

***Legislative Committee  
on  
Health Care***



***January 2001***

***Legislative Counsel Bureau  
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**LEGISLATIVE COMMITTEE ON HEALTH CARE**

**BULLETIN NO. 01-21**

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**SUMMARY OF RECOMMENDATIONS  
OF THE LEGISLATIVE COMMITTEE ON HEALTH CARE  
(NEVADA REVISED STATUTES 439B.200)  
ADOPTED AT THE JUNE 6, 2000, MEETING  
OF THE COMMITTEE**

*Diabetes Care and Funding*

1. **Require the University of Nevada School of Medicine (UNSOM) to establish the Pediatric Diabetes and Endocrinology Center (PDEC), and require the Division of Health Care Financing and Policy, Department of Human Resources (DHR), to provide podiatry services in Medicaid and insulin pump therapy for persons who are eligible for this diabetes treatment. Appropriate \$284,625 for each year of the biennium to the UNSOM for the PDEC, and appropriate \$412,857 to the Division to provide podiatry services and insulin pump therapy. (BDR 38-222)**

**Also, send a letter to the Board of Regents of the University and Community College System of Nevada and the Governor indicating that the PDEC should be part of the base budget of the University System's medical school.**

*Medicaid and the Nevada Check-Up Program Enhancements*

2. **Require the Division of Health Care Financing and Policy, DHR, to implement presumptive eligibility determinations in the Nevada Medicaid Program for women and children and for the Nevada Check-Up Program. Appropriate \$31,831,730 for each year of the biennium to the Division to implement presumptive eligibility (\$1,650,000 for pregnant women in Medicaid; \$29,500,000 for children in Medicaid; and \$681,730 for children in the Nevada Check-Up Program). (BDR 38-221)**
3. **Require the Division of Health Care Financing and Policy, DHR, to allow disabled persons who are eligible for Medicaid to receive income from employment and still retain their Medicaid eligibility. Appropriate \$1,500,000 for each year of the biennium to implement this provision. (BDR 38-227)**
4. **Require the Division of Health Care Financing and Policy, DHR, to pay rural hospitals at their cost for providing long-term care services to Medicaid patients. Appropriate \$700,000 to the Division for each year of the biennium to implement this provision. (BDR 28-223)**

5. **Require the Welfare Division, DHR, to eliminate the assets test as a requirement for eligibility for pregnant women and children in the Nevada Medicaid Program. Appropriate \$3,530,387 for each year of the biennium to the Division of Health Care Financing and Policy, DHR, to implement this provision. (BDR 38-224)**

*Data Analysis and Assessment of Children's Services*

6. **Require the Center for Business and Economic Research (CBER), University of Nevada, Las Vegas, to compile primary data concerning the number of children in Nevada who do not have health insurance coverage, to prepare an analysis of the number of children who are unable to access services from government sponsored programs, and to publish the Kids Count Databook. Appropriate \$150,000 to the CBER for each year of the biennium to conduct the research and publish the book. (BDR S-228)**

**Also, send a letter to the Board of Regents of the University and Community College System of Nevada and the Governor indicating that the Kids Count Project should be a recurring part of the CBER's base budget.**

*Autism Services*

7. **Create the Commission on Autism within the Division of Mental Health and Developmental Services, DHR, and require the Commission to establish two Autism Centers for Excellence. Appropriate \$700,000 to the Division for the establishment of the Commission and the two centers. (BDR 38-225)**

*Health Care Errors Reporting System*

8. **Require the Legislative Committee on Health Care to appoint a subcommittee to develop a mandatory health care errors reporting system. (BDR R-226)**

**REPORT OF THE NEVADA LEGISLATURE'S COMMITTEE ON  
HEALTH CARE TO THE MEMBERS OF THE 71st SESSION  
OF THE NEVADA LEGISLATURE**

**I. INTRODUCTION**

The Legislative Committee on Health Care, in compliance with *Nevada Revised Statutes* 439B.200 through 439B.240, oversees a broad spectrum of issues related to the quality, access, and cost of health care for all Nevadans. The committee was established in 1987 to provide continuous oversight of matters relating to health care. Since that time, the committee has addressed a variety of issues including health care cost containment, access to health care for the uninsured, Medicaid, managed care, the rural health service delivery system, and other health related issues.

During the 1999-2001 legislative interim period, the committee met seven times with meeting sites alternating between Carson City and Las Vegas, Nevada. All public hearings were conducted through simultaneous videoconferences.

At the sixth meeting, members conducted a work session at which they adopted eight recommendations, all of which are bill draft requests. The recommendations address the following topics: additional services and eligibility categories for the Medicaid program; assessing certain health related factors relevant to children; autism services; and health care errors reporting.

In addition, a number of recommendations for resolutions were presented to the committee. Although members did not recommend that these proposals be drafted as legislative measures, they are referenced in the report of the committee. These proposals address issues such as eliminating waiting lists for existing Medicaid waiver programs, enhancing the delivery of personal care assistant services for persons who are disabled, increasing marketing efforts in respect to the Nevada Check-Up Program, and ensuring that a person who is disabled is not institutionalized if his physician specifies that his condition does not require institutional placement.

Assemblywoman Ellen M. Koivisto served as the chairman of the committee, and Senator Raymond D. Rawson served as the vice chairman. Other legislative members of the committee during the 1999-2000 Interim included:

Senator Bernice Mathews  
Senator Maurice E. Washington  
Assemblywoman Vivian L. Freeman  
Assemblywoman Merle Berman

Legislative Counsel Bureau staff services were provided by:

Marla McDade Williams, Senior Research Analyst  
Risa B. Lang, Principal Deputy Legislative Counsel  
Leslie Hamner, Senior Deputy Legislative Counsel  
Kennedy, Senior Research Secretary

## **II. REVIEW OF COMMITTEE FUNCTIONS**

The primary responsibilities of the committee are established pursuant to *Nevada Revised Statutes* (NRS) 439B.220 through 439B.240. These responsibilities include reviewing and evaluating the quality and effectiveness of programs for the prevention of illness, reviewing and comparing the costs of medical care among communities in Nevada with similar communities in other states, and analyzing the overall system of medical care in the state. In addition, members strive to avoid duplication of services and achieve the most efficient use of all available resources. The committee also may review health insurance issues and may examine hospital related issues, medical malpractice issues, and the health education system. See Appendix A for the statutes that govern the committee.

Further, by statute, certain entities are required to submit reports to the committee. They are:

- Quarterly reports from the Office for Hospital Patients as required by NRS 232.543(2)(e). These reports present information about the number of complaints received on hospital bills, the number and type of disputes heard and arbitrated, as well as the outcome of arbitration.
- An annual report of the activities and recommendations of the Advisory Committee on Traumatic Brain Injuries as required by NRS 426A.060. This report provides information on the programs for traumatic brain injury patients and statistics from the head trauma registry.
- A biennial report from the Department of Human Services (DHR) regarding any laws or regulations that add to the cost of health care in the state as required by NRS 439A.083.

## **III. DISCUSSION OF TESTIMONY AND RECOMMENDATIONS**

A variety of issues were addressed at the seven meetings of the committee. This section provides background information and discusses only those issues for which recommendations were adopted for legislation. These issues relate to diabetes, the Nevada Medicaid Program,

the Nevada Check-Up Program, data collection for children's health needs, autism services, and health care errors reporting.

## A. DIABETES ISSUES

Members of the committee addressed two areas concerning diabetes. One area specifically relates to children, and the other area addresses general diabetes care in the Nevada Medicaid Program.

### 1. Pediatric Diabetes and Endocrinology Center

According to the Chairman of the State Board of Health, who is also a professor, and the Chairman/Residency Director of the Department of Pediatrics, University of Nevada School of Medicine (UNSOM), in 1985, Nevada had the lowest neonatal mortality rate nationally, but the state spent a large proportion of money on intensive care services. In an effort to redirect this spending, the UNSOM administered the Pediatric Diabetes and Endocrinology Center (PDEC), which was funded by the 1997 Nevada Legislature, to perform case management for children with diabetes and other endocrine disorders.<sup>1</sup>

Testimony illustrated that parents who have children with diabetes or other endocrine disorders experience extreme frustration because of the factors associated with caring for children with these conditions. Parents must assist their children in complying with an extensive medical regime in addition to negotiating insurance contracts and other managed care issues such as prior authorization of treatments and use of certain medical providers and facilities. Further, parents find that they are continually searching for financial assistance and resources because the costs of caring for children with intense medical conditions can be debilitating to a family's income. Additionally, children with diabetes and endocrine disorders often suffer from intense pain and psychological stress. Testimony alleged that when these children become teenagers, they have high suicide ideation rates.

Persons who testified indicated that having a program that coordinates referrals to diabetes support groups, camps, and other public and private health agencies relieves some of the burden on families and children. The PDEC is able to provide staff members to help families develop their abilities to obtain medical, emotional, and physical care for their children with diabetes. Systematic solutions can be developed for families to assist them with stress management, negotiating the relevant bureaucratic systems, identifying and treating childhood depression, and dealing with family dysfunction and other life adjustment issues. Further, testimony indicated that financing support services to families with children with diabetes is cost effective because it reduces hospitalizations that result from poor diabetic management. In addition, families may be encouraged to seek early care that will decrease serious complications such as blindness and kidney disease that may result from decisions to withhold or otherwise limit treatments because of the prohibitive costs of such treatments.

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<sup>1</sup>Senate Bill 560, which "Makes various changes relating to governmental administration," (Chapter 544, *Statutes of Nevada 1999*).

Parents of children with diabetes and other endocrine disorders testified that the program has eased their burdens tremendously. They testified to the relief they felt when finding out that this resource was available to them. One parent indicated that her hospitalization costs had been dramatically reduced because physicians were now available via telephone for advice.

The following points describe the key operations of the program:

- The PDEC has three clinic sites, one of which is in Reno, Nevada, and the other two are located at the University Medical Center of Southern Nevada and the Department of Pediatrics, UNSOM, in Las Vegas.
- A multidisciplinary approach is used that takes advantage of the expertise of nurses, social workers, and diabetes educators. The Chairman of the State Board of Health noted that, for the most part, these other practitioners are unable to bill their time to insurers.
- Since July 1, 2000, two physicians have performed 2,523 patient visits.
- Program physicians, since July 1, 1999, submitted bills to insurance companies, managed care organizations, other third-party payers, and patients that totaled \$352,116. However, the debt collection ratio in the southern part of Nevada was only 24 percent while it was 80 percent in the northern part of the state. Poor collection rates in the southern part of the state were attributed to Medicaid managed care contracts and the commercial bargaining power of health maintenance organizations. These figures are exacerbated by the high number of children who do not have medical insurance coverage, most of whom reside in Clark County. Thus, the “payer mix” is a major determinate that affects the self-sufficiency of the PDEC.
- Two positions that were authorized by the initial legislation have not been filled yet: a third pediatric endocrinologist and a psychologist. Persons who are trained as pediatric endocrinologists are in demand all over the country, and the field is highly competitive. Until a full-time psychologist is hired, psychological services will be provided by the PDEC’s social worker.
- Pursuant to the establishing legislation, an advisory board was created to analyze data and oversee the evaluation of the program. The data analysis must evaluate the financial situation of the program as well as the medical results of the patients who receive care under the program.
- The authorizing legislation does not allow the PDEC to purchase the necessary software and computer equipment to conduct the required evaluations because it specifically designated the appropriations for salaries and overlooked expenses for operations, supplies, travel, or equipment.

The chairman concluded by indicating that, after assessing the first nine months of the program, it appears that the revenues collected will be insufficient to fully support the program. Therefore, additional legislation is necessary to provide continued funding for the program, however, the requested amount is 25 percent less than the original appropriation. Additionally, he asked that the committee allow funding for equipment, operating, and travel costs.

Discussion on this issue indicated that the 1997 legislation was intended to be a mandate for the University and Community College System of Nevada (UCCSN) to establish the PDEC. Once the program was established, it should have become part of the system's base budget, and program administrators should not have had to return to the Legislature for continued authorization of the program. Members noted that they fully support the activities of the PDEC, and they want to reiterate that the program become part of the base budget of the UCCSN.

## 2. Diabetes Care Pursuant to the Nevada Medicaid Program

General background statistics were provided by designees of the Nevada Diabetes Council (NDC) concerning the incidence of diabetes in Nevada. This data is included in Appendix B. Additionally, representatives of the NDC expressed their commitment to enhancing available services for assessing diabetes, controlling risk factors, and treating the disease.<sup>2</sup> Finally, committee members heard testimony concerning podiatry services and their role in preventing adverse effects from the disease. This section will discuss only those issues related to podiatry services in the Nevada Medicaid Program, which is administered by the Division of Health Care Financing and Policy, DHR.

According to testimony, California's Medicaid program, which is MediCal, provides beneficiaries who have diabetes with an annual blood test, which is known as a "Hemoglobin A1C," a biennial eye exam, and a biennial lipid profile. These are the three measurable indicators of diabetes. In 1998, MediCal statistics indicated that:

- Seventy percent of beneficiaries who had diabetes received at least one Hemoglobin A1C;
- Sixty-four percent of them received an eye exam; and

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<sup>2</sup>Members of the Nevada Diabetes Council (NDC) plan to distribute pocket cards to physicians, which outline clinical practice recommendations, and they plan to distribute cards to patients that they may use to track their lipid profile dates. Approximately 1,600 physicians will be provided with the pocket cards for the purpose of dispensing them to patients with diabetes. Further, members will encourage physicians to regularly mail patient reminder cards with the intent of improving patient compliance in keeping medical appointments. Members of the NDC will work with representatives of minority communities to develop solutions for diabetes prevention, care, and treatment in these communities. Finally, members of the NDC will continue to establish collaborative relationships with pharmaceutical companies and other agencies to bring more attention to the disease and to develop methods for reducing the incidence of diabetes in Nevada.

- Sixty-two percent of them received lipid profiles.

This data was used to illustrate that the state of diabetes care in Nevada is “average” when compared to the management of diabetes by other states. Testimony indicated that the NDC performs valuable interventions, but the council needs the Hemoglobin A1C, eye exam, and lipid profile statistics for the State of Nevada to adequately measure the quantitative impact of these diabetes indicators for controlling this disease in Medicaid patients. Additionally, testimony focused on methods to decrease the risk of individuals losing limbs resulting from poor care and monitoring of their diabetic conditions because diabetes is the fourth leading cause of death in the United States.<sup>3</sup>

According to testimony, landmark studies have indicated that reducing blood sugar levels in patients with diabetes lowers their risk for long-term complications from the disease. One such study illustrated that preventive care that is exercised through the delivery of podiatry services by an interdisciplinary team may reduce the overall amputation rate by 40 to 50 percent. The cost of one amputation is \$40,000 for the surgical procedure and related problems associated with the removal of a limb. This figure does not reflect the cost for rehabilitation, the loss of future earnings, increased reliance on social programs, emotional trauma, or a decrease in the patient’s quality of life. Additionally, the Veterans Affairs Health Care System (VA) recognizes that 20 to 25 percent of outpatient services are for veterans afflicted with diabetes.

Continuing, a physician testified that he established a “critical pathway” in June 1992 at the VA. A critical pathway refers to the parameters that are assessed upon a diabetic patient’s discharge from hospitalization. The parameters include: (1) Hemoglobin A1C information; (2) a blood pressure reading; (3) a lipid count; and (4) a foot care exam. To address other problems within the VA system, an Interdisciplinary Diabetes Foot Clinic was established in 1995. Accordingly, the number of amputations within the first year of operation of the foot clinic decreased from 18 to 14 cases. All VA providers currently test for foot sensation with each diabetic patient, and the system provides easier patient access to podiatry physicians. Since 1996, the amputation rate has remained stable at a rate of 12 per year.

Testimony concluded by noting that a podiatry care review should be mandatory for all diabetic Medicaid patients because these individuals are at a 3 percent higher risk than the general population for developing the disease and its related complications. Further, drugs that control diabetes are necessary to decrease hospitalizations and inpatient care for complications as a result of diabetes. Testimony asserted that the cost of preventive outpatient podiatry care is “trivial” when compared to the high cost of inpatient care for amputations.

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<sup>3</sup>The Nevada Diabetes Council indicated that, nationwide, the direct costs attributable to diabetes are \$135 billion with 60 percent of these costs being directed at inpatient care because of complications that arise from heart disease, kidney failure, stroke, and amputations.

As a result of testimony on these issues, members of the committee recommended that a bill be drafted for introduction and discussion before the 2001 Nevada Legislature to:

**Require the University of Nevada School of Medicine (UNSOM) to establish the Pediatric Diabetes and Endocrinology Center (PDEC), and require the Division of Health Care Financing and Policy, Department of Human Resources, to provide podiatry services in Medicaid and insulin pump therapy for persons who are eligible for this diabetes treatment. Appropriate \$284,625 for each year of the biennium to the UNSOM for the PDEC, and appropriate \$412,857 to the Division to provide podiatry services and insulin pump therapy.**

**Also, send a letter to the Board of Regents of the University and Community College System of Nevada and the Governor indicating that the PDEC should be part of the base budget of the University System's medical school.**

## B. OTHER MEDICAID ISSUES

The aforementioned recommendation concerning podiatry services in Medicaid is one of five recommended changes to the Nevada Medicaid Program. The additional Medicaid issues that the committee addressed include implementing presumptive eligibility determinations, allowing certain disabled persons to work and continue to receive Medicaid benefits, paying rural hospitals at their cost for providing long-term care to Medicaid patients, and eliminating the assets test for eligibility for pregnant women and children. This section discusses these four remaining Medicaid recommendations.

### 1. Presumptive Eligibility

“Presumptive eligibility” is a method of granting Medicaid eligibility on an immediate, short-term basis. Federal law allows states to grant traditional Medicaid providers the ability to make presumptive eligibility determinations. During a presumptive eligibility period, health care providers are reimbursed for services they provide to patients regardless of whether the patient is ultimately determined to be eligible for Medicaid. Federal regulations require that presumptive eligibility be made available on a statewide basis, and this process cannot be restricted to subgroups of the Medicaid population.

Other than paying providers for services rendered at the time of a patient visit, other reasons that have been advocated for adopting presumptive eligibility are that it may:

- Increase and improve access to timely health care because health care providers will treat children when they are ill. For example, low-income children who are diagnosed with cancer and who need to begin immediate chemotherapy or radiation treatment will not have to wait up to 45 days for their Medicaid eligibility to be determined;

- Simplify the application process for families;
- Prevent pregnant women from waiting 30 to 45 days before their Medicaid eligibility is determined before they seek out and obtain recommended prenatal care; and
- Accelerate Medicaid enrollment.

Further, if implemented in the Nevada Check-Up Program, it was asserted that presumptive eligibility would increase enrollment in the program and prevent the state from a situation wherein not all of the federal money that has been set aside for Nevada’s Children’s Health Insurance Program (CHIP) is used.

Some key issues that should be considered concerning presumptive eligibility are:

- Applicants who fail to submit necessary documentation for final eligibility determinations, and who will therefore not be enrolled in Medicaid regardless of whether their financial situation would ultimately deem them to be eligible, may result in the Medicaid program being unable to recover matching federal funds for Medicaid payments that were made to health care providers for these patients;
- There may be potential for final enrollment denials and errors in eligibility determinations by health care providers that will result in an increased cost to the state for applicants who are ultimately deemed to be ineligible for Medicaid;
- There will be a need for additional funding to organize and implement statewide training programs for providers who make final eligibility determinations; and
- It is difficult to estimate the costs that will be associated with presumptive eligibility determinations.

Testimony further indicated that six states have extended the use of presumptive eligibility for Medicaid children, and three states have adopted presumptive eligibility for them but have not implemented it. Twenty-nine states use presumptive eligibility only for Medicaid pregnant women, and six states use presumptive eligibility in their CHIP. No states that have a “state-only” CHIP use presumptive eligibility, however. Those states that use presumptive eligibility in their CHIPS do so under what is known as a “Medicaid-expanded” CHIP.

Testimony indicated that Nebraska is a state that uses presumptive eligibility for its Medicaid-expanded CHIP. Less than four-tenths of a percent of the average monthly number of children applying for CHIP do so under presumptive eligibility. Further, the majority of Nebraska’s 75 presumptive eligibility providers are medical clinics in urban settings. This state has tracked the application process but not utilization of presumptive eligibility or the costs for providing services to children who are subsequently not determined eligible. Nebraska also has presumptive eligibility for pregnant women and children. For pregnant women, more than 85 percent of the presumptively eligible applicants are accepted.

Another state that uses presumptive eligibility in its Medicaid expanded CHIP is New Mexico. This state has a simplified application for pregnant women and children with eligibility beginning with the date of the presumptive eligibility determination and ending on the last day of the following month. Testimony asserted that presumptive eligibility has been an effective tool for enrolling children and for tracking persons who become eligible for the state program in this manner, but the state does not have the ability to quantify the number of women and children who are denied eligibility once a full review is done of their applications. Further, the state has not examined presumptive eligibility utilization patterns to determine if there are large payments for services for those who are subsequently deemed ineligible. Finally, the majority of cases not found eligible for Medicaid are due to failure of the applicant to provide follow-up documentation rather than a definitive finding of ineligibility.

General background testimony concluded by discussing why two states that considered adopting presumptive eligibility for their Medicaid-expanded CHIPs chose not to do so. Colorado chose not to implement presumptive eligibility because the cost is anticipated to be more than the 10 percent administrative cap that is authorized for the CHIP by federal regulations. This state has already exceeded the allowable cost cap by 7 percentage points. In addition, Kentucky chose not to implement presumptive eligibility because of the difficulty in developing cost estimates. Finally, the cost of training health care providers and the costs associated with administering the eligibility system were perceived to be high and difficult to overcome.

A health care provider, which is primarily a county funded hospital with clinics in a large urban area, testified that staff members in this facility have unique abilities and opportunities to develop personal relationships with families in the communities they serve. Further, presumptive eligibility may increase the number of women who seek prenatal care, which may be difficult to get in traditional medical formats with the exception of safety net institutions such as county funded facilities. Finally, in this hospital alone, 30 to 40 pregnant women who have not had prenatal care are admitted to the facility each month. These women are statistically known to deliver babies that require admittance to the hospital's neonatal intensive care unit. The representative testified that prenatal care is cost-effective for taxpayers in these cases because intensive neonatal care is more expensive than regular delivery costs.

In support of the concept of presumptive eligibility, committee members heard testimony concerning the importance of prenatal care in the first trimester and a presentation of data concerning infant health statistics and low birth-weight babies who risk a 50 percent rate of physical and mental disorders (Appendix C). Testimony further indicated that Hispanic women had the highest rate of not receiving first trimester prenatal care in Nevada between the years 1993 and 1995 at a rate of 40 percent. The rate for Native American women was 35 percent, and the rate for African American, non-Hispanic women was 32 percent.

Additional testimony suggested ways to implement presumptive eligibility, discussed behaviors of some persons who do not have health insurance, and estimated that \$6.1 million might be

generated in revenues to certain health care providers if presumptive eligibility is implemented in Nevada (Appendix D).

Upon hearing from individuals who were advocating for the adoption of a presumptive eligibility determination option in the Nevada Medicaid Program, committee members heard from a representative of the state agency that would implement presumptive eligibility, which is the Division of Health Care Financing and Policy, DHR. The representative indicated the key to implementing presumptive eligibility is estimating the additional cost to the State General Fund pursuant to this Medicaid expansion. Further, since the Nevada Check-Up Program is a “stand alone” CHIP, it is even more difficult to ascertain how to develop cost estimates because no other state in the nation has a stand-alone CHIP program that is using presumptive eligibility. Finally, the administrative requirements that must be considered also pose a problem for estimating costs and responsibilities for presumptive eligibility.

As a result of this discussion, members of the committee agreed to request that a bill be drafted to:

**Require the Division of Health Care Financing and Policy, Department of Human Resources, to implement presumptive eligibility determinations in the Nevada Medicaid Program for women and children and for the Nevada Check-Up Program. Appropriate \$31,831,730 for each year of the biennium to the Division to implement presumptive eligibility (\$1,650,000 for pregnant women in Medicaid; \$29,500,000 for children in Medicaid; and \$681,730 for children in Nevada Check-Up).**

## 2. Medicaid “Buy-In”

Another proposed expansion of the Nevada Medicaid Program involves allowing certain persons to receive income from employment while continuing to remain eligible for Medicaid benefits. Members of the Legislative Committee on Health Care discussed this issue during the 1997-1998 Interim Period, and committee members had a bill introduced to the 1999 Nevada Legislature for consideration of this program.<sup>4</sup>

The 1999 measure was not adopted, however federal law, which is termed the “Ticket to Work and Work Incentives Improvement Act of 1999” (*Public Law 106-170*), currently authorizes states to expand the availability of health care coverage for working individuals with disabilities (Appendix E).<sup>5</sup> Testimony asserted that this legislation was adopted because Congress recognized that the primary obstacle for people with disabilities going to work is the fear of losing their Medicaid, and in some cases Medicare, coverage.

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<sup>4</sup>Assembly Bill 139 would have required the Department of Human Resources to provide services pursuant to the Nevada Medicaid Program to certain persons with disabilities whose total household income is less than 250 percent of the federally designated level signifying poverty.

<sup>5</sup>H.R. 1180 from the 106<sup>th</sup> Congress.

According to testimony, the new law:

- Grants states discretion to determine an upper income limit for the eligibility of certain disabled persons;
- Provides funding to states over a period of five years to develop the necessary health care infrastructure for these individuals; and
- Allows states to develop demonstration projects concerning work activity and benefits for certain persons who are disabled.

Based on the testimony presented, members agreed to have a bill drafted to:

**Require the Division of Health Care Financing and Policy, Department of Human Resources, to allow disabled persons who are eligible for Medicaid to receive income from employment and still retain their Medicaid eligibility. Appropriate \$1,500,000 for each year of the biennium to implement this provision.**

### 3. Reimbursement for Rural Hospitals That Provide Long-term Care

As a result of a presentation to committee members concerning the provision of health care services in rural areas, another change was proposed for the Nevada Medicaid Program. In particular, this section discusses reimbursements for long-term care services for Medicaid patients in rural hospitals.

According to testimony, rural hospitals are highly dependent upon long-term care services for survival. It was reported that 90 percent of all long-term care patients that are cared for in rural hospital facilities rely fully on the Nevada Medicaid Program to cover their costs of care. Further, testimony indicated that the current Medicaid reimbursement methodology does not fiscally compensate these hospitals to cover the costs for providing these services — paying approximately 70 percent of the costs.

Testimony concluded with an explanation of the existing Medicaid reimbursement system. It was argued that this system is structured after the Medicare reimbursement model, which applies a “routine cost limit,” or imposed cap, against “cost reports” submitted by providers, and the Nevada Medicaid Program applies the same formula to allow reimbursements up to a specified limit. The Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services, has since broadened the reimbursement formula concerning certain Medicaid long-term care patients so that certain costs that are associated with stroke, physical therapy, rehabilitation, and so on, are not reimbursed to certain providers, and a published routine cost limit is no longer available.

Subsequently, a representative of rural hospital providers in Nevada appealed to members of the committee to return to a reimbursement model that was in existence prior to 1993 in which hospitals received reimbursements for Medicaid long-term care services based on their costs, which is known as “cost-based reimbursement.” Testimony emphasized that this change will assist rural hospitals that are facing financial ruin because they provide services to a high number of Medicaid and Medicare patient populations that are reimbursed at an extremely low rate, which intensifies the burden of meeting a hospital’s operating costs.

Further, rural hospitals are stable employers in small communities and serve an important role in sustaining rural economies. If a rural facility is forced to close because it cannot continue to operate, the entire community in rural Nevada areas will be adversely affected.

Therefore, members of the committee agreed to:

**Require the Division of Health Care Financing and Policy, Department of Human Resources, to pay rural hospitals at their cost for providing long-term care services to Medicaid patients. Appropriate \$700,000 to the Division for each year of the biennium to implement this provision.**

#### 4. Assets Test

The term “assets test” refers to an eligibility criterion for certain publicly funded programs, including the Temporary Assistance for Needy Families Program (TANF) and Medicaid. Committee members did not formally discuss this issue, but a written recommendation was received for consideration of it. This section briefly summarizes prior efforts of the committee concerning this issue, and it concludes with the committee’s recommendation.

During the 1997-1998 Interim Period, members of the committee adopted a recommendation that was ultimately introduced to the 1999 Nevada Legislature as Assembly Bill 4. This measure sought to prohibit the DHR from considering the assets of persons who apply for benefits from the Child Health Assurance Program, and it was not adopted by the Legislature. The bill had significant costs associated with its implementation, and testimony on the current recommendation indicated that those same estimates would apply to this recommendation. Therefore, a representative of the Welfare Division reported the estimated costs at \$3.1 million for the first year of operation for Fiscal Year (FY) 2000, and \$3.5 million in FY 2001. These figures are “total dollars,” with 50 percent being Nevada’s cost and 50 percent being provided by the Federal Government.

Therefore, committee members recommend that a bill be drafted to:

**Require the Welfare Division, Department of Human Resources (DHR), to eliminate the assets test as a requirement for eligibility for pregnant women and children in the Nevada Medicaid Program. Appropriate \$3,530,387 for each year of the biennium to the Division of Health Care Financing and Policy, DHR, to implement this provision.**

### C. CHILDREN'S HEALTH DATA

With the advent of the Nevada Check-Up Program, there has been an increased demand for data that addresses children's health. This section discusses current data collection efforts concerning children, and it concludes with a recommendation to enhance these efforts.

According to testimony presented to members of the committee, in 1996 the Annie E. Casey Foundation funded a project known as "Kids Count." This project was initiated as a national and state-by-state effort to track the status of children residing in the United States. Nevada was the last state in the U.S. to gain entrance into the Kids Count network, which was an effort that was intended to provide policymakers and citizens with benchmarks of child well-being. Further, the project sought to enrich national, state, and local discussions concerning ways to secure the future for all children.

In Nevada, Kids Count is a statewide, collaborative effort to develop, collect, analyze, present, and disseminate the best available data for the purpose of measuring economic, educational, physical, and social well-being of children in the state. The Center for Business and Economic Research (CBER) of the University of Nevada, Las Vegas (UNLV), is the entity that is currently responsible for this project. Additional partners of the project include:

- The Cooperative Extension unit of the University of Nevada, Reno;
- The School of Social Work located at UNLV;
- The Title IV-B Family Support and Family Preservation Steering Committee of the Division of Child and Family Services (DCFS), DHR; and
- The Nevada Kids Count Advisory Council.

The *2000 Kids Count Data Book* provides the community with a statistical portrait of the well-being of children in Nevada, and it contains:

- Demographic data;
- State to national comparisons; and
- Selected Nevada trend data.

Further, the book focuses upon the following areas:

- Early child care and education;
- Economic well-being;
- Regular education;
- Juvenile justice;
- Child safety; and
- Health.

In concluding testimony concerning this book and the data reported in it, an appeal was made to continue support of this project through the CBER. Additional discussion noted that the research that is conducted as a result of this funding should attempt to identify existing services for children and whether there are waiting lists for such services.

Consequently, committee members agreed to:

**Require the Center for Business and Economic Research (CBER), University of Nevada, Las Vegas, to compile primary data concerning the number of children in Nevada who do not have health insurance coverage, to prepare an analysis of the number of children who are unable to access services from government sponsored programs, and to publish the Kids Count Databook. Appropriate \$150,000 to the CBER for each year of the biennium to conduct the research and publish the book.**

**Also, send a letter to the Board of Regents of the University and Community College System of Nevada, and the Governor indicating that the Kids Count Project should be a recurring part of the CBER's base budget.**

#### D. AUTISM ISSUES

Testimony indicated that individuals who have autism may be unable to receive services from certain state agencies because these individuals do not fit a certain category of disability that would make them eligible for such services. Further, there is a need to coordinate services and ease the burden of accessing them. Finally, it may be prohibitively expensive for parents or caregivers to pay for some services through private sector providers. This section discusses a recommendation concerning these issues.

Individuals advocating for this issue stated that autism currently affects one in 500 children, and it is the third most common developmental disability in the nation. Funding relevant

services for these children will enable them to lead productive lives. Further, establishing a system that makes available “development specialists” or “diagnostic centers” will enable better provision of services and will prevent parents and caregivers from having to search for services beyond their home towns or out of state to have a diagnosis made for their children.

Testimony indicated that, due to the shortage of services and affordable interventions in Nevada, many autistic children and their families experience:

- Financial hardship, which results in further stress on their familial relationships;
- A lack of respite from the demands of raising an exceptional child; and
- Unusually high rates of divorce and custody abdication.

The mother of an autistic child explained that the number of autistic children in the state has been “greatly underestimated.” Nationally, 15 in 10,000 births is the incidence rate for autism. In her role as an advocate, she stated that she receives calls from people who are desperate to obtain services for their children. She notes that the challenges faced by families today are unchanged from those she has faced in the past with her child.

Discussions illustrated that for some children, 30 to 40 hours of therapy per week is needed for them to develop skills that will enable them to function in society, and some of these services may cost as much as \$30,000 per month at \$10 per hour for those sessions. Although a department at the University of Nevada, Reno, administers a program, which is the “Lovass Program,” that has been helpful for some families, this program is highly dependant on payments from families for its support.

Further, testimony indicated that it is important to keep autistic children in their homes; however, without appropriate interventions, many of these children may be institutionalized at a great cost to taxpayers. Additional information was provided to committee members concerning the incidence of autism and services that are helpful in treating individuals who are afflicted with this disorder (Appendix F).

Testimony also disclosed that the 1999 Legislature expanded the definition of mental retardation to include those individuals with a “related condition” such as autism. Representatives of the Division of Mental Health and Developmental Services (DMHDS) of the DHR noted that this expanded definition allows agencies of this division to provide services to individuals who have impaired adaptive behavior who need services similar to those provided for persons with mental retardation. These services are provided through the Division’s “developmental program,” which provides services for both children and adults. In addition to the mental health division, the DCFS provides mental health services for children and adolescents.

As of January 26, 2000, the DMHDS was serving 111 individuals with autism - half of whom were children. Further, about 10 percent of the Division’s clientele were children with autism.

Additionally, the 1999 funding allowed the Division to include programs and services for adults, but the focus of the Division's funding involves family support services such as in-home training, supportive living programs for adults, and foster placement.

The mother of an autistic child noted that her son's autism was overlooked by a physician at the Special Children's Clinic, Bureau of Family Health Services, Health Division of the DHR. She stated that initially her child was referred to a psychiatrist, and she subsequently went to the DCFS for assistance. At that point, her child received a diagnosis of autism, but years of potential treatment were lost while her son received one referral after another until a diagnosis was finally made.

Further testimony noted:

- In 1998 there were 238 children labeled as having autism in Nevada. Proponents of changing the delivery of autism services argue, however, that most children are not diagnosed with autism until the age of six when they enter school. Therefore, the number of children with autism in the state is undercounted.
- Pediatricians in the state may not have enough experience to adequately recognize the symptoms and therefore may be unable to identify children with autism.
- The majority of people do not recognize symptoms of autism in young children, and the public also must be educated about the symptoms of autism so that earlier intervention might occur.

Proponents conclude that if autistic children are diagnosed earlier and receive earlier intervention, their long-term institutional costs might be reduced. In addition, the cost for special education programs might be reduced.

Therefore, members of the committee recommend that a bill be drafted to:

**Create the Commission on Autism within the Division of Mental Health and Developmental Services, Department of Human Resources, and require the Commission to establish two Autism Centers for Excellence. Appropriate \$700,000 to the Division for the establishment of the Commission and the two centers.**

#### E. HEALTH CARE ERRORS REPORTING

Nursing representatives brought to the attention of committee members a report titled *To Err is Human*, from the Institute of Medicine (IOM), National Academy of Sciences. The study, which was published on December 1, 1999, reviewed health care errors throughout the country. Nursing representatives testifying to committee members asserted that one of the issues driving health care errors is poor staffing of medical facilities by trained nurses. These nurses called for consideration of nurse staffing ratios in medical facilities. Rather than move directly into mandating staffing ratios, however, committee members chose to conduct a more

thorough review of this issue. Consequently, this section briefly discusses the IOM report, describes the activities of the Federal Government and other states in regard to health care errors reporting, and it concludes with the committee's recommendation concerning this issue.

According to an article, "Medical errors kill tens of thousands annually," that summarized the findings of the IOM report, and that was published on November 30, 1999, on the Internet Web site [www.cnn.com](http://www.cnn.com), more people die each year in the United States from health care errors than from highway accidents, breast cancer, or AIDS. Further, the article summarized that between 44,000 and 98,000 people die each year because of mistakes by medical professionals. As a result, on December 1, 1999, a published report urged the U.S. Government to set up a \$100-million-per-year regulatory authority to monitor dangerous medical errors, and to force doctors to have regular competence checks. This article also cites arguments that the IOM report underestimated the incidence of medical errors in U.S. medical facilities. Others, however, argue that the numbers are inflated.<sup>6</sup>

According to a report of the National Conference of State Legislatures (NCSL), in response to the IOM report, President Clinton issued an Executive Order on December 7, 1999, that established the Quality Interagency Coordination Task Force and directed the task force to report within 60 days with recommendations on whether the government should adopt IOM's patient safety proposals (Appendix G). The task force reported to the President in mid-February 2000.

The NCSL notes that in response to the task force report, on February 22, 2000, President Clinton proposed to:

- Create a Center for Quality Improvement in Patient Safety that will research and develop national goals on reducing medical errors;
- Require every hospital participating in Medicare to implement patient safety programs; and
- Require states to administer a mandatory medical errors reporting system to be phased in over three years.

In addition to President Clinton's proposal, three bills have been introduced in Congress in 2000, and a series of hearings in both the House and Senate have been held.

Further, NCSL has identified at least 21 states that have adopted regulations or enacted laws since the early 1990s that address some aspect of reducing medical errors, including medication error reporting and quality improvement programs. These states include: Colorado, Florida, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Montana,

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<sup>6</sup>"Deaths Due to Medical Errors Are Exaggerated in Institute of Medicine Report" from the *Journal of the American Medical Association*, July 5, 2000, p. 93.

New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia, and Washington.

Further, according to the National Academy for State Health Policy, 15 states require mandatory reporting from hospitals for “adverse events.” These states are: Colorado, Florida, Kansas, Massachusetts, Nebraska, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas and Washington. Finally, six states (the District of Columbia, Georgia, New Mexico, North Carolina, Oregon, and Wyoming) have voluntary reporting of medical errors or adverse events.

A representative from an association of nurses in the state indicated that there is no system in Nevada that would allow external reporting of medical errors in medical facilities. Additionally, there was debate before the committee concerning which state agency might ultimately take responsibility for overseeing medical error reporting and methods to ensure that medical facilities provide safer care for patients.

Additional issues that were discussed concerning the prevention of medical errors in Nevada are:

- A need to consider the shift assignments of health care workers;
- The amount of training and experience that is given to new health care workers before they are given sole responsibility for patients; and
- Whether nurses and other personnel are assigned to care for patients for which they have the most experience or training to provide adequate care.

Testimony alleged that patients are being sent home “sicker,” and they are being sent home without the information they need to help them deal with their illnesses. These factors may lead to re-hospitalization and higher costs for both the patient and hospital.

Because of the numerous considerations concerning health care errors, committee members recommended a bill be drafted to:

**Require the Legislative Committee on Health Care to appoint a subcommittee to develop a mandatory health care errors reporting system.**

#### **IV. ADDITIONAL ISSUES**

In addition to the bills that were requested for introduction and discussion to the 2001 Nevada Legislature, committee members specified their support for other issues that members discussed during the 1999-2000 interim period. These issues include eliminating waiting lists for existing Medicaid waiver programs; providing effective personal care assistant services and personal care assistant for the disabled services; accessing the total amount of federal funding

that is available to the state to provide health insurance coverage to children through the Nevada Check-Up Program; complying with federal directives to ensure that persons who lose cash assistance, pursuant to the TANF Program, do not lose Medicaid coverage; and ensuring that persons who are disabled are not institutionalized if their physicians specify that their condition does not require institutional placement. This section summarizes the position of committee members concerning these issues.

A. Waiting Lists

A key Medicaid issue concerns the use of waiting lists for Medicaid waiver services. According to testimony to committee members, the Division of Health Care Financing and Policy of the DHR has a long-standing policy of using waiting lists when the approved number of “slots” are full in the Medicaid waivers that are administered by the Division. Members of the Legislative Committee on Health Care discussed waiting lists for waiver services in the 1997-1998 interim period, and the use of such lists continues to be an issue that is of concern to consumers, their families, and members of the Legislature. This section briefly discusses this issue.

According to testimony, in one particular Medicaid waiver, which is a waiver for the physically disabled, the DHCFFP currently serves 125 individuals, and the waiting list consists of approximately 160 people. The only method to move up on the waiting list is when a vacancy occurs, and vacancies often occur only in the event of the death of an individual who was receiving services. Testimony expressed concern that the DHR has been “treading water” with this issue, and no progress has been made to rectify the waiting list problem. Further, it was asserted that a court of law would most probably deem this style of problem solving as inappropriate and would likely find against the state if the matter were pursued through legal avenues. Proponents of eliminating waiting lists assert that services for which a person is eligible are effectively being denied to him by establishing waiting lists rather than providing him the services.

Therefore,

**The Division of Health Care Financing and Policy, Department of Human Resources, is encouraged to eliminate the waiting lists for existing Medicaid waiver programs, including the Community Home-based Initiatives Program, the Physically Disabled Waiver Program, and the Intermediate Care Facilities for the Mentally Retarded Waiver, by seeking funding from the Nevada Legislature for the 2003-2004 biennium.**

B. Institutionalization of Persons who are Disabled

Members of the committee heard discussion about a court case, *Olmstead v. L.C. ex rel. Zimring*, 119 S.Ct. 2176 (1999), referenced as “*Olmstead*” in the following text, which has the effect of requiring a comprehensive plan for providing services to

disabled persons primarily to prevent them from being placed in institutional settings. This section provides a discussion of these issues.

One speaker indicated that states must develop a “comprehensive, effectively working plan for the placement of qualified mentally disabled people into a less restrictive setting.” The speaker noted, however, that since the *Olmstead* decision was based on the Americans with Disabilities Act, which was created to protect individuals with “all disabilities,” the Medicaid State Plan should include, not exclude, individuals with physical disabilities as well. Another speaker noted that the decision applies to individuals who are being “assessed for possible institutionalization.”

In addition, testimony indicated that HCFA has provided states guidance concerning the implementation of *Olmstead*. The key to this guidance is that states should develop a plan to increase access to community-based services.

In response to assertions that key agencies of the State of Nevada may not have an adequate plan in place, state agency staff testified that they continue to approach the Nevada Legislature for funding of services to meet the obligations of *Olmstead*.

As a result of these discussions, members wish to:

**Encourage the Department of Human Resources to take all reasonable steps to comply with the *Olmstead v. L.C. ex rel. Zimring*, 119 S.Ct. 2176 (1999), court decision for the purpose of ensuring that a person who is disabled is not institutionalized if his physician specifies that his condition does not require institutional placement.**

#### C. Personal Care Assistance

Another recurring issue with members of the committee and consumers of services for the disabled concerns “personal care assistant” (PCA) services. This section briefly discusses this issue.

Members of the Legislative Committee on Health Care and the full Nevada Legislature have previously discussed issues concerning the use and availability of personal care assistant services. At five of its first six meetings, members of the committee heard testimony concerning the following points:

- Workers’ compensation insurance coverage;
- Revisions in the delivery of PCA services in the Nevada Medicaid Program; and
- Public hearings concerning proposed regulations of the Nevada Medicaid Program.

Therefore,

**The Division of Health Care Financing and Policy, Department of Human Resources, is encouraged to provide effective personal care assistant services and personal care assistant for the disabled services pursuant to suggestions that have been provided to the Division during the course of public hearings concerning regulations that govern these services.**

D. Nevada Check-Up Program

Another issue for which recurrent discussions have been brought before members of the committee relates to the Nevada Check-Up Program. Although one formal recommendation was adopted concerning this program, other concerns were expressed to members. This section briefly discusses those other issues.

Children's advocates testified that the Nevada Check-Up Program was unable to use the full amount of federal funding that was available to the state to provide insurance for low-income children. These individuals expressed their opinions that one of the reasons federal funding will go unused is that outreach and marketing efforts for the program have been inefficient. Further, some individuals asserted that the Division is unable to process applications in a timely manner because a sufficient number of staff has not been hired to process the applications and enrollment forms. Finally, children's advocates appealed to members of the committee to revise the eligibility criteria for the program to enable more children to qualify for its benefits.

Therefore,

**The Division of Health Care Financing and Policy, Department of Human Resources, is encouraged to access the total amount of federal funding that is available to the state to provide health insurance coverage to children through the Nevada Check-Up Program by:**

- 1. Hiring a sufficient number of personnel to process applications for the Nevada Check-Up Program;**
- 2. Revising the Division's existing outreach efforts for the program;**
- 3. Expanding the Division's marketing campaign; and**
- 4. Eliminating the six-month waiting period between a child's loss of health insurance coverage and eligibility for coverage by the Nevada Check-Up Program.**

E. Medicaid and the Temporary Assistance for Needy Families Program

Members of the committee were asked to examine whether persons who were discontinued from the TANF Program lost their Medicaid coverage. This section discusses this issue.

According to testimony, some persons who are no longer eligible for TANF benefits are still eligible for health care coverage from the Nevada Medicaid Program. It was alleged that some of these persons actually lost their coverage despite the fact that they should have remained eligible.

In response to these assertions, a representative of the Welfare Division indicated that Division staff has undertaken efforts to prevent certain recipients of TANF benefits from losing their Medicaid coverage. Further, if Division staff were able to confirm that a person lost this coverage but was still eligible for the benefit, the recipient would be reinstated. Methods for determining whether individuals and families lost their Medicaid coverage include the following points:

- Providing a “notice of decision” that explains the reason for a scheduled termination, which is routinely sent to the family at least 13 days prior to their termination date. The notice also provides the opportunity for a hearing and continued benefits should the family disagree with the reason for termination.
- Using the Division’s new automated management information system, called Nevada Operations Multi Automated Data Systems, or NOMADS, to search through all Medicaid eligibility categories using the latest case data to determine a person’s Medicaid eligibility when he does not meet the TANF requirements for assistance. In the event that a family is scheduled for termination from TANF assistance, the NOMADS determines each person’s eligibility for other programs.

Based on the activities of Welfare Division staff, it was determined that some families were inadvertently missed in the eligibility testing and subsequently were not provided with their Medicaid coverage. These individuals include a small percentage of women who were not pregnant and some older children.

Testimony indicated that the Division is taking the necessary steps to reenroll these individuals into the Medicaid program. However, the method of reenrollment was still under discussion at the time of the presentation to the committee.

Additionally, two categories of children were subject to termination of their Medicaid benefits because of changes in federal law. The categories include children who: (1) became ineligible for Supplemental Security Income (SSI) due to the 1996 change in the SSI disability rules and who were terminated from Medicaid without consideration of their eligibility pursuant to provisions of the Balanced Budget Act; or (2) were terminated without a proper redetermination including an ex parte review. The methods of reviewing their eligibility include:

- Reviewing names on a list that was provided to Division staff by representatives of the Social Security Administration. The list was forwarded to the Division's field staff with instructions to restore Medicaid eligibility on a retroactive basis to the termination date for each individual named on the list.
- Use of a less stringent disability standard as a result of a recent finding from a "federal certification visit."

Therefore,

**The Welfare Division, Department of Human Resources, is encouraged to comply with federal directives to ensure that persons who lose cash assistance, pursuant to the Temporary Assistance for Needy Families Program, do not lose Medicaid coverage. Further, the Division is encouraged to locate and assist persons who have lost such coverage for the purpose of reestablishing the coverage.**

## V. CONCLUSION

This report presents a summary of bill drafts that were requested by committee members for discussion before the 2001 Nevada Legislature. In addition, the report provides information identifying other issues that were addressed during the Interim. Persons wishing to have more specific information concerning these documents may find it useful to review the meeting minutes and exhibits for each of the meetings of the committee.



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APPENDIX A

*Nevada Revised Statutes* 439B.200, Legislative Committee On Health Care



## LEGISLATIVE COMMITTEE ON HEALTH CARE

**NRS 439B.200 Creation; appointment of and restrictions on members; officers; terms of members; vacancies; annual reports.**

1. There is hereby established a legislative committee on health care consisting of three members of the senate and three members of the assembly, appointed by the legislative commission. The members must be appointed with appropriate regard for their experience with and knowledge of matters relating to health care.

2. No member of the committee may:

(a) Have a financial interest in a health facility in this state;

(b) Be a member of a board of directors or trustees of a health facility in this state;

(c) Hold a position with a health facility in this state in which the legislator exercises control over any policies established for the health facility; or

(d) Receive a salary or other compensation from a health facility in this state.

3. The provisions of subsection 2 do not:

(a) Prohibit a member of the committee from selling goods which are not unique to the provision of health care to a health facility if the member primarily sells such goods to persons who are not involved in the provision of health care.

(b) Prohibit a member of the legislature from serving as a member of the committee if:

(1) The financial interest, membership on the board of directors or trustees, position held with the health facility or salary or other compensation received would not materially affect the independence of judgment of a reasonable person; and

(2) Serving on the committee would not materially affect any financial interest he has in a health facility in a manner greater than that accruing to any other person who has a similar interest.

4. The legislative commission shall select the chairman and vice chairman of the committee from among the members of the committee. Each such officer shall hold office for a term of 2 years commencing on July 1 of each odd-numbered year. The chairmanship of the committee must alternate each biennium between the houses of the legislature.

5. Any member of the committee who does not return to the legislature continues to serve until the next session of the legislature convenes.

6. Vacancies on the committee must be filled in the same manner as original appointments.

7. The committee shall report annually to the legislative commission concerning its activities and any recommendations.

(Added to NRS by 1987, 863; A 1989, 1841; 1991, 2333; 1993, 2590)

**REVISER'S NOTE.**

Ch. 620, Stats. 1993, the source of paragraph (b) of subsection 3 of this section, contains the following preamble and provisions not included in NRS:

"WHEREAS, The legislative committee on health care provides continuous oversight of matters relating to health care; and

WHEREAS, It is important to encourage participation on the legislative committee on health care of persons with the appropriate experience and knowledge of matters relating to health care; and

WHEREAS, The cost for medical care coverage for Medicaid-eligible patients is increasing at a rapid and unpredictable rate; and

WHEREAS, The number of Medicaid-eligible patients is also increasing at a rapid and unpredictable rate; and

WHEREAS, The need for health care reform is a national concern and the State of Nevada desires to be on the forefront of such reform; and

WHEREAS, The University of Nevada School of Medicine has 10 years of important and successful experience in a coordinated care program that currently serves 25 percent of the state's recipients of Aid to Families with Dependent Children; now, therefore,"

"1. The legislative committee on health care shall conduct a study to evaluate and develop a mandatory coordinated care medical system for all persons covered by the State of Nevada's Medicaid program. The study must include:

(a) An evaluation of the systems available to provide medical care to recipients of Medicaid;

(b) A review of the sources of available funding for a coordinated care system and the various methods of compensating providers of health care;

(c) An evaluation of the methods of containing the costs of providing medical care to recipients of Medicaid;

(d) The impact that a coordinated care medical system may have on the revenue received from the tax on hospitals imposed pursuant to NRS 422.383 and an analysis of the methods that may be used to replace lost revenues, if any; and

(e) The committee's recommendations for establishing a mandatory coordinated care program by July 1, 1995, to serve persons participating in the state's Medicaid program.

2. The legislative committee on health care shall:

(a) Report its recommendations to the governor and the department of human resources on or before July 1, 1994; and

(b) Submit quarterly reports to the interim finance committee concerning the progress of its study, its recommendations for establishing a coordinated care program and the implementation of the demonstration project and coordinated care program established pursuant to subsection 3.

3. The department of human resources shall, with the consent of the interim finance committee:

(a) Seek all necessary approvals and waivers and establish and conduct a demonstration project pursuant to section 1115 of the Social Security Act, 42 U.S.C. § 1315, in compliance with those recommendations of the legislative committee on health care that are approved by the governor. The purposes of the demonstration project must be to:

(1) Reduce the rate of growth in the overall costs of medical care over the long term;

(2) Improve access to primary and preventative health care for the Medicaid population;

(3) Institute health education programs for the Medicaid population; and

(4) Mainstream the Medicaid population into a coordinated care program with a balance of public and private members;

(b) Establish a mandatory coordinated care program not later than July 1, 1995; and

(c) Enroll all recipients of Aid to Families with Dependent Children upon the commencement of the program, with phased-in enrollment of the Aged, Blind and Disabled populations by the end of the second year of the program.

4. The coordinated care program established pursuant to subsection 3 must include participation by the University of Nevada School of Medicine in the development and implementation of the program, as well as in the delivery of services. The department of human resources shall cooperate with the University of Nevada School of Medicine to assist in the provision of an adequate and diverse patient population on which the school can base educational programs, including programs that support the education of generalist physicians. The University of Nevada School of Medicine may establish a nonprofit organization to assist in the research necessary for the program, receive and accept gifts, grants and donations to support the program and assist in establishing educational services for patients.

5. The director of the department of human resources shall report to the interim finance committee and the legislative committee on health care quarterly concerning the demonstration project and the coordinated care program established pursuant to this section.

6. As used in this section, "Medicaid" means the program established pursuant to Title XIX of the Social Security Act (42 U.S.C. §§ 1396 et seq.) to provide assistance for part or all of the cost of medical care rendered on behalf of indigent persons."

#### WEST PUBLISHING CO.

Health and Environment ⇐ 3.

Officers and Public Employees ⇐ 30.3.

WESTLAW Topic Nos. 199, 283.

C.J.S. Health and Environment §§ 9, 10.

C.J.S. Officers and Public Employees § 29.

#### NRS 439B.210 Meetings; quorum; compensation.

1. The members of the committee shall meet throughout each year at the times and places specified by a call of the chairman or a majority of the committee. The director of the legislative counsel bureau or a person he has designated shall act as the nonvoting recording secretary. The committee shall prescribe regulations for its own management and government. Four members of the committee constitute a quorum, and a quorum may exercise all the powers conferred on the committee.

2. Except during a regular or special session of the legislature, members of the committee are entitled to receive the compensation provided for a majority of the members of the legislature during the first 60 days of the preceding regular session for each day or portion of a day during which he attends a meeting of the committee or is otherwise engaged in the business of the committee plus the per diem allowance

provided for state officers and employees generally and the travel expenses provided pursuant to NRS 218.2207.

3. The salaries and expenses of the committee must be paid from the legislative fund.

(Added to NRS by 1987, 864; A 1987, 1629; 1989, 1221)

#### NRS CROSS REFERENCES.

Fee imposed on health insurers for support of committee, NRS 449.465

**NRS 439B.220 Powers.** The committee may:

1. Review and evaluate the quality and effectiveness of programs for the prevention of illness.
2. Review and compare the costs of medical care among communities in Nevada with similar communities in other states.
3. Analyze the overall system of medical care in the state to determine ways to coordinate the providing of services to all members of society, avoid the duplication of services and achieve the most efficient use of all available resources.
4. Examine the business of providing insurance, including the development of cooperation with health maintenance organizations and organizations which restrict the performance of medical services to certain physicians and hospitals, and procedures to contain the costs of these services.
5. Examine hospitals to:
  - (a) Increase cooperation among hospitals;
  - (b) Increase the use of regional medical centers; and
  - (c) Encourage hospitals to use medical procedures which do not require the patient to be admitted to the hospital and to use the resulting extra space in alternative ways.
6. Examine medical malpractice.
7. Examine the system of education to coordinate:
  - (a) Programs in health education, including those for the prevention of illness and those which teach the best use of available medical services; and
  - (b) The education of those who provide medical care.
8. Review competitive mechanisms to aid in the reduction of the costs of medical care.
9. Examine the problem of providing and paying for medical care for indigent and medically indigent persons, including medical care provided by physicians.
10. Examine the effectiveness of any legislation enacted to accomplish the purpose of restraining the costs of health care while ensuring the quality of services, and its effect on the subjects listed in subsections 1 to 9, inclusive.
11. Determine whether regulation by the state will be necessary in the future by examining hospitals for evidence of:
  - (a) Degradation or discontinuation of services previously offered, including without limitation, neonatal care, pulmonary services and pathology services; or
  - (b) A change in the policy of the hospital concerning contracts,
 as a result of any legislation enacted to accomplish the purpose of restraining the costs of health care while ensuring the quality of services.
12. Study the effect of the acuity of the care provided by a hospital upon the revenues of hospital and upon limitations upon that revenue.
13. Review the actions of the director in administering the provisions of this chapter and adopting regulations pursuant to those provisions. The director shall report to the committee concerning any regulations proposed or adopted pursuant to this chapter.

14. Conduct investigations and hold hearings in connection with its review and analysis.

15. Apply for any available grants and accept any gifts, grants or donations to aid the committee in carrying out its duties pursuant to this chapter.

16. Direct the legislative counsel bureau to assist in its research, investigations, review and analysis.

17. Recommend to the legislature as a result of its review any appropriate legislation.

(Added to NRS by 1987, 864)

WEST PUBLISHING CO.  
Health and Environment ⇌ 6.

WESTLAW Topic No. 199.  
C.J.S. Health and Environment § 13.

**NRS 439B.225 Committee to review certain regulations proposed or adopted by licensing boards; recommendations to legislature.**

1. As used in this section, "licensing board" means any board empowered to adopt standards for licensing or for the renewal of licenses pursuant to chapter 449, 630, 631, 632, 633, 637B, 639, 640, 641, 641B, 652 or 654 of NRS.

2. The committee shall review each regulation that a licensing board proposes or adopts that relates to standards for licensing or to the renewal of a license issued to a person or facility regulated by the board, giving consideration to:

(a) Any oral or written comment made or submitted to it by members of the public or by persons or facilities affected by the regulation;

(b) The effect of the regulation on the cost of health care in this state;

(c) The effect of the regulation on the number of licensed persons and facilities available to provide services in this state; and

(d) Any other related factor the committee deems appropriate.

3. After reviewing a proposed regulation, the committee shall notify the agency of the opinion of the committee regarding the advisability of adopting or revising the proposed regulation.

4. The committee shall recommend to the legislature as a result of its review of regulations pursuant to this section any appropriate legislation.

(Added to NRS by 1991, 940)

**NRS CROSS REFERENCES.**

Administrators of facilities for long-term care,  
NRS ch. 654  
Audiologists and speech pathologists, NRS ch.  
637B  
Dentistry and dental hygiene, NRS ch. 631  
Medical and other related facilities, NRS ch.  
449

Medical laboratories, NRS ch. 652  
Nursing, NRS ch. 632  
Osteopathic medicine, NRS ch. 633  
Pharmacists and pharmacy, NRS ch. 639  
Physical therapists, NRS ch. 640  
Physicians and assistants, NRS ch. 630  
Psychologists, NRS ch. 641  
Social workers, NRS ch. 641B

**NRS 439B.230 Investigations and hearings: Depositions; subpoenas.**

1. In conducting the investigations and hearings of the committee:

(a) The secretary of the committee, or in his absence any member of the committee, may administer oaths.

(b) The secretary or chairman of the committee may cause the deposition of witnesses, residing either within or outside of the state, to be taken in the manner prescribed by rule of court for taking depositions in civil actions in the district courts.

(c) The chairman of the committee may issue subpoenas to compel the attendance of witnesses and the production of books and papers.

2. If any witness refuses to attend or testify or produce any books and papers as required by the subpoena, the chairman of the committee may report to the district court by petition, setting forth that:

(a) Due notice has been given of the time and place of attendance of the witness or the production of the books and papers;

(b) The witness has been subpoenaed by the committee pursuant to this section; and

(c) The witness has failed or refused to attend or produce the books and papers required by the subpoena before the committee which is named in the subpoena, or has refused to answer questions propounded to him, and asking for an order of the court compelling the witness to attend and testify or produce the books and papers before the committee.

3. Upon such petition, the court shall enter an order directing the witness to appear before the court at a time and place to be fixed by the court in its order, the time to be not more than 10 days from the date of the order, and to show cause why he has not attended or testified or produced the books or papers before the committee. A certified copy of the order must be served upon the witness.

4. If it appears to the court that the subpoena was regularly issued by the committee, the court shall enter an order that the witness appear before the committee at the time and place fixed in the order and testify or produce the required books or papers. Failure to obey the order constitutes contempt of court.

(Added to NRS by 1987, 866; A 1987, 1630)

**NRS 439B.240 Investigations and hearings: Fees and mileage for witnesses.** Each witness who appears before the committee by its order, except a state officer or employee, is entitled to receive for his attendance the fees and mileage provided for witnesses in civil cases in the courts of record of this state. The fees and mileage must be audited and paid upon the presentation of proper claims sworn to by the witness and approved by the secretary and chairman of the committee.

(Added to NRS by 1987, 866)



APPENDIX B

Diabetes Data



## ***The Burden of Diabetes in Nevada***

### **Diabetes is a common disease in Nevada.**

In 1996, 50,842 adults in Nevada, 4.3% of the adult population, had diagnosed diabetes. An additional 430,237 persons in Nevada were at increased risk of undiagnosed diabetes because of the risk factors of age, obesity, and sedentary lifestyle.

### **Diabetes is a serious disease in Nevada.**

People with diabetes suffer from many diabetes-related complications. In Nevada during 1996, these included **87 new cases of blindness, 379 lower extremity amputations and 132 new cases of end-stage renal disease.** There were **13,947 diabetes-related hospitalizations, 4579 of which were for cardiovascular disease.** In addition, diabetes contributed to the death of **856 residents of Nevada in 1996.**

### **Diabetes is a costly disease in Nevada.**

The cost of diabetes in Nevada is staggering. The direct cost (medical care) and indirect cost (lost productivity and premature mortality) of diabetes in Nevada totaled about **\$665.4 million in 1996.**

### **Diabetes is a common, serious, and costly disease that poses a major health problem. Much of the health and economic burden of diabetes can be averted through known prevention measures.**

Data sources: 1995-97 BRFSS, CDC, 1996 multiple cause-of-death data tape, Nat'l Ctr for Health Statistics, CDC, 1994-96 Nat'l Hosp. Discharge Survey, Nat'l Ctr for Health Statistics, CDC, Massachusetts Comm for the Blind, 1996 Report of the Register, 1996 data from US Renal Data System, Nat'l Institutes of Health, ADA, Diabetes Care 21: 296-309, 1998, ADA, Diabetes Care 18: 382-387, 1995

Nevada has a high risk and at risk population for developing diabetes. It is estimated that Nevada's population will double in the next 20 years. Diabetes is a common, serious and costly disease that poses a major health problem in our state. Much of the health and economic burden of disease can be averted through known prevention measures.

### **Do You Know Your Risk for Developing Diabetes?**

Because diabetes is a serious and life-threatening disease you need to learn if you or a family member is at risk of developing diabetes. For a copy of the diabetes risk test or to find out how you can help reduce the burden of diabetes in Nevada call the **Nevada Diabetes Association for Children and Adults at (702) 856-3839.**

\*data source: Centers for Disease Control and Prevention and the Nevada State Diabetes Control Program

### **Diabetes Complications**

#### **Heart Disease**

- Heart attacks are the most common cause of death in persons with diabetes and having diabetes doubles the risk of having a heart attack. .

#### **Hypertension**

- Those with diabetes are at a higher risk of high blood pressure and it's complications.

## **Amputations**

- More than half of lower limb amputations in the United States occur among people with diabetes.

## **Blindness**

- Diabetes is the leading cause of blindness in the U.S.

## **Kidney Disease**

- Diabetes is the most common cause of ESRD (End Stage Renal Disease), resulting in about one-third of new ESRD cases. About 16 million people in the United States have diabetes, and about 50,000 people have ESRD as a result of diabetes

## **Diabetes and Pregnancy**

- According to a study in the July 1995 Diabetes Care, diabetes complicates about 4 percent of all U.S. pregnancies, with gestational diabetes accounting for 88 percent of them, or an estimated 135,000 pregnancies annually.

## **Deaths among persons with diabetes**

- Studies have found death rates to be twice as high among middle-aged people with diabetes as among middle-aged people without diabetes.
- Based on death certificate data, diabetes contributed to 193,140 deaths in 1996.
- Diabetes is the seventh leading cause of death listed on U.S. death certificates in 1996, according to CDC's National Center for Health Statistics. Diabetes has now been reclassified as the fourth leading cause of death to reflect its role in heart disease and high blood pressure.
- More people die each year from diabetes than die from the combined numbers of death from AIDS, breast cancer and automobile accidents in the US.
- Diabetes is still underreported on death certificates, both as a condition and as a cause of death.

APPENDIX C

Prenatal Care Data



# **Importance of Prenatal Care in First Trimester**

41

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**Mary Guinan, MD, PhD**  
**State Health Officer**  
**Testimony April 18, 2000**  
**Legislative Committee on**  
**Health Care**

## Infant Health Nevada

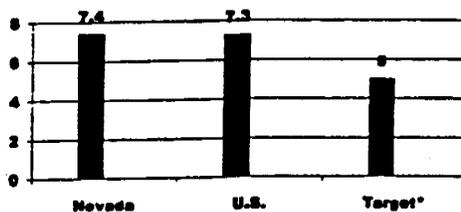
- Infant Mortality Rate decreased 33% between 1985-1995
- Nevada has fourth lowest infant mortality rate in nation.
- But percent of Low Birth-Weight Babies increased by 7%.

## Low Birth-Weight Babies

- Most frequent reason for infant mortality.
- Survivors face 50% rate of physical and mental disorders.

## Low-Birth Weight Babies

Percent Low Birth-Weight 1995



\*Y2010 Target

## Prevention of Low-Birth Weight

- Most common preventable cause of low-birth weight is cigarette smoking during pregnancy.
- Quitting smoking in first trimester has the greatest impact in reducing low birth weight.

## Cigarette Smoking During Pregnancy

- Smoking during pregnancy was reported by 14% of Nevada mothers in 1998.
- Estimates are that true rate is likely higher in the 25-28% range.

## **Importance of Prenatal Care in First Trimester**

**Maximize  
Positive Pregnancy  
Outcomes**

## **Prevention in First Trimester**

- **Screen mother for conditions that adversely affect pregnancy.**
- **Infections, Diabetes, High Blood Pressure, Substance Abuse.**
- **Treat Conditions.**
- **Assure proper nutrition for prevention of birth defects.**

## **Prevention in First Trimester**

- **Maximum protective effects of treating conditions that adversely affect pregnancy is achieved if mother is treated in first trimester.**
- **Maximum nutritional prevention is achieved if mother has nutritional supplements starting in first trimester.**

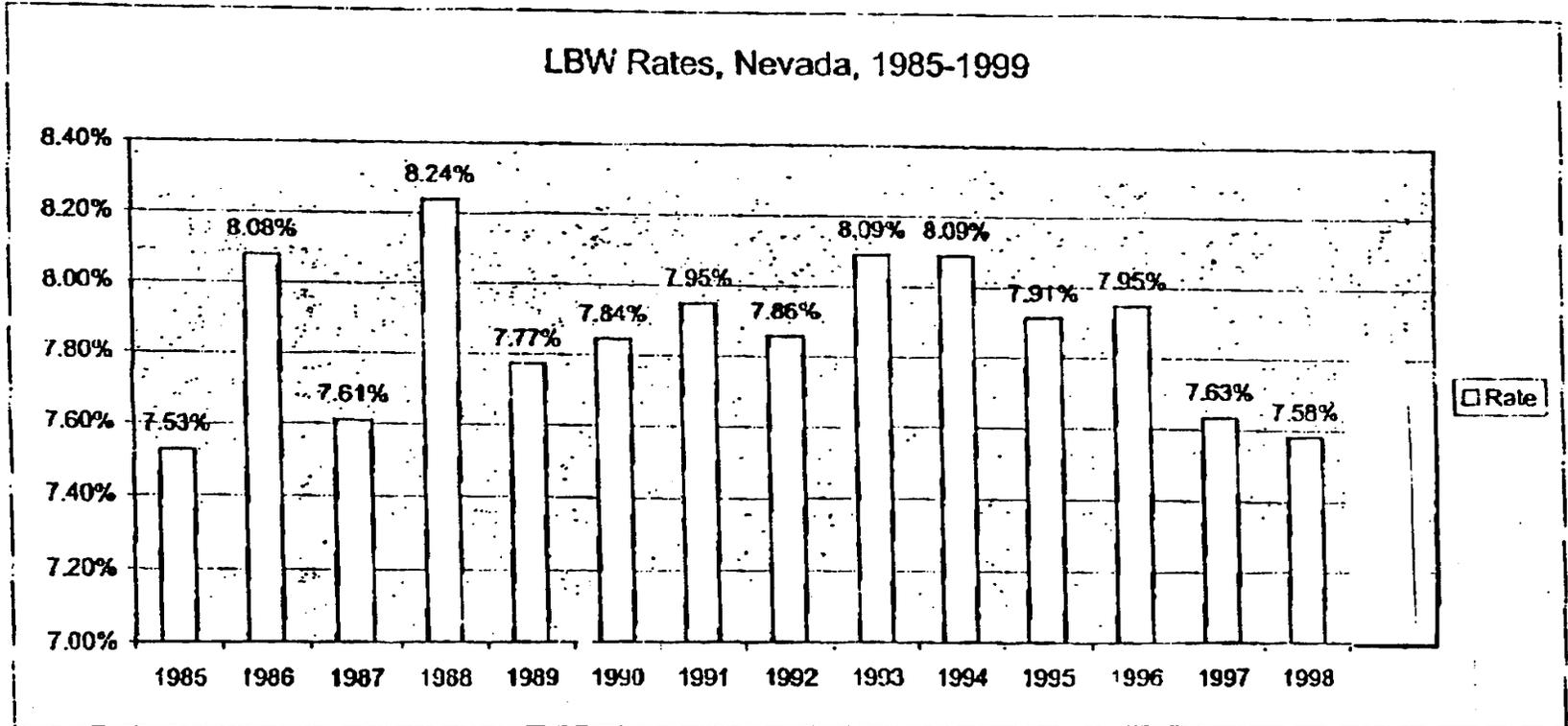
## Low Birth Weight Babies Nevada 1985-1998

Year	Percentage low birth weight
1985	7.53
1986	8.08
1987	7.61
1988	8.24
1989	7.77
1990	7.84
1991	7.95
1992	7.86
1993	8.09
1994	8.09
1995	7.9
1996	7.95
1997	7.6
1998	7.6

### Low Birthweight (<2,500g) Rates, Nevada, 1985-1999

	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
LBW	1105	1315	1296	1517	1554	1715	1764	1767	1837	1929	1967	2041	2033	2143
Live Births	15745	16277	17026	18415	19993	21862	22191	22493	22711	23853	24856	25680	26632	28275
Rate	7.53%	8.08%	7.61%	8.24%	7.77%	7.84%	7.95%	7.86%	8.09%	8.09%	7.91%	7.95%	7.63%	7.58%

LBW Rates, Nevada, 1985-1999





APPENDIX D

Presumptive Eligibility Information



KENNY C. GUINN  
Governor

STATE OF NEVADA

CHARLOTTE CRAWFORD  
Director

CHRISTOPHER THOMPSON  
Administrator



DEPARTMENT OF HUMAN RESOURCES  
DIVISION OF HEALTH CARE FINANCING AND POLICY

Date: April 2, 1999

**RECEIVED**

APR 02 1999  
325  
DIRECTOR'S OFFICE  
DHR

MEMORANDUM

TO: Jon Sasser, Esq.  
Legal Services

THROUGH: John Yacenda, Deputy Director  
Department of Human Resources

FROM: *Pat Maxwell*  
Janice A. Wright, Acting Administrator  
Division of Health Care Financing and Policy

SUBJECT: PRESUMPTIVE ELIGIBILITY - AB5

Pursuant to our discussion, enclosed are the revised provisions for AB5, which will allow for presumptive eligibility for children in the Nevada Check Up program.

Enclosed are our basic projections.

\$1,909,954 for FY2000  
\$ 124,118 for FY2001

Please review these figures and call me if you should have any questions or concerns.

JAW:pm  
attachment

cc: Governor's Office, Denice Miller

1100 E. William Street, Suite 116, Carson City, Nevada 89701  
(775) 687-4176 • Fax (775) 684-8792

Document

(97-441)

Division of Health Care Financing and Policy  
 Presumptive Eligibility  
 Nevada Check-Up

Assumption: Process will enroll children faster to 10,000 threshold.  
 Providers will need to be trained to complete application process.  
 Medicaid impact will be slight to non-existent within this model.  
 Computer enhancements will be required for the existing program.  
 The Presumptive Eligibility (PE) process will be as follows:  
 The state will wait until the child is either determined eligible under Nevada Check-Up, Medicaid or deemed ineligible before requesting a federal match. If the child is deemed eligible for Check-Up, the expenditures are reimbursed at the enhanced FMAP. If the child is determined eligible for Medicaid, the expenditures are funded through Federal Title XIX with the regular (50%) FMAP. If the children are not eligible for either program, the matching rate is 50% from the Title XXI allocation.

B/A 3178	FY 2000			FY 2001		
	State	Federal	Total	State	Federal	Total
Category 01	36,439	67,675	104,114	38,261	71,059	109,320
Category 03	2,172	4,034	6,206	2,172	4,034	6,206
Category 04	2,741	5,091	7,832	2,755	5,117	7,872
Category 05	2,163	4,019	6,182	0	0	0
Category 12	612,885	1,138,215	1,751,100	0	0	0
Category 26	11,830	21,970	33,800	0	0	0
Category 30	36	68	104	35	68	104
Category 59	215	401	616	215	401	616
<b>Total</b>	<b>668,481</b>	<b>1,241,473</b>	<b>1,909,954</b>	<b>43,439</b>	<b>80,679</b>	<b>124,118</b>

Personnel (Related Costs)		
Mgt Analyst II (2) Gr 35 - 07 (Pvdr Training)		
	FY 2000	FY 2001
Category 01	104,114	109,320
Category 03*	6,206	6,206
Category 04	7,832	7,872
Category 05	6,182	0
Category 26	33,800	0
Category 30	104	104
Category 59	616	616
<b>Total</b>	<b>158,854</b>	<b>124,118</b>

Program Expenditures		
	FY 2000	FY 2001
Category 12	1,751,100	0
<b>Total</b>	<b>1,751,100</b>	<b>0</b>

**Computer Expenditure**  
 To program the existing system to handle PE, it is estimated the cost would be between \$22,222 to \$36,400. The average of these estimates is: \$29,200

\*Anticipate 3 weeks in LV training, 1 week rural and 1 week Reno in addition to regular travel allowance.

Las Vegas (5 nights * 3 weeks)			Rural (5 Days)			Reno (5 Days)		
	Per Trip	Total						
Airfare	\$89.00	\$267.00	Mtr Pool	\$137.00	Est 350 miles	Mileage		\$94.50
Hotel	\$215.00	\$645.00	Hotel	\$215.00	\$19 day	Per Diem		\$130.00
Per Diem	\$130.00	\$390.00	Per Diem	\$130.00	.12/mile			
Mileage	\$18.90	\$56.70						
Parking	\$35.00	\$105.00						
<b>Total</b>	<b>\$487.90</b>	<b>\$1,463.70</b>	<b>Total</b>	<b>\$482.00</b>		<b>Total</b>		<b>\$224.50</b>

Caseload	Anticipated				Cost Per	
	Current	Increase	Revised	Difference	Month	Total Cost
July 1999	6,690		6,690	0	\$1,300	\$0
August 1999	7,263		7,263	0	\$1,300	\$0
September 1999	7,835	150	7,985	150	\$1,300	\$195,000
October 1999	8,408	300	8,708	300	\$1,300	\$390,000
November 1999	8,981	450	9,431	450	\$1,300	\$585,000
December 1999	9,553	447	10,000	447	\$1,300	\$581,100
January 2000	10,000	0	10,000	0	\$1,300	\$0
February 2000	10,000	0	10,000	0	\$1,300	\$0
March 2000	10,000	0	10,000	0	\$1,300	\$0
April 2000	10,000	0	10,000	0	\$1,300	\$0
May 2000	10,000	0	10,000	0	\$1,300	\$0
June 2000	10,000	0	10,000	0	\$1,300	\$0
<b>Total FY 2000</b>	<b>108,730</b>	<b>1,347</b>		<b>1,347</b>		<b>\$1,751,100</b>
July 2000	10,000	0	10,000	0	\$1,350	\$0
August 2000	10,000	0	10,000	0	\$1,350	\$0
September 2000	10,000	0	10,000	0	\$1,350	\$0
October 2000	10,000	0	10,000	0	\$1,350	\$0
November 2000	10,000	0	10,000	0	\$1,350	\$0
December 2000	10,000	0	10,000	0	\$1,350	\$0
January 2001	10,000	0	10,000	0	\$1,350	\$0
February 2001	10,000	0	10,000	0	\$1,350	\$0
March 2001	10,000	0	10,000	0	\$1,350	\$0
April 2001	10,000	0	10,000	0	\$1,350	\$0
May 2001	10,000	0	10,000	0	\$1,350	\$0
June 2001	10,000	0	10,000	0	\$1,350	\$0
<b>Total FY 2001</b>	<b>120,000</b>	<b>0</b>	<b>120,000</b>	<b>0</b>		<b>\$0</b>

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April 18, 2000

Presentation before members of the Legislative Committee on Health Care  
Concerning presumptive eligibility for the Medicaid and Nevada Check-Up Programs

By

Roger Volker, Executive Director

Great Basin Primary Care Association

300 S. Curry St. #6, Carson City, NV 89703

(775) 887-0417 887-3562 fax [info@gbpca.org](mailto:info@gbpca.org) [www.gbpca.org](http://www.gbpca.org)

Great Basin Primary Care Association represents all of Nevada's Community Health Centers, including Health Access Washoe County and Nevada Rural Health Centers, and most of Nevada's Tribal Health Centers. GBPCA is also the lead agency for the Nevada Covering Kids Project which is facilitated by coalitions in the south, north and rural areas of our state. Presumptive eligibility for Medicaid and the Children's Health Insurance Program (Nevada Check Up) is of extreme interest to our association members and stakeholders in the Covering Kids Project in our attempt to reduce the number of uninsured in our state and provide access to health care for Nevada's underserved populations.

While coverage alone does not guarantee access to health care, uninsured children are more likely than insured children to have health problems, experience difficulty obtaining needed care, rely on emergency care, under use preventive care, and face difficulties paying medical bills. Studies have also shown that uninsured children are more likely to experience restrictions on childhood activities such as rollerblading, bike riding, or team sports, because of parental concerns about possible accidents and attendant medical care costs, as well as regulations governing school sports programs. Many children will also demonstrate an inability to perform routine classroom activities due to undetected health impairment. Improving access to health insurance helps reduce such disparities.

To reach new and previously eligible but uninsured children, the nature and definition of outreach is undergoing a transformation. Efforts are shifting away from traditional methods, such as distributing fliers and media campaigns, and towards more targeted activities that facilitate individual enrollment. New federal, state and private funds support outreach opportunities that extend far beyond Nevada's previous experience. Current and enhanced enrollment objectives, while challenging, may be met through collaboration, innovation and building upon past successes. The following are examples of enrollment strategies that can be implemented to meet Nevada's enrollment objectives by instituting *presumptive eligibility*:

Presumptive eligibility is a method to facilitate enrollment of applicants into Medicaid and separate state CHIP programs. Presumptive eligibility refers to a preliminary determination made by a "qualified entity" that a child is eligible based on a declaration of family income, without supporting documentation. During the presumptive period, providers are reimbursed for their services without regard to the final eligibility determination.

The Balanced Budget Act of 1997 authorized the use of presumptive eligibility for children in the Medicaid program. Before this law, only pregnant women could be presumptively enrolled in Medicaid. Qualified entities for Medicaid and CHIP include agencies or organizations that provide health care items or services, WIC, Head Start, and state or local agencies or not-for-profit groups that determine eligibility for subsidized child care under the Child Care and Development Block Grant. Once the presumptive determination is made, Medicaid and CHIP providers may receive payment for services rendered to presumptively eligible children regardless of the ultimate determination of

the child's eligibility. The child's family will be required to complete and submit an application within a certain period.

Presumptive eligibility is intended to improve access to timely health care, simplify the application process for families, and reimburse providers for services they provide to otherwise uninsured children. Presumptive eligibility is considered an effective tool for accelerating enrollment. A 1991 U.S. Government Accounting Office study found that states that had implemented presumptive eligibility and eliminated the Medicaid assets tests experienced the greatest increase in enrollment.

Potential activities, which could be instituted in Nevada to facilitate enrollment through presumptive eligibility, are:

Providing clients with the availability of Certified Application Assistants (CAAs) or Health Advocates, stationed in Community Health Centers, Tribal Clinics, hospitals, WIC, Head Start, school health offices, and other essential community providers who can provisionally enroll families for 30 days in Nevada Check-Up or Medicaid. Families are determined to appear eligible based on an initial interview and a completed application at the time of the visit.

***Example:*** A young mother presents herself and her 6-month-old child at a Community Health Center in rural Nevada. The mother explains the baby has a terrible diaper rash and the child is in constant pain. The family's income is \$24,000.00 per year and could potentially qualify for Nevada Check-Up. Five minutes with a Certified Application Assistant to participate in an interview of the families income and the lack of existing health insurance would provide the basis for presumptive eligibility. The provider treats the child, an application is completed, the CAA follows up with the mother to obtain proof of income, a temporary identification number is issued to the family, and the Community Health Center can bill and received payment for the services provided to the child.

**Result:** The child obtains immediate health care services. The family obtains health care coverage, which will give the family increased access to future health care services, and the provider receives payment for their services.

**Benefit:** Children receive immediate services at the office of a primary care provider; the family identifies a local medical home; Regular primary and preventative health services are obtained for the children in this family; the primary care provider is reimbursed for their services.

GBPCA, in partnership with Nevada Covering Kids Project, will be implementing Nevada's largest-ever VISTA (Volunteers in Service to America) program to place 16 of the aforementioned Health Advocates in clinics throughout the state this summer. They will assist local families in gaining health insurance coverage and accessing health care services. Presumptive eligibility would be a great benefit to their work.

Children who may be eligible for Nevada Check-Up or Medicaid can also be reached through other programs for which they may be eligible. Many Medicaid-eligible children are also eligible for other government programs such as free or reduced price lunches, Food Stamps, Head Start, WIC, and Temporary Assistance for Needy Families. WIC and Medicaid have historically been linked in many states. Linking children to programs through adjunctive eligibility, which is the reliance of eligibility for one program to confer eligibility for another, is an effective method of increasing enrollment for children.

***Example:*** *Upon enrollment in one or more of the programs previously identified, based on income and the lack of health insurance, the agency taking the application could provisionally enroll the family in one of these programs and submit the application for formal approval.*

**Result:** Families have increased opportunity to obtain health care services for their children, based upon information provided, at one location rather than repeated trips to additional agencies.

**Benefit:** Families who are found eligible for these programs will obtain provisional enrollment in CHIP or Medicaid and will be more likely to obtain primary and preventative health care services for their children.

**Outstationing of eligibility workers in health care setting** is a natural remedy to many of these barriers. The federal government requires states to allow pregnant women and children to apply for Medicaid at locations other than the Medicaid office. By allowing parents to apply for health insurance in a hospital or clinic during non-business hours, parents are relieved of the burden of a trip to the Medicaid office. According to the National Governors' Association, forty-six states propose outstationing of eligibility workers in their SCHIP plans. Nevada has three full time and two part-time eligibility workers who are outstationed at various health care sites around the state. (This does not include the part time eligibility worker in the Nevada Check-Up Office). Clearly, while these eligibility workers are dedicated to help alleviate barriers to coverage, there is way to few of them to cover the vast distances in Nevada. Allowing non-governmental workers to conduct the interview is an important strategy to enhance access to Nevada Check-Up and Medicaid. In addition to the placement of CAA's in clinics, the following persons or agencies could be trained to perform the required enrollment tasks:

- School Health Nurses
- Local Family Resource Centers
- Hospitals
- Mental Health Providers
- WIC
- Boys and Girls Clubs
- Child Care Agencies
- Faith Based Organizations

Preliminary results from a study commissioned by Great Basin Primary Care Association indicate that there are approximately 345,000 people in Nevada who are uninsured. Of that number, approximately 110,000 are children including nearly 70,000 between the ages of 0-18 whose family's income is at or below 200% of the Federal Poverty Level and would qualify for Nevada Check Up or Medicaid.

The national average for primary care visits is 2.5 visits per year per patient. Assuming presumptive eligibility could be implemented in Nevada, and each of the 70,000 uninsured children identified at or below the 200% of the FPL accessed the Community Health Centers and other safety net provider clinics just half the national average (1.25 times) and because of presumptive eligibility, the first visit was compensated at the prevailing rate - the increased revenue to the safety net providers would be approximately 6.1 million dollars.

The ability of the safety net providers to increase revenues in their facilities would result in their ability to expand health care services to Nevada's uninsured and underserved population. This would come in the form of increased primary care providers, specialist services, and allied health care services such as dentistry. In addition, entry level and paraprofessional positions would be increased.

Thank you for consideration of these matters. If our Association can be of any service to the Committee, please contact us.



APPENDIX E

“Ticket To Work” Bill



PUBLIC LAW 106-170—DEC. 17, 1999

TICKET TO WORK AND WORK INCENTIVES  
IMPROVEMENT ACT OF 1999



Public Law 106-170  
106th Congress

An Act

Dec. 17, 1999  
[H.R. 1180]

To amend the Social Security Act to expand the availability of health care coverage for working individuals with disabilities, to establish a Ticket to Work and Self-Sufficiency Program in the Social Security Administration to provide such individuals with meaningful opportunities to work, and for other purposes.

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

Ticket to Work  
and Work  
Incentives  
Improvement Act  
of 1999.  
42 USC 1305  
note.

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the “Ticket to Work and Work Incentives Improvement Act of 1999”.

(b) TABLE OF CONTENTS.—The table of contents is as follows:

- Sec. 1. Short title; table of contents.  
Sec. 2. Findings and purposes.

TITLE I—TICKET TO WORK AND SELF-SUFFICIENCY AND RELATED PROVISIONS

Subtitle A—Ticket to Work and Self-Sufficiency

- Sec. 101. Establishment of the Ticket to Work and Self-Sufficiency Program.

Subtitle B—Elimination of Work Disincentives

- Sec. 111. Work activity standard as a basis for review of an individual’s disabled status.  
Sec. 112. Expedited reinstatement of disability benefits.

Subtitle C—Work Incentives Planning, Assistance, and Outreach

- Sec. 121. Work incentives outreach program.  
Sec. 122. State grants for work incentives assistance to disabled beneficiaries.

TITLE II—EXPANDED AVAILABILITY OF HEALTH CARE SERVICES

- Sec. 201. Expanding State options under the medicaid program for workers with disabilities.  
Sec. 202. Extending medicare coverage for OASDI disability benefit recipients.  
Sec. 203. Grants to develop and establish State infrastructures to support working individuals with disabilities.  
Sec. 204. Demonstration of coverage under the medicaid program of workers with potentially severe disabilities.  
Sec. 205. Election by disabled beneficiaries to suspend medigap insurance when covered under a group health plan.

TITLE III—DEMONSTRATION PROJECTS AND STUDIES

- Sec. 301. Extension of disability insurance program demonstration project authority.  
Sec. 302. Demonstration projects providing for reductions in disability insurance benefits based on earnings.  
Sec. 303. Studies and reports.

TITLE IV—MISCELLANEOUS AND TECHNICAL AMENDMENTS

- Sec. 401. Technical amendments relating to drug addicts and alcoholics.  
Sec. 402. Treatment of prisoners.

- Sec. 403. Revocation by members of the clergy of exemption from social security coverage.
- Sec. 404. Additional technical amendment relating to cooperative research or demonstration projects under titles II and XVI.
- Sec. 405. Authorization for State to permit annual wage reports.
- Sec. 406. Assessment on attorneys who receive their fees via the Social Security Administration.
- Sec. 407. Extension of authority of State medicaid fraud control units.
- Sec. 408. Climate database modernization.
- Sec. 409. Special allowance adjustment for student loans.
- Sec. 410. Schedule for payments under SSI state supplementation agreements.
- Sec. 411. Bonus commodities.
- Sec. 412. Simplification of definition of foster child under EIC.
- Sec. 413. Delay of effective date of organ procurement and transplantation network final rule.

## TITLE V—TAX RELIEF EXTENSION ACT OF 1999

- Sec. 500. Short title of title.

## Subtitle A—Extensions

- Sec. 501. Allowance of nonrefundable personal credits against regular and minimum tax liability.
- Sec. 502. Research credit.
- Sec. 503. Subpart F exemption for active financing income.
- Sec. 504. Taxable income limit on percentage depletion for marginal production.
- Sec. 505. Work opportunity credit and welfare-to-work credit.
- Sec. 506. Employer-provided educational assistance.
- Sec. 507. Extension and modification of credit for producing electricity from certain renewable resources.
- Sec. 508. Extension of duty-free treatment under Generalized System of Preferences.
- Sec. 509. Extension of credit for holders of qualified zone academy bonds.
- Sec. 510. Extension of first-time homebuyer credit for District of Columbia.
- Sec. 511. Extension of expensing of environmental remediation costs.
- Sec. 512. Temporary increase in amount of rum excise tax covered over to Puerto Rico and Virgin Islands.

## Subtitle B—Other Time-Sensitive Provisions

- Sec. 521. Advance pricing agreements treated as confidential taxpayer information.
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## Subtitle C—Revenue Offsets

## PART I—GENERAL PROVISIONS

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- Sec. 536. Modification of installment method and repeal of installment method for accrual method taxpayers.
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## PART II—PROVISIONS RELATING TO REAL ESTATE INVESTMENT TRUSTS

## SUBPART A—TREATMENT OF INCOME AND SERVICES PROVIDED BY TAXABLE REIT SUBSIDIARIES

- Sec. 541. Modifications to asset diversification test.
- Sec. 542. Treatment of income and services provided by taxable REIT subsidiaries.
- Sec. 543. Taxable REIT subsidiary.
- Sec. 544. Limitation on earnings stripping.

- Sec. 545. 100 percent tax on improperly allocated amounts.  
 Sec. 546. Effective date.  
 Sec. 547. Study relating to taxable REIT subsidiaries.

SUBPART B—HEALTH CARE REITS

- Sec. 551. Health care REITs.

SUBPART C—CONFORMITY WITH REGULATED INVESTMENT COMPANY RULES

- Sec. 556. Conformity with regulated investment company rules.

SUBPART D—CLARIFICATION OF EXCEPTION FROM IMPERMISSIBLE TENANT SERVICE INCOME

- Sec. 561. Clarification of exception for independent operators.

SUBPART E—MODIFICATION OF EARNINGS AND PROFITS RULES

- Sec. 566. Modification of earnings and profits rules.

SUBPART F—MODIFICATION OF ESTIMATED TAX RULES

- Sec. 571. Modification of estimated tax rules for closely held real estate investment trusts.

42 USC 1320b-19 note.

**SEC. 2. FINDINGS AND PURPOSES.**

(a) **FINDINGS.**—The Congress makes the following findings:

(1) It is the policy of the United States to provide assistance to individuals with disabilities to lead productive work lives.

(2) Health care is important to all Americans.

(3) Health care is particularly important to individuals with disabilities and special health care needs who often cannot afford the insurance available to them through the private market, are uninsurable by the plans available in the private sector, and are at great risk of incurring very high and economically devastating health care costs.

(4) Americans with significant disabilities often are unable to obtain health care insurance that provides coverage of the services and supports that enable them to live independently and enter or rejoin the workforce. Personal assistance services (such as attendant services, personal assistance with transportation to and from work, reader services, job coaches, and related assistance) remove many of the barriers between significant disability and work. Coverage for such services, as well as for prescription drugs, durable medical equipment, and basic health care are powerful and proven tools for individuals with significant disabilities to obtain and retain employment.

(5) For individuals with disabilities, the fear of losing health care and related services is one of the greatest barriers keeping the individuals from maximizing their employment, earning potential, and independence.

(6) Social Security Disability Insurance and Supplemental Security Income beneficiaries risk losing medicare or medicaid coverage that is linked to their cash benefits, a risk that is an equal, or greater, work disincentive than the loss of cash benefits associated with working.

(7) Individuals with disabilities have greater opportunities for employment than ever before, aided by important public policy initiatives such as the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), advancements in public understanding of disability, and innovations in assistive technology, medical treatment, and rehabilitation.

(8) Despite such historic opportunities and the desire of millions of disability recipients to work and support themselves, fewer than one-half of one percent of Social Security Disability

Insurance and Supplemental Security Income beneficiaries leave the disability rolls and return to work.

(9) In addition to the fear of loss of health care coverage, beneficiaries cite financial disincentives to work and earn income and lack of adequate employment training and placement services as barriers to employment.

(10) Eliminating such barriers to work by creating financial incentives to work and by providing individuals with disabilities real choice in obtaining the services and technology they need to find, enter, and maintain employment can greatly improve their short and long-term financial independence and personal well-being.

(11) In addition to the enormous advantages such changes promise for individuals with disabilities, redesigning government programs to help individuals with disabilities return to work may result in significant savings and extend the life of the Social Security Disability Insurance Trust Fund.

(12) If only an additional one-half of one percent of the current Social Security Disability Insurance and Supplemental Security Income recipients were to cease receiving benefits as a result of employment, the savings to the Social Security Trust Funds and to the Treasury in cash assistance would total \$3,500,000,000 over the worklife of such individuals, far exceeding the cost of providing incentives and services needed to assist them in entering work and achieving financial independence to the best of their abilities.

(b) PURPOSES.—The purposes of this Act are as follows:

(1) To provide health care and employment preparation and placement services to individuals with disabilities that will enable those individuals to reduce their dependency on cash benefit programs.

(2) To encourage States to adopt the option of allowing individuals with disabilities to purchase medicaid coverage that is necessary to enable such individuals to maintain employment.

(3) To provide individuals with disabilities the option of maintaining medicare coverage while working.

(4) To establish a return to work ticket program that will allow individuals with disabilities to seek the services necessary to obtain and retain employment and reduce their dependency on cash benefit programs.

## **TITLE I—TICKET TO WORK AND SELF-SUFFICIENCY AND RELATED PROVISIONS**

### **Subtitle A—Ticket to Work and Self-Sufficiency**

#### **SEC. 101. ESTABLISHMENT OF THE TICKET TO WORK AND SELF-SUFFICIENCY PROGRAM.**

(a) IN GENERAL.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new section:

## “THE TICKET TO WORK AND SELF-SUFFICIENCY PROGRAM

Establishment.  
42 USC 1320b-  
19.

“SEC. 1148. (a) IN GENERAL.—The Commissioner shall establish a Ticket to Work and Self-Sufficiency Program, under which a disabled beneficiary may use a ticket to work and self-sufficiency issued by the Commissioner in accordance with this section to obtain employment services, vocational rehabilitation services, or other support services from an employment network which is of the beneficiary’s choice and which is willing to provide such services to such beneficiary.

## “(b) TICKET SYSTEM.—

“(1) DISTRIBUTION OF TICKETS.—The Commissioner may issue a ticket to work and self-sufficiency to disabled beneficiaries for participation in the Program.

“(2) ASSIGNMENT OF TICKETS.—A disabled beneficiary holding a ticket to work and self-sufficiency may assign the ticket to any employment network of the beneficiary’s choice which is serving under the Program and is willing to accept the assignment.

“(3) TICKET TERMS.—A ticket issued under paragraph (1) shall consist of a document which evidences the Commissioner’s agreement to pay (as provided in paragraph (4)) an employment network, which is serving under the Program and to which such ticket is assigned by the beneficiary, for such employment services, vocational rehabilitation services, and other support services as the employment network may provide to the beneficiary.

“(4) PAYMENTS TO EMPLOYMENT NETWORKS.—The Commissioner shall pay an employment network under the Program in accordance with the outcome payment system under subsection (h)(2) or under the outcome-milestone payment system under subsection (h)(3) (whichever is elected pursuant to subsection (h)(1)). An employment network may not request or receive compensation for such services from the beneficiary.

## “(c) STATE PARTICIPATION.—

“(1) IN GENERAL.—Each State agency administering or supervising the administration of the State plan approved under title I of the Rehabilitation Act of 1973 (29 U.S.C. 720 et seq.) may elect to participate in the Program as an employment network with respect to a disabled beneficiary. If the State agency does elect to participate in the Program, the State agency also shall elect to be paid under the outcome payment system or the outcome-milestone payment system in accordance with subsection (h)(1). With respect to a disabled beneficiary that the State agency does not elect to have participate in the Program, the State agency shall be paid for services provided to that beneficiary under the system for payment applicable under section 222(d) and subsections (d) and (e) of section 1615. The Commissioner shall provide for periodic opportunities for exercising such elections.

## “(2) EFFECT OF PARTICIPATION BY STATE AGENCY.—

“(A) STATE AGENCIES PARTICIPATING.—In any case in which a State agency described in paragraph (1) elects under that paragraph to participate in the Program, the employment services, vocational rehabilitation services, and other support services which, upon assignment of tickets

to work and self-sufficiency, are provided to disabled beneficiaries by the State agency acting as an employment network shall be governed by plans for vocational rehabilitation services approved under title I of the Rehabilitation Act of 1973 (29 U.S.C. 720 et seq.).

“(B) STATE AGENCIES ADMINISTERING MATERNAL AND CHILD HEALTH SERVICES PROGRAMS.—Subparagraph (A) shall not apply with respect to any State agency administering a program under title V of this Act.

“(3) AGREEMENTS BETWEEN STATE AGENCIES AND EMPLOYMENT NETWORKS.—State agencies and employment networks shall enter into agreements regarding the conditions under which services will be provided when an individual is referred by an employment network to a State agency for services. The Commissioner shall establish by regulations the timeframe within which such agreements must be entered into and the mechanisms for dispute resolution between State agencies and employment networks with respect to such agreements.

“(d) RESPONSIBILITIES OF THE COMMISSIONER.—

“(1) SELECTION AND QUALIFICATIONS OF PROGRAM MANAGERS.—The Commissioner shall enter into agreements with 1 or more organizations in the private or public sector for service as a program manager to assist the Commissioner in administering the Program. Any such program manager shall be selected by means of a competitive bidding process, from among organizations in the private or public sector with available expertise and experience in the field of vocational rehabilitation or employment services.

“(2) TENURE, RENEWAL, AND EARLY TERMINATION.—Each agreement entered into under paragraph (1) shall provide for early termination upon failure to meet performance standards which shall be specified in the agreement and which shall be weighted to take into account any performance in prior terms. Such performance standards shall include—

“(A) measures for ease of access by beneficiaries to services; and

“(B) measures for determining the extent to which failures in obtaining services for beneficiaries fall within acceptable parameters, as determined by the Commissioner.

“(3) PRECLUSION FROM DIRECT PARTICIPATION IN DELIVERY OF SERVICES IN OWN SERVICE AREA.—Agreements under paragraph (1) shall preclude—

“(A) direct participation by a program manager in the delivery of employment services, vocational rehabilitation services, or other support services to beneficiaries in the service area covered by the program manager’s agreement; and

“(B) the holding by a program manager of a financial interest in an employment network or service provider which provides services in a geographic area covered under the program manager’s agreement.

“(4) SELECTION OF EMPLOYMENT NETWORKS.—

“(A) IN GENERAL.—The Commissioner shall select and enter into agreements with employment networks for service under the Program. Such employment networks

shall be in addition to State agencies serving as employment networks pursuant to elections under subsection (c).

“(B) ALTERNATE PARTICIPANTS.—In any State where the Program is being implemented, the Commissioner shall enter into an agreement with any alternate participant that is operating under the authority of section 222(d)(2) in the State as of the date of the enactment of this section and chooses to serve as an employment network under the Program.

“(5) TERMINATION OF AGREEMENTS WITH EMPLOYMENT NETWORKS.—The Commissioner shall terminate agreements with employment networks for inadequate performance, as determined by the Commissioner.

“(6) QUALITY ASSURANCE.—The Commissioner shall provide for such periodic reviews as are necessary to provide for effective quality assurance in the provision of services by employment networks. The Commissioner shall solicit and consider the views of consumers and the program manager under which the employment networks serve and shall consult with providers of services to develop performance measurements. The Commissioner shall ensure that the results of the periodic reviews are made available to beneficiaries who are prospective service recipients as they select employment networks. The Commissioner shall ensure that the periodic surveys of beneficiaries receiving services under the Program are designed to measure customer service satisfaction.

“(7) DISPUTE RESOLUTION.—The Commissioner shall provide for a mechanism for resolving disputes between beneficiaries and employment networks, between program managers and employment networks, and between program managers and providers of services. The Commissioner shall afford a party to such a dispute a reasonable opportunity for a full and fair review of the matter in dispute.

“(e) PROGRAM MANAGERS.—

“(1) IN GENERAL.—A program manager shall conduct tasks appropriate to assist the Commissioner in carrying out the Commissioner’s duties in administering the Program.

“(2) RECRUITMENT OF EMPLOYMENT NETWORKS.—A program manager shall recruit, and recommend for selection by the Commissioner, employment networks for service under the Program. The program manager shall carry out such recruitment and provide such recommendations, and shall monitor all employment networks serving in the Program in the geographic area covered under the program manager’s agreement, to the extent necessary and appropriate to ensure that adequate choices of services are made available to beneficiaries. Employment networks may serve under the Program only pursuant to an agreement entered into with the Commissioner under the Program incorporating the applicable provisions of this section and regulations thereunder, and the program manager shall provide and maintain assurances to the Commissioner that payment by the Commissioner to employment networks pursuant to this section is warranted based on compliance by such employment networks with the terms of such agreement and this section. The program manager shall not impose numerical limits on the number of employment networks to be recommended pursuant to this paragraph.

“(3) FACILITATION OF ACCESS BY BENEFICIARIES TO EMPLOYMENT NETWORKS.—A program manager shall facilitate access by beneficiaries to employment networks. The program manager shall ensure that each beneficiary is allowed changes in employment networks without being deemed to have rejected services under the Program. When such a change occurs, the program manager shall reassign the ticket based on the choice of the beneficiary. Upon the request of the employment network, the program manager shall make a determination of the allocation of the outcome or milestone-outcome payments based on the services provided by each employment network. The program manager shall establish and maintain lists of employment networks available to beneficiaries and shall make such lists generally available to the public. The program manager shall ensure that all information provided to disabled beneficiaries pursuant to this paragraph is provided in accessible formats.

“(4) ENSURING AVAILABILITY OF ADEQUATE SERVICES.—The program manager shall ensure that employment services, vocational rehabilitation services, and other support services are provided to beneficiaries throughout the geographic area covered under the program manager’s agreement, including rural areas.

“(5) REASONABLE ACCESS TO SERVICES.—The program manager shall take such measures as are necessary to ensure that sufficient employment networks are available and that each beneficiary receiving services under the Program has reasonable access to employment services, vocational rehabilitation services, and other support services. Services provided under the Program may include case management, work incentives planning, supported employment, career planning, career plan development, vocational assessment, job training, placement, follow-up services, and such other services as may be specified by the Commissioner under the Program. The program manager shall ensure that such services are available in each service area.

“(f) EMPLOYMENT NETWORKS.—

“(1) QUALIFICATIONS FOR EMPLOYMENT NETWORKS.—

“(A) IN GENERAL.—Each employment network serving under the Program shall consist of an agency or instrumentality of a State (or a political subdivision thereof) or a private entity, that assumes responsibility for the coordination and delivery of services under the Program to individuals assigning to the employment network tickets to work and self-sufficiency issued under subsection (b).

“(B) ONE-STOP DELIVERY SYSTEMS.—An employment network serving under the Program may consist of a one-stop delivery system established under subtitle B of title I of the Workforce Investment Act of 1998 (29 U.S.C. 2811 et seq.).

“(C) COMPLIANCE WITH SELECTION CRITERIA.—No employment network may serve under the Program unless it meets and maintains compliance with both general selection criteria (such as professional and educational qualifications, where applicable) and specific selection criteria (such as substantial expertise and experience in providing relevant employment services and supports).

“(D) SINGLE OR ASSOCIATED PROVIDERS ALLOWED.—An employment network shall consist of either a single provider of such services or of an association of such providers organized so as to combine their resources into a single entity. An employment network may meet the requirements of subsection (e)(4) by providing services directly, or by entering into agreements with other individuals or entities providing appropriate employment services, vocational rehabilitation services, or other support services.

“(2) REQUIREMENTS RELATING TO PROVISION OF SERVICES.—Each employment network serving under the Program shall be required under the terms of its agreement with the Commissioner to—

“(A) serve prescribed service areas; and

“(B) take such measures as are necessary to ensure that employment services, vocational rehabilitation services, and other support services provided under the Program by, or under agreements entered into with, the employment network are provided under appropriate individual work plans that meet the requirements of subsection (g).

“(3) ANNUAL FINANCIAL REPORTING.—Each employment network shall meet financial reporting requirements as prescribed by the Commissioner.

“(4) PERIODIC OUTCOMES REPORTING.—Each employment network shall prepare periodic reports, on at least an annual basis, itemizing for the covered period specific outcomes achieved with respect to specific services provided by the employment network. Such reports shall conform to a national model prescribed under this section. Each employment network shall provide a copy of the latest report issued by the employment network pursuant to this paragraph to each beneficiary upon enrollment under the Program for services to be received through such employment network. Upon issuance of each report to each beneficiary, a copy of the report shall be maintained in the files of the employment network. The program manager shall ensure that copies of all such reports issued under this paragraph are made available to the public under reasonable terms.

Public  
information.

“(g) INDIVIDUAL WORK PLANS.—

“(1) REQUIREMENTS.—Each employment network shall—

“(A) take such measures as are necessary to ensure that employment services, vocational rehabilitation services, and other support services provided under the Program by, or under agreements entered into with, the employment network are provided under appropriate individual work plans that meet the requirements of subparagraph (C);

“(B) develop and implement each such individual work plan, in partnership with each beneficiary receiving such services, in a manner that affords such beneficiary the opportunity to exercise informed choice in selecting an employment goal and specific services needed to achieve that employment goal;

“(C) ensure that each individual work plan includes at least—

“(i) a statement of the vocational goal developed with the beneficiary, including, as appropriate, goals for earnings and job advancement;

“(ii) a statement of the services and supports that have been deemed necessary for the beneficiary to accomplish that goal;

“(iii) a statement of any terms and conditions related to the provision of such services and supports; and

“(iv) a statement of understanding regarding the beneficiary’s rights under the Program (such as the right to retrieve the ticket to work and self-sufficiency if the beneficiary is dissatisfied with the services being provided by the employment network) and remedies available to the individual, including information on the availability of advocacy services and assistance in resolving disputes through the State grant program authorized under section 1150;

“(D) provide a beneficiary the opportunity to amend the individual work plan if a change in circumstances necessitates a change in the plan; and

“(E) make each beneficiary’s individual work plan available to the beneficiary in, as appropriate, an accessible format chosen by the beneficiary.

“(2) EFFECTIVE UPON WRITTEN APPROVAL.—A beneficiary’s individual work plan shall take effect upon written approval by the beneficiary or a representative of the beneficiary and a representative of the employment network that, in providing such written approval, acknowledges assignment of the beneficiary’s ticket to work and self-sufficiency.

“(h) EMPLOYMENT NETWORK PAYMENT SYSTEMS.—

“(1) ELECTION OF PAYMENT SYSTEM BY EMPLOYMENT NETWORKS.—

“(A) IN GENERAL.—The Program shall provide for payment authorized by the Commissioner to employment networks under either an outcome payment system or an outcome-milestone payment system. Each employment network shall elect which payment system will be utilized by the employment network, and, for such period of time as such election remains in effect, the payment system so elected shall be utilized exclusively in connection with such employment network (except as provided in subparagraph (B)).

“(B) NO CHANGE IN METHOD OF PAYMENT FOR BENEFICIARIES WITH TICKETS ALREADY ASSIGNED TO THE EMPLOYMENT NETWORKS.—Any election of a payment system by an employment network that would result in a change in the method of payment to the employment network for services provided to a beneficiary who is receiving services from the employment network at the time of the election shall not be effective with respect to payment for services provided to that beneficiary and the method of payment previously selected shall continue to apply with respect to such services.

“(2) OUTCOME PAYMENT SYSTEM.—

“(A) IN GENERAL.—The outcome payment system shall consist of a payment structure governing employment networks electing such system under paragraph (1)(A) which meets the requirements of this paragraph.

“(B) PAYMENTS MADE DURING OUTCOME PAYMENT PERIOD.—The outcome payment system shall provide for a schedule of payments to an employment network, in connection with each individual who is a beneficiary, for each month, during the individual’s outcome payment period, for which benefits (described in paragraphs (3) and (4) of subsection (k)) are not payable to such individual because of work or earnings.

“(C) COMPUTATION OF PAYMENTS TO EMPLOYMENT NETWORK.—The payment schedule of the outcome payment system shall be designed so that—

“(i) the payment for each month during the outcome payment period for which benefits (described in paragraphs (3) and (4) of subsection (k)) are not payable is equal to a fixed percentage of the payment calculation base for the calendar year in which such month occurs; and

“(ii) such fixed percentage is set at a percentage which does not exceed 40 percent.

“(3) OUTCOME-MILESTONE PAYMENT SYSTEM.—

“(A) IN GENERAL.—The outcome-milestone payment system shall consist of a payment structure governing employment networks electing such system under paragraph (1)(A) which meets the requirements of this paragraph.

“(B) EARLY PAYMENTS UPON ATTAINMENT OF MILESTONES IN ADVANCE OF OUTCOME PAYMENT PERIODS.—The outcome-milestone payment system shall provide for 1 or more milestones, with respect to beneficiaries receiving services from an employment network under the Program, that are directed toward the goal of permanent employment. Such milestones shall form a part of a payment structure that provides, in addition to payments made during outcome payment periods, payments made prior to outcome payment periods in amounts based on the attainment of such milestones.

“(C) LIMITATION ON TOTAL PAYMENTS TO EMPLOYMENT NETWORK.—The payment schedule of the outcome milestone payment system shall be designed so that the total of the payments to the employment network with respect to each beneficiary is less than, on a net present value basis (using an interest rate determined by the Commissioner that appropriately reflects the cost of funds faced by providers), the total amount to which payments to the employment network with respect to the beneficiary would be limited if the employment network were paid under the outcome payment system.

“(4) DEFINITIONS.—In this subsection:

“(A) PAYMENT CALCULATION BASE.—The term ‘payment calculation base’ means, for any calendar year—

“(i) in connection with a title II disability beneficiary, the average disability insurance benefit payable

under section 223 for all beneficiaries for months during the preceding calendar year; and

“(ii) in connection with a title XVI disability beneficiary (who is not concurrently a title II disability beneficiary), the average payment of supplemental security income benefits based on disability payable under title XVI (excluding State supplementation) for months during the preceding calendar year to all beneficiaries who have attained 18 years of age but have not attained 65 years of age.

“(B) OUTCOME PAYMENT PERIOD.—The term ‘outcome payment period’ means, in connection with any individual who had assigned a ticket to work and self-sufficiency to an employment network under the Program, a period—

“(i) beginning with the first month, ending after the date on which such ticket was assigned to the employment network, for which benefits (described in paragraphs (3) and (4) of subsection (k)) are not payable to such individual by reason of engagement in substantial gainful activity or by reason of earnings from work activity; and

“(ii) ending with the 60th month (consecutive or otherwise), ending after such date, for which such benefits are not payable to such individual by reason of engagement in substantial gainful activity or by reason of earnings from work activity.

“(5) PERIODIC REVIEW AND ALTERATIONS OF PRESCRIBED SCHEDULES.—

“(A) PERCENTAGES AND PERIODS.—The Commissioner shall periodically review the percentage specified in paragraph (2)(C), the total payments permissible under paragraph (3)(C), and the period of time specified in paragraph (4)(B) to determine whether such percentages, such permissible payments, and such period provide an adequate incentive for employment networks to assist beneficiaries to enter the workforce, while providing for appropriate economies. The Commissioner may alter such percentage, such total permissible payments, or such period of time to the extent that the Commissioner determines, on the basis of the Commissioner’s review under this paragraph, that such an alteration would better provide the incentive and economies described in the preceding sentence.

“(B) NUMBER AND AMOUNTS OF MILESTONE PAYMENTS.—The Commissioner shall periodically review the number and amounts of milestone payments established by the Commissioner pursuant to this section to determine whether they provide an adequate incentive for employment networks to assist beneficiaries to enter the workforce, taking into account information provided to the Commissioner by program managers, the Ticket to Work and Work Incentives Advisory Panel established by section 101(f) of the Ticket to Work and Work Incentives Improvement Act of 1999, and other reliable sources. The Commissioner may from time to time alter the number and amounts of milestone payments initially established by the Commissioner pursuant to this section to the extent that the Commissioner determines that such an alteration

would allow an adequate incentive for employment networks to assist beneficiaries to enter the workforce. Such alteration shall be based on information provided to the Commissioner by program managers, the Ticket to Work and Work Incentives Advisory Panel established by section 101(f) of the Ticket to Work and Work Incentives Improvement Act of 1999, or other reliable sources.

Deadline.

“(C) REPORT ON THE ADEQUACY OF INCENTIVES.—The Commissioner shall submit to the Congress not later than 36 months after the date of the enactment of the Ticket to Work and Work Incentives Improvement Act of 1999 a report with recommendations for a method or methods to adjust payment rates under subparagraphs (A) and (B), that would ensure adequate incentives for the provision of services by employment networks of—

“(i) individuals with a need for ongoing support and services;

“(ii) individuals with a need for high-cost accommodations;

“(iii) individuals who earn a subminimum wage; and

“(iv) individuals who work and receive partial cash benefits.

The Commissioner shall consult with the Ticket to Work and Work Incentives Advisory Panel established under section 101(f) of the Ticket to Work and Work Incentives Improvement Act of 1999 during the development and evaluation of the study. The Commissioner shall implement the necessary adjusted payment rates prior to full implementation of the Ticket to Work and Self-Sufficiency Program.

“(i) SUSPENSION OF DISABILITY REVIEWS.—During any period for which an individual is using, as defined by the Commissioner, a ticket to work and self-sufficiency issued under this section, the Commissioner (and any applicable State agency) may not initiate a continuing disability review or other review under section 221 of whether the individual is or is not under a disability or a review under title XVI similar to any such review under section 221.

“(j) AUTHORIZATIONS.—

“(1) PAYMENTS TO EMPLOYMENT NETWORKS.—

“(A) TITLE II DISABILITY BENEFICIARIES.—There are authorized to be transferred from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund each fiscal year such sums as may be necessary to make payments to employment networks under this section. Money paid from the Trust Funds under this section with respect to title II disability beneficiaries who are entitled to benefits under section 223 or who are entitled to benefits under section 202(d) on the basis of the wages and self-employment income of such beneficiaries, shall be charged to the Federal Disability Insurance Trust Fund, and all other money paid from the Trust Funds under this section shall be charged to the Federal Old-Age and Survivors Insurance Trust Fund.

“(B) TITLE XVI DISABILITY BENEFICIARIES.—Amounts authorized to be appropriated to the Social Security

Administration under section 1601 (as in effect pursuant to the amendments made by section 301 of the Social Security Amendments of 1972) shall include amounts necessary to carry out the provisions of this section with respect to title XVI disability beneficiaries.

“(2) ADMINISTRATIVE EXPENSES.—The costs of administering this section (other than payments to employment networks) shall be paid from amounts made available for the administration of title II and amounts made available for the administration of title XVI, and shall be allocated among such amounts as appropriate.

“(k) DEFINITIONS.—In this section:

“(1) COMMISSIONER.—The term ‘Commissioner’ means the Commissioner of Social Security.

“(2) DISABLED BENEFICIARY.—The term ‘disabled beneficiary’ means a title II disability beneficiary or a title XVI disability beneficiary.

“(3) TITLE II DISABILITY BENEFICIARY.—The term ‘title II disability beneficiary’ means an individual entitled to disability insurance benefits under section 223 or to monthly insurance benefits under section 202 based on such individual’s disability (as defined in section 223(d)). An individual is a title II disability beneficiary for each month for which such individual is entitled to such benefits.

“(4) TITLE XVI DISABILITY BENEFICIARY.—The term ‘title XVI disability beneficiary’ means an individual eligible for supplemental security income benefits under title XVI on the basis of blindness (within the meaning of section 1614(a)(2)) or disability (within the meaning of section 1614(a)(3)). An individual is a title XVI disability beneficiary for each month for which such individual is eligible for such benefits.

“(5) SUPPLEMENTAL SECURITY INCOME BENEFIT.—The term ‘supplemental security income benefit under title XVI’ means a cash benefit under section 1611 or 1619(a), and does not include a State supplementary payment, administered federally or otherwise.

“(l) REGULATIONS.—Not later than 1 year after the date of the enactment of the Ticket to Work and Work Incentives Improvement Act of 1999, the Commissioner shall prescribe such regulations as are necessary to carry out the provisions of this section.” Deadline.

(b) CONFORMING AMENDMENTS.—

(1) AMENDMENTS TO TITLE II.—

(A) Section 221(i) of the Social Security Act (42 U.S.C. 421(i)) is amended by adding at the end the following new paragraph:

“(5) For suspension of reviews under this subsection in the case of an individual using a ticket to work and self-sufficiency, see section 1148(i).”

(B) Section 222(a) of such Act (42 U.S.C. 422(a)) is repealed.

(C) Section 222(b) of such Act (42 U.S.C. 422(b)) is repealed.

(D) Section 225(b)(1) of such Act (42 U.S.C. 425(b)(1)) is amended by striking “a program of vocational rehabilitation services” and inserting “a program consisting of the Ticket to Work and Self-Sufficiency Program under section

1148 or another program of vocational rehabilitation services, employment services, or other support services”.

(2) AMENDMENTS TO TITLE XVI.—

(A) Section 1615(a) of such Act (42 U.S.C. 1382d(a)) is amended to read as follows:

“SEC. 1615. (a) In the case of any blind or disabled individual who—

“(1) has not attained age 16; and

“(2) with respect to whom benefits are paid under this title,

the Commissioner of Social Security shall make provision for referral of such individual to the appropriate State agency administering the State program under title V.”.

(B) Section 1615(c) of such Act (42 U.S.C. 1382d(c)) is repealed.

(C) Section 1631(a)(6)(A) of such Act (42 U.S.C. 1383(a)(6)(A)) is amended by striking “a program of vocational rehabilitation services” and inserting “a program consisting of the Ticket to Work and Self-Sufficiency Program under section 1148 or another program of vocational rehabilitation services, employment services, or other support services”.

(D) Section 1633(c) of such Act (42 U.S.C. 1383b(c)) is amended—

(i) by inserting “(1)” after “(c)”; and

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

“(2) For suspension of continuing disability reviews and other reviews under this title similar to reviews under section 221 in the case of an individual using a ticket to work and self-sufficiency, see section 1148(i).”.

42 USC 1320b-19 note.

(c) EFFECTIVE DATE.—Subject to subsection (d), the amendments made by subsections (a) and (b) shall take effect with the first month following 1 year after the date of the enactment of this Act.

42 USC 1320b-19 note.  
Deadline.

(d) GRADUATED IMPLEMENTATION OF PROGRAM.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Commissioner of Social Security shall commence implementation of the amendments made by this section (other than paragraphs (1)(C) and (2)(B) of subsection (b)) in graduated phases at phase-in sites selected by the Commissioner. Such phase-in sites shall be selected so as to ensure, prior to full implementation of the Ticket to Work and Self-Sufficiency Program, the development and refinement of referral processes, payment systems, computer linkages, management information systems, and administrative processes necessary to provide for full implementation of such amendments. Subsection (c) shall apply with respect to paragraphs (1)(C) and (2)(B) of subsection (b) without regard to this subsection.

(2) REQUIREMENTS.—Implementation of the Program at each phase-in site shall be carried out on a wide enough scale to permit a thorough evaluation of the alternative methods under consideration, so as to ensure that the most efficacious methods are determined and in place for full implementation of the Program on a timely basis.

(3) FULL IMPLEMENTATION.—The Commissioner shall ensure that ability to provide tickets and services to individuals under the Program exists in every State as soon as practicable on or after the effective date specified in subsection (c) but not later than 3 years after such date.

(4) ONGOING EVALUATION OF PROGRAM.—

(A) IN GENERAL.—The Commissioner shall provide for independent evaluations to assess the effectiveness of the activities carried out under this section and the amendments made thereby. Such evaluations shall address the cost-effectiveness of such activities, as well as the effects of this section and the amendments made thereby on work outcomes for beneficiaries receiving tickets to work and self-sufficiency under the Program.

(B) CONSULTATION.—Evaluations shall be conducted under this paragraph after receiving relevant advice from experts in the fields of disability, vocational rehabilitation, and program evaluation and individuals using tickets to work and self-sufficiency under the Program and in consultation with the Ticket to Work and Work Incentives Advisory Panel established under section 101(f) of this Act, the Comptroller General of the United States, other agencies of the Federal Government, and private organizations with appropriate expertise.

(C) METHODOLOGY.—

(i) IMPLEMENTATION.—The Commissioner, in consultation with the Ticket to Work and Work Incentives Advisory Panel established under section 101(f) of this Act, shall ensure that plans for evaluations and data collection methods under the Program are appropriately designed to obtain detailed employment information.

(ii) SPECIFIC MATTERS TO BE ADDRESSED.—Each such evaluation shall address (but is not limited to)—

(I) the annual cost (including net cost) of the Program and the annual cost (including net cost) that would have been incurred in the absence of the Program;

(II) the determinants of return to work, including the characteristics of beneficiaries in receipt of tickets under the Program;

(III) the types of employment services, vocational rehabilitation services, and other support services furnished to beneficiaries in receipt of tickets under the Program who return to work and to those who do not return to work;

(IV) the duration of employment services, vocational rehabilitation services, and other support services furnished to beneficiaries in receipt of tickets under the Program who return to work and the duration of such services furnished to those who do not return to work and the cost to employment networks of furnishing such services;

(V) the employment outcomes, including wages, occupations, benefits, and hours worked, of beneficiaries who return to work after receiving

tickets under the Program and those who return to work without receiving such tickets;

(VI) the characteristics of individuals in possession of tickets under the Program who are not accepted for services and, to the extent reasonably determinable, the reasons for which such beneficiaries were not accepted for services;

(VII) the characteristics of providers whose services are provided within an employment network under the Program;

(VIII) the extent (if any) to which employment networks display a greater willingness to provide services to beneficiaries with a range of disabilities;

(IX) the characteristics (including employment outcomes) of those beneficiaries who receive services under the outcome payment system and of those beneficiaries who receive services under the outcome-milestone payment system;

(X) measures of satisfaction among beneficiaries in receipt of tickets under the Program; and

(XI) reasons for (including comments solicited from beneficiaries regarding) their choice not to use their tickets or their inability to return to work despite the use of their tickets.

(D) PERIODIC EVALUATION REPORTS.—Following the close of the third and fifth fiscal years ending after the effective date under subsection (c), and prior to the close of the seventh fiscal year ending after such date, the Commissioner shall transmit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report containing the Commissioner's evaluation of the progress of activities conducted under the provisions of this section and the amendments made thereby. Each such report shall set forth the Commissioner's evaluation of the extent to which the Program has been successful and the Commissioner's conclusions on whether or how the Program should be modified. Each such report shall include such data, findings, materials, and recommendations as the Commissioner may consider appropriate.

(5) EXTENT OF STATE'S RIGHT OF FIRST REFUSAL IN ADVANCE OF FULL IMPLEMENTATION OF AMENDMENTS IN SUCH STATE.—

(A) IN GENERAL.—In the case of any State in which the amendments made by subsection (a) have not been fully implemented pursuant to this subsection, the Commissioner shall determine by regulation the extent to which—

(i) the requirement under section 222(a) of the Social Security Act (42 U.S.C. 422(a)) for prompt referrals to a State agency; and

(ii) the authority of the Commissioner under section 222(d)(2) of such Act (42 U.S.C. 422(d)(2)) to provide vocational rehabilitation services in such State by agreement or contract with other public or private agencies, organizations, institutions, or individuals, shall apply in such State.

(B) EXISTING AGREEMENTS.—Nothing in subparagraph (A) or the amendments made by subsection (a) shall be construed to limit, impede, or otherwise affect any agreement entered into pursuant to section 222(d)(2) of the Social Security Act (42 U.S.C. 422(d)(2)) before the date of the enactment of this Act with respect to services provided pursuant to such agreement to beneficiaries receiving services under such agreement as of such date, except with respect to services (if any) to be provided after 3 years after the effective date provided in subsection (c).

(e) SPECIFIC REGULATIONS REQUIRED.—

42 USC 1320b-19 note.

(1) IN GENERAL.—The Commissioner of Social Security shall prescribe such regulations as are necessary to implement the amendments made by this section.

(2) SPECIFIC MATTERS TO BE INCLUDED IN REGULATIONS.—The matters which shall be addressed in such regulations shall include—

(A) the form and manner in which tickets to work and self-sufficiency may be distributed to beneficiaries pursuant to section 1148(b)(1) of the Social Security Act;

(B) the format and wording of such tickets, which shall incorporate by reference any contractual terms governing service by employment networks under the Program;

(C) the form and manner in which State agencies may elect participation in the Ticket to Work and Self-Sufficiency Program pursuant to section 1148(c)(1) of such Act and provision for periodic opportunities for exercising such elections;

(D) the status of State agencies under section 1148(c)(1) of such Act at the time that State agencies exercise elections under that section;

(E) the terms of agreements to be entered into with program managers pursuant to section 1148(d) of such Act, including—

(i) the terms by which program managers are precluded from direct participation in the delivery of services pursuant to section 1148(d)(3) of such Act;

(ii) standards which must be met by quality assurance measures referred to in paragraph (6) of section 1148(d) of such Act and methods of recruitment of employment networks utilized pursuant to paragraph (2) of section 1148(e) of such Act; and

(iii) the format under which dispute resolution will operate under section 1148(d)(7) of such Act;

(F) the terms of agreements to be entered into with employment networks pursuant to section 1148(d)(4) of such Act, including—

(i) the manner in which service areas are specified pursuant to section 1148(f)(2)(A) of such Act;

(ii) the general selection criteria and the specific selection criteria which are applicable to employment networks under section 1148(f)(1)(C) of such Act in selecting service providers;

(iii) specific requirements relating to annual financial reporting by employment networks pursuant to section 1148(f)(3) of such Act; and

(iv) the national model to which periodic outcomes reporting by employment networks must conform under section 1148(f)(4) of such Act;

(G) standards which must be met by individual work plans pursuant to section 1148(g) of such Act;

(H) standards which must be met by payment systems required under section 1148(h) of such Act, including—

(i) the form and manner in which elections by employment networks of payment systems are to be exercised pursuant to section 1148(h)(1)(A) of such Act;

(ii) the terms which must be met by an outcome payment system under section 1148(h)(2) of such Act;

(iii) the terms which must be met by an outcome-milestone payment system under section 1148(h)(3) of such Act;

(iv) any revision of the percentage specified in paragraph (2)(C) of section 1148(h) of such Act or the period of time specified in paragraph (4)(B) of such section 1148(h) of such Act; and

(v) annual oversight procedures for such systems; and

(I) procedures for effective oversight of the Program by the Commissioner of Social Security, including periodic reviews and reporting requirements.

42 USC 1320b-19 note.

(f) THE TICKET TO WORK AND WORK INCENTIVES ADVISORY PANEL.—

(1) ESTABLISHMENT.—There is established within the Social Security Administration a panel to be known as the “Ticket to Work and Work Incentives Advisory Panel” (in this subsection referred to as the “Panel”).

(2) DUTIES OF PANEL.—It shall be the duty of the Panel to—

(A) advise the President, the Congress, and the Commissioner of Social Security on issues related to work incentives programs, planning, and assistance for individuals with disabilities, including work incentive provisions under titles II, XI, XVI, XVIII, and XIX of the Social Security Act (42 U.S.C. 401 et seq., 1301 et seq., 1381 et seq., 1395 et seq., 1396 et seq.); and

(B) with respect to the Ticket to Work and Self-Sufficiency Program established under section 1148 of such Act—

(i) advise the Commissioner of Social Security with respect to establishing phase-in sites for such Program and fully implementing the Program thereafter, the refinement of access of disabled beneficiaries to employment networks, payment systems, and management information systems, and advise the Commissioner whether such measures are being taken to the extent necessary to ensure the success of the Program;

(ii) advise the Commissioner regarding the most effective designs for research and demonstration projects associated with the Program or conducted pursuant to section 302 of this Act;

(iii) advise the Commissioner on the development of performance measurements relating to quality assurance under section 1148(d)(6) of the Social Security Act; and

(iv) furnish progress reports on the Program to the Commissioner and each House of Congress.

(3) MEMBERSHIP.—

(A) NUMBER AND APPOINTMENT.—The Panel shall be composed of 12 members as follows:

(i) four members appointed by the President, not more than two of whom may be of the same political party;

(ii) two members appointed by the Speaker of the House of Representatives, in consultation with the Chairman of the Committee on Ways and Means of the House of Representatives;

(iii) two members appointed by the minority leader of the House of Representatives, in consultation with the ranking member of the Committee on Ways and Means of the House of Representatives;

(iv) two members appointed by the majority leader of the Senate, in consultation with the Chairman of the Committee on Finance of the Senate; and

(v) two members appointed by the minority leader of the Senate, in consultation with the ranking member of the Committee on Finance of the Senate.

(B) REPRESENTATION.—

(i) IN GENERAL.—The members appointed under subparagraph (A) shall have experience or expert knowledge as a recipient, provider, employer, or employee in the fields of, or related to, employment services, vocational rehabilitation services, and other support services.

(ii) REQUIREMENT.—At least one-half of the members appointed under subparagraph (A) shall be individuals with disabilities, or representatives of individuals with disabilities, with consideration given to current or former title II disability beneficiaries or title XVI disability beneficiaries (as such terms are defined in section 1148(k) of the Social Security Act (as added by subsection (a))).

(C) TERMS.—

(i) IN GENERAL.—Each member shall be appointed for a term of 4 years (or, if less, for the remaining life of the Panel), except as provided in clauses (ii) and (iii). The initial members shall be appointed not later than 90 days after the date of the enactment of this Act.

(ii) TERMS OF INITIAL APPOINTEES.—Of the members first appointed under each clause of subparagraph (A), as designated by the appointing authority for each such clause—

(I) one-half of such members shall be appointed for a term of 2 years; and

(II) the remaining members shall be appointed for a term of 4 years.

(iii) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Panel shall be filled in the manner in which the original appointment was made.

(D) BASIC PAY.—Members shall each be paid at a rate, and in a manner, that is consistent with guidelines established under section 7 of the Federal Advisory Committee Act (5 U.S.C. App.).

(E) TRAVEL EXPENSES.—Each member shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

(F) QUORUM.—Eight members of the Panel shall constitute a quorum but a lesser number may hold hearings.

(G) CHAIRPERSON.—The Chairperson of the Panel shall be designated by the President. The term of office of the Chairperson shall be 4 years.

(H) MEETINGS.—The Panel shall meet at least quarterly and at other times at the call of the Chairperson or a majority of its members.

(4) DIRECTOR AND STAFF OF PANEL; EXPERTS AND CONSULTANTS.—

(A) DIRECTOR.—The Panel shall have a Director who shall be appointed by the Chairperson, and paid at a rate, and in a manner, that is consistent with guidelines established under section 7 of the Federal Advisory Committee Act (5 U.S.C. App.).

(B) STAFF.—Subject to rules prescribed by the Commissioner of Social Security, the Director may appoint and fix the pay of additional personnel as the Director considers appropriate.

(C) EXPERTS AND CONSULTANTS.—Subject to rules prescribed by the Commissioner of Social Security, the Director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(D) STAFF OF FEDERAL AGENCIES.—Upon request of the Panel, the head of any Federal department or agency may detail, on a reimbursable basis, any of the personnel of that department or agency to the Panel to assist it in carrying out its duties under this Act.

(5) POWERS OF PANEL.—

(A) HEARINGS AND SESSIONS.—The Panel may, for the purpose of carrying out its duties under this subsection, hold such hearings, sit and act at such times and places, and take such testimony and evidence as the Panel considers appropriate.

(B) POWERS OF MEMBERS AND AGENTS.—Any member or agent of the Panel may, if authorized by the Panel, take any action which the Panel is authorized to take by this section.

(C) MAILS.—The Panel may use the United States mails in the same manner and under the same conditions as other departments and agencies of the United States.

**(6) REPORTS.—**

(A) **INTERIM REPORTS.**—The Panel shall submit to the President and the Congress interim reports at least annually.

(B) **FINAL REPORT.**—The Panel shall transmit a final report to the President and the Congress not later than eight years after the date of the enactment of this Act. The final report shall contain a detailed statement of the findings and conclusions of the Panel, together with its recommendations for legislation and administrative actions which the Panel considers appropriate.

(7) **TERMINATION.**—The Panel shall terminate 30 days after the date of the submission of its final report under paragraph (6)(B).

(8) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated from the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, and the general fund of the Treasury, as appropriate, such sums as are necessary to carry out this subsection.

## **Subtitle B—Elimination of Work Disincentives**

### **SEC. 111. WORK ACTIVITY STANDARD AS A BASIS FOR REVIEW OF AN INDIVIDUAL'S DISABLED STATUS.**

(a) **IN GENERAL.**—Section 221 of the Social Security Act (42 U.S.C. 421) is amended by adding at the end the following new subsection:

“(m)(1) In any case where an individual entitled to disability insurance benefits under section 223 or to monthly insurance benefits under section 202 based on such individual's disability (as defined in section 223(d)) has received such benefits for at least 24 months—

“(A) no continuing disability review conducted by the Commissioner may be scheduled for the individual solely as a result of the individual's work activity;

“(B) no work activity engaged in by the individual may be used as evidence that the individual is no longer disabled; and

“(C) no cessation of work activity by the individual may give rise to a presumption that the individual is unable to engage in work.

“(2) An individual to which paragraph (1) applies shall continue to be subject to—

“(A) continuing disability reviews on a regularly scheduled basis that is not triggered by work; and

“(B) termination of benefits under this title in the event that the individual has earnings that exceed the level of earnings established by the Commissioner to represent substantial gainful activity.”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on January 1, 2002. 42 USC 421 note.

### **SEC. 112. EXPEDITED REINSTATEMENT OF DISABILITY BENEFITS.**

(a) **OASDI BENEFITS.**—Section 223 of the Social Security Act (42 U.S.C. 423) is amended—

- (1) by redesignating subsection (i) as subsection (j); and  
 (2) by inserting after subsection (h) the following new subsection:

“Reinstatement of Entitlement

“(i)(1)(A) Entitlement to benefits described in subparagraph (B)(i)(I) shall be reinstated in any case where the Commissioner determines that an individual described in subparagraph (B) has filed a request for reinstatement meeting the requirements of paragraph (2)(A) during the period prescribed in subparagraph (C). Reinstatement of such entitlement shall be in accordance with the terms of this subsection.

“(B) An individual is described in this subparagraph if—

“(i) prior to the month in which the individual files a request for reinstatement—

“(I) the individual was entitled to benefits under this section or section 202 on the basis of disability pursuant to an application filed therefor; and

“(II) such entitlement terminated due to the performance of substantial gainful activity;

“(ii) the individual is under a disability and the physical or mental impairment that is the basis for the finding of disability is the same as (or related to) the physical or mental impairment that was the basis for the finding of disability that gave rise to the entitlement described in clause (i); and

“(iii) the individual’s disability renders the individual unable to perform substantial gainful activity.

“(C)(i) Except as provided in clause (ii), the period prescribed in this subparagraph with respect to an individual is 60 consecutive months beginning with the month following the most recent month for which the individual was entitled to a benefit described in subparagraph (B)(i)(I) prior to the entitlement termination described in subparagraph (B)(i)(II).

“(ii) In the case of an individual who fails to file a reinstatement request within the period prescribed in clause (i), the Commissioner may extend the period if the Commissioner determines that the individual had good cause for the failure to so file.

“(2)(A)(i) A request for reinstatement shall be filed in such form, and containing such information, as the Commissioner may prescribe.

“(ii) A request for reinstatement shall include express declarations by the individual that the individual meets the requirements specified in clauses (ii) and (iii) of paragraph (1)(B).

“(B) A request for reinstatement filed in accordance with subparagraph (A) may constitute an application for benefits in the case of any individual who the Commissioner determines is not entitled to reinstated benefits under this subsection.

“(3) In determining whether an individual meets the requirements of paragraph (1)(B)(ii), the provisions of subsection (f) shall apply.

“(4)(A)(i) Subject to clause (ii), entitlement to benefits reinstated under this subsection shall commence with the benefit payable for the month in which a request for reinstatement is filed.

“(ii) An individual whose entitlement to a benefit for any month would have been reinstated under this subsection had the individual filed a request for reinstatement before the end of such month

shall be entitled to such benefit for such month if such request for reinstatement is filed before the end of the twelfth month immediately succeeding such month.

“(B)(i) Subject to clauses (ii) and (iii), the amount of the benefit payable for any month pursuant to the reinstatement of entitlement under this subsection shall be determined in accordance with the provisions of this title.

“(ii) For purposes of computing the primary insurance amount of an individual whose entitlement to benefits under this section is reinstated under this subsection, the date of onset of the individual’s disability shall be the date of onset used in determining the individual’s most recent period of disability arising in connection with such benefits payable on the basis of an application.

“(iii) Benefits under this section or section 202 payable for any month pursuant to a request for reinstatement filed in accordance with paragraph (2) shall be reduced by the amount of any provisional benefit paid to such individual for such month under paragraph (7).

“(C) No benefit shall be payable pursuant to an entitlement reinstated under this subsection to an individual for any month in which the individual engages in substantial gainful activity.

“(D) The entitlement of any individual that is reinstated under this subsection shall end with the benefits payable for the month preceding whichever of the following months is the earliest:

“(i) The month in which the individual dies.

“(ii) The month in which the individual attains retirement age.

“(iii) The third month following the month in which the individual’s disability ceases.

“(5) Whenever an individual’s entitlement to benefits under this section is reinstated under this subsection, entitlement to benefits payable on the basis of such individual’s wages and self-employment income may be reinstated with respect to any person previously entitled to such benefits on the basis of an application if the Commissioner determines that such person satisfies all the requirements for entitlement to such benefits except requirements related to the filing of an application. The provisions of paragraph (4) shall apply to the reinstated entitlement of any such person to the same extent that they apply to the reinstated entitlement of such individual.

“(6) An individual to whom benefits are payable under this section or section 202 pursuant to a reinstatement of entitlement under this subsection for 24 months (whether or not consecutive) shall, with respect to benefits so payable after such twenty-fourth month, be deemed for purposes of paragraph (1)(B)(i)(I) and the determination, if appropriate, of the termination month in accordance with subsection (a)(1) of this section, or subsection (d)(1), (e)(1), or (f)(1) of section 202, to be entitled to such benefits on the basis of an application filed therefor.

“(7)(A) An individual described in paragraph (1)(B) who files a request for reinstatement in accordance with the provisions of paragraph (2)(A) shall be entitled to provisional benefits payable in accordance with this paragraph, unless the Commissioner determines that the individual does not meet the requirements of paragraph (1)(B)(i) or that the individual’s declaration under paragraph (2)(A)(ii) is false. Any such determination by the Commissioner

shall be final and not subject to review under subsection (b) or (g) of section 205.

“(B) The amount of a provisional benefit for a month shall equal the amount of the last monthly benefit payable to the individual under this title on the basis of an application increased by an amount equal to the amount, if any, by which such last monthly benefit would have been increased as a result of the operation of section 215(i).

“(C)(i) Provisional benefits shall begin with the month in which a request for reinstatement is filed in accordance with paragraph (2)(A).

“(ii) Provisional benefits shall end with the earliest of—

“(I) the month in which the Commissioner makes a determination regarding the individual’s entitlement to reinstated benefits;

“(II) the fifth month following the month described in clause (i);

“(III) the month in which the individual performs substantial gainful activity; or

“(IV) the month in which the Commissioner determines that the individual does not meet the requirements of paragraph (1)(B)(i) or that the individual’s declaration made in accordance with paragraph (2)(A)(ii) is false.

“(D) In any case in which the Commissioner determines that an individual is not entitled to reinstated benefits, any provisional benefits paid to the individual under this paragraph shall not be subject to recovery as an overpayment unless the Commissioner determines that the individual knew or should have known that the individual did not meet the requirements of paragraph (1)(B).”

(b) SSI BENEFITS.—

(1) IN GENERAL.—Section 1631 of the Social Security Act (42 U.S.C. 1383) is amended by adding at the end the following new subsection:

“Reinstatement of Eligibility on the Basis of Blindness or Disability

“(p)(1)(A) Eligibility for benefits under this title shall be reinstated in any case where the Commissioner determines that an individual described in subparagraph (B) has filed a request for reinstatement meeting the requirements of paragraph (2)(A) during the period prescribed in subparagraph (C). Reinstatement of eligibility shall be in accordance with the terms of this subsection.

“(B) An individual is described in this subparagraph if—

“(i) prior to the month in which the individual files a request for reinstatement—

“(I) the individual was eligible for benefits under this title on the basis of blindness or disability pursuant to an application filed therefor; and

“(II) the individual thereafter was ineligible for such benefits due to earned income (or earned and unearned income) for a period of 12 or more consecutive months;

“(ii) the individual is blind or disabled and the physical or mental impairment that is the basis for the finding of blindness or disability is the same as (or related to) the physical or mental impairment that was the basis for the finding of blindness or disability that gave rise to the eligibility described in clause (i);

“(iii) the individual’s blindness or disability renders the individual unable to perform substantial gainful activity; and

“(iv) the individual satisfies the nonmedical requirements for eligibility for benefits under this title.

“(C)(i) Except as provided in clause (ii), the period prescribed in this subparagraph with respect to an individual is 60 consecutive months beginning with the month following the most recent month for which the individual was eligible for a benefit under this title (including section 1619) prior to the period of ineligibility described in subparagraph (B)(i)(II).

“(ii) In the case of an individual who fails to file a reinstatement request within the period prescribed in clause (i), the Commissioner may extend the period if the Commissioner determines that the individual had good cause for the failure to so file.

“(2)(A)(i) A request for reinstatement shall be filed in such form, and containing such information, as the Commissioner may prescribe.

“(ii) A request for reinstatement shall include express declarations by the individual that the individual meets the requirements specified in clauses (ii) through (iv) of paragraph (1)(B).

“(B) A request for reinstatement filed in accordance with subparagraph (A) may constitute an application for benefits in the case of any individual who the Commissioner determines is not eligible for reinstated benefits under this subsection.

“(3) In determining whether an individual meets the requirements of paragraph (1)(B)(ii), the provisions of section 1614(a)(4) shall apply.

“(4)(A) Eligibility for benefits reinstated under this subsection shall commence with the benefit payable for the month following the month in which a request for reinstatement is filed.

“(B)(i) Subject to clause (ii), the amount of the benefit payable for any month pursuant to the reinstatement of eligibility under this subsection shall be determined in accordance with the provisions of this title.

“(ii) The benefit under this title payable for any month pursuant to a request for reinstatement filed in accordance with paragraph (2) shall be reduced by the amount of any provisional benefit paid to such individual for such month under paragraph (7).

“(C) Except as otherwise provided in this subsection, eligibility for benefits under this title reinstated pursuant to a request filed under paragraph (2) shall be subject to the same terms and conditions as eligibility established pursuant to an application filed therefor.

“(5) Whenever an individual’s eligibility for benefits under this title is reinstated under this subsection, eligibility for such benefits shall be reinstated with respect to the individual’s spouse if such spouse was previously an eligible spouse of the individual under this title and the Commissioner determines that such spouse satisfies all the requirements for eligibility for such benefits except requirements related to the filing of an application. The provisions of paragraph (4) shall apply to the reinstated eligibility of the spouse to the same extent that they apply to the reinstated eligibility of such individual.

“(6) An individual to whom benefits are payable under this title pursuant to a reinstatement of eligibility under this subsection for twenty-four months (whether or not consecutive) shall, with respect to benefits so payable after such twenty-fourth month, be

deemed for purposes of paragraph (1)(B)(i)(I) to be eligible for such benefits on the basis of an application filed therefor.

“(7)(A) An individual described in paragraph (1)(B) who files a request for reinstatement in accordance with the provisions of paragraph (2)(A) shall be eligible for provisional benefits payable in accordance with this paragraph, unless the Commissioner determines that the individual does not meet the requirements of paragraph (1)(B)(i) or that the individual’s declaration under paragraph (2)(A)(ii) is false. Any such determination by the Commissioner shall be final and not subject to review under paragraph (1) or (3) of subsection (c).

“(B)(i) Except as otherwise provided in clause (ii), the amount of a provisional benefit for a month shall equal the amount of the monthly benefit that would be payable to an eligible individual under this title with the same kind and amount of income.

“(ii) If the individual has a spouse who was previously an eligible spouse of the individual under this title and the Commissioner determines that such spouse satisfies all the requirements of section 1614(b) except requirements related to the filing of an application, the amount of a provisional benefit for a month shall equal the amount of the monthly benefit that would be payable to an eligible individual and eligible spouse under this title with the same kind and amount of income.

“(C)(i) Provisional benefits shall begin with the month following the month in which a request for reinstatement is filed in accordance with paragraph (2)(A).

“(ii) Provisional benefits shall end with the earliest of—

“(I) the month in which the Commissioner makes a determination regarding the individual’s eligibility for reinstated benefits;

“(II) the fifth month following the month for which provisional benefits are first payable under clause (i); or

“(III) the month in which the Commissioner determines that the individual does not meet the requirements of paragraph (1)(B)(i) or that the individual’s declaration made in accordance with paragraph (2)(A)(ii) is false.

“(D) In any case in which the Commissioner determines that an individual is not eligible for reinstated benefits, any provisional benefits paid to the individual under this paragraph shall not be subject to recovery as an overpayment unless the Commissioner determines that the individual knew or should have known that the individual did not meet the requirements of paragraph (1)(B).

“(8) For purposes of this subsection other than paragraph (7), the term ‘benefits under this title’ includes State supplementary payments made pursuant to an agreement under section 1616(a) of this Act or section 212(b) of Public Law 93-66.”.

(2) CONFORMING AMENDMENTS.—

(A) Section 1631(j)(1) of such Act (42 U.S.C. 1383(j)(1)) is amended by striking the period and inserting “, or has filed a request for reinstatement of eligibility under subsection (p)(2) and been determined to be eligible for reinstatement.”.

(B) Section 1631(j)(2)(A)(i)(I) of such Act (42 U.S.C. 1383(j)(2)(A)(i)(I)) is amended by inserting “(other than pursuant to a request for reinstatement under subsection (p))” after “eligible”.

(c) EFFECTIVE DATE.—

42 USC 423 note.

(1) **IN GENERAL.**—The amendments made by this section shall take effect on the first day of the thirteenth month beginning after the date of the enactment of this Act.

(2) **LIMITATION.**—No benefit shall be payable under title II or XVI on the basis of a request for reinstatement filed under section 223(i) or 1631(p) of the Social Security Act (42 U.S.C. 423(i), 1383(p)) before the effective date described in paragraph (1).

## Subtitle C—Work Incentives Planning, Assistance, and Outreach

### SEC. 121. WORK INCENTIVES OUTREACH PROGRAM.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 101 of this Act, is amended by adding after section 1148 the following new section:

#### “WORK INCENTIVES OUTREACH PROGRAM

##### “SEC. 1149. (a) ESTABLISHMENT.—

“(1) **IN GENERAL.**—The Commissioner, in consultation with the Ticket to Work and Work Incentives Advisory Panel established under section 101(f) of the Ticket to Work and Work Incentives Improvement Act of 1999, shall establish a community-based work incentives planning and assistance program for the purpose of disseminating accurate information to disabled beneficiaries on work incentives programs and issues related to such programs.

“(2) **GRANTS, COOPERATIVE AGREEMENTS, CONTRACTS, AND OUTREACH.**—Under the program established under this section, the Commissioner shall—

“(A) establish a competitive program of grants, cooperative agreements, or contracts to provide benefits planning and assistance, including information on the availability of protection and advocacy services, to disabled beneficiaries, including individuals participating in the Ticket to Work and Self-Sufficiency Program established under section 1148, the program established under section 1619, and other programs that are designed to encourage disabled beneficiaries to work;

“(B) conduct directly, or through grants, cooperative agreements, or contracts, ongoing outreach efforts to disabled beneficiaries (and to the families of such beneficiaries) who are potentially eligible to participate in Federal or State work incentive programs that are designed to assist disabled beneficiaries to work, including—

“(i) preparing and disseminating information explaining such programs; and

“(ii) working in cooperation with other Federal, State, and private agencies and nonprofit organizations that serve disabled beneficiaries, and with agencies and organizations that focus on vocational rehabilitation and work-related training and counseling;

“(C) establish a corps of trained, accessible, and responsive work incentives specialists within the Social Security

42 USC 1320b-20.

Administration who will specialize in disability work incentives under titles II and XVI for the purpose of disseminating accurate information with respect to inquiries and issues relating to work incentives to—

“(i) disabled beneficiaries;

“(ii) benefit applicants under titles II and XVI;

and

“(iii) individuals or entities awarded grants under subparagraphs (A) or (B); and

“(D) provide—

“(i) training for work incentives specialists and individuals providing planning assistance described in subparagraph (C); and

“(ii) technical assistance to organizations and entities that are designed to encourage disabled beneficiaries to return to work.

“(3) COORDINATION WITH OTHER PROGRAMS.—The responsibilities of the Commissioner established under this section shall be coordinated with other public and private programs that provide information and assistance regarding rehabilitation services and independent living supports and benefits planning for disabled beneficiaries including the program under section 1619, the plans for achieving self-support program (PASS), and any other Federal or State work incentives programs that are designed to assist disabled beneficiaries, including educational agencies that provide information and assistance regarding rehabilitation, school-to-work programs, transition services (as defined in, and provided in accordance with, the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.)), a one-stop delivery system established under subtitle B of title I of the Workforce Investment Act of 1998 (29 U.S.C. 2811 et seq.), and other services.

“(b) CONDITIONS.—

“(1) SELECTION OF ENTITIES.—

“(A) APPLICATION.—An entity shall submit an application for a grant, cooperative agreement, or contract to provide benefits planning and assistance to the Commissioner at such time, in such manner, and containing such information as the Commissioner may determine is necessary to meet the requirements of this section.

“(B) STATEWIDENESS.—The Commissioner shall ensure that the planning, assistance, and information described in paragraph (2) shall be available on a statewide basis.

“(C) ELIGIBILITY OF STATES AND PRIVATE ORGANIZATIONS.—

“(i) IN GENERAL.—The Commissioner may award a grant, cooperative agreement, or contract under this section to a State or a private agency or organization (other than Social Security Administration Field Offices and the State agency administering the State medicaid program under title XIX, including any agency or entity described in clause (ii), that the Commissioner determines is qualified to provide the planning, assistance, and information described in paragraph (2)).

“(ii) AGENCIES AND ENTITIES DESCRIBED.—The agencies and entities described in this clause are the following:

“(I) Any public or private agency or organization (including Centers for Independent Living established under title VII of the Rehabilitation Act of 1973 (29 U.S.C. 796 et seq.), protection and advocacy organizations, client assistance programs established in accordance with section 112 of the Rehabilitation Act of 1973 (29 U.S.C. 732), and State Developmental Disabilities Councils established in accordance with section 124 of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6024)) that the Commissioner determines satisfies the requirements of this section.

“(II) The State agency administering the State program funded under part A of title IV.

“(D) EXCLUSION FOR CONFLICT OF INTEREST.—The Commissioner may not award a grant, cooperative agreement, or contract under this section to any entity that the Commissioner determines would have a conflict of interest if the entity were to receive a grant, cooperative agreement, or contract under this section.

“(2) SERVICES PROVIDED.—A recipient of a grant, cooperative agreement, or contract to provide benefits planning and assistance shall select individuals who will act as planners and provide information, guidance, and planning to disabled beneficiaries on the—

“(A) availability and interrelation of any Federal or State work incentives programs designed to assist disabled beneficiaries that the individual may be eligible to participate in;

“(B) adequacy of any health benefits coverage that may be offered by an employer of the individual and the extent to which other health benefits coverage may be available to the individual; and

“(C) availability of protection and advocacy services for disabled beneficiaries and how to access such services.

“(3) AMOUNT OF GRANTS, COOPERATIVE AGREEMENTS, OR CONTRACTS.—

“(A) BASED ON POPULATION OF DISABLED BENEFICIARIES.—Subject to subparagraph (B), the Commissioner shall award a grant, cooperative agreement, or contract under this section to an entity based on the percentage of the population of the State where the entity is located who are disabled beneficiaries.

“(B) LIMITATIONS.—

“(i) PER GRANT.—No entity shall receive a grant, cooperative agreement, or contract under this section for a fiscal year that is less than \$50,000 or more than \$300,000.

“(ii) TOTAL AMOUNT FOR ALL GRANTS, COOPERATIVE AGREEMENTS, AND CONTRACTS.—The total amount of all grants, cooperative agreements, and contracts awarded under this section for a fiscal year may not exceed \$23,000,000.

“(4) ALLOCATION OF COSTS.—The costs of carrying out this section shall be paid from amounts made available for the administration of title II and amounts made available for the administration of title XVI, and shall be allocated among those amounts as appropriate.

“(c) DEFINITIONS.—In this section:

“(1) COMMISSIONER.—The term ‘Commissioner’ means the Commissioner of Social Security.

“(2) DISABLED BENEFICIARY.—The term ‘disabled beneficiary’ has the meaning given that term in section 1148(k)(2).

“(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section \$23,000,000 for each of the fiscal years 2000 through 2004.”.

**SEC. 122. STATE GRANTS FOR WORK INCENTIVES ASSISTANCE TO DISABLED BENEFICIARIES.**

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 121 of this Act, is amended by adding after section 1149 the following new section:

**“STATE GRANTS FOR WORK INCENTIVES ASSISTANCE TO DISABLED BENEFICIARIES**

“SEC. 1150. (a) IN GENERAL.—Subject to subsection (c), the Commissioner may make payments in each State to the protection and advocacy system established pursuant to part C of title I of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6041 et seq.) for the purpose of providing services to disabled beneficiaries.

“(b) SERVICES PROVIDED.—Services provided to disabled beneficiaries pursuant to a payment made under this section may include—

“(1) information and advice about obtaining vocational rehabilitation and employment services; and

“(2) advocacy or other services that a disabled beneficiary may need to secure or regain gainful employment.

“(c) APPLICATION.—In order to receive payments under this section, a protection and advocacy system shall submit an application to the Commissioner, at such time, in such form and manner, and accompanied by such information and assurances as the Commissioner may require.

“(d) AMOUNT OF PAYMENTS.—

“(1) IN GENERAL.—Subject to the amount appropriated for a fiscal year for making payments under this section, a protection and advocacy system shall not be paid an amount that is less than—

“(A) in the case of a protection and advocacy system located in a State (including the District of Columbia and Puerto Rico) other than Guam, American Samoa, the United States Virgin Islands, and the Commonwealth of the Northern Mariana Islands, the greater of—

“(i) \$100,000; or

“(ii)  $\frac{1}{3}$  of 1 percent of the amount available for payments under this section; and

“(B) in the case of a protection and advocacy system located in Guam, American Samoa, the United States Virgin Islands, and the Commonwealth of the Northern Mariana Islands, \$50,000.

42 USC 1320b-21.

“(2) INFLATION ADJUSTMENT.—For each fiscal year in which the total amount appropriated to carry out this section exceeds the total amount appropriated to carry out this section in the preceding fiscal year, the Commissioner shall increase each minimum payment under subparagraphs (A) and (B) of paragraph (1) by a percentage equal to the percentage increase in the total amount so appropriated to carry out this section.

“(e) ANNUAL REPORT.—Each protection and advocacy system that receives a payment under this section shall submit an annual report to the Commissioner and the Ticket to Work and Work Incentives Advisory Panel established under section 101(f) of the Ticket to Work and Work Incentives Improvement Act of 1999 on the services provided to individuals by the system.

“(f) FUNDING.—

“(1) ALLOCATION OF PAYMENTS.—Payments under this section shall be made from amounts made available for the administration of title II and amounts made available for the administration of title XVI, and shall be allocated among those amounts as appropriate.

“(2) CARRYOVER.—Any amounts allotted for payment to a protection and advocacy system under this section for a fiscal year shall remain available for payment to or on behalf of the protection and advocacy system until the end of the succeeding fiscal year.

“(g) DEFINITIONS.—In this section:

“(1) COMMISSIONER.—The term ‘Commissioner’ means the Commissioner of Social Security.

“(2) DISABLED BENEFICIARY.—The term ‘disabled beneficiary’ has the meaning given that term in section 1148(k)(2).

“(3) PROTECTION AND ADVOCACY SYSTEM.—The term ‘protection and advocacy system’ means a protection and advocacy system established pursuant to part C of title I of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6041 et seq.).

“(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section \$7,000,000 for each of the fiscal years 2000 through 2004.”

## TITLE II—EXPANDED AVAILABILITY OF HEALTH CARE SERVICES

### SEC. 201. EXPANDING STATE OPTIONS UNDER THE MEDICAID PROGRAM FOR WORKERS WITH DISABILITIES.

(a) IN GENERAL.—

(1) STATE OPTION TO ELIMINATE INCOME, ASSETS, AND RESOURCE LIMITATIONS FOR WORKERS WITH DISABILITIES BUYING INTO MEDICAID.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

- (A) in subclause (XIII), by striking “or” at the end;
- (B) in subclause (XIV), by adding “or” at the end;

and

- (C) by adding at the end the following new subclause:
  - “(XV) who, but for earnings in excess of the limit established under section 1905(q)(2)(B), would be considered to be receiving supplemental security income, who is at least 16, but less than

65, years of age, and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish.”

(2) STATE OPTION TO PROVIDE OPPORTUNITY FOR EMPLOYED INDIVIDUALS WITH A MEDICALLY IMPROVED DISABILITY TO BUY INTO MEDICAID.—

(A) ELIGIBILITY.—Section 1902(a)(10) (A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by paragraph (1), is amended—

(i) in subclause (XIV), by striking “or” at the end;

(ii) in subclause (XV), by adding “or” at the end;

and

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

“(XVI) who are employed individuals with a medically improved disability described in section 1905(v)(1) and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish, but only if the State provides medical assistance to individuals described in subclause (XV);”.

(B) DEFINITION OF EMPLOYED INDIVIDUALS WITH A MEDICALLY IMPROVED DISABILITY.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

“(v)(1) The term ‘employed individual with a medically improved disability’ means an individual who—

“(A) is at least 16, but less than 65, years of age;

“(B) is employed (as defined in paragraph (2));

“(C) ceases to be eligible for medical assistance under section 1902(a)(10)(A)(ii)(XV) because the individual, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be eligible for benefits under section 223(d) or 1614(a)(3); and

“(D) continues to have a severe medically determinable impairment, as determined under regulations of the Secretary.

“(2) For purposes of paragraph (1), an individual is considered to be ‘employed’ if the individual—

“(A) is earning at least the applicable minimum wage requirement under section 6 of the Fair Labor Standards Act (29 U.S.C. 206) and working at least 40 hours per month; or

“(B) is engaged in a work effort that meets substantial and reasonable threshold criteria for hours of work, wages, or other measures, as defined by the State and approved by the Secretary.”.

(C) CONFORMING AMENDMENT.—Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(i) in clause (x), by striking “or” at the end;

(ii) in clause (xi), by adding “or” at the end; and

(iii) by inserting after clause (xi), the following

new clause:

“(xii) employed individuals with a medically improved disability (as defined in subsection (v)),”.

(3) STATE AUTHORITY TO IMPOSE INCOME-RELATED PREMIUMS AND COST-SHARING.—Section 1916 of such Act (42 U.S.C. 1396o) is amended—

(A) in subsection (a), by striking “The State plan” and inserting “Subject to subsection (g), the State plan”; and

(B) by adding at the end the following new subsection: “(g) With respect to individuals provided medical assistance only under subclause (XV) or (XVI) of section 1902(a)(10)(A)(ii)—

“(1) a State may (in a uniform manner for individuals described in either such subclause)—

“(A) require such individuals to pay premiums or other cost-sharing charges set on a sliding scale based on income that the State may determine; and

“(B) require payment of 100 percent of such premiums for such year in the case of such an individual who has income for a year that exceeds 250 percent of the income official poverty line (referred to in subsection (c)(1)) applicable to a family of the size involved, except that in the case of such an individual who has income for a year that does not exceed 450 percent of such poverty line, such requirement may only apply to the extent such premiums do not exceed 7.5 percent of such income; and

“(2) such State shall require payment of 100 percent of such premiums for a year by such an individual whose adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986) for such year exceeds \$75,000, except that a State may choose to subsidize such premiums by using State funds which may not be federally matched under this title. In the case of any calendar year beginning after 2000, the dollar amount specified in paragraph (2) shall be increased in accordance with the provisions of section 215(i)(2)(A)(ii).”.

(4) PROHIBITION AGAINST SUPPLANTATION OF STATE FUNDS AND STATE FAILURE TO MAINTAIN EFFORT.—Section 1903(i) of such Act (42 U.S.C. 1396b(i)) is amended—

(A) by striking the period at the end of paragraph (19) and inserting “; or”; and

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

“(20) with respect to amounts expended for medical assistance provided to an individual described in subclause (XV) or (XVI) of section 1902(a)(10)(A)(ii) for a fiscal year unless the State demonstrates to the satisfaction of the Secretary that the level of State funds expended for such fiscal year for programs to enable working individuals with disabilities to work (other than for such medical assistance) is not less than the level expended for such programs during the most recent State fiscal year ending before the date of the enactment of this paragraph.”.

(b) CONFORMING AMENDMENTS.—Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)) is amended in the matter preceding subparagraph (A) by inserting “1902(a)(10)(A)(ii)(XV), 1902(a)(10)(A)(ii)(XVI),” before “1905(p)(1)”.

(c) GAO REPORT.—Not later than 3 years after the date of the enactment of this Act, the Comptroller General of the United States shall submit a report to the Congress regarding the amendments made by this section that examines—

Deadline.  
42 USC 1396a  
note.

(1) the extent to which higher health care costs for individuals with disabilities at higher income levels deter employment or progress in employment;

(2) whether such individuals have health insurance coverage or could benefit from the State option established under such amendments to provide a medicaid buy-in; and

(3) how the States are exercising such option, including—

(A) how such States are exercising the flexibility afforded them with regard to income disregards;

(B) what income and premium levels have been set;

(C) the degree to which States are subsidizing premiums above the dollar amount specified in section 1916(g)(2) of the Social Security Act (42 U.S.C. 1396o(g)(2)); and

(D) the extent to which there exists any crowd-out effect.

42 USC 1396a  
note.

(d) **EFFECTIVE DATE.**—The amendments made by this section apply to medical assistance for items and services furnished on or after October 1, 2000.

**SEC. 202. EXTENDING MEDICARE COVERAGE FOR OASDI DISABILITY BENEFIT RECIPIENTS.**

(a) **IN GENERAL.**—The next to last sentence of section 226(b) of the Social Security Act (42 U.S.C. 426) is amended by striking “24” and inserting “78”.

42 USC 426 note.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall be effective on and after October 1, 2000.

42 USC 426 note.

(c) **GAO REPORT.**—Not later than 5 years after the date of the enactment of this Act, the Comptroller General of the United States shall submit a report to the Congress that—

(1) examines the effectiveness and cost of the amendment made by subsection (a);

(2) examines the necessity and effectiveness of providing continuation of medicare coverage under section 226(b) of the Social Security Act (42 U.S.C. 426(b)) to individuals whose annual income exceeds the contribution and benefit base (as determined under section 230 of such Act (42 U.S.C. 430));

(3) examines the viability of providing the continuation of medicare coverage under such section 226(b) based on a sliding scale premium for individuals whose annual income exceeds such contribution and benefit base;

(4) examines the viability of providing the continuation of medicare coverage under such section 226(b) based on a premium buy-in by the beneficiary's employer in lieu of coverage under private health insurance;

(5) examines the interrelation between the use of the continuation of medicare coverage under such section 226(b) and the use of private health insurance coverage by individuals during the extended period; and

(6) recommends such legislative or administrative changes relating to the continuation of medicare coverage for recipients of social security disability benefits as the Comptroller General determines are appropriate.

42 USC 1320b-  
22.

**SEC. 203. GRANTS TO DEVELOP AND ESTABLISH STATE INFRASTRUCTURES TO SUPPORT WORKING INDIVIDUALS WITH DISABILITIES.**

(a) **ESTABLISHMENT.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall award grants described in subsection (b) to States to support the design, establishment, and operation of State infrastructures that provide items and services to support working individuals with disabilities.

(2) **APPLICATION.**—In order to be eligible for an award of a grant under this section, a State shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary shall require.

(3) **DEFINITION OF STATE.**—In this section, the term “State” means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the United States Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(b) **GRANTS FOR INFRASTRUCTURE AND OUTREACH.**—

(1) **IN GENERAL.**—Out of the funds appropriated under subsection (e), the Secretary shall award grants to States to—

(A) support the establishment, implementation, and operation of the State infrastructures described in subsection (a); and

(B) conduct outreach campaigns regarding the existence of such infrastructures.

(2) **ELIGIBILITY FOR GRANTS.**—

(A) **IN GENERAL.**—No State may receive a grant under this subsection unless the State demonstrates to the satisfaction of the Secretary that the State makes personal assistance services available under the State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to the extent necessary to enable individuals with disabilities to remain employed, including individuals described in section 1902(a)(10)(A)(ii)(XIII) of such Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XIII)) if the State has elected to provide medical assistance under such plan to such individuals.

(B) **DEFINITIONS.**—In this section:

(i) **EMPLOYED.**—The term “employed” means—

(I) earning at least the applicable minimum wage requirement under section 6 of the Fair Labor Standards Act (29 U.S.C. 206) and working at least 40 hours per month; or

(II) being engaged in a work effort that meets substantial and reasonable threshold criteria for hours of work, wages, or other measures, as defined and approved by the Secretary.

(ii) **PERSONAL ASSISTANCE SERVICES.**—The term “personal assistance services” means a range of services, provided by 1 or more persons, designed to assist an individual with a disability to perform daily activities on and off the job that the individual would typically perform if the individual did not have a disability. Such services shall be designed to increase the individual’s control in life and ability to perform everyday activities on or off the job.

(3) **DETERMINATION OF AWARDS.**—

(A) **IN GENERAL.**—Subject to subparagraph (B), the Secretary shall develop a methodology for awarding grants

to States under this section for a fiscal year in a manner that—

(i) rewards States for their efforts in encouraging individuals described in paragraph (2)(A) to be employed; and

(ii) does not provide a State that has not elected to provide medical assistance under title XIX of the Social Security Act to individuals described in section 1902(a)(10)(A)(ii)(XIII) of that Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XIII)) with proportionally more funds for a fiscal year than a State that has exercised such election.

(B) AWARD LIMITS.—

(i) MINIMUM AWARDS.—

(I) IN GENERAL.—Subject to subclause (II), no State with an approved application under this section shall receive a grant for a fiscal year that is less than \$500,000.

(II) PRO RATA REDUCTIONS.—If the funds appropriated under subsection (e) for a fiscal year are not sufficient to pay each State with an application approved under this section the minimum amount described in subclause (I), the Secretary shall pay each such State an amount equal to the pro rata share of the amount made available.

(ii) MAXIMUM AWARDS.—

(I) STATES THAT ELECTED OPTIONAL MEDICAID ELIGIBILITY.—No State that has an application that has been approved under this section and that has elected to provide medical assistance under title XIX of the Social Security Act to individuals described in section 1902(a)(10)(A)(ii)(XIII) of such Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XIII)) shall receive a grant for a fiscal year that exceeds 10 percent of the total expenditures by the State (including the reimbursed Federal share of such expenditures) for medical assistance provided under such title for such individuals, as estimated by the State and approved by the Secretary.

(II) OTHER STATES.—The Secretary shall determine, consistent with the limit described in subclause (I), a maximum award limit for a grant for a fiscal year for a State that has an application that has been approved under this section but that has not elected to provide medical assistance under title XIX of the Social Security Act to individuals described in section 1902(a)(10)(A)(ii)(XIII) of that Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XIII)).

(c) AVAILABILITY OF FUNDS.—

(1) FUNDS AWARDED TO STATES.—Funds awarded to a State under a grant made under this section for a fiscal year shall remain available until expended.

(2) FUNDS NOT AWARDED TO STATES.—Funds not awarded to States in the fiscal year for which they are appropriated shall remain available in succeeding fiscal years for awarding by the Secretary.

(d) **ANNUAL REPORT.**—A State that is awarded a grant under this section shall submit an annual report to the Secretary on the use of funds provided under the grant. Each report shall include the percentage increase in the number of title II disability beneficiaries, as defined in section 1148(k)(3) of the Social Security Act (as added by section 101(a) of this Act) in the State, and title XVI disability beneficiaries, as defined in section 1148(k)(4) of the Social Security Act (as so added) in the State who return to work.

(e) **APPROPRIATION.**—

(1) **IN GENERAL.**—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to make grants under this section—

(A) for fiscal year 2001, \$20,000,000;

(B) for fiscal year 2002, \$25,000,000;

(C) for fiscal year 2003, \$30,000,000;

(D) for fiscal year 2004, \$35,000,000;

(E) for fiscal year 2005, \$40,000,000; and

(F) for each of fiscal years 2006 through 2011, the amount appropriated for the preceding fiscal year increased by the percentage increase (if any) in the Consumer Price Index for All Urban Consumers (United States city average) for the preceding fiscal year.

(2) **BUDGET AUTHORITY.**—This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under paragraph (1).

(f) **RECOMMENDATION.**—Not later than October 1, 2010, the Secretary, in consultation with the Ticket to Work and Work Incentives Advisory Panel established by section 101(f) of this Act, shall submit a recommendation to the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate regarding whether the grant program established under this section should be continued after fiscal year 2011.

Deadline.

**SEC. 204. DEMONSTRATION OF COVERAGE UNDER THE MEDICAID PROGRAM OF WORKERS WITH POTENTIALLY SEVERE DISABILITIES.**

42 USC 1396a note.

(a) **STATE APPLICATION.**—A State may apply to the Secretary of Health and Human Services (in this section referred to as the “Secretary”) for approval of a demonstration project (in this section referred to as a “demonstration project”) under which up to a specified maximum number of individuals who are workers with a potentially severe disability (as defined in subsection (b)(1)) are provided medical assistance equal to—

(1) that provided under section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) to individuals described in section 1902(a)(10)(A)(ii)(XIII) of that Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XIII)); or

(2) in the case of a State that has not elected to provide medical assistance under that section to such individuals, such medical assistance as the Secretary determines is an appropriate equivalent to the medical assistance described in paragraph (1).

(b) **WORKER WITH A POTENTIALLY SEVERE DISABILITY DEFINED.**—For purposes of this section—

(1) IN GENERAL.—The term “worker with a potentially severe disability” means, with respect to a demonstration project, an individual who—

(A) is at least 16, but less than 65, years of age;

(B) has a specific physical or mental impairment that, as defined by the State under the demonstration project, is reasonably expected, but for the receipt of items and services described in section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), to become blind or disabled (as defined under section 1614(a) of the Social Security Act (42 U.S.C. 1382c(a))); and

(C) is employed (as defined in paragraph (2)).

(2) DEFINITION OF EMPLOYED.—An individual is considered to be “employed” if the individual—

(A) is earning at least the applicable minimum wage requirement under section 6 of the Fair Labor Standards Act (29 U.S.C. 206) and working at least 40 hours per month; or

(B) is engaged in a work effort that meets substantial and reasonable threshold criteria for hours of work, wages, or other measures, as defined under the demonstration project and approved by the Secretary.

(c) APPROVAL OF DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—Subject to paragraph (3), the Secretary shall approve applications under subsection (a) that meet the requirements of paragraph (2) and such additional terms and conditions as the Secretary may require. The Secretary may waive the requirement of section 1902(a)(1) of the Social Security Act (42 U.S.C. 1396a(a)(1)) to allow for sub-State demonstrations.

(2) TERMS AND CONDITIONS OF DEMONSTRATION PROJECTS.—The Secretary may not approve a demonstration project under this section unless the State provides assurances satisfactory to the Secretary that the following conditions are or will be met:

(A) MAINTENANCE OF STATE EFFORT.—Federal funds paid to a State pursuant to this section must be used to supplement, but not supplant, the level of State funds expended for workers with potentially severe disabilities under programs in effect for such individuals at the time the demonstration project is approved under this section.

(B) INDEPENDENT EVALUATION.—The State provides for an independent evaluation of the project.

(3) LIMITATIONS ON FEDERAL FUNDING.—

(A) APPROPRIATION.—

(i) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this section—

(I) \$42,000,000 for each of fiscal years 2001 through 2004; and

(II) \$41,000,000 for each of fiscal years 2005 and 2006.

(ii) BUDGET AUTHORITY.—Clause (i) constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under clause (i).

(B) **LIMITATION ON PAYMENTS.**—In no case may—

(i) the aggregate amount of payments made by the Secretary to States under this section exceed \$250,000,000;

(ii) the aggregate amount of payments made by the Secretary to States for administrative expenses relating to annual reports required under subsection (d) exceed \$2,000,000 of such \$250,000,000; or

(iii) payments be provided by the Secretary for a fiscal year after fiscal year 2009.

(C) **FUNDS ALLOCATED TO STATES.**—The Secretary shall allocate funds to States based on their applications and the availability of funds. Funds allocated to a State under a grant made under this section for a fiscal year shall remain available until expended.

(D) **FUNDS NOT ALLOCATED TO STATES.**—Funds not allocated to States in the fiscal year for which they are appropriated shall remain available in succeeding fiscal years for allocation by the Secretary using the allocation formula established under this section.

(E) **PAYMENTS TO STATES.**—The Secretary shall pay to each State with a demonstration project approved under this section, from its allocation under subparagraph (C), an amount for each quarter equal to the Federal medical assistance percentage (as defined in section 1905(b) of the Social Security Act (42 U.S.C. 1395d(b)) of expenditures in the quarter for medical assistance provided to workers with a potentially severe disability.

(d) **ANNUAL REPORT.**—A State with a demonstration project approved under this section shall submit an annual report to the Secretary on the use of funds provided under the grant. Each report shall include enrollment and financial statistics on—

(1) the total population of workers with potentially severe disabilities served by the demonstration project; and

(2) each population of such workers with a specific physical or mental impairment described in subsection (b)(1)(B) served by such project.

(e) **RECOMMENDATION.**—Not later than October 1, 2004, the Secretary shall submit a recommendation to the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate regarding whether the demonstration project established under this section should be continued after fiscal year 2006. Deadline.

(f) **STATE DEFINED.**—In this section, the term “State” has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

**SEC. 205. ELECTION BY DISABLED BENEFICIARIES TO SUSPEND MEDIGAP INSURANCE WHEN COVERED UNDER A GROUP HEALTH PLAN.**

(a) **IN GENERAL.**—Section 1882(q) of the Social Security Act (42 U.S.C. 1395ss(q)) is amended—

(1) in paragraph (5)(C), by inserting “or paragraph (6)” after “this paragraph”; and

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

“(6) Each medicare supplemental policy shall provide that benefits and premiums under the policy shall be suspended

at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) and is covered under a group health plan (as defined in section 1862(b)(1)(A)(v)). If such suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, such policy shall be automatically reinstated (effective as of the date of such loss of coverage) under terms described in subsection (n)(6)(A)(ii) as of the loss of such coverage if the policyholder provides notice of loss of such coverage within 90 days after the date of such loss.”.

42 USC 1395ss  
note.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) apply with respect to requests made after the date of the enactment of this Act.

### **TITLE III—DEMONSTRATION PROJECTS AND STUDIES**

#### **SEC. 301. EXTENSION OF DISABILITY INSURANCE PROGRAM DEMONSTRATION PROJECT AUTHORITY.**

(a) **EXTENSION OF AUTHORITY.**—Title II of the Social Security Act (42 U.S.C. 401 et seq.) is amended by adding at the end the following new section:

##### **“DEMONSTRATION PROJECT AUTHORITY**

42 USC 434.

**“SEC. 234. (a) AUTHORITY.**—

**“(1) IN GENERAL.**—The Commissioner of Social Security (in this section referred to as the ‘Commissioner’) shall develop and carry out experiments and demonstration projects designed to determine the relative advantages and disadvantages of—

**“(A) various alternative methods of treating the work activity of individuals entitled to disability insurance benefits under section 223 or to monthly insurance benefits under section 202 based on such individual’s disability (as defined in section 223(d)), including such methods as a reduction in benefits based on earnings, designed to encourage the return to work of such individuals;**

**“(B) altering other limitations and conditions applicable to such individuals (including lengthening the trial work period (as defined in section 222(c)), altering the 24-month waiting period for hospital insurance benefits under section 226, altering the manner in which the program under this title is administered, earlier referral of such individuals for rehabilitation, and greater use of employers and others to develop, perform, and otherwise stimulate new forms of rehabilitation); and**

**“(C) implementing sliding scale benefit offsets using variations in—**

**“(i) the amount of the offset as a proportion of earned income;**

**“(ii) the duration of the offset period; and**

**“(iii) the method of determining the amount of income earned by such individuals,**

**to the end that savings will accrue to the Trust Funds, or to otherwise promote the objectives or facilitate the administration of this title.**

“(2) AUTHORITY FOR EXPANSION OF SCOPE.—The Commissioner may expand the scope of any such experiment or demonstration project to include any group of applicants for benefits under the program established under this title with impairments that reasonably may be presumed to be disabling for purposes of such demonstration project, and may limit any such demonstration project to any such group of applicants, subject to the terms of such demonstration project which shall define the extent of any such presumption.

“(b) REQUIREMENTS.—The experiments and demonstration projects developed under subsection (a) shall be of sufficient scope and shall be carried out on a wide enough scale to permit a thorough evaluation of the alternative methods under consideration while giving assurance that the results derived from the experiments and projects will obtain generally in the operation of the disability insurance program under this title without committing such program to the adoption of any particular system either locally or nationally.

“(c) AUTHORITY TO WAIVE COMPLIANCE WITH BENEFITS REQUIREMENTS.—In the case of any experiment or demonstration project conducted under subsection (a), the Commissioner may waive compliance with the benefit requirements of this title and the requirements of section 1148 as they relate to the program established under this title, and the Secretary may (upon the request of the Commissioner) waive compliance with the benefits requirements of title XVIII, insofar as is necessary for a thorough evaluation of the alternative methods under consideration. No such experiment or project shall be actually placed in operation unless at least 90 days prior thereto a written report, prepared for purposes of notification and information only and containing a full and complete description thereof, has been transmitted by the Commissioner to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate. Periodic reports on the progress of such experiments and demonstration projects shall be submitted by the Commissioner to such committees. When appropriate, such reports shall include detailed recommendations for changes in administration or law, or both, to carry out the objectives stated in subsection (a).

“(d) REPORTS.—

“(1) INTERIM REPORTS.—On or before June 9 of each year, the Commissioner shall submit to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate an annual interim report on the progress of the experiments and demonstration projects carried out under this subsection together with any related data and materials that the Commissioner may consider appropriate.

Deadline.

“(2) TERMINATION AND FINAL REPORT.—The authority under the preceding provisions of this section (including any waiver granted pursuant to subsection (c)) shall terminate 5 years after the date of the enactment of this Act. Not later than 90 days after the termination of any experiment or demonstration project carried out under this section, the Commissioner shall submit to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate a final report with respect to that experiment or demonstration project.”.

## (b) CONFORMING AMENDMENTS; TRANSFER OF PRIOR AUTHORITY.—

## (1) CONFORMING AMENDMENTS.—

(A) REPEAL OF PRIOR AUTHORITY.—Paragraphs (1) through (4) of subsection (a) and subsection (c) of section 505 of the Social Security Disability Amendments of 1980 (42 U.S.C. 1310 note) are repealed.

(B) CONFORMING AMENDMENT REGARDING FUNDING.—Section 201(k) of the Social Security Act (42 U.S.C. 401(k)) is amended by striking “section 505(a) of the Social Security Disability Amendments of 1980” and inserting “section 234”.

42 USC 1310  
note.

(2) TRANSFER OF PRIOR AUTHORITY.—With respect to any experiment or demonstration project being conducted under section 505(a) of the Social Security Disability Amendments of 1980 (42 U.S.C. 1310 note) as of the date of the enactment of this Act, the authority to conduct such experiment or demonstration project (including the terms and conditions applicable to the experiment or demonstration project) shall be treated as if that authority (and such terms and conditions) had been established under section 234 of the Social Security Act, as added by subsection (a).

42 USC 434 note.

**SEC. 302. DEMONSTRATION PROJECTS PROVIDING FOR REDUCTIONS IN DISABILITY INSURANCE BENEFITS BASED ON EARNINGS.**

(a) AUTHORITY.—The Commissioner of Social Security shall conduct demonstration projects for the purpose of evaluating, through the collection of data, a program for title II disability beneficiaries (as defined in section 1148(k)(3) of the Social Security Act) under which benefits payable under section 223 of such Act, or under section 202 of such Act based on the beneficiary's disability, are reduced by \$1 for each \$2 of the beneficiary's earnings that is above a level to be determined by the Commissioner. Such projects shall be conducted at a number of localities which the Commissioner shall determine is sufficient to adequately evaluate the appropriateness of national implementation of such a program. Such projects shall identify reductions in Federal expenditures that may result from the permanent implementation of such a program.

## (b) SCOPE AND SCALE AND MATTERS TO BE DETERMINED.—

(1) IN GENERAL.—The demonstration projects developed under subsection (a) shall be of sufficient duration, shall be of sufficient scope, and shall be carried out on a wide enough scale to permit a thorough evaluation of the project to determine—

(A) the effects, if any, of induced entry into the project and reduced exit from the project;

(B) the extent, if any, to which the project being tested is affected by whether it is in operation in a locality within an area under the administration of the Ticket to Work and Self-Sufficiency Program established under section 1148 of the Social Security Act; and

(C) the savings that accrue to the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, and other Federal programs under the project being tested.

The Commissioner shall take into account advice provided by the Ticket to Work and Work Incentives Advisory Panel pursuant to section 101(f)(2)(B)(ii) of this Act.

(2) ADDITIONAL MATTERS.—The Commissioner shall also determine with respect to each project—

(A) the annual cost (including net cost) of the project and the annual cost (including net cost) that would have been incurred in the absence of the project;

(B) the determinants of return to work, including the characteristics of the beneficiaries who participate in the project; and

(C) the employment outcomes, including wages, occupations, benefits, and hours worked, of beneficiaries who return to work as a result of participation in the project.

The Commissioner may include within the matters evaluated under the project the merits of trial work periods and periods of extended eligibility.

(c) WAIVERS.—The Commissioner may waive compliance with the benefit provisions of title II of the Social Security Act (42 U.S.C. 401 et seq.), and the Secretary of Health and Human Services may waive compliance with the benefit requirements of title XVIII of such Act (42 U.S.C. 1395 et seq.), insofar as is necessary for a thorough evaluation of the alternative methods under consideration. No such project shall be actually placed in operation unless at least 90 days prior thereto a written report, prepared for purposes of notification and information only and containing a full and complete description thereof, has been transmitted by the Commissioner to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate. Periodic reports on the progress of such projects shall be submitted by the Commissioner to such committees. When appropriate, such reports shall include detailed recommendations for changes in administration or law, or both, to carry out the objectives stated in subsection (a).

Reports.

(d) INTERIM REPORTS.—Not later than 2 years after the date of the enactment of this Act, and annually thereafter, the Commissioner of Social Security shall submit to the Congress an interim report on the progress of the demonstration projects carried out under this subsection together with any related data and materials that the Commissioner of Social Security may consider appropriate.

Deadline.

(e) FINAL REPORT.—The Commissioner of Social Security shall submit to the Congress a final report with respect to all demonstration projects carried out under this section not later than 1 year after their completion.

Deadline.

(f) EXPENDITURES.—Expenditures made for demonstration projects under this section shall be made from the Federal Disability Insurance Trust Fund and the Federal Old-Age and Survivors Insurance Trust Fund, as determined appropriate by the Commissioner of Social Security, and from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as determined appropriate by the Secretary of Health and Human Services, to the extent provided in advance in appropriation Acts.

#### SEC. 303. STUDIES AND REPORTS.

(a) STUDY BY GENERAL ACCOUNTING OFFICE OF EXISTING DISABILITY-RELATED EMPLOYMENT INCENTIVES.—

42 USC 1201  
note.

(1) STUDY.—As soon as practicable after the date of the enactment of this Act, the Comptroller General of the United States shall undertake a study to assess existing tax credits and other disability-related employment incentives under the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.) and other Federal laws. In such study, the Comptroller General shall specifically address the extent to which such credits and other incentives would encourage employers to hire and retain individuals with disabilities.

Deadline.

(2) REPORT.—Not later than 3 years after the date of the enactment of this Act, the Comptroller General shall transmit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a written report presenting the results of the Comptroller General's study conducted pursuant to this subsection, together with such recommendations for legislative or administrative changes as the Comptroller General determines are appropriate.

42 USC 401 note.

(b) STUDY BY GENERAL ACCOUNTING OFFICE OF EXISTING COORDINATION OF THE DI AND SSI PROGRAMS AS THEY RELATE TO INDIVIDUALS ENTERING OR LEAVING CONCURRENT ENTITLEMENT.—

(1) STUDY.—As soon as practicable after the date of the enactment of this Act, the Comptroller General of the United States shall undertake a study to evaluate the coordination under current law of the disability insurance program under title II of the Social Security Act (42 U.S.C. 401 et seq.) and the supplemental security income program under title XVI of such Act (42 U.S.C. 1381 et seq.), as such programs relate to individuals entering or leaving concurrent entitlement under such programs. In such study, the Comptroller General shall specifically address the effectiveness of work incentives under such programs with respect to such individuals and the effectiveness of coverage of such individuals under titles XVIII and XIX of such Act (42 U.S.C. 1395 et seq., 1396 et seq.).

(2) REPORT.—Not later than 3 years after the date of the enactment of this Act, the Comptroller General shall transmit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a written report presenting the results of the Comptroller General's study conducted pursuant to this subsection, together with such recommendations for legislative or administrative changes as the Comptroller General determines are appropriate.

42 USC 434 note.

(c) STUDY BY GENERAL ACCOUNTING OFFICE OF THE IMPACT OF THE SUBSTANTIAL GAINFUL ACTIVITY LIMIT ON RETURN TO WORK.—

(1) STUDY.—As soon as practicable after the date of the enactment of this Act, the Comptroller General of the United States shall undertake a study of the substantial gainful activity level applicable as of that date to recipients of benefits under section 223 of the Social Security Act (42 U.S.C. 423) and under section 202 of such Act (42 U.S.C. 402) on the basis of a recipient having a disability, and the effect of such level as a disincentive for those recipients to return to work. In the study, the Comptroller General also shall address the merits of increasing the substantial gainful activity level

applicable to such recipients of benefits and the rationale for not yearly indexing that level to inflation.

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General shall transmit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a written report presenting the results of the Comptroller General's study conducted pursuant to this subsection, together with such recommendations for legislative or administrative changes as the Comptroller General determines are appropriate. Deadline.

(d) REPORT ON DISREGARDS UNDER THE DI AND SSI PROGRAMS.—Not later than 90 days after the date of the enactment of this Act, the Commissioner of Social Security shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that— Deadline.

(1) identifies all income, assets, and resource disregards (imposed under statutory or regulatory authority) that are applicable to individuals receiving benefits under title II or XVI of the Social Security Act (42 U.S.C. 401 et seq., 1381 et seq.);

(2) with respect to each such disregard—

(A) specifies the most recent statutory or regulatory modification of the disregard; and

(B) recommends whether further statutory or regulatory modification of the disregard would be appropriate; and

(3) with respect to the disregard described in section 1612(b)(7) of such Act (42 U.S.C. 1382a(b)(7)) (relating to grants, scholarships, or fellowships received for use in paying the cost of tuition and fees at any educational (including technical or vocational education) institution)—

(A) identifies the number of individuals receiving benefits under title XVI of such Act (42 U.S.C. 1381 et seq.) who have attained age 22 and have not had any portion of any grant, scholarship, or fellowship received for use in paying the cost of tuition and fees at any educational (including technical or vocational education) institution excluded from their income in accordance with that section;

(B) recommends whether the age at which such grants, scholarships, or fellowships are excluded from income for purposes of determining eligibility under title XVI of such Act (42 U.S.C. 1381 et seq.) should be increased to age 25; and

(C) recommends whether such disregard should be expanded to include any such grant, scholarship, or fellowship received for use in paying the cost of room and board at any such institution.

(e) STUDY BY THE GENERAL ACCOUNTING OFFICE OF SOCIAL SECURITY ADMINISTRATION'S DISABILITY INSURANCE PROGRAM DEMONSTRATION AUTHORITY.— 42 USC 434 note.

(1) STUDY.—As soon as practicable after the date of the enactment of this Act, the Comptroller General of the United States shall undertake a study to assess the results of the Social Security Administration's efforts to conduct disability demonstrations authorized under prior law as well as under

section 234 of the Social Security Act (as added by section 301 of this Act).

Deadline.

(2) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Comptroller General shall transmit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a written report presenting the results of the Comptroller General's study conducted pursuant to this section, together with a recommendation as to whether the demonstration authority authorized under section 234 of the Social Security Act (as added by section 301 of this Act) should be made permanent.

## TITLE IV—MISCELLANEOUS AND TECHNICAL AMENDMENTS

### SEC. 401. TECHNICAL AMENDMENTS RELATING TO DRUG ADDICTS AND ALCOHOLICS.

(a) CLARIFICATION RELATING TO THE EFFECTIVE DATE OF THE DENIAL OF SOCIAL SECURITY DISABILITY BENEFITS TO DRUG ADDICTS AND ALCOHOLICS.—Section 105(a)(5) of the Contract with America Advancement Act of 1996 (42 U.S.C. 405 note) is amended—

(1) in subparagraph (A), by striking “by the Commissioner of Social Security” and “by the Commissioner”; and

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

“(D) For purposes of this paragraph, an individual's claim, with respect to benefits under title II based on disability, which has been denied in whole before the date of the enactment of this Act, may not be considered to be finally adjudicated before such date if, on or after such date—

“(i) there is pending a request for either administrative or judicial review with respect to such claim; or

“(ii) there is pending, with respect to such claim, a readjudication by the Commissioner of Social Security pursuant to relief in a class action or implementation by the Commissioner of a court remand order.

“(E) Notwithstanding the provisions of this paragraph, with respect to any individual for whom the Commissioner of Social Security does not perform the entitlement redetermination before the date prescribed in subparagraph (C), the Commissioner shall perform such entitlement redetermination in lieu of a continuing disability review whenever the Commissioner determines that the individual's entitlement is subject to redetermination based on the preceding provisions of this paragraph, and the provisions of section 223(f) shall not apply to such redetermination.”

(b) CORRECTION TO EFFECTIVE DATE OF PROVISIONS CONCERNING REPRESENTATIVE PAYEES AND TREATMENT REFERRALS OF SOCIAL SECURITY BENEFICIARIES WHO ARE DRUG ADDICTS AND ALCOHOLICS.—Section 105(a)(5)(B) of the Contract with America Advancement Act of 1996 (42 U.S.C. 405 note) is amended to read as follows:

“(B) The amendments made by paragraphs (2) and (3) shall take effect on July 1, 1996, with respect to any individual—

“(i) whose claim for benefits is finally adjudicated on or after the date of the enactment of this Act; or

“(ii) whose entitlement to benefits is based upon an entitlement redetermination made pursuant to subparagraph (C).”

(c) EFFECTIVE DATES.—The amendments made by this section shall take effect as if included in the enactment of section 105 of the Contract with America Advancement Act of 1996 (Public Law 104-121; 110 Stat. 852 et seq.).

42 USC 405 note.

**SEC. 402. TREATMENT OF PRISONERS.**

(a) IMPLEMENTATION OF PROHIBITION AGAINST PAYMENT OF TITLE II BENEFITS TO PRISONERS.—

(1) IN GENERAL.—Section 202(x)(3) of the Social Security Act (42 U.S.C. 402(x)(3)) is amended—

(A) by inserting “(A)” after “(3)”; and

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

“(B)(i) The Commissioner shall enter into an agreement under this subparagraph with any interested State or local institution comprising a jail, prison, penal institution, or correctional facility, or comprising any other institution a purpose of which is to confine individuals as described in paragraph (1)(A)(ii). Under such agreement—

“(I) the institution shall provide to the Commissioner, on a monthly basis and in a manner specified by the Commissioner, the names, Social Security account numbers, dates of birth, confinement commencement dates, and, to the extent available to the institution, such other identifying information concerning the individuals confined in the institution as the Commissioner may require for the purpose of carrying out paragraph (1) and other provisions of this title; and

“(II) the Commissioner shall pay to the institution, with respect to information described in subclause (I) concerning each individual who is confined therein as described in paragraph (1)(A), who receives a benefit under this title for the month preceding the first month of such confinement, and whose benefit under this title is determined by the Commissioner to be not payable by reason of confinement based on the information provided by the institution, \$400 (subject to reduction under clause (ii)) if the institution furnishes the information to the Commissioner within 30 days after the date such individual’s confinement in such institution begins, or \$200 (subject to reduction under clause (ii)) if the institution furnishes the information after 30 days after such date but within 90 days after such date.

“(ii) The dollar amounts specified in clause (i)(II) shall be reduced by 50 percent if the Commissioner is also required to make a payment to the institution with respect to the same individual under an agreement entered into under section 1611(e)(1)(I).

“(iii) There are authorized to be transferred from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, as appropriate, such sums as may be necessary to enable the Commissioner to make payments to institutions required by clause (i)(II).

“(iv) The Commissioner shall maintain, and shall provide on a reimbursable basis, information obtained pursuant to agreements entered into under this paragraph to any agency administering a Federal or federally-assisted cash, food, or medical assistance program for eligibility and other administrative purposes under such program.”.

(2) CONFORMING AMENDMENTS TO THE PRIVACY ACT.—Section 552a(a)(8)(B) of title 5, United States Code, is amended—

(A) in clause (vi), by striking “or” at the end;

(B) in clause (vii), by adding “or” at the end; and

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

“(viii) matches performed pursuant to section 202(x)(3) or 1611(e)(1) of the Social Security Act (42 U.S.C. 402(x)(3), 1382(e)(1));”.

(3) CONFORMING AMENDMENTS TO TITLE XVI.—

(A) Section 1611(e)(1)(I)(i)(I) of the Social Security Act (42 U.S.C. 1382(e)(1)(I)(i)(I)) is amended by striking “; and” and inserting “and the other provisions of this title; and”.

(B) Section 1611(e)(1)(I)(ii)(II) of such Act (42 U.S.C. 1382(e)(1)(I)(ii)(II)) is amended by striking “is authorized to provide, on a reimbursable basis,” and inserting “shall maintain, and shall provide on a reimbursable basis,”.

42 USC 402 note.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to individuals whose period of confinement in an institution commences on or after the first day of the fourth month beginning after the month in which this Act is enacted.

(b) ELIMINATION OF TITLE II REQUIREMENT THAT CONFINEMENT STEM FROM CRIME PUNISHABLE BY IMPRISONMENT FOR MORE THAN 1 YEAR.—

(1) IN GENERAL.—Section 202(x)(1)(A) of the Social Security Act (42 U.S.C. 402(x)(1)(A)) is amended—

(A) in the matter preceding clause (i), by striking “during which” and inserting “ending with or during or beginning with or during a period of more than 30 days throughout all of which”;

(B) in clause (i), by striking “an offense punishable by imprisonment for more than 1 year (regardless of the actual sentence imposed)” and inserting “a criminal offense”; and

(C) in clause (ii)(I), by striking “an offense punishable by imprisonment for more than 1 year” and inserting “a criminal offense”.

42 USC 402 note.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to individuals whose period of confinement in an institution commences on or after the first day of the fourth month beginning after the month in which this Act is enacted.

(c) CONFORMING TITLE XVI AMENDMENTS.—

(1) FIFTY PERCENT REDUCTION IN TITLE XVI PAYMENT IN CASE INVOLVING COMPARABLE TITLE II PAYMENT.—Section 1611(e)(1)(I) of the Social Security Act (42 U.S.C. 1382(e)(1)(I)) is amended—

(A) in clause (i)(II), by inserting “(subject to reduction under clause (ii))” after “\$400” and after “\$200”;

(B) by redesignating clauses (ii) and (iii) as clauses (iii) and (iv) respectively; and

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

“(ii) The dollar amounts specified in clause (i)(II) shall be reduced by 50 percent if the Commissioner is also required to make a payment to the institution with respect to the same individual under an agreement entered into under section 202(x)(3)(B).”.

(2) EXPANSION OF CATEGORIES OF INSTITUTIONS ELIGIBLE TO ENTER INTO AGREEMENTS WITH THE COMMISSIONER.—Section 1611(e)(1)(I)(i) of such Act (42 U.S.C. 1382(e)(1)(I)(i)) is amended in the matter preceding subclause (I) by striking “institution” and all that follows through “section 202(x)(1)(A),” and inserting “institution comprising a jail, prison, penal institution, or correctional facility, or with any other interested State or local institution a purpose of which is to confine individuals as described in section 202(x)(1)(A)(ii).”.

(3) ELIMINATION OF OVERLY BROAD EXEMPTION.—Section 1611(e)(1)(I)(iii) of such Act (42 U.S.C. 1382(e)(1)(I)(iii)) (as redesignated by paragraph (1)(B)) is amended further—

(A) by striking “(I) The provisions” and all that follows through “(II)”; and

(B) by striking “eligibility purposes” and inserting “eligibility and other administrative purposes under such program”.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall take effect as if included in the enactment of section 203(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193; 110 Stat. 2186). The reference to section 202(x)(1)(A)(ii) of the Social Security Act in section 1611(e)(1)(I)(i) of the Social Security Act, as amended by paragraph (2) of this subsection, shall be deemed a reference to such section 202(x)(1)(A)(ii) of such Act as amended by subsection (b)(1)(C) of this section.

42 USC 1382  
note.

(d) CONTINUED DENIAL OF BENEFITS TO SEX OFFENDERS REMAINING CONFINED TO PUBLIC INSTITUTIONS UPON COMPLETION OF PRISON TERM.—

(1) IN GENERAL.—Section 202(x)(1)(A) of the Social Security Act (42 U.S.C. 402(x)(1)(A)) is amended—

(A) in clause (i), by striking “or” at the end;

(B) in clause (ii)(IV), by striking the period and inserting “, or”; and

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

“(iii) immediately upon completion of confinement as described in clause (i) pursuant to conviction of a criminal offense an element of which is sexual activity, is confined by court order in an institution at public expense pursuant to a finding that the individual is a sexually dangerous person or a sexual predator or a similar finding.”.

(2) CONFORMING AMENDMENT.—Section 202(x)(1)(B)(ii) of such Act (42 U.S.C. 402(x)(1)(B)(ii)) is amended by striking “clause (ii)” and inserting “clauses (ii) and (iii)”.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to benefits for months ending after the date of the enactment of this Act.

42 USC 402 note.

26 USC 1402  
note.

**SEC. 403. REVOCATION BY MEMBERS OF THE CLERGY OF EXEMPTION FROM SOCIAL SECURITY COVERAGE.**

(a) **IN GENERAL.**—Notwithstanding section 1402(e)(4) of the Internal Revenue Code of 1986, any exemption which has been received under section 1402(e)(1) of such Code by a duly ordained, commissioned, or licensed minister of a church, a member of a religious order, or a Christian Science practitioner, and which is effective for the taxable year in which this Act is enacted, may be revoked by filing an application therefor (in such form and manner, and with such official, as may be prescribed by the Commissioner of Internal Revenue), if such application is filed no later than the due date of the Federal income tax return (including any extension thereof) for the applicant's second taxable year beginning after December 31, 1999. Any such revocation shall be effective (for purposes of chapter 2 of the Internal Revenue Code of 1986 and title II of the Social Security Act (42 U.S.C. 401 et seq.)), as specified in the application, either with respect to the applicant's first taxable year beginning after December 31, 1999, or with respect to the applicant's second taxable year beginning after such date, and for all succeeding taxable years; and the applicant for any such revocation may not thereafter again file application for an exemption under such section 1402(e)(1). If the application is filed after the due date of the applicant's Federal income tax return for a taxable year and is effective with respect to that taxable year, it shall include or be accompanied by payment in full of an amount equal to the total of the taxes that would have been imposed by section 1401 of the Internal Revenue Code of 1986 with respect to all of the applicant's income derived in that taxable year which would have constituted net earnings from self-employment for purposes of chapter 2 of such Code (notwithstanding paragraphs (4) and (5) of section 1402(c)) except for the exemption under section 1402(e)(1) of such Code.

(b) **EFFECTIVE DATE.**—Subsection (a) shall apply with respect to service performed (to the extent specified in such subsection) in taxable years beginning after December 31, 1999, and with respect to monthly insurance benefits payable under title II on the basis of the wages and self-employment income of any individual for months in or after the calendar year in which such individual's application for revocation (as described in such subsection) is effective (and lump-sum death payments payable under such title on the basis of such wages and self-employment income in the case of deaths occurring in or after such calendar year).

**SEC. 404. ADDITIONAL TECHNICAL AMENDMENT RELATING TO COOPERATIVE RESEARCH OR DEMONSTRATION PROJECTS UNDER TITLES II AND XVI.**

(a) **IN GENERAL.**—Section 1110(a)(3) of the Social Security Act (42 U.S.C. 1310(a)(3)) is amended by striking "title XVI" and inserting "title II or XVI".

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect as if included in the enactment of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103-296; 108 Stat. 1464).

42 USC 1310  
note.

**SEC. 405. AUTHORIZATION FOR STATE TO PERMIT ANNUAL WAGE REPORTS.**

(a) **IN GENERAL.**—Section 1137(a)(3) of the Social Security Act (42 U.S.C. 1320b-7(a)(3)) is amended by inserting before the semicolon the following: “, and except that in the case of wage reports with respect to domestic service employment, a State may permit employers (as so defined) that make returns with respect to such employment on a calendar year basis pursuant to section 3510 of the Internal Revenue Code of 1986 to make such reports on an annual basis”.

(b) **TECHNICAL AMENDMENTS.**—Section 1137(a)(3) of the Social Security Act (42 U.S.C. 1320b-7(a)(3)) is amended—

(1) by striking “(as defined in section 453A(a)(2)(B)(iii))”;

and

(2) by inserting “(as defined in section 453A(a)(2)(B))” after “employers”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to wage reports required to be submitted on and after the date of the enactment of this Act. 42 USC 1320b-7 note.

**SEC. 406. ASSESSMENT ON ATTORNEYS WHO RECEIVE THEIR FEES VIA THE SOCIAL SECURITY ADMINISTRATION.**

(a) **ASSESSMENT ON ATTORNEYS.**—

(1) **IN GENERAL.**—Section 206 of the Social Security Act (42 U.S.C. 406) is amended by adding at the end the following new subsection:

“(d) **ASSESSMENT ON ATTORNEYS.**—

“(1) **IN GENERAL.**—Whenever a fee for services is required to be certified for payment to an attorney from a claimant’s past-due benefits pursuant to subsection (a)(4) or (b)(1), the Commissioner shall impose on the attorney an assessment calculated in accordance with paragraph (2).

“(2) **AMOUNT.**—

“(A) The amount of an assessment under paragraph (1) shall be equal to the product obtained by multiplying the amount of the representative’s fee that would be required to be so certified by subsection (a)(4) or (b)(1) before the application of this subsection, by the percentage specified in subparagraph (B).

“(B) The percentage specified in this subparagraph is—

“(i) for calendar years before 2001, 6.3 percent,

and

“(ii) for calendar years after 2000, such percentage rate as the Commissioner determines is necessary in order to achieve full recovery of the costs of determining and certifying fees to attorneys from the past-due benefits of claimants, but not in excess of 6.3 percent.

“(3) **COLLECTION.**—The Commissioner may collect the assessment imposed on an attorney under paragraph (1) by offset from the amount of the fee otherwise required by subsection (a)(4) or (b)(1) to be certified for payment to the attorney from a claimant’s past-due benefits.

“(4) **PROHIBITION ON CLAIMANT REIMBURSEMENT.**—An attorney subject to an assessment under paragraph (1) may not, directly or indirectly, request or otherwise obtain

reimbursement for such assessment from the claimant whose claim gave rise to the assessment.

“(5) DISPOSITION OF ASSESSMENTS.—Assessments on attorneys collected under this subsection shall be credited to the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, as appropriate.

“(6) AUTHORIZATION OF APPROPRIATIONS.—The assessments authorized under this section shall be collected and available for obligation only to the extent and in the amount provided in advance in appropriations Acts. Amounts so appropriated are authorized to remain available until expended, for administrative expenses in carrying out this title and related laws.”.

(2) CONFORMING AMENDMENTS.—

(A) Section 206(a)(4)(A) of such Act (42 U.S.C. 406(a)(4)(A)) is amended by inserting “and subsection (d)” after “subparagraph (B)”.

(B) Section 206(b)(1)(A) of such Act (42 U.S.C. 406(b)(1)(A)) is amended by inserting “, but subject to subsection (d) of this section” after “section 205(i)”.

(b) ELIMINATION OF 15-DAY WAITING PERIOD FOR PAYMENT OF FEES.—Section 206(a)(4) of such Act (42 U.S.C. 406(a)(4)), as amended by subsection (a)(2)(A) of this section, is amended—

- (1) by striking “(4)(A)” and inserting “(4)”;
- (2) by striking “subparagraph (B) and”; and
- (3) by striking subparagraph (B).

(c) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study that—

(A) examines the costs incurred by the Social Security Administration in administering the provisions of subsection (a)(4) and (b)(1) of section 206 of the Social Security Act (42 U.S.C. 406) and itemizes the components of such costs, including the costs of determining fees to attorneys from the past-due benefits of claimants before the Commissioner of Social Security and of certifying such fees;

(B) identifies efficiencies that the Social Security Administration could implement to reduce such costs;

(C) examines the feasibility and advisability of linking the payment of, or the amount of, the assessment under section 206(d) of the Social Security Act (42 U.S.C. 406(d)) to the timeliness of the payment of the fee to the attorney as certified by the Commissioner of Social Security pursuant to subsection (a)(4) or (b)(1) of section 206 of such Act (42 U.S.C. 406);

(D) determines whether the provisions of subsection (a)(4) and (b)(1) of section 206 of such Act (42 U.S.C. 406) should be applied to claimants under title XVI of such Act (42 U.S.C. 1381 et seq.);

(E) determines the feasibility and advisability of stating fees under section 206(d) of such Act (42 U.S.C. 406(d)) in terms of a fixed dollar amount as opposed to a percentage;

(F) determines whether the dollar limit specified in section 206(a)(2)(A)(ii)(II) of such Act (42 U.S.C. 406(a)(2)(A)(ii)(II)) should be raised; and

(G) determines whether the assessment on attorneys required under section 206(d) of such Act (42 U.S.C. 406(d))

42 USC 406 note.

(as added by subsection (a)(1) of this section) impairs access to legal representation for claimants.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the study conducted under paragraph (1), together with any recommendations for legislation that the Comptroller General determines to be appropriate as a result of such study. Deadline.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply in the case of any attorney with respect to whom a fee for services is required to be certified for payment from a claimant's past-due benefits pursuant to subsection (a)(4) or (b)(1) of section 206 of the Social Security Act after the later of— 42 USC 406 note.

- (1) December 31, 1999, or
- (2) the last day of the first month beginning after the month in which this Act is enacted.

**SEC. 407. EXTENSION OF AUTHORITY OF STATE MEDICAID FRAUD CONTROL UNITS.**

(a) EXTENSION OF AUTHORITY TO INVESTIGATE AND PROSECUTE FRAUD IN OTHER FEDERAL HEALTH CARE PROGRAMS.—Section 1903(q)(3) of the Social Security Act (42 U.S.C. 1396b(q)(3)) is amended—

- (1) by inserting “(A)” after “in connection with”; and
- (2) by striking “title.” and inserting “title; and (B) upon the approval of the Inspector General of the relevant Federal agency, any aspect of the provision of health care services and activities of providers of such services under any Federal health care program (as defined in section 1128B(f)(1)), if the suspected fraud or violation of law in such case or investigation is primarily related to the State plan under this title.”.

(b) RECOUPMENT OF FUNDS.—Section 1903(q)(5) of such Act (42 U.S.C. 1396b(q)(5)) is amended—

- (1) by inserting “or under any Federal health care program (as so defined)” after “plan”; and
- (2) by adding at the end the following: “All funds collected in accordance with this paragraph shall be credited exclusively to, and available for expenditure under, the Federal health care program (including the State plan under this title) that was subject to the activity that was the basis for the collection.”.

(c) EXTENSION OF AUTHORITY TO INVESTIGATE AND PROSECUTE RESIDENT ABUSE IN NON-MEDICAID BOARD AND CARE FACILITIES.—Section 1903(q)(4) of such Act (42 U.S.C. 1396b(q)(4)) is amended to read as follows:

“(4)(A) The entity has—

“(i) procedures for reviewing complaints of abuse or neglect of patients in health care facilities which receive payments under the State plan under this title;

“(ii) at the option of the entity, procedures for reviewing complaints of abuse or neglect of patients residing in board and care facilities; and

“(iii) procedures for acting upon such complaints under the criminal laws of the State or for referring such complaints to other State agencies for action.

“(B) For purposes of this paragraph, the term ‘board and care facility’ means a residential setting which receives payment (regardless of whether such payment is made under the State plan under this title) from or on behalf of two or more unrelated adults who reside in such facility, and for whom one or both of the following is provided:

“(i) Nursing care services provided by, or under the supervision of, a registered nurse, licensed practical nurse, or licensed nursing assistant.

“(ii) A substantial amount of personal care services that assist residents with the activities of daily living, including personal hygiene, dressing, bathing, eating, toileting, ambulation, transfer, positioning, self-medication, body care, travel to medical services, essential shopping, meal preparation, laundry, and housework.”

42 USC 1396b  
note.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act.

#### SEC. 408. CLIMATE DATABASE MODERNIZATION.

Notwithstanding any other provision of law, the National Oceanic and Atmospheric Administration shall initiate a new competitive contract procurement for its multi-year program for key entry of valuable climate records, archive services, and database development in accordance with existing Federal procurement laws and regulations.

#### SEC. 409. SPECIAL ALLOWANCE ADJUSTMENT FOR STUDENT LOANS.

(a) AMENDMENT.—Section 438(b)(2) of the Higher Education Act of 1965 (20 U.S.C. 1087-1(b)(2)) is amended—

(1) in subparagraph (A), by striking “(G), and (H)” and inserting “(G), (H), and (I)”;

(2) in subparagraph (B)(iv), by striking “(G), or (H)” and inserting “(G), (H), or (I)”;

(3) in subparagraph (C)(ii), by striking “(G) and (H)” and inserting “(G), (H), and (I)”;

(4) in the heading of subparagraph (H), by striking “JULY 1, 2003” and inserting “JANUARY 1, 2000”;

(5) in subparagraph (H), by striking “July 1, 2003,” each place it appears and inserting “January 1, 2000,”; and

(6) by inserting after subparagraph (H) the following new subparagraph:

“(I) LOANS DISBURSED ON OR AFTER JANUARY 1, 2000, AND BEFORE JULY 1, 2003.—

“(i) IN GENERAL.—Notwithstanding subparagraphs (G) and (H), but subject to paragraph (4) and clauses (ii), (iii), and (iv) of this subparagraph, and except as provided in subparagraph (B), the special allowance paid pursuant to this subsection on loans for which the first disbursement is made on or after January 1, 2000, and before July 1, 2003, shall be computed—

“(I) by determining the average of the bond equivalent rates of the quotes of the 3-month commercial paper (financial) rates in effect for each of the days in such quarter as reported by the Federal Reserve in Publication H-15 (or its successor) for such 3-month period;

“(II) by subtracting the applicable interest rates on such loans from such average bond equivalent rate;

“(III) by adding 2.34 percent to the resultant percent; and

“(IV) by dividing the resultant percent by 4.

“(ii) IN SCHOOL AND GRACE PERIOD.—In the case of any loan for which the first disbursement is made on or after January 1, 2000, and before July 1, 2003, and for which the applicable rate of interest is described in section 427A(k)(2), clause (i)(III) of this subparagraph shall be applied by substituting ‘1.74 percent’ for ‘2.34 percent’.

“(iii) PLUS LOANS.—In the case of any loan for which the first disbursement is made on or after January 1, 2000, and before July 1, 2003, and for which the applicable rate of interest is described in section 427A(k)(3), clause (i)(III) of this subparagraph shall be applied by substituting ‘2.64 percent’ for ‘2.34 percent’, subject to clause (v) of this subparagraph.

“(iv) CONSOLIDATION LOANS.—In the case of any consolidation loan for which the application is received by an eligible lender on or after January 1, 2000, and before July 1, 2003, and for which the applicable interest rate is determined under section 427A(k)(4), clause (i)(III) of this subparagraph shall be applied by substituting ‘2.64 percent’ for ‘2.34 percent’, subject to clause (vi) of this subparagraph.

“(v) LIMITATION ON SPECIAL ALLOWANCES FOR PLUS LOANS.—In the case of PLUS loans made under section 428B and first disbursed on or after January 1, 2000, and before July 1, 2003, for which the interest rate is determined under section 427A(k)(3), a special allowance shall not be paid for such loan during any 12-month period beginning on July 1 and ending on June 30 unless, on the June 1 preceding such July 1—

“(I) the bond equivalent rate of 91-day Treasury bills auctioned at the final auction held prior to such June 1 (as determined by the Secretary for purposes of such section); plus

“(II) 3.1 percent,

exceeds 9.0 percent.

“(vi) LIMITATION ON SPECIAL ALLOWANCES FOR CONSOLIDATION LOANS.—In the case of consolidation loans made under section 428C and for which the application is received on or after January 1, 2000, and before July 1, 2003, for which the interest rate is determined under section 427A(k)(4), a special allowance shall not be paid for such loan during any 3-month period ending March 31, June 30, September 30, or December 31 unless—

“(I) the average of the bond equivalent rates of the quotes of the 3-month commercial paper (financial) rates in effect for each of the days in such quarter as reported by the Federal Reserve in Publication H-15 (or its successor) for such 3-month period; plus

Applicability.  
20 USC 1087-1  
note.

“(II) 2.64 percent,  
exceeds the rate determined under section 427A(k)(4).”  
(b) EFFECTIVE DATE.—Subparagraph (I) of section 438(b)(2) of the Higher Education Act of 1965 (20 U.S.C. 1087-1(b)(2)) as added by subsection (a) of this section shall apply with respect to any payment pursuant to such section with respect to any 3-month period beginning on or after January 1, 2000, for loans for which the first disbursement is made after such date.

**SEC. 410. SCHEDULE FOR PAYMENTS UNDER SSI STATE SUPPLEMENTATION AGREEMENTS.**

(a) SCHEDULE FOR SSI SUPPLEMENTATION PAYMENTS.—

(1) IN GENERAL.—Section 1616(d) of the Social Security Act (42 U.S.C. 1382e(d)) is amended—

(A) in paragraph (1), by striking “at such times and in such installments as may be agreed upon between the Commissioner of Social Security and such State” and inserting “in accordance with paragraph (5)”; and

(B) by adding at the end the following new paragraph:  
“(5)(A)(i) Any State which has entered into an agreement with the Commissioner of Social Security under this section shall remit the payments and fees required under this subsection with respect to monthly benefits paid to individuals under this title no later than—

“(I) the business day preceding the date that the Commissioner pays such monthly benefits; or

“(II) with respect to such monthly benefits paid for the month that is the last month of the State’s fiscal year, the fifth business day following such date.

“(ii) The Commissioner may charge States a penalty in an amount equal to 5 percent of the payment and the fees due if the remittance is received after the date required by clause (i).

“(B) The Cash Management Improvement Act of 1990 shall not apply to any payments or fees required under this subsection that are paid by a State before the date required by subparagraph (A)(i).

“(C) Notwithstanding subparagraph (A)(i), the Commissioner may make supplementary payments on behalf of a State with funds appropriated for payment of benefits under this title, and subsequently to be reimbursed for such payments by the State at such times as the Commissioner and State may agree. Such authority may be exercised only if extraordinary circumstances affecting a State’s ability to make payment when required by subparagraph (A)(i) are determined by the Commissioner to exist.”

(2) AMENDMENT TO SECTION 212.—Section 212 of Public Law 93-66 (42 U.S.C. 1382 note) is amended—

(A) in subsection (b)(3)(A), by striking “at such times and in such installments as may be agreed upon between the Secretary and the State” and inserting “in accordance with subparagraph (E)”; and

(B) by adding at the end of subsection (b)(3) the following new subparagraph:

“(E)(i) Any State which has entered into an agreement with the Commissioner of Social Security under this section shall remit the payments and fees required under this paragraph with respect to monthly benefits paid to individuals under title XVI of the Social Security Act no later than—

Deadlines.

“(I) the business day preceding the date that the Commissioner pays such monthly benefits; or

“(II) with respect to such monthly benefits paid for the month that is the last month of the State’s fiscal year, the fifth business day following such date.

“(ii) The Cash Management Improvement Act of 1990 shall not apply to any payments or fees required under this paragraph that are paid by a State before the date required by clause (i).

“(iii) Notwithstanding clause (i), the Commissioner may make supplementary payments on behalf of a State with funds appropriated for payment of supplemental security income benefits under title XVI of the Social Security Act, and subsequently to be reimbursed for such payments by the State at such times as the Commissioner and State may agree. Such authority may be exercised only if extraordinary circumstances affecting a State’s ability to make payment when required by clause (i) are determined by the Commissioner to exist.”; and

(C) by striking “Secretary of Health, Education, and Welfare” and “Secretary” each place such term appear and inserting “Commissioner of Social Security”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to payments and fees arising under an agreement between a State and the Commissioner of Social Security under section 1616 of the Social Security Act (42 U.S.C. 1382e) or under section 212 of Public Law 93-66 (42 U.S.C. 1382 note) with respect to monthly benefits paid to individuals under title XVI of the Social Security Act for months after September 2009 (October 2009 in the case of a State with a fiscal year that coincides with the Federal fiscal year), without regard to whether the agreement has been modified to reflect such amendments or the Commissioner has promulgated regulations implementing such amendments.

Applicability.  
42 USC 1382e  
note.

#### SEC. 411. BONUS COMMODITIES.

Section 6(e)(1) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1755(e)(1)) is amended—

(1) by striking “in the form of commodity assistance” and inserting “in the form of—

“(A) commodity assistance”;

(2) by striking the period at the end and inserting “; or”;

and

(3) by adding at the end the following:

“(B) during the period beginning October 1, 2000, and ending September 30, 2009, commodities provided by the Secretary under any provision of law.”.

#### SEC. 412. SIMPLIFICATION OF DEFINITION OF FOSTER CHILD UNDER EIC.

(a) **IN GENERAL.**—Section 32(c)(3)(B)(iii) of the Internal Revenue Code of 1986 (defining eligible foster child) is amended by redesignating subclauses (I) and (II) as subclauses (II) and (III), respectively, and by inserting before subclause (II), as so redesignated, the following:

26 USC 32.

“(I) is a brother, sister, stepbrother, or step-sister of the taxpayer (or a descendant of any such relative) or is placed with the taxpayer by an authorized placement agency.”.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning after December 31, 1999.

Applicability.  
26 USC 32 note.

**SEC. 413. DELAY OF EFFECTIVE DATE OF ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK FINAL RULE.**

(a) **IN GENERAL.**—The final rule entitled “Organ Procurement and Transplantation Network”, promulgated by the Secretary of Health and Human Services on April 2, 1998 (63 Fed. Reg. 16295 et seq.) (relating to part 121 of title 42, Code of Federal Regulations), together with the amendments to such rules promulgated on October 20, 1999 (64 Fed. Reg. 56649 et seq.) shall not become effective before the expiration of the 90-day period beginning on the date of the enactment of this Act.

(b) **NOTICE AND REVIEW.**—For purposes of subsection (a):

Deadline.

(1) Not later than 3 days after the date of the enactment of this Act, the Secretary of Health and Human Services (referred to in this subsection as the “Secretary”) shall publish in the Federal Register a notice providing that the period within which comments on the final rule may be submitted to the Secretary is 60 days after the date of such publication of the notice.

Deadline.

(2) Not later than 21 days after the expiration of such 60-day period, the Secretary shall complete the review of the comments submitted pursuant to paragraph (1) and shall amend the final rule with any revisions appropriate according to the review by the Secretary of such comments. The final rule may be in the form of amendments to the rule referred to in subsection (a) that was promulgated on April 2, 1998, and in the form of amendments to the rule referred to in such subsection that was promulgated on October 20, 1999.

Tax Relief  
Extension Act of  
1999.

**TITLE V—TAX RELIEF EXTENSION ACT  
OF 1999**

26 USC 1 note.

**SEC. 500. SHORT TITLE OF TITLE.**

This title may be cited as the “Tax Relief Extension Act of 1999”.

**Subtitle A—Extensions**

**SEC. 501. ALLOWANCE OF NONREFUNDABLE PERSONAL CREDITS AGAINST REGULAR AND MINIMUM TAX LIABILITY.**

26 USC 26.

(a) **IN GENERAL.**—Subsection (a) of section 26 of the Internal Revenue Code of 1986 (relating to limitation based on amount of tax) is amended to read as follows:

“(a) **LIMITATION BASED ON AMOUNT OF TAX.**—

“(1) **IN GENERAL.**—The aggregate amount of credits allowed by this subpart for the taxable year shall not exceed the excess (if any) of—

“(A) the taxpayer’s regular tax liability for the taxable year, over

“(B) the tentative minimum tax for the taxable year (determined without regard to the alternative minimum tax foreign tax credit).

For purposes of subparagraph (B), the taxpayer’s tentative minimum tax for any taxable year beginning during 1999 shall be treated as being zero.”.

“(2) SPECIAL RULE FOR 2000 AND 2001.—For purposes of any taxable year beginning during 2000 or 2001, the aggregate amount of credits allowed by this subpart for the taxable year shall not exceed the sum of—

“(A) the taxpayer’s regular tax liability for the taxable year reduced by the foreign tax credit allowable under section 27(a), and

“(B) the tax imposed by section 55(a) for the taxable year.”.

(b) CONFORMING AMENDMENTS.—

(1) Section 24(d)(2) of such Code is amended by striking “1998” and inserting “2001”. 26 USC 24.

(2) Section 904(h) of such Code is amended by adding at the end the following: “This subsection shall not apply to taxable years beginning during 2000 or 2001.”. 26 USC 904.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1998. Applicability. 26 USC 24 note.

#### SEC. 502. RESEARCH CREDIT.

(a) EXTENSION.—

(1) IN GENERAL.—Paragraph (1) of section 41(h) of the Internal Revenue Code of 1986 (relating to termination) is amended— 26 USC 41.

(A) by striking “June 30, 1999” and inserting “June 30, 2004”; and

(B) by striking the material following subparagraph (B).

(2) TECHNICAL AMENDMENT.—Subparagraph (D) of section 45C(b)(1) of such Code is amended by striking “June 30, 1999” and inserting “June 30, 2004”. 26 USC 45C.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to amounts paid or incurred after June 30, 1999. Applicability. 26 USC 41 note.

(b) INCREASE IN PERCENTAGES UNDER ALTERNATIVE INCREMENTAL CREDIT.—

(1) IN GENERAL.—Subparagraph (A) of section 41(c)(4) of such Code is amended—

(A) by striking “1.65 percent” and inserting “2.65 percent”;

(B) by striking “2.2 percent” and inserting “3.2 percent”; and

(C) by striking “2.75 percent” and inserting “3.75 percent”.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after June 30, 1999. Applicability. 26 USC 41 note.

(c) EXTENSION OF RESEARCH CREDIT TO RESEARCH IN PUERTO RICO AND THE POSSESSIONS OF THE UNITED STATES.—

(1) IN GENERAL.—Subsections (c)(6) and (d)(4)(F) of section 41 of such Code (relating to foreign research) are each amended by inserting “, the Commonwealth of Puerto Rico, or any possession of the United States” after “United States”.

(2) DENIAL OF DOUBLE BENEFIT.—Section 280C(c)(1) of such Code is amended by inserting “or credit” after “deduction” each place it appears. 26 USC 280C.

Applicability.  
26 USC 41 note.

26 USC 41 note.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to amounts paid or incurred after June 30, 1999.

(d) SPECIAL RULE.—

(1) IN GENERAL.—For purposes of the Internal Revenue Code of 1986, the credit determined under section 41 of such Code which is otherwise allowable under such Code—

(A) shall not be taken into account prior to October 1, 2000, to the extent such credit is attributable to the first suspension period; and

(B) shall not be taken into account prior to October 1, 2001, to the extent such credit is attributable to the second suspension period.

On or after the earliest date that an amount of credit may be taken into account, such amount may be taken into account through the filing of an amended return, an application for expedited refund, an adjustment of estimated taxes, or other means allowed by such Code.

(2) SUSPENSION PERIODS.—For purposes of this subsection—

(A) the first suspension period is the period beginning on July 1, 1999, and ending on September 30, 2000; and

(B) the second suspension period is the period beginning on October 1, 2000, and ending on September 30, 2001.

(3) EXPEDITED REFUNDS.—

(A) IN GENERAL.—If there is an overpayment of tax with respect to a taxable year by reason of paragraph (1), the taxpayer may file an application for a tentative refund of such overpayment. Such application shall be in such manner and form, and contain such information, as the Secretary may prescribe.

(B) DEADLINE FOR APPLICATIONS.—Subparagraph (A) shall apply only to an application filed before the date which is 1 year after the close of the suspension period to which the application relates.

(C) ALLOWANCE OF ADJUSTMENTS.—Not later than 90 days after the date on which an application is filed under this paragraph, the Secretary shall—

(i) review the application;

(ii) determine the amount of the overpayment; and

(iii) apply, credit, or refund such overpayment, in a manner similar to the manner provided in section 6411(b) of such Code.

(D) CONSOLIDATED RETURNS.—The provisions of section 6411(c) of such Code shall apply to an adjustment under this paragraph in such manner as the Secretary may provide.

(4) CREDIT ATTRIBUTABLE TO SUSPENSION PERIOD.—

(A) IN GENERAL.—For purposes of this subsection, in the case of a taxable year which includes a portion of the suspension period, the amount of credit determined under section 41 of such Code for such taxable year which is attributable to such period is the amount which bears the same ratio to the amount of credit determined under such section 41 for such taxable year as the number of months in the suspension period which are during such

Deadline.

taxable year bears to the number of months in such taxable year.

(B) **WAIVER OF ESTIMATED TAX PENALTIES.**—No addition to tax shall be made under section 6654 or 6655 of such Code for any period before July 1, 1999, with respect to any underpayment of tax imposed by such Code to the extent such underpayment was created or increased by reason of subparagraph (A).

(5) **SECRETARY.**—For purposes of this subsection, the term “Secretary” means the Secretary of the Treasury (or such Secretary’s delegate).

**SEC. 503. SUBPART F EXEMPTION FOR ACTIVE FINANCING INCOME.**

(a) **IN GENERAL.**—Sections 953(e)(10) and 954(h)(9) of the Internal Revenue Code of 1986 (relating to application) are each amended— 26 USC 953, 954.

(1) by striking “the first taxable year” and inserting “taxable years”;

(2) by striking “January 1, 2000” and inserting “January 1, 2002”; and

(3) by striking “within which such” and inserting “within which any such”.

(b) **TECHNICAL AMENDMENT.**—Paragraph (10) of section 953(e) of such Code is amended by adding at the end the following new sentence: “If this subsection does not apply to a taxable year of a foreign corporation beginning after December 31, 2001 (and taxable years of United States shareholders ending with or within such taxable year), then, notwithstanding the preceding sentence, subsection (a) shall be applied to such taxable years in the same manner as it would if the taxable year of the foreign corporation began in 1998.”

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning after December 31, 1999. Applicability. 26 USC 953 note.

**SEC. 504. TAXABLE INCOME LIMIT ON PERCENTAGE DEPLETION FOR MARGINAL PRODUCTION.**

(a) **IN GENERAL.**—Subparagraph (H) of section 613A(c)(6) of the Internal Revenue Code of 1986 (relating to temporary suspension of taxable limit with respect to marginal production) is amended by striking “January 1, 2000” and inserting “January 1, 2002”. 26 USC 613A.

(b) **EFFECTIVE DATE.**—The amendment made by this section shall apply to taxable years beginning after December 31, 1999. 26 USC 613A note.

**SEC. 505. WORK OPPORTUNITY CREDIT AND WELFARE-TO-WORK CREDIT.**

(a) **TEMPORARY EXTENSION.**—Sections 51(c)(4)(B) and 51A(f) of the Internal Revenue Code of 1986 (relating to termination) are each amended by striking “June 30, 1999” and inserting “December 31, 2001”. 26 USC 51, 51A.

(b) **CLARIFICATION OF FIRST YEAR OF EMPLOYMENT.**—Paragraph (2) of section 51(i) of such Code is amended by striking “during which he was not a member of a targeted group”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to individuals who begin work for the employer after June 30, 1999. Applicability. 26 USC 51 note.

**SEC. 506. EMPLOYER-PROVIDED EDUCATIONAL ASSISTANCE.**

26 USC 127. (a) **IN GENERAL.**—Subsection (d) of section 127 of the Internal Revenue Code of 1986 (relating to termination) is amended by striking “May 31, 2000” and inserting “December 31, 2001”.

Applicability.  
26 USC 127 note. (b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to courses beginning after May 31, 2000.

**SEC. 507. EXTENSION AND MODIFICATION OF CREDIT FOR PRODUCING ELECTRICITY FROM CERTAIN RENEWABLE RESOURCES.**

26 USC 45. (a) **EXTENSION AND MODIFICATION OF PLACED-IN-SERVICE RULES.**—Paragraph (3) of section 45(c) of the Internal Revenue Code of 1986 is amended to read as follows:

**“(3) QUALIFIED FACILITY.—**

**“(A) WIND FACILITY.**—In the case of a facility using wind to produce electricity, the term ‘qualified facility’ means any facility owned by the taxpayer which is originally placed in service after December 31, 1993, and before January 1, 2002.

**“(B) CLOSED-LOOP BIOMASS FACILITY.**—In the case of a facility using closed-loop biomass to produce electricity, the term ‘qualified facility’ means any facility owned by the taxpayer which is originally placed in service after December 31, 1992, and before January 1, 2002.

**“(C) POULTRY WASTE FACILITY.**—In the case of a facility using poultry waste to produce electricity, the term ‘qualified facility’ means any facility of the taxpayer which is originally placed in service after December 31, 1999, and before January 1, 2002.”

**(b) EXPANSION OF QUALIFIED ENERGY RESOURCES.—**

(1) **IN GENERAL.**—Section 45(c)(1) of such Code (defining qualified energy resources) is amended by striking “and” at the end of subparagraph (A), by striking the period at the end of subparagraph (B) and inserting “, and”, and by adding at the end the following new subparagraph:

“(C) poultry waste.”

(2) **DEFINITION.**—Section 45(c) of such Code is amended by adding at the end the following new paragraph:

“(4) **POULTRY WASTE.**—The term ‘poultry waste’ means poultry manure and litter, including wood shavings, straw, rice hulls, and other bedding material for the disposition of manure.”

(c) **SPECIAL RULES.**—Section 45(d) of such Code (relating to definitions and special rules) is amended by adding at the end the following new paragraphs:

**“(6) CREDIT ELIGIBILITY IN THE CASE OF GOVERNMENT-OWNED FACILITIES USING POULTRY WASTE.**—In the case of a facility using poultry waste to produce electricity and owned by a governmental unit, the person eligible for the credit under subsection (a) is the lessee or the operator of such facility.

**“(7) CREDIT NOT TO APPLY TO ELECTRICITY SOLD TO UTILITIES UNDER CERTAIN CONTRACTS.—**

**“(A) IN GENERAL.**—The credit determined under subsection (a) shall not apply to electricity—

**“(i) produced at a qualified facility described in paragraph (3)(A) which is placed in service by the taxpayer after June 30, 1999, and**

“(ii) sold to a utility pursuant to a contract originally entered into before January 1, 1987 (whether or not amended or restated after that date).

“(B) EXCEPTION.—Subparagraph (A) shall not apply if—

“(i) the prices for energy and capacity from such facility are established pursuant to an amendment to the contract referred to in subparagraph (A)(ii),

“(ii) such amendment provides that the prices set forth in the contract which exceed avoided cost prices determined at the time of delivery shall apply only to annual quantities of electricity (prorated for partial years) which do not exceed the greater of—

“(I) the average annual quantity of electricity sold to the utility under the contract during calendar years 1994, 1995, 1996, 1997, and 1998, or

“(II) the estimate of the annual electricity production set forth in the contract, or, if there is no such estimate, the greatest annual quantity of electricity sold to the utility under the contract in any of the calendar years 1996, 1997, or 1998, and

“(iii) such amendment provides that energy and capacity in excess of the limitation in clause (ii) may be—

“(I) sold to the utility only at prices that do not exceed avoided cost prices determined at the time of delivery, or

“(II) sold to a third party subject to a mutually agreed upon advance notice to the utility.

For purposes of this subparagraph, avoided cost prices shall be determined as provided for in 18 CFR 292.304(d)(1) or any successor regulation.”.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act. 26 USC 45 note.

**SEC. 508. EXTENSION OF DUTY-FREE TREATMENT UNDER GENERALIZED SYSTEM OF PREFERENCES.**

(a) IN GENERAL.—Section 505 of the Trade Act of 1974 (19 U.S.C. 2465) is amended by striking “June 30, 1999” and inserting “September 30, 2001”.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by this section applies to articles entered on or after the date of the enactment of this Act.

19 USC 2465  
note.

(2) RETROACTIVE APPLICATION FOR CERTAIN LIQUIDATIONS AND RELIQUIDATIONS.—

(A) GENERAL RULE.—Notwithstanding section 514 of the Tariff Act of 1930 or any other provision of law, and subject to paragraph (3), any entry—

(i) of an article to which duty-free treatment under title V of the Trade Act of 1974 would have applied if such entry had been made on July 1, 1999, and such title had been in effect on July 1, 1999; and

(ii) that was made—

(I) after June 30, 1999; and

(II) before the date of the enactment of this Act, shall be liquidated or reliquidated as free of duty, and the Secretary of the Treasury shall refund any duty paid with respect to such entry.

(B) ENTRY.—As used in this paragraph, the term “entry” includes a withdrawal from warehouse for consumption.

(3) REQUESTS.—Liquidation or reliquidation may be made under paragraph (2) with respect to an entry only if a request therefore is filed with the Customs Service, within 180 days after the date of the enactment of this Act, that contains sufficient information to enable the Customs Service—

(A) to locate the entry; or

(B) to reconstruct the entry if it cannot be located.

**SEC. 509. EXTENSION OF CREDIT FOR HOLDERS OF QUALIFIED ZONE ACADEMY BONDS.**

26 USC 1397E. (a) IN GENERAL.—Section 1397E(e)(1) of the Internal Revenue Code of 1986 (relating to national limitation) is amended by striking “and 1999” and inserting “, 1999, 2000, and 2001”.

(b) LIMITATION ON CARRYOVER PERIODS.—Paragraph (4) of section 1397E(e) of such Code is amended by adding at the end the following flush sentences:

“Any carryforward of a limitation amount may be carried only to the first 2 years (3 years for carryforwards from 1998 or 1999) following the unused limitation year. For purposes of the preceding sentence, a limitation amount shall be treated as used on a first-in first-out basis.”.

**SEC. 510. EXTENSION OF FIRST-TIME HOMEBUYER CREDIT FOR DISTRICT OF COLUMBIA.**

26 USC 1400C. Section 1400C(i) of the Internal Revenue Code of 1986 is amended by striking “2001” and inserting “2002”.

**SEC. 511. EXTENSION OF EXPENSING OF ENVIRONMENTAL REMEDIATION COSTS.**

26 USC 198. Section 198(h) of the Internal Revenue Code of 1986 is amended by striking “2000” and inserting “2001”.

**SEC. 512. TEMPORARY INCREASE IN AMOUNT OF RUM EXCISE TAX COVERED OVER TO PUERTO RICO AND VIRGIN ISLANDS.**

26 USC 7652. (a) IN GENERAL.—Section 7652(f)(1) of the Internal Revenue Code of 1986 (relating to limitation on cover over of tax on distilled spirits) is amended to read as follows:

“(1) \$10.50 (\$13.25 in the case of distilled spirits brought into the United States after June 30, 1999, and before January 1, 2002), or”.

Applicability.  
26 USC 7652  
note. (b) SPECIAL COVER OVER TRANSFER RULES.—Notwithstanding section 7652 of the Internal Revenue Code of 1986, the following rules shall apply with respect to any transfer before October 1, 2000, of amounts relating to the increase in the cover over of taxes by reason of the amendment made by subsection (a):

(1) INITIAL TRANSFER OF INCREMENTAL INCREASE IN COVER OVER.—The Secretary of the Treasury shall, within 15 days after the date of the enactment of this Act, transfer an amount equal to the lesser of—

(A) the amount of such increase otherwise required to be covered over after June 30, 1999, and before the date of the enactment of this Act; or

(B) \$20,000,000.

(2) TRANSFER OF INCREMENTAL INCREASE FOR FISCAL YEAR 2001.—The Secretary of the Treasury shall on October 1, 2000, transfer an amount equal to the excess of—

(A) the amount of such increase otherwise required to be covered over after June 30, 1999, and before October 1, 2000, over

(B) the amount of the transfer described in paragraph

(1).

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on July 1, 1999.

26 USC 7652  
note.

## Subtitle B—Other Time-Sensitive Provisions

### SEC. 521. ADVANCE PRICING AGREEMENTS TREATED AS CONFIDENTIAL TAXPAYER INFORMATION.

(a) IN GENERAL.—

(1) TREATMENT AS RETURN INFORMATION.—Paragraph (2) of section 6103(b) of the Internal Revenue Code of 1986 (defining return information) is amended by striking “and” at the end of subparagraph (A), by inserting “and” at the end of subparagraph (B), and by inserting after subparagraph (B) the following new subparagraph:

26 USC 6103.

“(C) any advance pricing agreement entered into by a taxpayer and the Secretary and any background information related to such agreement or any application for an advance pricing agreement.”

(2) EXCEPTION FROM PUBLIC INSPECTION AS WRITTEN DETERMINATION.—Paragraph (1) of section 6110(b) of such Code (defining written determination) is amended by adding at the end the following new sentence: “Such term shall not include any advance pricing agreement entered into by a taxpayer and the Secretary and any background information related to such agreement or any application for an advance pricing agreement.”

26 USC 6110.

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

26 USC 6103  
note.

(b) ANNUAL REPORT REGARDING ADVANCE PRICING AGREEMENTS.—

(1) IN GENERAL.—Not later than 90 days after the end of each calendar year, the Secretary of the Treasury shall prepare and publish a report regarding advance pricing agreements.

Deadline.

(2) CONTENTS OF REPORT.—The report shall include the following for the calendar year to which such report relates:

(A) Information about the structure, composition, and operation of the advance pricing agreement program office.

(B) A copy of each model advance pricing agreement.

(C) The number of—

(i) applications filed during such calendar year for advance pricing agreements;

(ii) advance pricing agreements executed cumulatively to date and during such calendar year;

(iii) renewals of advance pricing agreements issued;

(iv) pending requests for advance pricing agreements;

(v) pending renewals of advance pricing agreements;

(vi) for each of the items in clauses (ii) through (v), the number that are unilateral, bilateral, and multilateral, respectively;

(vii) advance pricing agreements revoked or canceled, and the number of withdrawals from the advance pricing agreement program; and

(viii) advance pricing agreements finalized or renewed by industry.

(D) General descriptions of—

(i) the nature of the relationships between the related organizations, trades, or businesses covered by advance pricing agreements;

(ii) the covered transactions and the business functions performed and risks assumed by such organizations, trades, or businesses;

(iii) the related organizations, trades, or businesses whose prices or results are tested to determine compliance with transfer pricing methodologies prescribed in advance pricing agreements;

(iv) methodologies used to evaluate tested parties and transactions and the circumstances leading to the use of those methodologies;

(v) critical assumptions made and sources of comparables used;

(vi) comparable selection criteria and the rationale used in determining such criteria;

(vii) the nature of adjustments to comparables or tested parties;

(viii) the nature of any ranges agreed to, including information regarding when no range was used and why, when interquartile ranges were used, and when there was a statistical narrowing of the comparables;

(ix) adjustment mechanisms provided to rectify results that fall outside of the agreed upon advance pricing agreement range;

(x) the various term lengths for advance pricing agreements, including rollback years, and the number of advance pricing agreements with each such term length;

(xi) the nature of documentation required; and

(xii) approaches for sharing of currency or other risks.

(E) Statistics regarding the amount of time taken to complete new and renewal advance pricing agreements.

(F) A detailed description of the Secretary of the Treasury's efforts to ensure compliance with existing advance pricing agreements.

(3) CONFIDENTIALITY.—The reports required by this subsection shall be treated as authorized by the Internal Revenue

Code of 1986 for purposes of section 6103 of such Code, but the reports shall not include information—

(A) which would not be permitted to be disclosed under section 6110(c) of such Code if such report were a written determination as defined in section 6110 of such Code;

or

(B) which can be associated with, or otherwise identify, directly or indirectly, a particular taxpayer.

(4) **FIRST REPORT.**—The report for calendar year 1999 shall include prior calendar years after 1990.

(c) **REGULATIONS.**—The Secretary of the Treasury or the Secretary's delegate shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of section 6103(b)(2)(C), and the last sentence of section 6110(b)(1), of the Internal Revenue Code of 1986, as added by this section.

26 USC 6103.

**SEC. 522. AUTHORITY TO POSTPONE CERTAIN TAX-RELATED DEADLINES BY REASON OF Y2K FAILURES.**

26 USC 7508A note.

(a) **IN GENERAL.**—In the case of a taxpayer determined by the Secretary of the Treasury (or the Secretary's delegate) to be affected by a Y2K failure, the Secretary may disregard a period of up to 90 days in determining, under the internal revenue laws, in respect of any tax liability (including any interest, penalty, additional amount, or addition to the tax) of such taxpayer—

(1) whether any of the acts described in paragraph (1) of section 7508(a) of the Internal Revenue Code of 1986 (without regard to the exceptions in parentheses in subparagraphs (A) and (B)) were performed within the time prescribed therefor; and

(2) the amount of any credit or refund.

(b) **APPLICABILITY OF CERTAIN RULES.**—For purposes of this section, rules similar to the rules of subsections (b) and (e) of section 7508 of the Internal Revenue Code of 1986 shall apply.

**SEC. 523. INCLUSION OF CERTAIN VACCINES AGAINST STREPTOCOCCUS PNEUMONIAE TO LIST OF TAXABLE VACCINES.**

(a) **INCLUSION OF VACCINES.**—

(1) **IN GENERAL.**—Section 4132(a)(1) of the Internal Revenue Code of 1986 (defining taxable vaccine) is amended by adding at the end the following new subparagraph:

26 USC 4132.

“(L) Any conjugate vaccine against streptococcus pneumoniae.”

(2) **EFFECTIVE DATE.**—

26 USC 4132 note.

(A) **SALES.**—The amendment made by this subsection shall apply to vaccine sales after the date of the enactment of this Act, but shall not take effect if subsection (b) does not take effect.

(B) **DELIVERIES.**—For purposes of subparagraph (A), in the case of sales on or before the date described in such subparagraph for which delivery is made after such date, the delivery date shall be considered the sale date.

(b) **VACCINE TAX AND TRUST FUND AMENDMENTS.**—

(1) Sections 1503 and 1504 of the Vaccine Injury Compensation Program Modification Act (and the amendments made by such sections) are hereby repealed.

26 USC 4132 and note, 9510 and note.

(2) Subparagraph (A) of section 9510(c)(1) of such Code is amended by striking “August 5, 1997” and inserting “December 31, 1999”.

26 USC 9510.

26 USC 4132  
note.

(3) The amendments made by this subsection shall take effect as if included in the provisions of the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 to which they relate.

Deadline.

(c) REPORT.—Not later than January 31, 2000, the Comptroller General of the United States shall prepare and submit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the operation of the Vaccine Injury Compensation Trust Fund and on the adequacy of such Fund to meet future claims made under the Vaccine Injury Compensation Program.

**SEC. 524. DELAY IN EFFECTIVE DATE OF REQUIREMENT FOR APPROVED DIESEL OR KEROSENE TERMINALS.**

26 USC 4041  
note.

Paragraph (2) of section 1032(f) of the Taxpayer Relief Act of 1997 is amended by striking “July 1, 2000” and inserting “January 1, 2002”.

7 USC 7212 note.

**SEC. 525. PRODUCTION FLEXIBILITY CONTRACT PAYMENTS.**

Any option to accelerate the receipt of any payment under a production flexibility contract which is payable under the Federal Agriculture Improvement and Reform Act of 1996 (7 U.S.C. 7200 et seq.), as in effect on the date of the enactment of this Act, shall be disregarded in determining the taxable year for which such payment is properly includible in gross income for purposes of the Internal Revenue Code of 1986.

**Subtitle C—Revenue Offsets**

**PART I—GENERAL PROVISIONS**

**SEC. 531. MODIFICATION OF ESTIMATED TAX SAFE HARBOR.**

26 USC 6654.

(a) IN GENERAL.—The table contained in clause (i) of section 6654(d)(1)(C) of the Internal Revenue Code of 1986 (relating to limitation on use of preceding year’s tax) is amended by striking the items relating to 1999 and 2000 and inserting the following new items:

“1999 .....	108.6
2000 .....	110”.

Applicability.  
26 USC 6654.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to any installment payment for taxable years beginning after December 31, 1999.

**SEC. 532. CLARIFICATION OF TAX TREATMENT OF INCOME AND LOSS ON DERIVATIVES.**

26 USC 1221.

(a) IN GENERAL.—Section 1221 of the Internal Revenue Code of 1986 (defining capital assets) is amended—

- (1) by striking “For purposes” and inserting the following: “(a) IN GENERAL.—For purposes”;
- (2) by striking the period at the end of paragraph (5) and inserting a semicolon; and
- (3) by adding at the end the following: “(6) any commodities derivative financial instrument held by a commodities derivatives dealer, unless—  
“(A) it is established to the satisfaction of the Secretary that such instrument has no connection to the activities of such dealer as a dealer, and

“(B) such instrument is clearly identified in such dealer’s records as being described in subparagraph (A) before the close of the day on which it was acquired, originated, or entered into (or such other time as the Secretary may by regulations prescribe);

“(7) any hedging transaction which is clearly identified as such before the close of the day on which it was acquired, originated, or entered into (or such other time as the Secretary may by regulations prescribe); or

“(8) supplies of a type regularly used or consumed by the taxpayer in the ordinary course of a trade or business of the taxpayer.

“(b) DEFINITIONS AND SPECIAL RULES.—

“(1) COMMODITIES DERIVATIVE FINANCIAL INSTRUMENTS.—

For purposes of subsection (a)(6)—

“(A) COMMODITIES DERIVATIVES DEALER.—The term ‘commodities derivatives dealer’ means a person which regularly offers to enter into, assume, offset, assign, or terminate positions in commodities derivative financial instruments with customers in the ordinary course of a trade or business.

“(B) COMMODITIES DERIVATIVE FINANCIAL INSTRUMENT.—

“(i) IN GENERAL.—The term ‘commodities derivative financial instrument’ means any contract or financial instrument with respect to commodities (other than a share of stock in a corporation, a beneficial interest in a partnership or trust, a note, bond, debenture, or other evidence of indebtedness, or a section 1256 contract (as defined in section 1256(b)), the value or settlement price of which is calculated by or determined by reference to a specified index.

“(ii) SPECIFIED INDEX.—The term ‘specified index’ means any one or more or any combination of—

“(I) a fixed rate, price, or amount, or

“(II) a variable rate, price, or amount,

which is based on any current, objectively determinable financial or economic information with respect to commodities which is not within the control of any of the parties to the contract or instrument and is not unique to any of the parties’ circumstances.

“(2) HEDGING TRANSACTION.—

“(A) IN GENERAL.—For purposes of this section, the term ‘hedging transaction’ means any transaction entered into by the taxpayer in the normal course of the taxpayer’s trade or business primarily—

“(i) to manage risk of price changes or currency fluctuations with respect to ordinary property which is held or to be held by the taxpayer,

“(ii) to manage risk of interest rate or price changes or currency fluctuations with respect to borrowings made or to be made, or ordinary obligations incurred or to be incurred, by the taxpayer, or

“(iii) to manage such other risks as the Secretary may prescribe in regulations.

- Regulations. “(B) TREATMENT OF NONIDENTIFICATION OR IMPROPER IDENTIFICATION OF HEDGING TRANSACTIONS.—Notwithstanding subsection (a)(7), the Secretary shall prescribe regulations to properly characterize any income, gain, expense, or loss arising from a transaction—
- “ (i) which is a hedging transaction but which was not identified as such in accordance with subsection (a)(7), or
- “ (ii) which was so identified but is not a hedging transaction.
- “(3) REGULATIONS.—The Secretary shall prescribe such regulations as are appropriate to carry out the purposes of paragraph (6) and (7) of subsection (a) in the case of transactions involving related parties.”.
- (b) MANAGEMENT OF RISK.—
- 26 USC 475. (1) Section 475(c)(3) of such Code is amended by striking “reduces” and inserting “manages”.
- 26 USC 871. (2) Section 871(h)(4)(C)(iv) of such Code is amended by striking “to reduce” and inserting “to manage”.
- 26 USC 988. (3) Clauses (i) and (ii) of section 988(d)(2)(A) of such Code are each amended by striking “to reduce” and inserting “to manage”.
- 26 USC 1256. (4) Paragraph (2) of section 1256(e) of such Code is amended to read as follows:
- “(2) DEFINITION OF HEDGING TRANSACTION.—For purposes of this subsection, the term ‘hedging transaction’ means any hedging transaction (as defined in section 1221(b)(2)(A)) if, before the close of the day on which such transaction was entered into (or such earlier time as the Secretary may prescribe by regulations), the taxpayer clearly identifies such transaction as being a hedging transaction.”.
- (c) CONFORMING AMENDMENTS.—
- (1) Each of the following sections of such Code are amended by striking “section 1221” and inserting “section 1221(a)”:
- 26 USC 170. (A) Section 170(e)(3)(A).
- (B) Section 170(e)(4)(B).
- 26 USC 367. (C) Section 367(a)(3)(B)(i).
- 26 USC 818. (D) Section 818(c)(3).
- 26 USC 865. (E) Section 865(i)(1).
- 26 USC 1092. (F) Section 1092(a)(3)(B)(ii)(II).
- 26 USC 1231. (G) Subparagraphs (C) and (D) of section 1231(b)(1).
- 26 USC 1234. (H) Section 1234(a)(3)(A).
- (2) Each of the following sections of such Code are amended by striking “section 1221(1)” and inserting “section 1221(a)(1)”:
- 26 USC 198. (A) Section 198(c)(1)(A)(i).
- 26 USC 263. (B) Section 263A(b)(2)(A).
- 26 USC 267. (C) Clauses (i) and (iii) of section 267(f)(3)(B).
- 26 USC 341. (D) Section 341(d)(3).
- 26 USC 543. (E) Section 543(a)(1)(D)(i).
- 26 USC 751. (F) Section 751(d)(1).
- 26 USC 775. (G) Section 775(c).
- 26 USC 856. (H) Section 856(c)(2)(D).
- (I) Section 856(c)(3)(C).
- (J) Section 856(e)(1).
- (K) Section 856(j)(2)(B).
- 26 USC 857. (L) Section 857(b)(4)(B)(i).
- (M) Section 857(b)(6)(B)(iii).

- (N) Section 864(c)(4)(B)(iii). 26 USC 864.  
(O) Section 864(d)(3)(A).  
(P) Section 864(d)(6)(A).  
(Q) Section 954(c)(1)(B)(iii). 26 USC 954.  
(R) Section 995(b)(1)(C). 26 USC 995.  
(S) Section 1017(b)(3)(E)(i). 26 USC 1017.  
(T) Section 1362(d)(3)(C)(ii). 26 USC 1362.  
(U) Section 4662(c)(2)(C). 26 USC 4662.  
(V) Section 7704(c)(3). 26 USC 7704.  
(W) Section 7704(d)(1)(D).  
(X) Section 7704(d)(1)(G).  
(Y) Section 7704(d)(5).
- (3) Section 818(b)(2) of such Code is amended by striking “section 1221(2)” and inserting “section 1221(a)(2)”. 26 USC 818.  
(4) Section 1397B(e)(2) of such Code is amended by striking “section 1221(4)” and inserting “section 1221(a)(4)”. 26 USC 1397B note.  
(d) EFFECTIVE DATE.—The amendments made by this section shall apply to any instrument held, acquired, or entered into, any transaction entered into, and supplies held or acquired on or after the date of the enactment of this Act. 26 USC 170 note.
- SEC. 533. EXPANSION OF REPORTING OF CANCELLATION OF INDEBTEDNESS INCOME.**
- (a) IN GENERAL.—Paragraph (2) of section 6050P(c) of the Internal Revenue Code of 1986 (relating to definitions and special rules) is amended by striking “and” at the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting “, and”, and by inserting after subparagraph (C) the following new subparagraph: 26 USC 6050P.  
“(D) any organization a significant trade or business of which is the lending of money.”
- (b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to discharges of indebtedness after December 31, 1999. 26 USC 6050P note.
- SEC. 534. LIMITATION ON CONVERSION OF CHARACTER OF INCOME FROM CONSTRUCTIVE OWNERSHIP TRANSACTIONS.**
- (a) IN GENERAL.—Part IV of subchapter P of chapter 1 of the Internal Revenue Code of 1986 (relating to special rules for determining capital gains and losses) is amended by inserting after section 1259 the following new section: 26 USC 1260.  
**“SEC. 1260. GAINS FROM CONSTRUCTIVE OWNERSHIP TRANSACTIONS.**  
“(a) IN GENERAL.—If the taxpayer has gain from a constructive ownership transaction with respect to any financial asset and such gain would (without regard to this section) be treated as a long-term capital gain—  
“(1) such gain shall be treated as ordinary income to the extent that such gain exceeds the net underlying long-term capital gain, and  
“(2) to the extent such gain is treated as a long-term capital gain after the application of paragraph (1), the determination of the capital gain rate (or rates) applicable to such gain under section 1(h) shall be determined on the basis of the respective rate (or rates) that would have been applicable to the net underlying long-term capital gain.  
“(b) INTEREST CHARGE ON DEFERRAL OF GAIN RECOGNITION.—  
“(1) IN GENERAL.—If any gain is treated as ordinary income for any taxable year by reason of subsection (a)(1), the tax

imposed by this chapter for such taxable year shall be increased by the amount of interest determined under paragraph (2) with respect to each prior taxable year during any portion of which the constructive ownership transaction was open. Any amount payable under this paragraph shall be taken into account in computing the amount of any deduction allowable to the taxpayer for interest paid or accrued during such taxable year.

“(2) AMOUNT OF INTEREST.—The amount of interest determined under this paragraph with respect to a prior taxable year is the amount of interest which would have been imposed under section 6601 on the underpayment of tax for such year which would have resulted if the gain (which is treated as ordinary income by reason of subsection (a)(1)) had been included in gross income in the taxable years in which it accrued (determined by treating the income as accruing at a constant rate equal to the applicable Federal rate as in effect on the day the transaction closed). The period during which such interest shall accrue shall end on the due date (without extensions) for the return of tax imposed by this chapter for the taxable year in which such transaction closed.

“(3) APPLICABLE FEDERAL RATE.—For purposes of paragraph (2), the applicable Federal rate is the applicable Federal rate determined under section 1274(d) (compounded semiannually) which would apply to a debt instrument with a term equal to the period the transaction was open.

“(4) NO CREDITS AGAINST INCREASE IN TAX.—Any increase in tax under paragraph (1) shall not be treated as tax imposed by this chapter for purposes of determining—

“(A) the amount of any credit allowable under this chapter, or

“(B) the amount of the tax imposed by section 55.

“(c) FINANCIAL ASSET.—For purposes of this section—

“(1) IN GENERAL.—The term ‘financial asset’ means—

“(A) any equity interest in any pass-thru entity, and

“(B) to the extent provided in regulations—

“(i) any debt instrument, and

“(ii) any stock in a corporation which is not a pass-thru entity.

“(2) PASS-THRU ENTITY.—For purposes of paragraph (1), the term ‘pass-thru entity’ means—

“(A) a regulated investment company,

“(B) a real estate investment trust,

“(C) an S corporation,

“(D) a partnership,

“(E) a trust,

“(F) a common trust fund,

“(G) a passive foreign investment company (as defined in section 1297 without regard to subsection (e) thereof),

“(H) a foreign personal holding company,

“(I) a foreign investment company (as defined in section 1246(b)), and

“(J) a REMIC.

“(d) CONSTRUCTIVE OWNERSHIP TRANSACTION.—For purposes of this section—

“(1) IN GENERAL.—The taxpayer shall be treated as having entered into a constructive ownership transaction with respect to any financial asset if the taxpayer—

“(A) holds a long position under a notional principal contract with respect to the financial asset,

“(B) enters into a forward or futures contract to acquire the financial asset,

“(C) is the holder of a call option, and is the grantor of a put option, with respect to the financial asset and such options have substantially equal strike prices and substantially contemporaneous maturity dates, or

“(D) to the extent provided in regulations prescribed by the Secretary, enters into one or more other transactions (or acquires one or more positions) that have substantially the same effect as a transaction described in any of the preceding subparagraphs.

“(2) EXCEPTION FOR POSITIONS WHICH ARE MARKED TO MARKET.—This section shall not apply to any constructive ownership transaction if all of the positions which are part of such transaction are marked to market under any provision of this title or the regulations thereunder.

“(3) LONG POSITION UNDER NOTIONAL PRINCIPAL CONTRACT.—A person shall be treated as holding a long position under a notional principal contract with respect to any financial asset if such person—

“(A) has the right to be paid (or receive credit for) all or substantially all of the investment yield (including appreciation) on such financial asset for a specified period, and

“(B) is obligated to reimburse (or provide credit for) all or substantially all of any decline in the value of such financial asset.

“(4) FORWARD CONTRACT.—The term ‘forward contract’ means any contract to acquire in the future (or provide or receive credit for the future value of) any financial asset.

“(e) NET UNDERLYING LONG-TERM CAPITAL GAIN.—For purposes of this section, in the case of any constructive ownership transaction with respect to any financial asset, the term ‘net underlying long-term capital gain’ means the aggregate net capital gain that the taxpayer would have had if—

“(1) the financial asset had been acquired for fair market value on the date such transaction was opened and sold for fair market value on the date such transaction was closed, and

“(2) only gains and losses that would have resulted from the deemed ownership under paragraph (1) were taken into account.

The amount of the net underlying long-term capital gain with respect to any financial asset shall be treated as zero unless the amount thereof is established by clear and convincing evidence.

“(f) SPECIAL RULE WHERE TAXPAYER TAKES DELIVERY.—Except as provided in regulations prescribed by the Secretary, if a constructive ownership transaction is closed by reason of taking delivery, this section shall be applied as if the taxpayer had sold all the contracts, options, or other positions which are part of such transaction for fair market value on the closing date. The amount of gain recognized under the preceding sentence shall not exceed the

amount of gain treated as ordinary income under subsection (a). Proper adjustments shall be made in the amount of any gain or loss subsequently realized for gain recognized and treated as ordinary income under this subsection.

“(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this section, including regulations—

“(1) to permit taxpayers to mark to market constructive ownership transactions in lieu of applying this section, and

“(2) to exclude certain forward contracts which do not convey substantially all of the economic return with respect to a financial asset.”

(b) CLERICAL AMENDMENT.—The table of sections for part IV of subchapter P of chapter 1 of such Code is amended by adding at the end the following new item:

“Sec. 1260. Gains from constructive ownership transactions.”

26 USC 1260  
note.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to transactions entered into after July 11, 1999.

**SEC. 535. TREATMENT OF EXCESS PENSION ASSETS USED FOR RETIREE HEALTH BENEFITS.**

(a) EXTENSION.—

26 USC 420.

(1) IN GENERAL.—Paragraph (5) of section 420(b) of the Internal Revenue Code of 1986 (relating to expiration) is amended by striking “in any taxable year beginning after December 31, 2000” and inserting “made after December 31, 2005”.

(2) CONFORMING AMENDMENTS.—

(A) Section 101(e)(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021(e)(3)) is amended by striking “January 1, 1995” and inserting “the date of the enactment of the Tax Relief Extension Act of 1999”.

(B) Section 403(c)(1) of such Act (29 U.S.C. 1103(c)(1)) is amended by striking “January 1, 1995” and inserting “the date of the enactment of the Tax Relief Extension Act of 1999”.

(C) Paragraph (13) of section 408(b) of such Act (29 U.S.C. 1108(b)(13)) is amended—

(i) by striking “in a taxable year beginning before January 1, 2001” and inserting “made before January 1, 2006”; and

(ii) by striking “January 1, 1995” and inserting “the date of the enactment of the Tax Relief Extension Act of 1999”.

(b) APPLICATION OF MINIMUM COST REQUIREMENTS.—

(1) IN GENERAL.—Paragraph (3) of section 420(c) of the Internal Revenue Code of 1986 is amended to read as follows:

“(3) MINIMUM COST REQUIREMENTS.—

“(A) IN GENERAL.—The requirements of this paragraph are met if each group health plan or arrangement under which applicable health benefits are provided provides that the applicable employer cost for each taxable year during the cost maintenance period shall not be less than the higher of the applicable employer costs for each of the

2 taxable years immediately preceding the taxable year of the qualified transfer.

“(B) APPLICABLE EMPLOYER COST.—For purposes of this paragraph, the term ‘applicable employer cost’ means, with respect to any taxable year, the amount determined by dividing—

“(i) the qualified current retiree health liabilities of the employer for such taxable year determined—

“(I) without regard to any reduction under subsection (e)(1)(B), and

“(II) in the case of a taxable year in which there was no qualified transfer, in the same manner as if there had been such a transfer at the end of the taxable year, by

“(ii) the number of individuals to whom coverage for applicable health benefits was provided during such taxable year.

“(C) ELECTION TO COMPUTE COST SEPARATELY.—An employer may elect to have this paragraph applied separately with respect to individuals eligible for benefits under title XVIII of the Social Security Act at any time during the taxable year and with respect to individuals not so eligible.

“(D) COST MAINTENANCE PERIOD.—For purposes of this paragraph, the term ‘cost maintenance period’ means the period of 5 taxable years beginning with the taxable year in which the qualified transfer occurs. If a taxable year is in two or more overlapping cost maintenance periods, this paragraph shall be applied by taking into account the highest applicable employer cost required to be provided under subparagraph (A) for such taxable year.

“(E) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to prevent an employer who significantly reduces retiree health coverage during the cost maintenance period from being treated as satisfying the minimum cost requirement of this subsection.”.

(2) CONFORMING AMENDMENTS.—

(A) Clause (iii) of section 420(b)(1)(C) of such Code is amended by striking “benefits” and inserting “cost”. 26 USC 420.

(B) Subparagraph (D) of section 420(e)(1) of such Code is amended by striking “and shall not be subject to the minimum benefit requirements of subsection (c)(3)” and inserting “or in calculating applicable employer cost under subsection (c)(3)(B)”.

(c) EFFECTIVE DATES.—

26 USC 420 note.

(1) IN GENERAL.—The amendments made by this section shall apply to qualified transfers occurring after the date of the enactment of this Act.

(2) TRANSITION RULE.—If the cost maintenance period for any qualified transfer after the date of the enactment of this Act includes any portion of a benefit maintenance period for any qualified transfer on or before such date, the amendments made by subsection (b) shall not apply to such portion of the cost maintenance period (and such portion shall be treated as a benefit maintenance period).

**SEC. 536. MODIFICATION OF INSTALLMENT METHOD AND REPEAL OF  
INSTALLMENT METHOD FOR ACCRUAL METHOD TAX-  
PAYERS.**

**(a) REPEAL OF INSTALLMENT METHOD FOR ACCRUAL BASIS TAX-  
PAYERS.—**

26 USC 453. (1) **IN GENERAL.**—Subsection (a) of section 453 of the Internal Revenue Code of 1986 (relating to installment method) is amended to read as follows:

**“(a) USE OF INSTALLMENT METHOD.—**

**“(1) IN GENERAL.**—Except as otherwise provided in this section, income from an installment sale shall be taken into account for purposes of this title under the installment method.

**“(2) ACCRUAL METHOD TAXPAYER.**—The installment method shall not apply to income from an installment sale if such income would be reported under an accrual method of accounting without regard to this section. The preceding sentence shall not apply to a disposition described in subparagraph (A) or (B) of subsection (1)(2).”

(2) **CONFORMING AMENDMENTS.**—Sections 453(d)(1), 453(i)(1), and 453(k) of such Code are each amended by striking “(a)” each place it appears and inserting “(a)(1)”.

26 USC 453A. (b) **MODIFICATION OF PLEDGE RULES.**—Paragraph (4) of section 453A(d) of such Code (relating to pledges, etc., of installment obligations) is amended by adding at the end the following: “A payment shall be treated as directly secured by an interest in an installment obligation to the extent an arrangement allows the taxpayer to satisfy all or a portion of the indebtedness with the installment obligation.”

26 USC 453 note. (c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to sales or other dispositions occurring on or after the date of the enactment of this Act.

**SEC. 537. DENIAL OF CHARITABLE CONTRIBUTION DEDUCTION FOR  
TRANSFERS ASSOCIATED WITH SPLIT-DOLLAR INSUR-  
ANCE ARRANGEMENTS.**

26 USC 170. (a) **IN GENERAL.**—Subsection (f) of section 170 of the Internal Revenue Code of 1986 (relating to disallowance of deduction in certain cases and special rules) is amended by adding at the end the following new paragraph:

**“(10) SPLIT-DOLLAR LIFE INSURANCE, ANNUITY, AND ENDOW-  
MENT CONTRACTS.—**

**“(A) IN GENERAL.**—Nothing in this section or in section 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or 2522 shall be construed to allow a deduction, and no deduction shall be allowed, for any transfer to or for the use of an organization described in subsection (c) if in connection with such transfer—

**“(i) the organization directly or indirectly pays, or has previously paid, any premium on any personal benefit contract with respect to the transferor, or**

**“(ii) there is an understanding or expectation that any person will directly or indirectly pay any premium on any personal benefit contract with respect to the transferor.**

**“(B) PERSONAL BENEFIT CONTRACT.**—For purposes of subparagraph (A), the term ‘personal benefit contract’ means, with respect to the transferor, any life insurance,

annuity, or endowment contract if any direct or indirect beneficiary under such contract is the transferor, any member of the transferor's family, or any other person (other than an organization described in subsection (c)) designated by the transferor.

“(C) APPLICATION TO CHARITABLE REMAINDER TRUSTS.— In the case of a transfer to a trust referred to in subparagraph (E), references in subparagraphs (A) and (F) to an organization described in subsection (c) shall be treated as a reference to such trust.

“(D) EXCEPTION FOR CERTAIN ANNUITY CONTRACTS.— If, in connection with a transfer to or for the use of an organization described in subsection (c), such organization incurs an obligation to pay a charitable gift annuity (as defined in section 501(m)) and such organization purchases any annuity contract to fund such obligation, persons receiving payments under the charitable gift annuity shall not be treated for purposes of subparagraph (B) as indirect beneficiaries under such contract if—

“(i) such organization possesses all of the incidents of ownership under such contract,

“(ii) such organization is entitled to all the payments under such contract, and

“(iii) the timing and amount of payments under such contract are substantially the same as the timing and amount of payments to each such person under such obligation (as such obligation is in effect at the time of such transfer).

“(E) EXCEPTION FOR CERTAIN CONTRACTS HELD BY CHARITABLE REMAINDER TRUSTS.—A person shall not be treated for purposes of subparagraph (B) as an indirect beneficiary under any life insurance, annuity, or endowment contract held by a charitable remainder annuity trust or a charitable remainder unitrust (as defined in section 664(d)) solely by reason of being entitled to any payment referred to in paragraph (1)(A) or (2)(A) of section 664(d) if—

“(i) such trust possesses all of the incidents of ownership under such contract, and

“(ii) such trust is entitled to all the payments under such contract.

“(F) EXCISE TAX ON PREMIUMS PAID.—

“(i) IN GENERAL.—There is hereby imposed on any organization described in subsection (c) an excise tax equal to the premiums paid by such organization on any life insurance, annuity, or endowment contract if the payment of premiums on such contract is in connection with a transfer for which a deduction is not allowable under subparagraph (A), determined without regard to when such transfer is made.

“(ii) PAYMENTS BY OTHER PERSONS.—For purposes of clause (i), payments made by any other person pursuant to an understanding or expectation referred to in subparagraph (A) shall be treated as made by the organization.

“(iii) REPORTING.—Any organization on which tax is imposed by clause (i) with respect to any premium shall file an annual return which includes—

“(I) the amount of such premiums paid during the year and the name and TIN of each beneficiary under the contract to which the premium relates, and

“(II) such other information as the Secretary may require.

The penalties applicable to returns required under section 6033 shall apply to returns required under this clause. Returns required under this clause shall be furnished at such time and in such manner as the Secretary shall by forms or regulations require.

“(iv) CERTAIN RULES TO APPLY.—The tax imposed by this subparagraph shall be treated as imposed by chapter 42 for purposes of this title other than subchapter B of chapter 42.

“(G) SPECIAL RULE WHERE STATE REQUIRES SPECIFICATION OF CHARITABLE GIFT ANNUITANT IN CONTRACT.—In the case of an obligation to pay a charitable gift annuity referred to in subparagraph (D) which is entered into under the laws of a State which requires, in order for the charitable gift annuity to be exempt from insurance regulation by such State, that each beneficiary under the charitable gift annuity be named as a beneficiary under an annuity contract issued by an insurance company authorized to transact business in such State, the requirements of clauses (i) and (ii) of subparagraph (D) shall be treated as met if—

“(i) such State law requirement was in effect on February 8, 1999,

“(ii) each such beneficiary under the charitable gift annuity is a bona fide resident of such State at the time the obligation to pay a charitable gift annuity is entered into, and

“(iii) the only persons entitled to payments under such contract are persons entitled to payments as beneficiaries under such obligation on the date such obligation is entered into.

“(H) MEMBER OF FAMILY.—For purposes of this paragraph, an individual’s family consists of the individual’s grandparents, the grandparents of such individual’s spouse, the lineal descendants of such grandparents, and any spouse of such a lineal descendant.

“(I) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this paragraph, including regulations to prevent the avoidance of such purposes.”.

26 USC 170 note.

(b) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as otherwise provided in this section, the amendment made by this section shall apply to transfers made after February 8, 1999.

(2) EXCISE TAX.—Except as provided in paragraph (3) of this subsection, section 170(f)(10)(F) of the Internal Revenue Code of 1986 (as added by this section) shall apply to premiums paid after the date of the enactment of this Act.

(3) REPORTING.—Clause (iii) of such section 170(f)(10)(F) shall apply to premiums paid after February 8, 1999 (determined as if the tax imposed by such section applies to premiums paid after such date).

**SEC. 538. DISTRIBUTIONS BY A PARTNERSHIP TO A CORPORATE PARTNER OF STOCK IN ANOTHER CORPORATION.**

(a) IN GENERAL.—Section 732 of the Internal Revenue Code of 1986 (relating to basis of distributed property other than money) is amended by adding at the end the following new subsection: 26 USC 732.

“(f) CORRESPONDING ADJUSTMENT TO BASIS OF ASSETS OF A DISTRIBUTED CORPORATION CONTROLLED BY A CORPORATE PARTNER.—

“(1) IN GENERAL.—If—

“(A) a corporation (hereafter in this subsection referred to as the ‘corporate partner’) receives a distribution from a partnership of stock in another corporation (hereafter in this subsection referred to as the ‘distributed corporation’),

“(B) the corporate partner has control of the distributed corporation immediately after the distribution or at any time thereafter, and

“(C) the partnership’s adjusted basis in such stock immediately before the distribution exceeded the corporate partner’s adjusted basis in such stock immediately after the distribution,

then an amount equal to such excess shall be applied to reduce (in accordance with subsection (c)) the basis of property held by the distributed corporation at such time (or, if the corporate partner does not control the distributed corporation at such time, at the time the corporate partner first has such control).

“(2) EXCEPTION FOR CERTAIN DISTRIBUTIONS BEFORE CONTROL ACQUIRED.—Paragraph (1) shall not apply to any distribution of stock in the distributed corporation if—

“(A) the corporate partner does not have control of such corporation immediately after such distribution, and

“(B) the corporate partner establishes to the satisfaction of the Secretary that such distribution was not part of a plan or arrangement to acquire control of the distributed corporation.

“(3) LIMITATIONS ON BASIS REDUCTION.—

“(A) IN GENERAL.—The amount of the reduction under paragraph (1) shall not exceed the amount by which the sum of the aggregate adjusted bases of the property and the amount of money of the distributed corporation exceeds the corporate partner’s adjusted basis in the stock of the distributed corporation.

“(B) REDUCTION NOT TO EXCEED ADJUSTED BASIS OF PROPERTY.—No reduction under paragraph (1) in the basis of any property shall exceed the adjusted basis of such property (determined without regard to such reduction).

“(4) GAIN RECOGNITION WHERE REDUCTION LIMITED.—If the amount of any reduction under paragraph (1) (determined after the application of paragraph (3)(A)) exceeds the aggregate adjusted bases of the property of the distributed corporation—

“(A) such excess shall be recognized by the corporate partner as long-term capital gain, and

“(B) the corporate partner’s adjusted basis in the stock of the distributed corporation shall be increased by such excess.

“(5) CONTROL.—For purposes of this subsection, the term ‘control’ means ownership of stock meeting the requirements of section 1504(a)(2).

“(6) INDIRECT DISTRIBUTIONS.—For purposes of paragraph (1), if a corporation acquires (other than in a distribution from a partnership) stock the basis of which is determined (by reason of being distributed from a partnership) in whole or in part by reference to subsection (a)(2) or (b), the corporation shall be treated as receiving a distribution of such stock from a partnership.

“(7) SPECIAL RULE FOR STOCK IN CONTROLLED CORPORATION.—If the property held by a distributed corporation is stock in a corporation which the distributed corporation controls, this subsection shall be applied to reduce the basis of the property of such controlled corporation. This subsection shall be reapplied to any property of any controlled corporation which is stock in a corporation which it controls.

“(8) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this subsection, including regulations to avoid double counting and to prevent the abuse of such purposes.”

26 USC 732 note.

(b) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by this section shall apply to distributions made after July 14, 1999.

(2) PARTNERSHIPS IN EXISTENCE ON JULY 14, 1999.—In the case of a corporation which is a partner in a partnership as of July 14, 1999, the amendment made by this section shall apply to any distribution made (or treated as made) to such partner from such partnership after June 30, 2001, except that this paragraph shall not apply to any distribution after the date of the enactment of this Act unless the partner makes an election to have this paragraph apply to such distribution on the partner’s return of Federal income tax for the taxable year in which such distribution occurs.

## PART II—PROVISIONS RELATING TO REAL ESTATE INVESTMENT TRUSTS

### Subpart A—Treatment of Income and Services Provided by Taxable REIT Subsidiaries

#### SEC. 541. MODIFICATIONS TO ASSET DIVERSIFICATION TEST.

26 USC 856.

(a) IN GENERAL.—Subparagraph (B) of section 856(c)(4) of the Internal Revenue Code of 1986 is amended to read as follows:

“(B)(i) not more than 25 percent of the value of its total assets is represented by securities (other than those includible under subparagraph (A)),

“(ii) not more than 20 percent of the value of its total assets is represented by securities of one or more taxable REIT subsidiaries, and

“(iii) except with respect to a taxable REIT subsidiary and securities includible under subparagraph (A)—

“(I) not more than 5 percent of the value of its total assets is represented by securities of any one issuer,

“(II) the trust does not hold securities possessing more than 10 percent of the total voting power of the outstanding securities of any one issuer, and

“(III) the trust does not hold securities having a value of more than 10 percent of the total value of the outstanding securities of any one issuer.”

(b) EXCEPTION FOR STRAIGHT DEBT SECURITIES.—Subsection (c) of section 856 of such Code is amended by adding at the end the following new paragraph:

“(7) STRAIGHT DEBT SAFE HARBOR IN APPLYING PARAGRAPH

(4).—Securities of an issuer which are straight debt (as defined in section 1361(c)(5) without regard to subparagraph (B)(iii) thereof) shall not be taken into account in applying paragraph (4)(B)(ii)(III) if—

“(A) the issuer is an individual, or

“(B) the only securities of such issuer which are held by the trust or a taxable REIT subsidiary of the trust are straight debt (as so defined), or

“(C) the issuer is a partnership and the trust holds at least a 20 percent profits interest in the partnership.”

**SEC. 542. TREATMENT OF INCOME AND SERVICES PROVIDED BY TAXABLE REIT SUBSIDIARIES.**

(a) INCOME FROM TAXABLE REIT SUBSIDIARIES NOT TREATED AS IMPERMISSIBLE TENANT SERVICE INCOME.—Clause (i) of section 856(d)(7)(C) of the Internal Revenue Code of 1986 (relating to exceptions to impermissible tenant service income) is amended by inserting “or through a taxable REIT subsidiary of such trust” after “income”.

(b) CERTAIN INCOME FROM TAXABLE REIT SUBSIDIARIES NOT EXCLUDED FROM RENTS FROM REAL PROPERTY.—

(1) IN GENERAL.—Subsection (d) of section 856 of such Code (relating to rents from real property defined) is amended by adding at the end the following new paragraphs:

“(8) SPECIAL RULE FOR TAXABLE REIT SUBSIDIARIES.—For purposes of this subsection, amounts paid to a real estate investment trust by a taxable REIT subsidiary of such trust shall not be excluded from rents from real property by reason of paragraph (2)(B) if the requirements of either of the following subparagraphs are met:

“(A) LIMITED RENTAL EXCEPTION.—The requirements of this subparagraph are met with respect to any property if at least 90 percent of the leased space of the property is rented to persons other than taxable REIT subsidiaries of such trust and other than persons described in section 856(d)(2)(B). The preceding sentence shall apply only to the extent that the amounts paid to the trust as rents from real property (as defined in paragraph (1) without regard to paragraph (2)(B)) from such property are substantially comparable to such rents made by the other tenants of the trust’s property for comparable space.

“(B) EXCEPTION FOR CERTAIN LODGING FACILITIES.—The requirements of this subparagraph are met with respect to an interest in real property which is a qualified

lodging facility leased by the trust to a taxable REIT subsidiary of the trust if the property is operated on behalf of such subsidiary by a person who is an eligible independent contractor.

“(9) ELIGIBLE INDEPENDENT CONTRACTOR.—For purposes of paragraph (8)(B)—

“(A) IN GENERAL.—The term ‘eligible independent contractor’ means, with respect to any qualified lodging facility, any independent contractor if, at the time such contractor enters into a management agreement or other similar service contract with the taxable REIT subsidiary to operate the facility, such contractor (or any related person) is actively engaged in the trade or business of operating qualified lodging facilities for any person who is not a related person with respect to the real estate investment trust or the taxable REIT subsidiary.

“(B) SPECIAL RULES.—Solely for purposes of this paragraph and paragraph (8)(B), a person shall not fail to be treated as an independent contractor with respect to any qualified lodging facility by reason of any of the following:

“(i) The taxable REIT subsidiary bears the expenses for the operation of the facility pursuant to the management agreement or other similar service contract.

“(ii) The taxable REIT subsidiary receives the revenues from the operation of such facility, net of expenses for such operation and fees payable to the operator pursuant to such agreement or contract.

“(iii) The real estate investment trust receives income from such person with respect to another property that is attributable to a lease of such other property to such person that was in effect as of the later of—

“(I) January 1, 1999, or

“(II) the earliest date that any taxable REIT subsidiary of such trust entered into a management agreement or other similar service contract with such person with respect to such qualified lodging facility.

“(C) RENEWALS, ETC., OF EXISTING LEASES.—For purposes of subparagraph (B)(iii)—

“(i) a lease shall be treated as in effect on January 1, 1999, without regard to its renewal after such date, so long as such renewal is pursuant to the terms of such lease as in effect on whichever of the dates under subparagraph (B)(iii) is the latest, and

“(ii) a lease of a property entered into after whichever of the dates under subparagraph (B)(iii) is the latest shall be treated as in effect on such date if—

“(I) on such date, a lease of such property from the trust was in effect, and

“(II) under the terms of the new lease, such trust receives a substantially similar or lesser benefit in comparison to the lease referred to in subclause (I).

“(D) QUALIFIED LODGING FACILITY.—For purposes of this paragraph—

“(i) IN GENERAL.—The term ‘qualified lodging facility’ means any lodging facility unless wagering activities are conducted at or in connection with such facility by any person who is engaged in the business of accepting wagers and who is legally authorized to engage in such business at or in connection with such facility.

“(ii) LODGING FACILITY.—The term ‘lodging facility’ means a hotel, motel, or other establishment more than one-half of the dwelling units in which are used on a transient basis.

“(iii) CUSTOMARY AMENITIES AND FACILITIES.—The term ‘lodging facility’ includes customary amenities and facilities operated as part of, or associated with, the lodging facility so long as such amenities and facilities are customary for other properties of a comparable size and class owned by other owners unrelated to such real estate investment trust.

“(E) OPERATE INCLUDES MANAGE.—References in this paragraph to operating a property shall be treated as including a reference to managing the property.

“(F) RELATED PERSON.—Persons shall be treated as related to each other if such persons are treated as a single employer under subsection (a) or (b) of section 52.”.

(2) CONFORMING AMENDMENT.—Subparagraph (B) of section 856(d)(2) of such Code is amended by inserting “except as provided in paragraph (8),” after “(B)”.

(3) DETERMINING RENTS FROM REAL PROPERTY.—

(A)(i) Paragraph (1) of section 856(d) of such Code is amended by striking “adjusted bases” each place it occurs and inserting “fair market values”.

(ii) The amendment made by this subparagraph shall apply to taxable years beginning after December 31, 2000.

(B)(i) Clause (i) of section 856(d)(2)(B) of such Code is amended by striking “number” and inserting “value”.

(ii) The amendment made by this subparagraph shall apply to amounts received or accrued in taxable years beginning after December 31, 2000, except for amounts paid pursuant to leases in effect on July 12, 1999, or pursuant to a binding contract in effect on such date and at all times thereafter.

Applicability.  
Effective date.

26 USC 856 note.

26 USC 856 note.

#### SEC. 543. TAXABLE REIT SUBSIDIARY.

(a) IN GENERAL.—Section 856 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

“(1) TAXABLE REIT SUBSIDIARY.—For purposes of this part—  
“(1) IN GENERAL.—The term ‘taxable REIT subsidiary’ means, with respect to a real estate investment trust, a corporation (other than a real estate investment trust) if—

“(A) such trust directly or indirectly owns stock in such corporation, and

“(B) such trust and such corporation jointly elect that such corporation shall be treated as a taxable REIT subsidiary of such trust for purposes of this part.

Such an election, once made, shall be irrevocable unless both such trust and corporation consent to its revocation. Such election, and any revocation thereof, may be made without the consent of the Secretary.

“(2) THIRTY-FIVE PERCENT OWNERSHIP IN ANOTHER TAXABLE REIT SUBSIDIARY.—The term ‘taxable REIT subsidiary’ includes, with respect to any real estate investment trust, any corporation (other than a real estate investment trust) with respect to which a taxable REIT subsidiary of such trust owns directly or indirectly—

“(A) securities possessing more than 35 percent of the total voting power of the outstanding securities of such corporation, or

“(B) securities having a value of more than 35 percent of the total value of the outstanding securities of such corporation.

The preceding sentence shall not apply to a qualified REIT subsidiary (as defined in subsection (i)(2)). The rule of section 856(c)(7) shall apply for purposes of subparagraph (B).

“(3) EXCEPTIONS.—The term ‘taxable REIT subsidiary’ shall not include—

“(A) any corporation which directly or indirectly operates or manages a lodging facility or a health care facility, and

“(B) any corporation which directly or indirectly provides to any other person (under a franchise, license, or otherwise) rights to any brand name under which any lodging facility or health care facility is operated.

Subparagraph (B) shall not apply to rights provided to an eligible independent contractor to operate or manage a lodging facility if such rights are held by such corporation as a franchisee, licensee, or in a similar capacity and such lodging facility is either owned by such corporation or is leased to such corporation from the real estate investment trust.

“(4) DEFINITIONS.—For purposes of paragraph (3)—

“(A) LODGING FACILITY.—The term ‘lodging facility’ has the meaning given to such term by paragraph (9)(D)(ii).

“(B) HEALTH CARE FACILITY.—The term ‘health care facility’ has the meaning given to such term by subsection (e)(6)(D)(ii).”.

(b) CONFORMING AMENDMENT.—Paragraph (2) of section 856(i) of such Code is amended by adding at the end the following new sentence: “Such term shall not include a taxable REIT subsidiary.”.

#### SEC. 544. LIMITATION ON EARNINGS STRIPPING.

26 USC 163.

Paragraph (3) of section 163(j) of the Internal Revenue Code of 1986 (relating to limitation on deduction for interest on certain indebtedness) is amended by striking “and” at the end of subparagraph (A), by striking the period at the end of subparagraph (B) and inserting “, and”, and by adding at the end the following new subparagraph:

“(C) any interest paid or accrued (directly or indirectly) by a taxable REIT subsidiary (as defined in section 856(l)) of a real estate investment trust to such trust.”.

#### SEC. 545. 100 PERCENT TAX ON IMPROPERLY ALLOCATED AMOUNTS.

(a) IN GENERAL.—Subsection (b) of section 857 of the Internal Revenue Code of 1986 (relating to method of taxation of real estate

investment trusts and holders of shares or certificates of beneficial interest) is amended by redesignating paragraphs (7) and (8) as paragraphs (8) and (9), respectively, and by inserting after paragraph (6) the following new paragraph:

“(7) INCOME FROM REDETERMINED RENTS, REDETERMINED DEDUCTIONS, AND EXCESS INTEREST.—

“(A) IMPOSITION OF TAX.—There is hereby imposed for each taxable year of the real estate investment trust a tax equal to 100 percent of redetermined rents, redetermined deductions, and excess interest.

“(B) REDETERMINED RENTS.—

“(i) IN GENERAL.—The term ‘redetermined rents’ means rents from real property (as defined in subsection 856(d)) the amount of which would (but for subparagraph (E)) be reduced on distribution, apportionment, or allocation under section 482 to clearly reflect income as a result of services furnished or rendered by a taxable REIT subsidiary of the real estate investment trust to a tenant of such trust.

“(ii) EXCEPTION FOR CERTAIN SERVICES.—Clause (i) shall not apply to amounts received directly or indirectly by a real estate investment trust for services described in paragraph (1)(B) or (7)(C)(i) of section 856(d).

“(iii) EXCEPTION FOR DE MINIMIS AMOUNTS.—Clause (i) shall not apply to amounts described in section 856(d)(7)(A) with respect to a property to the extent such amounts do not exceed the one percent threshold described in section 856(d)(7)(B) with respect to such property.

“(iv) EXCEPTION FOR COMPARABLY PRICED SERVICES.—Clause (i) shall not apply to any service rendered by a taxable REIT subsidiary of a real estate investment trust to a tenant of such trust if—

“(I) such subsidiary renders a significant amount of similar services to persons other than such trust and tenants of such trust who are unrelated (within the meaning of section 856(d)(8)(F)) to such subsidiary, trust, and tenants, but

“(II) only to the extent the charge for such service so rendered is substantially comparable to the charge for the similar services rendered to persons referred to in subclause (I).

“(v) EXCEPTION FOR CERTAIN SEPARATELY CHARGED SERVICES.—Clause (i) shall not apply to any service rendered by a taxable REIT subsidiary of a real estate investment trust to a tenant of such trust if—

“(I) the rents paid to the trust by tenants (leasing at least 25 percent of the net leasable space in the trust’s property) who are not receiving such service from such subsidiary are substantially comparable to the rents paid by tenants leasing comparable space who are receiving such service from such subsidiary, and

“(II) the charge for such service from such subsidiary is separately stated.

26 USC 857.

“(vi) EXCEPTION FOR CERTAIN SERVICES BASED ON SUBSIDIARY’S INCOME FROM THE SERVICES.—Clause (i) shall not apply to any service rendered by a taxable REIT subsidiary of a real estate investment trust to a tenant of such trust if the gross income of such subsidiary from such service is not less than 150 percent of such subsidiary’s direct cost in furnishing or rendering the service.

“(vii) EXCEPTIONS GRANTED BY SECRETARY.—The Secretary may waive the tax otherwise imposed by subparagraph (A) if the trust establishes to the satisfaction of the Secretary that rents charged to tenants were established on an arms’ length basis even though a taxable REIT subsidiary of the trust provided services to such tenants.

“(C) REDETERMINED DEDUCTIONS.—The term ‘redetermined deductions’ means deductions (other than redetermined rents) of a taxable REIT subsidiary of a real estate investment trust if the amount of such deductions would (but for subparagraph (E)) be decreased on distribution, apportionment, or allocation under section 482 to clearly reflect income as between such subsidiary and such trust.

“(D) EXCESS INTEREST.—The term ‘excess interest’ means any deductions for interest payments by a taxable REIT subsidiary of a real estate investment trust to such trust to the extent that the interest payments are in excess of a rate that is commercially reasonable.

“(E) COORDINATION WITH SECTION 482.—The imposition of tax under subparagraph (A) shall be in lieu of any distribution, apportionment, or allocation under section 482.

“(F) REGULATORY AUTHORITY.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this paragraph. Until the Secretary prescribes such regulations, real estate investment trusts and their taxable REIT subsidiaries may base their allocations on any reasonable method.”

(b) AMOUNT SUBJECT TO TAX NOT REQUIRED TO BE DISTRIBUTED.—Subparagraph (E) of section 857(b)(2) of such Code (relating to real estate investment trust taxable income) is amended by striking “paragraph (5)” and inserting “paragraphs (5) and (7)”.

26 USC 856 note. **SEC. 546. EFFECTIVE DATE.**

(a) IN GENERAL.—The amendments made by this subpart shall apply to taxable years beginning after December 31, 2000.

(b) TRANSITIONAL RULES RELATED TO SECTION 541.—

(1) EXISTING ARRANGEMENTS.—

(A) IN GENERAL.—Except as otherwise provided in this paragraph, the amendment made by section 541 shall not apply to a real estate investment trust with respect to—

(i) securities of a corporation held directly or indirectly by such trust on July 12, 1999;

(ii) securities of a corporation held by an entity on July 12, 1999, if such trust acquires control of such entity pursuant to a written binding contract in effect on such date and at all times thereafter before such acquisition;

(iii) securities received by such trust (or a successor) in exchange for, or with respect to, securities described in clause (i) or (ii) in a transaction in which gain or loss is not recognized; and

(iv) securities acquired directly or indirectly by such trust as part of a reorganization (as defined in section 368(a)(1) of the Internal Revenue Code of 1986) with respect to such trust if such securities are described in clause (i), (ii), or (iii) with respect to any other real estate investment trust.

(B) NEW TRADE OR BUSINESS OR SUBSTANTIAL NEW ASSETS.—Subparagraph (A) shall cease to apply to securities of a corporation as of the first day after July 12, 1999, on which such corporation engages in a substantial new line of business, or acquires any substantial asset, other than—

(i) pursuant to a binding contract in effect on such date and at all times thereafter before the acquisition of such asset;

(ii) in a transaction in which gain or loss is not recognized by reason of section 1031 or 1033 of the Internal Revenue Code of 1986; or

(iii) in a reorganization (as so defined) with another corporation the securities of which are described in paragraph (1)(A) of this subsection.

(C) LIMITATION ON TRANSITION RULES.—Subparagraph (A) shall cease to apply to securities of a corporation held, acquired, or received, directly or indirectly, by a real estate investment trust as of the first day after July 12, 1999, on which such trust acquires any additional securities of such corporation other than—

(i) pursuant to a binding contract in effect on July 12, 1999, and at all times thereafter; or

(ii) in a reorganization (as so defined) with another corporation the securities of which are described in paragraph (1)(A) of this subsection.

(2) TAX-FREE CONVERSION.—If—

(A) at the time of an election for a corporation to become a taxable REIT subsidiary, the amendment made by section 541 does not apply to such corporation by reason of paragraph (1); and

(B) such election first takes effect before January 1, 2004,

such election shall be treated as a reorganization qualifying under section 368(a)(1)(A) of such Code.

**SEC. 547. STUDY RELATING TO TAXABLE REIT SUBSIDIARIES.**

26 USC 856 note.

The Secretary of the Treasury shall conduct a study to determine how many taxable REIT subsidiaries are in existence and the aggregate amount of taxes paid by such subsidiaries. The Secretary shall submit a report to the Congress describing the results of such study.

### Subpart B—Health Care REITs

#### SEC. 551. HEALTH CARE REITs.

26 USC 856.

(a) SPECIAL FORECLOSURE RULE FOR HEALTH CARE PROPERTIES.—Subsection (e) of section 856 of the Internal Revenue Code of 1986 (relating to special rules for foreclosure property) is amended by adding at the end the following new paragraph:

“(6) SPECIAL RULE FOR QUALIFIED HEALTH CARE PROPERTIES.—For purposes of this subsection—

“(A) ACQUISITION AT EXPIRATION OF LEASE.—The term ‘foreclosure property’ shall include any qualified health care property acquired by a real estate investment trust as the result of the termination of a lease of such property (other than a termination by reason of a default, or the imminence of a default, on the lease).

“(B) GRACE PERIOD.—In the case of a qualified health care property which is foreclosure property solely by reason of subparagraph (A), in lieu of applying paragraphs (2) and (3)—

“(i) the qualified health care property shall cease to be foreclosure property as of the close of the second taxable year after the taxable year in which such trust acquired such property, and

“(ii) if the real estate investment trust establishes to the satisfaction of the Secretary that an extension of the grace period in clause (i) is necessary to the orderly leasing or liquidation of the trust’s interest in such qualified health care property, the Secretary may grant one or more extensions of the grace period for such qualified health care property.

Any such extension shall not extend the grace period beyond the close of the 6th year after the taxable year in which such trust acquired such qualified health care property.

“(C) INCOME FROM INDEPENDENT CONTRACTORS.—For purposes of applying paragraph (4)(C) with respect to qualified health care property which is foreclosure property by reason of subparagraph (A) or paragraph (1), income derived or received by the trust from an independent contractor shall be disregarded to the extent such income is attributable to—

“(i) any lease of property in effect on the date the real estate investment trust acquired the qualified health care property (without regard to its renewal after such date so long as such renewal is pursuant to the terms of such lease as in effect on such date), or

“(ii) any lease of property entered into after such date if—

“(I) on such date, a lease of such property from the trust was in effect, and

“(II) under the terms of the new lease, such trust receives a substantially similar or lesser benefit in comparison to the lease referred to in subclause (I).

“(D) QUALIFIED HEALTH CARE PROPERTY.—

“(i) IN GENERAL.—The term ‘qualified health care property’ means any real property (including interests therein), and any personal property incident to such real property, which—

“(I) is a health care facility, or

“(II) is necessary or incidental to the use of a health care facility.

“(ii) HEALTH CARE FACILITY.—For purposes of clause (i), the term ‘health care facility’ means a hospital, nursing facility, assisted living facility, congregate care facility, qualified continuing care facility (as defined in section 7872(g)(4)), or other licensed facility which extends medical or nursing or ancillary services to patients and which, immediately before the termination, expiration, default, or breach of the lease of or mortgage secured by such facility, was operated by a provider of such services which was eligible for participation in the medicare program under title XVIII of the Social Security Act with respect to such facility.”.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2000.

26 USC 856 note.

### Subpart C—Conformity With Regulated Investment Company Rules

#### SEC. 556. CONFORMITY WITH REGULATED INVESTMENT COMPANY RULES.

(a) DISTRIBUTION REQUIREMENT.—Clauses (i) and (ii) of section 857(a)(1)(A) of the Internal Revenue Code of 1986 (relating to requirements applicable to real estate investment trusts) are each amended by striking “95 percent (90 percent for taxable years beginning before January 1, 1980)” and inserting “90 percent”.

26 USC 857.

(b) IMPOSITION OF TAX.—Clause (i) of section 857(b)(5)(A) of such Code (relating to imposition of tax in case of failure to meet certain requirements) is amended by striking “95 percent (90 percent in the case of taxable years beginning before January 1, 1980)” and inserting “90 percent”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2000.

26 USC 857 note.

### Subpart D—Clarification of Exception From Impermissible Tenant Service Income

#### SEC. 561. CLARIFICATION OF EXCEPTION FOR INDEPENDENT OPERATORS.

(a) IN GENERAL.—Paragraph (3) of section 856(d) of the Internal Revenue Code of 1986 (relating to independent contractor defined) is amended by adding at the end the following flush sentence:

26 USC 856.

“In the event that any class of stock of either the real estate investment trust or such person is regularly traded on an established securities market, only persons who own, directly or indirectly, more than 5 percent of such class of stock shall be taken into account as owning any of the stock of such class for purposes of applying the 35 percent limitation set forth in subparagraph (B) (but all of the outstanding stock

of such class shall be considered outstanding in order to compute the denominator for purpose of determining the applicable percentage of ownership).”.

26 USC 856 note. (b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2000.

### Subpart E—Modification of Earnings and Profits Rules

#### SEC. 566. MODIFICATION OF EARNINGS AND PROFITS RULES.

(a) RULES FOR DETERMINING WHETHER REGULATED INVESTMENT COMPANY HAS EARNINGS AND PROFITS FROM NON-RIC YEAR.—

26 USC 852.

(1) IN GENERAL.—Subsection (c) of section 852 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

“(3) DISTRIBUTIONS TO MEET REQUIREMENTS OF SUBSECTION (a)(2)(B).—Any distribution which is made in order to comply with the requirements of subsection (a)(2)(B)—

“(A) shall be treated for purposes of this subsection and subsection (a)(2)(B) as made from earnings and profits which, but for the distribution, would result in a failure to meet such requirements (and allocated to such earnings on a first-in, first-out basis), and

“(B) to the extent treated under subparagraph (A) as made from accumulated earnings and profits, shall not be treated as a distribution for purposes of subsection (b)(2)(D) and section 855.”.

26 USC 857.

(2) CONFORMING AMENDMENT.—Subparagraph (A) of section 857(d)(3) of such Code is amended to read as follows:

“(A) shall be treated for purposes of this subsection and subsection (a)(2)(B) as made from earnings and profits which, but for the distribution, would result in a failure to meet such requirements (and allocated to such earnings on a first-in, first-out basis), and”.

(b) CLARIFICATION OF APPLICATION OF REIT SPILLOVER DIVIDEND RULES TO DISTRIBUTIONS TO MEET QUALIFICATION REQUIREMENT.—Subparagraph (B) of section 857(d)(3) of such Code is amended by inserting before the period “and section 858”.

(c) APPLICATION OF DEFICIENCY DIVIDEND PROCEDURES.—Paragraph (1) of section 852(e) of such Code is amended by adding at the end the following new sentence: “If the determination under subparagraph (A) is solely as a result of the failure to meet the requirements of subsection (a)(2), the preceding sentence shall also apply for purposes of applying subsection (a)(2) to the non-RIC year and the amount referred to in paragraph (2)(A)(i) shall be the portion of the accumulated earnings and profits which resulted in such failure.”.

26 USC 852 note.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions after December 31, 2000.

### Subpart F—Modification of Estimated Tax Rules

#### SEC. 571. MODIFICATION OF ESTIMATED TAX RULES FOR CLOSELY HELD REAL ESTATE INVESTMENT TRUSTS.

26 USC 6655.

(a) IN GENERAL.—Subsection (e) of section 6655 of the Internal Revenue Code of 1986 (relating to estimated tax by corporations) is amended by adding at the end the following new paragraph:

## “(5) TREATMENT OF CERTAIN REIT DIVIDENDS.—

“(A) IN GENERAL.—Any dividend received from a closely held real estate investment trust by any person which owns (after application of subsections (d)(5) and (1)(3)(B) of section 856) 10 percent or more (by vote or value) of the stock or beneficial interests in the trust shall be taken into account in computing annualized income installments under paragraph (2) in a manner similar to the manner under which partnership income inclusions are taken into account.

“(B) CLOSELY HELD REIT.—For purposes of subparagraph (A), the term ‘closely held real estate investment trust’ means a real estate investment trust with respect to which 5 or fewer persons own (after application of subsections (d)(5) and (1)(3)(B) of section 856) 50 percent or more (by vote or value) of the stock or beneficial interests in the trust.”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to estimated tax payments due on or after December 15, 1999. 26 USC 6655 note.

Approved December 17, 1999.

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**LEGISLATIVE HISTORY—H.R. 1180 (S. 331):**

HOUSE REPORTS: Nos. 106-220, Pt. 1 (Comm. on Commerce) and 106-478 (Comm. of Conference).

SENATE REPORTS: No. 106-37 accompanying S. 331 (Comm. on Finance).

CONGRESSIONAL RECORD, Vol. 145 (1999):

Oct. 19, considered and passed House.

Oct. 21, considered and passed Senate, amended, in lieu of S. 331.

Nov. 18, House agreed to conference report.

Nov. 19, Senate agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 35 (1999):

Dec. 17, Presidential remarks and statement.



APPENDIX F

Autism Statistics



## **Introduction**

I am Florence LaRoy, parent, tutor and advocate for my son, Jeffrey LaRoy, a 15 year old with autism. My child was born prematurely at Sunrise Hospital and I have tapped numerous service delivery systems within Nevada and in other states over the years. Jeff has attended public school in Clark County all of his life. I spent 10 years at home as my child's caregiver and teacher because I was unable to obtain regular in-home or outside daycare to pursue my career and obtain adequate early intervention services. I also needed to be available to shuttle my child to and from therapies and behavioral services.

During my years at home I networked with other parents of children with disabilities as a member of several parent support groups. My efforts culminated in coordinating the 1994 National Conference in Las Vegas for the Autism Society of America . Shortly thereafter, I began working for Nevada PEP, statewide Parent Training and Information center and my knowledge and advocacy work expanded. I have now been working for this very fine non-profit organization for four years. Because of my own experiences and the families I have encountered, my desire to effect change grows even stronger.



## Children in Nevada Affected by Autism

According to the *Kids Count* data from December 1, 1998 which provides information on disability categories according to eligibility there are

- **236 school aged children (3-21) with autism in Nevada**

In Reality, according to the incidence in the general population of 1 in 500 as given by the Autism Society of America there should be

- **3,618 people with autism in Nevada**

using the population data for Nevada from July 1, 1999 of 1,809,253.

Using the total enrollment for 1999 to 2000 of 325,610 school aged children (3 - 21) there should be

- **651 children with autism in Nevada.**

According to the 1998-99 enrollment of 203,777 school aged children (3 - 21) there should be

- **407 children with autism in Clark County.**

Not until 1993 was Autism considered a category under the Individuals with Disabilities Education Act (IDEA). Many children with autism are counted in other special education eligibility categories, such as developmental disabled, mental retardation, learning disabled, severely emotionally disturbed and language impaired, therefore the numbers given in *Nevada Kids Count* are not truly representative.

Nevada PEP provides information, referral and individual assistance for families who have children with autism. The number of calls received by Nevada PEP related to autism was

- **10 percent for 1998 - 99, as compared to the**
- **average percentage of \_\_\_\_\_ by PII's nationally. (lower)**

This difference supports the increased demand for autism services.

## Services Currently Available

- There are a limited number of private **medical** professionals, such as pediatricians, neurologists and psychiatrists who have expertise in autism. No developmental pediatricians are available in Clark County and the diagnosis of autism by pediatricians is often delayed or missed because of a lack of training in pervasive developmental disorders.
- There are a limited number of private **dental** professionals (dentists, hygienists) who are willing to treat special needs children who often require pre-medication for their behavior prior to treatment. Additionally, parents have difficulty finding providers who are willing to accept Medicaid.
- There are few mental health professionals, such as **psychologists and counselors**, who have expertise in autism and experience in recognizing the overlapping psychological conditions.
- There are many **therapists** in private practice (speech, occupational, physical, vision, music), but few are knowledgeable about autism and have experience working with this population. Parents are often limited in obtaining therapy for their children by their medical insurance coverage. Even if coverage is provided by insurers, the number of visits or caps in coverage may limit the intensity of therapy needed for children with autism.
- **Special Children's Clinic**  
Parents often find that there are long waiting lists to obtain services and that the level of service delivery is limited. They are faced with an inadequate amounts of therapy by staff who have limited expertise in autism. The delay in diagnosing and starting intervention services only serves to exacerbate the symptoms of autism.
- **Division of Child and Family Services**  
There are a limited number of professionals with a knowledge of autism and the experience to provide appropriate behavioral intervention. Families are unable to obtain acute crisis intervention for children with autism who have severe behavioral issues either in the home or at an acute treatment center. There are also no long-term out-of-home placements available in Nevada specifically designed to provide intense behavioral intervention or permanent

residential care for children with autism. See Autism Services for the Pathways Program.

- **Desert/ Sierra Regional Centers**

Until the Parry case, only a person with autism and mental retardation could access services at a regional center. Such limitations are still being imposed on families who are not familiar with current regulations. There is an extensive wait for services and staff are limited in their expertise in autism. Families who do tap these resources are limited to the amount of services they obtain, such as respite help. Staff are limited in their expertise and experience with individuals with autism. Interventions and behavioral supports are inadequate, leading to further regression.

- **Public Schools**

There are some programs specifically designed for children with autism, however, children with autism are also found in many different special education classes and in the general education setting depending on their level of functioning. Few educators, even those teaching autism classes have the necessary expertise, extensive training and experience using best practices that children with autism need. Maintaining a pool of qualified teachers for this difficult population with a relatively newly educated work force further creates chaos in the classroom. Even veteran teachers may not have the skills to work with children who have autism, as this expertise is most frequently obtained through specialized training. Many teachers simply do not understand their unique learning styles and therefore have either too many or too few expectations. There also seems to be difficulty in their ability to modify assignments to meet the unique needs of children with autism.

Also, little or no adequate program planning and intervention is available to address and remediate behavioral problems. Instead of children being taught new, more acceptable behaviors to replace disruptive ones, they are suspended or expelled from school. In essence this solves nothing; the children eventually return to school with the same or more severe behaviors because their desire to escape the challenging environment has been reinforced and they have lost the structure of a daily routine which is crucial for children with autism. The amount of time and effort required to address challenging behavior is not expended. The use of positive behavioral supports and functional behavioral analyses, as mandated by the Individuals with Disabilities Education Act and by Nevada's

AB 280, is poorly done or not at all.

There are a lack of therapists qualified to work with children who have autism and the type (individual or group sessions) or amount of therapy available do not meet their needs. These services are crucial because of the difficulty these children have in initiating and reciprocating communication. Speech and language therapy needs to begin early and intensely so that children have a means of communication. Some children who do not develop language or have limited verbal skills which necessitate the use of augmentative communication, requiring adequate time, effort and expertise to develop and facilitate its use.

Many children have sensory and motor planning difficulties making classroom environments and tasks challenging which requires staffing of specially trained and skilled therapists to help remediate or reduce these deficits.

In addition to teaching professionals, there is a dirth of adequately trained support staff available to individually assist children with autism. These assistants are crucial to integrating children with autism into the general education environment so that they may be educated with their typical peers who provide positive role models. Because children with autism have difficulties in communicating and understanding social rules, they must be taught play skills and how to interact with other children on a regular basis. Grouping children with autism together can aggravate autistic behaviors and not allow enough practice of typical childhood interactions. Parents have difficulty accessing extracurricular activities for their children which are supervised by staff not knowledgeable about autism and lack the support personnel to facilitate social interaction with peers. Children with autism do not get the rich and well-rounded education that their typical peers receive. There is also a lack of programming to allow for adequate skill development and transition planning from school to work and from school to community. Unfortunately, parents find themselves in a position to supply the education and experiences needed by their children with their time and money due to gaps in the public education that they are entitled to receive by federal law. Additionally, many parents are not treated with the respect they deserve and the expertise they have regarding their children's needs.

- **Parks and Recreation Programs**

Parents are simply limited in accessing regular and special programs because staff have limited expertise and training in autism. If indeed utilized, these programs do not have adequate support staff to address the challenging

behaviors, integration and participation difficulties experienced by children with autism. Programs available after school, before school, during track breaks and vacations are also inadequate due to the above reasons. When children are enrolled in such programs, they are often expelled because of the difficulties program staff encounter, although there should be no discrimination with regard to disability. There are simply insufficient opportunities for children with autism to engage in rewarding recreational activities with their typical peers.

- **Katie Beckett Program**

This funding stream taps Medicaid services for families with insurance whose children have extensive needs that are not covered by their policies or whose needs would deplete family resources. This program is limited in scope and does have income eligibility requirements.

- **Nevada Check Up**

This program provides low-cost, comprehensive health care coverage to uninsured children not covered by private insurance or Medicaid. This program does have income eligibility requirements that need to be met in order to enroll and appears to be under utilized.

## **Services Specific for Autism**

- **Division of Child and Family Services - Pathways Program**

This program was specifically designed to address autism services in the community, but has been staffed by only one person for many years. This service is woefully inadequate to meet current demands. There is a need for more training opportunities and increased support staff.

- **UNR Early Childhood Autism Program (see web site literature)**

This program limited to Reno and outlying areas provides center-based, home-based and consultative services to families using multiple layers of well trained support staff. Access to this highly effective program is limited due to the high cost of services, center openings and the supply and cost of support personnel.

- **Private Home Programs for Families**

This intervention requires parents to hire and pay for out-of-state consultants to provide individual workshops and develop programs for their children. The workshops are conducted by the consultant to provide family and staff training. Parents hire the individually trained support staff (home tutors) to work with their children. Service delivery is dependent upon the resources of the family and any alternate funding stream.

### **Services Needed**

- **A legislative committee is needed to assess current services available and determine immediate and long term needs. Effective programs and delivery systems from other states need to be researched and evaluated for use in Nevada. Families needed to be consulted throughout the process. This process should move quickly from study to service delivery so children will be served without delay!**
- **Statewide consultants need to be hired who have expertise and extensive training in autism, as well as, experience in working with children with autism and program development according to national standards and best practices.**
- **Trained evaluators using current evaluation instruments should be readily available.**
- **Program designers will be needed to develop individual intervention plans.**
- **Trained behaviorists are needed to carry out functional behavioral analyses and develop Positive behavioral supports for children with autism.**
- **An urban and rural training and delivery system needs to be developed.**
- **Ongoing training needs to be provided for families, support staff and professionals using current best practices. This would help maintain a steady supply of trained staff for intervention and respite.**
- **An autism awareness program needs to be implemented to promote early diagnosis and intervention.**

- **Funding sources**, such as a voucher program, need to be developed to help pay for or supplement resources required by families to make intervention accessible and affordable.
- Appropriate **social service links** needed to be facilitated so that families are tapping all available resources. These resources need to be integrated, opened up and increased so that valuable intervention time is not lost due to the lack of funds. Public agencies should be working together to ensure there are no gaps in service delivery.
- Qualified providers need to **link up** with families who need their services.
- **Case managers** are needed to assist families in coordinating service delivery, support and funding streams.
- An independent **support network** for families by families needs to be facilitated.
- Families should have **service delivery options**, such as home-based, center-base or consultative as required by individual needs.
- Adequately trained and qualified **support staff** need to be available to provide in-home behavioral intervention, respite services and family assistance without undue delays
- In-home or out-of-home **crisis intervention** needs to be available to parents without delay. Intensive intervention services should be provided to reduce out of home placement.
- Short term or long term **residential care** facilities with well trained personnel and appropriate behavioral support and intervention plans need to be developed.

## **Behavior Intervention Centers**

**A comprehensive coordination and delivery system option that would address autism and other overlying psychiatric or psychological conditions.**

This center would be staffed by individuals with expertise and training in providing appropriate behavioral intervention plans and develop positive

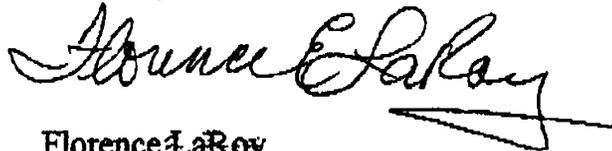
behavioral supports using current best practices. The center would be sensitive to the needs of families and include on staff knowledgeable family members who can provide support to other families. Families would be involved in determining the direction of the center's services. Assessment and referral services would be provided for families, as well as, consultation and referral services for private/public medical, therapeutic and other professionals so that there is a seamless link in service delivery. Case managers would be available to assist families in coordinating services, funding streams and linkage to appropriate medical, therapeutic and behavioral services. Ongoing training would be provided to help families, community professionals and support personnel to cope with children who have significant behavioral challenges. Services would be provided at the center or in the home or on a consultative basis. Inclusionary day, after school and weekend programs would available to help develop appropriate social skills and recreational opportunities for children who would ultimately be included in general community programs. Life and work skills training would provide readiness for community life and facilitate the use of community job development programs so that children and young adults experience success.

## Summary

The heart wrenching stories you've heard are not for sympathy, but to bring you into the world of autism and to help you understand the struggles of parents. Autism does not discriminate! It has no ethnic, racial or social boundaries, so for a moment picture the impact on your family if you had a child or grandchild with autism. Remember the chances are 1 in 500! Where would you get help and intervention for your loved one? How would you like to be treated? Where would you get the money for treatment? Parents have asked this year and last year, ten and even twenty years ago, "How can I get what my child needs?" The advice given to families of children with autism who are considering a move to Nevada from a state which provides monies, programs and services is, "Don't move here!" It is up to the leaders of this state to say, "We have waited long enough to serve our children!" The families and elected officials together must look at what we have and plan for what we need.

I want to thank Assemblywoman Ellen Kovisto and this legislative committee for the opportunity to come before you with the concerns of families of children with autism and provide you with some information and suggestions. More information will become available in the coming months, as a result of the fact-finding mission of a special committee on autism.

Sincerely,

A handwritten signature in cursive script that reads "Florence LaRoy". The signature is written in black ink and is positioned above the printed name.

Florence LaRoy

NEVADA  
Totals '98

December 1, 1998

Eligibility	Age									
	3	4	5	6	7	8	9	10	11	12
Mentally Handicapped	11	9	17	77	93	117	137	138	112	132
Aurally Handicapped	12	20	21	20	32	30	30	35	29	28
Speech/Language Handicapped	88	221	432	930	923	1,041	838	595	322	166
Visually Handicapped	0	8	7	3	13	10	9	10	12	5
Emotionally Disabled	0	0	2	33	72	74	104	146	135	150
Orthopedically Impaired	5	18	19	22	27	31	21	33	16	25
Health Impaired	9	19	7	63	100	89	94	122	109	92
Learning Disabled	0	0	17	447	744	1,262	1,784	2,032	1,978	2,048
Deaf-Blind	0	1	0	0	2	1	0	0	0	0
Multiple Handicapped	15	29	24	36	55	52	61	41	38	37
Autism	12	10	16	36	18	30	32	21	11	12
Traumatic Brain Injured	1	1	0	5	7	11	10	9	6	10
Developmentally Delayed	532	1,039	909	0	0	0	0	0	0	0
<b>Total</b>	<b>685</b>	<b>1,375</b>	<b>1,471</b>	<b>1,681</b>	<b>2,086</b>	<b>2,748</b>	<b>3,120</b>	<b>3,182</b>	<b>2,768</b>	<b>2,705</b>

Eligibility	Age									
	13	14	15	16	17	18	19	20	21	Total
Mentally Handicapped	118	128	142	122	125	87	58	35	24	1,682
Aurally Handicapped	26	21	33	23	21	10	1	2	0	394
Speech/Language Handicapped	94	52	29	17	12	7	1	0	0	5,777
Visually Handicapped	10	12	9	8	9	4	0	0	0	129
Emotionally Disabled	167	173	185	155	107	43	9	3	0	1,558
Orthopedically Impaired	19	17	13	19	18	6	1	2	0	312
Health Impaired	82	69	67	58	33	20	4	2	0	1,039
Learning Disabled	2,000	1,806	1,683	1,456	1,126	526	67	19	4	18,999
Deaf-Blind	0	0	0	0	0	0	0	0	0	4
Multiple Handicapped	28	26	35	31	32	24	15	21	8	608
Autism	6	6	7	6	7	2	1	3	0	236
Traumatic Brain Injured	6	5	7	4	12	2	4	1	0	101
Developmentally Delayed	0	0	0	0	0	0	0	0	0	2,480
<b>Total</b>	<b>2,556</b>	<b>2,315</b>	<b>2,210</b>	<b>1,899</b>	<b>1,502</b>	<b>731</b>	<b>161</b>	<b>86</b>	<b>36</b>	<b>33,319</b>

Print Date: 2/6/99



DEPARTMENT OF HUMAN RESOURCES  
DIRECTOR'S OFFICE  
505 E. King Street, Room 600  
Carson City, Nevada 89701-3708  
Telephone (775) 684-4000 • Fax (775) 684-4010

January 19, 2000

**M E M O R A N D U M**

**TO:** Marla McDade Williams, Senior Research Analyst  
Legislative Counsel Bureau

**FROM:** Charlotte Crawford, Director *CC/MO*

**SUBJECT:** Request from January 4, 2000

Please find the following responses to your January 4<sup>th</sup>, 2000 request for information for the Legislative Committee Meeting on January 26<sup>th</sup>:

Question 1 Responses:

Division of Child and Family Services

1. A discussion of services that are available through the Department of Human Resources (DHR) for autistic children in Nevada. If feasible, please include data that identifies issues relevant to one's eligibility for services, including whether eligibility is based on family or individual income, level of disability, or other criteria. Also, please include information concerning the providers of services and their availability throughout the state, the number of children who are served, and any information that will help members understand this issue and its impact on Nevada families.

DCFS Services for Autistic Children in Nevada

The term "autistic" in this discussion encompasses a range of diagnostic or descriptive categories, including Pervasive Developmental Disorders, Autistic Disorder, Asperger's Disorder, Rett's Disorder, and Childhood Disintegrative Disorder. Pervasive Developmental Disorders (PDD) is the broader, more inclusive category as described in the Diagnostic and Statistical manual of

Mental Disorders (DSM); "autistic disorder" is a sub-category within the broader PDD classification. Children diagnosed with a Pervasive Developmental Disorder have 'severe and pervasive impairment in several areas of development, including impairments in cognitive, communication, social interactive skills, and adaptive functioning' (DSM). Approximately 75% of children diagnosed with Autistic Disorder function within the mild to moderate level of mental retardation (IQ 35 – approximately 70).

The DCFS treatment programs – Desert Willow Treatment Center, Adolescent Treatment Center, On-Campus Treatment Homes, and Outpatient Services – are responsible for providing services to children, including those with Pervasive Developmental Disorders, whose intellectual functioning is assessed at IQ 70 and above on standardized measures, with a commensurate level of adaptive functioning. Desert Regional Center, and Sierra Regional Center under the Division of Mental Health and Developmental Services are responsible for serving children with IQs less than 70, with commensurate impairment in adaptive functioning. This distinction is not always readily apparent or easily assessed.

Ability to pay is not a criterion for eligibility. Families accessing DCFS treatment programs for autistic children are assessed fees on a sliding fee scale, based on gross family income. Medicaid covers most services, for eligible children. Many insurance plans will cover some, but not all treatment services. Other services are covered by the State under a variety of funding sources.

DCFS provides the following services: outpatient therapy, home-based and community-based services, crisis services, psychiatric and medication services, targeted case management, treatment homes, residential treatment programs, acute hospitalization.

In addition, DCFS contracts for a range of services that are also available to all qualifying children, including those diagnosed PDD. Those services are respite care, day treatment and after school programs, home and community-based services, therapeutic family care, group homes, and independent living/transitional homes. Few of the contract providers have been willing to accept autistic children into their programs or are able to provide the necessary levels of staffing, supervision, structure, and programming. The results that Outpatient staff have experienced in using contract services with autistic children have been mixed.

**Services for children with autism/pervasive developmental disorder (pdd)**  
**Division of Child and Family Services/Southern Region**  
**12/15/99**

**First Step (children 0-3 with developmental delays)**

- Served: eight children (3% of current caseload) with autism/pdd
  - Waitlist: none

- Unmet needs: services intensity is inadequate. Most children/families receive one hour of services per week including speech therapy, physical therapy, and developmental intervention. Best practice for infants and toddlers would range from 2 to 10 (sometimes more as children approach 3) hours per week. High caseloads preclude more intense services as this time.

#### **Desert Willow**

- There are 3 children diagnosed with PDD here at Desert Willow now. The other children that would be close to this category are FAS type kids.
- There are no children on the waiting list that hold that diagnosis.

#### **Waiting for residential placement at DCR (accepted) -youth with mental retardation & pdd/autism. All DCFS custody in Oasis, Therapeutic foster, or group homes**

Boy, 11, MR & PDD.  
Boy, 13, MH & PDD  
Boy, 8, MH & PDD

#### **Outpatient services:**

- Open cases for 15 children with diagnoses of autism/PDD/Aspergers, with 1 child officially on our waiting list and 2 more referred.
- One of the outpatient staff is specifically designated to work with this population; she reports that each month she speaks with 8 -10 families (not open cases) of children with these diagnoses or with professionals requesting information in this area.
- Staff report service gaps in after-school (non-therapeutic) programs, day treatment programs, respite services.

#### **Oasis**

- Currently serving in 2 homes on campus 7 youth who fit in to the PDD/FAS/Borderline Intellectual Functioning or M.R. category. Four of the youth have PDD as part of their diagnosis.
- 3 on the waiting list, a fourth was recently placed some where else.

#### **Services for children with autism/pervasive developmental disorder (pdd) Division of Child and Family Services/Northern Region**

**12/21/99**

#### **Early Childhood Program (Children 0-5 in Outpatient and Project Crisis Services)**

- **Waitlist:** There are currently 3 children on the Early Childhood waitlist with symptoms that could be consistent with PDD.

- **Served:** Early Childhood staff report 6 children with PDD have been served within the last year. This program has also served 3 children with strong limitations with regard to intelligence.

#### **Outpatient Services (Children 6-17)**

- **Waitlist:** There are currently 3 children awaiting services from the outpatient program. These youths have been described as either PDD or mildly autistic.
- **Served:** Review of agency database and reports from therapists indicate that the Outpatient staff currently serve 2 children with PDD diagnoses and an additional 3 with Mental Retardation.

#### **Community Treatment/Family Learning Homes**

- **Waitlist:** There are currently no children with PDD diagnoses awaiting services.
- **Served:** The Community Treatment/Family Learning Home programs currently serve three children with PDD diagnosis.

#### **Adolescent Treatment Services**

- **Waitlist:** There are currently no children with PDD diagnoses awaiting services.
- **Served:** The Adolescent Treatment Center currently serves 3 adolescents with PDD diagnoses.

#### **Mental Health and Developmental Services**

1. Services to persons with Autistic Spectrum Disorders (ASD) by the Division of MHDS. The attachment (Attachment 1) from the Autism Society of America provides a good overview of the diagnosis and frequently asked questions about Autism and related spectrum disorders. The term Autism Spectrum Disorder reflects the wide varieties of symptoms and severity that are associated with Autism.

MHDS serves persons with (ASD) through the Developmental Services (DS) section of the Division. Although an occasional acute service may be provided through the mental health agencies, the presented materials represent services provided through Developmental Services agencies. DS has three Regional Centers – Desert (in Las Vegas), Sierra (in Washoe County), and Rural (in Carson, Elko, Fallon and Winnemucca).

### Eligibility

Most persons with ASD (75%) also qualify as having mental retardation. Our Division has served these individuals over the years and continues to do so. In addition, during the 1999 session the Legislature expanded developmental services population to cover 187 persons with conditions related to mental retardation. The related conditions includes disorders such as Cerebral Palsy, Epilepsy and Autism when such individuals have impaired adaptive behavior and need services similar to those provided for persons with mental retardation. (Decision units M 600 - \$3,972,323; FY 00 \$1,195,661; FY 01 \$2,776,662). As a result, significant additional individuals are being enrolled in our services with an Autism diagnoses. DS currently serves 111 persons with ASD, 55 adults and 56 children (37 have enrolled since July of 1998). These cases represent 3% of our adult cases and 10% of children's cases. (see attached graphs)

### Service Descriptions/Financial Eligibility

Attached (Attachment 2 from the Division web page) is a description of available services and associated costs. Services include service coordination, family support, respite, jobs, day training and residential support. For most people, costs are covered by Medicaid.

### Providers of Service

The Division of MHDS provides most of the services via contracts with a variety of private providers. These include respite care providers, residential support providers, sheltered employment organizations, and job coaches. There are approximately 67 providers in the state (attachment 3 web page). Attached is a list of providers currently used by the Division organized by Region. Each program of service is an individualized service plan based on the needs of each person. This allows our Division to serve the wide range of specialty needs and individual disabilities that are present with our clients.

### Other Service Providers

In addition to our Division, the Health Division provides early intervention services through Special Children's Clinics (ages 0-3). The school districts provide an appropriate educational program for children regardless of disability. The University of Nevada-Reno has a specialized intensive training program for children with Autism using the "Lovaas" discrete trial method.





KENNY C. GUINN  
*Governor*

CHARLOTTE CRAWFORD  
*Director*

STATE OF NEVADA  
DIVISION OF MENTAL HEALTH  
AND DEVELOPMENTAL SERVICES

Kinkead Building, Room 602  
505 E. King Street  
Carson City, Nevada 89701-3790  
(775) 684-5943 • Fax (775) 684-5966

CARLOS BRANDENBURG, Ph.D.  
*Administrator*

DEBBIE HOSELKUS  
*Deputy Administrator*

January 18, 2000

MEMORANDUM

TO: Marla McDade Williams  
Senior Research Analyst  
Research Division

THROUGH: Charlotte Crawford, Director  
Department of Human Resources

FROM: Carlos Brandenburg, Ph.D., Administrator, MHDS  
Debbie Hosselkus, Deputy Administrator, MHDS  
David Luke, Ph.D., Associate Administrator, DS

cc: Denice Miller, Senior Policy Director, Governor's Office  
Joel Pinkerton, Principal Budget Analyst, Budget Division  
Bob Guernsey, Principal Deputy Fiscal Analyst, LCB

Pursuant to your request to have responses to the first 3 questions that will be discussed January 26, 2000 at the Legislative Committee on Health Care, we have taken the liberty of presenting information separately for the Mental Health and Developmental Services within our Division.

## DEVELOPMENTAL SERVICES

### Question #1

Please provide a discussion of services that are available through the Department of Human Resources (DHR) for autistic children in Nevada. If feasible, please include data that identifies issues relevant to one's eligibility for services, including whether eligibility is based on family or individual income, level of disability, or other criteria. Also, please include information concerning the providers of services and their availability throughout the state, the number of children who are served, and any other information that will help members understand this issue and its impact on Nevada families.

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Draft 1.Leg.Resp:c:mlr





# What Is Autism?

What is Autism?

Is there More than One Type of Autism?

What Causes Autism?

How is Autism Diagnosed?

What are People with Autism Like?

What are the Most Effective Approaches to Autism?

Is there a Cure for Autism?

The Autism Society of America

The Autism Society of America Foundation

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## • What is Autism?

Autism is a complex developmental disability that typically appears during the first three years of life. The result of a neurological disorder that affects the functioning of the brain, autism and its associated behaviors have been estimated to occur in as many as 1 in 500 individuals (Centers for Disease Control and Prevention 1997). Autism is four times more prevalent in boys than girls and knows no racial, ethnic, or social boundaries. Family income, lifestyle, and educational levels do not affect the chance of autism's occurrence.

## What is Autism?

Autism impacts the normal development of the brain in the areas of social interaction and communication skills. Children and adults with autism typically have difficulties in verbal and non-verbal communication, social interactions, and leisure or play activities. The disorder makes it hard for them to communicate with others and relate to the outside world. In some cases, aggressive and/or self-injurious behavior may be present. Persons with autism may exhibit repeated body movements (hand flapping, rocking), unusual responses to people or attachments to objects and resistance to changes in routines. Individuals may also experience sensitivities in the five senses of sight, hearing, touch, smell, and taste.

Over one half million people in the U.S. today have autism or some form of pervasive developmental disorder. Its prevalence rate makes autism one of the most common developmental disabilities. Yet most of the public, including many professionals in the medical, educational, and vocational fields, are still unaware of how autism affects people and how they can effectively work with individuals with autism.

## • Is There More Than One Type of Autism?

Several related disorders are grouped under the broad heading "Pervasive Developmental Disorder" or PDD-a general category of disorders which are characterized by severe and pervasive impairment in several areas of development (American Psychiatric Association 1994). A standard reference is the *Diagnostic and Statistical Manual (DSM)*, a diagnostic handbook now in its fourth edition. The *DSM-IV* lists criteria to be met for a specific diagnosis under the category of Pervasive Developmental Disorder. Diagnosis is made when a specified number of characteristics listed in the *DSM-IV* are present. Diagnostic evaluations are based on the presence of specific behaviors indicated by observation and through parent consultation, and should be made by an experienced, highly trained team. Thus, when professionals or parents are referring to different types of autism, often they are distinguishing autism from one of the other pervasive developmental disorders.

Individuals who fall under the Pervasive Developmental Disorder category in the *DSM-IV* exhibit commonalities in communication and social deficits, but differ in terms of severity. We have outlined some major points that help distinguish the differences between the specific diagnoses used:

### **Autistic Disorder**

impairments in social interaction, communication, and imaginative play prior to age 3 years. Stereotyped behaviors, interests and activities.

### **Asperger's Disorder**

characterized by impairments in social interactions and the presence of restricted interests and activities, with no clinically significant general delay in language, and testing in the range of average to above average intelligence.

### **Pervasive Developmental Disorder- Not Otherwise Specified**

(commonly referred to as atypical autism) a diagnosis of PDD-NOS may be made when a child does not meet the criteria for a specific diagnosis, but there is a severe and pervasive impairment in specified behaviors.

### **Rett's Disorder**

a progressive disorder which, to date, has occurred only in girls. Period of normal development and then loss of previously acquired skills, loss of purposeful use of the hands replaced with repetitive hand movements beginning at the age of 1-4 years.

### **Childhood Disintegrative Disorder**

characterized by normal development for at least the first 2 years, significant loss of previously acquired skills. (*American Psychiatric Association 1994*)

Autism is a *spectrum disorder*. In other words, the symptoms and characteristics of autism can present themselves in a wide variety of combinations, from mild to severe. Although autism is defined by a certain set of behaviors, children and adults can exhibit *any combination* of the behaviors in *any degree of severity*. Two children, both with the same diagnosis, can act very differently from one another and have varying skills.

Therefore, there is no standard "type" or "typical" person with autism. Parents may hear different terms used to describe children within this spectrum, such as: autistic-like, autistic tendencies, autism spectrum, high-functioning or low-functioning autism, more-abled or less-abled. More important to understand is, whatever the diagnosis, children can learn and function productively and show gains from appropriate education and treatment. The Autism Society of America provides information to serve the needs of all individuals within the

## What is Autism?

spectrum.

Diagnostic categories have changed over the years as research progresses and as new editions of the *DSM* have been issued. For that reason, we will use the term "autism" to refer to the above disorders.

## • What Causes Autism?

Researchers from all over the world are devoting considerable time and energy into finding the answer to this critical question. Medical researchers are exploring different explanations for the various forms of autism. Although a single specific cause of autism is not known, current research links autism to biological or neurological differences in the brain. In many families there appears to be a pattern of autism or related disabilities—which suggests there is a genetic basis to the disorder—although at this time no gene has been directly linked to autism. The genetic basis is believed by researchers to be highly complex, probably involving several genes in combination.

Several outdated theories about the cause of autism have been proven to be false. Autism is **not** a mental illness. Children with autism are **not** unruly kids who choose not to behave. Autism is **not** caused by bad parenting. Furthermore, no known psychological factors in the development of the child have been shown to cause autism.

## • How is Autism Diagnosed?

There are no *medical* tests for diagnosing autism. An accurate diagnosis must be based on observation of the individual's communication, behavior, and developmental levels. However, because many of the behaviors associated with autism are shared by other disorders, various medical tests may be ordered to rule out or identify other possible causes of the symptoms being exhibited.

Since the characteristics of the disorder vary so much, ideally a child should be evaluated by a multidisciplinary team which may include a neurologist, psychologist, developmental pediatrician, speech/language therapist, learning consultant, or another professional knowledgeable about autism. Diagnosis is difficult for a practitioner with limited training or exposure to autism. Sometimes, autism has been misdiagnosed by well-meaning professionals. Difficulties in the recognition and acknowledgment of autism often lead to a lack of services to meet the complex needs of individuals with autism.

A brief observation in a single setting cannot present a true picture of an individual's abilities and behaviors. Parental (and other caregivers') input and developmental history are very important components of making an accurate diagnosis. At first glance, some persons with autism may appear to have mental retardation, a behavior disorder, problems with hearing, or even odd and eccentric behavior. To complicate matters further, these conditions can co-occur with autism. However, it is important to distinguish autism from other conditions, since an accurate diagnosis and early identification can provide the basis for building an appropriate and effective educational and treatment program. Sometimes professionals who are not knowledgeable about the needs and opportunities for early intervention in autism do not offer an autism diagnosis even if it is appropriate. This hesitation may be due to a misguided wish to spare the family. Unfortunately, this too can lead to failure to obtain appropriate services for the child.

## • What are People with Autism Like?

Children within the pervasive developmental disorder spectrum often appear relatively normal in their development until the age of 24-30 months, when parents may notice delays in language, play or social interaction. Any of the following delays, by themselves, would not result in a diagnosis of a pervasive developmental disorder. Autism is a combination of several developmental challenges.

The following areas are among those that may be affected by autism:

### **Communication:**

language develops slowly or not at all; uses words without attaching the usual meaning to them;  
communicates with gestures instead of words; short attention span;

### **Social Interaction:**

spends time alone rather than with others; shows little interest in making friends; less responsive to social cues such as eye contact or smiles;

## What is Autism?

### **Sensory Impairment:**

may have sensitivities in the areas of sight, hearing, touch, smell, and taste to a greater or lesser degree;

### **Play:**

lack of spontaneous or imaginative play; does not imitate others' actions; does not initiate pretend games;

### **Behaviors:**

may be overactive or very passive; throws tantrums for no apparent reason; perseverates (shows an obsessive interest in a single item, idea, activity or person); apparent lack of common sense; may show aggression to others or self; often has difficulty with changes in routine.

Some individuals with autism may also have other disorders which affect the functioning of the brain such as: Epilepsy, Mental Retardation, Down Syndrome, or genetic disorders such as: Fragile X Syndrome, Landau-Kleffner Syndrome, William's Syndrome or Tourette's Syndrome. Many of those diagnosed with autism will test in the range of mental retardation. Approximately 25-30 percent may develop a seizure pattern at some period during life.

Every person with autism is an individual, and like all individuals, has a unique personality and combination of characteristics. There are great differences among people with autism. Some individuals mildly affected may exhibit only slight delays in language and greater challenges with social interactions. The person may have difficulty initiating and/or maintaining a conversation, or keeping a conversation going. Communication is often described as talking at others (for example, monologue on a favorite subject that continues despite attempts of others to interject comments). People with autism process and respond to information in unique ways. Educators and other service providers must consider the unique pattern of learning strengths and difficulties in the individual with autism when assessing learning and behavior to ensure effective intervention. Individuals with autism can learn when information about their unique styles of receiving and expressing information is addressed and implemented in their programs. The abilities of an individual with autism may fluctuate from day to day due to difficulties in concentration, processing, or anxiety. The child may show evidence of learning one day, but not the next. Changes in external stimuli and anxiety can affect learning. They may have average or above average verbal, memory or spatial skills but find it difficult to be imaginative or join in activities with others. Individuals with more severe challenges may require intensive support to manage the basic tasks and needs of living day to day.

Contrary to popular understanding, many children and adults with autism may make eye contact, show affection, smile and laugh, and demonstrate a variety of other emotions, although in varying degrees. Like other children, they respond to their environment in both positive and negative ways. Autism may affect their range of responses and make it more difficult to control how their bodies and minds react. Sometimes visual, motor, and/or processing problems make it difficult to maintain eye contact with others. Some individuals with autism use peripheral vision rather than looking directly at others. Sometimes the touch or closeness of others may be painful to a person with autism, resulting in withdrawal even from family members. Anxiety, fear and confusion may result from being unable to "make sense" of the world in a routine way. With appropriate treatment, some behaviors associated with autism may change or diminish over time. The communication and social deficits continue in some form throughout life, but difficulties in other areas may fade or change with age, education, or level of stress. Often, the person begins to use skills in natural situations and to participate in a broader range of interests and activities. Many individuals with autism enjoy their lives and contribute to their community in a meaningful way. People with autism can learn to compensate for and cope with their disability, often quite well.

While no one can predict the future, it is known that some adults with autism live and work independently in the community (drive a car, earn a college degree, get married); some may be fairly independent in the community and only need some support for daily pressures; while others depend on much support from family and professionals. Adults with autism can benefit from vocational training to provide them with the skills needed for obtaining jobs, in addition to social and recreational programs. Adults with autism may live in a variety of residential settings, ranging from an independent home or apartment to group homes, supervised apartment settings, living with other family members or more structured residential care. An increasing number of support groups for adults with autism are emerging around the country. Many self-advocates are forming networks to share information, support each other, and speak for themselves in the public arena. More frequently, people with autism are attending and/or speaking at conferences and workshops on autism. Individuals with autism are providing valuable insight into the challenges of this disability by publishing articles and books and appearing in television specials about themselves and their disabilities.

## • What are the Most Effective Approaches?

## What is Autism?

Evidence shows that early intervention results in dramatically positive outcomes for young children with autism. While various pre-school models emphasize different program components, all share an emphasis on early, appropriate, and intensive educational interventions for young children. Other common factors may be: some degree of inclusion, mostly behaviorally-based interventions, programs which build on the interests of the child, extensive use of visuals to accompany instruction, highly structured schedule of activities, parent and staff training, transition planning and follow-up. Because of the spectrum nature of autism and the many behavior combinations which can occur, no one approach is effective in alleviating symptoms of autism in all cases. Various types of therapies are available, including (but not limited to) applied behavior analysis, auditory integration training, dietary interventions, discrete trial teaching, medications, music therapy, occupational therapy, PECS, physical therapy, sensory integration, speech/language therapy, TEACCH, and vision therapy.

Studies show that individuals with autism respond well to a highly structured, specialized education program, tailored to their individual needs. A well designed intervention approach may include some elements of communication therapy, social skill development, sensory integration therapy and applied behavior analysis, delivered by trained professionals in a consistent, comprehensive and coordinated manner. The more severe challenges of some children with autism may be best addressed by a structured education and behavior program which contains a one-on-one teacher to student ratio or small group environment. However, many other children with autism may be successful in a fully inclusive general education environment with appropriate support.

In addition to appropriate educational supports in the area of academics, students with autism should have training in functional living skills at the earliest possible age. Learning to cross a street safely, to make a simple purchase or to ask assistance when needed are critical skills, and may be difficult, even for those with average intelligence levels. Tasks that enhance the person's independence and give more opportunity for personal choice and freedom in the community are important.

To be effective, any approach should be flexible in nature, rely on positive reinforcement, be re-evaluated on a regular basis and provide a smooth transition from home to school to community environments. A good program will also incorporate training and support systems for parents and caregivers, with generalization of skills to all settings. Rarely can a family, classroom teacher or other caregiver provide effective habilitation for a person with autism unless offered consultation or in-service training by an experienced specialist who is knowledgeable about the disability.

A generation ago, the vast majority of the people with autism were eventually placed in institutions. Professionals were much less educated about autism than they are today; autism specific supports and services were largely non-existent. Today the picture is brighter. With appropriate services, training, and information, most families are able to support their son or daughter at home. Group homes, assisted apartment living arrangements, or residential facilities offer more options for out of home support. Autism-specific programs and services provide the opportunity for individuals to be taught skills which allow them to reach their fullest potential.

Families of people with autism can experience high levels of stress. As a result of the challenging behaviors of their children, relationships with service providers, attempting to secure appropriate services, resulting financial hardships, or very busy schedules, families often have difficulty participating in typical community activities. This results in isolation and difficulty in developing needed community supports. **The Autism Society of America is here for you.**

Members of the ASA represent all walks of life from rural to metropolitan communities. Embracing the *diversity* of our group, the ASA seeks to provide an open forum for the exchange of ideas. At the very core of the ASA's philosophy is the belief that no single program or treatment will benefit all individuals with autism. Furthermore, the recommendation of what is "best" or "most effective" for a person with autism should be determined by those people directly involved—the individual with autism, to the extent possible, and the parents or family members.

The ASA provides information and education (including results of empirically-based scientific research on effective strategies) to assist parents, educators, and others in the decision-making process. Providing information on available intervention options, rather than advocating for any particular theory or philosophy, is the focus at the ASA.

## ◆ Is There a Cure?

Understanding of autism has grown tremendously since it was first described by Dr. Leo Kanner in 1943. Some of the earlier searches for "cures" now seem unrealistic in terms of today's understanding of brain-based

## What is Autism?

disorders. To cure means "to restore to health, soundness, or normality." In the medical sense, there is no cure for the differences in the brain which result in autism. However, better understanding of the disorder has led to the development of better coping mechanisms and strategies for the various manifestations of the disability. Some of these symptoms may lessen as the child ages; others may disappear altogether. With appropriate intervention, many of the associated behaviors can be positively changed, even to the point in some cases, that the child or adult may appear to the untrained person to no longer have autism. The majority of children and adults will, however, continue to exhibit some manifestations of autism to some degree throughout their entire lives.

## What is the Autism Society of America?

Founded in 1965 by a small group of parents, the \_\_\_\_\_ continues to be the leading source of information and referral on autism and the largest collective voice representing the autism community for more than 33 years. Today, more than 24,000 members are connected through a volunteer network of over 240 chapters in 50 states.

The mission of the Autism Society of America is to promote lifelong access and opportunities for persons within the autism spectrum and their families, to be fully included, participating members of their communities through advocacy, public awareness, education, and research related to autism.

In addition to its volunteer Board of Directors, composed primarily of parents of individuals with autism, the ASA has a Panel of Professional Advisors, comprised of nationally known and respected professionals who provide expertise and guidance to the Society on a volunteer basis.

The ASA is dedicated to increasing public awareness about autism and the day-to-day issues faced by individuals with autism, their families, and the professionals with whom they interact. The Society and its chapters share common goals of providing information and education, supporting research, and advocating for programs and services for the autism community.

## The ASA Foundation

\_\_\_\_\_ was founded with the primary mission to raise and allocate funds for research to address the many unanswered questions about autism. We are still far from fully understanding autism and knowing how to prevent it.

The ASAF has implemented action on several pressing autism research priorities as areas of initial focus: developing and publicizing up-to-date prevalence statistics; quantifying the societal and family economic consequences of autism; developing a national registry of individuals and families with autism who are willing to participate in research studies; and implementing a system to identify potential donors of autism brain tissue for research purposes and facilitating the donation process. In addition, the Foundation is contributing substantial funds for applied and biomedical research in the causes of and treatment approaches to autism.

References: Dr. Christopher Gillberg, Centers for Disease Control and Prevention Conference. *Autism: Emerging Issues in Prevalence and Etiology*. 1997  
*Diagnostic and Statistical Manual of Mental Disorders 4th ed.*, (DSM-IV). American Psychiatric Association, Washington, DC. 1994.

## Where Can I Get More Information?

Educating yourself and others about autism is a critical way to assist with the education and development of the individual with autism and to help society understand the nature of this common developmental disorder. \_\_\_\_\_ are available from the Autism Society of America. To request additional information or to find answers to other questions on autism, please call or write the ASA. *We are here to help.*



[Return to Top](#)

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*Autism Society of America,  
7910 Woodmont Ave, Suite 300,  
Bethesda, MD 20814-3015*

*Tel: (800)-3AUTISM x 150  
(301)-657-0881  
Fax: (301)-657-0869*

*Developed and Maintained on behalf of the ASA by: \_\_\_\_\_  
Last Updated 4/17/99*

**AUTISM - CURRENT CASES FY00**

Current Cases	South	North	Rural	Total
Adult	37	13	5	55
Children	35	12	9	56
Total	72	25	14	111

**AUTISM - CURRENT CASES AS A PERCENTAGE OF TOTAL CASES**

Current Cases	South	North	Rural	Total
Adult	37	13	5	55
Children	35	12	9	56
Total	72	25	14	111
Current Cases	South	North	Rural	Total
Adult	1202	434	235	1871
Children	345	126	70	541
Total	1547	560	305	2412
Current Cases	South	North	Rural	Total
Adult	3%	3%	2%	3%
Children	10%	10%	13%	10%
Total	5%	4%	5%	5%

**AUTISM - OPENED CASES**

Cases Opened	South	North	Rural	Total
FY 99 (12 months)	19	3	3	25
FY 00 ( 6 months)	11	0	1	12

## **SERVICE DESCRIPTIONS**

### **SERVICE COORDINATION**

All people who are eligible for services from a regional center are assigned a service coordinator (case manager). Service coordinators assist people in obtaining needed benefits and assessments. Through person-centered planning, the service coordinator works directly with the person (and others), helping the customer articulate his or her needs for the future. The service coordinator helps the person learn about and choose from available service providers and supports. Jointly, the customer and service coordinator develop service plans that focus on achieving consumer determined outcomes.

Service coordinators visit with the client at least quarterly to assess the efficacy of the plan and whether services are being provided as intended. Progress toward personal goals is assessed on an ongoing basis. Plans may be updated and changed as the client's goals and needs for support change. At least annually, the service coordinator assesses the satisfaction of the consumer with the supports and services being received.

Service coordinators have a very important relationship with the client they work for. They are responsible for overseeing the quality of services and for making sure that the clients plan of care and treatment is implemented and changed as needed. People are encouraged to choose their own service coordinator.

### **FAMILY SUPPORT PROGRAMS**

The Family Support Program was developed to assist families of individuals with mental retardation and related conditions to care for their relatives in their family home. All individuals who are eligible for mental retardation services through Desert Regional, Sierra Regional, and Rural Regional Centers are eligible to apply for Family Support Services. The goal of the Family Support Program is to prevent costly out-of-home placement by assisting the family in caring for their relatives. Any charges for services are determined by using a sliding fee scale. Most consumers who are eligible for Medicaid pay no fees for services.

The Family Support Program provides the following services to consumers and their families:

1. Respite
2. Purchase of Service Supplements
3. Clinical Assessments
4. In-Home Training Services
5. Counseling
6. Family Preservation

**Respite** provides temporary care in or out of the family home. Respite gives families a break from the day-to-day responsibilities of caring for their loved ones. Families receive respite vouchers to use at certified or licensed respite providers, in rural Nevada, or other providers of their choice. The amount of the voucher is based on the family's request, its financial co-pay (if any), and the available funding in the regional office. Families choose their respite providers and select the days and times when they want to use their vouchers. The respite provider charges the family any co-pay (if one is due) and then bills the remaining cost to the regional center after providing the respite services. Families may use their yearly allotments all at once for a vacation or in small monthly increments. The choice is up to the family.

**Purchase of Service Supplements (POS)** are provided to families to assist them with the excess costs of services for their relatives. All alternative funding sources and existing resources must be used by the family before the POS is issued to them. Families who request a POS must meet financial guidelines to receive vouchers from the MR agency. The POS is available to eligible families one time per year, for a maximum purchase of \$300. The family can use the voucher with any vendor or provider that accepts it. The service/goods are provided to the family and the State Agency is billed for the service. Examples of items that can be purchased with the voucher include such things as:

- Medical/dental services not covered by insurance
- Special diets, clothing, special equipment
- Car seats, beds, special furnishings
- Recreation, leisure needs, respite
- Food, rent, utilities

**Clinical Assessments** are available for consumers who are in need of assessments or evaluations by a social worker, psychologist, or nurse. The assessments provide information that can be used to assist the individual's treatment planning team to develop training programs, and help the person gain services, obtain a job, move to a community residential program, etc. A sliding fee scale is used to determine if the individual is responsible for any costs. Medicaid and private insurance companies will be billed for the covered individuals who use the service. Families who are uninsured or who are unable to pay for the services will not be required to do so when funding is available through the MR agency.

**In-Home Training** is available to consumers and their families who request assistance in their home with teaching skills that can help the family to cope better with their relative's special needs. The in-home trainer can work with individuals and their families in such areas as personal care, meal preparation, safety and leisure skills, transportation, behavior management, etc. The family identifies the training needs with assistance from the service coordinator. Training can be provided on a short or long term basis depending on the person's needs and the availability of funding in the MR agency.

**Counseling** is available to individuals and their family members to provide support and guidance in problem solving. Many different areas of need can be addressed with counseling services including, personal independence, self-esteem, community participation, social-sexual issues, work issues, etc. The individual and/or the family can choose the counselor and most services can be billed to Medicaid or private insurance. A co-pay may be charged if the person is able to contribute to the cost.

**Family Preservation** provides monthly financial aid to needy families caring for their relatives with severe or profound mental retardation in the family home. The financial assistance can be used for a variety of needed services (supplies, equipment transportation, general income supplement). The monthly allotment may vary from family to family and is determined by using a sliding fee scale and the available funding in the state budget.

Any individual or their family member who wants to apply for Family Support Programs should contact their service coordinator (case manager) for more information or local MR agency to open a case for services.

## **JOB AND DAY TRAINING PROGRAMS**

All adults who are eligible for services from Desert Regional Center, Sierra Regional Center, or Rural Regional Center are eligible for Jobs and Day Training Services. These services vary in the type and intensity of supports to allow individuals vocational choices. Supports range from pre-vocational and vocational training in supervised, structure settings, to enclaves (supervised work groups in community job setting), to supported employment, including activities needed to sustain paid competitive employment or follow-along services. Regional Centers contract with private, nonprofit organizations that operate Community Training Centers and other qualified providers that offer training choices to consumers based on their interests and skill levels.

**Job Services** are available to consumers who need assistance to secure and maintain jobs in the community. Regional Centers contract with various private agencies as well as work cooperatively with the Bureau of Vocational Rehabilitation to provide work skill assessments, job development, job training, and follow-along services through job coaching.

**Day Training Services** are available through Community Training Centers (CTCS) and other qualified providers. Day training is designed to provide vocational experiences for people who need more intensive personal or behavioral supports or to assist individuals to learn skills necessary for success in a job.

## **RESIDENTIAL PROGRAMS**

Residential Programs are available to consumers who require or request services in locations other than the family home. All individuals who have open cases with Desert Regional Center, Sierra Regional Center, or Rural Regional Center may request a residential program. This program is designed with a goal of allowing people to live in a home of their choice as self-sufficiently as possible. Most people prefer their own home rather than institutional care. These are important alternatives to restrictive and costly institutional settings.

Residential services are funded by using the individual's own resources (Social Security benefits, job income, etc.) and supplementing these as needed with state and federal funds. The Nevada Medicaid Program funds the costs of many support services if the individual is eligible. The State also provides funds to assist the person with expenses of living in the community.

The following residential options are available to consumers:

1. Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)
  - a. State ICFs/MR
  - b. Small Private ICFs/MR
2. Intensive Supported Living Arrangements
3. Supported Living Arrangements
4. Private Group Homes
5. Developmental Homes

**State ICFs/MR** provide twenty-four hour supervision and training to individuals who require intensive support medical care, treatment, and training. Located at Desert Regional Center or Sierra Regional Center, these campus-based homes are licensed to provide services to approximately 166 people. The homes house from four to twelve people. (In addition, the State operates ICF/MR Small programs in the south; see following description). Each facility is staffed by state employees on a 24-hour basis and must follow strict Federal and State guidelines. The programs are funded by Nevada Medicaid, and offer specialized services to consumers. This setting is also the most restrictive.

**Small Private ICFs/MR** provide residential services in small community residences for up to six people. The individuals who require this level of care need intense treatment and training but live in community neighborhood houses with 24-hour awake supervision and support. The services are provided by private organizations (or the state) and are funded by the Medicaid Program. The same Federal and State guidelines as guide larger ICFs/MR guide these homes. The services provided in an ICF/MR Small are considered less restrictive than the ICF/MR services provided in large State run facilities because they are located in community neighborhoods.

**Intensive Supported Living Arrangements (ISLAs)** provide services in community residences for up to four individuals who live in their own homes. The services are provided by private organizations. These services were developed as an alternative to

ICF/MR's so that individuals could live in the community while receiving intensive support and training. Individuals who choose ISLAs must be capable of contributing to the costs of their services, and may have intense medical or behavioral training/treatment needs. Awake supervision is provided to the residents as typically they need staff support at all times.

***Supported Living Arrangements (SLAs)*** are individualized living supports that supplement individuals' resources in their own homes. Assistance is designed to help persons achieve and maintain maximum independence in the community. Supports are contracted with private providers. Support staff visit the individual on an individualized schedule that depends on a person's needs and preferences. The services are paid for by the individual and may be subsidized by the State Agency and/or Nevada Medicaid. This is the most self-determined level of support for individuals and considered the least restrictive support option for adults. Because of this, SLAs are a preferred program.

***Private Group Homes*** are located in community neighborhoods and serve up to six individuals. The services are provided by private organizations. The homes are certified by the MR agency. They are able to serve individuals who are age 18 years or older and need some support and training. There is no awake staff at night and individuals may have intermittent periods unsupervised if their treatment team approves it.

***Developmental Homes*** are private homes in the community that typically serve up to four individuals who are usually younger or more dependent individuals who desire or need a more "family" type of living situation. The providers are private people who choose to have their homes licensed and/or certified to care for individuals with mental retardation and related conditions. The people who live in these homes are included in all the provider family's life and activities.



## **DEVELOPMENTAL SERVICES**

### **PROVIDER ORGANIZATIONS BY REGION**

#### **Northern Nevada**

**Alpha Productions Technology, Inc.**

50 Freeport #3

Sparks, NV 89431

775-359-4498

Fax: 775-359-1340

**Department of Employment Training and Rehabilitation**

Vocational Assessment Center

1325 Corporate Blvd.

Reno, NV 89502

775-688-2288

**Disability Resources, Inc.**

705 South Wells, Unit 200A

Reno, NV 89502

775-329-1126

Fax: 775-329-8911

**EduCare**

1577 E. Plumb Lane, Suite 258

Reno, NV 89502

775-786-1472

Fax: 775-786-1260

**EduCare Reno Pullman Home**

1211 Pullman Drive

Sparks, NV 89434

775-331-1559

**Nevada Disability Advocacy & Law Center, Inc.**

1201 Terminal Way, Suite 219

Reno, NV 89502

775-333-7878

Fax: 775-333-7878

**Nevada Easter Seal Society**

6100 Neil Road, Suite 201

Reno, NV 89511

775-322-6555

Fax: 775-689-5933

**S.T.E.P. Program**

Psychology Department, University of Nevada, Reno  
Reno, NV 89557

775-784-6225

Fax: 775-784-1126

**Trinity Services, Inc.**

3690 Grant Drive, Suite H  
Reno, NV 89509

775-827-6222

**Trinity Services West, Inc.**

220 South Rock Blvd. #15  
Reno, NV 89502

775-857-2500

Fax: 775-857-4857

**United Cerebral Palsy**

255 Glendale Avenue, Suites 3 & 4  
Sparks, NV 89431

775-331-3323

Fax: 775-331-7913

**Volunteers of America**

100 West Grove Street, Suite 555  
Reno, NV 89509

775-825-8400

Fax: 775-825-8494

**Washoe Association for Retarded Citizens**

790 Sutro Street  
Reno, NV 89512

775-333-9272

Fax: 775-333-8263

**Rural Nevada****Denise Linaman, MA**

205 South Minnesota Street  
Carson City, NV 89703

775-882-0687

**EduCare - Carson City**

PO Box 2224

Carson City, NV 89702

775-884-2337

Fax: 775-884-9068

**EduCare - Pioche Home**

516 Pioche

Carson City, NV 89701

775-884-9119

**EduCare - Slide Mountain**

1335 Slide Mountain Drive  
Carson City, NV 89706  
775-883-0619

**Jack Araza, Ph.D.**

309 East John Street, #1  
Carson City, NV 89706  
775-885-0206

**Ormsby Arc**

PO Box 491  
Carson City, NV 89702  
775-882-8520

Fax: 775-882-7202

**Roberta and Merrill Simon**

3 Audrey Drive  
Carson City, NV 89706  
775-246-5373

**David J. McIntyre, Ph.D.**

PO Box 5841  
Elko, NV 89802  
775-777-7822

**EduCare - Elko**

401 Railroad Street, #401  
Elko, NV 89801  
775-777-9642

**Nevada Easter Seal Society - Elko**

405 Idaho Street, #207  
Elko, NV 89801  
775-753-9612

Fax: 775-753-9612

**New Directions**

501 Railroad Street, #201  
Elko, NV 89801  
775-777-8358

**Roland Herndon**

PO Box 5955  
Elko, NV 89801  
775-744-2041

**Ruby Mountain Resource**

PO Box 1708  
Elko, NV 89801  
775-423-4760

**White Pine - CTC**

PO Box 1122  
Ely, NV 89301  
775-289-6713

**EduCare - Fallon**

90 North Maine  
Fallon, NV 89406  
775-423-6712

**Fallon Industries**

PO Box 1641  
Fallon, NV 89406  
775-423-4760  
Fax: 775-423-5801

**Elaine Moothart**

1315 Leonard Road  
Gardnerville, NV 89410  
775-265-5363

**Tri-County CTC**

PO Box 2110  
Hawthorne, NV 89415  
775-945-3118  
Fax: 775-945-3384

**Rainbow Adult Clinic**

PO Box 1061  
Lovelock, NV 89419  
775-273-2506

**Humboldt Human Development, Inc.**

7505 West Rose Creek  
Winnemucca, NV 89445  
775-625-3919  
Fax: 775-623-6546

**Sonoma Industries**

3280 Bengochea Circle  
Winnemucca, NV 89445  
775-623-4536

**Southern Nevada**

**D & S Services (Laughlin)**

1751 Hwy.95, Suite 79-203  
Bullhead City, AZ 86442  
702-298-0146

**Trimbath, Janet**

1318 Elsa Way  
Boulder City, NV 89005

**Anatihan, Desiree and Antonio**

1524 Spreading Oak  
Henderson, NV 89014

**Kapel, Lawrence (Ph.D.)**

2920 North Green Valley Park  
Henderson, NV 89014  
702-454-0201

**Kern, Jeffery (Ph.D.)**

2055 Pinion Springs  
Henderson, NV 89014  
702-895-0187

**REM**

321 John Henry Drive  
Henderson, NV 89015  
702-456-5333

**Salvation Army Adult Day Care**

PO Box 91300  
Henderson, NV 89009  
702-565-4855

**Clark County Parks and Recreation**

2601 East Sunset Road  
Las Vegas, NV 89120

**Community Choices**

1702 Western Avenue  
Las Vegas, NV 89102  
702-388-8805

Fax: 702-388-8807

**Cook, Olga**

4025 Shady Oak Drive  
Las Vegas, NV 89115

**Danville Services**

2595 South Cimmaron, Suite 200  
Las Vegas, NV 89117  
702-838-0222

Fax: 702-838-7026

**EduCare Community Living**

3811 West Charleston Blvd.  
Las Vegas, NV 89102  
702-880-0961

**Goodwill of Southern Nevada**

3585 East Patrick Lane, Suite 100  
Las Vegas, NV 89120  
702-597-1107

Fax: 702-597-5147

**Haven Developmental Resources**

1027 South Rainbow Blvd., #35

Las Vegas, NV 89128

702-248-6172

Fax: 702-252-4503

**Holdsworth, Inc.**

3100 South Valley View, Suite 104

Las Vegas, NV 89102

702-364-0211

Fax: 702-364-1142

**J & B Mendes**

7319 Cisco Lane

Las Vegas, NV 89123

702-361-8712

Fax: 702-229-0124

**JOR, Inc.**

1595 Coronado Avenue

Las Vegas, NV 89109

702-796-0464

Fax: 702-796-0124

**Lehmann, Patricia**

4105 Snead Drive

Las Vegas, NV 89107

**Lorenzi Recreation Program**

3333 West Washington

Las Vegas, NV 89106

702-229-6358

**McGee, Marge**

1917 Luning Drive

Las Vegas, NV 89106

**Nannys and Grannys**

3790 Redwood

Las Vegas, NV 89102

**New Vista Ranch**

4000 Boulder Highway

Las Vegas, NV 89121

702-457-4677

**Nevada Association for the Handicapped**

6200 West Oakey Blvd.

Las Vegas, NV 89102

702-870-7050

Fax: 702-870-7649

**Opportunity Village**  
6300 West Oakey Blvd.  
Las Vegas, NV 89102  
702-259-3700  
Fax: 702-259-3734

**Overby, Linda**  
%Variety School  
Las Vegas, NV  
**Progressive Choices**  
3294 Sunset Road  
Las Vegas, NV 89120  
702-458-4821

Fax: 702-458-4818

**Salcedo, Gina**  
2020 Ballard Drive  
Las Vegas, NV 89104

**Sklar, Linda**  
8248 Tivoli Cove Drive  
Las Vegas, NV 89128  
702-256-9600

**Transition Services**  
525 Park Paseo  
Las Vegas, NV 89104  
702-598-4105  
Fax: 702-320-4106

**Unger, Heidi S.**  
5871 Shiela Avenue  
Las Vegas, NV 89108

**Vinson, Lucia and Patrick**  
1759 Colt Place  
Las Vegas, NV 89119

**Wimsatt, Carole**  
857 North 24th Street  
Las Vegas, NV 89101

**Fletcher Employment Services**  
3100 East Lake Mead Blvd., #15B  
North Las Vegas, NV 89030  
702-369-5475

Fax: 702-642-6234

**Jackson, Jackie**  
5104 Waving Flower Drive  
North Las Vegas, NV 89031

**Johnson, Jean**  
3828 Bach Way  
North Las Vegas, NV 89030

**Nevada Association for the Handicapped**

4336 Losee Road, Bldg.. B

North Las Vegas, NV 89030

702-649-7151

Fax: 702-649-7353

**Rainbow Meadows**

1308 Red Hollow Drive

North Las Vegas, NV 89031

702-642-5289

Fax: 702-399-1507

**Vincent, Merrine**

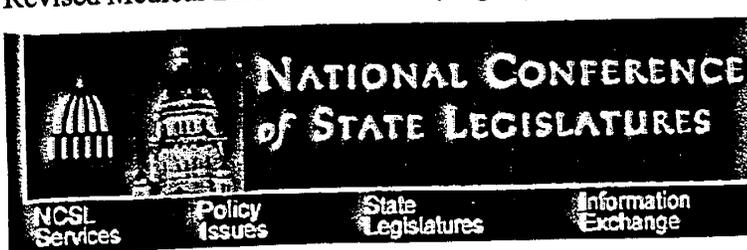
3708 Iverson Lane

North Las Vegas, NV 89030

APPENDIX G

Summary of Patient Safety Proposals





**NATIONAL CONFERENCE  
OF STATE LEGISLATURES**

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## AFI Health Committee: *ISSUES IN BRIEF*

August 1, 2000

Chair:  
Representative Kathryn Bowers, Tennessee

Vice Chairs:  
Representative Garnet Coleman, Texas  
Representative Mary McGratton, Connecticut  
Senator Patricia Miller, Indiana

### Medical Errors

#### ISSUE DESCRIPTION

On November 29, 1999, the Institutes of Medicine (IOM) released a report, *To Err is Human*. According to the report, an estimated 98,000 Americans die each year from preventable medical errors. The report calls for a reduction in the medical error rate by 50 percent over the next five years.<sup>1</sup>

In response to the report, President Clinton issued an Executive Order on December 7, 1999 that established the Quality Interagency Coordination Task Force and directed the task force to report within 60 days with recommendations on whether the government should adopt IOM's patient safety proposals. The task force reported to the President in mid-February.<sup>2</sup>

In response to the task force report, on February 22, 2000, President Clinton proposed to: (1) create a Center for Quality Improvement in Patient Safety that will research and develop national goals on reducing medical errors; (2) require every hospital participating in Medicare to implement patient safety programs; and (3) require states to administer a mandatory medical errors reporting system to be phased in over three years.<sup>3</sup>

In addition to President Clinton's proposal, three bills have been introduced in Congress in 2000 and a series of hearings in both the House and Senate have been held.

#### STATE CONCERN

The release of the IOM report inspired many states to examine ways to lower the number of preventable medical errors in their health care facilities. States are concerned about federal proposals that would: (1) impose unfunded mandated requirements on states; and/or (2) preempt existing or future state laws or regulations. States are also concerned about how the data collected will be used and stored and who will have access to the data. Finally states are concerned about how and by whom any enforcement actions would be taken.

- Unfunded Mandates

States are concerned about the imposition of any federally mandated reporting requirements that is not fully federally funded. Such funding would include, but not be limited to funding for upgrading computers, the hiring and training of

staff and the storage of data.

- **Preemption of State Law and Regulation**

A federally mandated reporting system may conflict and preempt state liability, malpractice and confidentiality laws, compromising state initiatives relating to medical errors and impacting a broad range of state regulatory and judicial proceedings.

- **Future Use of Data**

After the data is collected a number of questions come to mind. Where will the information be housed? Who has access to the information and under what circumstances? How long will the data be held? States have in interest in the answers to these questions.

- **Enforcement/Penalties for Noncompliance**

Finally, there is the question of enforcement. What happens if an entity fails to submit the required reports? How will success/failure be measured? What happens to an entity that seems to have an unacceptable number of medical errors? Who will make these determinations? These are all questions that must be discussed.

<b>CURRENT STATUS</b>
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### **Federal Initiatives**

#### ***The White House***

- Press Release: President Clinton: Taking New Steps to Ensure Patient Safety. December 7, 1999. <http://www2.whitehouse.gov/WH/Work/120799.html>
- S. 580, the Healthcare Research and Quality Act of 1999, was signed into law by President Clinton on December 6, 1999 (P.L. 106-129).
- The law renames, restructures and reauthorizes the Agency for Health Policy and Research. The new agency, the Agency for Health Care Research and Quality, is required to conduct and support research and build private-public partnerships to: (1) identify the causes of preventable health care errors and patient injury in health care delivery; (2) develop, demonstrate, and evaluate strategies for reducing errors and improving patient safety; and (3) disseminate such effective strategies throughout the health care industry.
- Press Release: President Signs Memorandum Calling for a Quality Interagency Coordination Task Force. March 13, 1998. <http://www.hcqualitycommission.gov/press/execord3.html>
- Speech By President Clinton: Establishment of the Quality Interagency Coordination Task Force. March 13, 1998. <http://www.quic.gov/press/indexframes.htm>

#### ***The Congress - Legislation***

***[<http://thomas.loc.gov/>] - on-line source for federal legislation]***

- H.R. 4577, as enacted by the U.S. Senate on June 30, 2000.
- The amendment to H.R. 4577, the "Patients Bill of Rights Plus Act", sponsored by Senator Nickles (R-Oklahoma) includes S. 2738 (see below) as Title V - Patient Safety and Error Reduction.
- S. 2743, Voluntary Error Reduction and Improvement in Patient Safety Act sponsored by Senator Ted Kennedy (D-Massachusetts), with Senators Christopher Dodd (D-Connecticut), and Patty Murray (D-Washington), referred to the Senate Health, Education, Labor and Pensions Committee. (June 15, 2000).
- Creates The Center for Quality Improvement and Patient Safety in the Agency for Healthcare Research and Quality (AHRQ), to improve and promote patient safety by conducting and supporting research on medical errors, administering the national medical error reporting systems created under the bill, and disseminating evidence-based practices and other error reduction and prevention strategies to health care providers, purchasers and the public.
- Establishes national voluntary reporting and surveillance system, the National Patient Safety Reporting System, under AHRQ to identify, track, prevent and reduce medical errors. It will allow health care professionals, health care facilities, and patients to voluntarily report adverse events and close calls.
- To encourage participation, reports and analyses from both programs will be protected from discovery, and health care workers who submit reports to the programs will be protected against workplace retaliation based on their participation in the reporting systems.
- In exchange for establishing this reporting system, health care facilities and professionals would be expected to voluntarily implement appropriate patient safety solutions as they are developed. In addition, in recognition of the significant federal investments in error reduction strategies and the provision of health services, the Secretary of Health and Human Services will be required to develop a process for determining which evidence-

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- based practices should be applied to programs under the Secretary's authority.
- The bill authorizes \$50,000,000 for the Agency for Healthcare Research and Quality for FY 2001, increasing to \$200,000,000 in FY 2005, to fund error-related research and the reporting systems.
- **S. 2738, Patient Safety and Errors Reduction Act** sponsored by Senator Jim Jeffords (R-Vermont), with Senators Bill Frist (R-Tennessee) and Michael Enzi (R-Wyoming), referred to the Senate Health, Education, Labor and Pensions Committee. (June 15, 2000).
- Establishes a Center for Quality Improvement and Patient Safety to: (1) provide national leadership for research and other initiatives to improve the quality and safety of patient care; (2) develop public/private sector partnerships to improve the quality and safety of patient care; and (3) serve as a national resource for research and learning from medical errors.
- Establishes a National Patient Safety Database that will consist of strictly confidential, de-identified reports of medical errors. The purpose of the database is to further the Nation's understanding of the causes of medical errors and the best approaches to their prevention.
- Creates a medical errors reporting system for hospitals. Hospitals that elect to participate are expected to submit a description of their medical error reports to the appropriate oversight agency. The legislation helps hospitals to develop local, on-site expertise in data collection, root cause analysis, and corrective action plan implementation.
- Authorizes \$50 million for FY 2001, and such sums as necessary for subsequent years.
- **S. 2378, Stop All Frequent Errors (SAFE) in Medicare and Medicaid Act of 2000** sponsored by Senator Richard Bryan (D-Nevada), Senator Joe Lieberman (D-Connecticut), Senator Charles Grassley (R-Iowa), and Senator Bob Kerrey (D-Nebraska), referred to Senate Committee on Finance. (4/6/00)
- Requires every medical facility that serves Medicare or Medicaid patients to establish a medical safety program that produced measurable reductions in medical errors.
- Requires all accidental deaths or serious injuries be reported and that their causes be identified.
- Facilities that fail to comply with the Act would have their names and addresses publicly disclosed.
- **H.R. 3672, Medication Error Prevention Act of 2000** sponsored by Representative Constance A. Morella (R-Maryland), referred to House Committee on Commerce. (2/16/00)

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- Provides for voluntary reporting by health care providers of medication error information.
- Voluntary programs that receive the approval of the Secretary would be privileged for purposes of Federal and State judicial proceedings.
- **S. 2038, Medical Error Reduction Act of 2000** sponsored by Senator Arlen Specter (R-Pennsylvania), referred to Senate Committee on Health, Education, Labor and Pensions. (2/8/00)

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- Authorizes the Secretary of Health and Human Services to provide grants to states to establish reporting systems.
  - Grants will be awarded to those states that adopt reporting systems that use guidelines developed by the Agency for Healthcare Research and Quality.
  - Provides funding for 15 demonstration projects in health care facilities and organizations to determine the causes of medical errors.
  - Information that would be reported under this bill would be confidential.

### ***The Congress - Hearings***

- The Senate Health Education, Labor, and Pensions Committee and the Senate Appropriations Subcommittee on Health, Education, and Labor held a joint hearing February 22, 2000 which focused on the President's proposal. (<http://www.senate.gov/~labor/hearings/feb00hrg/022200wt/022200wt.htm>)
- The Senate Health, Education, Labor, and Pensions Committee held hearings January 26, 2000 (<http://www.senate.gov/~labor/hearings/jan00hrg/jan00hrg.htm>), February 1, 2000 (<http://www.senate.gov/~labor/hearings/feb00hrg/020100wt/020100wt.htm>) and February 16, 2000 (<http://www.senate.gov/~labor/hearings/feb00hrg/021600wt/021600wt.htm>). The first hearing focused on the broad issue of medical errors, while the second hearing focused on adverse events related to prescription drugs.
- The House Commerce Subcommittee on Health and Environment, the Subcommittee on Oversight and Investigations, and the Veterans Affairs Health Subcommittee held a joint hearing Feb. 9, 2000 which focused on improving quality of care and consumer information. (<http://com-notes.house.gov/ccheat/hearings106.nsf/HearingExpand?OpenView&StartKey=70A7887059527EE58525687F0050E5D4>)

### ***Federal Agency Activities***

- The Quality Interagency Coordination Task Force (QuIC) <http://www.quic.gov/>
- The Centers for Disease Control and Prevention (CDC) guidelines on Prevention of Nosocomial Infections: The Hospital Infections Program within the CDC has adopted seven guidelines regarding the prevention and

control of nosocomial infections. These guidelines include prevention of catheter-associated urinary tract infections; prevention of intravascular infections; prevention for surgical wound infections and infection control in hospital personnel. <sup>4</sup> <http://www.cdc.gov/>

- o CDC reports on hospital and home health infections: During the 4<sup>th</sup> Decennial International Conference on Nosocomial and Healthcare-associated Infections, the CDC reported that an estimated two million patients annually get an infection while in the hospital and that the costs of such infections totals nearly \$5 million every year. At the same conference, the CDC reported that the number of patients receiving home care has significantly increased and with that, the number of infections patients are acquiring at home has increased dramatically. <sup>5</sup>
- **The Agency for Healthcare Research and Quality (AHRQ)**, formerly the Agency for Health Care Policy and Research, began a research program in September 1999 to improve the safe and effective use of medical products. <sup>6</sup> <http://www.ahrq.gov>
- **Food and Drug Administration (FDA)**
  - o The Safe Medical Device Act of 1990 requires user facilities such as hospitals and nursing homes to report suspected medical device related deaths to the FDA and the manufacturer and serious injuries to either the manufacturer or the FDA, if the manufacturer is unknown. The FDA uses Medical Device Reporting (MDR) and User Facility Device Experience (MAUDE) to monitor significant adverse events involving medical equipment. <sup>7</sup>

### State Initiatives

Reporting requirements are found throughout state statutes and regulations. It is not easy to determine the actual number of states with reporting requirements because the various laws and regulations apply to a broad range of health care entities (ie. nursing homes, hospitals, hospices). According to the IOM, 21 states have mandatory reporting systems in place. <sup>8</sup>

NCSL has identified at least 21 states-Colorado, Florida, Kansas, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Montana, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia, and Washington-that have adopted regulations or enacted laws since the early 1990's that address some aspect of reducing medical errors, including medication error reporting and quality improvement programs. <sup>9</sup>

According to the National Academy for State Health Policy, 15 states-Colorado, Florida, Kansas, Massachusetts, Nebraska, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas and Washington-require mandatory reporting from hospitals for adverse events. Six states-Georgia, New Mexico, North Carolina, Oregon, Wyoming and the District of Columbia-have voluntary reporting of medical errors or adverse events. <sup>10</sup>

### Highlights of Selected State Laws

- **Washington** enacted legislation on March 17, 2000 that requires the Department of Health to develop recommendations on reducing medical errors and submit their findings to the Legislature by December 31, 2000.
- **South Dakota** enacted legislation on March 3, 2000 that relates to medication training for adjustment training center employees. The new law requires trainees to receive instruction on reporting of medication administration errors.
- **Florida** enacted legislation on June 18, 1999 that requires reports of adverse incidents in office practice settings. The new law requires any doctor's office to report any adverse incidents occurring after January 1, 2000. <sup>11</sup> In addition to the 1999 law, the Department of Health, Board of Medicine adopted a rule in April 1999 that requires each hospital making an adverse incident report to identify any unlicensed physician involved that is the basis of the report (FAC 64B8-6.008 and .10). <sup>12</sup> The Florida Department of Health, Division of Medical Quality Assurance recently proposed rules implementing the 1999 law requiring physicians to report adverse incidents that occur in the office. Comments were due on the rule February 18, 2000. <sup>13</sup>
- **New York** first began collecting information on medical errors in 1985. In 1995, the state convened a task force to examine ways to improve their existing reporting system known as Patient Event Tracking System (PETS). In 1998, the state began implementation of its improved program referred to as the New York Patient Occurrence Reporting and Tracking System (NYPORTS). Under PETS, hospitals used subjective decisions before reporting an adverse event to the state, but under NYPORTS hospitals were given specific examples of adverse events that must be reported to the state. Besides its process for determining which events to be reported, NYPORTS includes paperless reporting, on-line access for hospitals and easier identification of patterns or trends of adverse events. <sup>14</sup>
- **Massachusetts** has had regulations requiring hospitals to report serious incidents and accidents to the Department of Public Health, Division of Health Care Quality since 1995. The regulations identify certain incidents, including serious physical injury to a patient resulting from accident or unknown cause to be reported immediately to the department over the telephone. The telephoned reports must be followed by a written report a week within the incident. (105 CMR 130.331) In December 1998, the department sent a letter to hospital administrators in the state as a reminder of their duty to report serious incidents. As a guideline, the letter

provided many examples of reportable and non-reportable incidents.<sup>15</sup>

**PUBLICATIONS**

- *States Reporting of Medical Errors and Adverse Events: Results of a 50-State Survey*, National Academy for State Health Policy (April 2000) <http://www.nashp.org>
- *Doing What Counts for Patient Safety: Federal Actions to Reduce Medical Errors and Their Impact*, Report of the Quality Interagency Coordination Task Force (QulC) (February 2000) <http://www.ahrq.gov/errors.htm>
- *To Error is Human*, Institutes of Medicine (1999) <http://www.iom.edu/>

AFI HEALTH COMMITTEE STAFF CONTACT  
Joy Johnson Wilson, Director

**ENDNOTES:**

- <sup>1</sup> Institute of Medicine. *To Err is Human: Building a Safer Health System*. Washington, DC: National Academy Press, 1999.
- <sup>2</sup> Quality Interagency Coordination Task Force. *Doing What Counts for Patient Safety: Federal Actions to Reduce Medical Errors and Their Impact*. Washington, DC: February 2000.
- <sup>3</sup> Office of the White House; Remarks by the President on Medical Errors. February 22, 2000.
- <sup>4</sup> Centers for Disease Control and Prevention; Hospital Infections Program: CDC Guidelines on Prevention of Nosocomial Infections, 1994.
- <sup>5</sup> Centers for Disease Control and Prevention; Press Releases: Hospital Infections Cost U.S. Billion of Dollars Annually and Infections Associated with Home Health Care Focus of Health Experts. March 6, 2000.
- <sup>6</sup> Agency for Healthcare Research and Quality, Press Release: AHCPR Launches Research Program to Improve the Safe and Effective Use of Medical Products. September 29, 1999.
- <sup>7</sup> Food and Drug Administration's Center for Devices and Radiological Health: Reporting Problems with Medical Devices. <http://www.fda.gov/cdrh/mdr.html>
- <sup>8</sup> See note 1.
- <sup>9</sup> National Conference of State Legislatures, Health Policy Tracking Service, April 2000.
- <sup>10</sup> National Academy for State Health Policy. *State Reporting of Medical Errors and Adverse Events: Results of a 50-State Survey*. Portland, Maine, April 2000.
- <sup>11</sup> 1999 Florida Laws ch. 99-397.
- <sup>12</sup> 25 FLAR 1394; Final Rule adopted April 2, 1999.
- <sup>13</sup> 26 FLAR 326-7; Proposed Rule January 28, 2000.
- <sup>14</sup> New York State Department of Health; Press Release: New York State to Change Hospital Incident Reporting System. March 27, 1998.
- <sup>15</sup> Massachusetts Department of Public, Health Division of Health Care Quality. Letter to Hospital Administrators. December 7, 1998.

National Conference of State Legislatures  
INFO@NCSL.ORG (autoresponse directory)

Denver Office:  
1560 Broadway, Suite 700  
Denver, CO 80202  
Tel: 303-830-2200  
Fax: 303-863-8003

Washington Office:  
444 North Capitol Street, N.W., Suite 515  
Washington, D.C. 20001  
Tel: 202-624-5400  
Fax: 202-737-1069



APPENDIX H

Suggested Legislation

(The bill draft requests are not available as of this publication date.)