UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

Pub. L. 100–360, title IV, subtitle A, §§ 401–408, July 1, 1988, 102 Stat. 765–768, as amended by Pub. L. 100–647, title VIII, § 8414, Nov. 10, 1988, 102 Stat. 3801; Pub. L. 101–239, title VI, § 6220, Dec. 19, 1989, 103 Stat. 2254, established the United States Bipartisan Commission on Comprehensive Health Care, also known as the ''Claude Pepper Commission'' or the ''Pepper Commission'', and directed Commission to examine shortcomings in health care delivery and financing mechanisms that limit or prevent access of all individuals in United States to comprehensive health care, and make specific recommendations respecting Federal programs, policies, and financing needed to assure the availability of comprehensive long-term care services for elderly and disabled, as well as comprehensive health care services for all individuals in the United States, and further provided for membership of Commission, staff and consultants, powers, authorization of appropriations, submission of findings and recommendations to Congress not later than Nov. 9, 1989, and for termination of Commission 30 days after submissions to Congress.

MAINTENANCE OF EFFORT REGARDING DUPLICATIVE BENEFITS

Pub. L. 100–360, title IV, § 421, July 1, 1988, 102 Stat. 808, as amended by Pub. L. 100–485, title VI, § 608(a), Oct. 13, 1988, 102 Stat. 2411, which required employers who had been providing health care benefits to employees that were duplicative part A and part B benefits to provide the employees with additional benefits equal to the total actuarial value of such duplicative benefits, was repealed by Pub. L. 101–234, title III, § 301(a), Dec. 13, 1989, 103 Stat. 1985. [Repeal not applicable to duplicative part A benefits for periods before Jan. 1, 1990, see section 301(e)(1) of Pub. L. 101–234, set out as an Effective Date of 1989 Amendment note under section 1395u of this title.]

TASK FORCE ON LONG-TERM HEALTH CARE POLICIES

Pub. L. 99–272, title IX, § 9601, Apr. 7, 1986, 100 Stat. 221, as amended by Pub. L. 105–362, title VI, § 601(b)(3), Nov. 10, 1998, 112 Stat. 3286, directed Secretary of Health and Human Services, in consultation with National Association of Insurance Commissioners, to establish Task Force on Long-Term Health Care Policies to develop recommendations for long-term health care policies designed to limit marketing and agent abuse for those policies, to assure dissemination of such information to consumers as is necessary to permit informed choice in purchasing policies and to reduce purchase of unnecessary or duplicative coverage, to assure that benefits provided under policies are reasonable in relationship to premiums charged, and to promote development and availability of long-term health care policies which meet these recommendations, and further provided for composition of Task Force, definition of long-term health care policy, assurance of States' jurisdiction, submission of recommendations to Secretary and Congress not later than 18 months after Apr. 7, 1986, and termination of Task Force 90 days after submission of recommendations.

§ 1395b–1. Incentives for economy while maintaining or improving quality in provision of health services

(a) Grants and contracts to develop and engage in experiments and demonstration projects

(1) The Secretary of Health and Human Services is authorized, either directly or through grants to public or private agencies, institutions, and organizations or contracts with public or private agencies, institutions, and organizations, to develop and engage in experiments and demonstration projects for the following purposes:

(A) to determine whether, and if so which, changes in methods of payment or reimbursement (other than those dealt with in section 222(a) of the Social Security Amendments of 1972) for health care and services under health programs established by this chapter, including a change to methods based on negotiated rates, would have the effect of increasing the efficiency and economy of health services under such programs through the creation of additional incentives to these ends without adversely affecting the quality of such services;

(B) to determine whether payments for services other than those for which payment may be made under such programs (and which are incidental to services for which payment may be made under such programs) would, in the judgment of the Secretary, result in more economical provision and more effective utilization of services for which payment may be made under such program, where such services are furnished by organizations and institutions which have the capability of providing—

(i) comprehensive health care services,

(ii) mental health care services (as defined by section 2691(c)[1] of this title),

(iii) ambulatory health care services (including surgical services provided on an outpatient basis), or

(iv) institutional services which may substitute, at lower cost, for hospital care;

(C) to determine whether the rates of payment or reimbursement for health care services, approved by a State for purposes of the administration of one or more of its laws, when utilized to determine the amount to be paid for services furnished in such State under the health programs established by this chapter, would have the effect of reducing the costs of such programs without adversely affecting the quality of such services;

(D) to determine whether payments under such programs based on a single combined rate of reimbursement or charge for the teaching activities and patient care which residents, interns, and supervising physicians render in connection with a graduate medical education program in a patient facility would result in more equitable and economical patient care arrangements without adversely affecting the quality of such care;

(E) to determine whether coverage of intermediate care facility services and homemaker services would provide suitable alternatives to posthospital benefits presently provided under this subchapter; such experiment and demonstration projects may include:

(i) counting each day of care in an intermediate care facility as one day of care in a skilled nursing facility, if such care was for a condition for which the individual was hospitalized,

(ii) covering the services of homemakers for a maximum of 21 days, if institutional services are not medically appropriate,

(iii) determining whether such coverage would reduce long-range costs by reducing

[1] See References in Text note below.

the lengths of stay in hospitals and skilled nursing facilities, and

(iv) establishing alternative eligibility requirements and determining the probable cost of applying each alternative, if the project suggests that such extension of coverage would be desirable;

(F) to determine whether, and if so which type of, fixed price or performance incentive contract would have the effect of inducing to the greatest degree effective, efficient, and economical performance of agencies and organizations making payment under agreements or contracts with the Secretary for health care and services under health programs established by this chapter;

(G) to determine under what circumstances payment for services would be appropriate and the most appropriate, equitable, and noninflationary methods and amounts of reimbursement under health care programs established by this chapter for services, which are performed independently by an assistant to a physician, including a nurse practitioner (whether or not performed in the office of or at a place at which such physician is physically present), and—

(i) which such assistant is legally authorized to perform by the State or political subdivision wherein such services are performed, and

(ii) for which such physician assumes full legal and ethical responsibility as to the necessity, propriety, and quality thereof;

(H) to establish an experimental program to provide day-care services, which consist of such personal care, supervision, and services as the Secretary shall by regulation prescribe, for individuals eligible to enroll in the supplemental medical insurance program established under part B of this subchapter and subchapter XIX of this chapter, in day-care centers which meet such standards as the Secretary shall by regulation establish;

(I) to determine whether the services of clinical psychologists may be made more generally available to persons eligible for services under this subchapter and subchapter XIX of this chapter in a manner consistent with quality of care and equitable and efficient administration;

(J) to develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by this chapter; and

(K) to determine whether the use of competitive bidding in the awarding of contracts, or the use of other methods of reimbursement, under part B of subchapter XI would be efficient and effective methods of furthering the purposes of that part.

For purposes of this subsection, ''health programs established by this chapter'' means the program established by this subchapter and a program established by a plan of a State approved under subchapter XIX of this chapter.

(2) Grants, payments under contracts, and other expenditures made for experiments and demonstration projects under paragraph (1) shall be made in appropriate part from the Federal Hospital Insurance Trust Fund (established by section 1395i of this title) and the Federal Supplementary Medical Insurance Trust Fund (established by section 1395t of this title) and from funds appropriated under subchapter XIX of this chapter. Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section. With respect to any such grant, payment, or other expenditure, the amount to be paid from each of such trust funds (and from funds appropriated under such subchapter XIX) shall be determined by the Secretary, giving due regard to the purposes of the experiment or project involved.

(b) Waiver of certain payment or reimbursement requirements; advice and recommendations of specialists preceding experiments and demonstration projects

In the case of any experiment or demonstration project under subsection (a), the Secretary may waive compliance with the requirements of this subchapter and subchapter XIX of this chapter insofar as such requirements relate to reimbursement or payment on the basis of reasonable cost, or (in the case of physicians) on the basis of reasonable charge, or to reimbursement or payment only for such services or items as may be specified in the experiment; and costs incurred in such experiment or demonstration project in excess of the costs which would otherwise be reimbursed or paid under such subchapters may be reimbursed or paid to the extent that such waiver applies to them (with such excess being borne by the Secretary). No experiment or demonstration project shall be engaged in or developed under subsection (a) until the Secretary obtains the advice and recommendations of specialists who are competent to evaluate the proposed experiment or demonstration project as to the soundness of its objectives, the possibilities of securing productive results, the adequacy of resources to conduct the proposed experiment or demonstration project, and its relationship to other similar experiments and projects already completed or in process.

(Pub. L. 90–248, title IV, § 402(a), (b), Jan. 2, 1968, 81 Stat. 930, 931; Pub. L. 92–603, title II, §§ 222(b), 278(b)(2), Oct. 30, 1972, 86 Stat. 1391, 1453; Pub. L. 95–142, § 17(d), Oct. 25, 1977, 91 Stat. 1202; Pub. L. 96–88, title V, § 509(b), Oct. 17, 1979, 93 Stat. 695; Pub. L. 97–35, title XXI, § 2193(d), Aug. 13, 1981, 95 Stat. 828; Pub. L. 97–248, title I, § 147, Sept. 3, 1982, 96 Stat. 394; Pub. L. 98–369, div. B, title III, § 2331(b), July 18, 1984, 98 Stat. 1088.)

REFERENCES IN TEXT

Section 222(a) of the Social Security Amendments of 1972, referred to in subsec. (a)(1)(A), is section 222(a) of Pub. L. 92–603, Oct. 30, 1972, 86 Stat. 1329, which is set out as a note below.

Section 2691(c) of this title, referred to in subsec. (a)(1)(B)(ii), was repealed by Pub. L. 94–103, title III, § 302(c), Oct. 4, 1975, 89 Stat. 507.

CODIFICATION

Section is comprised of subsecs. (a) and (b) of section 402 of Pub. L. 90–248. Subsec. (c) of such section 402 amended section 1395*ll*(b) of this title.

Section was enacted as a part of the Social Security Amendments of 1967, and not as a part of the Social Security Act which comprises this chapter.

AMENDMENTS

1984—Subsec. (a)(1). Pub. L. 98–369 substituted ''grants to public or private agencies'' for ''grants to public or nonprofit private agencies'' in provisions preceding subpar. (A).

1982—Subsec. (a)(1)(K). Pub. L. 97–248 added subpar. (K).

1981—Subsec. (a)(1). Pub. L. 97–35, § 2193(d)(1), substituted ''this subchapter and a program established by a plan of a State approved under subchapter XIX of this chapter'' for ''this subchapter, a program established by a plan of a State approved under subchapter XIX of this chapter, and a program established by a plan of a State approved under subchapter V of this chapter''.

Subsec. (a)(2). Pub. L. 97–35, § 2193(d)(2), substituted reference to subchapter XIX of this chapter for reference to subchapters V and XIX of this chapter in two places.

Subsec. (b). Pub. L. 97–35, § 2193(d)(3), substituted reference to subchapter XIX of this chapter for reference to subchapters V and XIX of this chapter.

1977—Subsec. (a)(1)(J). Pub. L. 95–142 added subpar. (J).

1972—Subsec. (a). Pub. L. 92–603, §§ 222(b)(1), 278(b)(2), substituted provisions spelling out in detail the purposes for which experiments and demonstration projects may be carried out for a general statement setting out the increase in efficiency and economy of health services as the purpose of experiments selected by the Secretary, inserted references to demonstration projects, and inserted references to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

Subsec. (b). Pub. L. 92–603, § 222(b)(2), inserted references to demonstration projects and inserted '', or to reimbursement or payment only for such services or items as may be specified in the experiment''.

CHANGE OF NAME

''Secretary of Health and Human Services'' substituted for ''Secretary of Health, Education, and Welfare'' in subsec. (a)(1) pursuant to section 509(b) Pub. L. 96–88, which is classified to section 3508(b) of Title 20, Education.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, see section 2331(c) of Pub. L. 98–369, set out as a note under section 1310 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 effective with respect to contracts entered into or renewed on or after Sept. 3, 1982, see section 149 of Pub. L. 97–248, set out as an Effective Date note under section 1320c of this title.

EFFECTIVE DATE OF 1981 AMENDMENT, SAVINGS, AND TRANSITIONAL PROVISIONS

For effective date, savings, and transitional provisions relating to amendment by Pub. L. 97–35, see section 2194 of Pub. L. 97–35, set out as a note under section 701 of this title.

COMMUNITY-BASED CARE TRANSITIONS PROGRAM

Pub. L. 111–148, title III, § 3026, Mar. 23, 2010, 124 Stat. 413, provided that:

''(a) IN GENERAL.—The Secretary shall establish a Community-Based Care Transitions Program under which the Secretary provides funding to eligible entities that furnish improved care transition services to high-risk Medicare beneficiaries.

''(b) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means the following:

''(A) A subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) identified by the Secretary as having a high readmission rate, such as under section 1886(q) of the Social Security Act, as added by section 3025.

''(B) An appropriate community-based organization that provides care transition services under this section across a continuum of care through arrangements with subsection (d) hospitals (as so defined) to furnish the services described in subsection (c)(2)(B)(i) and whose governing body includes sufficient representation of multiple health care stakeholders (including consumers).

''(2) HIGH-RISK MEDICARE BENEFICIARY.—The term 'high-risk Medicare beneficiary' means a Medicare beneficiary who has attained a minimum hierarchical condition category score, as determined by the Secretary, based on a diagnosis of multiple chronic conditions or other risk factors associated with a hospital readmission or substandard transition into post-hospitalization care, which may include 1 or more of the following:

''(A) Cognitive impairment.

''(B) Depression.

''(C) A history of multiple readmissions.

''(D) Any other chronic disease or risk factor as determined by the Secretary.

''(3) MEDICARE BENEFICIARY.—The term 'Medicare beneficiary' means an individual who is entitled to benefits under part A [42 U.S.C. 1395c et seq.] of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and enrolled under part B [42 U.S.C. 1395j et seq.] of such title, but not enrolled under part C [42 U.S.C. 1395w–21 et seq.] of such title.

''(4) PROGRAM.—The term 'program' means the program conducted under this section.

''(5) READMISSION.—The term 'readmission' has the meaning given such term in section 1886(q)(5)(E) of the Social Security Act [42 U.S.C. 1395ww(q)(5)(E)], as added by section 3025.

''(6) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(c) REQUIREMENTS.—

''(1) DURATION.—

''(A) IN GENERAL.—The program shall be conducted for a 5-year period, beginning January 1, 2011.

''(B) EXPANSION.—The Secretary may expand the duration and the scope of the program, to the extent determined appropriate by the Secretary, if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to spending under this title [title III of Pub. L. 111–148, see Tables for classification], certifies) that such expansion would reduce spending under this title without reducing quality.

''(2) APPLICATION; PARTICIPATION.—

''(A) IN GENERAL.—

''(i) APPLICATION.—An eligible entity seeking to participate in the program shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(ii) PARTNERSHIP.—If an eligible entity is a hospital, such hospital shall enter into a partnership with a community-based organization to participate in the program.

''(B) INTERVENTION PROPOSAL.—Subject to subparagraph (C), an application submitted under subparagraph (A)(i) shall include a detailed proposal for at least 1 care transition intervention, which may include the following:

''(i) Initiating care transition services for a high-risk Medicare beneficiary not later than 24 hours prior to the discharge of the beneficiary from the eligible entity.

''(ii) Arranging timely post-discharge follow-up services to the high-risk Medicare beneficiary to provide the beneficiary (and, as appropriate, the primary caregiver of the beneficiary) with information regarding responding to symptoms that may indicate additional health problems or a deteriorating condition.

''(iii) Providing the high-risk Medicare beneficiary (and, as appropriate, the primary caregiver of the beneficiary) with assistance to ensure productive and timely interactions between patients and post-acute and outpatient providers.

''(iv) Assessing and actively engaging with a high-risk Medicare beneficiary (and, as appropriate, the primary caregiver of the beneficiary) through the provision of self-management support and relevant information that is specific to the beneficiary's condition.

''(v) Conducting comprehensive medication review and management (including, if appropriate, counseling and self-management support).

''(C) LIMITATION.—A care transition intervention proposed under subparagraph (B) may not include payment for services required under the discharge planning process described in section 1861(ee) of the Social Security Act (42 U.S.C. 1395x(ee)).

''(3) SELECTION.—In selecting eligible entities to participate in the program, the Secretary shall give priority to eligible entities that—

''(A) participate in a program administered by the Administration on Aging to provide concurrent care transitions interventions with multiple hospitals and practitioners; or

''(B) provide services to medically underserved populations, small communities, and rural areas.

''(d) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement the provisions of this section by program instruction or otherwise.

''(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act [42 U.S.C. 1301 et seq., 1395 et seq.] as may be necessary to carry out the program.

''(f) FUNDING.—For purposes of carrying out this section, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $500,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2011 through 2015. Amounts transferred under the preceding sentence shall remain available until expended.''

PILOT TESTING PAY-FOR-PERFORMANCE PROGRAMS FOR CERTAIN MEDICARE PROVIDERS

Pub. L. 111–148, title X, § 10326, Mar. 23, 2010, 124 Stat. 961, provided that:

''(a) IN GENERAL.—Not later than January 1, 2016, the Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall, for each provider described in subsection (b), conduct a separate pilot program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] to test the implementation of a value-based purchasing program for payments under such title for the provider.

''(b) PROVIDERS DESCRIBED.—The providers described in this paragraph are the following:

''(1) Psychiatric hospitals (as described in clause (i) of section 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B))) and psychiatric units (as described in the matter following clause (v) of such section).

''(2) Long-term care hospitals (as described in clause (iv) of such section).

''(3) Rehabilitation hospitals (as described in clause (ii) of such section).

''(4) PPS-exempt cancer hospitals (as described in clause (v) of such section).

''(5) Hospice programs (as defined in section 1861(dd)(2) of such Act (42 U.S.C. 1395x(dd)(2))).

''(c) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act [42 U.S.C. 1301 et seq., 1395 et seq.] as may be necessary solely for purposes of carrying out the pilot programs under this section.

''(d) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments under this section under the separate pilot program for value based purchasing (as described in subsection (a)) for each provider type described in paragraphs (1) through (5) of subsection (b) for applicable items and services under title XVIII of the Social Security Act for a year shall be established in a manner that does not result in spending more under each such value based purchasing program for such year than would otherwise be expended for such provider type for such year if the pilot program were not implemented, as estimated by the Secretary.

''(e) EXPANSION OF PILOT PROGRAM.—The Secretary may, at any point after January 1, 2018, expand the duration and scope of a pilot program conducted under this subsection, to the extent determined appropriate by the Secretary, if—

''(1) the Secretary determines that such expansion is expected to—

''(A) reduce spending under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] without reducing the quality of care; or

''(B) improve the quality of care and reduce spending;

''(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under such title XVIII; and

''(3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under such title XIII [XVIII] for Medicare beneficiaries.''

MEDICARE MEDICAL HOME DEMONSTRATION PROJECT

Pub. L. 109–432, div. B, title II, § 204, Dec. 20, 2006, 120 Stat. 2987, as amended by Pub. L. 110–275, title I, § 133(a), July 15, 2008, 122 Stat. 2531, provided that:

''(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall establish under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] a medical home demonstration project (in this section referred to as the 'project') to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations and under which—

''(1) care management fees are paid to persons performing services as personal physicians; and

''(2) incentive payments are paid to physicians participating in practices that provide services as a medical home under subsection (d).

For purposes of this subsection, the term 'high-need population' means individuals with multiple chronic illnesses that require regular medical monitoring, advising, or treatment.

''(b) DETAILS.—

''(1) DURATION; SCOPE.—Subject to paragraph (3), the project shall operate during a period of three years and shall include urban, rural, and underserved areas in a total of no more than 8 States.

''(2) ENCOURAGING PARTICIPATION OF SMALL PHYSICIAN PRACTICES.—The project shall be designed to include the participation of physicians in practices with fewer than three full-time equivalent physicians, as well as physicians in larger practices particularly in rural and underserved areas.

''(3) EXPANSION.—The Secretary may expand the duration and the scope of the project under paragraph (1), to an extent determined appropriate by the Secretary, if the Secretary determines that such expansion will result in any of the following conditions being met:

''(A) The expansion of the project is expected to improve the quality of patient care without in-

creasing spending under the Medicare program (not taking into account amounts available under subsection (g)).

''(B) The expansion of the project is expected to reduce spending under the Medicare program (not taking into account amounts available under subsection (g)) without reducing the quality of patient care.

''(c) PERSONAL PHYSICIAN DEFINED.—

''(1) IN GENERAL.—For purposes of this section, the term 'personal physician' means a physician (as defined in section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)(1))[)] who—

''(A) meets the requirements described in paragraph (2); and

''(B) performs the services described in paragraph (3).

Nothing in this paragraph shall be construed as preventing such a physician from being a specialist or subspecialist for an individual requiring ongoing care for a specific chronic condition or multiple chronic conditions (such as severe asthma, complex diabetes, cardiovascular disease, rheumatologic disorder) or for an individual with a prolonged illness.

''(2) REQUIREMENTS.—The requirements described in this paragraph for a personal physician are as follows:

''(A) The physician is a board certified physician who provides first contact and continuous care for individuals under the physician's care.

''(B) The physician has the staff and resources to manage the comprehensive and coordinated health care of each such individual.

''(3) SERVICES PERFORMED.—A personal physician shall perform or provide for the performance of at least the following services:

''(A) Advocates for and provides ongoing support, oversight, and guidance to implement a plan of care that provides an integrated, coherent, cross-discipline plan for ongoing medical care developed in partnership with patients and including all other physicians furnishing care to the patient involved and other appropriate medical personnel or agencies (such as home health agencies).

''(B) Uses evidence-based medicine and clinical decision support tools to guide decision-making at the point-of-care based on patient-specific factors.

''(C) Uses health information technology, that may include remote monitoring and patient registries, to monitor and track the health status of patients and to provide patients with enhanced and convenient access to health care services.

''(D) Encourages patients to engage in the management of their own health through education and support systems.

''(d) MEDICAL HOME DEFINED.—For purposes of this section, the term 'medical home' means a physician practice that—

''(1) is in charge of targeting beneficiaries for participation in the project; and

''(2) is responsible for—

''(A) providing safe and secure technology to promote patient access to personal health information;

''(B) developing a health assessment tool for the individuals targeted; and

''(C) providing training programs for personnel involved in the coordination of care.

''(e) PAYMENT MECHANISMS.—

''(1) PERSONAL PHYSICIAN CARE MANAGEMENT FEE.—Under the project, the Secretary shall provide for payment under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) of a care management fee to personal physicians providing care management under the project. Under such section and using the relative value scale update committee (RUC) process under such section, the Secretary shall develop a care management fee code for such payments and a value for such code.

''(2) MEDICAL HOME SHARING IN SAVINGS.—The Secretary shall provide for payment under the project of a medical home based on the payment methodology applied to physician group practices under section 1866A of the Social Security Act (42 U.S.C. 1395cc–1). Under such methodology, 80 percent of the reductions in expenditures under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] resulting from participation of individuals that are attributable to the medical home (as reduced by the total care managements fees paid to the medical home under the project) shall be paid to the medical home. The amount of such reductions in expenditures shall be determined by using assumptions with respect to reductions in the occurrence of health complications, hospitalization rates, medical errors, and adverse drug reactions.

''(3) SOURCE.—Payments paid under the project shall be made from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t).

''(f) EVALUATIONS AND REPORTS.—

''(1) ANNUAL INTERIM EVALUATIONS AND REPORTS.—For each year of the project, the Secretary shall provide for an evaluation of the project and shall submit to Congress, by a date specified by the Secretary, a report on the project and on the evaluation of the project for each such year.

''(2) FINAL EVALUATION AND REPORT.—The Secretary shall provide for an evaluation of the project and shall submit to Congress, not later than one year after completion of the project, a report on the project and on the evaluation of the project.

''(g) FUNDING FROM SMI TRUST FUND.—There shall be available, from the Federal Supplementary Medical Insurance Trust Fund (under section 1841 of the Social Security Act (42 U.S.C. 1395t)), the amount of $100,000,000 to carry out the project.

''(h) APPLICATION.—Chapter 35 of title 44, United States Code, shall not apply to the conduct of the project.''

POST-ACUTE CARE PAYMENT REFORM DEMONSTRATION PROGRAM

Pub. L. 109–171, title V, § 5008, Feb. 8, 2006, 120 Stat. 36, provided that:

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—By not later than January 1, 2008, the Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall establish a demonstration program for purposes of understanding costs and outcomes across different post-acute care sites. Under such program, with respect to diagnoses specified by the Secretary, an individual who receives treatment from a provider for such a diagnosis shall receive a single comprehensive assessment on the date of discharge from a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) of the needs of the patient and the clinical characteristics of the diagnosis to determine the appropriate placement of such patient in a post-acute care site. The Secretary shall use a standardized patient assessment instrument across all post-acute care sites to measure functional status and other factors during the treatment and at discharge from each provider. Participants in the program shall provide information on the fixed and variable costs for each individual. An additional comprehensive assessment shall be provided at the end of the episode of care.

''(2) NUMBER OF SITES.—The Secretary shall conduct the demonstration program under this section with sufficient numbers to determine statistically reliable results.

''(3) DURATION.—The Secretary shall conduct the demonstration program under this section for a 3-year period.

''(b) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 42 U.S.C. 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

''(c) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, that includes the results of the program and recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

''(d) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i), $6,000,000 for the costs of carrying out the demonstration program under this section.''

MEDICARE CARE MANAGEMENT PERFORMANCE DEMONSTRATION

Pub. L. 108–173, title VI, §649, Dec. 8, 2003, 117 Stat. 2329, provided that:

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary [of Health and Human Services] shall establish a pay-for-performance demonstration program with physicians to meet the needs of eligible beneficiaries through the adoption and use of health information technology and evidence-based outcomes measures for—

''(A) promoting continuity of care;

''(B) helping stabilize medical conditions;

''(C) preventing or minimizing acute exacerbations of chronic conditions; and

''(D) reducing adverse health outcomes, such as adverse drug interactions related to polypharmacy.

''(2) SITES.—The Secretary shall designate no more than 4 sites at which to conduct the demonstration program under this section, of which—

''(A) two shall be in an urban area;

''(B) one shall be in a rural area; and

''(C) one shall be in a State with a medical school with a Department of Geriatrics that manages rural outreach sites and is capable of managing patients with multiple chronic conditions, one of which is dementia.

''(3) DURATION.—The Secretary shall conduct the demonstration program under this section for a 3-year period.

''(4) CONSULTATION.—In carrying out the demonstration program under this section, the Secretary shall consult with private sector and non-profit groups that are undertaking similar efforts to improve quality and reduce avoidable hospitalizations for chronically ill patients.

''(b) PARTICIPATION.—

''(1) IN GENERAL.—A physician who provides care for a minimum number of eligible beneficiaries (as specified by the Secretary) may participate in the demonstration program under this section if such physician agrees, to phase-in over the course of the 3-year demonstration period and with the assistance provided under subsection (d)(2)—

''(A) the use of health information technology to manage the clinical care of eligible beneficiaries consistent with paragraph (3); and

''(B) the electronic reporting of clinical quality and outcomes measures in accordance with requirements established by the Secretary under the demonstration program.

''(2) SPECIAL RULE.—In the case of the sites referred to in subparagraphs (B) and (C) of subsection (a)(2), a physician who provides care for a minimum number of beneficiaries with two or more chronic conditions, including dementia (as specified by the Secretary), may participate in the program under this section if such physician agrees to the requirements in subparagraphs (A) and (B) of paragraph (1).

''(3) PRACTICE STANDARDS.—Each physician participating in the demonstration program under this section must demonstrate the ability—

''(A) to assess each eligible beneficiary for conditions other than chronic conditions, such as impaired cognitive ability and co-morbidities, for the purposes of developing care management requirements;

''(B) to serve as the primary contact of eligible beneficiaries in accessing items and services for which payment may be made under the medicare program;

''(C) to establish and maintain health care information system for such beneficiaries;

''(D) to promote continuity of care across providers and settings;

''(E) to use evidence-based guidelines and meet such clinical quality and outcome measures as the Secretary shall require;

''(F) to promote self-care through the provision of patient education and support for patients or, where appropriate, family caregivers;

''(G) when appropriate, to refer such beneficiaries to community service organizations; and

''(H) to meet such other complex care management requirements as the Secretary may specify.

The guidelines and measures required under subparagraph (E) shall be designed to take into account beneficiaries with multiple chronic conditions.

''(c) PAYMENT METHODOLOGY.—Under the demonstration program under this section the Secretary shall pay a per beneficiary amount to each participating physician who meets or exceeds specific performance standards established by the Secretary with respect to the clinical quality and outcome measures reported under subsection (b)(1)(B). Such amount may vary based on different levels of performance or improvement.

''(d) ADMINISTRATION.—

''(1) USE OF QUALITY IMPROVEMENT ORGANIZATIONS.—The Secretary shall contract with quality improvement organizations or such other entities as the Secretary deems appropriate to enroll physicians and evaluate their performance under the demonstration program under this section.

''(2) TECHNICAL ASSISTANCE.—The Secretary shall require in such contracts that the contractor be responsible for technical assistance and education as needed to physicians enrolled in the demonstration program under this section for the purpose of aiding their adoption of health information technology, meeting practice standards, and implementing required clinical and outcomes measures.

''(e) FUNDING.—

''(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

''(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary estimates would have been paid if the demonstration program under this section was not implemented.

''(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq. and 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

''(g) REPORT.—Not later than 12 months after the date of completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

''(h) DEFINITIONS.—In this section:

''(1) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means any individual who—

''(A) is entitled to benefits under part A and enrolled for benefits under part B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.] and is not enrolled in a plan under part C of such title [42 U.S.C. 1395w–21 et seq.]; and

''(B) has one or more chronic medical conditions specified by the Secretary (one of which may be cognitive impairment).

''(2) HEALTH INFORMATION TECHNOLOGY.—The term 'health information technology' means email communication, clinical alerts and reminders, and other information technology that meets such functionality, interoperability, and other standards as prescribed by the Secretary.''

DEMONSTRATION PROJECT FOR DISEASE MANAGEMENT FOR SEVERELY CHRONICALLY ILL MEDICARE BENEFICIARIES

Pub. L. 106–554, §1(a)(6) [title I, §121], Dec. 21, 2000, 114 Stat. 2763, 2763A–474, provided that the Secretary of Health and Human Services was to conduct a demonstration project under this section to demonstrate the impact on costs and health outcomes of applying disease management to medicare beneficiaries with diagnosed, advanced-stage congestive heart failure, diabetes, or coronary heart disease, that the project was to last for not longer than 3 years, and that the Secretary was to submit a final report to Congress not later than 6 months after the project's completion.

CANCER PREVENTION AND TREATMENT DEMONSTRATION FOR ETHNIC AND RACIAL MINORITIES

Pub. L. 106–554, §1(a)(6) [title I, §122], Dec. 21, 2000, 114 Stat. 2763, 2763A–476, provided that:

''(a) DEMONSTRATION.—

''(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall conduct demonstration projects (in this section referred to as 'demonstration projects') for the purpose of developing models and evaluating methods that—

''(A) improve the quality of items and services provided to target individuals in order to facilitate reduced disparities in early detection and treatment of cancer;

''(B) improve clinical outcomes, satisfaction, quality of life, and appropriate use of medicare-covered services and referral patterns among those target individuals with cancer;

''(C) eliminate disparities in the rate of preventive cancer screening measures, such as pap smears and prostate cancer screenings, among target individuals; and

''(D) promote collaboration with community-based organizations to ensure cultural competency of health care professionals and linguistic access for persons with limited English proficiency.

''(2) TARGET INDIVIDUAL DEFINED.—In this section, the term 'target individual' means an individual of a racial and ethnic minority group, as defined by section 1707 of the Public Health Service Act [42 U.S.C. 300u–6], who is entitled to benefits under part A, and enrolled under part B, of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.].

''(b) PROGRAM DESIGN.—

''(1) INITIAL DESIGN.—Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Secretary shall evaluate best practices in the private sector, community programs, and academic research of methods that reduce disparities among individuals of racial and ethnic minority groups in the prevention and treatment of cancer and shall design the demonstration projects based on such evaluation.

''(2) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall implement at least nine demonstration projects, including the following:

''(A) Two projects for each of the four following major racial and ethnic minority groups:

''(i) American Indians, including Alaska Natives, Eskimos, and Aleuts.

''(ii) Asian Americans and Pacific Islanders.

''(iii) Blacks.

''(iv) Hispanics.

The two projects must target different ethnic subpopulations.

''(B) One project within the Pacific Islands.

''(C) At least one project each in a rural area and inner-city area.

''(3) EXPANSION OF PROJECTS; IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—If the initial report under subsection (c) contains an evaluation that demonstration projects—

''(A) reduce expenditures under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]; or

''(B) do not increase expenditures under the medicare program and reduce racial and ethnic health disparities in the quality of health care services provided to target individuals and increase satisfaction of beneficiaries and health care providers;

the Secretary shall continue the existing demonstration projects and may expand the number of demonstration projects.

''(c) REPORT TO CONGRESS.—

''(1) IN GENERAL.—Not later than 2 years after the date the Secretary implements the initial demonstration projects, and biannually thereafter, the Secretary shall submit to Congress a report regarding the demonstration projects.

''(2) CONTENTS OF REPORT.—Each report under paragraph (1) shall include the following:

''(A) A description of the demonstration projects.

''(B) An evaluation of—

''(i) the cost-effectiveness of the demonstration projects;

''(ii) the quality of the health care services provided to target individuals under the demonstration projects; and

''(iii) beneficiary and health care provider satisfaction under the demonstration projects.

''(C) Any other information regarding the demonstration projects that the Secretary determines to be appropriate.

''(d) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

''(e) FUNDING.—

''(1) DEMONSTRATION PROJECTS.—

''(A) STATE PROJECTS.—Except as provided in subparagraph (B), the Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary [Medical] Insurance Trust Fund under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], in such proportions as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration projects.

''(B) TERRITORY PROJECTS.—In the case of a demonstration project described in subsection (b)(2)(B), amounts shall be available only as provided in any Federal law making appropriations for the territories.

''(2) LIMITATION.—In conducting demonstration projects, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the sum of the amount which the Secretary would have paid under the program for the prevention and treatment of cancer if the demonstration projects were not implemented, plus $25,000,000.''

LIFESTYLE MODIFICATION PROGRAM DEMONSTRATION

Pub. L. 106–554, §1(a)(6) [title I, §128], Dec. 21, 2000, 114 Stat. 2763, 2763A–480, as amended by Pub. L. 108–173, title VII, §736(b)(13), Dec. 8, 2003, 117 Stat. 2356, provided that:

''(a) IN GENERAL.—The Secretary of Health and Human Services shall carry out the demonstration project known as the Lifestyle Modification Program Demonstration, as described in the Health Care Financing Administration Memorandum of Understanding entered into on November 13, 2000, and as subsequently modified, (in this section referred to as the 'project') in accordance with the following requirements:

''(1) The project shall include no fewer than 1,800 medicare beneficiaries who complete under the

project the entire course of treatment under the Lifestyle Modification Program.

''(2) The project shall be conducted over a course of 4 years.

''(b) STUDY ON COST-EFFECTIVENESS.—

''(1) STUDY.—The Secretary shall conduct a study on the cost-effectiveness of the Lifestyle Modification Program as conducted under the project. In determining whether such Program is cost-effective, the Secretary shall determine (using a control group under a matched paired experimental design) whether expenditures incurred for medicare beneficiaries enrolled under the project exceed expenditures for the control group of medicare beneficiaries with similar health conditions who are not enrolled under the project.

''(2) REPORTS.—

''(A) INITIAL REPORT.—Not later than 1 year after the date on which 900 medicare beneficiaries have completed the entire course of treatment under the Lifestyle Modification Program under the project, the Secretary shall submit to Congress an initial report on the study conducted under paragraph (1).

''(B) FINAL REPORT.—Not later than 1 year after the date on which 1,800 medicare beneficiaries have completed the entire course of treatment under such Program under the project, the Secretary shall submit to Congress a final report on the study conducted under paragraph (1).''

MEDICARE COORDINATED CARE DEMONSTRATION PROJECT

Pub. L. 105–33, title IV, § 4016, Aug. 5, 1997, 111 Stat. 343, as amended by Pub. L. 106–113, div. B, § 1000(a)(6) [title V, § 535], Nov. 29, 1999, 113 Stat. 1536, 1501A–390, provided that:

''(a) DEMONSTRATION PROJECTS.—

''(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall conduct demonstration projects for the purpose of evaluating methods, such as case management and other models of coordinated care, that—

''(A) improve the quality of items and services provided to target individuals; and

''(B) reduce expenditures under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for items and services provided to target individuals.

''(2) TARGET INDIVIDUAL DEFINED.—In this section, the term 'target individual' means an individual that has a chronic illness, as defined and identified by the Secretary, and is enrolled under the fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.).

''(b) PROGRAM DESIGN.—

''(1) INITIAL DESIGN.—The Secretary shall evaluate best practices in the private sector of methods of coordinated care for a period of 1 year and design the demonstration project based on such evaluation.

''(2) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of enactment of this Act [Aug. 5, 1997], the Secretary shall implement at least 9 demonstration projects, including—

''(A) 5 projects in urban areas;

''(B) 3 projects in rural areas; and

''(C) 1 project within the District of Columbia which is operated by a nonprofit academic medical center that maintains a National Cancer Institute certified comprehensive cancer center.

''(3) EXPANSION OF PROJECTS; IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—

''(A) EXPANSION OF PROJECTS.—If the initial report under subsection (c) contains an evaluation that demonstration projects—

''(i) reduce expenditures under the medicare program; or

''(ii) do not increase expenditures under the medicare program and increase the quality of health care services provided to target individuals and satisfaction of beneficiaries and health care providers;

the Secretary shall continue the existing demonstration projects and may expand the number of demonstration projects.

''(B) IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—If a report under subsection (c) contains an evaluation as described in subparagraph (A), the Secretary may issue regulations to implement, on a permanent basis, the components of the demonstration project that are beneficial to the medicare program.

''(c) REPORT TO CONGRESS.—

''(1) IN GENERAL.—Not later than 2 years after the Secretary implements the initial demonstration projects under this section, and biannually thereafter, the Secretary shall submit to Congress a report regarding the demonstration projects conducted under this section.

''(2) CONTENTS OF REPORT.—The report in paragraph (1) shall include the following:

''(A) A description of the demonstration projects conducted under this section.

''(B) An evaluation of—

''(i) the cost-effectiveness of the demonstration projects;

''(ii) the quality of the health care services provided to target individuals under the demonstration projects; and

''(iii) beneficiary and health care provider satisfaction under the demonstration project.

''(C) Any other information regarding the demonstration projects conducted under this section that the Secretary determines to be appropriate.

''(d) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

''(e) FUNDING.—

''(1) DEMONSTRATION PROJECTS.—

''(A) IN GENERAL.—

''(i) STATE PROJECTS.—Except as provided in clause (ii), the Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary [Medical] Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t), in such proportions as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration projects under this section.

''(ii) CANCER HOSPITAL.—In the case of the project described in subsection (b)(2)(C), the Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund [Medical] under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t), in such proportions as the Secretary determines to be appropriate, of such funds as are necessary to cover costs of the project, including costs for information infrastructure and recurring costs of case management services, flexible benefits, and program management.

''(B) LIMITATION.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration projects under this section were not implemented.

''(2) EVALUATION AND REPORT.—There are authorized to be appropriated such sums as are necessary for the purpose of developing and submitting the report to Congress under subsection (c).''

INFORMATICS, TELEMEDICINE, AND EDUCATION DEMONSTRATION PROJECT

Pub. L. 105–33, title IV, § 4207, Aug. 5, 1997, 111 Stat. 379, as amended by Pub. L. 106–113, div. B, § 1000(a)(6)

[title IV, § 413], Nov. 29, 1999, 113 Stat. 1536, 1501A–377; Pub. L. 108–173, title IV, § 417, Dec. 8, 2003, 117 Stat. 2282, provided that:

''(a) PURPOSE AND AUTHORIZATION.—

''(1) IN GENERAL.—Not later than 9 months after the date of enactment of this section [Aug. 5, 1997], the Secretary of Health and Human Services shall provide for a demonstration project described in paragraph (2). The Secretary shall make an award for such project not later than 3 months after the date of the enactment of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 [Nov. 29, 1999]. The Secretary shall accept the proposal adjudged to be the best technical proposal as of such date of enactment without the need for additional review or resubmission of proposals.

''(2) DESCRIPTION OF PROJECT.—

''(A) IN GENERAL.—The demonstration project described in this paragraph is a single demonstration project to use eligible health care provider telemedicine networks to apply high-capacity computing and advanced networks to improve primary care (and prevent health care complications) to medicare beneficiaries with diabetes mellitus who are residents of medically underserved rural areas or residents of medically underserved inner-city areas that qualify as Federally designated medically underserved areas or health professional shortage areas at the time of enrollment of beneficiaries under the project.

''(B) MEDICALLY UNDERSERVED DEFINED.—As used in this paragraph, the term 'medically underserved' has the meaning given such term in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3)).

''(3) WAIVER.—The Secretary shall waive such provisions of title XVIII of the Social Security Act [this subchapter] as may be necessary to provide for payment for services under the project in accordance with subsection (d).

''(4) DURATION OF PROJECT.—The project shall be conducted over a 8-year period.

''(b) OBJECTIVES OF PROJECT.—The objectives of the project include the following:

''(1) Improving patient access to and compliance with appropriate care guidelines for individuals with diabetes mellitus through direct telecommunications link with information networks in order to improve patient quality-of-life and reduce overall health care costs.

''(2) Developing a curriculum to train health professionals (particularly primary care health professionals) in the use of medical informatics and telecommunications.

''(3) Demonstrating the application of advanced technologies, such as video-conferencing from a patient's home, remote monitoring of a patient's medical condition, interventional informatics, and applying individualized, automated care guidelines, to assist primary care providers in assisting patients with diabetes in a home setting.

''(4) Application of medical informatics to residents with limited English language skills.

''(5) Developing standards in the application of telemedicine and medical informatics.

''(6) Developing a model for the cost-effective delivery of primary and related care both in a managed care environment and in a fee-for-service environment.

''(c) ELIGIBLE HEALTH CARE PROVIDER TELEMEDICINE NETWORK DEFINED.—For purposes of this section, the term 'eligible health care provider telemedicine network' means a consortium that includes at least one tertiary care hospital (but no more than 2 such hospitals), at least one medical school, no more than 4 facilities in rural or urban areas, and at least one regional telecommunications provider and that meets the following requirements:

''(1) The consortium is located in an area with a high concentration of medical schools and tertiary care facilities in the United States and has appropriate arrangements (within or outside the consortium) with such schools and facilities, universities, and telecommunications providers, in order to conduct the project.

''(2) The consortium submits to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the use to which the consortium would apply any amounts received under the project.

''(3) The consortium guarantees that it will be responsible for payment for all costs of the project that are not paid under this section and that the maximum amount of payment that may be made to the consortium under this section shall not exceed the amount specified in subsection (d)(3).

''(d) COVERAGE AS MEDICARE PART B SERVICES.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, services related to the treatment or management of (including prevention of complications from) diabetes for medicare beneficiaries furnished under the project shall be considered to be services covered under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.].

''(2) PAYMENTS.—

''(A) IN GENERAL.—Subject to paragraph (3), payment for such services shall be made for the costs that are related to the provision of such services. In computing such costs, the Secretary shall include costs described in subparagraph (B), but may not include costs described in subparagraph (C).

''(B) COSTS THAT MAY BE INCLUDED.—The costs described in this subparagraph are the permissible costs (as recognized by the Secretary) for the following:

''(i) The acquisition of telemedicine equipment for use in patients' homes or at sites providing health care to patients located in medically underserved areas.

''(ii) Curriculum development and training of health professionals in medical informatics and telemedicine.

''(iii) Payment of telecommunications costs (including salaries and maintenance of equipment), including costs of telecommunications between patients' homes and the eligible network and between the network and other entities under the arrangements described in subsection (c)(1).

''(iv) Payments to practitioners and providers under the medicare programs.

''(C) COSTS NOT INCLUDED.—The costs described in this subparagraph are costs for any of the following:

''(i) The purchase or installation of transmission equipment (other than such equipment used by health professionals for activities related to the project).

''(ii) The establishment or operation of a telecommunications common carrier network.

''(iii) Construction (except for minor renovations related to the installation of reimbursable equipment) or the acquisition or building of real property.

''(3) LIMITATION.—The total amount of the payments that may be made under this section shall not exceed $60,000,000 for the period of the project (described in subsection (a)(4)).

''(4) COST-SHARING.—The project may not impose cost-sharing on a medicare beneficiary for the receipt of services under the project. Project costs will cover all costs to medicare beneficiaries and providers related to participation in the project.

''(e) REPORTS.—The Secretary shall submit to the Committee on Ways and Means and the Committee [on] Commerce [now Committee on Energy and Commerce] of the House of Representatives and the Committee on Finance of the Senate interim reports on the project and a final report on the project within 6 months after the conclusion of the project. The final report shall in-

clude an evaluation of the impact of the use of telemedicine and medical informatics on improving access of medicare beneficiaries to health care services, on reducing the costs of such services, and on improving the quality of life of such beneficiaries.

''(f) DEFINITIONS.—For purposes of this section:

''(1) INTERVENTIONAL INFORMATICS.—The term 'interventional informatics' means using information technology and virtual reality technology to intervene in patient care.

''(2) MEDICAL INFORMATICS.—The term 'medical informatics' means the storage, retrieval, and use of biomedical and related information for problem solving and decision-making through computing and communications technologies.

''(3) PROJECT.—The term 'project' means the demonstration project under this section.''

CLARIFICATION OF SECRETARIAL WAIVER AUTHORITY FOR RURAL HOSPITAL DEMONSTRATIONS

Pub. L. 101–508, title IV, § 4008(i)(1), Nov. 5, 1990, 104 Stat. 1388–50, as amended by Pub. L. 103–66, title XIII, § 13507, Aug. 10, 1993, 107 Stat. 579, provided that: ''The Secretary of Health and Human Services is authorized to waive such provisions of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] as are necessary to conduct any demonstration project for limited-service rural hospitals with respect to which the Secretary has entered into an agreement before the date of the enactment of the Omnibus Budget Reconciliation Act of 1989 [Dec. 19, 1989]. The Secretary shall continue any such demonstration project until at least July 1, 1997.''

VOLUNTEER SENIOR AIDES DEMONSTRATION PROJECTS FOR BASIC MEDICAL ASSISTANCE AND SUPPORT TO FAMILIES WITH DISABLED OR ILL CHILDREN

Pub. L. 101–239, title X, § 10404, Dec. 19, 1989, 103 Stat. 2488, provided that:

''(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.''

TREATMENT OF CERTAIN NURSING EDUCATION PROGRAMS

Pub. L. 100–647, title VIII, § 8411, Nov. 10, 1988, 102 Stat. 3800, as amended by Pub. L. 101–239, title VI, § 6205(a)(1)(B), Dec. 19, 1989, 103 Stat. 2243, provided that:

''(a) DEMONSTRATION OF JOINT NURSING GRADUATE EDUCATION PROGRAMS.—

''(1) The Secretary of Health and Human Services shall provide for demonstration programs under this subsection in each of 5 hospitals for cost reporting periods beginning on or after July 1, 1989, and before July 1, 1994.

''(2) Under each demonstration project, subject to paragraph (4), the reasonable costs incurred by a hospital pursuant to a written agreement with an educational institution for the activities described in paragraph (3) conducted as part of an approved educational program that—

''(A) involves a substantial clinical component (as determined by the Secretary), and

''(B) leads to a master's or doctoral degree in nursing,

shall be allowable as reasonable costs under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and reimbursed under such title on the same basis as if they were allowable direct costs of a hospital-operated approved educational program (other than an approved graduate medical education program).

''(3) The activities described in this paragraph are the activities for which the reasonable costs of conducting such activities are allowable under title XVIII of the Social Security Act if conducted under a hospital-operated approved educational program (other than an approved graduate medical education program), but only to the extent such activities are directly related to the operation of the educational program conducted pursuant to the written agreement between the hospital and the educational institution.

''(4) The amount paid under a demonstration program under this subsection to a hospital for a cost reporting period may not exceed $200,000.

''(5) The Secretary shall report to Congress, by not later than January 1, 1995, on the demonstration programs conducted under this subsection and on the supply and characteristics of nurses trained under such programs.

''(b) JOINT UNDERGRADUATE EDUCATION PROGRAM.—In the case of a hospital which (1) was paid under a waiver under section 402 of the Social Security Amendments of 1967 [section 402 of Pub. L. 90–248, enacting this section and amending section 1395*ll* of this title] and section 222 of the Social Security Amendments of 1972 [section 222 of Pub. L. 92–603, amending this section and section 1395*ll* of this title and enacting provisions set out below], which waiver expired on September 30, 1985, and (2) during its cost reporting period beginning in fiscal year 1985 and for each subsequent cost reporting period, has been and is associated with, and has incurred and incurs substantial costs with respect to, a nursing college with which it has shared and shares common directors, educational activities of the nursing college shall be considered to be educational activities operated directly by such hospital for purposes of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], and shall be allowable as reasonable costs under such title and reimbursed under such title on the same basis as if they were allowable direct costs of a hospital-operated approved educational program (other than an approved graduate medical education program), for hospital cost reporting periods beginning in fiscal years 1986 though 1991.''

RESEARCH ON LONG-TERM CARE SERVICES FOR MEDICARE BENEFICIARIES

Pub. L. 100–360, title II, § 207, July 1, 1988, 102 Stat. 732, which provided for research on issues relating to the delivery and financing of long-term care services for

medicare beneficiaries, was repealed by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

ADJUSTMENT OF CONTRACTS WITH PREPAID HEALTH PLANS

For requirement that Secretary of Health and Human Services modify contracts with health maintenance organizations under subsec. (a) of this section and section 222(a) of Pub. L. 92–603, set out below, so as to apply to such organizations and contracts the requirements imposed by the amendments made by Pub. L. 100–360, see section 222 of Pub. L. 100–360, set out as a note under section 1395mm of this title.

CASE MANAGEMENT DEMONSTRATION PROJECTS

Pub. L. 101–508, title IV, §4207(f), formerly §4027(f), Nov. 5, 1990, 104 Stat. 1388–123, as renumbered by Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that:

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall resume the 3 case management demonstration projects described in paragraph (2) and approved under section 425 of the Medicare Catastrophic Coverage Act of 1988 [Pub. L. 100–360, formerly set out below] (in this subsection referred to as 'MCCA').

''(2) PROJECT DESCRIPTIONS.—The demonstration projects referred to in paragraph (1) are—

''(A) the project proposed to be conducted by Providence Hospital for case management of the elderly at risk for acute hospitalization as described in Project No. 18–P–99379/5–01;

''(B) the project proposed to be conducted by the Iowa Foundation for Medical Care to study patients with chronic congestive conditions to reduce repeated hospitalizations of such patients as described in Project No. P–99399/4–01; and

''(C) the project proposed to be conducted by Key Care Health Resources, Inc., to examine the effects of case management on 2,500 high cost medicare beneficiaries as described in Project No. 18–P–99396/5.

''(3) TERMS AND CONDITIONS.—Except as provided in paragraph (4), the demonstration projects resumed pursuant to paragraph (1) shall be subject to the same terms and conditions established under section 425 of MCCA. In determining the 2-year duration period of a project resumed pursuant to paragraph (1), the Secretary may not take into account any period of time for which the project was in effect under section 425 of MCCA.

''(4) AUTHORIZATION OF APPROPRIATIONS.—Notwithstanding section 425(g) of MCCA, there are authorized to be appropriated for administrative costs in carrying out the demonstration projects resumed pursuant to paragraph (1) $2,000,000 in each of fiscal years 1991 and 1992.''

Pub. L. 100–360, title IV, §425, July 1, 1988, 102 Stat. 813, which directed Secretary of Health and Human Services to establish 4 demonstration projects under which an appropriate entity agreed to provide case management services, was repealed by Pub. L. 101–234, title III, §301(a), Dec. 13, 1989, 103 Stat. 1985.

DEMONSTRATION PROJECTS WITH RESPECT TO CHRONIC VENTILATOR-DEPENDENT UNITS IN HOSPITALS

Pub. L. 100–360, title IV, §429, July 1, 1988, 102 Stat. 817, as amended by Pub. L. 100–647, title VIII, §8404(a), Nov. 10, 1988, 102 Stat. 3800, directed Secretary of Health and Human Services, in consultation with the Prospective Payment Assessment Commission, to provide for at least 5 demonstration projects, for at least 3 years each, to review appropriateness of classifying chronic ventilator-dependent units in hospitals as rehabilitation units.

RESEARCH AND DEMONSTRATION PROJECTS ON RURAL AND INNER-CITY HEALTH ISSUES

Pub. L. 100–203, title IV, §4403, Dec. 22, 1987, 1330–226, as amended by Pub. L. 100–360, title IV, §411(m)(2)(A), July 1, 1988, 102 Stat. 806, provided that:

''(a) SET ASIDES FOR ISSUES OF HEALTH CARE IN RURAL AREAS AND IN INNER-CITY AREAS.—(1) Not less than ten percent of the total amounts annually appropriated to, and expended by, the Health Care Financing Administration for the conduct of research and demonstration projects in fiscal years 1988, 1989, and 1990 shall be expended for research and demonstration projects relating exclusively or substantially to rural health issues, including (but not limited to) the impact of the payment methodology under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] on the financial viability of small rural hospitals, the effect of medicare payment policies on the ability of rural areas (and rural hospitals in particular) to attract and retain physicians and other health professionals, the appropriateness of medicare conditions of participation and staffing requirements for small rural hospitals, and the impact of medicare policies on access to (and the quality of) health care in rural areas.

''(2) Not less than ten percent of the total amounts annually appropriated to, and expended by, the Health Care Financing Administration for the conduct of research and demonstration projects in fiscal years 1988, 1989, and 1990 shall be expended for research and demonstration projects relating exclusively or substantially to issues of providing health care in inner-city areas, including (but not limited to) the impact of the payment methodology under section 1886(d) of the Social Security Act on the financial viability of inner-city hospitals and the impact of medicare policies on access to (and the quality of) health care in inner-city areas.

''(b) AGENDA.—The Secretary of Health and Human Services shall establish an agenda of research and demonstration projects, relating exclusively or substantially to rural health issues or to inner-city health issues, that are in progress or have been proposed, and shall include such agenda in the annual report submitted pursuant to section 1875(b) of the Social Security Act [42 U.S.C. 1395*ll*(b)]. The agenda shall be accompanied by a statement setting forth the amounts that have been obligated and expended with respect to such projects in the current and most recently completed fiscal years.''

ALZHEIMER'S DISEASE DEMONSTRATION PROJECTS

Pub. L. 99–509, title IX, §9342, Oct. 21, 1986, 100 Stat. 2038, as amended by Pub. L. 101–508, title IV, §4164(a)(2), Nov. 5, 1990, 104 Stat. 1388–101; Pub. L. 103–66, title XIII, §13552, Aug. 10, 1993, 107 Stat. 591, required Secretary of Health and Human Services to conduct at least 5 (and not more than 10) demonstration projects, each over a period of 5 years, to determine effectiveness, cost, and impact on health status and functioning of providing comprehensive services for individuals entitled to benefits under this subchapter who are victims of Alzheimer's disease or related disorders and to report to Congress upon completion of the projects.

SPECIAL TREATMENT OF STATES FORMERLY UNDER WAIVER

For treatment of hospitals in States which have had a waiver approved under this section, upon termination of waiver, see section 9202(j) of Pub. L. 99–272, as amended, set out as a note under section 1395ww of this title.

EXTENSION OF CERTAIN MEDICARE MUNICIPAL HEALTH SERVICES DEMONSTRATION PROJECTS

Pub. L. 99–272, title IX, §9215, Apr. 7, 1986, 100 Stat. 180, as amended by Pub. L. 101–239, title VI, §6135, Dec. 19, 1989, 103 Stat. 2222; Pub. L. 103–66, title XIII, §13557, Aug. 10, 1993, 107 Stat. 592; Pub. L. 105–33, title IV, §4017, Aug. 5, 1997, 111 Stat. 345; Pub. L. 106–113, div. B, §1000(a)(6) [title V, §534], Nov. 29, 1999, 113 Stat. 1536, 1501A–390; Pub. L. 106–554, §1(a)(6) [title VI, §633], Dec. 21, 2000, 114 Stat. 2763, 2763A–568; Pub. L. 108–173, title II, §235, Dec. 8, 2003, 117 Stat. 2210, provided that:

''(a) The Secretary of Health and Human Services shall extend through December 31, 1997, approval of

four municipal health services demonstration projects (located in Baltimore, Cincinnati, Milwaukee, and San Jose) authorized under section 402(a) of the Social Security Amendments of 1967 [42 U.S.C. 1395b–1(a)]. The Secretary shall submit a report to Congress on the waiver program with respect to the quality of health care, beneficiary costs, costs to the medicaid program and other payers, access to care, outcomes, beneficiary satisfaction, utilization differences among the different populations served by the projects, and such other factors as may be appropriate. Subject to subsection (c), the Secretary may further extend such demonstration projects through December 31, 2006, but only with respect to individuals who received at least one service during the period beginning on January 1, 1996, and ending on the date of the enactment of the Balanced Budget Act of 1997 [Aug. 5, 1997].

''(b) The Secretary shall work with each such demonstration project to develop a plan, to be submitted to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate by March 31, 1998, for the orderly transition of demonstration projects and the project participants to a non-demonstration project health care delivery system, such as through integration with a private or public health plan, including a medicaid managed care or Medicare+Choice plan.

''(c) A demonstration project under subsection (a) which does not develop and submit a transition plan under subsection (b) by March 31, 1998, or, if later, 6 months after the date of the enactment of the Balanced Budget Act of 1997 [Aug. 5, 1997], shall be discontinued as of December 31, 1998. The Secretary shall provide appropriate technical assistance to assist in the transition so that disruption of medical services to project participants may be minimized.''

[References to Medicare+Choice deemed to refer to Medicare Advantage, see section 201(b) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.]

DEMONSTRATION PROGRAM FOR REDUCTION OF DISABILITY AND DEPENDENCY THROUGH PROVISION OF PREVENTIVE HEALTH SERVICES UNDER MEDICARE

Pub. L. 99–272, title IX, § 9314, Apr. 7, 1986, 100 Stat. 194, as amended by Pub. L. 99–509, title IX, § 9344(d), Oct. 21, 1986, 100 Stat. 2042; Pub. L. 101–508, title IV, § 4164(a)(1), Nov. 5, 1990, 104 Stat. 1388–100, required Secretary of Health and Human Services to establish a 5-year demonstration program designed to reduce disability and dependency through the provision of preventive health services to individuals entitled to benefits under this subchapter and to submit reports to Congress including a final report on the project not later than April 1, 1995.

PAYMENT FOR COSTS OF HOSPITAL-BASED MOBILE INTENSIVE CARE UNITS

Pub. L. 98–369, div. B, title III, § 2320, July 18, 1984, 98 Stat. 1083, provided that:

''(a)(1) In the case of a project described in subsection (b), the Secretary of Health and Human Services shall provide, except as provided in paragraph (2), that the amount of payments to hospitals covered under the project during the period described in paragraph (3) shall include payments for their operation of hospital-based mobile intensive care units (as defined by State statute) if the State provides satisfactory assurances that the total amount of payments to such hospitals under titles XVIII and XIX of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq.] under the demonstration project (including any such additional amount of payment) would not exceed the total amount of payments which would have been paid under such titles if the demonstration project were not in effect.

''(2) Paragraph (1) shall not apply if the State in which the project is located notifies the Secretary, within 30 days after the date of the enactment of this section [July 18, 1984], that the State does not want paragraph (1) to apply to that project.

''(3) The period referred to in paragraph (1) begins on the date of the enactment of this section and continues so long as the Secretary continues the Statewide waiver referred to in subsection (b), but in no case ends earlier than 90 days after the date final regulations to implement section 1886(c) of the Social Security Act [42 U.S.C. 1395ww(c)] are published.

''(b) The project referred to in subsection (a) is the statewide demonstration project established in the State of New Jersey under section 402 of the Social Security Amendments of 1967, as amended by section 222(b) of the Social Security Amendments of 1972 (Public Law 92–603) [42 U.S.C. 1395b–1], which project provides for payments to hospitals in the State on a prospective basis and related to a classification of patients by diagnosis-related groups.

''(c) Payment for services described in this section shall be considered to be payments for services under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.].''

CONTINUATION OF SECRETARY'S AUTHORITY REGARDING EXPERIMENTS AND DEMONSTRATION PROJECTS

Pub. L. 98–21, title VI, § 603(b), Apr. 20, 1983, 97 Stat. 167, provided that:

''(1) Except as provided in paragraph (2), the amendments made by this title [amending sections 1320a–1, 1320c–2, 1395f, 1395i–2, 1395n, 1395r, 1395v, 1395w, 1395x, 1395y, 1395cc, 1395mm, 1395*oo*, 1395rr, 1395ww, and 1395xx of this title, enacting provisions set out as notes under this section and sections 1395r, 1395x, 1395y, 1395cc, and 1395ww of this title, and amending provisions set out as a note under section 1395x of this title] shall not affect the authority of the Secretary to develop, carry out, or continue experiments and demonstration projects.

''(2) The Secretary shall provide that, upon the request of a State which has a demonstration project, for payment of hospitals under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] approved under section 402(a) of the Social Security Amendments of 1967 [42 U.S.C. 1395b–1(a)] or section 222(a) of the Social Security Amendments of 1972 [set out as a note below], which (A) is in effect as of March 1, 1983, and (B) was entered into after August 1982 (or upon the request of another party to demonstration project agreement), the terms of the demonstration agreement shall be modified so that the demonstration project is not required to maintain the rate of increase in medicare hospital costs in that State below the national rate of increase in medicare hospital costs.''

ALTERNATIVE CARE DEMONSTRATION PROJECTS IN HOSPITALS SHORT OF SKILLED NURSING FACILITIES

Pub. L. 98–21, title VI, § 603(d), Apr. 20, 1983, 97 Stat. 168, provided that: ''The Secretary shall conduct demonstrations with hospitals in areas with critical shortages of skilled nursing facilities to study the feasibility of providing alternative systems of care or methods of payment.''

CONTINUATION OF HOSPICE DEMONSTRATION PROJECTS; REPORT TO CONGRESS

Pub. L. 97–248, title I, § 122(i), formerly § 122(h), Sept. 3, 1982, 96 Stat. 362, as redesignated and amended by Pub. L. 97–448, title III, § 309(a)(6), (e), Jan. 12, 1983, 96 Stat. 2408, 2410, provided that:

''(1) Notwithstanding any provision of law which has the effect of restricting the time period of a hospice demonstration project in effect on July 15, 1982, pursuant to section 402(a) of the Social Security Amendments of 1967 [42 U.S.C. 1395b–1(a)], the Secretary of Health and Human Services, upon request of the hospice involved, shall permit continuation of the project until November 1, 1983, or, if later, the date on which payments can first be made to any hospice program under the amendments made by this section.

''(2) Prior to September 30, 1983, the Secretary shall submit to Congress a report on the effectiveness of demonstration projects referred to in paragraph (1), in-

cluding an evaluation of the cost-effectiveness of hospice care, the reasonableness of the 40-percent cap amount for hospice care as provided in section 1814(i) of the Social Security Act [42 U.S.C. 1395f(i)] (as added by this section), proposed methodology for determining such cap amount, proposed standards for requiring and measuring the maintenance of effort for utilizing volunteers as required under section 1861(dd) of such Act [42 U.S.C. 1395x(dd)], an evaluation of physician reimbursement for services furnished as a part of hospice care and for services furnished to individuals receiving hospice care but which are not reimbursed as a part of the hospice care, and any proposed legislative changes in the hospice care provisions of title XVIII of such Act [42 U.S.C. 1395 et seq.].

''(3)(A) Notwithstanding the provisions of paragraph (1), the Secretary of Health and Human Services, upon request of the hospice involved, shall permit continuation of a hospice demonstration project described in paragraph (1) until September 30, 1986, if the hospice involved in such demonstration project does not provide hospice care directly but acts as a channeling agency for the provision of hospice care.

''(B) During the period after the date on which a hospice demonstration project described in subparagraph (A) would otherwise have terminated under the provisions of paragraph (1), and prior to September 30, 1986, any such hospice demonstration project shall be subject to the same requirements as are imposed under the hospice program provided for under the amendments made by this section [amending sections 1395c to 1395f, 1395h, and 1395x to 1395cc of this title and section 231f of Title 45, Railroads, and enacting provisions set out as notes under sections 1395c and 1395f of this title] with respect to reimbursement and benefits, other than the requirement that certain benefits be provided directly by the hospice involved.''

STATE MEDICARE HOSPITAL REIMBURSEMENT DEMONSTRATION PROJECT LIMITATION

Pub. L. 96–499, title IX, §903(c), Dec. 5, 1980, 94 Stat. 2615, which provided for a maximum number of six Statewide medicare hospital reimbursement demonstration projects, was repealed by Pub. L. 97–35, title XXI, §2154, Aug. 13, 1981, 95 Stat. 802.

STUDY OF NEED FOR DUAL PARTICIPATION OF SKILLED NURSING FACILITIES

Pub. L. 96–499, title IX, §919, Dec. 5, 1980, 94 Stat. 2627, required study of need for dual participation of skilled nursing facilities and submission of a report and recommendations to Congress within one year after Dec. 5, 1980.

DEMONSTRATION PROJECTS FOR PHYSICIAN-DIRECTED CLINICS IN URBAN MEDICALLY UNDERSERVED AREAS; REPORT SUBMITTED NO LATER THAN JANUARY 1, 1981

Pub. L. 95–210, §3, Dec. 13, 1977, 91 Stat. 1489, required the Secretary to provide, through demonstration projects, reimbursement on a cost basis for services provided by physician-directed clinics in urban medically underserved areas for which payment may be made under this subchapter and, notwithstanding any other provision of this subchapter, for services provided by a physician assistant or nurse practitioner employed by such clinics which would otherwise be covered under this subchapter if provided by a physician. The Secretary was to evaluate the relative advantages and disadvantages of reimbursement on the basis of costs and fee-for-service for physician-directed clinics employing a physician assistant or nurse practitioner, the appropriate method of determining the compensation for physician services on a cost basis for the purposes of reimbursement of services provided in such clinics, the appropriate definition for such clinics, the appropriate criteria to use for the purposes of designating urban medically underserved areas, and such other possible changes in the provisions of this subchapter as might be appropriate for the efficient and cost-effective reimbursement of services provided in such clinics. Grants, payments under contracts, and other expenditures made for demonstration projects were to be made in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The Secretary was to submit to the Congress, no later than Jan. 1, 1981, a complete detailed report on the demonstration projects.

SCOPE OF GRANTS FOR EXPERIMENTS AND DEMONSTRATION PROJECTS TO DETERMINE METHODS FOR PROSPECTIVE PAYMENTS TO HOSPITALS, SKILLED NURSING FACILITIES, AND OTHER PROVIDERS OF SERVICES

Pub. L. 94–182, title I, §107, Dec. 31, 1975, 89 Stat. 1053, provided that: ''Nothing contained in section 222(a) of Public Law 92–603 [set out below] shall be construed to preclude or prohibit the Secretary of Health, Education, and Welfare [now Health and Human Services] from including in any grant otherwise authorized to be made under such section moneys which are to be used for payments, to a participant in a demonstration or experiment with respect to which the grant is made, for or on account of costs incurred or services performed by such participant for a period prior to the date that the project of such participant is placed in operation, if—

''(1) the applicant for such grant is a State or an agency thereof,

''(2) such participant is an individual practice association which has been in existence for at least 3 years prior to the date of enactment of this section [Dec. 31, 1975] and which has in effect a contract with such State (or an agency thereof), entered into prior to the date on which the grant is approved by the Secretary, under which such association will, for a period which begins before and ends after the date such grant is so approved, provide health care services for individuals entitled to care and services under the State plan of such State which is approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.],

''(3) the purpose of the inclusion of the project of such association is to test the utility of a particular rate-setting methodology, designed to be employed in prepaid health plans, in an individual practice association operation, and

''(4) the applicant for such grant affirms that the use of moneys from such grant to make such payments to such individual practice association is necessary or useful in assuring that such association will be able to continue in operation and carry out the project described in clause (3).''

EXPERIMENTS AND DEMONSTRATION PROJECTS TO DETERMINE METHODS FOR PROSPECTIVE PAYMENTS TO HOSPITALS, SKILLED NURSING FACILITIES, AND OTHER PROVIDERS OF SERVICES FOR CARE AND SERVICES FURNISHED; SCOPE; WAIVER OF PAYMENT REQUIREMENTS; SOURCE AND MANNER OF PAYMENTS FOR GRANTS, ETC.; REPORTS TO CONGRESS

Pub. L. 92–603, title II, §222(a), Oct. 30, 1972, 86 Stat. 1390, as amended by Pub. L. 97–35, title XXI, §2193(e), Aug. 13, 1981, 95 Stat. 828, provided that:

''(1) The Secretary of Health, Education, and Welfare [now Health and Human Services], directly or through contracts with, or grants to, public or private agencies or organizations, shall develop and carry out experiments and demonstration projects designed to determine the relative advantages and disadvantages of various alternative methods of making payment on a prospective basis to hospitals, skilled nursing facilities, and other providers of services for care and services provided by them under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and under State plans approved under title XIX of such Act [42 U.S.C. 1396 et seq.], including alternative methods for classifying providers, for establishing prospective rates of payment, and for implementing on a gradual, selective, or other basis the establishment of a prospective payment sys-

tem, in order to stimulate such providers through positive (or negative) financial incentives to use their facilities and personnel more efficiently and thereby to reduce the total costs of the health programs involved without adversely affecting the quality of services by containing or lowering the rate of increase in provider costs that has been and is being experienced under the existing system of retroactive cost reimbursement.

''(2) The experiments and demonstration projects developed under paragraph (1) shall be of sufficient scope and shall be carried out on a wide enough scale to permit a thorough evaluation of the alternative methods of prospective payment under consideration while giving assurance that the results derived from the experiments and projects will obtain generally in the operation of the programs involved (without committing such programs to the adoption of any prospective payment system either locally or nationally).

''(3) In the case of any experiment or demonstration project under paragraph (1), the Secretary may waive compliance with the requirements of titles XVIII and XIX of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq.] insofar as such requirements relate to methods of payment for services provided; and costs incurred in such experiment or project in excess of those which would otherwise be reimbursed or paid under such titles [subchapters] may be reimbursed or paid to the extent that such waiver applies to them (with such excess being borne by the Secretary). No experiment or demonstration project shall be developed or carried out under paragraph (1) until the Secretary obtains the advice and recommendations of specialists who are competent to evaluate the proposed experiment or project as to the soundness of its objectives, the possibilities of securing productive results, the adequacy of resources to conduct it, and its relationship to other similar experiments or projects already completed or in process; and no such experiment or project shall be actually placed in operation unless at least 30 days prior thereto a written report, prepared for purposes of notification and information only, containing a full and complete description thereof has been transmitted to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate.

''(4) Grants, payments under contracts, and other expenditures made for experiments and demonstration projects under this subsection shall be made in appropriate part from the Federal Hospital Insurance Trust Fund (established by section 1817 of the Social Security Act [42 U.S.C. 1395i]) and the Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act [42 U.S.C. 1395t]) and from funds appropriated under title XIX of such Act [42 U.S.C. 1396 et seq.]. Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this subsection. With respect to any such grant, payment, or other expenditure, the amount to be paid from each of such trust funds (and from funds appropriated under such title XIX) shall be determined by the Secretary, giving due regard to the purposes of the experiment or project involved.

''(5) The Secretary shall submit to the Congress no later than July 1, 1974, a full report on the experiments and demonstration projects carried out under this subsection and on the experience of other programs with respect to prospective reimbursement together with any related data and materials which he may consider appropriate. Such report shall include detailed recommendations with respect to the specific methods which could be used in the full implementation of a system of prospective payment to providers of services under the programs involved.''

§ 1395b–2. Notice of medicare benefits; medicare and medigap information

(a) Notice of medicare benefits

The Secretary shall prepare (in consultation with groups representing the elderly and with health insurers) and provide for distribution of a notice containing—

(1) a clear, simple explanation of the benefits available under this subchapter and the major categories of health care for which benefits are not available under this subchapter,

(2) the limitations on payment (including deductibles and coinsurance amounts) that are imposed under this subchapter, and

(3) a description of the limited benefits for long-term care services available under this subchapter and generally available under State plans approved under subchapter XIX.

Such notice shall be mailed annually to individuals entitled to benefits under part A or part B of this subchapter and when an individual applies for benefits under part A or enrolls under part B.

(b) Medicare and medigap information

The Secretary shall provide information via a toll-free telephone number on the programs under this subchapter. The Secretary shall provide, through the toll-free telephone number 1–800–MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.

(c) Contents of notice

The notice provided under subsection (a) shall include—

(1) a statement which indicates that because errors do occur and because medicare fraud, waste, and abuse is a significant problem, beneficiaries should carefully check any explanation of benefits or itemized statement furnished pursuant to section 1395b–7 of this title for accuracy and report any errors or questionable charges by calling the toll-free phone number described in paragraph (4);

(2) a statement of the beneficiary's right to request an itemized statement for medicare items and services (as provided in section 1395b–7(b) of this title);

(3) a description of the program to collect information on medicare fraud and abuse established under section 1395b–5(b) of this title; and

(4) a toll-free telephone number maintained by the Inspector General in the Department of Health and Human Services for the receipt of complaints and information about waste, fraud, and abuse in the provision or billing of services under this subchapter.

(Aug. 14, 1935, ch. 531, title XVIII, § 1804, as added Pub. L. 100–360, title II, § 223(a), July 1, 1988, 102 Stat. 747; amended Pub. L. 103–432, title I, § 171(j)(1), Oct. 31, 1994, 108 Stat. 4450; Pub. L.