107TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPT. 107–540
Part 1

MEDICARE MODERNIZATION AND PRESCRIPTION DRUG ACT OF 2002 (TITLE III: RURAL HEALTH CARE IMPROVEMENTS)

JUNE 26, 2002.—Ordered to be printed

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

R E P O R T

[To accompany H.R. 4962]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 4962) to amend title XVIII of the Social Security Act to make rural health care improvements under the medicare program, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

CONTENTS

PURPOSE AND SUMMARY

The purpose of H.R. 4962 is to increase incentives for providers to serve beneficiaries in rural areas and communities to ensure that beneficiaries have continued access to the best medical care possible.

99–006

BACKGROUND AND NEED FOR LEGISLATION

The geographic isolation, low population density, and poor economic conditions associated with rural areas often serve as impediments to Medicare beneficiaries getting the medical care they want and need. These barriers also impose financial hardships on providers and make it difficult to recruit physicians and other health professionals into rural areas. Concerned that Medicare beneficiaries living in rural areas may not receive the care they need while many rural providers continue to experience financial hardship, the Committee worked in collaboration with the Committee on Ways and Means to develop the provisions included in H.R. 4962.

The financial status of rural hospitals and home health agencies continues to be a source of concern for the Committee. Rural hospitals rely more on Medicare and on outpatient services as sources of revenue than do urban hospitals. The home health prospective payment system may not adequately account for the unique conditions facing home health agencies that operate in rural areas.

There are also differences in payment amounts under the physician fee schedule for physicians' services furnished in different geographical areas. Physician fees are made up of three components: work, practice expense, and malpractice. About 14% of the average physician fee is adjusted based on the value of their wages in the area of the country where they practice. While economists support this geographic adjustment of payment, many physicians feel they practice in a national market and therefore deserve a more level playing field for payment.

HEARINGS

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

COMMITTEE CONSIDERATION

On Wednesday, June 19, 2002, the Full Committee met in open markup session and favorably ordered reported a Committee Print on Rural Health Care Improvements. Chairman Tauzin then introduced H.R. 4962 to reflect the Committee's action.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. The following are the recorded votes taken on the amendments offered to the measure, including the names of those members voting for and against. A motion by Mr. Tauzin to order H.R. 4962 reported to the House, without amendment, was agreed to by a voice vote.

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 31

BILL: H.R. 4692, Rural Health Care Improvements.

AMENDMENT: An amendment offered by Mr. Barrett, No. 1, on the Establishment of a Rural Community Hospital (RCH) Program.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 21 yeas to 28 nays.

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

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee has not held oversight or legislative hearings on this legislation.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

The objective of H.R. 4962 is to increase incentives for providers to serve beneficiaries in rural areas and communities to ensure that these beneficiaries continue to have access to the best hospital, home health, hospice, physician, and health center services possible.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 4962, to amend title XVIII of the Social Security Act to make rural health care improvements under the Medicare Program, would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

COMMITTEE COST ESTIMATE

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

CONGRESSIONAL BUDGET OFFICE ESTIMATE

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

FEDERAL MANDATES STATEMENT

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

ADVISORY COMMITTEE STATEMENT

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

CONSTITUTIONAL AUTHORITY STATEMENT

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

APPLICABILITY TO LEGISLATIVE BRANCH

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

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 301. Reference to Full Market Basket Increase for Sole Community Hospitals

Section 301 will eliminate the reduction from the market based index (MBI) update specified in Section 401(a) for sole community hospitals (SCHs) for FY 2003 (see section 401).

This section is effective upon enactment.

Section 302. Enhanced Disproportionate Share Hospital (DSH) Treatment for Rural and Urban Hospitals with Fewer than 100 Beds

Section 302 states that starting for discharges on or after October 1, 2002, the DSH adjustment that rural and small urban hospitals receive is based on a blend of their current DSH adjustment and the current DSH adjustment for large urban hospitals. However, the new DSH adjustment would not exceed 10% for any hospital that was not classified as a rural referral center. A hospital's new DSH adjustment will be calculated using 80% of the existing DSH adjustment in FY 2003; 60% in FY 2004; 20% in FY 2006; and 0% in FY 2007 and subsequently.

Section 303. 2-Year Phased-In Increase in the Standardized Amount in Rural and Small Urban Areas to Achieve a Single, Uniform Standardized Amount

Section 303 provides for discharges occurring in FY 2003, the average standardized amount for rural and small urban hospitals would be increased by half the difference between the current amount and the larger standardized amount paid to the hospitals in large urban areas. For discharges occurring in FY 2004, the Secretary will compute one standardized amount for hospitals located in any area equal to the average standardized amount for hospitals in large urban areas computed for the previous year and increased by the applicable update. For discharges occurring in FY 2005, the Secretary will compute one standardized amount for hospitals located in any area equal to the average standardized amount computed for the previous year for all hospitals increased by the applicable update.

This section is effective upon enactment.

Section 304. More Frequent Update in Weights Used in Hospital Market Basket.

Section 304 directs the Secretary to revise the MBI cost weights to reflect the most current data available and to establish a schedule for revising the cost weights with the most current data available more often than once every 5 years. The Secretary is required to submit a report to Congress by October 1, 2003 on the reasons for and the options considered in establishing such a schedule.

This section is effective upon enactment.

Section 305. Improvement to Critical Access Hospital Program

Section 305(a) states that starting with payments made on or after January 1, 2003, eligible critical access hospitals (CAHs) will be able to receive payments made on a PIP basis for inpatient services.

This provision is effective starting with payments made on or after January 1, 2003.

Section 305(b) precludes the Secretary from requiring that all physicians providing services in a CAH assign their billing right to the CAH in order for it to be able to be paid at 115% of the fee schedule for the professional services provided by the physicians. A CAH cannot receive payment based on 115% of the fee schedule for any individual physician who did not assign billing rights to the CAH.

This provision is effective as if included in the Balanced Budget Refinement Act of 1999 (BBRA), P.L. 106–113.

Section 305(c) requires the Secretary to specify standards for determining whether a CAH has seasonal variations in patient admissions that would justify a 5-bed increase in the number of beds it can maintain (and still retain its classification as a CAH).

This provision applies to designations made on or after January 1, 2003, but would not apply to CAHs that were designated as of that date.

Section 305(d) extends the grant program that permits annual appropriations from Medicare's Federal Hospital Insurance Trust Fund of $25 million through FY 2007.

This section is effective upon enactment.

Section 306. Extension of Temporary Increase for Home Health Services Furnished in a Rural Area

Section 306 extends the 10% additional payment for home health services furnished in rural areas through the end of calendar year 2004.

This section is effective upon enactment.

Section 307. Reference to 10 Percent Increase in Payment for Hospice Care Furnished in a Frontier Area and Rural Hospice Demonstration Project

Section 307 increases by 10% the Medicare daily payment rate for hospice care furnished in a frontier area on or after January 1, 2003, and before January 1, 2008. A frontier area is defined as a county in which the population density is less than 7 persons per square mile. The GAO is required to submit a report to Congress, not later than January 1, 2007, on the costs of furnishing hospice care in frontier areas. The report must include recommendations regarding the appropriateness of extending, and modifying, the payment increase provided under this section (see section 422).

This section requires the Secretary to conduct a demonstration project for the delivery of hospice care for beneficiaries in rural areas. Under the project, beneficiaries who are unable to receive hospice care at home because they lack an appropriate caregiver will be provided such care in a facility of 20 or fewer beds, which offers within its walls the full range of covered hospice benefits. The project is limited to three hospice programs over a period of 3 years for each. The hospice programs participating in the project

will comply with requirements otherwise applicable to hospice care, except that they will not be required to offer services outside the home nor be subject to the limitation on inpatient days. Payments will be at the same rates. The Secretary may require the participating programs to comply with additional quality assurance standards for provisions of services in their facilities. The Secretary is required to submit a report to Congress, including recommendations regarding extension of such project to all programs serving rural areas upon completion of the project (see section 423).

This section is effective upon enactment.

Section 308. Reference to Priority for Hospitals Located in Rural or Small Urban Areas in Redistribution of Unused Graduate Medical Education Residencies

Section 308 redistributes unused resident positions. Starting on July 1, 2003, hospitals can apply to receive these unfilled positions and applications will be accepted through December 31, 2004. The Secretary will consider the need for an increase by specialty and location, first distributing an increase to programs or hospitals located in rural or small urban areas on a first-come, first-served basis, based on a demonstration that the hospital will fill the positions made available under this clause. No hospital can receive more than an increase of 25 full-time equivalent positions during this redistribution process. Hospitals will be reimbursed for direct graduate medical education costs for the new positions they receive at 100% of the adjusted national average per resident amount. Those hospitals that have unfilled positions (they have not reached their cap on the number of residents for which Medicare will pay direct graduate medical education costs) and have not met their cap over the past 3 cost reporting periods will have their cap adjusted. Starting January 1, 2003, their cap will be reduced by 75% of the difference between the cap and the highest number of filled positions over the past 3 cost reporting periods. In other words, their cap will be adjusted to reflect the highest number of filled positions over the past 3 cost reporting periods, plus 25% of the remaining unfilled positions. Those hospitals that fill positions during the cost reporting period that includes July 1, 2002 can apply to the Secretary for an adjustment to reflect a greater number of filled positions than would otherwise be demonstrated based on their past 3 cost reporting periods.

Reductions in resident counts would affect a hospital's indirect medical education (IME) adjustment. Any resulting increase in resident counts would not affect a hospital's IME adjustment.

This section requires the Secretary to submit a report to Congress by July 1, 2004, which recommends whether to extend the application deadline for increases in resident limits.

This section is effective upon enactment.

Section 309. GAO Study of Geographic Differences in Payments for Physician Services

Section 309 requires the Comptroller General to conduct a study of differences in payment amounts under the physician fee schedule for physicians' services furnished in different geographical areas. This study will include an assessment of the validity of the geographic adjustment factors used for each component of the fee

schedule, an evaluation of the measures used for such adjustment (including the frequency of revisions), and an evaluation of the methods used to determine professional liability costs used in computing the malpractice component. Within 1 year of enactment, the Comptroller General will submit to Congress a report detailing the results of this study with recommendations regarding the use of more current data in computing geographic cost of practice indices and the use of data directly representative of physicians' costs (rather than proxy measures of such costs).

This section is effective upon enactment.

Section 310. Providing Safe Harbor for Certain Collaborative Efforts that Benefit Medically Underserved Populations

Section 310 creates a safe harbor for certain health center arrangements that contribute to the ability of such centers to maintain or increase the availability, or enhance the quality, of services provided to medically underserved populations served by the health center. Coverage under the safe harbor is limited to agreements between a health center receiving grant money under section 330 of the Public Health Service Act and any individual or entity providing goods, items, services, donations, or loans to the health center. As Section 330 grantees, these health centers serve medically underserved areas or medically underserved populations and are obligated to provide primary care services to patients regardless of their ability to pay.

The Committee is aware that health centers are required, as a condition of their grant, to establish and maintain collaborative agreements with other health care providers in their catchment area. To comply with this requirement and to assure access to a broad range of services for the increasing number of uninsured patients in their service area, some health centers seek out (and/or are offered) opportunities to enter into arrangements with hospitals or other providers, which promise to enhance service access or quality for their uninsured patients.

It is the Committee's understanding that both health centers and the providers with whom they might contract have been reluctant to enter into these arrangements since they might be viewed as violating the federal anti-kickback law if there is any intent on the part of either of the parties to induce referrals or the purchase of goods or services in which federal health care program funds (such as Medicaid or Medicare) may be expended. The safe harbor provides that the agreement to provide such goods, items, services, donations, or loans will not be considered unlawful remuneration under the anti-kickback statute if the agreement satisfies standards established by the Secretary. The Committee expects the Secretary to establish a safe harbor under this section that contains protections necessary to minimize the possibility of abuse by the parties. The Secretary is required to publish an interim final rule, which would be effective immediately, within 180 days of enactment to establish these standards.

This section is effective upon enactment.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill,

as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

* * * * * * *

PART A—GENERAL PROVISIONS

* * * * * * *

CRIMINAL PENALTIES FOR ACTS INVOLVING FEDERAL HEALTH CARE PROGRAMS

SEC. 1128B. (a) * * *
(b)(1) * * *

* * * * * * *

(3) Paragraphs (1) and (2) shall not apply to—
(A) * * *

* * * * * * *

(E) any payment practice specified by the Secretary in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987; **[**and**]**

(F) any remuneration between an organization and an individual or entity providing items or services, or a combination thereof, pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1876 or if the written agreement, through a risk-sharing arrangement, places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide**[**.**]***;*

(G) any remuneration between a public or nonprofit private health center entity described under clause (i) or (ii) of section 1905(l)(2)(B) and any individual or entity providing goods, items, services, donations or loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity.

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

PAYMENT TO PROVIDERS OF SERVICES

SEC. 1815. (a) * * *

* * * * * * *

(e)(1) * * *

(2) The Secretary shall provide (or continue to provide) for payment on a periodic interim payment basis (under the standards established under section 405.454(j) of title 42, Code of Federal Regulations, as in effect on October 1, 1986) with respect to—

(A) * * *

* * * * * * *

(C) extended care services; [and]

(D) hospice care; *and*

(E) inpatient critical access hospital services;

if the provider of such services elects to receive, and qualifies for, such payments.

* * * * * * *

MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

SEC. 1820. (a) * * *

* * * * * * *

(c) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM DESCRIBED.—

(1) * * *

(2) STATE DESIGNATION OF FACILITIES.—

(A) * * *

(B) CRITERIA FOR DESIGNATION AS CRITICAL ACCESS HOSPITAL.—A State may designate a facility as a critical access hospital if the facility—

(i) * * *

* * * * * * *

(iii) provides *subject to paragraph (3)* not more than 15 (or, in the case of a facility under an agreement described in subsection (f), 25) acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;

* * * * * * *

(3) INCREASE IN MAXIMUM NUMBER OF BEDS FOR HOSPITALS WITH STRONG SEASONAL CENSUS FLUCTUATIONS.—

(A) IN GENERAL.—In the case of a hospital that demonstrates that it meets the standards established under subparagraph (B), the bed limitations otherwise applicable under paragraph (2)(B)(iii) and subsection (f) shall be increased by 5 beds.

(B) STANDARDS.—The Secretary shall specify standards for determining whether a critical access hospital has suffi-

ciently strong seasonal variations in patient admissions to justify the increase in bed limitation provided under subparagraph (A).

* * * * * * *

(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for making grants to all States under subsection (g), $25,000,000 in each of the fiscal years 1998 through [2002] *2007*.

* * * * * * *

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

* * * * * * *

SPECIAL PAYMENT RULES FOR PARTICULAR ITEMS AND SERVICES

SEC. 1834. (a) * * *

* * * * * * *

(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

(1) * * *

(2) ELECTION OF COST-BASED HOSPITAL OUTPATIENT SERVICE PAYMENT PLUS FEE SCHEDULE FOR PROFESSIONAL SERVICES.—A critical access hospital may elect to be paid for outpatient critical access hospital services amounts equal to the sum of the following, less the amount that such hospital may charge as described in section 1866(a)(2)(A):

(A) * * *

(B) FEE SCHEDULE FOR PROFESSIONAL SERVICES.—With respect to professional services otherwise included within outpatient critical access hospital services, 115 percent of such amounts as would otherwise be paid under this part if such services were not included in outpatient critical access hospital services.

The Secretary may not require, as a condition for applying subparagraph (B) with respect to a critical access hospital, that each physician providing professional services in the hospital must assign billing rights with respect to such services, except that such subparagraph shall not apply to those physicians who have not assigned such billing rights.

* * * * * * *

PART D—MISCELLANEOUS PROVISIONS

* * * * * * *

PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

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

* * * * * * *

(3)(A) * * *

(B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—

(I) * * *

* * * * * * *

[(XVIII) for fiscal year 2003, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas, and]

(XVIII) for fiscal year 2003, the market basket percentage increase for sole community hospitals and such increase minus 0.25 percentage points for other hospitals, and

* * * * * * *

(d)(1) * * *

* * * * * * *

(3) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in a fiscal year after fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region for which payment may be made under part A of this title. Each such rate shall be determined for hospitals located in large urban, other urban, or rural areas within the United States and within each such region, respectively, as follows:

(A) UPDATING PREVIOUS STANDARDIZED AMOUNTS.—(i) * * *

* * * * * * *

[(iv) For discharges] *(iv)(I) Subject to the succeeding provisions of this clause, for discharges* occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(II) For discharges occurring during fiscal year 2003, the average standardized amount for hospitals located other than in a large urban area shall be increased by ½ of the difference between the average standardized amount determined under subclause (I) for hospitals located in large urban areas for such fiscal year and such amount determined (without regard to this subclause) for other hospitals for such fiscal year.

(III) For discharges occurring in a fiscal year beginning with fiscal year 2004, the Secretary shall compute an average standardized amount for hospitals located in any area within the United States and within each region equal to the average standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for hospitals located

in any area) increased by the applicable percentage increase under subsection (b)(3)(B)(i).

* * * * * * *

(F)(i) * * *

* * * * * * *

(iv) The disproportionate share adjustment percentage for a cost reporting period for a hospital that is not described in clause (i)(II) and that—

(I) * * *

(II) is located in an urban area and has less than 100 beds, is equal to 5 percent or, *subject to clause (xiv) and* for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xiii);

(III) is located in a rural area and is not described in subclause (IV) or (V) or in the second sentence of clause (v), is equal to 4 percent or, *subject to clause (xiv) and* for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xii);

(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) or, *subject to clause (xiv) and* for discharges occurring on or after April 1, 2001, the greater of the percentages determined under clause (x) or (xi);

(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, *subject to clause (xiv) and* for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xi); 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 or, *subject to clause (xiv) and* for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (x).

* * * * * * *

(viii) ⟦The formula⟧ *Subject to clause (xiv), 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)).

* * * * * * *

(x) ⟦For purposes⟧ *Subject to clause (xiv), for purposes* of clause (iv)(VI) (relating to sole community hospitals), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) * * *

* * * * * * *

(xi) [For purposes] *Subject to clause (xiv), for purposes* of clause (iv)(V) (relating to rural referral centers), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) * * *

* * * * * * *

(xii) [For purposes] *Subject to clause (xiv), for purposes* of clause (iv)(III) (relating to small rural hospitals generally), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) * * *

* * * * * * *

(xiii) [For purposes] *Subject to clause (xiv), for purposes* of clause (iv)(II) (relating to urban hospitals with less than 100 beds), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) * * *

* * * * * * *

(xiv)(I) In the case of discharges in a fiscal year beginning on or after October 1, 2002, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other than subclause (I)) or under clause (viii), (x), (xi), (xii), or (xiii), the old blend proportion (specified under subclause (III)) of the disproportionate share adjustment percentage otherwise determined under the respective clause and 100 percent minus such old blend proportion of the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

(II) Under subclause (I), the disproportionate share adjustment percentage shall not exceed 10 percent for a hospital that is not classified as a rural referral center under subparagraph (C).

(III) For purposes of subclause (I), the old blend proportion for fiscal year 2003 is 80 percent, for each subsequent year (through 2006) is the old blend proportion under this subclause for the previous year minus 20 percentage points, and for each year beginning with 2007 is 0 percent.

* * * * * * *

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

* * * * * * *

TITLE V—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

* * * * * * *

SEC. 508. TEMPORARY INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) [24-MONTH INCREASE BEGINNING APRIL 1, 2001] *IN GENERAL*.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) on or after April 1, 2001, and before [April 1, 2003] *January 1, 2005*, the Secretary of Health and Human Services shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 10 percent.

* * * * * * *

Subtitle E—Other Provisions

* * * * * * *

SEC. 547. CLARIFICATION OF APPLICATION OF TEMPORARY PAYMENT INCREASES FOR 2001.

(a) * * *

* * * * * * *

(c) HOME HEALTH SERVICES.—

(1) * * *

(2) TEMPORARY INCREASE FOR RURAL HOME HEALTH SERVICES.—The payment increase provided under section 508(a) for [the period beginning on April 1, 2001, and ending on September 30, 2002,] *a period under such section* shall not apply to episodes and visits ending after such period, and shall not be taken into account in calculating the payment amounts applicable for episodes and visits occurring after such period.

* * * * * * *

○