) IN GENERAL- Section 1614(f)(2) (42 U.S.C. 1382c(f)(2)) is amended--
(1) by inserting `(A)' after `(2)'; and
(2) by adding at the end the following:
`(B) Subparagraph (A) shall not apply in the case of any child who has not attained the age of 18 years who--
(i) is disabled;
(ii) received benefits under this title, pursuant to section 1611(e)(1)(B), while in an institution described in section 1611(e)(1)(B);
(iii) is eligible for medical assistance under a State home care plan approved by the Secretary under the provisions of section 1915(c) relating to waivers, or authorized under section 1902(e)(3); and
(iv) but for this subparagraph, would not be eligible for benefits under this title.'.

(b) PERSONAL NEEDS ALLOWANCE- Section 1611(e)(1)(B) (42 U.S.C. 1382(e)(1)(B)) is amended by inserting `or an eligible individual is a child described in section 1614(f)(2)(B),' before `the benefit under this title'.
(c) EFFECTIVE DATE- The amendments made by subsections (a) and (b) shall take effect on the 1st day of the 6th calendar month beginning after the date of the enactment of this Act.

SEC. 8011. EXCLUSION FROM INCOME OF DOMESTIC COMMERCIAL TRANSPORTATION TICKETS RECEIVED AS GIFTS.

(a) EXCLUSION FROM INCOME- Section 1612(b) (42 U.S.C. 1382a(b)) is amended--
(1) by striking `and' at the end of paragraph (13);
(2) by striking the period at the end of paragraph (14) and inserting `; and'; and
(3) by adding at the end the following:
`(15) the value of any commercial transportation ticket, for travel by such individual (or spouse) among the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, which is received as a gift by such individual (or such spouse) and is not converted to cash.'.

(b) EFFECTIVE DATE- The amendments made by subsection (a) shall take effect on the 1st day of the 3rd calendar month beginning after the date of the enactment of this Act.

SEC. 8012. REDUCTION IN TIME DURING WHICH INCOME AND RESOURCES OF SEPARATED COUPLES MUST BE TREATED AS JOINTLY AVAILABLE.

(a) IN GENERAL- Section 1614(b) (42 U.S.C. 1382c(b)) is amended by striking the 1st sentence and inserting `For purposes of this title, the term `eligible spouse' means an aged, blind, or disabled individual who is the husband or wife of another aged, blind, or disabled individual, and who, in a month, is living with such aged, blind, or disabled individual on the first day of the month or, in any case in which either spouse files an application for benefits or requests restoration of eligibility under this title during the month, at the time the application or request is filed.'.
(b) EFFECTIVE DATE- The amendment made by subsection (a) shall take effect on October 1, 1990.

SEC. 8013. EXCLUSION OF ACCRUED INCOME WITH RESPECT TO PURCHASE OF CERTAIN BURIAL SPACES.

(a) EXCLUSION FROM INCOME- Section 1612(b) (42 U.S.C. 1382a(b)), as amended by section 8011(a) of this Act, is amended--
(1) by striking `and' at the end of paragraph (14);
(2) by striking the period at the end of paragraph (15) and inserting `; and'; and
(3) by adding at the end the following:
`(16) interest accrued on the value of an agreement entered into by such individual (or such spouse) representing the purchase of a burial space excluded under section 1613(a)(2)(B), and left to accumulate.'.
(b) EXCLUSION FROM RESOURCES- Section 1613(a)(2)(B) (42 U.S.C. 1382b(a)(2)(B)) is amended by inserting `or agreement (including any interest accumulated thereon) representing the purchase of a burial space' after `the value of any burial space'.
(c) EFFECTIVE DATE- The amendments made by subsections (a) and (b) shall take effect on the 1st day of the 4th month beginning after the date of the enactment of this Act.

SEC. 8014. EXCLUSION FROM RESOURCES OF ALL INCOME-PRODUCING PROPERTY.

(a) IN GENERAL- Section 1613(a)(3) (42 U.S.C. 1382b(a)(3)) is amended to read as follows:
`(3) other property which is so essential to the means of self-support of such individual (and such spouse) as to warrant its exclusion, as determined in accordance with and subject to limitations prescribed by the Secretary, except that the Secretary shall not establish a limitation on property (including the tools of a tradesperson and the machinery and livestock of a farmer) that is used in a trade or business or by such individual as an employee;'.
(b) EFFECTIVE DATE- The amendment made by subsection (a) shall take effect on the 1st day of the 5th calendar month beginning after the date of the enactment of this Act.

SEC. 8015. DEMONSTRATION OF EFFECTIVENESS OF MINNESOTA FAMILY INVESTMENT PLAN.

(a) IN GENERAL- Upon written application of the State of Minnesota (in this section referred to as the `State') within 24 months after the date of the
enactment of this Act, and after the Secretary of Health and Human Services approves the application as meeting the requirements set forth in subsection (b), the State may conduct a demonstration project to determine whether the State family investment plan helps families to become self-supporting and enhances the ability of families to care for their children more effectively than does the State program of aid to families with dependent children under part A of title IV of the Social Security Act.

(b) PROJECT REQUIREMENTS- In an application submitted under subsection (a), the State shall provide that the following terms and conditions shall be in effect under the demonstration project:

(1) FIELD TRIALS- The project will consist of 2 field trials, conducted as follows:

(A) URBAN FIELD TRIAL- 1 field trial will be conducted in 1 or more of the following counties in the State:

(i) Anoka.
(ii) Carver.
(iii) Dakota.
(iv) Hennepin.
(v) Scott.
(vi) Washington.

(B) RURAL FIELD TRIAL- 1 field trial will be conducted in 1 or more counties in the State not specified in subparagraph (A).

(C) NUMBER OF FAMILIES INVOLVED- The field trials will not involve more than a total of 6,000 families at any one time, excluding families whose sole involvement is as members of control groups needed to evaluate the project.

(2) AUTHORITY TO IMPLEMENT FIELD TRIALS DIFFERENTLY- The implementation of the family investment plan in 1 field trial may be different from the implementation of such plan in the other field trial.

(3) WAIVERS REQUIRED BEFORE PROJECT BEGINS- The project will not begin before all waivers required as described in subsection (e) have been granted.

(4) BEGINNING OF PROJECT-

(A) IN GENERAL- The project will begin during the first month of a calendar quarter.

(B) BEGIN DEFINED- For purposes of this section, the project begins when the first family receives assistance under the project.

(5) PROJECT TO BE OPERATED IN ACCORDANCE WITH CERTAIN MINNESOTA LAWS- The project will be operated in accordance with the 1989 Minnesota Laws, sections 6 through 11, 13, 130, and 132 of article 5 of chapter 282, and all amendments to the Laws of Minnesota, to the extent that such laws and amendments are consistent with the goals of the project and this subsection.
(6) PROJECT PARTICIPANTS INELIGIBLE FOR AFDC - Each family which participates in the project will not be eligible for aid under the State plan approved under section 402(a) of the Social Security Act.

(7) MEDICAID ELIGIBILITY RULES APPLICABLE TO PROJECT -
(A) ELIGIBILITY OF PARTICIPANTS -
(i) IN GENERAL - Each family which participates in the project and would (but for such participation) be eligible for aid under the State plan approved under section 402(a) of the Social Security Act will be treated as receiving such aid for purposes of the State plan approved under section 1902(a) of such Act.

(ii) ELIGIBILITY EXTENDED FOR PROJECT PARTICIPANTS WITH INCREASED EMPLOYMENT INCOME - Each family which participates in the project and, during such participation, would (but for such participation) become ineligible for aid under the State plan approved under section 402(a) of the Social Security Act by reason of increased income from employment will, for purposes of section 1925 of such Act, be treated as a family that has become ineligible for such aid.

(B) ELIGIBILITY EXTENDED FOR PERSONS LEAVING PROJECT BECAUSE OF INCREASED RECEIPT OF CHILD SUPPORT - Each family whose participation in the project is terminated by reason of the collection or increased collection of child support under part D of title IV of the Social Security Act will be treated as a recipient of aid to families with dependent children for purposes of title XIX of such Act for an additional 4 calendar months beginning with the month in which the termination occurs.

(8) AFDC RULES TO APPLY GENERALLY -
(A) IN GENERAL - Except where inconsistent with this subsection, the requirements of the State plan approved under section 402(a) of the Social Security Act will apply to the project, unless waived by the Secretary of Health and Human Services in accordance with subsection (d).

(B) RULES RELATING TO PARTICIPATION IN EDUCATION, EMPLOYMENT, AND TRAINING ACTIVITIES -
(i) PARTICIPATION GENERALLY NOT REQUIRED - Except as provided in clause (ii), the State will not require any individual who applies for or receives assistance under the project to comply with any education, employment, or training requirement of title IV of the Social Security Act, unless required to do so under a contract entered into under the project.

(ii) AUTHORITY TO REQUIRE PARTICIPATION OF PARENT OF CHILD AGE 1 OR OLDER - The State may require any individual to comply with any education, employment, or training requirement imposed under the project if the State plan approved under section 402(a) of the Social Security Act does not prohibit the State from requiring such compliance, and the individual--
(I) receives assistance under the project;
(II) is the parent or relative of a child who has attained the age of 1 year; and
(III) is personally providing care for the child.

(9) AVAILABILITY OF EDUCATION, EMPLOYMENT, AND TRAINING SERVICES-The education, employment, and training services available under the State plan approved under part F of title IV of the Social Security Act will be made available to each family required to enter into a contract with a county agency under the 1989 Minnesota Laws, section 10 of article 5 of chapter 282.

(10) ASSISTANCE UNDER PROJECT NOT LESS THAN UNDER AFDC AND FOOD STAMP PROGRAM-
(A) ESTABLISHMENT OF POLICIES AND STANDARDS- The State will establish policies and standards to ensure that families participating in the project receive cash assistance under the project in an amount not less than the aggregate value of the assistance that such families would have received under the State plan approved under section 402(a) of such Act and under the food stamp program established under the Food Stamp Act of 1977 in the absence of the project.

(B) IDENTIFICATION OF CHARACTERISTICS OF PARTICIPANTS WHO MIGHT RECEIVE LESS BENEFITS THAN UNDER AFDC AND FOOD STAMP PROGRAM- The State will identify the set or sets of characteristics of families that (but for this paragraph) might receive benefits under the project in an amount less than the amount required under subparagraph (A) to be provided to such family.

(C) DETERMINATION OF BENEFIT LEVEL FOR PARTICIPANTS WITH IDENTIFIED CHARACTERISTICS- The State will establish a mechanism to determine, for each family with any set of characteristics identified under subparagraph (B), whether the family would (but for this paragraph) receive benefits under the project in an amount less than the amount required under subparagraph (A) to be provided to such family.

(D) ASSISTANCE UNDER PROJECT INCREASED WHERE NECESSARY- The State will, for each family which would (but for this paragraph) receive benefits under the project in an amount less than the amount required under subparagraph (A) to be provided to such family, increase the amount of such benefits to such family to the amount so required.

(11) TERMINATION OF PROJECT- The project will terminate at the end of the 5-year period beginning on the first day of the month during which the project begins, or, if earlier--
(A) 180 days after the State notifies the Secretary of Health and Human Services that the State intends to terminate the project;
(B) 180 days after the Secretary of Health and Human Services, after 30 days written notice to the State and opportunity for a hearing, determines that the State has materially failed to comply with this section; or
(C) on agreement by the State and the Secretary of Health and Human Services.

(c) FUNDING-
(1) IN GENERAL- If an application submitted under subsection (a) by the State complies with the requirements specified in subsection (b) and contains an evaluation plan which meets the requirements of subsection (g), and the Secretary of Health and Human Services approves the application, then the Secretary shall, from amounts made available under parts A and F of title IV of the Social Security Act--
(A) pay the State for each calendar quarter, pursuant to section 403 of such Act, the amounts that would have been payable to the State during such calendar quarter, in the absence of the demonstration project, for cash assistance, child care, education, employment and training, and administrative expenses under the State plan approved under section 402(a) of such Act;
(B) reimburse the State at the rate of 50 percent, for expenses of evaluating the effects of the project.
(2) RULE OF CONSTRUCTION- Paragraph (1) shall not be construed to prevent the State from claiming and receiving reimbursement for additional persons who would qualify for assistance under the State plan approved under section 402(a) of the Social Security Act, for costs attributable to increases in the State's payment standard under such plan, or for any other benefits and services for which Federal matching funds are available under part A of title IV of such Act.
(d) WAIVER AUTHORITY-
(1) AFDC WAIVERS-
(A) IN GENERAL- Except as provided in subparagraph (B), the Secretary of Health and Human Services shall, with respect to the demonstration project under this section, waive any requirement of part A or F of title IV of the Social Security Act that, if applied, would prevent the State from (i) carrying out the project in accordance with subsection (b), or (ii) effectively achieving its purposes, but only to the extent necessary to enable the State to carry out the project.
(B) LIMITATIONS- The Secretary of Health and Human Services may not, with respect to the demonstration project under this section--
(i) waive any requirement of section 402(a)(4) or 482(h) of the Social Security Act;
(ii) permit the State to provide cash assistance to any family under the project in an amount less than the aggregate value of the assistance that would have been provided to such family under the State plan approved under section 402(a) of such Act and under the food stamp program established under the Food Stamp Act of 1977 in the absence of the project; or
(iii) waive any requirement of section 402(a)(19)(C) of such Act.
(2) OTHER WAIVERS- If, under this section, the Secretary of Health and Human Services approves an application by the State to conduct a demonstration project relating to the State family investment plan, the
Secretary of Health and Human Services shall, in order to enable the State to implement the demonstration project—
(A)(i) require that the State treat each family participating in the project as individuals eligible for medical assistance under section 1902(a)(10)(A) of the Social Security Act,
(ii) require that the State treat, for purposes of section 1925 of such Act, each family whose participation in the project is terminated by reason of increased income from employment as a family that has become ineligible for aid under the State plan approved under part A of title IV of such Act, and
(iii) require that the State treat each family whose participation in the project is terminated by reason of the collection or increased collection of child support under part D of title IV of the Social Security Act as a recipient of aid to families with dependent children for purposes of title XIX of such Act for an additional 4 calendar months beginning with the month in which such termination occurs; and
(B) make payment, under section 1903 of such Act, for medical assistance and administrative expenses for families participating in the project in the same manner as such payments may be made for medical assistance and administrative expenses for individuals entitled to benefits under title XIX of such Act, except that the aggregate amount of such payments may not exceed the aggregate amount of payments that would have been made for those families in the absence of such project.
(e) DEFINITIONS OF CERTAIN TERMS- As used in this section, the terms `family' and `contract' shall have the meaning given such terms by the 1989 Minnesota Laws, sections 6 through 11, 13, 130, and 132 of article 5 of chapter 282.
(f) QUALITY CONTROL- Cases participating in the demonstration project under this section during a fiscal year shall be excluded from any sample taken for purposes of determining under section 403(i) or 408 of the Social Security Act, whichever is applicable, the rate at which the State made overpayments under part A of title IV of such Act for the fiscal year. For purposes of such sections 403(i) and 408, payments made by the State under the project shall be treated as payments made under the State plan approved under section 402(a) of such Act.
(g) EVALUATION OF PROJECT-
(1) EVALUATION PLAN- The State shall develop and implement an evaluation plan designed to provide reliable information on the impact and implementation of the demonstration project. The evaluation plan shall include groups of project participants and control groups assigned at random in the field trial conducted in accordance with subsection (b)(1)(A).
(2) EVALUATION- The evaluation conducted under the evaluation plan shall measure the extent to which the project increases family employment and income, prevents long-term dependency, moves families toward self-
support, reduces total assistance payments, and simplifies the welfare system.

(3) REPORTS- The State shall issue an interim report and a final report on the results of the evaluation described in paragraph (2) to the Secretary of Health and Human Services at such times as the Secretary shall require. (h) REPORT TO CONGRESS- Within 3 months after receipt of the final report issued pursuant to subsection (g)(3), the Secretary of Health and Human Services shall report to the Congress the results of the evaluation described in subsection (g)(2).

SEC. 8016. INCREASE IN FUNDING FOR TITLE XX SOCIAL SERVICES BLOCK GRANT.

Section 2003(c) (42 U.S.C. 1397b(c)) is amended-- (1) in paragraph (3), by striking `and 1987, and for each succeeding fiscal year other than the fiscal year 1988; and' and inserting `1987, and 1989;'; (2) in paragraph (4), by striking the period and inserting `; and'; and (3) by adding at the end the following:

`(5) $2,800,000,000 for each fiscal year after fiscal year 1989.'.
TITLE X--MISCELLANEOUS AND TECHNICAL SOCIAL SECURITY ACT AMENDMENTS

SEC. 10000. SHORT TITLE; TABLE OF CONTENTS.

This title may be cited as the `Miscellaneous and Technical Social Security Act Amendments of 1989'.

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SEC. 10101. CONTINUATION OF DISABILITY BENEFITS DURING APPEAL.
Subsection (g) of section 223 of the Social Security Act (42 U.S.C. 423(g)) is amended--
(1) in paragraph (1)(iii), by striking `June 1990' and inserting `June 1991'; and
(2) in paragraph (3)(B), by striking `January 1, 1990' and inserting `January 1, 1991'.

SEC. 10102. TRANSFER TO RAILROAD RETIREMENT ACCOUNT.
Subsection (c)(1)(A) of section 224 of the Railroad Retirement Solvency Act of 1983 (relating to section 72(r) revenue increase transferred to certain railroad accounts) is amended by striking `1989' and inserting `1990'.

SEC. 10103. EXTENSION OF DISABILITY INSURANCE PROGRAM DEMONSTRATION PROJECT AUTHORITY.
(a) IN GENERAL- Section 505 of the Social Security Disability Amendments of 1980 (Public Law 96-265), as amended by section 12101 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), is further amended--
(1) in paragraph (3) of subsection (a), by striking `June 10, 1990' and inserting `June 10, 1993';
(2) in paragraph (4) of subsection (a), by striking `in each of the years 1986, 1987, 1988, and 1989' and inserting `in 1986 and each of the succeeding years through 1992'; and
(3) in subsection (c), by striking `June 9, 1990' and inserting `June 9, 1993'.
(b) EFFECTIVE DATE- The amendments made by this section shall take effect on the date of the enactment of this Act.

Subtitle B--Technical Provisions

SEC. 10201. PROHIBITION OF TERMINATION OF COVERAGE OF U.S. CITIZENS AND RESIDENTS EMPLOYED ABROAD BY A FOREIGN AFFILIATE OF AN AMERICAN EMPLOYER.
(a) IN GENERAL- Subsection (l) of section 3121 of the Internal Revenue Code of 1986 (relating to agreements entered into by American employers with respect to foreign affiliates) is amended--
(1) in paragraph (2), by adding at the end the following: `Notwithstanding any other provision of this subsection, the period for which any such agreement is effective with respect to any foreign entity shall terminate at
the end of any calendar quarter in which the foreign entity, at any time in such quarter, ceases to be a foreign affiliate as defined in paragraph (6).'

(2) by striking paragraphs (3), (4), and (5);

(3) by inserting after paragraph (2) the following new paragraph:
`(3) NO TERMINATION OF AGREEMENT- No agreement under this subsection may be terminated, either in its entirety or with respect to any foreign affiliate, on or after June 15, 1989.'; and

(4) by redesignating paragraphs (6) through (10) as paragraphs (4) through (8), respectively.

(b) CONFORMING AMENDMENTS- (1) Subsection (a) of section 210 of the Social Security Act (42 U.S.C. 410(a)) and subsection (a) of section 406 of the Internal Revenue Code of 1986 (relating to treatment of employees of American employer) are each amended by striking `section 3121(l)(8)' and inserting `section 3121(l)(6)'.

(2) Paragraph (3) of section 406(c) of the Internal Revenue Code of 1986 (relating to termination of status as deemed employee not be treated as separation from service for purposes of limitation of tax) is amended by striking `section 3121(l)(8)(B)' and inserting `section 3121(l)(6)(B)'.

(3) Paragraph (1) of section 3121(l) of such Code (relating to agreements entered into by American employers with respect to foreign affiliates) is amended, in the matter preceding subparagraph (A), by striking `paragraph (8)' and inserting `paragraph (6)'.

(c) EFFECTIVE DATE- The amendments made by this section shall apply with respect to any agreement in effect under section 3121(l) of the Internal Revenue Code of 1986 on or after June 15, 1989, with respect to which no notice of termination is in effect on such date.

**SEC. 10202. EXCLUSION FROM WAGES AND COMPENSATION OF REFUNDS REQUIRED FROM EMPLOYERS TO COMPENSATE FOR DUPLICATION OF MEDICARE BENEFITS BY HEALTH CARE BENEFITS PROVIDED BY THE EMPLOYERS.**

(a) OLD-AGE, SURVIVORS, AND DISABILITY, AND HOSPITAL INSURANCE PROGRAMS- For purposes of title II of the Social Security Act and chapter 21 of the Internal Revenue Code of 1986, the term `wages' shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

(b) RAILROAD RETIREMENT PROGRAM- For purposes of chapter 22 of the Internal Revenue Code of 1986, the term `compensation' shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

(c) FEDERAL UNEMPLOYMENT PROGRAMS-

(1) FEDERAL UNEMPLOYMENT TAX- For purposes of chapter 23 of the Internal Revenue Code of 1986, the term `wages' shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.
(2) RAILROAD UNEMPLOYMENT CONTRIBUTIONS- For purposes of the Railroad Unemployment Insurance Act, the term 'compensation' shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

(3) RAILROAD UNEMPLOYMENT REPAYMENT TAX- For purposes of chapter 23A of the Internal Revenue Code of 1986, the term 'rail wages' shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

(d) REPORTING REQUIREMENTS- Any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988 shall be reported to the Secretary of the Treasury or his delegate and to the person to whom such refund is made in such manner as the Secretary of the Treasury or his delegate shall prescribe.

(e) EFFECTIVE DATE- This section shall apply with respect to refunds provided on or after January 1, 1989.

SEC. 10203. ELIMINATION OF ANY CARRYOVER REDUCTION IN RETIREMENT OR DISABILITY BENEFITS DUE TO RECEIPT OF WIDOW'S OR WIDOWER'S BENEFITS BEFORE ATTAINING AGE 62.

(a) IN GENERAL- Section 202(q)(3) of the Social Security Act (42 U.S.C. 402(q)(3)) is amended--

(1) by striking subparagraphs (E), (F), and (G); and
(2) by redesignating subparagraph (H) as subparagraph (E).

(b) EFFECTIVE DATE- The amendments made by this section shall apply--

(1) in the case of any individual's old-age insurance benefit referred to in section 202(q)(3)(E) of the Social Security Act (as in effect before the amendments made by this section), only if such individual attains age 62 on or after January 1, 1990, and
(2) in the case of any individual's disability insurance benefit referred to in section 202(q)(3)(F) or (G) of such Act (as so in effect), only if such individual both attains age 62 and becomes disabled on or after such date.

SEC. 10204. CLARIFICATION OF RULES GOVERNING TAXATION UNDER FICA AND SECA OF INDIVIDUALS OF CERTAIN RELIGIOUS FAITHS.

(a) EXEMPTION FROM SECA TAXATION FOR CERTAIN EMPLOYEES EXEMPT FROM FICA TAXATION-

(1) IN GENERAL- Paragraph (3) of section 1402(g) of the Internal Revenue Code of 1986 (relating to inapplicability of exemption to certain church employees) is amended--

(A) in the heading, by striking `NOT TO APPLY' and inserting `TO APPLY'; and
(B) by striking `shall not' and inserting `shall'.

(2) EFFECTIVE DATE- The amendments made by paragraph (1) shall apply with respect to taxable years beginning after December 31, 1989.
(b) TECHNICAL AMENDMENT CLARIFYING INCLUSION OF PARTNERSHIPS AMONG EMPLOYERS ELIGIBLE FOR RELIGIOUS EXEMPTION FROM FICA-
(1) IN GENERAL- Section 3127 of the Internal Revenue Code of 1986 (relating to exemption for employers and their employees where both are members of religious faiths opposed to participation in Social Security Act programs) is amended--
(A) in subsection (a)(1), by inserting `(or, if the employer is a partnership, each partner therein)' after `an employer';
(B) in subsection (a), in the matter following paragraph (2), by striking `his employees' and inserting `the employees thereof';
(C) in subsection (b), by inserting `(or a partner)' after `an employer';
(D) in subsection (c), by striking `his employees' and inserting `the employees thereof';
(E) in subsection (c)(1), by inserting `(or, if the employer is a partnership, each partner therein)' after `such employer'; and
(F) in subsection (c)(2), by striking `such employer or the employee involved ceases to meet' and inserting `such employer (or, if the employer is a partnership, any partner therein) or the employee involved does not meet', and by inserting `(or, if the employer is a partnership, any partner therein)' after `such employer' the second place it appears.
(2) EFFECTIVE DATE- The amendments made by this subsection shall be effective as if they were included in the amendments made by section 8007(a)(1) of the Technical and Miscellaneous Revenue Act of 1988 (102 Stat. 3781).

SEC. 10205. TREATMENT OF GROUP-TERM LIFE INSURANCE UNDER RAILROAD RETIREMENT TAXES.
(a) IN GENERAL- The second sentence of section 3231(e)(1) of the Internal Revenue Code of 1986 (defining compensation) is amended by striking `, (ii) tips' and inserting `or death, except that this clause does not apply to a payment for group-term life insurance to the extent that such payment is includible in the gross income of the employee, (ii) tips'.
(b) EFFECTIVE DATE-
(1) IN GENERAL- Except as provided in paragraph (2), the amendment made by subsection (a) shall apply to--
(A) group-term life insurance coverage in effect after December 31, 1989, and
(B) remuneration paid before January 1, 1990, which the employer treated as compensation when paid.
(2) EXCEPTION- The amendment made by subsection (a) shall not apply with respect to payments by the employer (or a successor of such employer) for group-term life insurance for such employer's former employees who separated from employment with the employer on or before December 31, 1989, to the extent that such payments are not for coverage for any such employee for any period for which such employee is employed by such
employer (or a successor of such employer) after the date of such separation.

(3) BENEFIT DETERMINATIONS TO TAKE INTO ACCOUNT REMUNERATION ON WHICH TAX PAID- The term `compensation' as defined in section 1(h) of the Railroad Retirement Act of 1974 includes any remuneration which is included in the term `compensation' as defined in section 3231(e)(1) of the Internal Revenue Code of 1986 by reason of the amendment made by subsection (a).

SEC. 10206. TREATMENT OF CERTAIN DEFERRED COMPENSATION AND SALARY REDUCTION ARRANGEMENTS UNDER RAILROAD RETIREMENT TAXES.

(a) IN GENERAL- The second sentence of section 3231(e)(1) of the Internal Revenue Code of 1986 (defining compensation) is amended by striking `or (iii)' and inserting `(iii)' and by inserting before the period `, or (iv) any remuneration which would not (if chapter 21 applied to such remuneration) be treated as wages (as defined in section 3121(a)) by reason of section 3121(a)(5)'.

(b) TREATMENT OF CERTAIN DEFERRED COMPENSATION AND SALARY REDUCTION ARRANGEMENTS- Subsection (e) of section 3231 of such Code is amended by adding at the end thereof the following new paragraph:

`(9) TREATMENT OF CERTAIN DEFERRED COMPENSATION AND SALARY REDUCTION ARRANGEMENTS-

`(A) CERTAIN EMPLOYER CONTRIBUTIONS TREATED AS COMPENSATION- Nothing in any paragraph of this subsection (other than paragraph (2)) shall exclude from the term `compensation' any amount described in subparagraph (A) or (B) of section 3121(v)(1).

` (B) TREATMENT OF CERTAIN NONQUALIFIED DEFERRED COMPENSATION- The rules of section 3121(v)(2) which apply for purposes of chapter 21 shall also apply for purposes of this chapter.'.

(c) EFFECTIVE DATES-

(1) SUBSECTION (a)- The amendment made by subsection (a) shall apply to remuneration paid after December 31, 1989.

(2) SUBSECTION (b)- Except as otherwise provided in this subsection--

(A) IN GENERAL- The amendment made by subsection (b) shall apply to--

(i) remuneration paid after December 31, 1989, and

(ii) remuneration paid before January 1, 1990, which the employer treated as compensation when paid.

(B) BENEFIT DETERMINATIONS TO TAKE INTO ACCOUNT REMUNERATION ON WHICH TAX PAID- The term `compensation' as defined in section 1(h) of the Railroad Retirement Act of 1974 includes any remuneration which is included in the term `compensation' as defined in section 3231(e)(1) of the Internal Revenue Code of 1986 by reason of the amendment made by subsection (b).
(3) SPECIAL RULE FOR CERTAIN PAYMENTS- For purposes of applying the amendment made by subsection (b) to remuneration paid after December 31, 1989, which would have been taken into account before January 1, 1990, if such amendments had applied to periods before January 1, 1990, such remuneration shall be taken into account when paid (or, at the election of the payor, at the time which would be appropriate if such amendments had applied).

(4) EXCEPTION FOR CERTAIN 401(k) CONTRIBUTIONS- The amendment made by subsection (b) shall not apply to employer contributions made during 1990 and attributable to services performed during 1989 under a qualified cash or deferred arrangement (as defined in section 401(k) of the Internal Revenue Code of 1986) if, under the terms of the arrangement as in effect on June 15, 1989--
(A) the employee makes an election with respect to such contributions before January 1, 1990, and
(B) the employer identifies the amount of such contribution before January 1, 1990.

(5) SPECIAL RULE WITH RESPECT TO NONQUALIFIED DEFERRED COMPENSATION PLANS- In the case of an agreement in existence on June 15, 1989, between a nonqualified deferred compensation plan (as defined in section 3121(v)(2)(C) of such Code) and an individual, the amendment made by subsection (b) shall apply with respect to services performed by the individual after December 31, 1989. The preceding sentence shall not apply in the case of a plan to which section 457(a) of such Code applies.

SEC. 10207. TREATMENT OF ROWAN DECISION UNDER RAILROAD RETIREMENT TAXES.
(a) EXCLUSION OF MEALS AND LODGING- Subsection (e) of section 3231 of the Internal Revenue Code of 1986 is further amended by adding at the end the following new paragraph:
`(10) MEALS AND LODGING- The term `compensation' shall not include the value of meals or lodging furnished by or on behalf of the employer if at the time of such furnishing it is reasonable to believe that the employee will be able to exclude such items from income under section 119.'.
(b) INCOME TAX WITHHOLDING REGULATIONS NOT TO APPLY- Paragraph (1) of section 3231(e) of such Code is amended by adding at the end the following new sentence: `Nothing in the regulations prescribed for purposes of chapter 24 (relating to wage withholding) which provides an exclusion from `wages' as used in such chapter shall be construed to require a similar exclusion from `compensation' in regulations prescribed for purposes of this chapter.'.
(c) EFFECTIVE DATE- The amendments made by this section shall apply to remuneration paid after December 31, 1989.

SEC. 10208. INCLUSION OF CERTAIN DEFERRED COMPENSATION IN DETERMINATION OF WAGE-BASED ADJUSTMENTS.
(a) IN GENERAL- Section 209 of the Social Security Act (42 U.S.C. 409) is amended by adding at the end the following new subsection:

`\(k\)(1) For purposes of sections 203(f)(8)(B)(ii), 213(d)(2)(B), 215(a)(1)(B)(ii), 215(b)(3)(A)(ii), 224(f)(2)(B), and 230(b)(2) (and 230(b)(2) as in effect immediately prior to the enactment of the Social Security Amendments of 1977), the term `deemed average total wages' for any particular calendar year means the product of--

`(A) the SSA average wage index (as defined in section 215(i)(1)(G) and promulgated by the Secretary) for the calendar year preceding such particular calendar year, and

`(B) the quotient obtained by dividing--

`(i) the average of total wages (as defined in regulations of the Secretary and computed without regard to the limitation specified in subsection (a)(1) and by including deferred compensation amounts) reported to the Secretary of the Treasury or his delegate for such particular calendar year, by

`(ii) the average of total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate for the calendar year preceding such particular calendar year.

`(2) For purposes of paragraph (1), the term `deferred compensation amount' means--

`(A) any amount excluded from gross income under chapter 1 of the Internal Revenue Code of 1986 by reason of section 402(a)(8), 402(h)(1)(B), or 457(a) of such Code or by reason of a salary reduction agreement under section 403(b) of such Code,

`(B) any amount with respect to which a deduction is allowable under chapter 1 of such Code by reason of a contribution to a plan described in section 501(c)(18) of such Code, and

`(C) to the extent provided in regulations of the Secretary, deferred compensation provided under any arrangement, agreement, or plan referred to in subsection (i) or (j).'

(b) Conforming Amendments-


(A) by striking `the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitation specified in section 209(a)(1)) reported to the Secretary of the Treasury or his delegate' and inserting `the deemed average total wages (as defined in section 209(k)(1))';

(B) by striking `the average of the total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate' and inserting `the deemed average total wages (as so defined)'; and

(C) in section 215(b)(3)(A)(ii)(I), by striking `(after 1976)'.

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(2) Sections 213(d)(2)(B), 215(a)(1)(B)(ii), and 224(f)(2)(B) of such Act (42 U.S.C. 413(d)(2)(B), 415(a)(1)(B)(ii), and 424a(f)(2)(B)), as amended by subsection (d)(2)(A)(i), are each further amended--

(A) by striking `the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1)) reported to the Secretary of the Treasury or his delegate' and inserting `the deemed average total wages (as defined in section 209(k)(1))';

(B) in section 213(d)(2)(B) and 215(a)(1)(B)(ii)(II), by striking `(as so defined and computed)' and inserting `(as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1))'; and

(C) in section 224(f)(2)(B)(ii), by inserting `(I)' after `(ii)', by striking `as so defined and computed)' and inserting `(as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1))', and by inserting after `disability' the following: `, if such calendar year is before 1991, or (II) the deemed average total wages (as defined in section 209(k)(1)) for the calendar year before the year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability), if such calendar year is after 1990'.

(3) Section 215(i)(1)(G) of such Act (42 U.S.C. 415(i)(1)(G)) is amended by striking `the average of the total wages reported to the Secretary of the Treasury or his delegate as determined for purposes of subsection (b)(3)(A)(ii)' and inserting `the amount determined for such calendar year under subsection (b)(3)(A)(ii)(I)'.

(4) Section 215(a)(1)(C)(ii) of such Act (42 U.S.C. 415(a)(1)(C)(ii)) is amended by striking `change.' and inserting `change (except that, for purposes of subsection (b)(2)(A) of such section 230 as so in effect, the reference therein to the average of the wages of all employees as reported to the Secretary of the Treasury for any calendar year shall be deemed a reference to the deemed average total wages (within the meaning of section 209(k)(1)) for such calendar year).'.

(5) Section 230(d) of such Act (42 U.S.C. 430(d)) is amended by striking `change.' and inserting `change (except that, for purposes of subsection (b)(2)(A) of such section 230 as so in effect, the reference therein to the average of the wages of all employees as reported to the Secretary of the Treasury for any calendar year shall be deemed a reference to the deemed average total wage (within the meaning of section 209(k)(1)) for such calendar year).'.

(c) Effective Date-

(1) IN GENERAL- The amendments made by subsections (a) and (b) shall apply with respect to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.
(2) TRANSITIONAL RULE- For purposes of determining the contribution and benefit base for 1990, 1991, and 1992 under section 230(b) of the Social Security Act (and section 230(b) of such Act as in effect immediately prior to enactment of the Social Security Amendments of 1977)--

(A) the average of total wages for 1988 shall be deemed to be equal to the amount which would have been determined without regard to this paragraph, plus 2 percent of the amount which has been determined to the average of total wages for 1987,

(B) the average of total wages for 1989 shall be deemed to be equal to the amount which would have been determined without regard to this paragraph, plus 2 percent of the amount which would have been determined to be the average of total wages for 1988 without regard to subparagraph (A), and

(C) the average of total wages reported to the Secretary of the Treasury for 1990 shall be deemed to be equal to the product of--

(i) the SSA average wage index (as defined in section 215(i)(1)(G) of the Social Security Act and promulgated by the Secretary) for 1989, and

(ii) the quotient obtained by dividing--

(I) the average of total wages (as defined in regulations of the Secretary and computed without regard to the limitations of section 209(a)(1) of the Social Security Act and by including deferred compensation amounts, within the meaning of section 209(k)(2) of such Act as added by this section) reported to the Secretary of the Treasury or his delegate for 1990, by

(II) the average of total wages (as so defined and computed without regard to the limitations specified in such section 209(a)(1) and by excluding deferred compensation amounts within the meaning of such section 209(k)(2)) reported to the Secretary of the Treasury or his delegate for 1989.

(3) DETERMINATION OF CONTRIBUTION AND BENEFIT BASE FOR 1993- For purposes of determining the contribution and benefit base for 1993 under section 230(b) of the Social Security Act (and section 230(b) of such Act as in effect immediately prior to enactment of the Social Security Amendments of 1977), the average of total wages for 1990 shall be determined without regard to subparagraph (C) of paragraph (2).

(4) REVISED DETERMINATION UNDER SECTION 230 OF THE SOCIAL SECURITY ACT- As soon as possible after the enactment of this Act, the Secretary of Health and Human Services shall revise and publish, in accordance with the provisions of this Act and the amendments made thereby, the contribution and benefit base under section 230 of the Social Security Act with respect to remuneration paid after 1989 and taxable years beginning after calendar year 1989.

(d) Clerical Amendments-

(1) DESIGNATION OF UNDESIGNATED PROVISIONS- Section 209 of the Social Security Act is further amended--
(A) by redesignating paragraphs (1) through (9) of subsection (a) as subparagraphs (A) through (I), respectively;
(B) by redesignating clauses (1) through (3) of subsection (b) as clauses (A) through (C), respectively;
(C) by redesignating clauses (1) through (9) of subsection (e) as clauses (A) through (I), respectively;
(D) by redesignating paragraphs (1) and (2) of subsection (f) as subparagraphs (A) and (B), respectively;
(E) by redesignating paragraphs (1), (2), and (3) of subsection (g) as subparagraphs (A), (B), and (C), respectively;
(F) in subsection (h), by redesignating clauses (i), (ii), and (iii) as clauses (I), (II), and (III), respectively, by redesignating subparagraphs (A) and (B) of paragraph (2) as clauses (i) and (ii), respectively, and by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively;
(G) by redesignating paragraphs (1) and (2) of subsection (1) as subparagraphs (A) and (B), respectively;
(H) by redesignating paragraphs (1) and (2) of subsection (m) as subparagraphs (A) and (B), respectively;
(I) by redesignating paragraphs (1) and (2) of subsection (p) as subparagraphs (A) and (B), respectively;
(J) by redesignating subsections (a), (b), (d), (e), (f), (g), (h), (j), (k), (l), (m), (n), (o), (p), (q), (r), (s), and (t) (in the matter preceding subsection (k) added by subsection (a) of this section, and as amended by the preceding provisions of this paragraph) as paragraphs (1), (2), (3), (4), (5), (6), (7), (8), (9), (10), (11), (12), (13), (14), (15), (16), (17), and (18), respectively;
(K) by inserting `(a)' after `Sec. 209.';
(L) by striking `Nothing in the regulations' and inserting the following: `(b) Nothing in the regulations';
(M) in the undesignated paragraph commencing with `For purposes of this title, in the case of domestic service', by inserting `(c)' at the beginning thereof, and by striking `subsection (g)(2)' each place it appears and inserting `subsection (a)(6)(B)';
(N) in the undesignated paragraph commencing with `For purposes of this title, in the case of an individual performing service, as a member', by inserting `(d)' at the beginning thereof, and by striking `subsection (a)' and inserting `subsection (a)(1)';
(O) by inserting `(e)' at the beginning of the undesignated paragraph commencing with `For purposes of this title, in the case of an individual performing service, as a volunteer';
(P) by inserting `(f)' at the beginning of the undesignated paragraph commencing with `For purposes of this title, tips received';
(Q) by inserting `(g)' at the beginning of the undesignated paragraph commencing with `For purposes of this title, in any case where';
(R) by inserting `(h)' at the beginning of the undesignated paragraph commencing with `For purposes of this title, in the case of an individual performing service under the provisions';
(S) by inserting `(i)' at the beginning of the undesignated paragraph commencing with `Nothing in any of the foregoing'; and
(T) by inserting `(j)' at the beginning of the undesignated paragraph commencing with `Any amount deferred'.

(2) Conforming amendments-
(A) Title II of such Act is amended--
(ii) in section 203(f)(5)(C), by striking `subsections (a), (g)(2), (g)(3), (h)(2), and (j) of section 209' and inserting `paragraphs (1), (6)(B), (6)(C), (7)(B), and (8) of section 209(a)';
(iii) in clauses (B) and (C) of the last sentence of section 224(a), by striking `209(a)' and inserting `209(a)(1)';
(iv) in section 217(b)(1), by striking `209(e)(2)' and inserting `209(a)(4)(B)';
(v) in section 218(c)(5), by striking `paragraph (2) of section 209(h)' and inserting `subparagraph (B) of section 209(a)(7)'; and
(vi) in section 203(f)(5)(C)(ii), by striking `209(m)(2)' and inserting `209(a)(11)(B)'.

(B)(i) Section 6(f)(1) of the Fair Labor Standards Act of 1938 (29 U.S.C. 206(f)(1)) is amended by striking `209(g)' and inserting `209(a)(6)'.
(ii) Section 1(h)(5)(iii) of the Railroad Retirement Act of 1974 (45 U.S.C. 231(h)(5)(iii)) is amended by striking `the third paragraph of section 209' and inserting `section 209(d)'.

Subtitle C--Additional Amendments

SEC. 10301. ELIMINATION OF THE DEPENDENCY TEST APPLICABLE TO CERTAIN ADOPTED CHILDREN.
(a) IN GENERAL- Section 202(d)(8)(D) of the Social Security Act (42 U.S.C. 402(d)(8)(D)) is amended--
(1) by adding `and' after the comma at the end of clause (i); and
(2) by striking clauses (ii) and (iii) and inserting the following new clause: `in the case of a child who attained the age of 18 prior to the commencement of proceedings for adoption, the child was living with or receiving at least one-half of the child's support from such individual for the year immediately preceding the month in which the adoption is decreed.'.
(b) CONFORMING AMENDMENT- Paragraph (8) of section 202(d) of such Act is further amended by striking the last sentence.
(c) EFFECTIVE DATE- The amendments made by this section shall apply with respect to benefits payable for months after December 1989, but only on the basis of applications filed on or after January 1, 1990.

SEC. 10302. AUTHORITY FOR SECRETARY TO TAKE INTO ACCOUNT MISINFORMATION PROVIDED TO APPLICANTS IN DETERMINING DATE OF APPLICATION FOR BENEFITS.

(a) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE-
(1) IN GENERAL- Section 202(j) of the Social Security Act (42 U.S.C. 402(j)) is amended by adding at the end the following new paragraph:
  '(5) In any case in which it is determined to the satisfaction of the Secretary that an individual failed as of any date to apply for monthly insurance benefits under this title by reason of misinformation provided to such individual by any officer or employee of the Social Security Administration relating to such individual's eligibility for benefits under this title, such individual shall be deemed to have applied for such benefits on the later of--
    '(A) the date on which such misinformation was provided to such individual, or
    '(B) the date on which such individual met all requirements for entitlement to such benefits (other than application therefor).'.
(2) EFFECTIVE DATE- The amendment made by paragraph (1) shall apply with respect to misinformation furnished after December 1982 and to benefits for months after December 1982.
(b) SUPPLEMENTAL SECURITY INCOME-
(1) IN GENERAL- Section 1631(e) of such Act (42 U.S.C. 1383(e)) is amended by adding at the end the following new paragraph:
  '(5) In any case in which it is determined to the satisfaction of the Secretary that an individual failed as of any date to apply for benefits under this title by reason of misinformation provided to such individual by any officer or employee of the Social Security Administration relating to such individual's eligibility for benefits under this title, such individual shall be deemed to have applied for such benefits on the later of--
    '(A) the date on which such misinformation was provided to such individual, or
    '(B) the date on which such individual met all requirements for entitlement to such benefits (other than application therefor).'.
(2) EFFECTIVE DATE- The amendment made by paragraph (1) shall apply with respect to misinformation furnished on or after the date of the enactment of this Act and to benefits for months after the month in which this Act is enacted.

SEC. 10303. SAME-DAY PERSONAL INTERVIEWS AT FIELD OFFICES OF THE SOCIAL SECURITY ADMINISTRATION IN CERTAIN CASES WHERE TIME IS OF THE ESSENCE.
(a) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE- Section 205 of the Social Security Act (42 U.S.C. 405) is amended by adding at the end the following new subsection:

`Same-Day Personal Interviews at Field Offices In Cases Where Time Is of The Essence`

(t) In any case in which an individual visits a field office of the Social Security Administration and represents during the visit to an officer or employee of the Social Security Administration in the office that the individual's visit is occasioned by--

(1) the receipt of a notice from the Social Security Administration indicating a time limit for response by the individual, or

(2) the theft, loss, or nonreceipt of a benefit payment under this title, the Secretary shall ensure that the individual is granted a face-to-face interview at the office with an officer or employee of the Social Security Administration before the close of business on the day of the visit.'.

(b) SUPPLEMENTAL SECURITY INCOME- Section 1631(e) of such Act (42 U.S.C. 1383(e)) is amended by adding after the paragraph added by section 10302(b)(1) of this Act the following new paragraph:

(6) In any case in which an individual visits a field office of the Social Security Administration and represents during the visit to an officer or employee of the Social Security Administration in the office that the individual's visit is occasioned by--

(1) the receipt of a notice from the Social Security Administration indicating a time limit for response by the individual, or

(2) the theft, loss, or nonreceipt of a benefit payment under this title, the Secretary shall ensure that the individual is granted a face-to-face interview at the office with an officer or employee of the Social Security Administration before the close of business on the day of the visit.'.

(c) EFFECTIVE DATE- The amendments made by this section shall apply to visits to field offices of the Social Security Administration on or after January 1, 1990.

SEC. 10304. AUTHORITY TO AMEND WAGE RECORDS AFTER EXPIRATION OF TIME LIMITATION.

Subparagraph (H) of section 205(c)(5) of the Social Security Act (42 U.S.C. 405(c)(5)(H)) is amended by striking `if' and all that follows through `period'.

SEC. 10305. STANDARDS APPLICABLE IN CERTAIN DETERMINATIONS OF GOOD CAUSE, FAULT, AND GOOD FAITH.

(a) GOOD CAUSE FOR FAILURE TO MAKE EARNINGS REPORTS TIMELY- Section 203(l) of the Social Security Act (42 U.S.C. 403(l)) is amended in the last sentence by striking `Secretary' and inserting `Secretary, except that in making any such determination, the Secretary shall specifically take
into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language)."

(b) WAIVERS OF RECOVERY OF OVERPAYMENTS - Section 204(b) of such Act (42 U.S.C. 404(b)) is amended by adding at the end the following new sentence: `In making for purposes of this subsection any determination of whether any individual is without fault, the Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language).'.

(c) STANDARD OF REVIEW IN TERMINATION OF DISABILITY BENEFITS - Section 223(f) of such Act (42 U.S.C. 423(f)) is amended by inserting after the first sentence in the matter following paragraph (4) the following new sentence: `In making for purposes of the preceding sentence any determination relating to fraudulent behavior by any individual or failure by any individual without good cause to cooperate or to take any required action, the Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language).'.

(d) CONTINUATION OF BENEFITS PENDING APPEAL - Section 223(g)(2)(B) of such Act (42 U.S.C. 423(g)(2)(B)) is amended by adding at the end the following new sentence: `In making for purposes of this subparagraph any determination of whether any individual's appeal is made in good faith, the Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language).'.

(e) SUPPLEMENTAL SECURITY INCOME - Section 1631(c)(1) of such Act (42 U.S.C. 1383(c)(1)) is amended by adding at the end the following: `The Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation of such individual (including any lack of facility with the English language) in determining, with respect to the eligibility of such individual for benefits under this title, whether such individual acted in good faith or was at fault, and in determining fraud, deception, or intent.'.

(f) EFFECTIVE DATE - The amendments made by this section shall apply with respect to determinations made on or after July 1, 1990.

SEC. 10306. NOTICE REQUIREMENTS.

(a) APPLICABILITY TO BLIND BENEFICIARIES UNDER TITLE II OF NOTICE STANDARDS CURRENTLY APPLICABLE TO BLIND BENEFICIARIES UNDER TITLE XVI - (1) IN GENERAL - Section 221 of the Social Security Act (42 U.S.C. 421) is amended by adding at the end the following new subsection:
In any case where an individual who is applying for or receiving benefits under this title on the basis of disability by reason of blindness is entitled to receive notice from the Secretary of any decision or determination made or other action taken or proposed to be taken with respect to his or her rights under this title, such individual shall at his or her election be entitled either (A) to receive a supplementary notice of such decision, determination, or action, by telephone, within 5 working days after the initial notice is mailed, (B) to receive the initial notice in the form of a certified letter, or (C) to receive notification by some alternative procedure established by the Secretary and agreed to by the individual.

The election under paragraph (1) may be made at any time, but an opportunity to make such an election shall in any event be given, to every individual who is an applicant for benefits under this title on the basis of disability by reason of blindness, at the time of his or her application. Such an election, once made by an individual, shall apply with respect to all notices of decisions, determinations, and actions which such individual may thereafter be entitled to receive under this title until such time as it is revoked or changed.

APPLICATION TO CURRENT RECIPIENTS- Not later than July 1, 1990, the Secretary of Health and Human Services shall provide every individual receiving benefits under title II of the Social Security Act on the basis of disability by reason of blindness an opportunity to make an election under section 221(l)(1) of such Act (as added by paragraph (1)).

EFFECTIVE DATE- The amendment made by this section shall apply with respect to notices issued on or after July 1, 1990.

(b) REPORT REGARDING NOTICES IN LANGUAGES OTHER THAN ENGLISH- Not later than January 1, 1991, the Secretary of Health and Human Services shall submit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate setting forth--
(1) the procedures of the Social Security Administration currently in effect for issuing notices in languages other than English to individuals who have a limited capacity to communicate with such Administration in English, and
(2) reasonable options for expanding the use of notices in languages other than English.

SEC. 10307. REPRESENTATION OF CLAIMANTS.

(a) RECORDING OF IDENTITY OF REPRESENTATIVES IN ELECTRONIC INFORMATION RETRIEVAL SYSTEM-
(1) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE- Section 206(a) of the Social Security Act (42 U.S.C. 406(a)) is amended by adding at the end the following new sentence: `The Secretary shall maintain in the electronic information retrieval system used by the Social Security Administration a current record, with respect to any claimant before the Secretary, of the
identity of any person representing such claimant in accordance with this subsection.'.

(2) SUPPLEMENTAL SECURITY INCOME- Section 1631(d)(2) of such Act (42 U.S.C. 1383(d)(2)) is amended by adding at the end the following new sentence: `The Secretary shall maintain in the electronic information retrieval system used by the Social Security Administration a current record, with respect to any claimant before the Secretary, of the identity of any person representing such claimant in accordance with this paragraph.'.

(3) EFFECTIVE DATE- The amendments made by this subsection shall take effect June 1, 1991.

(b) NOTIFICATION OF OPTIONS FOR OBTAINING ATTORNEYS-
(1) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE- Section 206 of such Act (42 U.S.C. 406) is further amended by adding at the end the following new subsection:

`The Secretary shall notify each claimant in writing, together with the notice to such claimant of an adverse determination, of the options for obtaining attorneys to represent individuals in presenting their cases before the Secretary. Such notification shall also advise the claimant of the availability to qualifying claimants of legal services organizations which provide legal services free of charge.'.

(2) SUPPLEMENTAL SECURITY INCOME- Section 1631(d)(2) of such Act (42 U.S.C. 1383(d)(2)) is amended--
(A) by inserting `(A)' after `(2)'; and
(B) by adding at the end the following new subparagraph:

`The Secretary shall notify each claimant in writing, together with the notice to such claimant of an adverse determination, of the options for obtaining attorneys to represent individuals in presenting their cases before the Secretary. Such notification shall also advise the claimant of the availability to qualifying claimants of legal services organizations which provide legal services free of charge.'.

(3) EFFECTIVE DATE- The amendments made by this subsection shall apply with respect to adverse determinations made on or after January 1, 1991.

SEC. 10308. EARNINGS AND BENEFIT STATEMENTS.

Part A of title XI of the Social Security Act is amended by adding at the end thereof the following new section:

`SOCIAL SECURITY ACCOUNT STATEMENTS

Provision Upon Request
'SEC. 1142. (a)(1) Beginning not later than October 1, 1990, the Secretary shall provide upon the request of an eligible individual a social security account statement (hereinafter referred to as the `statement').

(2) Each statement shall contain--

(A) the amount of wages paid to and self-employment income derived by the eligible individual as shown by the records of the Secretary at the date of the request;

(B) an estimate of the aggregate of the employee and self-employment contributions of the eligible individual for old-age, survivors, and disability insurance as shown by the records of the Secretary on the date of the request;

(C) a separate estimate of the aggregate of the employee and self-employment contributions of the eligible individual for hospital insurance as shown by the records of the Secretary on the date of the request; and

(D) an estimate of the potential monthly retirement, disability, survivor, and auxiliary benefits payable on the eligible individual's account together with a description of the benefits payable under the medicare program of title XVIII.

(3) For purposes of this section, the term `eligible individual' means an individual who--

(A) has a social security account number,

(B) has attained age 25 or over, and

(C) has wages or net earnings from self-employment.

Notice to Eligible Individuals

(b) The Secretary shall, to the maximum extent practicable, take such steps as are necessary to assure that eligible individuals are informed of the availability of the statement described in subsection (a).

Mandatory Provision of Statements

(c)(1) By not later than September 30, 1995, the Secretary shall provide a statement to each eligible individual who has attained age 60 by October 1, 1994, and who is not receiving benefits under title II and for whom a current mailing address can be determined through such methods as the Secretary determines to be appropriate. In fiscal years 1995 through 1999 the Secretary shall provide a statement to each eligible individual who attains age 60 in such fiscal years and who is not receiving benefits under title II and for whom a current mailing address can be determined through such methods as the Secretary determines to be appropriate. The Secretary shall provide with each statement to an eligible individual notice that such statement is updated annually and is available upon request.
Beginning not later than October 1, 1999, the Secretary shall provide a statement on a biennial basis to each eligible individual who is not receiving benefits under title II and for whom a mailing address can be determined through such methods as the Secretary determines to be appropriate. With respect to statements provided to eligible individuals who have not attained age 50, such statements need not include estimates of monthly retirement benefits. However, if such statements provided to eligible individuals who have not attained age 50 do not include estimates of retirement benefit amounts, such statements shall include a description of the benefits (including auxiliary benefits) that are available upon retirement.


SEC. 10401. INCREASE IN AUTHORIZATION FOR CHILD WELFARE SERVICES UNDER TITLE IV-B OF THE SOCIAL SECURITY ACT.
(a) IN GENERAL- Sections 420(a), 427(b), 474(c)(4)(B), and 474(c)(4)(C) of the Social Security Act (42 U.S.C. 620(a), 627(b), 674(c)(4)(B), and 674(c)(4)(C)) are each amended by striking `$266,000,000' and inserting `$325,000,000'.
(b) EFFECTIVE DATE- The amendments made by subsection (a) shall take effect on October 1, 1989.

SEC. 10402. EXTENSION AND PERMANENT INCREASE IN FOSTER CARE CEILING.
(a) PERMANENT INCREASE IN APPROPRIATIONS LEVEL WHICH TRIGGERS FOSTER CARE CEILING- Section 474(b)(2)(A) of the Social Security Act (42 U.S.C. 674(b)(2)(A)) is amended--
(1) by striking `and' at the end of clause (ii);
(2) by striking the period at the end of clause (iii) and inserting `; and'; and
(3) by adding at the end the following new clause:
`(iv) with respect to each fiscal year succeeding the fiscal year 1989, only if $325,000,000 is appropriated under section 420 for such succeeding fiscal year.'.
(b) EFFECTIVE DATE- The amendments made by subsection (a) shall take effect on October 1, 1989.

SEC. 10403. MISCELLANEOUS TECHNICAL CORRECTIONS.
(a) TECHNICAL CORRECTIONS RELATING TO THE FAMILY SUPPORT ACT OF 1988-
(1) CORRECTIONS TAKING EFFECT RETROACTIVELY-

(ii) The amendment made by clause (i) shall take effect as if such amendment had been included in section 202(b)(8)(A) of the Family Support Act of 1988 on the date of the enactment of such Act.

(B)(i) Sections 402(a)(30) and 452(d)(2)(B) of the Social Security Act (42 U.S.C. 602(a)(30) and 652(d)(2)(B)) are each amended by striking `automatic' and inserting `automated'.

(ii) The amendments made by clause (i) shall take effect as if such amendments had been included in section 123(d) of the Family Support Act of 1988 on the date of the enactment of such Act.

(C)(i) Section 402(g)(1)(A) of the Social Security Act (42 U.S.C. 602(g)(1)(A)) is amended--

(I) in clause (iv), by striking `includes a child who is (or, if needy,' and inserting `received aid to families with dependent'; and

(II) in clause (v), by striking the first comma.

(ii) The amendments made by clause (i) shall take effect as if such amendments had been included in section 302(c) of the Family Support Act of 1988 on the date of the enactment of such Act.

(2) CORRECTION TAKING EFFECT PROSPECTIVELY- Effective September 30, 1998, section 407(d)(1) of the Social Security Act (42 U.S.C. 607(d)(1)) is amended by striking `participated' and all that follows and inserting `participated in a program under part F'.

(b) TECHNICAL CORRECTION RELATING TO THE TAX REFORM ACT OF 1986-

(1) CORRECTION- Section 422(b)(1)(A) of the Social Security Act (42 U.S.C. 622(b)(1)(A)) is amended by striking `the individual or agency designated pursuant to section 2003(d)(1)(C) to administer or supervise the administration of the State's services program' and inserting `the individual or agency that administers or supervises the administration of the State's services program under title XX'.

(2) EFFECTIVE DATE- The amendment made by paragraph (1) shall take effect as if such amendment had been included in section 1883(e)(1) of the Tax Reform Act of 1986 on the date of the enactment of such Act.

(c) TECHNICAL CORRECTION RELATING TO SECTION 474(b)(2)(B) OF THE SOCIAL SECURITY ACT-

(1) CORRECTION- Section 4(a)(1) of Public Law 98-617 is amended to read as follows:

`(1)(A) in paragraphs (1) and (4)(B), by striking out `1981 through 1984' and inserting in lieu thereof `1981 through 1985'; and

`(B) in paragraph (2)(B), by striking out `1982 through 1984' and inserting in lieu thereof `1981 through 1985'.'.

(2) EFFECTIVE DATE- The amendment made by paragraph (1) of this subsection shall take effect as if included in section 4 of Public Law 98-617 at the time such section became law.

SEC. 10404. DEMONSTRATION PROJECT.
(a) NUMBER OF PROJECTS- In order to determine whether, and if so, the extent to which, the use of volunteer senior aides to provide basic medical assistance and support to families with moderately or severely disabled or chronically ill children contributes to reducing the costs of care for such children, not more than 10 communities may conduct demonstration projects under this section.

(b) DUTIES OF THE SECRETARY-
(1) CONSIDERATION OF APPLICATIONS- The Secretary of Health and Human Services (in this section referred to as the `Secretary') shall consider all applications received from communities desiring to conduct demonstration projects under this section.
(2) APPROVAL OF CERTAIN APPLICATIONS- The Secretary shall approve not more than 10 applications to conduct projects which appear likely to contribute significantly to the achievement of the purpose of this section.
(3) GRANTS- The Secretary shall make grants to each community the application of which to conduct a demonstration project under this section is approved by the Secretary to assist the community in carrying out the project.

(c) REQUIREMENTS- Each community receiving a grant with respect to a demonstration project under this section shall conduct the project in accordance with such requirements as the Secretary may prescribe.

(d) LIMITATION ON AUTHORIZATION OF APPROPRIATIONS- For grants under this section, there are authorized to be appropriated to the Secretary of Health and Human Services not to exceed--
(1) $1,000,000 for each of the fiscal years 1990 and 1991; and
(2) $2,000,000 for each of the fiscal years 1992, 1993, and 1994.

(e) EFFECTIVE DATE- This section shall take effect on October 1, 1989.

SEC. 10405. AGENT ORANGE SETTLEMENT PAYMENTS EXCLUDED FROM COUNTABLE INCOME AND RESOURCES UNDER FEDERAL MEANS-TESTED PROGRAMS.

(a) IN GENERAL-
(1) TREATMENT OF PAYMENTS- The payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.), shall not be considered income or resources in determining eligibility for the amount of benefits under any Federal or federally assisted program described in paragraph (2).
(2) PROGRAMS INVOLVED- The program benefits described in this paragraph are--
(A) benefits under the supplemental security income program under title XVI of the Social Security Act;
(B) aid to families with dependent children under a State plan approved under section 402(a) of the Social Security Act;
(C) medical assistance under a State plan approved under section 1902(a) of the Social Security Act;
(D) benefits under title XX of the Social Security Act;
(E) benefits under the food stamp program (as defined in section 3(h) of the Food Stamp Act of 1977);
(F) benefits under the special supplemental food program for women, infants, and children established under section 17 of the Child Nutrition Act of 1966;
(G) benefits under section 336 of the Older Americans Act;
(H) benefits under the National School Lunch Act;
(I) benefits under any housing assistance program for lower income families or elderly or handicapped persons which is administered by the Secretary of Housing and Urban Development or the Secretary of Agriculture;
(J) benefits under the Low-Income Home Energy Assistance Act of 1981;
(K) benefits under part A of the Energy Conservation in Existing Buildings Act of 1976;
(L) benefits under any educational assistance grant or loan program which is administered by the Secretary of Education; and
(M) benefits under a State plan approved under title I, X, XIV, or XVI of the Social Security Act.

(b) EFFECTIVE DATE- Subsection (a) shall take effect on January 1, 1989.

SEC. 10406. TREATMENT OF TRIENNIAL REVIEWS OF STATE FOSTER CARE PROTECTIONS FOR FISCAL YEARS BEFORE OCTOBER 1, 1990.
The Secretary of Health and Human Services shall not, before October 1, 1990, reduce any payment to, withhold any payment from, or seek any repayment from, any State under part B or E of title IV of the Social Security Act, by reason of a determination made in connection with any triennial review of State compliance with the foster care protections of section 427 of such Act for any Federal fiscal year preceding fiscal year 1991.

TITLE XI--MISCELLANEOUS

SEC. 11001. SECTION 202(b) EXCEPTION.
Any transfer of outlays, receipts, or revenues from one fiscal year to an adjacent fiscal year that occurs pursuant to any provision of this Act or any amendment made by this Act shall be considered a necessary (but secondary) result of a significant policy change as provided in section 202(b) of the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987.

SEC. 11002. RESTORATION OF FUNDS SEQUESTERED.
(a) ORDER RESCINDED- (1) Upon the issuance of a new final order by the President under subsection (b)(4), the order issued by the President on October 16, 1989, pursuant to section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 is rescinded.
(2) Except as otherwise provided in sections 6001, 6101, and 6201, and subject to subsection (b), any action taken to implement the order issued by the President on October 16, 1989, shall be reversed, and any sequesterable budgetary resource that has been reduced or sequestered by such order is restored, revived, or released and shall be available to the same extent and for the same purpose as if an order had not been issued.
(3) For purposes of section 702(d) and 1101(c) of the Ethics Reform Act of 1989, the order issued by the President on October 16, 1989, pursuant to section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 is deemed to be rescinded on January 31, 1990.
(b) ADJUSTED REDUCTION-
(1) Before the close of the fifteenth calendar day beginning after the date of enactment of this Act, the Director of OMB shall issue a revised report using the exact budget baseline set forth in the report of October 16, 1989, and following the requirements, specifications, definitions, and calculations required by the Balanced Budget and Emergency Deficit Control Act of 1985 for the final report issued under section 251(c)(2) for fiscal year 1990, except that the aggregate outlay reduction to be achieved shall be an amount equal to $16.1 billion multiplied by 130 divided by 365. Calculations made to carry out the preceding sentence shall take into account the reductions and cancellations achieved by paragraphs (2) and (3) and shall not be affected by subsection (d).
(2) Notwithstanding any provision of law other than this paragraph, the reductions and cancellations in the student loan programs described in section 256(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 achieved by the order issued by the President on October 16, 1989, shall remain in effect through December 31, 1989, and no reductions or cancellations in such programs shall be made by the order issued under paragraph (4).
(3) Notwithstanding any provision of law other than this paragraph, any automatic spending increase suspended or cancelled by the order issued by the President on October 16, 1989, shall be paid at a rate that is 130/365ths less than the rate that would have been paid under the laws providing for such automatic spending increase.
(4) On the date that the Director submits a revised report to the President under paragraph (1) for fiscal year 1990, the President shall issue a new final order to make all of the reductions and cancellations specified in such report in conformity with section 252(a)(2) of the Balanced Budget and Emergency Deficit Control Act of 1985. Such order shall be deemed to have become effective on October 16, 1989.
(c) COMPLIANCE REPORT BY COMPTROLLER GENERAL- Before the close of the thirtieth day beginning after the date the President issues a new final order under subsection (b)(4), the Comptroller General shall submit to the Congress and the President a compliance report setting forth the information required under section 253 of the Balanced Budget and Emergency Deficit Control Act of 1985 with respect to such order.

(d) NO DOUBLE REDUCTION IN MEDICARE- With respect to items and services described in section 6001, 6101, or 6201 for periods for which reductions are made pursuant to the respective sections, no reduction shall be made under subsection (b).

Speaker of the House of Representatives.

Vice President of the United States and

President of the Senate.

END