

106TH CONGRESS
2^D SESSION

H. R. 5543

To amend titles XVIII, XIX, and XXI of the Social Security Act to provide benefits improvements and beneficiary protections in the Medicare and Medicaid Programs and the State child health insurance program (SCHIP), as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 25, 2000

Mr. THOMAS (for himself, Mr. BILEY, and Mr. BILIRAKIS) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend titles XVIII, XIX, and XXI of the Social Security Act to provide benefits improvements and beneficiary protections in the Medicare and Medicaid Programs and the State child health insurance program (SCHIP), as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECU-**
 2 **RITY ACT; REFERENCES TO OTHER ACTS;**
 3 **TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the
 5 “Medicare, Medicaid, and SCHIP Benefits Improvement
 6 and Protection Act of 2000”.

7 (b) **AMENDMENTS TO SOCIAL SECURITY ACT.**—Ex-
 8 cept as otherwise specifically provided, whenever in this
 9 Act an amendment is expressed in terms of an amendment
 10 to or repeal of a section or other provision, the reference
 11 shall be considered to be made to that section or other
 12 provision of the Social Security Act.

13 (c) **REFERENCES TO OTHER ACTS.**—In this Act:

14 (1) **BALANCED BUDGET ACT OF 1997.**—The
 15 term “BBA” means the Balanced Budget Act of
 16 1997 (Public Law 105–33; 111 Stat. 251).

17 (2) **MEDICARE, MEDICAID, AND SCHIP BAL-**
 18 **ANCED BUDGET REFINEMENT ACT OF 1999.**—The
 19 term “BBRA” means the Medicare, Medicaid, and
 20 SCHIP Balanced Budget Refinement Act of 1999
 21 (Appendix F, 113 Stat. 1501A–321), as enacted into
 22 law by section 1000(a)(6) of Public Law 106–113.

23 (d) **TABLE OF CONTENTS.**—The table of contents of
 24 this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references to other Acts;
 table of contents.

TITLE I—MEDICARE BENEFICIARY IMPROVEMENTS

Subtitle A—Improved Preventive Benefits

- Sec. 101. Coverage of biennial screening pap smear and pelvic exams.
- Sec. 102. Coverage of screening for glaucoma.
- Sec. 103. Coverage of screening colonoscopy for average risk individuals.
- Sec. 104. Modernization of screening mammography benefit.
- Sec. 105. Coverage of medical nutrition therapy services for beneficiaries with diabetes or a renal disease.

Subtitle B—Other Beneficiary Improvements

- Sec. 111. Acceleration of reduction of beneficiary copayment for hospital outpatient department services.
- Sec. 112. Preservation of coverage of drugs and biologicals under part B of the medicare program.
- Sec. 113. Elimination of time limitation on medicare benefits for immunosuppressive drugs.
- Sec. 114. Imposition of billing limits on prescription drugs.

Subtitle C—Demonstration Projects and Studies

- Sec. 121. Demonstration project for disease management for severely chronically ill medicare beneficiaries.
- Sec. 122. Cancer prevention and treatment demonstration for ethnic and racial minorities.
- Sec. 123. Study on medicare coverage of routine thyroid screening.
- Sec. 124. MedPAC study on consumer coalitions.
- Sec. 125. Study on limitation on State payment for medicare cost-sharing affecting access to services for qualified medicare beneficiaries.
- Sec. 126. Institute of Medicine study on waiver of 24-month waiting period for medicare disability eligibility for amyotrophic lateral sclerosis (ALS) and other devastating diseases.
- Sec. 127. Studies on preventive interventions in primary care for older Americans.
- Sec. 128. MedPAC study and report on medicare coverage of cardiac and pulmonary rehabilitation therapy services.

TITLE II—RURAL HEALTH CARE IMPROVEMENTS

Subtitle A—Critical Access Hospital Provisions

- Sec. 201. Clarification of no beneficiary cost-sharing for clinical diagnostic laboratory tests furnished by critical access hospitals.
- Sec. 202. Assistance with fee schedule payment for professional services under all-inclusive rate.
- Sec. 203. Exemption of critical access hospital swing beds from SNF PPS.
- Sec. 204. Payment in critical access hospitals for emergency room on-call physicians.
- Sec. 205. Treatment of ambulance services furnished by certain critical access hospitals.
- Sec. 206. GAO study on certain eligibility requirements for critical access hospitals.

Subtitle B—Other Rural Hospitals Provisions

- Sec. 211. Equitable treatment for rural disproportionate share hospitals.

- Sec. 212. Option to base eligibility for medicare dependent, small rural hospital program on discharges during 2 of the 3 most recently audited cost reporting periods.
- Sec. 213. Extension of option to use rebased target amounts to all sole community hospitals.
- Sec. 214. MedPAC analysis of impact of volume on per unit cost of rural hospitals with psychiatric units.

Subtitle C—Other Rural Provisions

- Sec. 221. Assistance for providers of ambulance services in rural areas.
- Sec. 222. Payment for certain physician assistant services.
- Sec. 223. Revision of medicare reimbursement for telehealth services.
- Sec. 224. Expanding access to rural health clinics.
- Sec. 225. MedPAC study on low-volume, isolated rural health care providers.

TITLE III—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

- Sec. 301. Revision of acute care hospital payment update for 2001.
- Sec. 302. Additional modification in transition for indirect medical education (IME) percentage adjustment.
- Sec. 303. Decrease in reductions for disproportionate share hospital (DSH) payments.
- Sec. 304. Wage index improvements.
- Sec. 305. Payment for inpatient services of rehabilitation hospitals.
- Sec. 306. Payment for inpatient services of psychiatric hospitals.
- Sec. 307. Payment for inpatient services of long-term care hospitals.

Subtitle B—Adjustments to PPS Payments for Skilled Nursing Facilities

- Sec. 311. Elimination of reduction in skilled nursing facility (SNF) market basket update in 2001.
- Sec. 312. Increase in nursing component of PPS Federal rate.
- Sec. 313. Application of SNF consolidated billing requirement limited to part A covered stays.
- Sec. 314. Adjustment of rehabilitation RUGs to correct anomaly in payment rates.
- Sec. 315. Establishment of process for geographic reclassification.

Subtitle C—Hospice Care

- Sec. 321. Full market basket increase for 2001.
- Sec. 322. Clarification of physician certification.
- Sec. 323. MedPAC report on access to, and use of, hospice benefit.

Subtitle D—Other Provisions

- Sec. 331. Relief from medicare part A late enrollment penalty for group buy-in for State and local retirees.
- Sec. 332. Posting of information on nursing facility staffing.

TITLE IV—PROVISIONS RELATING TO PART B

Subtitle A—Hospital Outpatient Services

- Sec. 401. Revision of hospital outpatient PPS payment update.

- Sec. 402. Clarifying process and standards for determining eligibility of devices for pass-through payments under hospital outpatient PPS.
- Sec. 403. Application of OPD PPS transitional corridor payments to certain hospitals that did not submit a 1996 cost report.
- Sec. 404. Application of rules for determining provider-based status for certain entities.
- Sec. 405. Treatment of children's hospitals under prospective payment system.
- Sec. 406. Inclusion of temperature monitored cryoablation in transitional pass-through for certain medical devices, drugs, and biologicals under OPD PPS.

Subtitle B—Provisions Relating to Physicians' Services

- Sec. 411. GAO studies relating to physicians' services.
- Sec. 412. Physician group practice demonstration.
- Sec. 413. Study on enrollment procedures for groups that retain independent contractor physicians.

Subtitle C—Other Services

- Sec. 421. 1-year extension of moratorium on therapy caps; report on standards for supervision of physical therapy assistants.
- Sec. 422. Update in renal dialysis composite rate.
- Sec. 423. Payment for ambulance services.
- Sec. 424. Ambulatory surgical centers.
- Sec. 425. Full update for durable medical equipment.
- Sec. 426. Full update for orthotics and prosthetics.
- Sec. 427. Establishment of special payment provisions and requirements for prosthetics and certain custom fabricated orthotic items.
- Sec. 428. Replacement of prosthetic devices and parts.
- Sec. 429. Revised part B payment for drugs and biologicals and related services.
- Sec. 430. Contrast enhanced diagnostic procedures under hospital prospective payment system.
- Sec. 431. Qualifications for community mental health centers.
- Sec. 432. Modification of medicare billing requirements for certain Indian providers.
- Sec. 433. GAO study on coverage of surgical first assisting services of certified registered nurse first assistants.
- Sec. 434. MedPAC study and report on medicare reimbursement for services provided by certain providers.
- Sec. 435. MedPAC study and report on medicare coverage of services provided by certain nonphysician providers.
- Sec. 436. GAO study and report on the costs of emergency and medical transportation services.
- Sec. 437. GAO studies and reports on medicare payments.
- Sec. 438. MedPAC study on access to outpatient pain management services.

TITLE V—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

- Sec. 501. 1-year additional delay in application of 15 percent reduction on payment limits for home health services.
- Sec. 502. Restoration of full home health market basket update for home health services for fiscal year 2001.
- Sec. 503. Temporary two-month extension of periodic interim payments.

- Sec. 504. Use of telehealth in delivery of home health services.
- Sec. 505. Study on costs to home health agencies of purchasing nonroutine medical supplies.
- Sec. 506. Treatment of branch offices; GAO study on supervision of home health care provided in isolated rural areas.
- Sec. 507. Clarification of the homebound definition under the medicare home health benefit.

Subtitle B—Direct Graduate Medical Education

- Sec. 511. Increase in floor for direct graduate medical education payments.
- Sec. 512. Change in distribution formula for Medicare+Choice-related nursing and allied health education costs.

Subtitle C—Changes in Medicare Coverage and Appeals Process

- Sec. 521. Revisions to medicare appeals process.
- Sec. 522. Revisions to medicare coverage process.

Subtitle D—Improving Access to New Technologies

- Sec. 531. Reimbursement improvements for new clinical laboratory tests and durable medical equipment.
- Sec. 532. Retention of HCPCS level III codes.
- Sec. 533. Recognition of new medical technologies under inpatient hospital PPS.

Subtitle E—Other Provisions

- Sec. 541. Increase in reimbursement for bad debt.
- Sec. 542. Treatment of certain physician pathology services under medicare.
- Sec. 543. Extension of advisory opinion authority.
- Sec. 544. Change in annual MedPAC reporting.
- Sec. 545. Development of patient assessment instruments.
- Sec. 546. GAO report on impact of the Emergency Medical Treatment and Active Labor Act (EMTALA) on hospital emergency departments.

TITLE VI—PROVISIONS RELATING TO PART C (MEDICARE+CHOICE PROGRAM) AND OTHER MEDICARE MAN- AGED CARE PROVISIONS

Subtitle A—Medicare+Choice Payment Reforms

- Sec. 601. Increase in minimum payment amount.
- Sec. 602. Increase in minimum percentage increase.
- Sec. 603. 10-year phase-in of risk adjustment.
- Sec. 604. Transition to revised Medicare+Choice payment rates.
- Sec. 605. Revision of payment rates for ESRD patients enrolled in Medicare+Choice plans.
- Sec. 606. Permitting premium reductions as additional benefits under Medicare+Choice plans.
- Sec. 607. Full implementation of risk adjustment for congestive heart failure enrollees for 2001.
- Sec. 608. Expansion of application of Medicare+Choice new entry bonus.
- Sec. 609. Report on inclusion of certain costs of the Department of Veterans Affairs and military facility services in calculating Medicare+Choice payment rates.

Subtitle B—Other Medicare+Choice Reforms

- Sec. 611. Payment of additional amounts for new benefits covered during a contract term.
- Sec. 612. Restriction on implementation of significant new regulatory requirements mid-year.
- Sec. 613. Timely approval of marketing material that follows model marketing language.
- Sec. 614. Avoiding duplicative regulation.
- Sec. 615. Election of uniform local coverage policy for Medicare+Choice plan covering multiple localities.
- Sec. 616. Eliminating health disparities in Medicare+Choice program.
- Sec. 617. Medicare+Choice program compatibility with employer or union group health plans.
- Sec. 618. Special medigap enrollment antidiscrimination provision for certain beneficiaries.
- Sec. 619. Restoring effective date of elections and changes of elections of Medicare+Choice plans.
- Sec. 620. Permitting ESRD beneficiaries to enroll in another Medicare+Choice plan if the plan in which they are enrolled is terminated.
- Sec. 621. Providing choice for skilled nursing facility services under the Medicare+Choice program.
- Sec. 622. Providing for accountability of Medicare+Choice plans.

Subtitle C—Other Managed Care Reforms

- Sec. 631. 1-year extension of social health maintenance organization (SHMO) demonstration project.
- Sec. 632. Revised terms and conditions for extension of medicare community nursing organization (CNO) demonstration project.
- Sec. 633. Extension of medicare municipal health services demonstration projects.
- Sec. 634. Service area expansion for medicare cost contracts during transition period.

TITLE VII—MEDICAID

- Sec. 701. DSH payments.
- Sec. 702. New prospective payment system for Federally-qualified health centers and rural health clinics.
- Sec. 703. Streamlined approval of continued State-wide section 1115 medicaid waivers.
- Sec. 704. Medicaid county-organized health systems.
- Sec. 705. Deadline for issuance of final regulation relating to medicaid upper payment limits.
- Sec. 706. Alaska FMAP.

TITLE VIII—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

- Sec. 801. Special rule for redistribution and availability of unused fiscal year 1998 and 1999 SCHIP allotments.
- Sec. 802. Authority to pay medicaid expansion SCHIP costs from title XXI appropriation.

TITLE IX—OTHER PROVISIONS

Subtitle A—PACE Program

- Sec. 901. Extension of transition for current waivers.
 Sec. 902. Continuing of certain operating arrangements permitted.
 Sec. 903. Flexibility in exercising waiver authority.

Subtitle B—Outreach to Eligible Low-Income Medicare Beneficiaries

- Sec. 911. Outreach on availability of medicare cost-sharing assistance to eligible low-income medicare beneficiaries.

Subtitle C—Maternal and Child Health Block Grant

- Sec. 921. Increase in authorization of appropriations for the maternal and child health services block grant.

Subtitle D—Diabetes

- Sec. 931. Increase in appropriations for special diabetes programs for type I diabetes and Indians.
 Sec. 932. Appropriations for Ricky Ray Hemophilia Relief Fund.

1 **TITLE I—MEDICARE**
 2 **BENEFICIARY IMPROVEMENTS**
 3 **Subtitle A—Improved Preventive**
 4 **Benefits**

5 **SEC. 101. COVERAGE OF BIENNIAL SCREENING PAP SMEAR**
 6 **AND PELVIC EXAMS.**

7 (a) IN GENERAL.—

8 (1) BIENNIAL SCREENING PAP SMEAR.—Section
 9 1861(nn)(1) (42 U.S.C. 1395x(nn)(1)) is amended
 10 by striking “3 years” and inserting “2 years”.

11 (2) BIENNIAL SCREENING PELVIC EXAM.—Sec-
 12 tion 1861(nn)(2) (42 U.S.C. 1395x(nn)(2)) is
 13 amended by striking “3 years” and inserting “2
 14 years”.

15 (b) EFFECTIVE DATE.—The amendments made by
 16 subsection (a) apply to items and services furnished on
 17 or after July 1, 2001.

1 **SEC. 102. COVERAGE OF SCREENING FOR GLAUCOMA.**

2 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.
3 1395x(s)(2)) is amended—

4 (1) by striking “and” at the end of subpara-
5 graph (S);

6 (2) by inserting “and” at the end of subpara-
7 graph (T); and

8 (3) by adding at the end the following:

9 “(U) screening for glaucoma (as defined in sub-
10 section (uu)) for individuals determined to be at
11 high risk for glaucoma, individuals with a family his-
12 tory of glaucoma and individuals with diabetes;”.

13 (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.
14 1395x) is amended by adding at the end the following new
15 subsection:

16 “Screening for Glaucoma

17 “(uu) The term ‘screening for glaucoma’ means a di-
18 lated eye examination with an intraocular pressure meas-
19 urement, and a direct ophthalmoscopy or a slit-lamp bio-
20 microscopic examination for the early detection of glau-
21 coma which is furnished by or under the direct supervision
22 of an optometrist or ophthalmologist who is legally author-
23 ized to furnish such services under State law (or the State
24 regulatory mechanism provided by State law) of the State
25 in which the services are furnished, as would otherwise
26 be covered if furnished by a physician or as an incident

1 to a physician’s professional service, if the individual in-
2 volved has not had such an examination in the preceding
3 year.”.

4 (c) CONFORMING AMENDMENT.—Section
5 1862(a)(1)(F) (42 U.S.C. 1395y(a)(1)(F)) is amended—

6 (1) by striking “and,”; and

7 (2) by adding at the end the following: “and, in
8 the case of screening for glaucoma, which is per-
9 formed more frequently than is provided under sec-
10 tion 1861(uu),”.

11 (d) EFFECTIVE DATE.—The amendments made by
12 this section shall apply to services furnished on or after
13 January 1, 2002.

14 **SEC. 103. COVERAGE OF SCREENING COLONOSCOPY FOR**
15 **AVERAGE RISK INDIVIDUALS.**

16 (a) IN GENERAL.—Section 1861(pp) (42 U.S.C.
17 1395x(pp)) is amended—

18 (1) in paragraph (1)(C), by striking “In the
19 case of an individual at high risk for colorectal can-
20 cer, screening colonoscopy” and inserting “Screening
21 colonoscopy”; and

22 (2) in paragraph (2), by striking “In paragraph
23 (1)(C), an” and inserting “An”.

1 (b) FREQUENCY LIMITS FOR SCREENING
2 COLONOSCOPY.—Section 1834(d) (42 U.S.C. 1395m(d))
3 is amended—

4 (1) in paragraph (2)(E)(ii), by inserting before
5 the period at the end the following: “or, in the case
6 of an individual who is not at high risk for colorectal
7 cancer, if the procedure is performed within the 119
8 months after a previous screening colonoscopy”;

9 (2) in paragraph (3)—

10 (A) in the heading by striking “FOR INDI-
11 VIDUALS AT HIGH RISK FOR COLORECTAL CAN-
12 CER”;

13 (B) in subparagraph (A), by striking “for
14 individuals at high risk for colorectal cancer (as
15 defined in section 1861(pp)(2))”;

16 (C) in subparagraph (E), by inserting be-
17 fore the period at the end the following: “or for
18 other individuals if the procedure is performed
19 within the 119 months after a previous screen-
20 ing colonoscopy or within 47 months after a
21 previous screening flexible sigmoidoscopy”.

22 (c) EFFECTIVE DATE.—The amendments made by
23 this section apply to colorectal cancer screening services
24 provided on or after July 1, 2001.

1 **SEC. 104. MODERNIZATION OF SCREENING MAMMOGRAPHY**

2 **BENEFIT.**

3 (a) **INCLUSION IN PHYSICIAN FEE SCHEDULE.**—Sec-
4 tion 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)) is amended by
5 inserting “(13),” after “(4),”.

6 (b) **CONFORMING AMENDMENT.**—Section 1834(c)
7 (42 U.S.C. 1395m(c)) is amended to read as follows:

8 “(c) **PAYMENT AND STANDARDS FOR SCREENING**
9 **MAMMOGRAPHY.**—

10 “(1) **IN GENERAL.**—With respect to expenses
11 incurred for screening mammography (as defined in
12 section 1861(jj)), payment may be made only—

13 “(A) for screening mammography con-
14 ducted consistent with the frequency permitted
15 under paragraph (2); and

16 “(B) if the screening mammography is
17 conducted by a facility that has a certificate (or
18 provisional certificate) issued under section 354
19 of the Public Health Service Act.

20 “(2) **FREQUENCY COVERED.**—

21 “(A) **IN GENERAL.**—Subject to revision by
22 the Secretary under subparagraph (B)—

23 “(i) no payment may be made under
24 this part for screening mammography per-
25 formed on a woman under 35 years of age;

1 “(ii) payment may be made under this
2 part for only one screening mammography
3 performed on a woman over 34 years of
4 age, but under 40 years of age; and

5 “(iii) in the case of a woman over 39
6 years of age, payment may not be made
7 under this part for screening mammog-
8 raphy performed within 11 months fol-
9 lowing the month in which a previous
10 screening mammography was performed.

11 “(B) REVISION OF FREQUENCY.—

12 “(i) REVIEW.—The Secretary, in con-
13 sultation with the Director of the National
14 Cancer Institute, shall review periodically
15 the appropriate frequency for performing
16 screening mammography, based on age
17 and such other factors as the Secretary be-
18 lieves to be pertinent.

19 “(ii) REVISION OF FREQUENCY.—The
20 Secretary, taking into consideration the re-
21 view made under clause (i), may revise
22 from time to time the frequency with
23 which screening mammography may be
24 paid for under this subsection.”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 subsections (a) and (b) apply with respect to screening
3 mammographies furnished on or after January 1, 2002.

4 (d) PAYMENT FOR NEW TECHNOLOGIES.—

5 (1) TESTS FURNISHED IN 2001.—

6 (A) SCREENING.—For a screening mam-
7 mography (as defined in section 1861(jj) of the
8 Social Security Act (42 U.S.C. 1395(jj))) fur-
9 nished during the period beginning on April 1,
10 2001, and ending on December 31, 2001, that
11 uses a new technology, payment for such
12 screening mammography shall be made as fol-
13 lows:

14 (i) In the case of a technology which
15 directly takes a digital image (without in-
16 volving film) and subsequently analyzes
17 such resulting image with software to iden-
18 tify possible problem areas, in an amount
19 equal to 150 percent of the amount of pay-
20 ment under section 1848 of such Act (42
21 U.S.C. 1395w-4) for a bilateral diagnostic
22 mammography (under HCPCS code
23 76091) for such year.

24 (ii) In the case of a technology which
25 allows conversion of a standard film mam-

1 mogram into a digital image and subse-
2 quently analyzes such resulting image with
3 software to identify possible problem areas,
4 in an amount equal to the limit that would
5 otherwise be applied under section
6 1834(c)(3) of such Act (42 U.S.C.
7 1395m(c)(3)) for 2001, increased by \$15.

8 (B) BILATERAL DIAGNOSTIC MAMMOG-
9 RAPHY.—For a bilateral diagnostic mammog-
10 raphy (under HCPCS code 76091) furnished
11 during the period beginning on April 1, 2001,
12 and ending on December 31, 2001, that uses a
13 new technology described in subparagraph
14 (A)(i), payment for such mammography shall
15 be the amount of payment provided for under
16 such subparagraph.

17 The Secretary of Health and Human Services may
18 implement the provisions of this paragraph by pro-
19 gram memorandum or otherwise.

20 (2) CONSIDERATION OF NEW HCPCS CODE FOR
21 NEW TECHNOLOGIES AFTER 2001.—The Secretary
22 shall determine, for such screening mammographies
23 performed after 2001, whether the assignment of a
24 new HCPCS code is appropriate for screening mam-
25 mography that uses a new technology. If the Sec-

1 retary determines that a new code is appropriate for
2 such screening mammography, the Secretary shall
3 provide for such new code for such tests furnished
4 after 2001.

5 (3) NEW TECHNOLOGY DESCRIBED.—For pur-
6 poses of this subsection, a new technology with re-
7 spect to a screening mammography is an advance in
8 technology with respect to the test or equipment
9 that results in the following:

10 (A) A significant increase or decrease in
11 the resources used in the test or in the manu-
12 facture of the equipment.

13 (B) A significant improvement in the per-
14 formance of the test or equipment.

15 (C) A significant advance in medical tech-
16 nology that is expected to significantly improve
17 the treatment of medicare beneficiaries.

18 (4) HCPCS CODE DEFINED.—The term
19 “HCPCS code” means an alphanumeric code under
20 the Health Care Financing Administration Common
21 Procedure Coding System (HCPCS).

1 **SEC. 105. COVERAGE OF MEDICAL NUTRITION THERAPY**
2 **SERVICES FOR BENEFICIARIES WITH DIABE-**
3 **TES OR A RENAL DISEASE.**

4 (a) **COVERAGE.**—Section 1861(s)(2) (42 U.S.C.
5 1395x(s)(2)), as amended by section 102(a), is amended—

6 (1) in subparagraph (T), by striking “and” at
7 the end;

8 (2) in subparagraph (U), by inserting “and” at
9 the end; and

10 (3) by adding at the end the following new sub-
11 paragraph:

12 “(V) medical nutrition therapy services (as de-
13 fined in subsection (vv)(1)) in the case of a bene-
14 ficiary with diabetes or a renal disease who—

15 “(i) has not received diabetes outpatient
16 self-management training services within a time
17 period determined by the Secretary; and

18 “(ii) meets such other criteria determined
19 by the Secretary after consideration of protocols
20 established by dietitian or nutrition professional
21 organizations;”.

22 (b) **SERVICES DESCRIBED.**—Section 1861 (42 U.S.C.
23 1395x), as amended by section 102(b), is amended by add-
24 ing at the end the following:

1 “Medical Nutrition Therapy Services; Registered
2 Dietitian or Nutrition Professional

3 “(vv)(1) The term ‘medical nutrition therapy serv-
4 ices’ means nutritional diagnostic, therapy, and counseling
5 services for the purpose of disease management which are
6 furnished by a registered dietitian or nutrition profes-
7 sional (as defined in paragraph (2)) pursuant to a referral
8 by a physician (as defined in subsection (r)(1)).

9 “(2) Subject to paragraph (3), the term ‘registered
10 dietitian or nutrition professional’ means an individual
11 who—

12 “(A) holds a baccalaureate or higher degree
13 granted by a regionally accredited college or univer-
14 sity in the United States (or an equivalent foreign
15 degree) with completion of the academic require-
16 ments of a program in nutrition or dietetics, as ac-
17 credited by an appropriate national accreditation or-
18 ganization recognized by the Secretary for this pur-
19 pose;

20 “(B) has completed at least 900 hours of super-
21 vised dietetics practice under the supervision of a
22 registered dietitian or nutrition professional; and

23 “(C)(i) is licensed or certified as a dietitian or
24 nutrition professional by the State in which the serv-
25 ices are performed; or

1 “(ii) in the case of an individual in a State that
2 does not provide for such licensure or certification,
3 meets such other criteria as the Secretary estab-
4 lishes.

5 “(3) Subparagraphs (A) and (B) of paragraph (2)
6 shall not apply in the case of an individual who, as of the
7 date of the enactment of this subsection, is licensed or cer-
8 tified as a dietitian or nutrition professional by the State
9 in which medical nutrition therapy services are per-
10 formed.”.

11 (c) PAYMENT.—Section 1833(a)(1) (42 U.S.C.
12 1395l(a)(1)) is amended—

13 (1) by striking “and” before “(S)”; and

14 (2) by inserting before the semicolon at the end
15 the following: “, and (T) with respect to medical nu-
16 trition therapy services (as defined in section
17 1861(vv)), the amount paid shall be 80 percent of
18 the lesser of the actual charge for the services or 85
19 percent of the amount determined under the fee
20 schedule established under section 1848(b) for the
21 same services if furnished by a physician”.

22 (d) APPLICATION OF LIMITS ON BILLING.—Section
23 1842(b)(18)(C) (42 U.S.C. 1395u(b)(18)(C)) is amended
24 by adding at the end the following new clause:

1 “(vi) A registered dietitian or nutrition profes-
2 sional.”.

3 (e) EFFECTIVE DATE.—The amendments made by
4 this section apply to services furnished on or after Janu-
5 ary 1, 2002.

6 (f) STUDY.—Not later than July 1, 2003, the Sec-
7 retary of Health and Human Services shall submit to Con-
8 gress a report that contains recommendations with respect
9 to the expansion to other medicare beneficiary populations
10 of the medical nutrition therapy services benefit (furnished
11 under the amendments made by this section).

12 **Subtitle B—Other Beneficiary** 13 **Improvements**

14 **SEC. 111. ACCELERATION OF REDUCTION OF BENEFICIARY** 15 **COPAYMENT FOR HOSPITAL OUTPATIENT DE-** 16 **PARTMENT SERVICES.**

17 (a) REDUCING THE UPPER LIMIT ON BENEFICIARY
18 COPAYMENT.—

19 (1) IN GENERAL.—Section 1833(t)(8)(C) (42
20 U.S.C. 1395l(t)(8)(C)) is amended to read as fol-
21 lows:

22 “(C) LIMITATION ON COPAYMENT
23 AMOUNT.—

24 “(i) TO INPATIENT HOSPITAL DE-
25 DUCTIBLE AMOUNT.—In no case shall the

1 copayment amount for a procedure per-
2 formed in a year exceed the amount of the
3 inpatient hospital deductible established
4 under section 1813(b) for that year.

5 “(ii) TO SPECIFIED PERCENTAGE.—
6 The Secretary shall reduce the national
7 unadjusted copayment amount for a cov-
8 ered OPD service (or group of such serv-
9 ices) furnished in a year in a manner so
10 that the effective copayment rate (deter-
11 mined on a national unadjusted basis) for
12 that service in the year does not exceed the
13 following percentage:

14 “(I) For procedures performed in
15 2001, 60 percent.

16 “(II) For procedures performed
17 in 2002 or 2003, 55 percent.

18 “(III) For procedures performed
19 in 2004, 50 percent.

20 “(IV) For procedures performed
21 in 2005, 45 percent.

22 “(V) For procedures performed
23 in 2006 and thereafter, 40 percent.”.

1 (2) EFFECTIVE DATE.—The amendment made
2 by paragraph (1) applies with respect to services
3 furnished on or after January 1, 2001.

4 (b) CONSTRUCTION REGARDING LIMITING IN-
5 CREASES IN COST-SHARING.—Nothing in this Act or the
6 Social Security Act shall be construed as preventing a hos-
7 pital from waiving the amount of any coinsurance for out-
8 patient hospital services under the medicare program
9 under title XVIII of the Social Security Act that may have
10 been increased as a result of the implementation of the
11 prospective payment system under section 1833(t) of the
12 Social Security Act (42 U.S.C. 1395l(t)).

13 (c) GAO STUDY OF REDUCTION IN MEDIGAP PRE-
14 MIUM LEVELS RESULTING FROM REDUCTIONS IN COIN-
15 SURANCE.—The Comptroller General of the United States
16 shall work, in concert with the National Association of In-
17 surance Commissioners, to evaluate the extent to which
18 the premium levels for medicare supplemental policies re-
19 flect the reductions in coinsurance resulting from the
20 amendment made by subsection (a). Not later than April
21 1, 2004, the Comptroller General shall submit to Congress
22 a report on such evaluation and the extent to which the
23 reductions in beneficiary coinsurance effected by such
24 amendment have resulted in actual savings to medicare
25 beneficiaries.

1 **SEC. 112. PRESERVATION OF COVERAGE OF DRUGS AND**
2 **BIOLOGICALS UNDER PART B OF THE MEDI-**
3 **CARE PROGRAM.**

4 (a) IN GENERAL.—Section 1861(s)(2) (42 U.S.C.
5 1395x(s)(2)) is amended, in each of subparagraphs (A)
6 and (B), by striking “(including drugs and biologicals
7 which cannot, as determined in accordance with regula-
8 tions, be self-administered)” and inserting “(including
9 drugs and biologicals which are not usually self-adminis-
10 tered by the patient)”.

11 (b) EFFECTIVE DATE.—The amendment made by
12 subsection (a) applies to drugs and biologicals adminis-
13 tered on or after the date of the enactment of this Act.

14 **SEC. 113. ELIMINATION OF TIME LIMITATION ON MEDI-**
15 **CARE BENEFITS FOR IMMUNOSUPPRESSIVE**
16 **DRUGS.**

17 (a) IN GENERAL.—Section 1861(s)(2)(J) (42 U.S.C.
18 1395x(s)(2)(J)) is amended by striking “, but only” and
19 all that follows up to the semicolon at the end.

20 (b) CONFORMING AMENDMENTS.—

21 (1) EXTENDED COVERAGE.—Section 1832 (42
22 U.S.C. 1395k) is amended—

23 (A) by striking subsection (b); and

24 (B) by redesignating subsection (c) as sub-
25 section (b).

1 **Subtitle C—Demonstration**
2 **Projects and Studies**

3 **SEC. 121. DEMONSTRATION PROJECT FOR DISEASE MAN-**
4 **AGEMENT FOR SEVERELY CHRONICALLY ILL**
5 **MEDICARE BENEFICIARIES.**

6 (a) IN GENERAL.—The Secretary of Health and
7 Human Services shall conduct a demonstration project
8 under this section (in this section referred to as the
9 “project”) to demonstrate the impact on costs and health
10 outcomes of applying disease management to medicare
11 beneficiaries with diagnosed, advanced-stage congestive
12 heart failure, diabetes, or coronary heart disease. In no
13 case may the number of participants in the project exceed
14 30,000 at any time.

15 (b) VOLUNTARY PARTICIPATION.—

16 (1) ELIGIBILITY.—Medicare beneficiaries are
17 eligible to participate in the project only if—

18 (A) they meet specific medical criteria
19 demonstrating the appropriate diagnosis and
20 the advanced nature of their disease;

21 (B) their physicians approve of participa-
22 tion in the project; and

23 (C) they are not enrolled in a
24 Medicare+Choice plan.

1 (2) BENEFITS.—A beneficiary who is enrolled
2 in the project shall be eligible—

3 (A) for disease management services re-
4 lated to their chronic health condition; and

5 (B) for payment for all costs for prescrip-
6 tion drugs without regard to whether or not
7 they relate to the chronic health condition, ex-
8 cept that the project may provide for modest
9 cost-sharing with respect to prescription drug
10 coverage.

11 (c) CONTRACTS WITH DISEASE MANAGEMENT ORGA-
12 NIZATIONS.—

13 (1) IN GENERAL.—The Secretary of Health and
14 Human Services shall carry out the project through
15 contracts with up to three disease management orga-
16 nizations. The Secretary shall not enter into such a
17 contract with an organization unless the organiza-
18 tion demonstrates that it can produce improved
19 health outcomes and reduce aggregate medicare ex-
20 penditures consistent with paragraph (2).

21 (2) CONTRACT PROVISIONS.—Under such
22 contracts—

23 (A) such an organization shall be required
24 to provide for prescription drug coverage de-
25 scribed in subsection (b)(2)(B);

1 (B) such an organization shall be paid a
2 fee negotiated and established by the Secretary
3 in a manner so that (taking into account sav-
4 ings in expenditures under parts A and B of
5 the medicare program under title XVIII of the
6 Social Security Act) there will be a net reduc-
7 tion in expenditures under the medicare pro-
8 gram as a result of the project; and

9 (C) such an organization shall guarantee,
10 through an appropriate arrangement with a re-
11 insurance company or otherwise, the net reduc-
12 tion in expenditures described in subparagraph
13 (B).

14 (3) PAYMENTS.—Payments to such organiza-
15 tions shall be made in appropriate proportion from
16 the Trust Funds established under title XVIII of the
17 Social Security Act.

18 (d) APPLICATION OF MEDIGAP PROTECTIONS TO
19 DEMONSTRATION PROJECT ENROLLEES.—(1) Subject to
20 paragraph (2), the provisions of section 1882(s)(3) (other
21 than clauses (i) through (iv) of subparagraph (B)) and
22 1882(s)(4) of the Social Security Act shall apply to enroll-
23 ment (and termination of enrollment) in the demonstra-
24 tion project under this section, in the same manner as they
25 apply to enrollment (and termination of enrollment) with

1 a Medicare+Choice organization in a Medicare+Choice
2 plan.

3 (2) In applying paragraph (1)—

4 (A) any reference in clause (v) or (vi) of section
5 1882(s)(3)(B) of such Act to 12 months is deemed
6 a reference to the period of the demonstration
7 project; and

8 (B) the notification required under section
9 1882(s)(3)(D) of such Act shall be provided in a
10 manner specified by the Secretary of Health and
11 Human Services.

12 (e) DURATION.—The project shall last for not longer
13 than 3 years.

14 (f) WAIVER.—The Secretary of Health and Human
15 Services shall waive such provisions of title XVIII of the
16 Social Security Act as may be necessary to provide for
17 payment for services under the project in accordance with
18 subsection (c)(3).

19 (g) REPORT.—The Secretary of Health and Human
20 Services shall submit to Congress an interim report on the
21 project not later than 2 years after the date it is first im-
22 plemented and a final report on the project not later than
23 6 months after the date of its completion. Such reports
24 shall include information on the impact of the project on

1 costs and health outcomes and recommendations on the
2 cost-effectiveness of extending or expanding the project.

3 **SEC. 122. CANCER PREVENTION AND TREATMENT DEM-**
4 **ONSTRATION FOR ETHNIC AND RACIAL MI-**
5 **NORITIES.**

6 (a) DEMONSTRATION.—

7 (1) IN GENERAL.—The Secretary of Health and
8 Human Services (in this section referred to as the
9 “Secretary”) shall conduct demonstration projects
10 (in this section referred to as “demonstration
11 projects”) for the purpose of developing models and
12 evaluating methods that—

13 (A) improve the quality of items and serv-
14 ices provided to target individuals in order to
15 facilitate reduced disparities in early detection
16 and treatment of cancer;

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

21 (C) eliminate disparities in the rate of pre-
22 ventive cancer screening measures, such as pap
23 smears and prostate cancer screenings, among
24 target individuals; and

1 (D) promote collaboration with community-
2 based organizations to ensure cultural com-
3 petency of health care professionals and lin-
4 guistic access for persons with limited English
5 proficiency.

6 (2) TARGET INDIVIDUAL DEFINED.—In this
7 section, the term “target individual” means an indi-
8 vidual of a racial and ethnic minority group, as de-
9 fined by section 1707 of the Public Health Service
10 Act, who is entitled to benefits under part A, and
11 enrolled under part B, of title XVIII of the Social
12 Security Act.

13 (b) PROGRAM DESIGN.—

14 (1) INITIAL DESIGN.—Not later than 1 year
15 after the date of the enactment of this Act, the Sec-
16 retary shall evaluate best practices in the private
17 sector, community programs, and academic research
18 of methods that reduce disparities among individuals
19 of racial and ethnic minority groups in the preven-
20 tion and treatment of cancer and shall design the
21 demonstration projects based on such evaluation.

22 (2) NUMBER AND PROJECT AREAS.—Not later
23 than 2 years after the date of the enactment of this
24 Act, the Secretary shall implement at least 9 dem-
25 onstration projects, including the following:

1 (A) 2 projects for each of the 4 major ra-
2 cial and ethnic minority groups (American Indi-
3 ans (including Alaska Natives, Eskimos, and
4 Aleuts); Asian Americans and Pacific Islanders;
5 Blacks; and Hispanics. The 2 projects must
6 target different ethnic subpopulations.

7 (B) 1 project within the Pacific Islands.

8 (C) At least 1 project each in a rural area
9 and inner-city area.

10 (3) EXPANSION OF PROJECTS; IMPLEMENTA-
11 TION OF DEMONSTRATION PROJECT RESULTS.—If
12 the initial report under subsection (c) contains an
13 evaluation that demonstration projects—

14 (A) reduce expenditures under the medi-
15 care program under title XVIII of the Social
16 Security Act; or

17 (B) do not increase expenditures under the
18 medicare program and reduce racial and ethnic
19 health disparities in the quality of health care
20 services provided to target individuals and in-
21 crease satisfaction of beneficiaries and health
22 care providers;

23 the Secretary shall continue the existing demonstra-
24 tion projects and may expand the number of dem-
25 onstration projects.

1 (c) REPORT TO CONGRESS.—

2 (1) IN GENERAL.—Not later than 2 years after
3 the date the Secretary implements the initial dem-
4 onstration projects, and biannually thereafter, the
5 Secretary shall submit to Congress a report regard-
6 ing the demonstration projects.

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

9 (A) A description of the demonstration
10 projects.

11 (B) An evaluation of—

12 (i) the cost-effectiveness of the dem-
13 onstration projects;

14 (ii) the quality of the health care serv-
15 ices provided to target individuals under
16 the demonstration projects; and

17 (iii) beneficiary and health care pro-
18 vider satisfaction under the demonstration
19 projects.

20 (C) Any other information regarding the
21 demonstration projects that the Secretary de-
22 termines to be appropriate.

23 (d) WAIVER AUTHORITY.—The Secretary shall waive
24 compliance with the requirements of title XVIII of the So-
25 cial Security Act to such extent and for such period as

1 the Secretary determines is necessary to conduct dem-
2 onstration projects.

3 (e) FUNDING.—

4 (1) DEMONSTRATION PROJECTS.—

5 (A) STATE PROJECTS.—Except as provided
6 in subparagraph (B), the Secretary shall pro-
7 vide for the transfer from the Federal Hospital
8 Insurance Trust Fund and the Federal Supple-
9 mentary Insurance Trust Fund under title
10 XVIII of the Social Security Act, in such pro-
11 portions as the Secretary determines to be ap-
12 propriate, of such funds as are necessary for
13 the costs of carrying out the demonstration
14 projects.

15 (B) TERRITORY PROJECTS.—In the case of
16 a demonstration project described in subsection
17 (b)(2)(B), amounts shall be available only as
18 provided in any Federal law making appropria-
19 tions for the territories.

20 (2) LIMITATION.—In conducting demonstration
21 projects, the Secretary shall ensure that the aggre-
22 gate payments made by the Secretary do not exceed
23 the sum of the amount which the Secretary would
24 have paid under the program for the prevention and

1 treatment of cancer if the demonstration projects
2 were not implemented, plus \$25,000,000.

3 **SEC. 123. STUDY ON MEDICARE COVERAGE OF ROUTINE**
4 **THYROID SCREENING.**

5 (a) STUDY.—The Secretary of Health and Human
6 Services shall request the National Academy of Sciences,
7 and as appropriate in conjunction with the United States
8 Preventive Services Task Force, to conduct a study on the
9 addition of coverage of routine thyroid screening using a
10 thyroid stimulating hormone test as a preventive benefit
11 provided to medicare beneficiaries under title XVIII of the
12 Social Security Act for some or all medicare beneficiaries.
13 In conducting the study, the Academy shall consider the
14 short-term and long-term benefits, and costs to the medi-
15 care program, of such addition.

16 (b) REPORT.—Not later than 2 years after the date
17 of the enactment of this Act, the Secretary of Health and
18 Human Services shall submit a report on the findings of
19 the study conducted under subsection (a) to the Com-
20 mittee on Ways and Means and the Committee on Com-
21 merce of the House of Representatives and the Committee
22 on Finance of the Senate.

23 **SEC. 124. MEDPAC STUDY ON CONSUMER COALITIONS.**

24 (a) STUDY.—The Medicare Payment Advisory Com-
25 mission shall conduct a study that examines the use of

1 consumer coalitions in the marketing of Medicare+Choice
2 plans under the medicare program under title XVIII of
3 the Social Security Act. The study shall examine—

4 (1) the potential for increased efficiency in the
5 medicare program through greater beneficiary
6 knowledge of their health care options, decreased
7 marketing costs of Medicare+Choice organizations,
8 and creation of a group market;

9 (2) the implications of Medicare+Choice plans
10 and medicare supplemental policies (under section
11 1882 of the Social Security Act (42 U.S.C. 1395ss))
12 offering medicare beneficiaries in the same geo-
13 graphic location different benefits and premiums
14 based on their affiliation with a consumer coalition;

15 (3) how coalitions should be governed, how they
16 should be accountable to the Secretary of Health
17 and Human Services, and how potential conflicts of
18 interest in the activities of consumer coalitions
19 should be avoided; and

20 (4) how such coalitions should be funded.

21 (b) REPORT.—Not later than 1 year after the date
22 of the enactment of this Act, the Commission shall submit
23 to Congress a report on the study conducted under sub-
24 section (a). The report shall include a recommendation on
25 whether and how a demonstration project might be con-

1 ducted for the operation of consumer coalitions under the
2 medicare program.

3 (c) CONSUMER COALITION DEFINED.—For purposes
4 of this section, the term “consumer coalition” means a
5 nonprofit, community-based group of organizations that—

6 (1) provides information to medicare bene-
7 ficiaries about their health care options under the
8 medicare program; and

9 (2) negotiates benefits and premiums for medi-
10 care beneficiaries who are members or otherwise af-
11 filiated with the group of organizations with
12 Medicare+Choice organizations offering
13 Medicare+Choice plans, issuers of medicare supple-
14 mental policies, issuers of long-term care coverage,
15 and pharmacy benefit managers.

16 **SEC. 125. STUDY ON LIMITATION ON STATE PAYMENT FOR**
17 **MEDICARE COST-SHARING AFFECTING AC-**
18 **CESS TO SERVICES FOR QUALIFIED MEDI-**
19 **CARE BENEFICIARIES.**

20 (a) IN GENERAL.—The Secretary of Health and
21 Human Services shall conduct a study to determine if ac-
22 cess to certain services (including mental health services)
23 for qualified medicare beneficiaries has been affected by
24 limitations on a State’s payment for medicare cost-sharing
25 for such beneficiaries under section 1902(n) of the Social

1 Security Act (42 U.S.C. 1396a(n)). As part of such study,
2 the Secretary shall analyze the effect of such payment lim-
3 itation on providers who serve a disproportionate share of
4 such beneficiaries.

5 (b) REPORT.—Not later than 1 year after the date
6 of the enactment of this Act, the Secretary shall submit
7 to Congress a report on the study under subsection (a).
8 The report shall include recommendations regarding any
9 changes that should be made to the State payment limits
10 under section 1902(n) for qualified medicare beneficiaries
11 to ensure appropriate access to services.

12 **SEC. 126. INSTITUTE OF MEDICINE STUDY ON WAIVER OF**
13 **24-MONTH WAITING PERIOD FOR MEDICARE**
14 **DISABILITY ELIGIBILITY FOR AMYOTROPHIC**
15 **LATERAL SCLEROSIS (ALS) AND OTHER DEV-**
16 **ASTATING DISEASES.**

17 (a) STUDY.—The Secretary of Health and Human
18 Services shall enter into a contract with the Institute of
19 Medicine to conduct a study that examines the appro-
20 priateness of waiving the 24-month waiting period for eli-
21 gibility for benefits under the medicare program under
22 title XVIII of the Social Security Act applicable under sec-
23 tion 226(b) of such Act (42 U.S.C. 426(b)) for individuals
24 with a devastating disease. For purposes of this section,
25 the term “devastating disease” means amyotrophic lateral

1 sclerosis (ALS) and includes any other disease that is as
2 rapidly debilitating as ALS.

3 (b) REPORT.—The contract shall provide for the sub-
4 mission to Congress and the Secretary of a report on the
5 study conducted under subsection (a) by not later than
6 18 months after the date of the enactment of this Act.

7 **SEC. 127. STUDIES ON PREVENTIVE INTERVENTIONS IN**
8 **PRIMARY CARE FOR OLDER AMERICANS.**

9 (a) STUDIES.—The Secretary of Health and Human
10 Services, acting through the United States Preventive
11 Services Task Force, shall conduct a series of studies de-
12 signed to identify preventive interventions that can be de-
13 livered in the primary care setting and that are most valu-
14 able to older Americans.

15 (b) MISSION STATEMENT.—The mission statement of
16 the United States Preventive Services Task Force is
17 amended to include the evaluation of services that are of
18 particular relevance to older Americans.

19 (c) REPORT.—Not later than 1 year after the date
20 of the enactment of this Act, and annually thereafter, the
21 Secretary of Health and Human Services shall submit to
22 Congress a report on the conclusions of the studies con-
23 ducted under subsection (a), together with recommenda-
24 tions for such legislation and administrative actions as the
25 Secretary considers appropriate.

1 **SEC. 128. MEDPAC STUDY AND REPORT ON MEDICARE COV-**
2 **ERAGE OF CARDIAC AND PULMONARY REHA-**
3 **BILITATION THERAPY SERVICES.**

4 (a) STUDY.—

5 (1) IN GENERAL.—The Medicare Payment Ad-
6 visory Commission shall conduct a study on coverage
7 of cardiac and pulmonary rehabilitation therapy
8 services under the medicare program under title
9 XVIII of the Social Security Act.

10 (2) FOCUS.—In conducting the study under
11 paragraph (1), the Commission shall focus on the
12 appropriate—

13 (A) qualifying diagnoses required for cov-
14 erage of cardiac and pulmonary rehabilitation
15 therapy services;

16 (B) level of physician direct involvement
17 and supervision in furnishing such services; and

18 (C) level of reimbursement for such serv-
19 ices.

20 (b) REPORT.—Not later than 18 months after the
21 date of the enactment of this Act, the Commission shall
22 submit to Congress a report on the study conducted under
23 subsection (a) together with such recommendations for
24 legislation and administrative action as the Commission
25 determines appropriate.

1 **TITLE II—RURAL HEALTH CARE**
2 **IMPROVEMENTS**
3 **Subtitle A—Critical Access**
4 **Hospital Provisions**

5 **SEC. 201. CLARIFICATION OF NO BENEFICIARY COST-SHAR-**
6 **ING FOR CLINICAL DIAGNOSTIC LABORA-**
7 **TORY TESTS FURNISHED BY CRITICAL AC-**
8 **CESS HOSPITALS.**

9 (a) PAYMENT CLARIFICATION.—Section 1834(g) (42
10 U.S.C. 1395m(g)) is amended by adding at the end the
11 following new paragraph:

12 “(4) NO BENEFICIARY COST-SHARING FOR
13 CLINICAL DIAGNOSTIC LABORATORY SERVICES.—No
14 coinsurance, deductible, copayment, or other cost-
15 sharing otherwise applicable under this part shall
16 apply with respect to clinical diagnostic laboratory
17 services furnished as an outpatient critical access
18 hospital service. Nothing in this title shall be con-
19 strued as providing for payment for clinical diag-
20 nostic laboratory services furnished as part of out-
21 patient critical access hospital services, other than
22 on the basis described in this subsection.”.

23 (b) TECHNICAL AND CONFORMING AMENDMENTS.—

24 (1) Paragraphs (1)(D)(i) and (2)(D)(i) of sec-
25 tion 1833(a) (42 U.S.C. 1395l(a)) are each amended

1 by striking “or which are furnished on an outpatient
2 basis by a critical access hospital”.

3 (2) Section 403(d)(2) of BBRA (113 Stat.
4 1501A–371) is amended by striking “The amend-
5 ment made by subsection (a) shall apply” and in-
6 serting “Paragraphs (1) through (3) of section
7 1834(g) of the Social Security Act (as amended by
8 paragraph (1)) apply”.

9 (c) EFFECTIVE DATES.—The amendment made—

10 (1) by subsection (a) applies to services fur-
11 nished on or after the date of the enactment of
12 BBRA;

13 (2) by subsection (b)(1) applies as if included
14 in the enactment of section 403(e)(1) of BBRA (113
15 Stat. 1501A–371); and

16 (3) by subsection (b)(2) applies as if included
17 in the enactment of section 403(d)(2) of BBRA
18 (113 Stat. 1501A–371).

19 **SEC. 202. ASSISTANCE WITH FEE SCHEDULE PAYMENT FOR**
20 **PROFESSIONAL SERVICES UNDER ALL-INCLU-**
21 **SIVE RATE.**

22 (a) IN GENERAL.—Section 1834(g)(2)(B) (42 U.S.C.
23 1395m(g)(2)(B)) is amended by inserting “115 percent
24 of” before “such amounts”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) applies with respect to items and services
3 furnished on or after April 1, 2001.

4 **SEC. 203. EXEMPTION OF CRITICAL ACCESS HOSPITAL**
5 **SWING BEDS FROM SNF PPS.**

6 (a) IN GENERAL.—Section 1888(e)(7) (42 U.S.C.
7 1395yy(e)(7)) is amended—

8 (1) in the heading, by striking “TRANSITION
9 FOR” and inserting “TREATMENT OF”;

10 (2) in subparagraph (A), by striking “IN GEN-
11 ERAL.—The” and inserting “TRANSITION.—Subject
12 to subparagraph (C), the”;

13 (3) in subparagraph (A), by inserting “(other
14 than critical access hospitals)” after “facilities de-
15 scribed in subparagraph (B)”;

16 (4) in subparagraph (B), by striking “, for
17 which payment” and all that follows before the pe-
18 riod; and

19 (5) by adding at the end the following new sub-
20 paragraph:

21 “(C) EXEMPTION FROM PPS OF SWING-
22 BED SERVICES FURNISHED IN CRITICAL ACCESS
23 HOSPITALS.—The prospective payment system
24 established under this subsection shall not
25 apply to services furnished by a critical access

1 hospital pursuant to an agreement under sec-
2 tion 1883.”.

3 (b) PAYMENT ON A REASONABLE COST BASIS FOR
4 SWING BED SERVICES FURNISHED BY CRITICAL ACCESS
5 HOSPITALS.—Section 1883(a) (42 U.S.C. 1395tt(a)) is
6 amended—

7 (1) in paragraph (2)(A), by inserting “(other
8 than a critical access hospital)” after “any hospital”;
9 and

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

12 “(3) Notwithstanding any other provision of this title,
13 a critical access hospital shall be paid for covered skilled
14 nursing facility services furnished under an agreement en-
15 tered into under this section on the basis of the reasonable
16 costs of such services (as determined under section
17 1861(v)).”.

18 (c) EFFECTIVE DATE.—The amendments made by
19 this section shall apply to cost reporting periods beginning
20 on or after the date of the enactment of this Act.

21 **SEC. 204. PAYMENT IN CRITICAL ACCESS HOSPITALS FOR**
22 **EMERGENCY ROOM ON-CALL PHYSICIANS.**

23 (a) IN GENERAL.—Section 1834(g) (42 U.S.C.
24 1395m(g)), as amended by section 201(a), is further

1 amended by adding at the end the following new para-
2 graph:

3 “(5) **COVERAGE OF COSTS FOR EMERGENCY**
4 **ROOM ON-CALL PHYSICIANS.**—In determining the
5 reasonable costs of outpatient critical access hospital
6 services under paragraphs (1) and (2)(A), the Sec-
7 retary shall recognize as allowable costs, amounts
8 (as defined by the Secretary) for reasonable com-
9 pensation and related costs for emergency room phy-
10 sicians who are on-call (as defined by the Secretary)
11 but who are not present on the premises of the crit-
12 ical access hospital involved, and are not otherwise
13 furnishing physicians’ services and are not on-call at
14 any other provider or facility.”.

15 (b) **EFFECTIVE DATE.**—The amendment made by
16 subsection (a) applies to cost reporting periods beginning
17 on or after October 1, 2001.

18 **SEC. 205. TREATMENT OF AMBULANCE SERVICES FUR-**
19 **NISHED BY CERTAIN CRITICAL ACCESS HOS-**
20 **PITALS.**

21 (a) **IN GENERAL.**—Section 1834(l) (42 U.S.C.
22 1395m(l)) is amended by adding at the end the following
23 new paragraph:

24 “(8) **SERVICES FURNISHED BY CRITICAL AC-**
25 **CESS HOSPITALS.**—Notwithstanding any other provi-

1 sion of this subsection, the Secretary shall pay the
2 reasonable costs incurred in furnishing ambulance
3 services if such services are furnished—

4 “(A) by a critical access hospital (as de-
5 fined in —section 1861(mm)(1)), or

6 “(B) by an entity that is owned and oper-
7 ated by a —critical access hospital,

8 but only if the critical access hospital or entity is the
9 —only provider or supplier of ambulance services that
10 is located within a 35-mile drive of such critical ac-
11 cess hospital.”.

12 (b) CONFORMING AMENDMENT.—Section

13 1833(a)(1)(R) (42 U.S.C. 1395l(a)(1)(R)) is amended—

14 (1) by striking “ambulance service,” and insert-
15 ing “ambulance services, (i)”; and

16 (2) by inserting before the comma at the end
17 the —following: “and (ii) with respect to ambulance
18 services described in section 1834(l)(8), the amounts
19 paid shall be the amounts determined under section
20 1834(g) for outpatient critical access hospital serv-
21 ices”.

22 (c) EFFECTIVE DATE.—The amendments made by
23 this section apply to services furnished on or after the date
24 of the enactment of this Act.

1 **SEC. 206. GAO STUDY ON CERTAIN ELIGIBILITY REQUIRE-**
2 **MENTS FOR CRITICAL ACCESS HOSPITALS.**

3 (a) STUDY.—The Comptroller General of the United
4 States shall conduct a study on the eligibility requirements
5 for critical access hospitals under section 1820(c) of the
6 Social Security Act (42 U.S.C. 1395i–4(c)) with respect
7 to limitations on average length of stay and number of
8 beds in such a hospital, including an analysis of—

9 (1) the feasibility of having a distinct part unit
10 as part of a critical access hospital for purposes of
11 the medicare program under title XVIII of such Act,
12 and

13 (2) the effect of seasonal variations in patient
14 admissions on critical access hospital eligibility re-
15 quirements with respect to limitations on average
16 annual length of stay and number of beds.

17 (b) REPORT.—Not later than 1 year after the date
18 of the enactment of this Act, the Comptroller General shall
19 submit to Congress a report on the study conducted under
20 subsection (a) together with recommendations
21 regarding—

22 (1) whether distinct part units should be per-
23 mitted as part of a critical access hospital under the
24 medicare program;

1 (2) if so permitted, the payment methodologies
2 that should apply with respect to services provided
3 by such units;

4 (3) whether, and to what extent, such units
5 should be included in or excluded from the bed limits
6 applicable to critical access hospitals under the
7 medicare program; and

8 (4) any adjustments to such eligibility require-
9 ments to account for seasonal variations in patient
10 admissions.

11 **Subtitle B—Other Rural Hospitals** 12 **Provisions**

13 **SEC. 211. EQUITABLE TREATMENT FOR RURAL DISPROPOR-** 14 **TIONATE SHARE HOSPITALS.**

15 (a) APPLICATION OF UNIFORM THRESHOLD.—Sec-
16 tion 1886(d)(5)(F)(v) (42 U.S.C. 1395ww(d)(5)(F)(v)) is
17 amended—

18 (1) in subclause (II), by inserting “(or 15 per-
19 cent, for discharges occurring on or after April 1,
20 2001)” after “30 percent”;

21 (2) in subclause (III), by inserting “(or 15 per-
22 cent, for discharges occurring on or after April 1,
23 2001)” after “40 percent”; and

1 (3) in subclause (IV), by inserting “(or 15 per-
2 cent, for discharges occurring on or after April 1,
3 2001)” after “45 percent”.

4 (b) ADJUSTMENT OF PAYMENT FORMULAS.—

5 (1) SOLE COMMUNITY HOSPITALS.—Section
6 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is
7 amended—

8 (A) in clause (iv)(VI), by inserting after
9 “10 percent” the following: “or, for discharges
10 occurring on or after April 1, 2001, is equal to
11 the percent determined in accordance with
12 clause (x)”;

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

15 “(x) For purposes of clause (iv)(VI) (relating to sole
16 community hospitals), in the case of a hospital for a cost
17 reporting period with a disproportionate patient percent-
18 age (as defined in clause (vi)) that—

19 “(I) is less than 17.3, the disproportionate
20 share adjustment percentage is determined in ac-
21 cordance with the following formula: $(P-15)(.65) +$
22 2.5;

23 “(II) is equal to or exceeds 17.3, but is less
24 than 30.0, such adjustment percentage is equal to 4
25 percent; or

1 “(III) is equal to or exceeds 30, such adjust-
2 ment percentage is equal to 10 percent,
3 where ‘P’ is the hospital’s disproportionate patient per-
4 centage (as defined in clause (vi)).”.

5 (2) RURAL REFERRAL CENTERS.—Such section
6 is further amended—

7 (A) in clause (iv)(V), by inserting after
8 “clause (viii)” the following: “or, for discharges
9 occurring on or after April 1, 2001, is equal to
10 the percent determined in accordance with
11 clause (xi)”; and

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

14 “(xi) For purposes of clause (iv)(V) (relating to rural
15 referral centers), in the case of a hospital for a cost report-
16 ing period with a disproportionate patient percentage (as
17 defined in clause (vi)) that—

18 “(I) is less than 17.3, the disproportionate
19 share adjustment percentage is determined in ac-
20 cordance with the following formula: $(P-15)(.65) +$
21 2.5;

22 “(II) is equal to or exceeds 17.3, but is less
23 than 30.0, such adjustment percentage is equal to 4
24 percent; or

1 “(III) is equal to or exceeds 30, such adjust-
2 ment percentage is determined in accordance with
3 the following formula: $(P-30)(.6) + 4$,
4 where ‘P’ is the hospital’s disproportionate patient per-
5 centage (as defined in clause (vi)).”.

6 (3) SMALL RURAL HOSPITALS GENERALLY.—

7 Such section is further amended—

8 (A) in clause (iv)(III), by inserting after
9 “4 percent” the following: “or, for discharges
10 occurring on or after April 1, 2001, is equal to
11 the percent determined in accordance with
12 clause (xii)”;

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

15 “(xii) For purposes of clause (iv)(III) (relating to
16 small rural hospitals generally), in the case of a hospital
17 for a cost reporting period with a disproportionate patient
18 percentage (as defined in clause (vi)) that—

19 “(I) is less than 17.3, the disproportionate
20 share adjustment percentage is determined in ac-
21 cordance with the following formula: $(P-15)(.65) +$
22 2.5;

23 “(II) is equal to or exceeds 17.3, such adjust-
24 ment percentage is equal to 4 percent,

1 where ‘P’ is the hospital’s disproportionate patient per-
2 centage (as defined in clause (vi)).”.

3 (4) HOSPITALS THAT ARE BOTH SOLE COMMU-
4 NITY HOSPITALS AND RURAL REFERRAL CENTERS.—
5 Such section is further amended, in clause (iv)(IV),
6 by inserting after “clause (viii)” the following: “or,
7 for discharges occurring on or after April 1, 2001,
8 the greater of the percentages determined under
9 clause (x) or (xi)”.

10 (5) URBAN HOSPITALS WITH LESS THAN 100
11 BEDS.—Such section is further amended—

12 (A) in clause (iv)(II), by inserting after “5
13 percent” the following: “or, for discharges oc-
14 ccurring on or after April 1, 2001, is equal to
15 the percent determined in accordance with
16 clause (xiii)”;

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

19 “(xiii) For purposes of clause (iv)(II) (relating to
20 urban hospitals with less than 100 beds), in the case of
21 a hospital for a cost reporting period with a dispropor-
22 tionate patient percentage (as defined in clause (vi))
23 that—

24 “(I) is less than 17.3, the disproportionate
25 share adjustment percentage is determined in ac-

1 cordance with the following formula: $(P-15)(.65) +$
2 2.5;

3 “(II) is equal to or exceeds 17.3, but is less
4 than 40.0, such adjustment percentage is equal to 4
5 percent; or

6 “(III) is equal to or exceeds 40, such adjust-
7 ment percentage is equal to 5 percent,

8 where ‘P’ is the hospital’s disproportionate patient per-
9 centage (as defined in clause (vi)).”.

10 **SEC. 212. OPTION TO BASE ELIGIBILITY FOR MEDICARE DE-**
11 **PENDENT, SMALL RURAL HOSPITAL PRO-**
12 **GRAM ON DISCHARGES DURING 2 OF THE 3**
13 **MOST RECENTLY AUDITED COST REPORTING**
14 **PERIODS.**

15 (a) IN GENERAL.—Section 1886(d)(5)(G)(iv)(IV)
16 (42 U.S.C. 1395ww(d)(5)(G)(iv)(IV)) is amended by in-
17 serting “, or 2 of the 3 most recently audited cost report-
18 ing periods for which the Secretary has a settled cost re-
19 port,” after “1987”.

20 (b) EFFECTIVE DATE.—The amendment made by
21 this section shall apply with respect to cost reporting peri-
22 ods beginning on or after April 1, 2001.

1 **SEC. 213. EXTENSION OF OPTION TO USE REBASED TARGET**
2 **AMOUNTS TO ALL SOLE COMMUNITY HOS-**
3 **PITALS.**

4 (a) **IN GENERAL.**—Section 1886(b)(3)(I)(i) (42
5 U.S.C. 1395ww(b)(3)(I)(i)) is amended—

6 (1) in the matter preceding subclause (I), by
7 striking “that for its cost reporting period beginning
8 during 1999” and all that follows through “for such
9 target amount” and inserting “there shall be sub-
10 stituted for the amount otherwise determined under
11 subsection (d)(5)(D)(i), if such substitution results
12 in a greater amount of payment under this section
13 for the hospital”;

14 (2) in subclause (I), by striking “target amount
15 otherwise applicable” and all that follows through
16 “target amount’”)” and inserting “the amount other-
17 wise applicable to the hospital under subsection
18 (d)(5)(D)(i) (referred to in this clause as the ‘sub-
19 section (d)(5)(D)(i) amount’)”;

20 (3) in each of subclauses (II) and (III), by
21 striking “subparagraph (C) target amount” and in-
22 serting “subsection (d)(5)(D)(i) amount”.

23 (b) **EFFECTIVE DATE.**—The amendments made by
24 this section shall take effect as if included in the enact-
25 ment of section 405 of BBRA (113 Stat. 1501A–372).

1 **SEC. 214. MEDPAC ANALYSIS OF IMPACT OF VOLUME ON**
2 **PER UNIT COST OF RURAL HOSPITALS WITH**
3 **PSYCHIATRIC UNITS.**

4 The Medicare Payment Advisory Commission, in its
5 study conducted pursuant to subsection (a) of section 411
6 of BBRA (113 Stat. 1501A–377), shall include—

7 (1) in such study an analysis of the impact of
8 volume on the per unit cost of rural hospitals with
9 psychiatric units; and

10 (2) in its report under subsection (b) of such
11 section a recommendation on whether special treat-
12 ment for such hospitals may be warranted.

13 **Subtitle C—Other Rural Provisions**

14 **SEC. 221. ASSISTANCE FOR PROVIDERS OF AMBULANCE**
15 **SERVICES IN RURAL AREAS.**

16 (a) **TRANSITIONAL ASSISTANCE IN CERTAIN MILE-**
17 **AGE RATES.**—Section 1834(l) (42 U.S.C. 1395m(l)) is
18 amended by adding at the end the following new para-
19 graph:

20 “(8) **TRANSITIONAL ASSISTANCE FOR RURAL**
21 **PROVIDERS.**—In the case of ground ambulance serv-
22 ices furnished on or after the date on which the Sec-
23 retary implements the fee schedule under this sub-
24 section and before January 1, 2004, for which the
25 transportation originates in a rural area (as defined
26 in section 1886(d)(2)(D)) or in a rural census tract

1 of a metropolitan statistical area (as determined
2 under the most recent modification of the Goldsmith
3 Modification, originally published in the Federal
4 Register on February 27, 1992 (57 Fed. Reg.
5 6725)), the fee schedule established under this sub-
6 section shall provide that, with respect to the pay-
7 ment rate for mileage for a trip above 17 miles, and
8 up to 50 miles, the rate otherwise established shall
9 be increased by not less than $\frac{1}{2}$ of the additional
10 payment per mile established for the first 17 miles
11 of such a trip originating in a rural area.”.

12 (b) GAO STUDIES ON THE COSTS OF AMBULANCE
13 SERVICES FURNISHED IN RURAL AREAS.—

14 (1) STUDY.—The Comptroller General of the
15 United States shall conduct a study on each of the
16 matters described in paragraph (2).

17 (2) MATTERS DESCRIBED.—The matters re-
18 ferred to in paragraph (1) are the following:

19 (A) The cost of efficiently providing ambu-
20 lance services for trips originating in rural
21 areas, with special emphasis on collection of
22 cost data from rural providers.

23 (B) The means by which rural areas with
24 low population densities can be identified for
25 the purpose of designating areas in which the

1 cost of providing ambulance services would be
2 expected to be higher than similar services pro-
3 vided in more heavily populated areas because
4 of low usage. Such study shall also include an
5 analysis of the additional costs of providing am-
6 bulance services in areas designated under the
7 previous sentence.

8 (3) REPORT.—Not later than June 30, 2002,
9 the Comptroller General shall submit to Congress a
10 report on the results of the studies conducted under
11 paragraph (1) and shall include recommendations on
12 steps that should be taken to assure access to ambu-
13 lance services in rural areas.

14 (c) ADJUSTMENT IN RURAL RATES.—In providing
15 for adjustments under subparagraph (D) of section
16 1834(l)(2) of the Social Security Act (42 U.S.C.
17 1395m(l)(2)) for years beginning with 2004, the Secretary
18 of Health and Human Services shall take into consider-
19 ation the recommendations contained in the report under
20 subsection (b)(2) and shall adjust the fee schedule pay-
21 ment rates under such section for ambulance services pro-
22 vided in low density rural areas based on the increased
23 cost (if any) of providing such services in such areas.

24 (d) EFFECTIVE DATE.—The amendment made by
25 subsection (a) applies to services furnished on or after the

1 date the Secretary implements the fee schedule under sec-
2 tion 1834(l) of the Social Security Act (42 U.S.C.
3 1395m(l)). In applying such amendment to services fur-
4 nished on or after such date and before January 1, 2002,
5 the amount of the rate increase provided under such
6 amendment shall be equal to \$1.25 per mile.

7 **SEC. 222. PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT**
8 **SERVICES.**

9 (a) PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT
10 SERVICES.—Section 1842(b)(6)(C) (42 U.S.C.
11 1395u(b)(6)(C)) is amended—

12 (1) by striking “for such services provided be-
13 fore January 1, 2003,”; and

14 (2) by striking the semicolon at the end and in-
15 serting a comma.

16 (b) EFFECTIVE DATE.—The amendments made by
17 subsection (a) shall take effect on the date of the enact-
18 ment of this Act.

19 **SEC. 223. REVISION OF MEDICARE REIMBURSEMENT FOR**
20 **TELEHEALTH SERVICES.**

21 (a) TIME LIMIT FOR BBA PROVISION.—Section
22 4206(a) of BBA (42 U.S.C. 1395l note) is amended by
23 striking “Not later than January 1, 1999” and inserting
24 “For services furnished on and after January 1, 1999, and
25 before July 1, 2001”.

1 (b) EXPANSION OF MEDICARE PAYMENT FOR TELE-
2 HEALTH SERVICES.—Section 1834 (42 U.S.C. 1395m) is
3 amended by adding at the end the following new sub-
4 section:

5 “(m) PAYMENT FOR TELEHEALTH SERVICES.—

6 “(1) IN GENERAL.—The Secretary shall pay for
7 telehealth services that are furnished via a tele-
8 communications system by a physician (as defined in
9 section 1861(r)) or a practitioner (described in sec-
10 tion 1842(b)(18)(C)) to an eligible telehealth indi-
11 vidual enrolled under this part notwithstanding that
12 the individual physician or practitioner providing the
13 telehealth service is not at the same location as the
14 beneficiary. For purposes of the preceding sentence,
15 in the case of any Federal telemedicine demonstra-
16 tion program conducted in Alaska or Hawaii, the
17 term ‘telecommunications system’ includes store-
18 and-forward technologies that provide for the asyn-
19 chronous transmission of health care information in
20 single or multimedia formats.

21 “(2) PAYMENT AMOUNT.—

22 “(A) DISTANT SITE.—The Secretary shall
23 pay to a physician or practitioner located at a
24 distant site that furnishes a telehealth service
25 to an eligible telehealth individual an amount

1 equal to the amount that such physician or
2 practitioner would have been paid under this
3 title had such service been furnished without
4 the use of a telecommunications system.

5 “(B) FACILITY FEE FOR ORIGINATING
6 SITE.—With respect to a telehealth service, sub-
7 ject to section 1833(a)(1)(U), there shall be
8 paid to the originating site a facility fee equal
9 to—

10 “(i) for the period beginning on July
11 1, 2001, and ending on December 31,
12 2001, and for 2002, \$20; and

13 “(ii) for a subsequent year, the facil-
14 ity fee specified in clause (i) or this clause
15 for the preceding year increased by the
16 percentage increase in the MEI (as defined
17 in section 1842(i)(3)) for such subsequent
18 year.

19 “(C) TELEPRESENTER NOT REQUIRED.—
20 Nothing in this subsection shall be construed as
21 requiring an eligible telehealth individual to be
22 presented by a physician or practitioner at the
23 originating site for the furnishing of a service
24 via a telecommunications system, unless it is

1 medically necessary (as determined by the phy-
2 sician or practitioner at the distant site).

3 “(3) LIMITATION ON BENEFICIARY CHARGES.—

4 “(A) PHYSICIAN AND PRACTITIONER.—

5 The provisions of section 1848(g) and subpara-
6 graphs (A) and (B) of section 1842(b)(18) shall
7 apply to a physician or practitioner receiving
8 payment under this subsection in the same
9 manner as they apply to physicians or practi-
10 tioners under such sections.

11 “(B) ORIGINATING SITE.—The provisions
12 of section 1842(b)(18) shall apply to originating
13 sites receiving a facility fee in the same manner
14 as they apply to practitioners under such sec-
15 tion.

16 “(4) DEFINITIONS.—For purposes of this sub-
17 section:

18 “(A) DISTANT SITE.—The term ‘distant
19 site’ means the site at which the physician or
20 practitioner is located at the time the service is
21 provided via a telecommunications system.

22 “(B) ELIGIBLE TELEHEALTH INDIVIDUAL.—The term ‘eligible telehealth indi-
23 vidual’ means an individual enrolled under this
24

1 part who receives a telehealth service furnished
2 at an originating site.

3 “(C) ORIGINATING SITE.—

4 “(i) IN GENERAL.—The term ‘origi-
5 nating site’ means only those sites de-
6 scribed in clause (ii) at which the eligible
7 telehealth individual is located at the time
8 the service is furnished via a telecommuni-
9 cations system and only if such site is
10 located—

11 “(I) in an area that is designated
12 as a rural health professional shortage
13 area under section 332(a)(1)(A) of
14 the Public Health Service Act (42
15 U.S.C. 254e(a)(1)(A));

16 “(II) in a county that is not in-
17 cluded in a Metropolitan Statistical
18 Area; or

19 “(III) from an entity that partici-
20 pates in a Federal telemedicine dem-
21 onstration project that has been ap-
22 proved by (or receives funding from)
23 the Secretary of Health and Human
24 Services as of December 31, 2000.

1 “(ii) SITES DESCRIBED.—The sites
2 referred to in clause (i) are the following
3 sites:

4 “(I) The office of a physician or
5 practitioner.

6 “(II) A critical access hospital
7 (as defined in section 1861(mm)(1)).

8 “(III) A rural health clinic (as
9 defined in section 1861(aa)(s)).

10 “(IV) A Federally qualified
11 health center (as defined in section
12 1861(aa)(4)).

13 “(V) A hospital (as defined in
14 section 1861(e)).

15 “(D) PHYSICIAN.—The term ‘physi-
16 cian’ has the meaning given that term in
17 section 1861(r).

18 “(E) PRACTITIONER.—The term
19 ‘practitioner’ has the meaning given that
20 term in section 1842(b)(18)(C).

21 “(F) TELEHEALTH SERVICE.—

22 “(i) IN GENERAL.—The term ‘tele-
23 health service’ means professional con-
24 sultations, office visits, and office psychi-
25 atry services (identified as of July 1, 2000,

1 by HCPCS codes 99241–99275, 99201–
2 99215, 90804–90809, and 90862 (and as
3 subsequently modified by the Secretary),
4 and any additional service specified by the
5 Secretary.

6 “(ii) YEARLY UPDATE.—The Sec-
7 retary shall establish a process that pro-
8 vides, on an annual basis, for the addition
9 or deletion of services (and HCPCS codes),
10 as appropriate, to those specified in clause
11 (i) for authorized payment under para-
12 graph (1).”.

13 (c) CONFORMING AMENDMENT.—Section 1833(a)(1)
14 (42 U.S.C. 1395l(1)), as amended by section 105(c), is
15 further amended—

16 (1) by striking “and (T)” and inserting “(T)”;

17 and

18 (2) by inserting before the semicolon at the end
19 the following: “, and (U) with respect to facility fees
20 described in section 1834(m)(2)(B), the amounts
21 paid shall be 80 percent of the lesser of the actual
22 charge or the amounts specified in such section”.

23 (d) STUDY AND REPORT ON ADDITIONAL COV-
24 ERAGE.—

1 (1) STUDY.—The Secretary of Health and
2 Human Services shall conduct a study to identify—

3 (A) settings and sites for the provision of
4 telehealth services that are in addition to those
5 permitted under section 1834(m) of the Social
6 Security Act, as added by subsection (b);

7 (B) practitioners that may be reimbursed
8 under such section for furnishing telehealth
9 services that are in addition to the practitioners
10 that may be reimbursed for such services under
11 such section; and

12 (C) geographic areas in which telehealth
13 services may be reimbursed that are in addition
14 to the geographic areas where such services
15 may be reimbursed under such section.

16 (2) REPORT.—Not later than 2 years after the
17 date of the enactment of this Act, the Secretary
18 shall submit to Congress a report on the study con-
19 ducted under paragraph (1) together with such rec-
20 ommendations for legislation that the Secretary de-
21 termines are appropriate.

22 (e) EFFECTIVE DATE.—The amendments made by
23 subsections (b) and (c) shall be effective for services fur-
24 nished on or after July 1, 2001.

1 **SEC. 224. EXPANDING ACCESS TO RURAL HEALTH CLINICS.**

2 (a) IN GENERAL.—The matter in section 1833(f) (42
3 U.S.C. 1395l(f)) preceding paragraph (1) is amended by
4 striking “rural hospitals” and inserting “hospitals”.

5 (b) EFFECTIVE DATE.—The amendment made by
6 subsection (a) shall apply to services furnished on or after
7 July 1, 2001.

8 **SEC. 225. MEDPAC STUDY ON LOW-VOLUME, ISOLATED**
9 **RURAL HEALTH CARE PROVIDERS.**

10 (a) STUDY.—The Medicare Payment Advisory Com-
11 mission shall conduct a study on the effect of low patient
12 and procedure volume on the financial status of low-vol-
13 ume, isolated rural health care providers participating in
14 the medicare program under title XVIII of the Social Se-
15 curity Act.

16 (b) REPORT.—Not later than 18 months after the
17 date of the enactment of this Act, the Commission shall
18 submit to Congress a report on the study conducted under
19 subsection (a) indicating—

20 (1) whether low-volume, isolated rural health
21 care providers are having, or may have, significantly
22 decreased medicare margins or other financial dif-
23 ficulties resulting from any of the payment meth-
24 odologies described in subsection (c);

25 (2) whether the status as a low-volume, isolated
26 rural health care provider should be designated

1 under the medicare program and any criteria that
2 should be used to qualify for such a status; and

3 (3) any changes in the payment methodologies
4 described in subsection (c) that are necessary to pro-
5 vide appropriate reimbursement under the medicare
6 program to low-volume, isolated rural health care
7 providers (as designated pursuant to paragraph (2)).

8 (c) PAYMENT METHODOLOGIES DESCRIBED.—The
9 payment methodologies described in this subsection are
10 the following:

11 (1) The prospective payment system for hos-
12 pital outpatient department services under section
13 1833(t) of the Social Security Act (42 U.S.C.
14 1395l(t)).

15 (2) The fee schedule for ambulance services
16 under section 1834(l) of such Act (42 U.S.C.
17 1395m(l)).

18 (3) The prospective payment system for inpa-
19 tient hospital services under section 1886 of such
20 Act (42 U.S.C. 1395ww).

21 (4) The prospective payment system for routine
22 service costs of skilled nursing facilities under sec-
23 tion 1888(e) of such Act (42 U.S.C. 1395yy(e)).

1 (5) The prospective payment system for home
2 health services under section 1895 of such Act (42
3 U.S.C. 1395fff).

4 **TITLE III—PROVISIONS**
5 **RELATING TO PART A**
6 **Subtitle A—Inpatient Hospital**
7 **Services**

8 **SEC. 301. REVISION OF ACUTE CARE HOSPITAL PAYMENT**
9 **UPDATE FOR 2001.**

10 (a) IN GENERAL.—Section 1886(b)(3)(B)(i) (42
11 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

12 (1) in subclause (XVI), by striking “minus 1.1
13 percentage points for hospitals (other than sole com-
14 munity hospitals) in all areas, and the market bas-
15 ket percentage increase for sole community hos-
16 pitals,” and inserting “for hospitals in all areas,”;

17 (2) in subclause (XVII)—

18 (A) by striking “minus 1.1 percentage
19 points” and inserting “minus 0.55 percentage
20 points; and

21 (B) by striking “and” at the end;

22 (3) by redesignating subclause (XVIII) as sub-
23 clause (XIX);

1 (4) in subclause (XIX), as so redesignated, by
2 striking “fiscal year 2003” and inserting “fiscal year
3 2004”; and

4 (5) by inserting after subclause (XVII) the fol-
5 lowing new subclause:

6 “(XVIII) for fiscal year 2003, the market bas-
7 ket percentage increase minus 0.55 percentage
8 points for hospitals in all areas, and”.

9 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR
10 2001.—Notwithstanding the amendment made by sub-
11 section (a), for purposes of making payments for fiscal
12 year 2001 for inpatient hospital services furnished by sub-
13 section (d) hospitals (as defined in section 1886(d)(1)(B)
14 of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)),
15 the “applicable percentage increase” referred to in section
16 1886(b)(3)(B)(i) of such Act (42 U.S.C.
17 1395ww(b)(3)(B)(i))—

18 (1) for discharges occurring on or after October
19 1, 2000, and before April 1, 2001, shall be deter-
20 mined in accordance with subclause (XVI) of such
21 section as in effect on the day before the date of the
22 enactment of this Act; and

23 (2) for discharges occurring on or after April 1,
24 2001, and before October 1, 2001, shall be equal
25 to—

1 (A) the market basket percentage increase
2 plus 1.1 percentage points for hospitals (other
3 than sole community hospitals) in all areas; and

4 (B) the market basket percentage increase
5 for sole community hospitals.

6 (c) CONSIDERATION OF PRICE OF BLOOD AND
7 BLOOD PRODUCTS IN MARKET BASKET INDEX.—The
8 Secretary of Health and Human Services shall, when next
9 (after the date of the enactment of this Act) rebasing and
10 revising the hospital market basket index (as defined in
11 section 1886(b)(3)(B)(iii) of the Social Security Act (42
12 U.S.C. 1395ww(b)(3)(B)(iii))), consider the prices of
13 blood and blood products purchased by hospitals and de-
14 termine whether those prices are adequately reflected in
15 such index.

16 (d) MEDPAC STUDY AND REPORT REGARDING CER-
17 TAIN HOSPITAL COSTS.—

18 (1) STUDY.—The Medicare Payment Advisory
19 Commission shall conduct a study on—

20 (A) any increased costs incurred by sub-
21 section (d) hospitals (as defined in paragraph
22 (1)(B) of section 1886(d) of the Social Security
23 Act (42 U.S.C. 1395ww(d))) in providing inpa-
24 tient hospital services to medicare beneficiaries
25 under title XVIII of such Act during the period

1 beginning on October 1, 1983, and ending on
2 September 30, 1999, that were attributable
3 to—

4 (i) complying with new blood safety
5 measure requirements; and

6 (ii) providing such services using new
7 technologies;

8 (B) the extent to which the prospective
9 payment system for such services under such
10 section provides adequate and timely recogni-
11 tion of such increased costs;

12 (C) the prospects for (and to the extent
13 practicable, the magnitude of) cost increases
14 that hospitals will incur in providing such serv-
15 ices that are attributable to complying with new
16 blood safety measure requirements and pro-
17 viding such services using new technologies dur-
18 ing the 10 years after the date of the enact-
19 ment of this Act; and

20 (D) the feasibility and advisability of es-
21 tablishing mechanisms under such payment sys-
22 tem to provide for more timely and accurate
23 recognition of such cost increases in the future.

24 (2) CONSULTATION.—In conducting the study
25 under this subsection, the Commission shall consult

1 with representatives of the blood community,
2 including—

3 (A) hospitals;

4 (B) organizations involved in the collection,
5 processing, and delivery of blood; and

6 (C) organizations involved in the develop-
7 ment of new blood safety technologies.

8 (3) REPORT.—Not later than 1 year after the
9 date of the enactment of this Act, the Commission
10 shall submit to Congress a report on the study con-
11 ducted under paragraph (1) together with such rec-
12 ommendations for legislation and administrative ac-
13 tion as the Commission determines appropriate.

14 (e) ADJUSTMENT FOR INPATIENT CASE MIX
15 CHANGES.—

16 (1) IN GENERAL.—Section 1886(d)(3)(A) (42
17 U.S.C. 1395ww(d)(3)(A)) is amended by adding at
18 the end the following new clause:

19 “(vi) Insofar as the Secretary determines that
20 the adjustments under paragraph (4)(C)(i) for a
21 previous fiscal year (or estimates that such adjust-
22 ments for a future fiscal year) did (or are likely to)
23 result in a change in aggregate payments under this
24 subsection during the fiscal year that are a result of
25 changes in the coding or classification of discharges

1 that do not reflect real changes in case mix, the Sec-
2 retary may adjust the average standardized amounts
3 computed under this paragraph for subsequent fiscal
4 years so as to eliminate the effect of such coding or
5 classification changes.”.

6 (2) EFFECTIVE DATE.—The amendment made
7 by paragraph (1) applies to discharges occurring on
8 or after October 1, 2001.

9 **SEC. 302. ADDITIONAL MODIFICATION IN TRANSITION FOR**
10 **INDIRECT MEDICAL EDUCATION (IME) PER-**
11 **CENTAGE ADJUSTMENT.**

12 (a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42
13 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

14 (1) in subclause (V) by striking “and” at the
15 end;

16 (2) by redesignating subclause (VI) as sub-
17 clause (VII);

18 (3) in subclause (VII) as so redesignated, by
19 striking “2001” and inserting “2002”; and

20 (4) by inserting after subclause (V) the fol-
21 lowing new subclause:

22 “(VI) during fiscal year 2002, ‘c’ is equal
23 to 1.57; and”.

24 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR
25 2001.—Notwithstanding paragraph (5)(B)(ii)(V) of sec-

1 tion 1886(d) of the Social Security Act (42 U.S.C.
2 1395ww(d)(5)(B)(ii)(V)), for purposes of making pay-
3 ments for subsection (d) hospitals (as defined in para-
4 graph (1)(B) of such section) with indirect costs of med-
5 ical education, the indirect teaching adjustment factor re-
6 ferred to in paragraph (5)(B)(ii) of such section shall be
7 determined, for discharges occurring on or after April 1,
8 2001, and before October 1, 2001, as if “c” in paragraph
9 (5)(B)(ii)(V) of such section equalled 1.66 rather than
10 1.54.

11 (c) CONFORMING AMENDMENT RELATING TO DE-
12 TERMINATION OF STANDARDIZED AMOUNT.—Section
13 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is
14 amended by inserting “or of section 302 of the Medicare,
15 Medicaid, and SCHIP Benefits Improvement and Protec-
16 tion Act of 2000” after “Balanced Budget Refinement Act
17 of 1999”.

18 (d) CLERICAL AMENDMENTS.—Section
19 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)), as amended
20 by subsection (a), is further amended by moving the in-
21 dentation of each of the following 2 ems to the left:

22 (1) Clauses (ii), (v), and (vi).

23 (2) Subclauses (I) (II), (III), (IV), (V), and
24 (VII) of clause (ii).

1 (3) Subclauses (I) and (II) of clause (vi) and
2 the flush sentence at the end of such clause.

3 **SEC. 303. DECREASE IN REDUCTIONS FOR DISPROPOR-**
4 **TIONATE SHARE HOSPITAL (DSH) PAYMENTS.**

5 (a) IN GENERAL.—Section 1886(d)(5)(F)(ix) (42
6 U.S.C. 1395ww(d)(5)(F)(ix)) is amended—

7 (1) in subclause (III), by striking “each of” and
8 by inserting “and 2 percent, respectively” after “3
9 percent”; and

10 (2) in subclause (IV), by striking “4 percent”
11 and inserting “3 percent”.

12 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR
13 2001.—Notwithstanding the amendment made by sub-
14 section (a)(1), for purposes of making disproportionate
15 share payments for subsection (d) hospitals (as defined
16 in section 1886(d)(1)(B) of the Social Security Act (42
17 U.S.C. 1395ww(d)(1)(B)) for fiscal year 2001, the addi-
18 tional payment amount otherwise determined under clause
19 (ii) of section 1886(d)(5)(F) of the Social Security Act
20 (42 U.S.C. 1395ww(d)(5)(F))—

21 (1) for discharges occurring on or after October
22 1, 2000, and before April 1, 2001, shall be adjusted
23 as provided by clause (ix)(III) of such section as in
24 effect on the day before the date of the enactment
25 of this Act; and

1 (2) for discharges occurring on or after April 1,
2 2001, and before October 1, 2001, shall, instead of
3 being reduced by 3 percent as provided by clause
4 (ix)(III) of such section as in effect after the date
5 of the enactment of this Act, be reduced by 1 per-
6 cent.

7 (c) CONFORMING AMENDMENTS RELATING TO DE-
8 TERMINATION OF STANDARDIZED AMOUNT.—Section
9 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)), is
10 amended—

11 (1) by striking “1989 or” and inserting
12 “1989,”; and

13 (2) by inserting “, or the enactment of section
14 303 of the Medicare, Medicaid, and SCHIP Benefits
15 Improvement and Protection Act of 2000” after
16 “Omnibus Budget Reconciliation Act of 1990”.

17 (d) TECHNICAL AMENDMENT.—

18 (1) IN GENERAL.—Section 1886(d)(5)(F)(i) (42
19 U.S.C. 1395ww(d)(5)(F)(i)) is amended by striking
20 “and before October 1, 1997,”.

21 (2) EFFECTIVE DATE.—The amendment made
22 by paragraph (1) is effective as if included in the en-
23 actment of BBA.

1 (e) REFERENCE TO CHANGES IN DSH FOR RURAL
2 HOSPITALS.—For additional changes in the DSH pro-
3 gram for rural hospitals, see section 211.

4 **SEC. 304. WAGE INDEX IMPROVEMENTS.**

5 (a) DURATION OF WAGE INDEX RECLASSIFICATION;
6 USE OF 3-YEAR WAGE DATA.—Section 1886(d)(10)(D)
7 (42 U.S.C. 1395ww(d)(10)(D)) is amended by adding at
8 the end the following new clauses:

9 “(v) Any decision of the Board to reclassify a sub-
10 section (d) hospital for purposes of the adjustment factor
11 described in subparagraph (C)(i)(II) for fiscal year 2001
12 or any fiscal year thereafter shall be effective for a period
13 of 3 fiscal years, except that the Secretary shall establish
14 procedures under which a subsection (d) hospital may
15 elect to terminate such reclassification before the end of
16 such period.

17 “(vi) Such guidelines shall provide that, in making
18 decisions on applications for reclassification for the pur-
19 poses described in clause (v) for fiscal year 2003 and any
20 succeeding fiscal year, the Board shall base any compari-
21 son of the average hourly wage for the hospital with the
22 average hourly wage for hospitals in an area on—

23 “(I) an average of the average hourly wage
24 amount for the hospital from the most recently pub-
25 lished hospital wage survey data of the Secretary (as

1 of the date on which the hospital applies for reclassi-
2 fication) and such amount from each of the two im-
3 mediately preceding surveys; and

4 “(II) an average of the average hourly wage
5 amount for hospitals in such area from the most re-
6 cently published hospital wage survey data of the
7 Secretary (as of the date on which the hospital ap-
8 plies for reclassification) and such amount from each
9 of the two immediately preceding surveys.”.

10 (b) PROCESS TO PERMIT STATEWIDE WAGE INDEX
11 CALCULATION AND APPLICATION.—

12 (1) IN GENERAL.—The Secretary of Health and
13 Human Services shall establish a process (based on
14 the voluntary process utilized by the Secretary of
15 Health and Human Services under section 1848 of
16 the Social Security Act (42 U.S.C. 1395w-4) for
17 purposes of computing and applying a statewide geo-
18 graphic wage index) under which an appropriate
19 statewide entity may apply to have all the geo-
20 graphic areas in a State treated as a single geo-
21 graphic area for purposes of computing and applying
22 the area wage index under section 1886(d)(3)(E) of
23 such Act (42 U.S.C. 1395ww(d)(3)(E)). Such proc-
24 ess shall be established by October 1, 2001, for re-
25 classifications beginning in fiscal year 2003.

1 (2) PROHIBITION ON INDIVIDUAL HOSPITAL RE-
2 CLASSIFICATION.—Notwithstanding any other provi-
3 sion of law, if the Secretary applies a statewide geo-
4 graphic wage index under paragraph (1) with re-
5 spect to a State, any application submitted by a hos-
6 pital in that State under section 1886(d)(10) of the
7 Social Security Act (42 U.S.C. 1395ww(d)(10)) for
8 geographic reclassification shall not be considered.

9 (c) COLLECTION OF INFORMATION ON OCCUPA-
10 TIONAL MIX.—

11 (1) IN GENERAL.—The Secretary of Health and
12 Human Services shall provide for the collection of
13 data every 3 years on occupational mix for employ-
14 ees of each subsection (d) hospital (as defined in
15 section 1886(d)(1)(D) of the Social Security Act (42
16 U.S.C. 1395ww(d)(1)(D))) in the provision of inpa-
17 tient hospital services, in order to construct an occu-
18 pational mix adjustment in the hospital area wage
19 index applied under section 1886(d)(3)(E) of such
20 Act (42 U.S.C. 1395ww(d)(3)(E)).

21 (2) APPLICATION.—The third sentence of sec-
22 tion 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is
23 amended by striking “To the extent determined fea-
24 sible by the Secretary, such survey shall measure”
25 and inserting “Not less often than once every 3

1 years the Secretary (through such survey or other-
2 wise) shall measure”.

3 (3) EFFECTIVE DATE.—By not later than Sep-
4 tember 30, 2003, for application beginning October
5 1, 2004, the Secretary shall first complete—

6 (A) the collection of data under paragraph
7 (1); and

8 (B) the measurement under the third sen-
9 tence of section 1886(d)(3)(E), as amended by
10 paragraph (2).

11 **SEC. 305. PAYMENT FOR INPATIENT SERVICES OF REHA-**
12 **BILITATION HOSPITALS.**

13 (a) ASSISTANCE WITH ADMINISTRATIVE COSTS AS-
14 SOCIATED WITH COMPLETION OF PATIENT ASSESS-
15 MENT.—Section 1886(j)(3)(B) (42 U.S.C.
16 1395ww(j)(3)(B)) is amended by striking “98 percent”
17 and inserting “98 percent for fiscal year 2001 and 100
18 percent for fiscal year 2002”.

19 (b) ELECTION TO APPLY FULL PROSPECTIVE PAY-
20 MENT RATE WITHOUT PHASE-IN.—

21 (1) IN GENERAL.—Paragraph (1) of section
22 1886(j) (42 U.S.C. 1395ww(j)) is amended—

23 (A) in subparagraph (A), by inserting
24 “other than a facility making an election under

1 subparagraph (F)” before “in a cost reporting
2 period”;

3 (B) in subparagraph (B), by inserting “or,
4 in the case of a facility making an election
5 under subparagraph (F), for any cost reporting
6 period described in such subparagraph,” after
7 “2002,”; and

8 (C) by adding at the end the following new
9 subparagraph:

10 “(F) ELECTION TO APPLY FULL PROSPEC-
11 TIVE PAYMENT SYSTEM.—A rehabilitation facil-
12 ity may elect, not later than 30 days before its
13 first cost reporting period for which the pay-
14 ment methodology under this subsection applies
15 to the facility, to have payment made to the fa-
16 cility under this subsection under the provisions
17 of subparagraph (B) (rather than subparagraph
18 (A)) for each cost reporting period to which
19 such payment methodology applies.”.

20 (2) CLARIFICATION.—Paragraph (3)(B) of such
21 section is amended by inserting “but not taking into
22 account any payment adjustment resulting from an
23 election permitted under paragraph (1)(F)” after
24 “paragraphs (4) and (6)”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section take effect as if included in the enactment of
3 BBA.

4 **SEC. 306. PAYMENT FOR INPATIENT SERVICES OF PSY-**
5 **CHIATRIC HOSPITALS.**

6 With respect to hospitals described in clause (i) of
7 section 1886(d)(1)(B) of the Social Security Act (42
8 U.S.C. 1395ww(d)(1)(B)) and psychiatric units described
9 in the matter following clause (v) of such section, in mak-
10 ing incentive payments to such hospitals under section
11 1886(b)(1)(A) of such Act (42 U.S.C. 1395ww(b)(1)(A))
12 for cost reporting periods beginning on or after October
13 1, 2000, and before October 1, 2001, the Secretary of
14 Health and Human Services, in clause (ii) of such section,
15 shall substitute “3 percent” for “2 percent”.

16 **SEC. 307. PAYMENT FOR INPATIENT SERVICES OF LONG-**
17 **TERM CARE HOSPITALS.**

18 (a) INCREASED TARGET AMOUNTS AND CAPS FOR
19 LONG-TERM CARE HOSPITALS BEFORE IMPLEMENTA-
20 TION OF THE PROSPECTIVE PAYMENT SYSTEM.—

21 (1) IN GENERAL.—Section 1886(b)(3) (42
22 U.S.C. 1395ww(b)(3)) is amended—

23 (A) in subparagraph (H)(ii)(III), by insert-
24 ing “subject to subparagraph (J),” after
25 “2002,”; and

1 (B) by adding at the end the following new
2 subparagraph:

3 “(J) For cost reporting periods beginning during fis-
4 cal year 2001, for a hospital described in subsection
5 (d)(1)(B)(iv)—

6 “(i) the limiting or cap amount otherwise deter-
7 mined under subparagraph (H) shall be increased by
8 2 percent; and

9 “(ii) the target amount otherwise determined
10 under subparagraph (A) shall be increased by 25
11 percent (subject to the limiting or cap amount deter-
12 mined under subparagraph (H), as increased by
13 clause (i)).”.

14 (2) APPLICATION.—The amendments made by
15 subsection (a) and by section 122 of BBRA (113
16 Stat. 1501A–331) shall not be taken into account in
17 the development and implementation of the prospec-
18 tive payment system under section 123 of BBRA
19 (113 Stat. 1501A–331).

20 (b) IMPLEMENTATION OF PROSPECTIVE PAYMENT
21 SYSTEM FOR LONG-TERM CARE HOSPITALS.—

22 (1) MODIFICATION OF REQUIREMENT.—In de-
23 veloping the prospective payment system for pay-
24 ment for inpatient hospital services provided in long-
25 term care hospitals described in section

1 1886(d)(1)(B)(iv) of the Social Security Act (42
2 U.S.C. 1395ww(d)(1)(B)(iv)) under the medicare
3 program under title XVIII of such Act required
4 under section 123 of BBRA, the Secretary of Health
5 and Human Services shall examine the feasibility
6 and the impact of basing payment under such a sys-
7 tem on the use of existing (or refined) hospital diag-
8 nosis-related groups (DRGs) that have been modi-
9 fied to account for different resource use of long-
10 term care hospital patients as well as the use of the
11 most recently available hospital discharge data. The
12 Secretary shall examine and may provide for appro-
13 priate adjustments to the long-term hospital pay-
14 ment system, including adjustments to DRG
15 weights, area wage adjustments, geographic reclassi-
16 fication, outliers, updates, and a disproportionate
17 share adjustment consistent with section
18 1886(d)(5)(F) of the Social Security Act (42 U.S.C.
19 1395ww(d)(5)(F)).

20 (2) DEFAULT IMPLEMENTATION OF SYSTEM
21 BASED ON EXISTING DRG METHODOLOGY.—If the
22 Secretary is unable to implement the prospective
23 payment system under section 123 of the BBRA by
24 October 1, 2002, the Secretary shall implement a
25 prospective payment system for such hospitals that

1 bases payment under such a system using existing
2 hospital diagnosis-related groups (DRGs), modified
3 where feasible to account for resource use of long-
4 term care hospital patients using the most recently
5 available hospital discharge data for such services
6 furnished on or after that date.

7 **Subtitle B—Adjustments to PPS**
8 **Payments for Skilled Nursing**
9 **Facilities**

10 **SEC. 311. ELIMINATION OF REDUCTION IN SKILLED NURS-**
11 **ING FACILITY (SNF) MARKET BASKET UP-**
12 **DATE IN 2001.**

13 (a) IN GENERAL.—Section 1888(e)(4)(E)(ii) (42
14 U.S.C. 1395yy(e)(4)(E)(ii)) is amended—

15 (1) by redesignating subclauses (II) and (III)
16 as subclauses (III) and (IV), respectively;

17 (2) in subclause (III), as so redesignated—

18 (A) by striking “each of fiscal years 2001
19 and 2002” and inserting “each of fiscal years
20 2002 and 2003”; and

21 (B) by striking “minus 1 percentage
22 point” and inserting “minus 0.5 percentage
23 points”; and

24 (3) by inserting after subclause (I) the fol-
25 lowing new subclause:

1 “(II) for fiscal year 2001, the
2 rate computed for the previous fiscal
3 year increased by the skilled nursing
4 facility market basket percentage
5 change for the fiscal year;”.

6 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR
7 2001.—Notwithstanding the amendments made by sub-
8 section (a), for purposes of making payments for covered
9 skilled nursing facility services under section 1888(e) of
10 the Social Security Act (42 U.S.C. 1395yy(e)) for fiscal
11 year 2001, the Federal per diem rate referred to in para-
12 graph (4)(E)(ii) of such section—

13 (1) for the period beginning on October 1,
14 2000, and ending on March 31, 2001, shall be the
15 rate determined in accordance with the law as in ef-
16 fect on the day before the date of the enactment of
17 this Act; and

18 (2) for the period beginning on April 1, 2001,
19 and ending on September 30, 2001, shall be the rate
20 that would have been determined under such section
21 if “plus 1 percentage point” had been substituted
22 for “minus 1 percentage point” under subclause (II)
23 of such paragraph (as in effect on the day before the
24 date of the enactment of this Act).

1 (c) RELATION TO TEMPORARY INCREASE IN
2 BBRA.—The increases provided under section 101 of
3 BBRA (113 Stat. 1501A–325) shall be in addition to any
4 increase resulting from the amendments made by sub-
5 section (a).

6 (d) GAO REPORT ON ADEQUACY OF SNF PAYMENT
7 RATES.—Not later than July 1, 2002, the Comptroller
8 General of the United States shall submit to Congress a
9 report on the adequacy of medicare payment rates to
10 skilled nursing facilities and the extent to which medicare
11 contributes to the financial viability of such facilities. Such
12 report shall take into account the role of private payors,
13 medicaid, and case mix on the financial performance of
14 these facilities, and shall include an analysis (by specific
15 RUG classification) of the number and characteristics of
16 such facilities.

17 (e) HCFA STUDY OF CLASSIFICATION SYSTEMS FOR
18 SNF RESIDENTS.—

19 (1) STUDY.—The Secretary of Health and
20 Human Services shall conduct a study of the dif-
21 ferent systems for categorizing patients in medicare
22 skilled nursing facilities in a manner that accounts
23 for the relative resource utilization of different pa-
24 tient types.

1 (2) REPORT.—Not later than August 1, 2002,
2 the Comptroller General shall submit to Congress a
3 report on the audits conducted under paragraph (1).
4 Such report shall include an assessment of the im-
5 pact of the increased payments under this subtitle
6 on increased nursing staff ratios and shall make rec-
7 ommendations as to whether increased payments
8 under subsection (a) should be continued.

9 **SEC. 313. APPLICATION OF SNF CONSOLIDATED BILLING**
10 **REQUIREMENT LIMITED TO PART A COV-**
11 **ERED STAYS.**

12 (a) IN GENERAL.—Section 1862(a)(18) (42 U.S.C.
13 1395y(a)(18)) is amended by striking “or of a part of a
14 facility that includes a skilled nursing facility (as deter-
15 mined under regulations),” and inserting “during a period
16 in which the resident is provided covered post-hospital ex-
17 tended care services (or, for services described in section
18 1861(s)(2)(D), which are furnished to such an individual
19 without regard to such period),”.

20 (b) CONFORMING AMENDMENTS.—(1) Section
21 1842(b)(6)(E) (42 U.S.C. 1395u(b)(6)(E)) is amended—

22 (A) by inserting “by, or under arrangements
23 made by, a skilled nursing facility” after “fur-
24 nished”;

1 (B) by striking “or of a part of a facility that
2 includes a skilled nursing facility (as determined
3 under regulations)”;

4 (C) by striking “(without regard to whether or
5 not the item or service was furnished by the facility,
6 by others under arrangement with them made by the
7 facility, under any other contracting or consulting
8 arrangement, or otherwise)”.

9 (2) Section 1842(t) (42 U.S.C. 1395u(t)) is amended
10 by striking “by a physician” and “or of a part of a facility
11 that includes a skilled nursing facility (as determined
12 under regulations),”.

13 (3) Section 1866(a)(1)(H)(ii)(I) (42 U.S.C.
14 1395cc(a)(1)(H)(ii)(I)) is amended by inserting after
15 “who is a resident of the skilled nursing facility” the fol-
16 lowing: “during a period in which the resident is provided
17 covered post-hospital extended care services (or, for serv-
18 ices described in section 1861(s)(2)(D), that are furnished
19 to such an individual without regard to such period)”.

20 (c) EFFECTIVE DATE.—The amendments made by
21 subsections (a) and (b) apply to services furnished on or
22 after January 1, 2001.

23 (d) OVERSIGHT.—The Secretary of Health and
24 Human Services, through the Office of the Inspector Gen-
25 eral in the Department of Health and Human Services

1 or otherwise, shall monitor payments made under part B
2 of the title XVIII of the Social Security Act for items and
3 services furnished to residents of skilled nursing facilities
4 during a time in which the residents are not being pro-
5 vided medicare covered post-hospital extended care serv-
6 ices to ensure that there is not duplicate billing for serv-
7 ices or excessive services provided.

8 **SEC. 314. ADJUSTMENT OF REHABILITATION RUGS TO COR-**
9 **RECT ANOMALY IN PAYMENT RATES.**

10 (a) ADJUSTMENT FOR REHABILITATION RUGS.—

11 (1) IN GENERAL.—For purposes of computing
12 payments for covered skilled nursing facility services
13 under paragraph (1) of section 1888(e) of the Social
14 Security Act (42 U.S.C. 1395yy(e)) for such services
15 furnished on or after April 1, 2001, and before the
16 date described in section 101(c)(2) of BBRA (113
17 Stat. 1501A–324), the Secretary of Health and
18 Human Services shall increase by 6.7 percent the
19 adjusted Federal per diem rate otherwise determined
20 under paragraph (4) of such section (but for this
21 section) for covered skilled nursing facility services
22 for RUG–III rehabilitation groups described in para-
23 graph (2) furnished to an individual during the pe-
24 riod in which such individual is classified in such a
25 RUG–III category.

1 (2) REHABILITATION GROUPS DESCRIBED.—

2 The RUG–III rehabilitation groups for which the
3 adjustment described in paragraph (1) applies are
4 RUC, RUB, RUA, RVC, RVB, RVA, RHC, RHB,
5 RHA, RMC, RMB, RMA, RLB, and RLA, as speci-
6 fied in Tables 3 and 4 of the final rule published in
7 the Federal Register by the Health Care Financing
8 Administration on July 31, 2000 (65 Fed. Reg.
9 46770).

10 (b) CORRECTION WITH RESPECT TO REHABILITA-
11 TION RUGS.—

12 (1) IN GENERAL.—Section 101(b) of BBRA
13 (113 Stat. 1501A–324) is amended by striking
14 “CA1, RHC, RMC, and RMB” and inserting “and
15 CA1”.

16 (2) EFFECTIVE DATE.—The amendment made
17 by paragraph (1) applies to services furnished on or
18 after April 1, 2001.

19 (c) REVIEW BY OFFICE OF INSPECTOR GENERAL.—

20 The Inspector General of the Department of Health and
21 Human Services shall review the medicare payment struc-
22 ture for services classified within rehabilitation resource
23 utilization groups (RUGs) (as in effect after the date of
24 the enactment of the BBRA) to assess whether payment
25 incentives exist for the delivery of inadequate care. Not

1 later than October 1, 2001, the Inspector General shall
 2 submit to Congress a report on such review.

3 **SEC. 315. ESTABLISHMENT OF PROCESS FOR GEOGRAPHIC**
 4 **RECLASSIFICATION.**

5 (a) IN GENERAL.—The Secretary of Health and
 6 Human Services may establish a procedure for the geo-
 7 graphic reclassification of a skilled nursing facility for pur-
 8 poses of payment for covered skilled nursing facility serv-
 9 ices under the prospective payment system established
 10 under section 1888(e) of the Social Security Act (42
 11 U.S.C. 1395yy(e)). Such procedure may be based upon the
 12 method for geographic reclassifications for inpatient hos-
 13 pitals established under section 1886(d)(10) of the Social
 14 Security Act (42 U.S.C. 1395ww(d)(10)).

15 (b) REQUIREMENT FOR SKILLED NURSING FACILITY
 16 WAGE DATA.—In no case may the Secretary implement
 17 the procedure under subsection (a) before such time as
 18 the Secretary has collected data necessary to establish an
 19 area wage index for skilled nursing facilities based on
 20 wage data from such facilities.

21 **Subtitle C—Hospice Care**

22 **SEC. 321. FULL MARKET BASKET INCREASE FOR 2001.**

23 (a) IN GENERAL.—Section 1814(i)(1)(C)(ii) (42
 24 U.S.C. 1395f(i)(1)(C)(ii)) is amended—

1 (1) by redesignating subclause (VII) as sub-
2 clause (IX);

3 (2) in subclause (VI)—

4 (A) by striking “through 2002” and insert-
5 ing “through 2000”; and

6 (B) by striking “and” at the end; and

7 (3) by inserting after subclause (VI) the fol-
8 lowing new subclauses:

9 “(VII) for fiscal year 2001, the market basket
10 percentage increase for the fiscal year;

11 “(VIII) for fiscal year 2002, the market basket
12 percentage increase for the fiscal year minus 0.25
13 percentage points; and”.

14 (b) TRANSITION DURING FISCAL YEAR 2001.—Not-
15 withstanding the amendments made by subsection (a), for
16 purposes of making payments for hospice care under sec-
17 tion 1814(i) of the Social Security Act (42 U.S.C.
18 1395f(i)) for fiscal year 2001, the payment rates referred
19 to in paragraph (1)(C) of such section—

20 (1) for the period beginning on October 1,
21 2000, and ending on March 31, 2001, shall be the
22 rate determined in accordance with the law as in ef-
23 fect on the day before the date of the enactment of
24 this Act; and

1 (2) for the period beginning on April 1, 2001,
2 and ending on September 30, 2001, shall be the rate
3 that would have been determined under paragraph
4 (1) if “plus 1.0 percentage points” were substituted
5 for “minus 1.0 percentage points” under paragraph
6 (1)(C)(ii)(VI) of such section for fiscal year 2001.

7 (c) CONFORMING AMENDMENTS TO BBRA.—

8 (1) IN GENERAL.—Section 131 of BBRA (113
9 Stat. 1501A–333) is repealed.

10 (2) EFFECTIVE DATE.—The amendment made
11 by paragraph (1) shall take effect as if included in
12 the enactment of BBRA.

13 (d) TECHNICAL AMENDMENT.—Section
14 1814(a)(7)(A)(ii) (42 U.S.C. 1395f(a)(7)(A)(ii)) is
15 amended by striking the period at the end and inserting
16 a semicolon.

17 **SEC. 322. CLARIFICATION OF PHYSICIAN CERTIFICATION.**

18 (a) CERTIFICATION BASED ON NORMAL COURSE OF
19 ILLNESS.—

20 (1) IN GENERAL.—Section 1814(a) (42 U.S.C.
21 1395f(a)) is amended by adding at the end the fol-
22 lowing new sentence: “The certification regarding
23 terminal illness of an individual under paragraph (7)
24 shall be based on the physician’s or medical direc-

1 tor's clinical judgment regarding the normal course
2 of the individual's illness.".

3 (2) EFFECTIVE DATE.—The amendment made
4 by paragraph (1) applies to certifications made on or
5 after the date of the enactment of this Act.

6 (b) STUDY AND REPORT ON PHYSICIAN CERTIFI-
7 CATION REQUIREMENT FOR HOSPICE BENEFITS.—

8 (1) STUDY.—The Secretary of Health and
9 Human Services shall conduct a study to examine
10 the appropriateness of the certification regarding
11 terminal illness of an individual under section
12 1814(a)(7) of the Social Security Act (42 U.S.C.
13 1395f(a)(7)) that is required in order for such indi-
14 vidual to receive hospice benefits under the medicare
15 program under title XVIII of such Act. In con-
16 ducting such study, the Secretary shall take into ac-
17 count the effect of the amendment made by sub-
18 section (a).

19 (2) REPORT.—Not later than 2 years after the
20 date of the enactment of this Act, the Secretary of
21 Health and Human Services shall submit to Con-
22 gress a report on the study conducted under para-
23 graph (1), together with any recommendations for
24 legislation that the Secretary deems appropriate.

1 **SEC. 323. MEDPAC REPORT ON ACCESS TO, AND USE OF,**
 2 **HOSPICE BENEFIT.**

3 (a) IN GENERAL.—The Medicare Payment Advisory
 4 Commission shall conduct a study to examine the factors
 5 affecting the use of hospice benefits under the medicare
 6 program under title XVIII of the Social Security Act, in-
 7 cluding a delay in the time (relative to death) of entry
 8 into a hospice program, and differences in such use be-
 9 tween urban and rural hospice programs and based upon
 10 the presenting condition of the patient.

11 (b) REPORT.—Not later than 18 months after the
 12 date of the enactment of this Act, the Commission shall
 13 submit to Congress a report on the study conducted under
 14 subsection (a), together with any recommendations for leg-
 15 islation that the Commission deems appropriate.

16 **Subtitle D—Other Provisions**

17 **SEC. 331. RELIEF FROM MEDICARE PART A LATE ENROLL-**
 18 **MENT PENALTY FOR GROUP BUY-IN FOR**
 19 **STATE AND LOCAL RETIREES.**

20 (a) IN GENERAL.—Section 1818 (42 U.S.C. 1395i-
 21 2) is amended—

22 (1) in subsection (c)(6), by inserting before the
 23 semicolon at the end the following: “and shall be
 24 subject to reduction in accordance with subsection
 25 (d)(6)”;

1 (2) by adding at the end of subsection (d) the
2 following new paragraph:

3 “(6)(A) In the case where a State, a political subdivi-
4 sion of a State, or an agency or instrumentality of a State
5 or political subdivision thereof determines to pay, for the
6 life of each individual, the monthly premiums due under
7 paragraph (1) on behalf of each of the individuals in a
8 qualified State or local government retiree group who
9 meets the conditions of subsection (a), the amount of any
10 increase otherwise applicable under section 1839(b) (as
11 applied and modified by subsection (c)(6) of this section)
12 with respect to the monthly premium for benefits under
13 this part for an individual who is a member of such group
14 shall be reduced by the total amount of taxes paid under
15 section 3101(b) of the Internal Revenue Code of 1986 by
16 such individual and under section 3111(b) by the employ-
17 ers of such individual on behalf of such individual with
18 respect to employment (as defined in section 3121(b) of
19 such Code).

20 “(B) For purposes of this paragraph, the term ‘quali-
21 fied State or local government retiree group’ means all of
22 the individuals who retire prior to a specified date that
23 is before January 1, 2002, from employment in 1 or more
24 occupations or other broad classes of employees of—

25 “(i) the State;

1 “(ii) a political subdivision of the State; or

2 “(iii) an agency or instrumentality of the State
3 or political subdivision of the State.”.

4 (b) **EFFECTIVE DATE.**—The amendments made by
5 subsection (a) apply to premiums for months beginning
6 with July 1, 2001.

7 **SEC. 332. POSTING OF INFORMATION ON NURSING FACIL-**
8 **ITY STAFFING.**

9 (a) **MEDICARE.**—Section 1819(b) (42 U.S.C. 1395i–
10 3(b)) is amended by adding at the end the following new
11 paragraph:

12 “(8) **INFORMATION ON NURSE STAFFING.**—

13 “(A) **IN GENERAL.**—A skilled nursing fa-
14 cility shall post daily for each shift the current
15 number of licensed and unlicensed nursing staff
16 directly responsible for resident care in the fa-
17 cility. The information shall be displayed in a
18 uniform manner (as specified by the Secretary)
19 and in a clearly visible place.

20 “(B) **PUBLICATION OF DATA.**—A skilled
21 nursing facility shall, upon request, make avail-
22 able to the public the nursing staff data de-
23 scribed in subparagraph (A).”.

1 (b) MEDICAID.—Section 1919(b) (42 U.S.C.
2 1395r(b)) is amended by adding at the end the following
3 new paragraph:

4 “(8) INFORMATION ON NURSE STAFFING.—

5 “(A) IN GENERAL.—A nursing facility
6 shall post daily for each shift the current num-
7 ber of licensed and unlicensed nursing staff di-
8 rectly responsible for resident care in the facil-
9 ity. The information shall be displayed in a uni-
10 form manner (as specified by the Secretary)
11 and in a clearly visible place.

12 “(B) PUBLICATION OF DATA.—A nursing
13 facility shall, upon request, make available to
14 the public the nursing staff data described in
15 subparagraph (A).”.

16 **TITLE IV—PROVISIONS**
17 **RELATING TO PART B**
18 **Subtitle A—Hospital Outpatient**
19 **Services**

20 **SEC. 401. REVISION OF HOSPITAL OUTPATIENT PPS PAY-**
21 **MENT UPDATE.**

22 (a) IN GENERAL.—Section 1833(t)(3)(C)(iii) (42
23 U.S.C. 1395l(t)(3)(C)(iii)) is amended by striking “in
24 each of 2000, 2001, and 2002” and inserting “in each
25 of 2000 and 2002”.

1 (b) ADJUSTMENT FOR CASE MIX CHANGES.—

2 (1) IN GENERAL.—Section 1833(t)(3)(C) (42
3 U.S.C. 1395l(t)(3)(C)) is amended—

4 (A) by redesignating clause (iii) as clause
5 (iv); and

6 (B) by inserting after clause (ii) the fol-
7 lowing new clause:

8 “(iii) ADJUSTMENT FOR SERVICE MIX
9 CHANGES.—Insofar as the Secretary deter-
10 mines that the adjustments for service mix
11 under paragraph (2) for a previous year
12 (or estimates that such adjustments for a
13 future year) did (or are likely to) result in
14 a change in aggregate payments under this
15 subsection during the year that are a re-
16 sult of changes in the coding or classifica-
17 tion of covered OPD services that do not
18 reflect real changes in service mix, the Sec-
19 retary may adjust the conversion factor
20 computed under this subparagraph for
21 subsequent years so as to eliminate the ef-
22 fect of such coding or classification
23 changes.”.

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

4 **SEC. 402. CLARIFYING PROCESS AND STANDARDS FOR DE-**
5 **TERMINING ELIGIBILITY OF DEVICES FOR**
6 **PASS-THROUGH PAYMENTS UNDER HOSPITAL**
7 **OUTPATIENT PPS.**

8 (a) IN GENERAL.—Section 1833(t)(6) (42 U.S.C.
9 1395l(t)(6)) is amended—

10 (1) by redesignating subparagraphs (C) and
11 (D) as subparagraphs (D) and (E), respectively; and

12 (2) by striking subparagraph (B) and inserting
13 the following new subparagraphs:

14 “(B) USE OF CATEGORIES IN DETER-
15 MINING ELIGIBILITY OF A DEVICE FOR PASS-
16 THROUGH PAYMENTS.—The following provi-
17 sions apply for purposes of determining whether
18 a medical device qualifies for additional pay-
19 ments under clause (ii) or (iv) of subparagraph
20 (A):

21 “(i) ESTABLISHMENT OF INITIAL CAT-
22 EGORIES.—The Secretary shall initially es-
23 tablish under this clause categories of med-
24 ical devices based on type of device by
25 April 1, 2001. Such categories shall be es-

1 tablISHED in a manner such that each med-
2 ical device that meets the requirements of
3 clause (ii) or (iv) of subparagraph (A) as
4 of as of January 1, 2001, is included in
5 such a category and no such device is in-
6 cluded in more than one category. For pur-
7 poses of the preceding sentence, whether a
8 medical device meets such requirements as
9 of such date shall be determined on the
10 basis of the program memoranda issued
11 before such date or if the Secretary deter-
12 mines the medical device would have been
13 included in the program memoranda but
14 for the requirement of subparagraph
15 (A)(iv)(I). The categories may be estab-
16 lished under this clause by program memo-
17 randum or otherwise, after consultation
18 with groups representing hospitals, manu-
19 facturers of medical devices, and other af-
20 fected parties.

21 “(ii) ESTABLISHING CRITERIA FOR
22 ADDITIONAL CATEGORIES.—

23 “(I) IN GENERAL.—The Sec-
24 retary shall establish criteria that will
25 be used for creation of additional cat-

1 egories (other than those established
2 under clause (i)) through rulemaking
3 (which may include use of an interim
4 final rule with comment period).

5 “(II) STANDARD.—Such cat-
6 egories shall be established under this
7 clause in a manner such that no med-
8 ical device is described by more than
9 one category. Such criteria shall in-
10 clude a test of whether the average
11 cost of devices that would be included
12 in a category and are in use at the
13 time the category is established is not
14 insignificant, as described in subpara-
15 graph (A)(iv)(II).

16 “(III) DEADLINE.—Criteria shall
17 first be established under this clause
18 by July 1, 2001. The Secretary may
19 establish in compelling circumstances
20 categories under this clause before the
21 date such criteria are established.

22 “(IV) ADDING CATEGORIES.—
23 The Secretary shall promptly establish
24 a new category of medical devices
25 under this clause for any medical de-

1 vice that meets the requirements of
2 subparagraph (A)(iv) and for which
3 none of the categories in effect (or
4 that were previously in effect) is ap-
5 propriate.

6 “(iii) PERIOD FOR WHICH CATEGORY
7 IS IN EFFECT.—A category of medical de-
8 vices established under clause (i) or clause
9 (ii) shall be in effect for a period of at
10 least 2 years, but not more than 3 years,
11 that begins—

12 “(I) in the case of a category es-
13 tablished under clause (i), on the first
14 date on which payment was made
15 under this paragraph for any device
16 described by such category (including
17 payments made during the period be-
18 fore April 1, 2001); and

19 “(II) in the case of any other
20 category, on the first date on which
21 payment is made under this para-
22 graph for any medical device that is
23 described by such category.

24 “(iv) REQUIREMENTS TREATED AS
25 MET.—A medical device shall be treated as

1 meeting the requirements of subparagraph
2 (A)(iv) if—

3 “(I) the device is described by a
4 category established and in effect
5 under clause (i); or

6 “(II) the device is described by a
7 category established and in effect
8 under clause (ii) and an application
9 under section 515 of the Federal
10 Food, Drug, and Cosmetic Act has
11 been approved with respect to the de-
12 vice, or the device has been cleared for
13 market under section 510(k) of such
14 Act, or the device is exempt from the
15 requirements of section 510(k) of
16 such Act pursuant to subsection (l) or
17 (m) of section 510 of such Act or sec-
18 tion 520(g) of such Act.

19 Nothing in this clause shall be construed
20 as requiring an application or prior ap-
21 proval (other than that described in sub-
22 clause (II)) in order for a covered device to
23 qualify for payment under this paragraph.

24 “(C) LIMITED PERIOD OF PAYMENT.—

1 “(i) DRUGS AND BIOLOGICALS.—The
2 payment under this paragraph with respect
3 to a drug or biological shall only apply dur-
4 ing a period of at least 2 years, but not
5 more than 3 years, that begins—

6 “(I) on the first date this sub-
7 section is implemented in the case of
8 a drug or biological described in
9 clause (i), (ii), or (iii) of subparagraph
10 (A) and in the case of a drug or bio-
11 logical described in subparagraph
12 (A)(iv) and for which payment under
13 this part is made as an outpatient
14 hospital service before such first date;
15 or

16 “(II) in the case of a drug or bio-
17 logical described in subparagraph
18 (A)(iv) not described in subclause (I),
19 on the first date on which payment is
20 made under this part for the drug or
21 biological as an outpatient hospital
22 service.

23 “(ii) MEDICAL DEVICES.—Payment
24 shall be made under this paragraph with

1 respect to a medical device only if such
2 device—

3 “(I) is described by a category of
4 medical devices established and in ef-
5 fect under subparagraph (B); and

6 “(II) is provided as part of a
7 service (or group of services) paid for
8 under this subsection and provided
9 during the period for which such cat-
10 egory is in effect under such subpara-
11 graph.”.

12 (b) CONFORMING AMENDMENTS.—Section 1833(t)
13 (42 U.S.C. 1395l(t)) is further amended—

14 (1) in paragraph (6)(A)(iv)(II), by striking “the
15 cost of the device, drug, or biological” and inserting
16 “the cost of the drug or biological or the average
17 cost of the category of devices”;

18 (2) in paragraph (6)(D) (as redesignated by
19 subsection (a)(1)), by striking “subparagraph
20 (D)(iii)” in the matter preceding clause (i) and in-
21 serting “subparagraph (E)(iii)”; and

22 (3) in paragraph (12)(E), by striking “addi-
23 tional payments (consistent with paragraph (6)(B))”
24 and inserting “additional payments, the determina-
25 tion and deletion of initial and new categories (con-

1 sistent with subparagraphs (B) and (C) of para-
2 graph (6))”.

3 (c) EFFECTIVE DATE.—The amendments made by
4 this section take effect on the date of the enactment of
5 this Act.

6 (d) TRANSITION.—

7 (1) IN GENERAL.—In the case of a medical de-
8 vice provided as part of a service (or group of serv-
9 ices) furnished during the period before initial cat-
10 gories are implemented under subparagraph (B)(i)
11 of section 1833(t)(6) of the Social Security Act (as
12 amended by subsection (a)), payment shall be made
13 for such device under such section in accordance
14 with the provisions in effect before the date of the
15 enactment of this Act, except that, beginning on the
16 date that is 30 days after the date of the enactment
17 of this Act, payment shall also be made for such a
18 device that is not included in a program memo-
19 randum described in such subparagraph if the Sec-
20 retary of Health and Human Services determines
21 that the device is likely to be described by such an
22 initial category or would have been included in such
23 program memoranda but for the requirement of sub-
24 paragraph (A)(iv)(I) of that section.

1 (2) APPLICATION OF CURRENT PROCESS.—Not-
2 withstanding any other provision of law, the Sec-
3 retary shall continue to accept applications with re-
4 spect to medical devices under the process estab-
5 lished pursuant to paragraph (6) of section 1833(t)
6 of the Social Security Act (as in effect on the day
7 before the date of the enactment of this Act)
8 through December 1, 2000, and any device—

9 (A) with respect to which an application
10 was submitted (pursuant to such process) on or
11 before such date; and

12 (B) that meets the requirements of clause
13 (ii) or (iv) of subparagraph (A) of such para-
14 graph (as determined pursuant to such proe-
15 cess),

16 shall be treated as a device with respect to which an
17 initial category is required to be established under
18 subparagraph (B)(i) of such paragraph (as amended
19 by subsection (a)(2)).

20 **SEC. 403. APPLICATION OF OPD PPS TRANSITIONAL COR-**
21 **RIDOR PAYMENTS TO CERTAIN HOSPITALS**
22 **THAT DID NOT SUBMIT A 1996 COST REPORT.**

23 (a) IN GENERAL.—Section 1833(t)(7)(F)(ii)(I) (42
24 U.S.C. 1395l(t)(7)(F)(ii)(I)) is amended by inserting “(or
25 in the case of a hospital that did not submit a cost report

1 for such period, during the first subsequent cost reporting
2 period ending before 2001 for which the hospital sub-
3 mitted a cost report)” after “1996”.

4 (b) EFFECTIVE DATE.—The amendment made by
5 subsection (a) shall take effect as if included in the enact-
6 ment of BBRA.

7 **SEC. 404. APPLICATION OF RULES FOR DETERMINING PRO-**
8 **VIDER-BASED STATUS FOR CERTAIN ENTI-**
9 **TIES.**

10 (a) GRANDFATHER.—Notwithstanding any other pro-
11 vision of law, for purposes of making determinations of
12 provider-based status under title XVIII of the Social Secu-
13 rity Act on or after October 1, 2000, any facility or organi-
14 zation that is treated as provider-based in relation to a
15 hospital or critical access hospital under such title as of
16 October 1, 2000—

17 (1) shall continue to be treated as provider-
18 based in relation to such hospital or critical access
19 hospital under such title during the 2-year period
20 beginning on October 1, 2000; and

21 (2) the requirements, limitations, and exclu-
22 sions specified in paragraphs (d), (e), (f), and (h) of
23 section 413.65 of title 42, Code of Federal Regula-
24 tions shall not apply to such facility or organization

1 in relation to such hospital or critical access hospital
2 until after the end of such 2-year period.

3 (b) TEMPORARY CRITERIA.—For purposes of title
4 XVIII of the Social Security Act—

5 (1) a facility or organization for which a deter-
6 mination of provider-based status in relation to a
7 hospital or critical access hospital is requested on or
8 after October 1, 2000, and before October 1, 2002,
9 may not be treated as not having provider-based sta-
10 tus in relation to such a hospital for any period be-
11 fore a determination is made with respect to such
12 status pursuant to such request; and

13 (2) in making a determination with respect to
14 such status for any facility or organization in rela-
15 tionship to such a hospital on or after October 1,
16 2000, the following rules apply:

17 (A) The facility or organization shall be
18 treated as satisfying any requirements and
19 standards for geographic location in relation to
20 such a hospital if the facility or organization—

21 (i) satisfies the requirements of sec-
22 tion 413.65(d)(7) of title 42, Code of Fed-
23 eral Regulations; or

1 (ii) is located not more than 35 miles
2 from the main campus of the hospital or
3 critical access hospital.

4 (B) The facility or organization shall be
5 treated as satisfying any of the requirements
6 and standards for geographic location in rela-
7 tion to such a hospital if the facility or organi-
8 zation is owned and operated by a hospital or
9 critical access hospital that—

10 (i) is owned or operated by a unit of
11 State or local government, is a public or
12 private nonprofit corporation that is for-
13 mally granted governmental powers by a
14 unit of State or local government, or is a
15 private hospital that has a contract with a
16 State or local government that includes the
17 operation of clinics located off the main
18 campus of the hospital to assure access in
19 a well-defined service area to health care
20 services for low-income individuals who are
21 not entitled to benefits under title XVIII
22 (or medical assistance under a State plan
23 under title XIX) of such Act; and

24 (ii) has a disproportionate share ad-
25 justment percentage (as determined under

1 section 1886(d)(5)(F) of such Act (42
2 U.S.C. 1395ww(d)(5)(F))) greater than
3 11.75 percent or is described in clause
4 (i)(II) of such section.

5 (c) DEFINITIONS.—For purposes of this section, the
6 terms “hospital” and “critical access hospital” have the
7 meanings given such terms in subsections (e) and
8 (mm)(1), respectively, of section 1861 of the Social Secu-
9 rity Act (42 U.S.C. 1395x).

10 **SEC. 405. TREATMENT OF CHILDREN’S HOSPITALS UNDER**
11 **PROSPECTIVE PAYMENT SYSTEM.**

12 (a) IN GENERAL.—Section 1833(t) (42 U.S.C.
13 1395l(t)) is amended—

14 (1) in the heading of paragraph (7)(D)(ii), by
15 inserting “AND CHILDREN’S HOSPITALS” after “CAN-
16 CER HOSPITALS”; and

17 (2) in paragraphs (7)(D)(ii) and (11), by strik-
18 ing “section 1886(d)(1)(B)(v)” and inserting
19 “clause (iii) or (v) of section 1886(d)(1)(B)”.

20 (b) EFFECTIVE DATE.—The amendments made by
21 subsection (a) apply as if included in the enactment of
22 section 202 of BBRA (113 Stat. 1501A–342).

1 **SEC. 406. INCLUSION OF TEMPERATURE MONITORED**
2 **CRYOABLATION IN TRANSITIONAL PASS-**
3 **THROUGH FOR CERTAIN MEDICAL DEVICES,**
4 **DRUGS, AND BIOLOGICALS UNDER OPD PPS.**

5 (a) IN GENERAL.—Section 1833(t)(6)(A)(ii) (42
6 U.S.C. 1395l(t)(6)(A)(ii)) is amended by inserting “or
7 temperature monitored cryoablation” after “device of
8 brachytherapy”.

9 (b) EFFECTIVE DATE.—The amendment made by
10 subsection (a) applies to devices furnished on or after
11 April 1, 2001.

12 **Subtitle B—Provisions Relating to**
13 **Physicians’ Services**

14 **SEC. 411. GAO STUDIES RELATING TO PHYSICIANS’ SERV-**
15 **ICES.**

16 (a) STUDY OF SPECIALIST PHYSICIANS’ SERVICES
17 FURNISHED IN PHYSICIANS’ OFFICES AND HOSPITAL
18 OUTPATIENT DEPARTMENT SERVICES.—

19 (1) STUDY.—The Comptroller General of the
20 United States shall conduct a study to examine the
21 appropriateness of furnishing in physicians’ offices
22 specialist physicians’ services (such as gastro-
23 intestinal endoscopic physicians’ services) which are
24 ordinarily furnished in hospital outpatient depart-
25 ments. In conducting this study, the Comptroller
26 General shall—

1 (A) review available scientific and clinical
2 evidence about the safety of performing proce-
3 dures in physicians' offices and hospital out-
4 patient departments;

5 (B) assess whether resource-based practice
6 expense relative values established by the Sec-
7 retary of Health and Human Services under the
8 medicare physician fee schedule under section
9 1848 of the Social Security Act (42 U.S.C.
10 1395w-4) for such specialist physicians' serv-
11 ices furnished in physicians' offices and hospital
12 outpatient departments create an incentive to
13 furnish such services in physicians' offices in-
14 stead of hospital outpatient departments; and

15 (C) assess the implications for access to
16 care for medicare beneficiaries if the medicare
17 program were not to cover such services in phy-
18 sicians' offices.

19 (2) REPORT.—Not later than July 1, 2001, the
20 Comptroller General shall submit to Congress a re-
21 port on such study and include such recommenda-
22 tions as the Comptroller General determines to be
23 appropriate.

24 (b) STUDY OF THE RESOURCE-BASED PRACTICE EX-
25 PENSE SYSTEM.—

1 (1) STUDY.—The Comptroller General of the
2 United States shall conduct a study on the refine-
3 ments to the practice expense relative value units
4 during the transition to a resource-based practice ex-
5 pense system for physician payments under the
6 medicare program under title XVIII of the Social
7 Security Act. Such study shall examine how the Sec-
8 retary of Health and Human Services has accepted
9 and used the practice expense data submitted under
10 section 212 of BBRA (113 Stat. 1501A–350).

11 (2) REPORT.—Not later than July 1, 2001, the
12 Comptroller General shall submit to Congress a re-
13 port on the study conducted under paragraph (1) to-
14 gether with recommendations regarding—

15 (A) improvements in the process for ac-
16 ceptance and use of practice expense data
17 under section 212 of BBRA;

18 (B) any change or adjustment that is ap-
19 propriate to ensure full access to a spectrum of
20 care for beneficiaries under the medicare pro-
21 gram; and

22 (C) the appropriateness of payments to
23 physicians.

1 **SEC. 412. PHYSICIAN GROUP PRACTICE DEMONSTRATION.**

2 (a) IN GENERAL.—Title XVIII is amended by insert-
3 ing after section 1866 the following new sections:

4 “DEMONSTRATION OF APPLICATION OF PHYSICIAN
5 VOLUME INCREASES TO GROUP PRACTICES

6 “SEC. 1866A. (a) DEMONSTRATION PROGRAM AU-
7 THORIZED.—

8 “(1) IN GENERAL.—The Secretary shall con-
9 duct demonstration projects to test and, if proven ef-
10 fective, expand the use of incentives to health care
11 groups participating in the program under this title
12 that—

13 “(A) encourage coordination of the care
14 furnished to individuals under the programs
15 under parts A and B by institutional and other
16 providers, practitioners, and suppliers of health
17 care items and services;

18 “(B) encourage investment in administra-
19 tive structures and processes to ensure efficient
20 service delivery; and

21 “(C) reward physicians for improving
22 health outcomes.

23 Such projects shall focus on the efficiencies of fur-
24 nishing health care in a group-practice setting as
25 compared to the efficiencies of furnishing health care
26 in other health care delivery systems.

1 “(2) ADMINISTRATION BY CONTRACT.—Except
2 as otherwise specifically provided, the Secretary may
3 administer the program under this section in accord-
4 ance with section 1866B.

5 “(3) DEFINITIONS.—For purposes of this sec-
6 tion, terms have the following meanings:

7 “(A) PHYSICIAN.—Except as the Secretary
8 may otherwise provide, the term ‘physician’
9 means any individual who furnishes services
10 which may be paid for as physicians’ services
11 under this title.

12 “(B) HEALTH CARE GROUP.—The term
13 ‘health care group’ means a group of physicians
14 (as defined in subparagraph (A)) organized at
15 least in part for the purpose of providing physi-
16 cians’ services under this title. As the Secretary
17 finds appropriate, a health care group may in-
18 clude a hospital and any other individual or en-
19 tity furnishing items or services for which pay-
20 ment may be made under this title that is affili-
21 ated with the health care group under an ar-
22 rangement structured so that such individual or
23 entity participates in a demonstration under
24 this section and will share in any bonus earned
25 under subsection (d).

1 “(b) ELIGIBILITY CRITERIA.—

2 “(1) IN GENERAL.—The Secretary is authorized
3 to establish criteria for health care groups eligible to
4 participate in a demonstration under this section, in-
5 cluding criteria relating to numbers of health care
6 professionals in, and of patients served by, the
7 group, scope of services provided, and quality of
8 care.

9 “(2) PAYMENT METHOD.—A health care group
10 participating in the demonstration under this section
11 shall agree with respect to services furnished to
12 beneficiaries within the scope of the demonstration
13 (as determined under subsection (c))—

14 “(A) to be paid on a fee-for-service basis;
15 and

16 “(B) that payment with respect to all such
17 services furnished by members of the health
18 care group to such beneficiaries shall (where de-
19 termined appropriate by the Secretary) be made
20 to a single entity.

21 “(3) DATA REPORTING.—A health care group
22 participating in a demonstration under this section
23 shall report to the Secretary such data, at such
24 times and in such format as the Secretary requires,

1 for purposes of monitoring and evaluation of the
2 demonstration under this section.

3 “(c) PATIENTS WITHIN SCOPE OF DEMONSTRA-
4 TION.—

5 “(1) IN GENERAL.—The Secretary shall specify,
6 in accordance with this subsection, the criteria for
7 identifying those patients of a health care group who
8 shall be considered within the scope of the dem-
9 onstration under this section for purposes of applica-
10 tion of subsection (d) and for assessment of the ef-
11 fectiveness of the group in achieving the objectives
12 of this section.

13 “(2) OTHER CRITERIA.—The Secretary may es-
14 tablish additional criteria for inclusion of bene-
15 ficiaries within a demonstration under this section,
16 which may include frequency of contact with physi-
17 cians in the group or other factors or criteria that
18 the Secretary finds to be appropriate.

19 “(3) NOTICE REQUIREMENTS.—In the case of
20 each beneficiary determined to be within the scope
21 of a demonstration under this section with respect to
22 a specific health care group, the Secretary shall en-
23 sure that such beneficiary is notified of the incen-
24 tives, and of any waivers of coverage or payment

1 rules, applicable to such group under such dem-
2 onstration.

3 “(d) INCENTIVES.—

4 “(1) PERFORMANCE TARGET.—The Secretary
5 shall establish for each health care group partici-
6 pating in a demonstration under this section—

7 “(A) a base expenditure amount, equal to
8 the average total payments under parts A and
9 B for patients served by the health care group
10 on a fee-for-service basis in a base period deter-
11 mined by the Secretary; and

12 “(B) an annual per capita expenditure tar-
13 get for patients determined to be within the
14 scope of the demonstration, reflecting the base
15 expenditure amount adjusted for risk and ex-
16 pected growth rates.

17 “(2) INCENTIVE BONUS.—The Secretary shall
18 pay to each participating health care group (subject
19 to paragraph (4)) a bonus for each year under the
20 demonstration equal to a portion of the medicare
21 savings realized for such year relative to the per-
22 formance target.

23 “(3) ADDITIONAL BONUS FOR PROCESS AND
24 OUTCOME IMPROVEMENTS.—At such time as the
25 Secretary has established appropriate criteria based

1 on evidence the Secretary determines to be suffi-
2 cient, the Secretary shall also pay to a participating
3 health care group (subject to paragraph (4)) an ad-
4 ditional bonus for a year, equal to such portion as
5 the Secretary may designate of the saving to the
6 program under this title resulting from process im-
7 provements made by and patient outcome improve-
8 ments attributable to activities of the group.

9 “(4) LIMITATION.—The Secretary shall limit
10 bonus payments under this section as necessary to
11 ensure that the aggregate expenditures under this
12 title (inclusive of bonus payments) with respect to
13 patients within the scope of the demonstration do
14 not exceed the amount which the Secretary esti-
15 mates would be expended if the demonstration
16 projects under this section were not implemented.

17 “PROVISIONS FOR ADMINISTRATION OF DEMONSTRATION
18 PROGRAM

19 “SEC. 1866B. (a) GENERAL ADMINISTRATIVE AU-
20 THORITY.—

21 “(1) BENEFICIARY ELIGIBILITY.—Except as
22 otherwise provided by the Secretary, an individual
23 shall only be eligible to receive benefits under the
24 program under section 1866A (in this section re-
25 ferred to as the ‘demonstration program’) if such
26 individual—

1 “(A) is enrolled in under the program
2 under part B and entitled to benefits under
3 part A; and

4 “(B) is not enrolled in a Medicare+Choice
5 plan under part C, an eligible organization
6 under a contract under section 1876 (or a simi-
7 lar organization operating under a demonstra-
8 tion project authority), an organization with an
9 agreement under section 1833(a)(1)(A), or a
10 PACE program under section 1894.

11 “(2) SECRETARY’S DISCRETION AS TO SCOPE
12 OF PROGRAM.—The Secretary may limit the imple-
13 mentation of the demonstration program to—

14 “(A) a geographic area (or areas) that the
15 Secretary designates for purposes of the pro-
16 gram, based upon such criteria as the Secretary
17 finds appropriate;

18 “(B) a subgroup (or subgroups) of bene-
19 ficiaries or individuals and entities furnishing
20 items or services (otherwise eligible to partici-
21 pate in the program), selected on the basis of
22 the number of such participants that the Sec-
23 retary finds consistent with the effective and ef-
24 ficient implementation of the program;

1 “(C) an element (or elements) of the pro-
2 gram that the Secretary determines to be suit-
3 able for implementation; or

4 “(D) any combination of any of the limits
5 described in subparagraphs (A) through (C).

6 “(3) VOLUNTARY RECEIPT OF ITEMS AND
7 SERVICES.—Items and services shall be furnished to
8 an individual under the demonstration program only
9 at the individual’s election.

10 “(4) AGREEMENTS.—The Secretary is author-
11 ized to enter into agreements with individuals and
12 entities to furnish health care items and services to
13 beneficiaries under the demonstration program.

14 “(5) PROGRAM STANDARDS AND CRITERIA.—
15 The Secretary shall establish performance standards
16 for the demonstration program including, as applica-
17 ble, standards for quality of health care items and
18 services, cost-effectiveness, beneficiary satisfaction,
19 and such other factors as the Secretary finds appro-
20 priate. The eligibility of individuals or entities for
21 the initial award, continuation, and renewal of
22 agreements to provide health care items and services
23 under the program shall be conditioned, at a min-
24 imum, on performance that meets or exceeds such
25 standards.

1 “(6) ADMINISTRATIVE REVIEW OF DECISIONS
2 AFFECTING INDIVIDUALS AND ENTITIES FUR-
3 NISHING SERVICES.—An individual or entity fur-
4 nishing services under the demonstration program
5 shall be entitled to a review by the program adminis-
6 trator (or, if the Secretary has not contracted with
7 a program administrator, by the Secretary) of a de-
8 cision not to enter into, or to terminate, or not to
9 renew, an agreement with the entity to provide
10 health care items or services under the program.

11 “(7) SECRETARY’S REVIEW OF MARKETING MA-
12 TERIALS.—An agreement with an individual or enti-
13 ty furnishing services under the demonstration pro-
14 gram shall require the individual or entity to guar-
15 antee that it will not distribute materials that mar-
16 ket items or services under the program without the
17 Secretary’s prior review and approval.

18 “(8) PAYMENT IN FULL.—

19 “(A) IN GENERAL.—Except as provided in
20 subparagraph (B), an individual or entity re-
21 ceiving payment from the Secretary under a
22 contract or agreement under the demonstration
23 program shall agree to accept such payment as
24 payment in full, and such payment shall be in
25 lieu of any payments to which the individual or

1 entity would otherwise be entitled under this
2 title.

3 “(B) COLLECTION OF DEDUCTIBLES AND
4 COINSURANCE.—Such individual or entity may
5 collect any applicable deductible or coinsurance
6 amount from a beneficiary.

7 “(b) CONTRACTS FOR PROGRAM ADMINISTRATION.—

8 “(1) IN GENERAL.—The Secretary may admin-
9 ister the demonstration program through a contract
10 with a program administrator in accordance with the
11 provisions of this subsection.

12 “(2) SCOPE OF PROGRAM ADMINISTRATOR CON-
13 TRACTS.—The Secretary may enter into such con-
14 tracts for a limited geographic area, or on a regional
15 or national basis.

16 “(3) ELIGIBLE CONTRACTORS.—The Secretary
17 may contract for the administration of the program
18 with—

19 “(A) an entity that, under a contract
20 under section 1816 or 1842, determines the
21 amount of and makes payments for health care
22 items and services furnished under this title; or

23 “(B) any other entity with substantial ex-
24 perience in managing the type of program con-
25 cerned.

1 “(4) CONTRACT AWARD, DURATION, AND RE-
2 NEWAL.—

3 “(A) IN GENERAL.—A contract under this
4 subsection shall be for an initial term of up to
5 three years, renewable for additional terms of
6 up to three years.

7 “(B) NONCOMPETITIVE AWARD AND RE-
8 NEWAL FOR ENTITIES ADMINISTERING PART A
9 OR PART B PAYMENTS.—The Secretary may
10 enter or renew a contract under this subsection
11 with an entity described in paragraph (3)(A)
12 without regard to the requirements of section 5
13 of title 41, United States Code.

14 “(5) APPLICABILITY OF FEDERAL ACQUISITION
15 REGULATION.—The Federal Acquisition Regulation
16 shall apply to program administration contracts
17 under this subsection.

18 “(6) PERFORMANCE STANDARDS.—The Sec-
19 retary shall establish performance standards for the
20 program administrator including, as applicable,
21 standards for the quality and cost-effectiveness of
22 the program administered, and such other factors as
23 the Secretary finds appropriate. The eligibility of en-
24 tities for the initial award, continuation, and renewal
25 of program administration contracts shall be condi-

1 tioned, at a minimum, on performance that meets or
2 exceeds such standards.

3 “(7) FUNCTIONS OF PROGRAM ADMINIS-
4 TRATOR.—A program administrator shall perform
5 any or all of the following functions, as specified by
6 the Secretary:

7 “(A) AGREEMENTS WITH ENTITIES FUR-
8 NISHING HEALTH CARE ITEMS AND SERV-
9 ICES.—Determine the qualifications of entities
10 seeking to enter or renew agreements to provide
11 services under the demonstration program, and
12 as appropriate enter or renew (or refuse to
13 enter or renew) such agreements on behalf of
14 the Secretary.

15 “(B) ESTABLISHMENT OF PAYMENT
16 RATES.—Negotiate or otherwise establish, sub-
17 ject to the Secretary’s approval, payment rates
18 for covered health care items and services.

19 “(C) PAYMENT OF CLAIMS OR FEES.—Ad-
20 minister payments for health care items or serv-
21 ices furnished under the program.

22 “(D) PAYMENT OF BONUSES.—Using such
23 guidelines as the Secretary shall establish, and
24 subject to the approval of the Secretary, make
25 bonus payments as described in subsection

1 (c)(2)(A)(ii) to entities furnishing items or serv-
2 ices for which payment may be made under the
3 program.

4 “(E) OVERSIGHT.—Monitor the compli-
5 ance of individuals and entities with agreements
6 under the program with the conditions of par-
7 ticipation.

8 “(F) ADMINISTRATIVE REVIEW.—Conduct
9 reviews of adverse determinations specified in
10 subsection (a)(6).

11 “(G) REVIEW OF MARKETING MATE-
12 RIALS.—Conduct a review of marketing mate-
13 rials proposed by an entity furnishing services
14 under the program.

15 “(H) ADDITIONAL FUNCTIONS.—Perform
16 such other functions as the Secretary may
17 specify.

18 “(8) LIMITATION OF LIABILITY.—The provi-
19 sions of section 1157(b) shall apply with respect to
20 activities of contractors and their officers, employ-
21 ees, and agents under a contract under this sub-
22 section.

23 “(9) INFORMATION SHARING.—Notwithstanding
24 section 1106 and section 552a of title 5, United
25 States Code, the Secretary is authorized to disclose

1 to an entity with a program administration contract
2 under this subsection such information (including
3 medical information) on individuals receiving health
4 care items and services under the program as the
5 entity may require to carry out its responsibilities
6 under the contract.

7 “(c) RULES APPLICABLE TO BOTH PROGRAM
8 AGREEMENTS AND PROGRAM ADMINISTRATION CON-
9 TRACTS.—

10 “(1) RECORDS, REPORTS, AND AUDITS.—The
11 Secretary is authorized to require entities with
12 agreements to provide health care items or services
13 under the demonstration program, and entities with
14 program administration contracts under subsection
15 (b), to maintain adequate records, to afford the Sec-
16 retary access to such records (including for audit
17 purposes), and to furnish such reports and other
18 materials (including audited financial statements
19 and performance data) as the Secretary may require
20 for purposes of implementation, oversight, and eval-
21 uation of the program and of individuals’ and enti-
22 ties’ effectiveness in performance of such agreements
23 or contracts.

24 “(2) BONUSES.—Notwithstanding any other
25 provision of law, but subject to subparagraph

1 (B)(ii), the Secretary may make bonus payments
2 under the demonstration program from the Federal
3 Health Insurance Trust Fund and the Federal Sup-
4 plementary Medical Insurance Trust Fund in
5 amounts that do not exceed the amounts authorized
6 under the program in accordance with the following:

7 “(A) PAYMENTS TO PROGRAM ADMINIS-
8 TRATORS.—The Secretary may make bonus
9 payments under the program to program ad-
10 ministrators.

11 “(B) PAYMENTS TO ENTITIES FURNISHING
12 SERVICES.—

13 “(i) IN GENERAL.—Subject to clause
14 (ii), the Secretary may make bonus pay-
15 ments to individuals or entities furnishing
16 items or services for which payment may
17 be made under the demonstration pro-
18 gram, or may authorize the program ad-
19 ministrator to make such bonus payments
20 in accordance with such guidelines as the
21 Secretary shall establish and subject to the
22 Secretary’s approval.

23 “(ii) LIMITATIONS.—The Secretary
24 may condition such payments on the
25 achievement of such standards related to

1 efficiency, improvement in processes or
2 outcomes of care, or such other factors as
3 the Secretary determines to be appropriate.

4 “(3) ANTIDISCRIMINATION LIMITATION.—The
5 Secretary shall not enter into an agreement with an
6 entity to provide health care items or services under
7 the demonstration program, or with an entity to ad-
8 minister the program, unless such entity guarantees
9 that it will not deny, limit, or condition the coverage
10 or provision of benefits under the program, for indi-
11 viduals eligible to be enrolled under such program,
12 based on any health status-related factor described
13 in section 2702(a)(1) of the Public Health Service
14 Act.

15 “(d) LIMITATIONS ON JUDICIAL REVIEW.—The fol-
16 lowing actions and determinations with respect to the
17 demonstration program shall not be subject to review by
18 a judicial or administrative tribunal:

19 “(1) Limiting the implementation of the pro-
20 gram under subsection (a)(2).

21 “(2) Establishment of program participation
22 standards under subsection (a)(5) or the denial or
23 termination of, or refusal to renew, an agreement
24 with an entity to provide health care items and serv-
25 ices under the program.

1 “(3) Establishment of program administration
2 contract performance standards under subsection
3 (b)(6), the refusal to renew a program administra-
4 tion contract, or the noncompetitive award or re-
5 newal of a program administration contract under
6 subsection (b)(4)(B).

7 “(5) Establishment of payment rates, through
8 negotiation or otherwise, under a program agree-
9 ment or a program administration contract.

10 “(6) A determination with respect to the pro-
11 gram (where specifically authorized by the program
12 authority or by subsection (c)(2))—

13 “(A) as to whether cost savings have been
14 achieved, and the amount of savings; or

15 “(B) as to whether, to whom, and in what
16 amounts bonuses will be paid.

17 “(e) APPLICATION LIMITED TO PARTS A AND B.—
18 None of the provisions of this section or of the demonstra-
19 tion program shall apply to the programs under part C.

20 “(f) REPORTS TO CONGRESS.—Not later than two
21 years after the date of the enactment of this section, and
22 biennially thereafter for six years, the Secretary shall re-
23 port to Congress on the use of authorities under the dem-
24 onstration program. Each report shall address the impact

1 of the use of those authorities on expenditures, access, and
2 quality under the programs under this title.”.

3 (b) GAO REPORT.—Not later than 2 years after the
4 date on which the demonstration project under section
5 1866A of the Social Security Act, as added by subsection
6 (a), is implemented, the Comptroller General of the United
7 States shall submit to Congress a report on such dem-
8 onstration project. The report shall include such rec-
9 ommendations with respect to changes to the demonstra-
10 tion project that the Comptroller General determines ap-
11 propriate.

12 **SEC. 413. STUDY ON ENROLLMENT PROCEDURES FOR**
13 **GROUPS THAT RETAIN INDEPENDENT CON-**
14 **TRACTOR PHYSICIANS.**

15 (a) IN GENERAL.—The Comptroller General of the
16 United States shall conduct a study of the current medi-
17 care enrollment process for groups that retain independent
18 contractor physicians with particular emphasis on hos-
19 pital-based physicians, such as emergency department
20 staffing groups. In conducting the evaluation, the Comp-
21 troller General shall consult with groups that retain inde-
22 pendent contractor physicians and shall—

23 (1) review the issuance of individual medicare
24 provider numbers and the possible medicare program
25 integrity vulnerabilities of the current process;

1 (2) review direct and indirect costs associated
2 with the current process incurred by the medicare
3 program and groups that retain independent con-
4 tractor physicians;

5 (3) assess the effect on program integrity by
6 the enrollment of groups that retain independent
7 contractor hospital-based physicians; and

8 (4) develop suggested procedures for the enroll-
9 ment of these groups.

10 (b) REPORT.—Not later than 1 year after the date
11 of the enactment of this Act, the Comptroller General shall
12 submit to Congress a report on the study conducted under
13 subsection (a).

14 **Subtitle C—Other Services**

15 **SEC. 421. 1-YEAR EXTENSION OF MORATORIUM ON THER-** 16 **APY CAPS; REPORT ON STANDARDS FOR SU-** 17 **PERVISION OF PHYSICAL THERAPY ASSIST-** 18 **ANTS.**

19 (a) IN GENERAL.—Section 1833(g)(4) (42 U.S.C.
20 1395l(g)(4)) is amended by striking “2000 and 2001.”
21 and inserting “2000, 2001, and 2002.”.

22 (b) CONFORMING AMENDMENT TO CONTINUE FO-
23 CUSED MEDICAL REVIEWS OF CLAIMS DURING MORATO-
24 RIUM PERIOD.—Section 221(a)(2) of BBRA (113 Stat.

1 1501A–351) is amended by striking “(under the amend-
2 ment made by paragraph (1)(B))”.

3 (c) STUDY ON STANDARDS FOR SUPERVISION OF
4 PHYSICAL THERAPIST ASSISTANTS.—

5 (1) STUDY.—The Secretary of Health and
6 Human Services shall conduct a study of the
7 implications—

8 (A) of eliminating the “in the room” su-
9 pervision requirement for medicare payment for
10 services of physical therapy assistants who are
11 supervised by physical therapists; and

12 (B) of such requirement on the cap im-
13 posed under section 1833(g) of the Social Secu-
14 rity Act (42 U.S.C. 1395l(g)) on physical ther-
15 apy services.

16 (2) REPORT.—Not later than 18 months after
17 the date of the enactment of this Act, the Secretary
18 shall submit to Congress a report on the study con-
19 ducted under paragraph (1).

20 **SEC. 422. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.**

21 (a) UPDATE.—

22 (1) IN GENERAL.—The last sentence of section
23 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by
24 striking “for such services furnished on or after
25 January 1, 2001, by 1.2 percent” and inserting “for

1 such services furnished on or after January 1, 2001,
2 by 2.4 percent”.

3 (2) PROHIBITION ON EXEMPTIONS.—

4 (A) IN GENERAL.—Subject to subpara-
5 graph (B), the Secretary of Health and Human
6 Services may not provide for an exception under
7 section 1881(b)(7) of the Social Security Act
8 (42 U.S.C. 1395rr(b)(7)) on or after December
9 31, 2000.

10 (B) SPECIAL RULES FOR 2000.—

11 (i) IN GENERAL.—Any exemption rate
12 under such section 1881(b)(7) in effect on
13 December 31, 2000, shall continue in ef-
14 fect so long as such rate is greater than
15 the composite rate as updated by the
16 amendment made by paragraph (1).

17 (ii) RESUBMISSION OF CERTAIN AP-
18 PPLICATIONS.—In the case of an application
19 for an exemption rate under such section
20 that was filed by a facility during 2000
21 that was not approved by the Secretary of
22 Health and Human Services, the facility
23 may submit an application for an exemp-
24 tion rate for that year by not later than
25 July 1, 2001.

1 (b) DEVELOPMENT OF ESRD MARKET BASKET.—

2 (1) DEVELOPMENT.—The Secretary of Health
3 and Human Services shall collect data and develop
4 an ESRD market basket whereby the Secretary can
5 estimate, before the beginning of a year, the percent-
6 age by which the costs for the year of the mix of
7 labor and nonlabor goods and services included in
8 the ESRD composite rate under section 1881(b)(7)
9 of the Social Security Act (42 U.S.C. 1395rr(b)(7))
10 will exceed the costs of such mix of goods and serv-
11 ices for the preceding year. In developing such index,
12 the Secretary may take into account measures of
13 changes in—

14 (A) technology used in furnishing dialysis
15 services;

16 (B) the manner or method of furnishing
17 dialysis services; and

18 (C) the amounts by which the payments
19 under such section for all services billed by a
20 facility for a year exceed the aggregate allow-
21 able audited costs of such services for such fa-
22 cility for such year.

23 (2) REPORT.—The Secretary of Health and
24 Human Services shall submit to Congress a report
25 on the index developed under paragraph (1) no later

1 than July 1, 2002, and shall include in the report
2 recommendations on the appropriateness of an an-
3 nual or periodic update mechanism for renal dialysis
4 services under the medicare program under title
5 XVIII of the Social Security Act based on such
6 index.

7 (c) INCLUSION OF ADDITIONAL SERVICES IN COM-
8 POSITE RATE.—

9 (1) DEVELOPMENT.—The Secretary of Health
10 and Human Services shall develop a system which
11 includes, to the maximum extent feasible, in the
12 composite rate used for payment under section
13 1881(b)(7) of the Social Security Act (42 U.S.C.
14 1395rr(b)(7)), payment for clinical diagnostic lab-
15 oratory tests and drugs (including drugs paid under
16 section 1881(b)(11)(B) of such Act (42 U.S.C.
17 1395rr(b)(11)(B)) that are routinely used in fur-
18 nishing dialysis services to medicare beneficiaries but
19 which are currently separately billable by renal dialy-
20 sis facilities.

21 (2) REPORT.—The Secretary shall include, as
22 part of the report submitted under subsection (b)(2),
23 a report on the system developed under paragraph
24 (1) and recommendations on the appropriateness of

1 incorporating the system into medicare payment for
2 renal dialysis services.

3 (d) GAO STUDY ON ACCESS TO SERVICES.—

4 (1) STUDY.—The Comptroller General of the
5 United States shall study access of medicare bene-
6 ficiaries to renal dialysis services. Such study shall
7 include whether there is a sufficient supply of facili-
8 ties to furnish needed renal dialysis services, whether
9 medicare payment levels are appropriate, taking into
10 account audited costs of facilities for all services fur-
11 nished, to ensure continued access to such services,
12 and improvements in access (and quality of care)
13 that may result in the increased use of long nightly
14 and short daily hemodialysis modalities.

15 (2) REPORT.—Not later than January 1, 2003,
16 the Comptroller General shall submit to Congress a
17 report on the study conducted under paragraph (1).

18 **SEC. 423. PAYMENT FOR AMBULANCE SERVICES.**

19 (a) RESTORATION OF FULL CPI INCREASE FOR
20 2001.—Section 1834(l)(3) (42 U.S.C. 1395m(l)(3)) is
21 amended by striking “reduced in the case of 2001 and
22 2002” each place it appears and inserting “reduced in the
23 case of 2002”.

24 (b) MILEAGE PAYMENTS.—Section 1834(l)(2)(E)
25 (42 U.S.C. 1395m(l)(2)(E)) is amended by inserting be-

1 fore the period at the end the following: “, except that,
2 beginning on the date on which the Secretary implements
3 such fee schedule, such phase-in shall provide for full pay-
4 ment of any national mileage rate for ambulance services
5 provided by suppliers that are paid by carriers in any of
6 the 50 States where payment by a carrier for such services
7 for all such suppliers in such State did not, prior to the
8 implementation of the fee schedule, include a separate
9 amount for all mileage within the county from which the
10 beneficiary is transported”.

11 (c) **EFFECTIVE DATE.**—The amendment made by
12 subsection (a) applies to services furnished on or after the
13 date on which the Secretary of Health and Human Serv-
14 ices implements the fee schedule under section 1834(l) of
15 the Social Security Act (42 U.S.C. 1395m(l)).

16 **SEC. 424. AMBULATORY SURGICAL CENTERS.**

17 (a) **DELAY IN IMPLEMENTATION OF PROSPECTIVE**
18 **PAYMENT SYSTEM.**—The Secretary of Health and Human
19 Services may not implement a revised prospective payment
20 system for services of ambulatory surgical facilities under
21 section 1833(i) of the Social Security Act (42 U.S.C.
22 1395l(i)) before January 1, 2002.

23 (b) **EXTENDING PHASE-IN TO 4 YEARS.**—Section
24 226 of the BBRA (113 Stat. 1501A–354) is amended by

1 striking paragraphs (1) and (2) and inserting the fol-
2 lowing:

3 “(1) in the first year of its implementation,
4 only a proportion (specified by the Secretary and not
5 to exceed $\frac{1}{4}$) of the payment for such services shall
6 be made in accordance with such system and the re-
7 mainder shall be made in accordance with current
8 regulations; and

9 “(2) in each of the following 2 years a propor-
10 tion (specified by the Secretary and not to exceed
11 $\frac{1}{2}$, and $\frac{3}{4}$, respectively) of the payment for such
12 services shall be made under such system and the
13 remainder shall be made in accordance with current
14 regulations.”.

15 (c) DEADLINE FOR USE OF 1999 OR LATER COST
16 SURVEYS.—Section 226 of BBRA (113 Stat. 1501A–354)
17 is amended by adding at the end the following:

18 “By not later than January 1, 2003, the Secretary shall
19 incorporate data from a 1999 medicare cost survey or a
20 subsequent cost survey for purposes of implementing or
21 revising such system.”.

22 **SEC. 425. FULL UPDATE FOR DURABLE MEDICAL EQUIP-**
23 **MENT.**

24 (a) IN GENERAL.—Section 1834(a)(14) (42 U.S.C.
25 1395m(a)(14)) is amended—

1 (1) by redesignating subparagraph (D) as sub-
2 paragraph (F);

3 (2) in subparagraph (C)—

4 (A) by striking “through 2002” and insert-
5 ing “through 2000”; and

6 (B) by striking “and” at the end; and

7 (3) by inserting after subparagraph (C) the fol-
8 lowing new subparagraphs:

9 “(D) for 2001, the percentage increase in
10 the Consumer Price Index for all urban con-
11 sumers (U.S. city average) for the 12-month
12 period ending with June 2000;

13 “(E) for 2002, 0 percentage points; and”.

14 (b) CONFORMING AMENDMENTS TO BBRA.—Sub-
15 section (a) of section 228 of BBRA (113 Stat. 1501A–
16 356) is amended—

17 (1) in the matter preceding paragraph (1), by
18 striking “for such items”;

19 (2) in paragraph (1), by inserting “oxygen and
20 oxygen equipment for” after “(1)”; and

21 (3) in paragraph (2), by inserting “all such cov-
22 ered items for” after “(2)”.

23 (c) EFFECTIVE DATE.—The amendments made by
24 subsection (b) shall take effect as if included in the enact-
25 ment of BBRA.

1 **SEC. 426. FULL UPDATE FOR ORTHOTICS AND PROS-**
2 **THETICS.**

3 Section 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A))
4 is amended—

5 (1) by redesignating clause (vi) as clause (viii);

6 (2) in clause (v)—

7 (A) by striking “through 2002” and insert-
8 ing “through 2000”; and

9 (B) by striking “and” at the end; and

10 (3) by inserting after clause (v) the following
11 new clause:

12 “(vi) for 2001, the percentage in-
13 crease in the consumer price index for all
14 urban consumers (U.S. city average) for
15 the 12-month period ending with June
16 2000;

17 “(vii) for 2002, 1 percent; and”.

18 **SEC. 427. ESTABLISHMENT OF SPECIAL PAYMENT PROVI-**
19 **SIONS AND REQUIREMENTS FOR PROS-**
20 **THETICS AND CERTAIN CUSTOM FABRICATED**
21 **ORTHOTIC ITEMS.**

22 (a) IN GENERAL.—Section 1834(h)(1) (42 U.S.C.
23 1395m(h)(1)) is amended by adding at the end the fol-
24 lowing:

1 “(F) SPECIAL PAYMENT RULES FOR CER-
2 TAIN PROSTHETICS AND CUSTOM FABRICATED
3 ORTHOTICS.—

4 “(i) IN GENERAL.—No payment shall
5 be made under this subsection for an item
6 of custom fabricated orthotics described in
7 clause (ii) or for an item of prosthetics un-
8 less such item is—

9 “(I) furnished by a qualified
10 practitioner; and

11 “(II) fabricated by a qualified
12 practitioner or a qualified supplier at
13 a facility that meets such criteria as
14 the Secretary determines appropriate.

15 “(ii) DESCRIPTION OF CUSTOM FAB-
16 RICATED ITEM.—

17 “(I) IN GENERAL.—An item de-
18 scribed in this clause is an item of
19 custom fabricated orthotics that re-
20 quires education, training, and experi-
21 ence to custom fabricate and that is
22 included in a list established by the
23 Secretary in subclause (II). Such an
24 item does not include shoes and shoe
25 inserts.

1 “(II) LIST OF ITEMS.—The Sec-
2 retary, in consultation with appro-
3 priate experts in orthotics (including
4 national organizations representing
5 manufacturers of orthotics), shall es-
6 tablish and update as appropriate a
7 list of items to which this subpara-
8 graph applies. No item may be in-
9 cluded in such list unless the item is
10 individually fabricated for the patient
11 over a positive model of the patient.

12 “(iii) QUALIFIED PRACTITIONER DE-
13 FINED.—In this subparagraph, the term
14 ‘qualified practitioner’ means a physician
15 or other individual who—

16 “(I) is a qualified physical thera-
17 pist or a qualified occupational thera-
18 pist;

19 “(II) in the case of a State that
20 provides for the licensing of orthotics
21 and prosthetics, is licensed in
22 orthotics or prosthetics by the State
23 in which the item is supplied; or

24 “(III) in the case of a State that
25 does not provide for the licensing of

1 orthotics and prosthetics, is specifi-
2 cally trained and educated to provide
3 or manage the provision of prosthetics
4 and custom-designed or fabricated
5 orthotics, and is certified by the
6 American Board for Certification in
7 Orthotics and Prosthetics, Inc. or by
8 the Board for Orthotist/Prosthetist
9 Certification, or is credentialed and
10 approved by a program that the Sec-
11 retary determines, in consultation
12 with appropriate experts in orthotics
13 and prosthetics, has training and edu-
14 cation standards that are necessary to
15 provide such prosthetics and orthotics.

16 “(iv) QUALIFIED SUPPLIER DE-
17 FINED.—In this subparagraph, the term
18 ‘qualified supplier’ means any entity that
19 is accredited by the American Board for
20 Certification in Orthotics and Prosthetics,
21 Inc. or by the Board for Orthotist/Pros-
22 thetist Certification, or accredited and ap-
23 proved by a program that the Secretary
24 determines has accreditation and approval

1 standards that are essentially equivalent to
2 those of such Board.”.

3 (b) EFFECTIVE DATE.—Not later than 1 year after
4 the date of the enactment of this Act, the Secretary of
5 Health and Human Services shall promulgate revised reg-
6 ulations to carry out the amendment made by subsection
7 (a) using a negotiated rulemaking process under sub-
8 chapter III of chapter 5 of title 5, United States Code.

9 (c) GAO STUDY AND REPORT.—

10 (1) STUDY.—The Comptroller General of the
11 United States shall conduct a study on HCFA Rul-
12 ing 96–1, issued on September 1, 1996, with respect
13 to distinguishing orthotics from durable medical
14 equipment under the medicare program under title
15 XVIII of the Social Security Act. The study shall as-
16 sess the following matters:

17 (A) The compliance of the Secretary of
18 Health and Human Services with the Adminis-
19 trative Procedures Act (under chapter 5 of title
20 5, United States Code) in making such ruling.

21 (B) The potential impact of such ruling on
22 the health care furnished to medicare bene-
23 ficiaries under the medicare program, especially
24 those beneficiaries with degenerative musculo-
25 skeletal conditions.

1 (C) The potential for fraud and abuse
2 under the medicare program if payment were
3 provided for orthotics used as a component of
4 durable medical equipment only when made
5 under the special payment provision for certain
6 prosthetics and custom fabricated orthotics
7 under section 1834(h)(1)(F) of the Social Secu-
8 rity Act, as added by subsection (a) and fur-
9 nished by qualified practitioners under that sec-
10 tion.

11 (D) The impact on payments under titles
12 XVIII and XIX of the Social Security Act if
13 such ruling were overturned.

14 (2) REPORT.—Not later than 6 months after
15 the date of the enactment of this Act, the Comp-
16 troller General shall submit to Congress a report on
17 the study conducted under paragraph (1).

18 **SEC. 428. REPLACEMENT OF PROSTHETIC DEVICES AND**
19 **PARTS.**

20 (a) IN GENERAL.—Section 1834(h)(1) (42 U.S.C.
21 1395m(h)(1)), as amended by section 427(a), is further
22 amended by adding at the end the following new subpara-
23 graph:

24 “(G) REPLACEMENT OF PROSTHETIC DE-
25 VICES AND PARTS.—

1 “(i) IN GENERAL.—Payment shall be
2 made for the replacement of prosthetic de-
3 vices which are artificial limbs, or for the
4 replacement of any part of such devices,
5 without regard to continuous use or useful
6 lifetime restrictions if an ordering physi-
7 cian determines that the provision of a re-
8 placement device, or a replacement part of
9 such a device, is necessary because of any
10 of the following:

11 “(I) A change in the physio-
12 logical condition of the patient.

13 “(II) An irreparable change in
14 the condition of the device, or in a
15 part of the device.

16 “(III) The condition of the de-
17 vice, or the part of the device, re-
18 quires repairs and the cost of such re-
19 pairs would be more than 60 percent
20 of the cost of a replacement device, or,
21 as the case may be, of the part being
22 replaced.

23 “(ii) CONFIRMATION MAY BE RE-
24 QUIRED IF REPLACEMENT DEVICE OR
25 PART IS LESS THAN 3 YEARS OLD.—If a

1 physician determines that a replacement
2 device, or a replacement part, is necessary
3 pursuant to clause (i)—

4 “(I) such determination shall be
5 controlling; and

6 “(II) such replacement device or
7 part shall be deemed to be reasonable
8 and necessary for purposes of section
9 1862(a)(1)(A);

10 except that if the device, or part, being re-
11 placed is less than 3 years old (calculated
12 from the date on which the beneficiary
13 began to use the device or part), the Sec-
14 retary may also require confirmation of ne-
15 cessity of the replacement device, or, as the
16 case may be, the replacement part.”.

17 (b) PREEMPTION OF RULE.—The provisions of sec-
18 tion 1834(h)(1)(G) as added by subsection (a) shall super-
19 sede any rule that as of the date of the enactment of this
20 Act may have applied a 5-year replacement rule with re-
21 gard to prosthetic devices.

22 (c) EFFECTIVE DATE.—The amendment made by
23 subsection (a) shall apply to items replaced on or after
24 April 1, 2001.

1 **SEC. 429. REVISED PART B PAYMENT FOR DRUGS AND**
2 **BIOLOGICALS AND RELATED SERVICES.**

3 (a) RECOMMENDATIONS FOR REVISED PAYMENT
4 METHODOLOGY FOR DRUGS AND BIOLOGICALS.—

5 (1) STUDY.—

6 (A) IN GENERAL.—The Comptroller Gen-
7 eral of the United States shall conduct a study
8 on the reimbursement for drugs and biologicals
9 under the current medicare payment method-
10 ology (provided under section 1842(o) of the
11 Social Security Act (42 U.S.C. 1395u(o)) and
12 for related services under part B of title XVIII
13 of such Act. In the study, the Comptroller Gen-
14 eral shall—

15 (i) identify the average prices at
16 which such drugs and biologicals are ac-
17 quired by physicians and other suppliers;

18 (ii) quantify the difference between
19 such average prices and the reimbursement
20 amount under such section; and

21 (iii) determine the extent to which (if
22 any) payment under such part is adequate
23 to compensate physicians, providers of
24 services, or other suppliers of such drugs
25 and biologicals for costs incurred in the ad-

1 ministration, handling, or storage of such
2 drugs or biologicals.

3 (B) CONSULTATION.—In conducting the
4 study under subparagraph (A), the Comptroller
5 General shall consult with physicians, providers
6 of services, and suppliers of drugs and
7 biologicals under the medicare program under
8 title XVIII of such Act, as well as other organi-
9 zations involved in the distribution of such
10 drugs and biologicals to such physicians, pro-
11 viders of services, and suppliers.

12 (2) REPORT.—Not later than 9 months after
13 the date of the enactment of this Act, the Comp-
14 troller General shall submit to Congress and to the
15 Secretary of Health and Human Services a report
16 on the study conducted under this subsection, and
17 shall include in such report recommendations for re-
18 vised payment methodologies described in paragraph
19 (3).

20 (3) RECOMMENDATIONS FOR REVISED PAY-
21 MENT METHODOLOGIES.—

22 (A) IN GENERAL.—The Comptroller Gen-
23 eral shall provide specific recommendations for
24 revised payment methodologies for reimburse-
25 ment for drugs and biologicals and for related

1 services under the medicare program. The
2 Comptroller General may include in the
3 recommendations—

4 (i) proposals to make adjustments
5 under subsection (c) of section 1848 of the
6 Social Security Act (42 U.S.C. 1395w-4)
7 for the practice expense component of the
8 physician fee schedule under such section
9 for the costs incurred in the administra-
10 tion, handling, or storage of certain cat-
11 egories of such drugs and biologicals, if ap-
12 propriate; and

13 (ii) proposals for new payments to
14 providers of services or suppliers for such
15 costs, if appropriate.

16 (B) ENSURING PATIENT ACCESS TO
17 CARE.—In making recommendations under this
18 paragraph, the Comptroller General shall en-
19 sure that any proposed revised payment meth-
20 odology is designed to ensure that medicare
21 beneficiaries continue to have appropriate ac-
22 cess to health care services under the medicare
23 program.

1 (C) MATTERS CONSIDERED.—In making
2 recommendations under this paragraph, the
3 Comptroller General shall consider—

4 (i) the method and amount of reim-
5 bursement for similar drugs and biologicals
6 made by large group health plans;

7 (ii) as a result of any revised payment
8 methodology, the potential for patients to
9 receive inpatient or outpatient hospital
10 services in lieu of services in a physician's
11 office; and

12 (iii) the effect of any revised payment
13 methodology on the delivery of drug thera-
14 pies by hospital outpatient departments.

15 (D) COORDINATION WITH BBRA STUDY.—

16 In making recommendations under this para-
17 graph, the Comptroller General shall conclude
18 and take into account the results of the study
19 provided for under section 213(a) of BBRA
20 (113 Stat. 1501A–350).

21 (b) IMPLEMENTATION OF NEW PAYMENT METHOD-
22 OLOGY.—

23 (1) IN GENERAL.—Notwithstanding any other
24 provision of law, based on the recommendations con-
25 tained in the report under subsection (a), the Sec-

1 retary of Health and Human Services, subject to
2 paragraph (2), shall revise the payment methodology
3 under section 1842(o) of the Social Security Act (42
4 U.S.C. 1395u(o)) for drugs and biologicals furnished
5 under part B of the medicare program. To the ex-
6 tent the Secretary determines appropriate, the Sec-
7 retary may provide for the adjustments to payments
8 amounts referred to in subsection (a)(3)(A)(i) or ad-
9 ditional payments referred to in subsection
10 (a)(2)(A)(ii).

11 (2) LIMITATION.—In revising the payment
12 methodology under paragraph (1), in no case may
13 the estimated aggregate payments for drugs and
14 biologicals under the revised system (including addi-
15 tional payments referred to in subsection
16 (a)(3)(A)(ii)) exceed the aggregate amount of pay-
17 ment for such drugs and biologicals, as projected by
18 the Secretary, that would have been made under the
19 payment methodology in effect under such section
20 1842(o).

21 (c) TEMPORARY INJUNCTION AGAINST REDUCTIONS
22 IN PAYMENT RATES.—Notwithstanding any other provi-
23 sion of law, the Administrator of the Health Care Financ-
24 ing Administration may not directly or indirectly increase
25 or decrease the rates of reimbursement (in effect on Sep-

1 tember 1, 2000) for drugs and biologicals under the cur-
2 rent medicare payment methodology (provided under sec-
3 tion 1842(o) of such Act (42 U.S.C. 1395u(o)) until such
4 time as the Secretary has reviewed the report submitted
5 under subsection (a)(2).

6 **SEC. 430. CONTRAST ENHANCED DIAGNOSTIC PROCE-**
7 **DURES UNDER HOSPITAL PROSPECTIVE PAY-**
8 **MENT SYSTEM.**

9 (a) SEPARATE CLASSIFICATION.—Section 1833(t)(2)
10 (42 U.S.C. 1395l(t)(2)) is amended—

11 (1) by striking “and” at the end of subpara-
12 graph (E);

13 (2) by striking the period at the end of sub-
14 paragraph (F) and inserting “; and”; and

15 (3) by inserting after subparagraph (F) the fol-
16 lowing new subparagraph:

17 “(G) the Secretary shall create additional
18 groups of covered OPD services that classify
19 separately those procedures that utilize contrast
20 media from those that do not.”.

21 (b) CONFORMING AMENDMENT.—Section 1861(t)(1)
22 (42 U.S.C. 1395x(t)(1)) is amended by inserting “(includ-
23 ing contrast agents)” after “only such drugs”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section apply to items and services furnished on or
3 after January 1, 2001.

4 **SEC. 431. QUALIFICATIONS FOR COMMUNITY MENTAL**
5 **HEALTH CENTERS.**

6 (a) MEDICARE PROGRAM.—Section 1861(ff)(3)(B)
7 (42 U.S.C. 1395x(ff)(3)(B)) is amended by striking “enti-
8 ty” and all that follows and inserting the following: “entity
9 that—

10 “(i)(I) provides the mental health services de-
11 scribed in section 1913(c)(1) of the Public Health
12 Service Act; or

13 “(II) in the case of an entity operating in a
14 State that by law precludes the entity from pro-
15 viding itself the service described in subparagraph
16 (E) of such section, provides for such service by con-
17 tract with an approved organization or entity (as de-
18 termined by the Secretary);

19 “(ii) meets applicable licensing or certification
20 requirements for community mental health centers
21 in the State in which it is located; and

22 “(iii) meets such additional conditions as the
23 Secretary shall specify to ensure (I) the health and
24 safety of individuals being furnished such services,
25 (II) the effective and efficient furnishing of such

1 services, and (III) the compliance of such entity with
2 the criteria described in section 1931(c)(1) of the
3 Public Health Service Act.”.

4 (b) EFFECTIVE DATE.—The amendment made by
5 subsection (a) applies with respect to community mental
6 health centers with respect to services furnished on or
7 after the first day of the third month beginning after the
8 date of the enactment of this Act.

9 **SEC. 432. MODIFICATION OF MEDICARE BILLING REQUIRE-**
10 **MENTS FOR CERTAIN INDIAN PROVIDERS.**

11 (a) IN GENERAL.—Section 1880(a) (42 U.S.C.
12 1395qq(a)) is amended by adding at the end the following
13 new sentence: “A hospital or a free-standing ambulatory
14 care clinic (as defined by the Secretary), whether operated
15 by the Indian Health Service or by an Indian tribe or trib-
16 al organization (as those terms are defined in section 4
17 of the Indian Health Care Improvement Act), shall be eli-
18 gible for payments for services for which payment is made
19 pursuant to section 1848, notwithstanding sections
20 1814(c) and 1835(d), if and for so long as it meets all
21 of the requirements which are applicable generally to such
22 payments, services, hospitals, and clinics.”.

23 (b) EFFECTIVE DATE.—The amendment made by
24 this section shall apply to services furnished on or after
25 January 1, 2001.

1 **SEC. 433. GAO STUDY ON COVERAGE OF SURGICAL FIRST**
2 **ASSISTING SERVICES OF CERTIFIED REG-**
3 **ISTERED NURSE FIRST ASSISTANTS.**

4 (a) **STUDY.**—The Comptroller General of the United
5 States shall conduct a study on the effect on the medicare
6 program under title XVIII of the Social Security Act and
7 on medicare beneficiaries of coverage under the program
8 of surgical first assisting services of certified registered
9 nurse first assistants. The Comptroller General shall con-
10 sider the following when conducting the study:

11 (1) Any impact on the quality of care furnished
12 to medicare beneficiaries by reason of such coverage.

13 (2) Appropriate education and training require-
14 ments for certified registered nurse first assistants
15 who furnish such first assisting services.

16 (3) Appropriate rates of payment under the
17 program to such certified registered nurse first as-
18 sistants for furnishing such services, taking into ac-
19 count the costs of compensation, overhead, and su-
20 pervision attributable to certified registered nurse
21 first assistants.

22 (b) **REPORT.**—Not later than 1 year after the date
23 of the enactment of this Act, the Comptroller General shall
24 submit to Congress a report on the study conducted under
25 subsection (a).

1 **SEC. 434. MEDPAC STUDY AND REPORT ON MEDICARE RE-**
2 **IMBURSEMENT FOR SERVICES PROVIDED BY**
3 **CERTAIN PROVIDERS.**

4 (a) STUDY.—The Medicare Payment Advisory Com-
5 mission shall conduct a study on the appropriateness of
6 the current payment rates under the medicare program
7 under title XVIII of the Social Security Act for services
8 provided by a—

9 (1) certified nurse-midwife (as defined in sub-
10 section (gg)(2) of section 1861 of such Act (42
11 U.S.C. 1395x);

12 (2) physician assistant (as defined in subsection
13 (aa)(5)(A) of such section);

14 (3) nurse practitioner (as defined in such sub-
15 section); and

16 (4) clinical nurse specialist (as defined in sub-
17 section (aa)(5)(B) of such section).

18 (b) REPORT.—Not later than 18 months after the
19 date of the enactment of this Act, the Commission shall
20 submit to Congress a report on the study conducted under
21 subsection (a), together with any recommendations for leg-
22 islation that the Commission determines to be appropriate
23 as a result of such study.

1 **SEC. 435. MEDPAC STUDY AND REPORT ON MEDICARE COV-**
2 **ERAGE OF SERVICES PROVIDED BY CERTAIN**
3 **NONPHYSICIAN PROVIDERS.**

4 (a) STUDY.—

5 (1) IN GENERAL.—The Medicare Payment Ad-
6 visory Commission shall conduct a study to deter-
7 mine the appropriateness of providing coverage
8 under the medicare program under title XVIII of the
9 Social Security Act for services provided by a—

10 (A) surgical technologist;

11 (B) marriage counselor;

12 (C) marriage and family therapist;

13 (D) pastoral care counselor; and

14 (E) licensed professional counselor of men-
15 tal health.

16 (2) COSTS TO PROGRAM.—The study shall con-
17 sider the short-term and long-term benefits, and
18 costs to the medicare program, of providing the cov-
19 erage described in paragraph (1).

20 (b) REPORT.—Not later than 18 months after the
21 date of the enactment of this Act, the Commission shall
22 submit to Congress a report on the study conducted under
23 subsection (a), together with any recommendations for leg-
24 islation that the Commission determines to be appropriate
25 as a result of such study.

1 **SEC. 436. GAO STUDY AND REPORT ON THE COSTS OF**
2 **EMERGENCY AND MEDICAL TRANSPOR-**
3 **TATION SERVICES.**

4 (a) STUDY.—The Comptroller General of the United
5 States shall conduct a study on the costs of providing
6 emergency and medical transportation services across the
7 range of acuity levels of conditions for which such trans-
8 portation services are provided.

9 (b) REPORT.—Not later than 18 months after the
10 date of the enactment of this Act, the Comptroller General
11 shall submit to Congress a report on the study conducted
12 under subsection (a), together with recommendations for
13 any changes in methodology or payment level necessary
14 to fairly compensate suppliers of emergency and medical
15 transportation services and to ensure the access of bene-
16 ficiaries under the medicare program under title XVIII of
17 the Social Security Act.

18 **SEC. 437. GAO STUDIES AND REPORTS ON MEDICARE PAY-**
19 **MENTS.**

20 (a) GAO STUDY ON HCFA POST-PAYMENT AUDIT
21 PROCESS.—

22 (1) STUDY.—The Comptroller General of the
23 United States shall conduct a study on the post-pay-
24 ment audit process under the medicare program
25 under title XVIII of the Social Security Act as such
26 process applies to physicians, including the proper

1 level of resources that the Health Care Financing
2 Administration should devote to educating physi-
3 cians regarding—

4 (A) coding and billing;

5 (B) documentation requirements; and

6 (C) the calculation of overpayments.

7 (2) REPORT.—Not later than 18 months after
8 the date of the enactment of this Act, the Comp-
9 troller General shall submit to Congress a report on
10 the study conducted under paragraph (1) together
11 with specific recommendations for changes or im-
12 provements in the post-payment audit process de-
13 scribed in such paragraph.

14 (b) GAO STUDY ON ADMINISTRATION AND OVER-
15 SIGHT.—

16 (1) STUDY.—The Comptroller General of the
17 United States shall conduct a study on the aggre-
18 gate effects of regulatory, audit, oversight, and pa-
19 perwork burdens on physicians and other health care
20 providers participating in the medicare program
21 under title XVIII of the Social Security Act.

22 (2) REPORT.—Not later than 18 months after
23 the date of the enactment of this Act, the Comp-
24 troller General shall submit to Congress a report on
25 the study conducted under paragraph (1) together

1 with recommendations regarding any area in
2 which—

3 (A) a reduction in paperwork, an ease of
4 administration, or an appropriate change in
5 oversight and review may be accomplished; or

6 (B) additional payments or education are
7 needed to assist physicians and other health
8 care providers in understanding and complying
9 with any legal or regulatory requirements.

10 **SEC. 438. MEDPAC STUDY ON ACCESS TO OUTPATIENT PAIN**
11 **MANAGEMENT SERVICES.**

12 (a) STUDY.—The Medicare Payment Advisory Com-
13 mission shall conduct a study on the barriers to coverage
14 and payment for outpatient interventional pain medicine
15 procedures under the medicare program under title XVIII
16 of the Social Security Act. Such study shall examine—

17 (1) the specific barriers imposed under the
18 medicare program on the provision of pain manage-
19 ment procedures in hospital outpatient departments,
20 ambulatory surgery centers, and physicians' offices;
21 and

22 (2) the consistency of medicare payment poli-
23 cies for pain management procedures in those dif-
24 ferent settings.

1 (b) REPORT.—Not later than 1 year after the date
2 of the enactment of this Act, the Commission shall submit
3 to Congress a report on the study.

4 **TITLE V—PROVISIONS**
5 **RELATING TO PARTS A AND B**
6 **Subtitle A—Home Health Services**

7 **SEC. 501. 1-YEAR ADDITIONAL DELAY IN APPLICATION OF**
8 **15 PERCENT REDUCTION ON PAYMENT LIM-**
9 **ITS FOR HOME HEALTH SERVICES.**

10 (a) IN GENERAL.—Section 1895(b)(3)(A)(i) (42
11 U.S.C. 1395fff(b)(3)(A)(i)) is amended—

12 (1) by redesignating subclause (II) as subclause
13 (III);

14 (2) in subclause (III), as redesignated, by strik-
15 ing “described in subclause (I)” and inserting “de-
16 scribed in subclause (II)”;

17 (3) by inserting after subclause (I) the fol-
18 lowing new subclause:

19 “(II) For the 12-month period
20 beginning after the period described
21 in subclause (I), such amount (or
22 amounts) shall be equal to the amount
23 (or amounts) determined under sub-
24 clause (I), updated under subpara-
25 graph (B).”.

1 (b) CHANGE IN REPORT.—Section 302(c) of BBRA
2 (113 Stat. 1501A–360) is amended—

3 (1) by striking “Not later than” and all that
4 follows through “(42 U.S.C. 1395fff)” and inserting
5 “Not later than April 1, 2002”; and

6 (2) by striking “Secretary” and inserting
7 “Comptroller General of the United States”.

8 (c) CASE MIX ADJUSTMENT CORRECTIONS.—

9 (1) IN GENERAL.—Section 1895(b)(3)(B) (42
10 U.S.C. 1395fff(b)(3)(B)) is amended by adding at
11 the end the following new clause:

12 “(iv) ADJUSTMENT FOR CASE MIX
13 CHANGES.—Insofar as the Secretary deter-
14 mines that the adjustments under para-
15 graph (4)(A)(i) for a previous fiscal year
16 (or estimates that such adjustments for a
17 future fiscal year) did (or are likely to) re-
18 sult in a change in aggregate payments
19 under this subsection during the fiscal year
20 that are a result of changes in the coding
21 or classification of different units of serv-
22 ices that do not reflect real changes in case
23 mix, the Secretary may adjust the stand-
24 ard prospective payment amount (or
25 amounts) under paragraph (3) for subse-

1 quent fiscal years so as to eliminate the ef-
2 fect of such coding or classification
3 changes.”.

4 (2) EFFECTIVE DATE.—The amendment made
5 by paragraph (1) applies to episodes concluding on
6 or after October 1, 2001.

7 **SEC. 502. RESTORATION OF FULL HOME HEALTH MARKET**
8 **BASKET UPDATE FOR HOME HEALTH SERV-**
9 **ICES FOR FISCAL YEAR 2001.**

10 (a) IN GENERAL.—Section 1861(v)(1)(L)(x) (42
11 U.S.C. 1395x(v)(1)(L)(x)) is amended—

12 (1) by striking “2001,”; and

13 (2) by adding at the end the following: “With
14 respect to cost reporting periods beginning during
15 fiscal year 2001, the update to any limit under this
16 subparagraph shall be the home health market bas-
17 ket index.”.

18 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR
19 2001 BASED ON ADJUSTED PROSPECTIVE PAYMENT
20 AMOUNTS.—

21 (1) IN GENERAL.—Notwithstanding the amend-
22 ments made by subsection (a), for purposes of mak-
23 ing payments under section 1895(b) of the Social
24 Security Act (42 U.S.C. 1395fff(b)) for home health

1 services for fiscal year 2001, the Secretary of Health
2 and Human Services shall—

3 (A) with respect to episodes and visits end-
4 ing on or after October 1, 2000, and before
5 April 1, 2001, use the final standardized and
6 budget neutral prospective payment amounts
7 for 60 day episodes and standardized average
8 per visit amounts for fiscal year 2001 as pub-
9 lished by the Secretary in Federal Register of
10 the July 3, 2000 (65 Federal Register 41128–
11 41214); and

12 (B) with respect to episodes and visits end-
13 ing on or after April 1, 2001, and before Octo-
14 ber 1, 2001, use such amounts increased by 2.2
15 percent.

16 (2) NO EFFECT ON OTHER PAYMENTS OR DE-
17 TERMINATIONS.—The Secretary shall not take the
18 provisions of paragraph (1) into account for pur-
19 poses of payments, determinations, or budget neu-
20 trality adjustments under section 1895 of the Social
21 Security Act.

22 **SEC. 503. TEMPORARY TWO-MONTH EXTENSION OF PERI-**
23 **ODIC INTERIM PAYMENTS.**

24 (a) TEMPORARY EXTENSION.—Notwithstanding sub-
25 section (d) of section 4603 of BBA (42 U.S.C. 1395fff

1 note), as amended by section 5101(e)(2) of the Tax and
2 Trade Relief Extension Act of 1998 (contained in division
3 J of Public Law 105–277)), the amendments made by
4 subsection (b) of such section 4603 shall not take effect
5 until December 1, 2000, in the case of a home health
6 agency that was receiving periodic interim payments under
7 section 1815(e)(2) as of September 30, 2000.

8 (b) PAYMENT RULE.—The amount of such periodic
9 interim payment made to a home health agency by reason
10 of subsection (a) during each of November and December,
11 2000, shall be equal to the amount of such payment made
12 to the agency in their last full monthly periodic interim
13 payment. Such amount of payment shall be included in
14 the tentative settlement of the last cost report for the
15 home health agency under the payment system in effect
16 prior to the implementation of the prospective payment
17 system under section 1895(b) of the Social Security Act
18 (42 U.S.C. 1395fff(b)).

19 **SEC. 504. USE OF TELEHEALTH IN DELIVERY OF HOME**
20 **HEALTH SERVICES.**

21 Section 1895 (42 U.S.C. 1395fff) is amended by add-
22 ing at the end the following new subsection:

23 “(e) CONSTRUCTION RELATED TO HOME HEALTH
24 SERVICES.—

1 “(1) TELECOMMUNICATIONS.—Nothing in this
2 section shall be construed as preventing a home
3 health agency furnishing a home health unit of serv-
4 ice for which payment is made under the prospective
5 payment system established by this section for such
6 units of service from furnishing services via a tele-
7 communication system if such services—

8 “(A) do not substitute for in-person home
9 health services ordered as part of a plan of care
10 certified by a physician pursuant to section
11 1814(a)(2)(C) or section 1835(a)(2)(A); and

12 “(B) are not considered a home health
13 visit for purposes of eligibility or payment
14 under this title.

15 “(2) PHYSICIAN CERTIFICATION.—Nothing in
16 this section shall be construed as waiving the re-
17 quirement for a physician certification under section
18 1814(a)(2)(C) or section 1835(a)(2)(A) of such Act
19 (42 U.S.C. 1395f(a)(2)(C), 1395n(a)(2)(A)) for the
20 payment for home health services, whether or not
21 furnished via a telecommunications system.”.

1 **SEC. 505. STUDY ON COSTS TO HOME HEALTH AGENCIES**
2 **OF PURCHASING NONROUTINE MEDICAL**
3 **SUPPLIES.**

4 (a) STUDY.—The Comptroller General of the United
5 States shall conduct a study on variations in prices paid
6 by home health agencies furnishing home health services
7 under the medicare program under title XVIII of the So-
8 cial Security Act in purchasing nonroutine medical sup-
9 plies, including ostomy supplies, and volumes if such sup-
10 plies used, shall determine the effect (if any) of variations
11 on prices and volumes in the provision of such services.

12 (b) REPORT.—Not later than October 1, 2001, the
13 Comptroller General shall submit to Congress a report on
14 the study conducted under subsection (a), and shall in-
15 clude in the report recommendations respecting whether
16 payment for nonroutine medical supplies furnished in con-
17 nection with home health services should be made sepa-
18 rately from the prospective payment system for such serv-
19 ices.

20 **SEC. 506. TREATMENT OF BRANCH OFFICES; GAO STUDY**
21 **ON SUPERVISION OF HOME HEALTH CARE**
22 **PROVIDED IN ISOLATED RURAL AREAS.**

23 (a) TREATMENT OF BRANCH OFFICES.—

24 (1) IN GENERAL.—Notwithstanding any other
25 provision of law, in determining for purposes of title
26 XVIII of the Social Security Act whether an office

1 of a home health agency constitutes a branch office
2 or a separate home health agency, neither the time
3 nor distance between a parent office of the home
4 health agency and a branch office shall be the sole
5 determinant of a home health agency's branch office
6 status.

7 (2) CONSIDERATION OF FORMS OF TECH-
8 NOLOGY IN DEFINITION OF SUPERVISION.—The Sec-
9 retary of Health and Human Services may include
10 forms of technology in determining what constitutes
11 “supervision” for purposes of determining a home
12 health agency's branch office status under paragraph
13 (1).

14 (b) GAO STUDY.—

15 (1) STUDY.—The Comptroller General of the
16 United States shall conduct a study of the provision
17 of adequate supervision to maintain quality of home
18 health services delivered under the medicare pro-
19 gram under title XVIII of the Social Security Act in
20 isolated rural areas. The study shall evaluate the
21 methods that home health agency branches and
22 subunits use to maintain adequate supervision in the
23 delivery of services to clients residing in those areas,
24 how these methods of supervision compare to re-
25 quirements that subunits independently meet medi-

1 care conditions of participation, and the resources
2 utilized by subunits to meet such conditions.

3 (2) REPORT.—Not later than January 1, 2002,
4 the Comptroller General shall submit to Congress a
5 report on the study conducted under paragraph (1).
6 The report shall include recommendations on wheth-
7 er exceptions are needed for subunits and branches
8 of home health agencies under the medicare program
9 to maintain access to the home health benefit or
10 whether alternative policies should be developed to
11 assure adequate supervision and access and rec-
12 ommendations on whether a national standard for
13 supervision is appropriate.

14 **SEC. 507. CLARIFICATION OF THE HOMEBOUND DEFINI-**
15 **TION UNDER THE MEDICARE HOME HEALTH**
16 **BENEFIT.**

17 (a) CLARIFICATION.—

18 (1) IN GENERAL.—Sections 1814(a) and
19 1835(a) (42 U.S.C. 1395f(a) and 1395n(a)) are
20 each amended—

21 (A) in the last sentence, by striking “, and
22 that absences of the individual from home are
23 infrequent or of relatively short duration, or are
24 attributable to the need to receive medical
25 treatment”; and

1 (B) by adding at the end the following new
2 sentences: “Any absence of an individual from
3 the home attributable to the need to receive
4 health care treatment, including regular ab-
5 sences for the purpose of participating in thera-
6 peutic, psychosocial, or medical treatment in an
7 adult day-care program that is licensed or cer-
8 tified by a State, or accredited, to furnish adult
9 day-care services in the State shall not dis-
10 qualify an individual from being considered to
11 be ‘confined to his home’. Any other absence of
12 an individual from the home shall not so dis-
13 qualify an individual if the absence is of infre-
14 quent or of relatively short duration. For pur-
15 poses of the preceding sentence, any absence for
16 the purpose of attending a religious service
17 shall be deemed to be an absence of infrequent
18 or short duration.”.

19 (2) EFFECTIVE DATE.—The amendments made
20 by paragraph (1) shall apply to items and services
21 provided on or after the date of enactment of this
22 Act.

23 (b) STUDY.—

24 (1) IN GENERAL.—The Comptroller General of
25 the United States shall conduct an evaluation of the

1 effect of the amendment on the cost of and access
 2 to home health services under the medicare program
 3 under title XVIII of the Social Security Act.

4 (2) REPORT.—Not later than 1 year after the
 5 date of the enactment of this Act, the Comptroller
 6 General shall submit to Congress a report on the
 7 study conducted under paragraph (1).

8 **Subtitle B—Direct Graduate**
 9 **Medical Education**

10 **SEC. 511. INCREASE IN FLOOR FOR DIRECT GRADUATE**
 11 **MEDICAL EDUCATION PAYMENTS.**

12 Section 1886(h)(2)(D)(iii) (42 U.S.C.
 13 1395ww(h)(2)(D)(iii)) is amended—

14 (1) in the heading, by striking “IN FISCAL YEAR
 15 2001 AT 70 PERCENT OF” and inserting “FOR”; and

16 (2) by inserting after “70 percent” the fol-
 17 lowing: “, and for the cost reporting period begin-
 18 ning during fiscal year 2002 shall not be less than
 19 85 percent,”.

20 **SEC. 512. CHANGE IN DISTRIBUTION FORMULA FOR**
 21 **MEDICARE+CHOICE-RELATED NURSING AND**
 22 **ALLIED HEALTH EDUCATION COSTS.**

23 (a) IN GENERAL.—Section 1886(l)(2)(C) (42 U.S.C.
 24 1395ww(l)(2)(C)) is amended by striking all that follows

1 “multiplied by” and inserting the following: “the ratio
2 of—

3 “(i) the product of (I) the Secretary’s
4 estimate of the ratio of the amount of pay-
5 ments made under section 1861(v) to the
6 hospital for nursing and allied health edu-
7 cation activities for the hospital’s cost re-
8 porting period ending in the second pre-
9 ceding fiscal year, to the hospital’s total in-
10 patient days for such period, and (II) the
11 total number of inpatient days (as estab-
12 lished by the Secretary) for such period
13 which are attributable to services furnished
14 to individuals who are enrolled under a
15 risk sharing contract with an eligible orga-
16 nization under section 1876 and who are
17 entitled to benefits under part A or who
18 are enrolled with a Medicare+Choice orga-
19 nization under part C; to

20 “(ii) the sum of the products deter-
21 mined under clause (i) for such cost re-
22 porting periods.”.

23 (b) EFFECTIVE DATE.—The amendment made by
24 subsection (a) applies to portions of cost reporting periods
25 occurring on or after January 1, 2001.

1 **Subtitle C—Changes in Medicare**
2 **Coverage and Appeals Process**

3 **SEC. 521. REVISIONS TO MEDICARE APPEALS PROCESS.**

4 (a) CONDUCT OF RECONSIDERATIONS OF DETER-
5 MINATIONS BY INDEPENDENT CONTRACTORS.—Section
6 1869 (42 U.S.C. 1395ff) is amended to read as follows:

7 “DETERMINATIONS; APPEALS

8 “SEC. 1869. (a) INITIAL DETERMINATIONS.—

9 “(1) PROMULGATIONS OF REGULATIONS.—The
10 Secretary shall promulgate regulations and make ini-
11 tial determinations with respect to benefits under
12 part A or part B in accordance with those regula-
13 tions for the following:

14 “(A) The initial determination of whether
15 an individual is entitled to benefits under such
16 parts.

17 “(B) The initial determination of the
18 amount of benefits available to the individual
19 under such parts.

20 “(C) Any other initial determination with
21 respect to a claim for benefits under such parts,
22 including an initial determination by the Sec-
23 retary that payment may not be made, or may
24 no longer be made, for an item or service under
25 such parts, an initial determination made by a

1 utilization and quality control peer review orga-
2 nization under section 1154(a)(2), and an ini-
3 tial determination made by an entity pursuant
4 to a contract (other than a contract under sec-
5 tion 1852) with the Secretary to administer
6 provisions of this title or title XI.

7 “(2) DEADLINES FOR MAKING INITIAL DETER-
8 MINATIONS.—

9 “(A) IN GENERAL.—Subject to subpara-
10 graph (B), in promulgating regulations under
11 paragraph (1), initial determinations shall be
12 concluded by not later than the 45-day period
13 beginning on the date the fiscal intermediary or
14 the carrier, as the case may be, receives a claim
15 for benefits from an individual as described in
16 paragraph (1). Notice of such determination
17 shall be mailed to the individual filing the claim
18 before the conclusion of such 45-day period.

19 “(B) CLEAN CLAIMS.—Subparagraph (A)
20 shall not apply with respect to any claim that
21 is subject to the requirements of section
22 1816(c)(2) or section 1842(c)(2).

23 “(3) REDETERMINATIONS.—

24 “(A) IN GENERAL.—In promulgating regu-
25 lations under paragraph (1) with respect to ini-

1 tial determinations, such regulations shall pro-
2 vide for a fiscal intermediary or a carrier to
3 make a redetermination with respect to a claim
4 for benefits that is denied in whole or in part.

5 “(B) LIMITATIONS.—

6 “(i) APPEALS RIGHTS.—No initial de-
7 termination may be reconsidered or ap-
8 pealed under subsection (b) unless the fis-
9 cal intermediary or carrier has made a re-
10 determination of that initial determination
11 under this paragraph.

12 “(ii) DECISION MAKER.—No redeter-
13 mination may be made by any individual
14 involved in the initial determination.

15 “(C) DEADLINES.—

16 “(i) FILING FOR REDETERMINA-
17 TION.—A redetermination under subpara-
18 graph (A) shall be available only if notice
19 is filed with the Secretary to request the
20 redetermination by not later than the end
21 of the 120-day period beginning on the
22 date the individual receives notice of the
23 initial determination under paragraph (2).

24 “(ii) CONCLUDING REDETERMINATIONS.—

25 Redeterminations shall be concluded by not

1 later than the 30-day period beginning on the
2 date the fiscal intermediary or the carrier, as
3 the case may be, receives a request for a rede-
4 termination. Notice of such determination shall
5 be mailed to the individual filing the claim be-
6 fore the conclusion of such 30-day period.

7 “(D) CONSTRUCTION.—For purposes of
8 the succeeding provisions of this section a rede-
9 termination under this paragraph shall be con-
10 sidered to be part of the initial determination.

11 “(b) APPEAL RIGHTS.—

12 “(1) IN GENERAL.—

13 “(A) RECONSIDERATION OF INITIAL DE-
14 TERMINATION.—Subject to subparagraph (D),
15 any individual dissatisfied with any initial de-
16 termination under subsection (a)(1) shall be en-
17 titled to reconsideration of the determination,
18 and, subject to subparagraphs (D) and (E), a
19 hearing thereon by the Secretary to the same
20 extent as is provided in section 205(b) and to
21 judicial review of the Secretary’s final decision
22 after such hearing as is provided in section
23 205(g). For purposes of the preceding sentence,
24 any reference to the ‘Commissioner of Social
25 Security’ or the ‘Social Security Administration’

1 in subsection (g) or (l) of section 205 shall be
2 considered a reference to the ‘Secretary’ or the
3 ‘Department of Health and Human Services’,
4 respectively.

5 “(B) REPRESENTATION BY PROVIDER OR
6 SUPPLIER.—

7 “(i) IN GENERAL.—Sections 206(a),
8 1102, and 1871 shall not be construed as
9 authorizing the Secretary to prohibit an in-
10 dividual from being represented under this
11 section by a person that furnishes or sup-
12 plies the individual, directly or indirectly,
13 with services or items, solely on the basis
14 that the person furnishes or supplies the
15 individual with such a service or item.

16 “(ii) MANDATORY WAIVER OF RIGHT
17 TO PAYMENT FROM BENEFICIARY.—Any
18 person that furnishes services or items to
19 an individual may not represent an indi-
20 vidual under this section with respect to
21 the issue described in section 1879(a)(2)
22 unless the person has waived any rights for
23 payment from the beneficiary with respect
24 to the services or items involved in the ap-
25 peal.

1 “(iii) PROHIBITION ON PAYMENT FOR
2 REPRESENTATION.—If a person furnishes
3 services or items to an individual and rep-
4 resents the individual under this section,
5 the person may not impose any financial li-
6 ability on such individual in connection
7 with such representation.

8 “(iv) REQUIREMENTS FOR REP-
9 RESENTATIVES OF A BENEFICIARY.—The
10 provisions of section 205(j) and section
11 206 (other than subsection (a)(4) of such
12 section) regarding representation of claim-
13 ants shall apply to representation of an in-
14 dividual with respect to appeals under this
15 section in the same manner as they apply
16 to representation of an individual under
17 those sections.

18 “(C) SUCCESSION OF RIGHTS IN CASES OF
19 ASSIGNMENT.—The right of an individual to an
20 appeal under this section with respect to an
21 item or service may be assigned to the provider
22 of services or supplier of the item or service
23 upon the written consent of such individual
24 using a standard form established by the Sec-
25 retary for such an assignment.

1 “(D) TIME LIMITS FOR FILING APPEALS.—

2 “(i) RECONSIDERATIONS.—Reconsid-
3 eration under subparagraph (A) shall be
4 available only if the individual described in
5 subparagraph (A) files notice with the Sec-
6 retary to request reconsideration by not
7 later than the end of the 180-day period
8 beginning on the date the individual re-
9 ceives notice of the redetermination under
10 subsection (a)(3), or within such additional
11 time as the Secretary may allow.

12 “(ii) HEARINGS CONDUCTED BY THE
13 SECRETARY.—The Secretary shall establish
14 in regulations time limits for the filing of
15 a request for a hearing by the Secretary in
16 accordance with provisions in sections 205
17 and 206.

18 “(E) AMOUNTS IN CONTROVERSY.—

19 “(i) IN GENERAL.—A hearing (by the
20 Secretary) shall not be available to an indi-
21 vidual under this section if the amount in
22 controversy is less than \$100, and judicial
23 review shall not be available to the indi-
24 vidual if the amount in controversy is less
25 than \$1,000.

1 “(ii) AGGREGATION OF CLAIMS.—In
2 determining the amount in controversy, the
3 Secretary, under regulations, shall allow
4 two or more appeals to be aggregated if
5 the appeals involve—

6 “(I) the delivery of similar or re-
7 lated services to the same individual
8 by one or more providers of services
9 or suppliers, or

10 “(II) common issues of law and
11 fact arising from services furnished to
12 two or more individuals by one or
13 more providers of services or sup-
14 pliers.

15 “(F) EXPEDITED PROCEEDINGS.—

16 “(i) EXPEDITED DETERMINATION.—
17 In the case of an individual who has re-
18 ceived notice by a provider of services that
19 the provider of services plans—

20 “(I) to terminate services pro-
21 vided to an individual and a physician
22 certifies that failure to continue the
23 provision of such services is likely to
24 place the individual’s health at signifi-
25 cant risk, or

1 “(II) to discharge the individual
2 from the provider of services,
3 the individual may request, in writing or
4 orally, an expedited determination or an
5 expedited reconsideration of an initial de-
6 termination made under subsection (a)(1),
7 as the case may be, and the Secretary shall
8 provide such expedited determination or
9 expedited reconsideration.

10 “(ii) EXPEDITED HEARING.—In a
11 hearing by the Secretary under this sec-
12 tion, in which the moving party alleges
13 that no material issues of fact are in dis-
14 pute, the Secretary shall make an expe-
15 dited determination as to whether any such
16 facts are in dispute and, if not, shall
17 render a decision expeditiously.

18 “(G) REOPENING AND REVISION OF DE-
19 TERMINATIONS.—The Secretary may reopen or
20 revise any initial determination or reconsidered
21 determination described in this subsection
22 under guidelines established by the Secretary in
23 regulations.

24 “(c) CONDUCT OF RECONSIDERATIONS BY INDE-
25 PENDENT CONTRACTORS.—

1 “(1) IN GENERAL.—The Secretary shall enter
2 into contracts with qualified independent contractors
3 to conduct reconsiderations of initial determinations
4 made under subparagraphs (B) and (C) of sub-
5 section (a)(1). Contracts shall be for an initial term
6 of three years and shall be renewable on a triennial
7 basis thereafter.

8 “(2) QUALIFIED INDEPENDENT CON-
9 TRACTOR.—For purposes of this subsection, the
10 term ‘qualified independent contractor’ means an en-
11 tity or organization that is independent of any orga-
12 nization under contract with the Secretary that
13 makes initial determinations under subsection
14 (a)(1), and that meets the requirements established
15 by the Secretary consistent with paragraph (3).

16 “(3) REQUIREMENTS.—Any qualified inde-
17 pendent contractor entering into a contract with the
18 Secretary under this subsection shall meet the all of
19 the following requirements:

20 “(A) IN GENERAL.—The qualified inde-
21 pendent contractor shall perform such duties
22 and functions and assume such responsibilities
23 as may be required by the Secretary to carry
24 out the provisions of this subsection, and shall
25 have sufficient training and expertise in medical

1 science and legal matters to make reconsider-
2 ations under this subsection.

3 “(B) RECONSIDERATIONS.—

4 “(i) IN GENERAL.—The qualified
5 independent contractor shall review initial
6 determinations. In the case an initial de-
7 termination made with respect to whether
8 an item or service is reasonable and nec-
9 essary for the diagnosis or treatment of ill-
10 ness or injury (under section
11 1862(a)(1)(A)), such review shall include
12 consideration of the facts and cir-
13 cumstances of the initial determination by
14 a panel of physicians or other appropriate
15 health care professionals and any decisions
16 with respect to the reconsideration shall be
17 based on applicable information, including
18 clinical experience and medical, technical,
19 and scientific evidence.

20 “(ii) EFFECT OF NATIONAL AND
21 LOCAL COVERAGE DETERMINATIONS.—

22 “(I) NATIONAL COVERAGE DE-
23 TERMINATIONS.—If the Secretary has
24 made a national coverage determina-
25 tion pursuant to the requirements es-

1 tablished under the third sentence of
2 section 1862(a), such determination
3 shall be binding on the qualified inde-
4 pendent contractor in making a deci-
5 sion with respect to a reconsideration
6 under this section.

7 “(II) LOCAL COVERAGE DETER-
8 MINATIONS.—If the Secretary has
9 made a local coverage determination,
10 such determination shall not be bind-
11 ing on the qualified independent con-
12 tractor in making a decision with re-
13 spect to a reconsideration under this
14 section. Notwithstanding the previous
15 sentence, the qualified independent
16 contractor shall consider the local cov-
17 erage determination in making such
18 decision.

19 “(III) ABSENCE OF NATIONAL OR
20 LOCAL COVERAGE DETERMINATION.—
21 In the absence of such a national cov-
22 erage determination or local coverage
23 determination, the qualified inde-
24 pendent contractor shall make a deci-
25 sion with respect to the reconsider-

1 ation based on applicable information,
2 including clinical experience and med-
3 ical, technical, and scientific evidence.

4 “(C) DEADLINES FOR DECISIONS.—

5 “(i) RECONSIDERATIONS.—Except as
6 provided in clauses (iii) and (iv), the quali-
7 fied independent contractor shall conduct
8 and conclude a reconsideration under sub-
9 paragraph (B), and mail the notice of the
10 decision with respect to the reconsideration
11 by not later than the end of the 30-day pe-
12 riod beginning on the date a request for
13 reconsideration has been timely filed.

14 “(ii) CONSEQUENCES OF FAILURE TO
15 MEET DEADLINE.—In the case of a failure
16 by the qualified independent contractor to
17 mail the notice of the decision by the end
18 of the period described in clause (i) or to
19 provide notice by the end of the period de-
20 scribed in clause (iii), as the case may be,
21 the party requesting the reconsideration or
22 appeal may request a hearing before the
23 Secretary, notwithstanding any require-
24 ments for a reconsidered determination for

1 purposes of the party's right to such hear-
2 ing.

3 “(iii) EXPEDITED RECONSIDER-
4 ATIONS.—The qualified independent con-
5 tractor shall perform an expedited recon-
6 sideration under subsection (b)(1)(F) as
7 follows:

8 “(I) DEADLINE FOR DECISION.—

9 Notwithstanding section 216(j) and
10 subject to clause (iv), not later than
11 the end of the 72-hour period begin-
12 ning on the date the qualified inde-
13 pendent contractor has received a re-
14 quest for such reconsideration and has
15 received such medical or other records
16 needed for such reconsideration, the
17 qualified independent contractor shall
18 provide notice (by telephone and in
19 writing) to the individual and the pro-
20 vider of services and attending physi-
21 cian of the individual of the results of
22 the reconsideration. Such reconsider-
23 ation shall be conducted regardless of
24 whether the provider of services or
25 supplier will charge the individual for

1 continued services or whether the indi-
2 vidual will be liable for payment for
3 such continued services.

4 “(II) CONSULTATION WITH BEN-
5 EFICIARY.—In such reconsideration,
6 the qualified independent contractor
7 shall solicit the views of the individual
8 involved.

9 “(III) SPECIAL RULE FOR HOS-
10 PITAL DISCHARGES.—A reconsider-
11 ation of a discharge from a hospital
12 shall be conducted under this clause
13 in accordance with the provisions of
14 paragraphs (2), (3), and (4) of section
15 1154(e) as in effect on the date that
16 precedes the date of the enactment of
17 this subparagraph.

18 “(iv) EXTENSION.—An individual re-
19 questing a reconsideration under this sub-
20 paragraph may be granted such additional
21 time as the individual specifies (not to ex-
22 ceed 14 days) for the qualified independent
23 contractor to conclude the reconsideration.
24 The individual may request such additional
25 time in orally or in writing.

1 “(D) LIMITATION ON INDIVIDUAL REVIEW-
2 ING DETERMINATIONS.—

3 “(i) PHYSICIANS AND HEALTH CARE
4 PROFESSIONAL.—No physician or health
5 care professional under the employ of a
6 qualified independent contractor may
7 review—

8 “(I) determinations regarding
9 health care services furnished to a pa-
10 tient if the physician or health care
11 professional was directly responsible
12 for furnishing such services; or

13 “(II) determinations regarding
14 health care services provided in or by
15 an institution, organization, or agen-
16 cy, if the physician or any member of
17 the family of the physician or health
18 care professional has, directly or indi-
19 rectly, a significant financial interest
20 in such institution, organization, or
21 agency.

22 “(ii) FAMILY DESCRIBED.—For pur-
23 poses of this paragraph, the family of a
24 physician or health care professional in-
25 cludes the spouse (other than a spouse who

1 is legally separated from the physician or
2 health care professional under a decree of
3 divorce or separate maintenance), children
4 (including stepchildren and legally adopted
5 children), grandchildren, parents, and
6 grandparents of the physician or health
7 care professional.

8 “(E) EXPLANATION OF DECISION.—Any
9 decision with respect to a reconsideration of a
10 qualified independent contractor shall be in
11 writing, and shall include a detailed explanation
12 of the decision as well as a discussion of the
13 pertinent facts and applicable regulations ap-
14 plied in making such decision, and in the case
15 of a determination of whether an item or serv-
16 ice is reasonable and necessary for the diag-
17 nosis or treatment of illness or injury (under
18 section 1862(a)(1)(A)) an explanation of the
19 medical and scientific rational for the decision.

20 “(F) NOTICE REQUIREMENTS.—Whenever
21 a qualified independent contractor makes a de-
22 cision with respect to a reconsideration under
23 this subsection, the qualified independent con-
24 tractor shall promptly notify the entity respon-

1 sible for the payment of claims under part A or
2 part B of such decision.

3 “(G) DISSEMINATION OF DECISIONS ON
4 RECONSIDERATIONS.—Each qualified inde-
5 pendent contractor shall make available all deci-
6 sions with respect to reconsiderations of such
7 qualified independent contractors to fiscal inter-
8 mediaries (under section 1816), carriers (under
9 section 1842), peer review organizations (under
10 part B of title XI), Medicare+Choice organiza-
11 tions offering Medicare+Choice plans under
12 part C, other entities under contract with the
13 Secretary to make initial determinations under
14 part A or part B or title XI, and to the public.
15 The Secretary shall establish a methodology
16 under which qualified independent contractors
17 shall carry out this subparagraph.

18 “(H) ENSURING CONSISTENCY IN DECI-
19 SIONS.—Each qualified independent contractor
20 shall monitor its decisions with respect to re-
21 considerations to ensure the consistency of such
22 decisions with respect to requests for reconsid-
23 eration of similar or related matters.

24 “(I) DATA COLLECTION.—

1 “(i) IN GENERAL.—Consistent with
2 the requirements of clause (ii), a qualified
3 independent contractor shall collect such
4 information relevant to its functions, and
5 keep and maintain such records in such
6 form and manner as the Secretary may re-
7 quire to carry out the purposes of this sec-
8 tion and shall permit access to and use of
9 any such information and records as the
10 Secretary may require for such purposes.

11 “(ii) TYPE OF DATA COLLECTED.—
12 Each qualified independent contractor
13 shall keep accurate records of each deci-
14 sion made, consistent with standards es-
15 tablished by the Secretary for such pur-
16 pose. Such records shall be maintained in
17 an electronic database in a manner that
18 provides for identification of the following:

19 “(I) Specific claims that give rise
20 to appeals.

21 “(II) Situations suggesting the
22 need for increased education for pro-
23 viders of services, physicians, or sup-
24 pliers.

1 “(III) Situations suggesting the
2 need for changes in national or local
3 coverage policy.

4 “(IV) Situations suggesting the
5 need for changes in local medical re-
6 view policies.

7 “(iii) ANNUAL REPORTING.—Each
8 qualified independent contractor shall sub-
9 mit annually to the Secretary (or otherwise
10 as the Secretary may request) records
11 maintained under this paragraph for the
12 previous year.

13 “(J) HEARINGS BY THE SECRETARY.—The
14 qualified independent contractor shall (i) pre-
15 pare such information as is required for an ap-
16 peal of a decision of the contractor with respect
17 to a reconsideration to the Secretary for a hear-
18 ing, including as necessary, explanations of
19 issues involved in the decision and relevant poli-
20 cies, and (ii) participate in such hearings as re-
21 quired by the Secretary.

22 “(4) NUMBER OF QUALIFIED INDEPENDENT
23 CONTRACTORS.—The Secretary shall enter into con-
24 tracts with not fewer than 12 qualified independent
25 contractors under this subsection.

1 “(5) LIMITATION ON QUALIFIED INDEPENDENT
2 CONTRACTOR LIABILITY.—No qualified independent
3 contractor having a contract with the Secretary
4 under this subsection and no person who is em-
5 ployed by, or who has a fiduciary relationship with,
6 any such qualified independent contractor or who
7 furnishes professional services to such qualified inde-
8 pendent contractor, shall be held by reason of the
9 performance of any duty, function, or activity re-
10 quired or authorized pursuant to this subsection or
11 to a valid contract entered into under this sub-
12 section, to have violated any criminal law, or to be
13 civilly liable under any law of the United States or
14 of any State (or political subdivision thereof) pro-
15 vided due care was exercised in the performance of
16 such duty, function, or activity.

17 “(d) DEADLINES FOR HEARINGS BY THE SEC-
18 RETARY.—

19 “(1) HEARING BY ADMINISTRATIVE LAW
20 JUDGE.—

21 “(A) IN GENERAL.—Except as provided in
22 subparagraph (B), an administrative law judge
23 shall conduct and conclude a hearing on a deci-
24 sion of a qualified independent contractor under
25 subsection (c) and render a decision on such

1 hearing by not later than the end of the 90-day
2 period beginning on the date a request for hear-
3 ing has been timely filed.

4 “(B) WAIVER OF DEADLINE BY PARTY
5 SEEKING HEARING.—The 90-day period under
6 subparagraph (A) shall not apply in the case of
7 a motion or stipulation by the party requesting
8 the hearing to waive such period.

9 “(2) DEPARTMENTAL APPEALS BOARD RE-
10 VIEW.—

11 “(A) IN GENERAL.—The Departmental
12 Appeals Board of the Department of Health
13 and Human Services shall conduct and conclude
14 a review of the decision on a hearing described
15 in paragraph (1) and make a decision or re-
16 mand the case to the administrative law judge
17 for reconsideration by not later than the end of
18 the 90-day period beginning on the date a re-
19 quest for review has been timely filed.

20 “(B) DAB HEARING PROCEDURE.—In re-
21 viewing a decision on a hearing under this para-
22 graph, the Departmental Appeals Board shall
23 review the case de novo.

24 “(3) CONSEQUENCES OF FAILURE TO MEET
25 DEADLINES.—

1 “(A) HEARING BY ADMINISTRATIVE LAW
2 JUDGE.—In the case of a failure by an adminis-
3 trative law judge to render a decision by the
4 end of the period described in paragraph (1),
5 the party requesting the hearing may request a
6 review by the Departmental Appeals Board of
7 the Department of Health and Human Services,
8 notwithstanding any requirements for a hearing
9 for purposes of the party’s right to such a re-
10 view.

11 “(B) DEPARTMENTAL APPEALS BOARD RE-
12 VIEW.—In the case of a failure by the Depart-
13 mental Appeals Board to render a decision by
14 the end of the period described in paragraph
15 (2), the party requesting the hearing may seek
16 judicial review, notwithstanding any require-
17 ments for a hearing for purposes of the party’s
18 right to such judicial review.

19 “(e) ADMINISTRATIVE PROVISIONS.—

20 “(1) LIMITATION ON REVIEW OF CERTAIN REG-
21 ULATIONS.—A regulation or instruction that relates
22 to a method for determining the amount of payment
23 under part B and that was initially issued before
24 January 1, 1981, shall not be subject to judicial re-
25 view.

1 “(2) OUTREACH.—The Secretary shall perform
2 such outreach activities as are necessary to inform
3 individuals entitled to benefits under this title and
4 providers of services and suppliers with respect to
5 their rights of, and the process for, appeals made
6 under this section. The Secretary shall use the toll-
7 free telephone number maintained by the Secretary
8 under section 1804(b) to provide information re-
9 garding appeal rights and respond to inquiries re-
10 garding the status of appeals.

11 “(3) CONTINUING EDUCATION REQUIREMENT
12 FOR QUALIFIED INDEPENDENT CONTRACTORS AND
13 ADMINISTRATIVE LAW JUDGES.—The Secretary shall
14 provide to each qualified independent contractor,
15 and, in consultation with the Commissioner of Social
16 Security, to administrative law judges that decide
17 appeals of reconsiderations of initial determinations
18 or other decisions or determinations under this sec-
19 tion, such continuing education with respect to cov-
20 erage of items and services under this title or poli-
21 cies of the Secretary with respect to part B of title
22 XI as is necessary for such qualified independent
23 contractors and administrative law judges to make
24 informed decisions with respect to appeals.

25 “(4) REPORTS.—

1 “(A) ANNUAL REPORT TO CONGRESS.—

2 The Secretary shall submit to Congress an an-
3 nual report describing the number of appeals
4 for the previous year, identifying issues that re-
5 quire administrative or legislative actions, and
6 including any recommendations of the Secretary
7 with respect to such actions. The Secretary
8 shall include in such report an analysis of de-
9 terminations by qualified independent contrac-
10 tors with respect to inconsistent decisions and
11 an analysis of the causes of any such inconsis-
12 tencies.

13 “(B) SURVEY.—Not less frequently than
14 every 5 years, the Secretary shall conduct a
15 survey of a valid sample of individuals entitled
16 to benefits under this title who have filed ap-
17 peals of determinations under this section, pro-
18 viders of services, and suppliers to determine
19 the satisfaction of such individuals or entities
20 with the process for appeals of determinations
21 provided for under this section and education
22 and training provided by the Secretary with re-
23 spect to that process. The Secretary shall sub-
24 mit to Congress a report describing the results
25 of the survey, and shall include any rec-

1 ommendations for administrative or legislative
2 actions that the Secretary determines appro-
3 priate.”.

4 (b) **APPLICABILITY OF REQUIREMENTS AND LIMITA-**
5 **TIONS ON LIABILITY OF QUALIFIED INDEPENDENT CON-**
6 **TRACTORS TO MEDICARE+CHOICE INDEPENDENT AP-**
7 **PEALS CONTRACTORS.**—Section 1852(g)(4) (42 U.S.C.
8 1395w–22(g)(4)) is amended by adding at the end the fol-
9 lowing: “The provisions of section 1869(c)(5) shall apply
10 to independent outside entities under contract with the
11 Secretary under this paragraph.”.

12 (c) **CONFORMING AMENDMENT.**—Section 1154(e)
13 (42 U.S.C. 1320c–3(e)) is amended by striking para-
14 graphs (2), (3), and (4).

15 (d) **EFFECTIVE DATE.**—The amendments made by
16 this section apply with respect to initial determinations
17 made on or after October 1, 2002.

18 **SEC. 522. REVISIONS TO MEDICARE COVERAGE PROCESS.**

19 (a) **REVIEW OF DETERMINATIONS.**—Section 1869
20 (42 U.S.C. 1395ff), as amended by section 521, is further
21 amended by adding at the end the following new sub-
22 section:

23 “(f) **REVIEW OF COVERAGE DETERMINATIONS.**—

24 “(1) **NATIONAL COVERAGE DETERMINATIONS.**—

1 “(A) IN GENERAL.—Review of any na-
2 tional coverage determination shall be subject to
3 the following limitations:

4 “(i) Such a determination shall not be
5 reviewed by any administrative law judge.

6 “(ii) Such a determination shall not
7 be held unlawful or set aside on the ground
8 that a requirement of section 553 of title
9 5, United States Code, or section 1871(b)
10 of this title, relating to publication in the
11 Federal Register or opportunity for public
12 comment, was not satisfied.

13 “(iii) Upon the filing of a complaint
14 by an aggrieved party, such a determina-
15 tion shall be reviewed by the Departmental
16 Appeals Board of the Department of
17 Health and Human Services. In con-
18 ducting such a review, the Departmental
19 Appeals Board shall review the record and
20 shall permit discovery and the taking of
21 evidence to evaluate the reasonableness of
22 the determination, if the Board determines
23 that the record is incomplete or lacks ade-
24 quate information to support the validity
25 of the determination. In reviewing such a

1 determination, the Departmental Appeals
2 Board shall defer only to the reasonable
3 findings of fact, reasonable interpretations
4 of law, and reasonable applications of fact
5 to law by the Secretary.

6 “(iv) A decision of the Departmental
7 Appeals Board constitutes a final agency
8 action and is subject to judicial review.

9 “(B) DEFINITION OF NATIONAL COVERAGE
10 DETERMINATION.—For purposes of this section,
11 the term ‘national coverage determination’
12 means a determination by the Secretary with
13 respect to whether or not a particular item or
14 service is covered nationally under this title, but
15 does not include a determination of what code,
16 if any, is assigned to a particular item or serv-
17 ice covered under this title or a determination
18 with respect to the amount of payment made
19 for a particular item or service so covered.

20 “(2) LOCAL COVERAGE DETERMINATION.—

21 “(A) IN GENERAL.—Review of any local
22 coverage determination shall be subject to the
23 following limitations:

24 “(i) Upon the filing of a complaint by
25 an aggrieved party, such a determination

1 shall be reviewed by an administrative law
2 judge of the Social Security Administra-
3 tion. The administrative law judge shall re-
4 view the record and shall permit discovery
5 and the taking of evidence to evaluate the
6 reasonableness of the determination, if the
7 administrative law judge determines that
8 the record is incomplete or lacks adequate
9 information to support the validity of the
10 determination. In reviewing such a deter-
11 mination, the administrative law judge
12 shall defer only to the reasonable findings
13 of fact, reasonable interpretations of law,
14 and reasonable applications of fact to law
15 by the Secretary.

16 “(ii) Upon the filing of a complaint by
17 an aggrieved party, a decision of an admin-
18 istrative law judge under clause (i) shall be
19 reviewed by the Departmental Appeals
20 Board of the Department of Health and
21 Human Services.

22 “(iii) A decision of the Departmental
23 Appeals Board constitutes a final agency
24 action and is subject to judicial review.

1 “(B) DEFINITION OF LOCAL COVERAGE
2 DETERMINATION.—For purposes of this section,
3 the term ‘local coverage determination’ means a
4 determination by a fiscal intermediary or a car-
5 rier under part A or part B, as applicable, re-
6 specting whether or not a particular item or
7 service is covered on an intermediary- or car-
8 rier-wide basis under such parts, in accordance
9 with section 1862(a)(1)(A).

10 “(3) NO MATERIAL ISSUES OF FACT IN DIS-
11 PUTE.—In the case of a determination that may oth-
12 erwise be subject to review under paragraph
13 (1)(A)(iii) or paragraph (2)(A)(i), where the moving
14 party alleges that—

15 “(A) there are no material issues of fact in
16 dispute, and

17 “(B) the only issue of law is the constitu-
18 tionality of a provision of this title, or that a
19 regulation, determination, or ruling by the Sec-
20 retary is invalid,

21 the moving party may seek review by a court of com-
22 petent jurisdiction without filing a complaint under
23 such paragraph and without otherwise exhausting
24 other administrative remedies.

1 “(4) PENDING NATIONAL COVERAGE DETER-
2 MINATIONS.—

3 “(A) IN GENERAL.—In the event the Sec-
4 retary has not issued a national coverage or
5 noncoverage determination with respect to a
6 particular type or class of items or services, an
7 aggrieved person (as described in paragraph
8 (5)) may submit to the Secretary a request to
9 make such a determination with respect to such
10 items or services. By not later than the end of
11 the 90-day period beginning on the date the
12 Secretary receives such a request (notwith-
13 standing the receipt by the Secretary of new
14 evidence (if any) during such 90-day period),
15 the Secretary shall take one of the following ac-
16 tions:

17 “(i) Issue a national coverage deter-
18 mination, with or without limitations.

19 “(ii) Issue a national noncoverage de-
20 termination.

21 “(iii) Issue a determination that no
22 national coverage or noncoverage deter-
23 mination is appropriate as of the end of
24 such 90-day period with respect to national
25 coverage of such items or services.

1 “(iv) Issue a notice that states that
2 the Secretary has not completed a review
3 of the request for a national coverage de-
4 termination and that includes an identi-
5 fication of the remaining steps in the Sec-
6 retary’s review process and a deadline by
7 which the Secretary will complete the re-
8 view and take an action described in sub-
9 clause (I), (II), or (III).

10 “(B) In the case of an action described in
11 clause (i)(IV), if the Secretary fails to take an
12 action referred to in such clause by the deadline
13 specified by the Secretary under such clause,
14 then the Secretary is deemed to have taken an
15 action described in clause (i)(III) as of the
16 deadline.

17 “(C) When issuing a determination under
18 clause (i), the Secretary shall include an expla-
19 nation of the basis for the determination. An
20 action taken under clause (i) (other than sub-
21 clause (IV)) is deemed to be a national coverage
22 determination for purposes of review under sub-
23 paragraph (A).

24 “(5) STANDING.—An action under this sub-
25 section seeking review of a national coverage deter-

1 mination or local coverage determination may be ini-
2 tiated only by individuals entitled to benefits under
3 part A, or enrolled under part B, or both, who are
4 in need of the items or services that are the subject
5 of the coverage determination.

6 “(6) PUBLICATION ON THE INTERNET OF DECI-
7 SIONS OF HEARINGS OF THE SECRETARY.—Each de-
8 cision of a hearing by the Secretary with respect to
9 a national coverage determination shall be made
10 public, and the Secretary shall publish each decision
11 on the Medicare Internet site of the Department of
12 Health and Human Services. The Secretary shall re-
13 move from such decision any information that would
14 identify any individual, provider of services, or sup-
15 plier.

16 “(7) ANNUAL REPORT ON NATIONAL COVERAGE
17 DETERMINATIONS.—

18 “(A) IN GENERAL.—Not later than De-
19 cember 1 of each year, beginning in 2001, the
20 Secretary shall submit to Congress a report
21 that sets forth a detailed compilation of the ac-
22 tual time periods that were necessary to com-
23 plete and fully implement national coverage de-
24 terminations that were made in the previous fis-
25 cal year for items, services, or medical devices

1 not previously covered as a benefit under this
2 title, including, with respect to each new item,
3 service, or medical device, a statement of the
4 time taken by the Secretary to make and imple-
5 ment the necessary coverage, coding, and pay-
6 ment determinations, including the time taken
7 to complete each significant step in the process
8 of making and implementing such determina-
9 tions.

10 “(B) PUBLICATION OF REPORTS ON THE
11 INTERNET.—The Secretary shall publish each
12 report submitted under clause (i) on the medi-
13 care Internet site of the Department of Health
14 and Human Services.

15 “(8) CONSTRUCTION.—Nothing in this sub-
16 section shall be construed as permitting administra-
17 tive or judicial review pursuant to this section inso-
18 far as such review is explicitly prohibited or re-
19 stricted under another provision of law.”.

20 (b) ESTABLISHMENT OF A PROCESS FOR COVERAGE
21 DETERMINATIONS.—Section 1862(a) (42 U.S.C.
22 1395y(a)) is amended by adding at the end the following
23 new sentence: “In making a national coverage determina-
24 tion (as defined in paragraph (1)(B) of section 1869(f))
25 the Secretary shall ensure that the public is afforded no-

1 tice and opportunity to comment prior to implementation
2 by the Secretary of the determination; meetings of advi-
3 sory committees established under section 1114(f) with re-
4 spect to the determination are made on the record; in
5 making the determination, the Secretary has considered
6 applicable information (including clinical experience and
7 medical, technical, and scientific evidence) with respect to
8 the subject matter of the determination; and in the deter-
9 mination, provide a clear statement of the basis for the
10 determination (including responses to comments received
11 from the public), the assumptions underlying that basis,
12 and make available to the public the data (other than pro-
13 prietary data) considered in making the determination.”.

14 (c) IMPROVEMENTS TO THE MEDICARE ADVISORY
15 COMMITTEE PROCESS.—Section 1114 (42 U.S.C. 1314)
16 is amended by adding at the end the following new sub-
17 section:

18 “(i)(1) Any advisory committee appointed under sub-
19 section (f) to advise the Secretary on matters relating to
20 the interpretation, application, or implementation of sec-
21 tion 1862(a)(1) shall assure the full participation of a
22 nonvoting member in the deliberations of the advisory
23 committee, and shall provide such nonvoting member ac-
24 cess to all information and data made available to voting

1 members of the advisory committee, other than informa-
2 tion that—

3 “(A) is exempt from disclosure pursuant to sub-
4 section (a) of section 552 of title 5, United States
5 Code, by reason of subsection (b)(4) of such section
6 (relating to trade secrets); or

7 “(B) the Secretary determines would present a
8 conflict of interest relating to such nonvoting mem-
9 ber.

10 “(2) If an advisory committee described in paragraph
11 (1) organizes into panels of experts according to types of
12 items or services considered by the advisory committee,
13 any such panel of experts may report any recommendation
14 with respect to such items or services directly to the Sec-
15 retary without the prior approval of the advisory com-
16 mittee or an executive committee thereof.”.

17 (d) EFFECTIVE DATE.—The amendments made by
18 this section apply with respect to—

19 (1) a review of any national or local coverage
20 determination filed,

21 (2) a request to make such a determination
22 made,

23 (3) a national coverage determination made,
24 on or after October 1, 2001.

1 **Subtitle D—Improving Access to**
2 **New Technologies**

3 **SEC. 531. REIMBURSEMENT IMPROVEMENTS FOR NEW**
4 **CLINICAL LABORATORY TESTS AND DURA-**
5 **BLE MEDICAL EQUIPMENT.**

6 (a) PAYMENT RULE FOR NEW LABORATORY
7 TESTS.—Section 1833(h)(4)(B)(viii) (42 U.S.C.
8 1395l(h)(4)(B)(viii)) is amended by inserting before the
9 period at the end the following: “(or 100 percent of such
10 median in the case of a clinical diagnostic laboratory test
11 performed on or after January 1, 2001, that the Secretary
12 determines is a new test for which no limitation amount
13 has previously been established under this subpara-
14 graph)”.

15 (b) ESTABLISHMENT OF CODING AND PAYMENT
16 PROCEDURES FOR NEW CLINICAL DIAGNOSTIC LABORA-
17 TORY TESTS AND OTHER ITEMS ON A FEE SCHEDULE.—
18 Not later than 1 year after the date of the enactment of
19 this Act, the Secretary of Health and Human Services
20 shall establish procedures for coding and payment deter-
21 minations for the categories of new clinical diagnostic lab-
22 oratory tests and new durable medical equipment under
23 part B of the title XVIII of the Social Security Act that
24 permit public consultation in a manner consistent with the

1 procedures established for implementing coding modifica-
2 tions for ICD–9–CM.

3 (c) REPORT ON PROCEDURES USED FOR ADVANCED,
4 IMPROVED TECHNOLOGIES.—Not later than 1 year after
5 the date of the enactment of this Act, the Secretary of
6 Health and Human Services shall submit to Congress a
7 report that identifies the specific procedures used by the
8 Secretary under part B of title XVIII of the Social Secu-
9 rity Act to adjust payments for clinical diagnostic labora-
10 tory tests and durable medical equipment which are classi-
11 fied to existing codes where, because of an advance in
12 technology with respect to the test or equipment, there has
13 been a significant increase or decrease in the resources
14 used in the test or in the manufacture of the equipment,
15 and there has been a significant improvement in the per-
16 formance of the test or equipment. The report shall in-
17 clude such recommendations for changes in law as may
18 be necessary to assure fair and appropriate payment levels
19 under such part for such improved tests and equipment
20 as reflects increased costs necessary to produce improved
21 results.

22 **SEC. 532. RETENTION OF HCPCS LEVEL III CODES.**

23 (a) IN GENERAL.—The Secretary of Health and
24 Human Services shall maintain and continue the use of
25 level III codes of the HCPCS coding system (as such sys-

1 tem was in effect on August 16, 2000) through December
2 31, 2003, and shall make such codes available to the pub-
3 lic.

4 (b) DEFINITION.—For purposes of this section, the
5 term “HCPCS Level III codes” means the alphanumeric
6 codes for local use under the Health Care Financing Ad-
7 ministration Common Procedure Coding System
8 (HCPCS).

9 **SEC. 533. RECOGNITION OF NEW MEDICAL TECHNOLOGIES**
10 **UNDER INPATIENT HOSPITAL PPS.**

11 (a) EXPEDITING RECOGNITION OF NEW TECH-
12 NOLOGIES INTO INPATIENT PPS CODING SYSTEM.—

13 (1) REPORT.—Not later than April 1, 2001, the
14 Secretary of Health and Human Services shall sub-
15 mit to Congress a report on methods of expeditiously
16 incorporating new medical services and technologies
17 into the clinical coding system used with respect to
18 payment for inpatient hospital services furnished
19 under the medicare program under title XVIII of the
20 Social Security Act, together with a detailed descrip-
21 tion of the Secretary’s preferred methods to achieve
22 this purpose.

23 (2) IMPLEMENTATION.—Not later than October
24 1, 2001, the Secretary shall implement the preferred

1 methods described in the report transmitted pursu-
2 ant to paragraph (1).

3 (b) ENSURING APPROPRIATE PAYMENTS FOR HOS-
4 PITALS INCORPORATING NEW MEDICAL SERVICES AND
5 TECHNOLOGIES.—

6 (1) ESTABLISHMENT OF MECHANISM.—Section
7 1886(d)(5) (42 U.S.C. 1395ww(d)(5)) is amended
8 by adding at the end the following new subpara-
9 graphs:

10 “(K)(i) Effective for discharges beginning on or after
11 October 1, 2001, the Secretary shall establish a mecha-
12 nism to recognize the costs of new medical services and
13 technologies under the payment system established under
14 this subsection. Such mechanism shall be established after
15 notice and opportunity for public comment (in the publica-
16 tions required by subsection (e)(5) for a fiscal year or oth-
17 erwise).

18 “(ii) The mechanism established pursuant to clause
19 (i) shall—

20 “(I) apply to a new medical service or tech-
21 nology if, based on the estimated costs incurred with
22 respect to discharges involving such service or tech-
23 nology, the DRG prospective payment rate otherwise
24 applicable to such discharges under this subsection
25 is inadequate;

1 “(II) provide for the collection of data with re-
2 spect to the costs of a new medical service or tech-
3 nology described in subclause (I) for a period of not
4 less than two years and not more than three years
5 beginning on the date on which an inpatient hospital
6 code is issued with respect to the service or tech-
7 nology;

8 “(III) subject to paragraph (4)(C)(iii), provide
9 for additional payment to be made under this sub-
10 section with respect to discharges involving a new
11 medical service or technology described in subclause
12 (I) that occur during the period described in sub-
13 clause (II) in an amount that adequately reflects the
14 estimated average cost of such service or technology;
15 and

16 “(IV) provide that discharges involving such a
17 service or technology that occur after the close of the
18 period described in subclause (II) will be classified
19 within a new or existing diagnosis-related group with
20 a weighting factor under paragraph (4)(B) that is
21 derived from cost data collected with respect to dis-
22 charges occurring during such period.

23 “(iii) For purposes of clause (ii)(II), the term ‘inpa-
24 tient hospital code’ means any code that is used with re-
25 spect to inpatient hospital services for which payment may

1 be made under this subsection and includes an alpha-
2 numeric code issued under the International Classification
3 of Diseases, 9th Revision, Clinical Modification ('ICD-9-
4 CM') and its subsequent revisions.

5 “(iv) For purposes of clause (ii)(III), the term ‘addi-
6 tional payment’ means, with respect to a discharge for a
7 new medical service or technology described in clause
8 (ii)(I), an amount that exceeds the prospective payment
9 rate otherwise applicable under this subsection to dis-
10 charges involving such service or technology that would
11 be made but for this subparagraph.

12 “(v) The requirement under clause (ii)(III) for an ad-
13 ditional payment may be satisfied by means of a new-tech-
14 nology group (described in subparagraph (L)), an add-on
15 payment, a payment adjustment, or any other similar
16 mechanism for increasing the amount otherwise payable
17 with respect to a discharge under this subsection. The Sec-
18 retary may not establish a separate fee schedule for such
19 additional payment for such services and technologies, by
20 utilizing a methodology established under subsection (a)
21 or (h) of section 1834 to determine the amount of such
22 additional payment, or by other similar mechanisms or
23 methodologies.

24 “(vi) For purposes of this subparagraph and sub-
25 paragraph (L), a medical service or technology will be con-

1 sidered a ‘new medical service or technology’ if the service
2 or technology meets criteria established by the Secretary
3 after notice and an opportunity for public comment.

4 “(L)(i) In establishing the mechanism under sub-
5 paragraph (K), the Secretary may establish new-tech-
6 nology groups into which a new medical service or tech-
7 nology will be classified if, based on the estimated average
8 costs incurred with respect to discharges involving such
9 service or technology, the DRG prospective payment rate
10 otherwise applicable to such discharges under this sub-
11 section is inadequate.

12 “(ii) Such groups—

13 “(I) shall not be based on the costs associated
14 with a specific new medical service or technology;
15 but

16 “(II) shall, in combination with the applicable
17 standardized amounts and the weighting factors as-
18 signed to such groups under paragraph (4)(B), re-
19 flect such cost cohorts as the Secretary determines
20 are appropriate for all new medical services and
21 technologies that are likely to be provided as inpa-
22 tient hospital services in a fiscal year.

23 “(iii) The methodology for classifying specific hos-
24 pital discharges within a diagnosis-related group under
25 paragraph (4)(A) or a new-technology group shall provide

1 that a specific hospital discharge may not be classified
2 within both a diagnosis-related group and a new-tech-
3 nology group.”.

4 (2) PRIOR CONSULTATION.—The Secretary of
5 Health and Human Services shall consult with
6 groups representing hospitals, physicians, and manu-
7 facturers of new medical technologies before pub-
8 lishing the notice of proposed rulemaking required
9 by section 1886(d)(5)(K)(i) of the Social Security
10 Act (as added by paragraph (1)).

11 (3) CONFORMING AMENDMENT.—Section
12 1886(d)(4)(C)(i) (42 U.S.C. 1395ww(d)(4)(C)(i)) is
13 amended by striking “technology,” and inserting
14 “technology (including a new medical service or
15 technology under paragraph (5)(K)),”.

16 **Subtitle E—Other Provisions**

17 **SEC. 541. INCREASE IN REIMBURSEMENT FOR BAD DEBT.**

18 Section 1861(v)(1)(T) (42 U.S.C. 1395x(v)(1)(T)) is
19 amended—

20 (1) in clause (ii), by striking “and” at the end;

21 (2) in clause (iii)—

22 (A) by striking “during a subsequent fiscal
23 year” and inserting “during fiscal year 2000”;

24 and

1 (B) by striking the period at the end and
2 inserting “, and”; and

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

5 “(iv) for cost reporting periods beginning dur-
6 ing a subsequent fiscal year, by 30 percent of such
7 amount otherwise allowable.”.

8 **SEC. 542. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY**
9 **SERVICES UNDER MEDICARE.**

10 (a) IN GENERAL.—When an independent laboratory
11 furnishes the technical component of a physician pathol-
12 ogy service to a fee-for-service medicare beneficiary who
13 is an inpatient or outpatient of a covered hospital, the Sec-
14 retary of Health and Human Services shall treat such
15 component as a service for which payment shall be made
16 to the laboratory under section 1848 of the Social Security
17 Act (42 U.S.C. 1395w-4) and not as an inpatient hospital
18 service for which payment is made to the hospital under
19 section 1886(d) of such Act (42 U.S.C. 1395ww(d)) or
20 as an outpatient hospital service for which payment is
21 made to the hospital under section 1833(t) of such Act
22 (42 U.S.C. 1395l(t)).

23 (b) DEFINITIONS.—For purposes of this section:

24 (1) COVERED HOSPITAL.—The term “covered
25 hospital” means, with respect to an inpatient or an

1 outpatient, a hospital that had an arrangement with
2 an independent laboratory that was in effect as of
3 July 22, 1999, under which a laboratory furnished
4 the technical component of physician pathology serv-
5 ices to fee-for-service medicare beneficiaries who
6 were hospital inpatients or outpatients, respectively,
7 and submitted claims for payment for such compo-
8 nent to a medicare carrier (that has a contract with
9 the Secretary under section 1842 of the Social Secu-
10 rity Act, 42 U.S.C. 1395u) and not to such hospital.

11 (2) FEE-FOR-SERVICE MEDICARE BENE-
12 FICIARY.—The term “fee-for-service medicare bene-
13 ficiary” means an individual who—

14 (A) is entitled to benefits under part A, or
15 enrolled under part B, or both, of such title;
16 and

17 (B) is not enrolled in any of the following:

18 (i) A Medicare+Choice plan under
19 part C of such title.

20 (ii) A plan offered by an eligible orga-
21 nization under section 1876 of such Act
22 (42 U.S.C. 1395mm).

23 (iii) A program of all-inclusive care
24 for the elderly (PACE) under section 1894
25 of such Act (42 U.S.C. 1395eee).

1 (iv) A social health maintenance orga-
2 nization (SHMO) demonstration project
3 established under section 4018(b) of the
4 Omnibus Budget Reconciliation Act of
5 1987 (Public Law 100–203).

6 (c) EFFECTIVE DATE.—This section applies to serv-
7 ices furnished during the 2-year period beginning on Jan-
8 uary 1, 2001.

9 (d) GAO REPORT.—

10 (1) STUDY.—The Comptroller General of the
11 United States shall conduct a study of the effects of
12 the previous provisions of this section on hospitals
13 and laboratories and access of fee-for-service medi-
14 care beneficiaries to the technical component of phy-
15 sician pathology services.

16 (2) REPORT.—Not later than April 1, 2002, the
17 Comptroller General shall submit to Congress a re-
18 port on such study. The report shall include rec-
19 ommendations about whether such provisions should
20 be extended after the end of the period specified in
21 subsection (c) for either or both inpatient and out-
22 patient hospital services, and whether the provisions
23 should be extended to other hospitals.

1 **SEC. 543. EXTENSION OF ADVISORY OPINION AUTHORITY.**

2 Section 1128D(b)(6) (42 U.S.C. 1320a-7d(b)(6)) is
3 amended by striking “and before the date which is 4 years
4 after such date of enactment”.

5 **SEC. 544. CHANGE IN ANNUAL MEDPAC REPORTING.**

6 (a) REVISION OF DEADLINES FOR SUBMISSION OF
7 REPORTS.—

8 (1) IN GENERAL.—Section 1805(b)(1)(D) (42
9 U.S.C. 1395b-6(b)(1)(D)) is amended by striking
10 “June 1 of each year (beginning with 1998),” and
11 inserting “June 15 of each year,”.

12 (2) EFFECTIVE DATE.—The amendment made
13 by paragraph (1) applies beginning with 2001.

14 (b) REQUIREMENT FOR ON THE RECORD VOTES ON
15 RECOMMENDATIONS.—Section 1805(b) (42 U.S.C.
16 1395b-6(b)) is amended by adding at the end the fol-
17 lowing new paragraph:

18 “(7) VOTING AND REPORTING REQUIRE-
19 MENTS.—With respect to each recommendation con-
20 tained in a report submitted under paragraph (1),
21 each member of the Commission shall vote on the
22 recommendation, and the Commission shall include,
23 by member, the results of that vote in the report
24 containing the recommendation.”.

1 **SEC. 545. DEVELOPMENT OF PATIENT ASSESSMENT IN-**
2 **STRUMENTS.**

3 (a) DEVELOPMENT.—

4 (1) IN GENERAL.—Not later than January 1,
5 2005, the Secretary of Health and Human Services
6 shall submit to the Committee on Ways and Means
7 and the Committee on Commerce of the House of
8 Representatives and the Committee on Finance of
9 the Senate a report on the development of standard
10 instruments for the assessment of the health and
11 functional status of patients, for whom items and
12 services described in subsection (b) are furnished,
13 and include in the report a recommendation on the
14 use of such standard instruments for payment pur-
15 poses.

16 (2) DESIGN FOR COMPARISON OF COMMON ELE-
17 MENTS.—The Secretary shall design such standard
18 instruments in a manner such that—

19 (A) elements that are common to the items
20 and services described in subsection (b) may be
21 readily comparable and are statistically compat-
22 ible;

23 (B) only elements necessary to meet pro-
24 gram objectives are collected; and

1 (C) the standard instruments supersede
2 any other assessment instrument used before
3 that date.

4 (3) CONSULTATION.—In developing an assess-
5 ment instrument under paragraph (1), the Secretary
6 shall consult with the Medicare Payment Advisory
7 Commission, the Agency for Healthcare Research
8 and Quality, and qualified organizations rep-
9 resenting providers of services and suppliers under
10 title XVIII.

11 (b) DESCRIPTION OF SERVICES.—For purposes of
12 subsection (a), items and services described in this sub-
13 section are those items and services furnished to individ-
14 uals entitled to benefits under part A, or enrolled under
15 part B, or both of title XVIII of the Social Security Act
16 for which payment is made under such title, and include
17 the following:

18 (1) Inpatient and outpatient hospital services.

19 (2) Inpatient and outpatient rehabilitation serv-
20 ices.

21 (3) Covered skilled nursing facility services.

22 (4) Home health services.

23 (5) Physical or occupational therapy or speech-
24 language pathology services.

1 (6) Items and services furnished to such indi-
2 viduals determined to have end stage renal disease.

3 (7) Partial hospitalization services and other
4 mental health services.

5 (8) Any other service for which payment is
6 made under such title as the Secretary determines to
7 be appropriate.

8 **SEC. 546. GAO REPORT ON IMPACT OF THE EMERGENCY**
9 **MEDICAL TREATMENT AND ACTIVE LABOR**
10 **ACT (EMTALA) ON HOSPITAL EMERGENCY DE-**
11 **PARTMENTS.**

12 (a) REPORT.—The Comptroller General of the
13 United States shall submit a report to the Committee on
14 Commerce and the Committee on Ways and Means of the
15 House of Representatives and the Committee on Finance
16 of the Senate by May 1, 2001, on the effect of the Emer-
17 gency Medical Treatment and Active Labor Act on hos-
18 pitals, emergency physicians, and physicians covering
19 emergency department call throughout the United States.

20 (b) REPORT REQUIREMENTS.—The report should
21 evaluate—

22 (1) the extent to which hospitals, emergency
23 physicians, and physicians covering emergency de-
24 partment call provide uncompensated services in re-
25 lation to the requirements of EMTALA;

1 (2) the extent to which the regulatory require-
2 ments and enforcement of EMTALA have expanded
3 beyond the legislation's original intent;

4 (3) estimates for the total dollar amount of
5 EMTALA-related care uncompensated costs to
6 emergency physicians, physicians covering emer-
7 gency department call, hospital emergency depart-
8 ments, and other hospital services;

9 (4) the extent to which different portions of the
10 United States may be experiencing different levels of
11 uncompensated EMTALA-related care;

12 (5) the extent to which EMTALA would be
13 classified as an unfunded mandate if it were enacted
14 today;

15 (6) the extent to which States have programs to
16 provide financial support for such uncompensated
17 care;

18 (7) possible sources of funds, including medi-
19 care hospital bad debt accounts, that are available to
20 hospitals to assist with the cost of such uncompen-
21 sated care; and

22 (8) the financial strain that illegal immigration
23 populations, the uninsured, and the underinsured
24 place on hospital emergency departments, other hos-

1 pital services, emergency physicians, and physicians
2 covering emergency department call.

3 (c) DEFINITION.—In this section, the terms “Emer-
4 gency Medical Treatment and Active Labor Act” and
5 “EMTALA” mean section 1867 of the Social Security Act
6 (42 U.S.C. 1395dd).

7 **TITLE VI—PROVISIONS RELAT-**
8 **ING TO PART C**
9 **(MEDICARE+CHOICE PRO-**
10 **GRAM) AND OTHER MEDI-**
11 **CARE MANAGED CARE PROVI-**
12 **SIONS**

13 **Subtitle A—Medicare+Choice**
14 **Payment Reforms**

15 **SEC. 601. INCREASE IN MINIMUM PAYMENT AMOUNT.**

16 Section 1853(c)(1)(B)(ii) (42 U.S.C. 1395w–
17 23(c)(1)(B)(ii)) is amended—

18 (1) by striking “(ii) For a succeeding year” and
19 inserting “(ii)(I) Subject to subclauses (II) and
20 (III), for a succeeding year”; and

21 (2) by adding at the end the following new sub-
22 clauses:

23 “(II) For 2001, for any area in a
24 Metropolitan Statistical Area within any of
25 the 50 States and the District of Columbia

1 with a population of more than 250,000,
2 \$525 (and for any other area within any of
3 the 50 States, \$475).

4 “(III) For 2001, for any area in a
5 Metropolitan Statistical Area outside the
6 50 States and the District of Columbia
7 with a population of more than 250,000,
8 \$525 (and for any other area outside the
9 50 States and the District of Columbia,
10 \$475), but not to exceed 120 percent of
11 the amount determined under this sub-
12 paragraph for such area for 2000.”.

13 **SEC. 602. INCREASE IN MINIMUM PERCENTAGE INCREASE.**

14 Section 1853(c)(1)(C)(ii) (42 U.S.C. 1395w-
15 23(c)(1)(C)(ii)) is amended by inserting “(or 103 percent
16 in the case of 2001)” after “102 percent”.

17 **SEC. 603. 10-YEAR PHASE-IN OF RISK ADJUSTMENT.**

18 Section 1853(a)(3)(C)(ii) (42 U.S.C. 1395w-
19 23(a)(3)(C)(ii)) is amended—

20 (1) in subclause (I), by striking “and 2001”
21 and inserting “and each succeeding year through the
22 first year in which risk adjustment is based on data
23 from inpatient hospital and ambulatory settings”;
24 and

1 (2) by amending subclause (II) to read as fol-
2 lows:

3 “(II) beginning after such first
4 year, insofar as such risk adjustment
5 is based on data from inpatient hos-
6 pital and ambulatory settings, the
7 methodology shall be phased in equal
8 increments over a 10-year period that
9 begins with such first year.”.

10 **SEC. 604. TRANSITION TO REVISED MEDICARE+CHOICE**
11 **PAYMENT RATES.**

12 (a) ANNOUNCEMENT OF REVISED
13 MEDICARE+CHOICE PAYMENT RATES.—Within 2 weeks
14 after the date of the enactment of this Act, the Secretary
15 of Health and Human Services shall determine, and shall
16 announce (in a manner intended to provide notice to inter-
17 ested parties) Medicare+Choice capitation rates under
18 section 1853 of the Social Security Act (42 U.S.C.
19 1395w–23) for 2001, revised in accordance with the provi-
20 sions of this Act.

21 (b) REENTRY INTO PROGRAM PERMITTED FOR
22 MEDICARE+CHOICE PROGRAMS IN 2000.—A
23 Medicare+Choice organization that provided notice to the
24 Secretary of Health and Human Services before the date
25 of the enactment of this Act that it was terminating its

1 contract under part C of title XVIII of the Social Security
2 Act or was reducing the service area of a
3 Medicare+Choice plan offered under such part shall be
4 permitted to continue participation under such part, or to
5 maintain the service area of such plan, for 2001 if it pro-
6 vides the Secretary with the information described in sec-
7 tion 1854(a)(1) of the Social Security Act (42 U.S.C.
8 1395w-24(a)(1)) within 2 weeks after the date revised
9 rates are announced by the Secretary under subsection
10 (a).

11 (c) REVISED SUBMISSION OF PROPOSED PREMIUMS
12 AND RELATED INFORMATION.—If—

13 (1) a Medicare+Choice organization provided
14 notice to the Secretary of Health and Human Serv-
15 ices as of July 3, 2000, that it was renewing its con-
16 tract under part C of title XVIII of the Social Secu-
17 rity Act for all or part of the service area or areas
18 served under its current contract, and

19 (2) any part of the service area or areas ad-
20 dressed in such notice includes a payment area for
21 which the Medicare+Choice capitation rate under
22 section 1853(c) of such Act (42 U.S.C. 1395w-
23 23(c)) for 2001, as determined under subsection (a),
24 is higher than the rate previously determined for
25 such year,

1 such organization shall revise its submission of the infor-
2 mation described in section 1854(a)(1) of the Social Secu-
3 rity Act (42 U.S.C. 1395w-24(a)(1)), and shall submit
4 such revised information to the Secretary, within 2 weeks
5 after the date revised rates are announced by the Sec-
6 retary under subsection (a). In making such submission,
7 the organization may only reduce premiums, cost-sharing,
8 enhance benefits, or utilize the stabilization fund described
9 in section 1854(f)(2) of such Act (42 U.S.C. 1395w-
10 24(f)(2)).

11 (d) DISREGARD OF NEW RATE ANNOUNCEMENT IN
12 APPLYING PASS-THROUGH FOR NEW NATIONAL COV-
13 ERAGE DETERMINATIONS.—For purposes of applying sec-
14 tion 1852(a)(5) of the Social Security Act (42 U.S.C.
15 1395w-22(a)(5)), the announcement of revised rates
16 under subsection (a) shall not be treated as an announce-
17 ment under section 1853(b) of such Act (42 U.S.C.
18 1395w-23(b)).

19 **SEC. 605. REVISION OF PAYMENT RATES FOR ESRD PA-**
20 **TIENTS ENROLLED IN MEDICARE+CHOICE**
21 **PLANS.**

22 (a) IN GENERAL.—Section 1853(a)(1)(B) (42 U.S.C.
23 1395w-23(a)(1)(B)) is amended by adding at the end the
24 following: “In establishing such rates, the Secretary shall
25 provide for appropriate adjustments to increase each rate

1 to reflect the demonstration rate (including the risk ad-
2 justment methodology associated with such rate) of the
3 social health maintenance organization end-stage renal
4 disease capitation demonstrations (established by section
5 2355 of the Deficit Reduction Act of 1984, as amended
6 by section 13567(b) of the Omnibus Budget Reconciliation
7 Act of 1993), and shall compute such rates by taking into
8 account such factors as renal treatment modality, age, and
9 the underlying cause of the end-stage renal disease.”.

10 (b) EFFECTIVE DATE.—The amendment made by
11 subsection (a) shall apply to payments for months begin-
12 ning with January 2002.

13 (c) PUBLICATION.—Not later than 6 months after
14 the date of the enactment of this Act, the Secretary of
15 Health and Human Services shall publish for public com-
16 ment a description of the appropriate adjustments de-
17 scribed in the last sentence of section 1853(a)(1)(B) of
18 the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B)),
19 as added by subsection (a). The Secretary shall publish
20 such adjustments in final form by not later than July 1,
21 2001, so that the amendment made by subsection (a) is
22 implemented on a timely basis consistent with subsection
23 (b).

1 **SEC. 606. PERMITTING PREMIUM REDUCTIONS AS ADDI-**
2 **TIONAL BENEFITS UNDER**
3 **MEDICARE+CHOICE PLANS.**

4 (a) IN GENERAL.—

5 (1) AUTHORIZATION OF PART B PREMIUM RE-
6 Ductions.—Section 1854(f)(1) (42 U.S.C. 1395w-
7 24(f)(1)) is amended—

8 (A) by redesignating subparagraph (E) as
9 subparagraph (F); and

10 (B) by inserting after subparagraph (D)
11 the following new subparagraph:

12 “(E) PREMIUM REDUCTIONS.—

13 “(i) IN GENERAL.—Subject to clause
14 (ii), as part of providing any additional
15 benefits required under subparagraph (A),
16 a Medicare+Choice organization may elect
17 a reduction in its payments under section
18 1853(a)(1)(A) with respect to a
19 Medicare+Choice plan and the Secretary
20 shall apply such reduction to reduce the
21 premium under section 1839 of each en-
22 rollee in such plan as provided in section
23 1840(i).

24 “(ii) AMOUNT OF REDUCTION.—The
25 amount of the reduction under clause (i)

1 with respect to any enrollee in a
2 Medicare+Choice plan—

3 “(I) may not exceed 125 percent
4 of the premium described under sec-
5 tion 1839(a)(3); and

6 “(II) shall apply uniformly to
7 each enrollee of the Medicare+Choice
8 plan to which such reduction ap-
9 plies.”.

10 (2) CONFORMING AMENDMENTS.—

11 (A) ADJUSTMENT OF PAYMENTS TO
12 MEDICARE+CHOICE ORGANIZATIONS.—Section
13 1853(a)(1)(A) (42 U.S.C. 1395w-23(a)(1)(A))
14 is amended by inserting “reduced by the
15 amount of any reduction elected under section
16 1854(f)(1)(E) and” after “for that area,”.

17 (B) ADJUSTMENT AND PAYMENT OF PART
18 B PREMIUMS.—

19 (i) ADJUSTMENT OF PREMIUMS.—
20 Section 1839(a)(2) (42 U.S.C.
21 1395r(a)(2)) is amended by striking
22 “shall” and all that follows and inserting
23 the following: “shall be the amount deter-
24 mined under paragraph (3), adjusted as
25 required in accordance with subsections

1 (b), (c), and (f), and to reflect 80 percent
2 of any reduction elected under section
3 1854(f)(1)(E).”.

4 (ii) PAYMENT OF PREMIUMS.—Section
5 1840 (42 U.S.C. 1395s) is amended by
6 adding at the end the following new sub-
7 section:

8 “(i) In the case of an individual enrolled in a
9 Medicare+Choice plan, the Secretary shall provide for
10 necessary adjustments of the monthly beneficiary pre-
11 mium to reflect 80 percent of any reduction elected under
12 section 1854(f)(1)(E). This premium adjustment may be
13 provided directly or as an adjustment to any social secu-
14 rity, railroad retirement, and civil service retirement bene-
15 fits, to the extent which the Secretary determines that
16 such an adjustment is appropriate with the concurrence
17 of the agencies responsible for the administration of such
18 benefits.”.

19 (C) INFORMATION COMPARING PLAN PRE-
20 MIUMS UNDER PART C.—Section 1851(d)(4)(B)
21 (42 U.S.C. 1395w-21(d)(4)(B)) is amended—

22 (i) by striking “PREMIUMS.—The”
23 and inserting “PREMIUMS.—

24 “(i) IN GENERAL.—The”; and

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

3 “(ii) REDUCTIONS.—The reduction in
4 part B premiums, if any.”.

5 (D) TREATMENT OF REDUCTION FOR PUR-
6 POSES OF DETERMINING GOVERNMENT CON-
7 TRIBUTION UNDER PART B.—Section 1844 (42
8 U.S.C. 1395w) is amended by adding at the
9 end the following new subsection:

10 “(c) The Secretary shall determine the Government
11 contribution under subparagraphs (A) and (B) of sub-
12 section (a)(1) without regard to any premium reduction
13 resulting from an election under section 1854(f)(1)(E).”.

14 (b) EFFECTIVE DATE.—The amendments made by
15 subsection (a) shall apply to years beginning with 2002.

16 **SEC. 607. FULL IMPLEMENTATION OF RISK ADJUSTMENT**
17 **FOR CONGESTIVE HEART FAILURE ENROLL-**
18 **EES FOR 2001.**

19 (a) IN GENERAL.—Section 1853(a)(3)(C) (42 U.S.C.
20 1395w-23(a)(3)(C)) is amended—

21 (1) in clause (ii), by striking “Such risk adjust-
22 ment” and inserting “Except as provided in clause
23 (iii), such risk adjustment”; and

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

1 “(iii) FULL IMPLEMENTATION OF
2 RISK ADJUSTMENT FOR CONGESTIVE
3 HEART FAILURE ENROLLEES FOR 2001.—

4 “(I) EXEMPTION FROM PHASE-
5 IN.—Subject to subclause (II), the
6 Secretary shall fully implement the
7 risk adjustment methodology de-
8 scribed in clause (i) with respect to
9 each individual who has had a quali-
10 fying congestive heart failure inpa-
11 tient diagnosis (as determined by the
12 Secretary under such risk adjustment
13 methodology) during the period begin-
14 ning on July 1, 1999, and ending on
15 June 30, 2000, and who is enrolled in
16 a coordinated care plan that is the
17 only coordinated care plan offered on
18 January 1, 2001, in the service area
19 of the individual.

20 “(II) PERIOD OF APPLICATION.—
21 Subclause (I) shall only apply during
22 the 1-year period beginning on Janu-
23 ary 1, 2001.”.

24 (b) EXCLUSION FROM DETERMINATION OF THE
25 BUDGET NEUTRALITY FACTOR.—Section 1853(c)(5) (42

1 U.S.C. 1395w-23(c)(5)) is amended by striking “sub-
2 section (i)” and inserting “subsections (a)(3)(C)(iii) and
3 (i)”.

4 **SEC. 608. EXPANSION OF APPLICATION OF**
5 **MEDICARE+CHOICE NEW ENTRY BONUS.**

6 (a) IN GENERAL.—Section 1853(i)(1) (42 U.S.C.
7 1395w-23(i)(1)) is amended in the matter preceding sub-
8 paragraph (A) by inserting “, or filed notice with the Sec-
9 retary as of October 3, 2000, that they will not be offering
10 such a plan as of January 1, 2001” after “January 1,
11 2000”.

12 (b) EFFECTIVE DATE.—The amendment made by
13 subsection (a) shall apply as if included in the enactment
14 of BBRA.

15 **SEC. 609. REPORT ON INCLUSION OF CERTAIN COSTS OF**
16 **THE DEPARTMENT OF VETERANS AFFAIRS**
17 **AND MILITARY FACILITY SERVICES IN CAL-**
18 **CULATING MEDICARE+CHOICE PAYMENT**
19 **RATES.**

20 The Secretary of Health and Human Services shall
21 report to Congress by not later than January 1, 2003,
22 on a method to phase-in the costs of military facility serv-
23 ices furnished by the Department of Veterans Affairs, and
24 the costs of military facility services furnished by the De-
25 partment of Defense, to medicare-eligible beneficiaries in

1 the calculation of an area's Medicare+Choice capitation
2 payment. Such report shall include on a county-by-county
3 basis—

4 (1) the actual or estimated cost of such services
5 to medicare-eligible beneficiaries;

6 (2) the change in Medicare+Choice capitation
7 payment rates if such costs are included in the cal-
8 culation of payment rates;

9 (3) one or more proposals for the implementa-
10 tion of payment adjustments to Medicare+Choice
11 plans in counties where the payment rate has been
12 affected due to the failure to calculate the cost of
13 such services to medicare-eligible beneficiaries; and

14 (4) a system to ensure that when a
15 Medicare+Choice enrollee receives covered services
16 through a facility of the Department of Veterans Af-
17 fairs or the Department of Defense there is an ap-
18 propriate payment recovery to the medicare program
19 under title XVIII of the Social Security Act.

1 **Subtitle B—Other Medicare+Choice**
2 **Reforms**

3 **SEC. 611. PAYMENT OF ADDITIONAL AMOUNTS FOR NEW**
4 **BENEFITS COVERED DURING A CONTRACT**
5 **TERM.**

6 (a) IN GENERAL.—Section 1853(c)(7) (42 U.S.C.
7 1395w–23(c)(7)) is amended to read as follows:

8 “(7) ADJUSTMENT FOR NATIONAL COVERAGE
9 DETERMINATIONS AND LEGISLATIVE CHANGES IN
10 BENEFITS.—If the Secretary makes a determination
11 with respect to coverage under this title or there is
12 a change in benefits required to be provided under
13 this part that the Secretary projects will result in a
14 significant increase in the costs to Medicare+Choice
15 of providing benefits under contracts under this part
16 (for periods after any period described in section
17 1852(a)(5)), the Secretary shall adjust appropriately
18 the payments to such organizations under this part.
19 Such projection and adjustment shall be based on an
20 analysis by the Chief Actuary of the Health Care Fi-
21 nancing Administration of the actuarial costs associ-
22 ated with the new benefits.”.

23 (b) CONFORMING AMENDMENT.—Section 1852(a)(5)
24 (42 U.S.C. 1395w–22(a)(5)) is amended—

1 (1) in the heading, by inserting “AND LEGISLA-
2 TIVE CHANGES IN BENEFITS” after “NATIONAL COV-
3 ERAGE DETERMINATIONS”;

4 (2) by inserting “or legislative change in bene-
5 fits required to be provided under this part” after
6 “national coverage determination”;

7 (3) in subparagraph (A), by inserting “or legis-
8 lative change in benefits” after “such determina-
9 tion”;

10 (4) in subparagraph (B), by inserting “or legis-
11 lative change” after “if such coverage determina-
12 tion”; and

13 (5) by adding at the end the following:

14 “The projection under the previous sentence shall be
15 based on an analysis by the Chief Actuary of the
16 Health Care Financing Administration of the actu-
17 arial costs associated with the coverage determina-
18 tion or legislative change in benefits.”.

19 (c) EFFECTIVE DATE.—The amendments made by
20 this section are effective on the date of the enactment of
21 this Act and apply to national coverage determinations
22 and legislative changes in benefits occurring on or after
23 such date.

1 **SEC. 612. RESTRICTION ON IMPLEMENTATION OF SIGNIFI-**
2 **CANT NEW REGULATORY REQUIREMENTS**
3 **MIDYEAR.**

4 (a) IN GENERAL.—Section 1856(b) (42 U.S.C.
5 1395w–26(b)) is amended by adding at the end the fol-
6 lowing new paragraph:

7 “(4) PROHIBITION OF MIDYEAR IMPLEMENTA-
8 TION OF SIGNIFICANT NEW REGULATORY REQUIRE-
9 MENTS.—The Secretary may not implement, other
10 than at the beginning of a calendar year, regulations
11 under this section that impose new, significant regu-
12 latory requirements on a Medicare+Choice organiza-
13 tion or plan.”.

14 (b) EFFECTIVE DATE.—The amendment made by
15 subsection (a) takes effect on the date of the enactment
16 of this Act.

17 **SEC. 613. TIMELY APPROVAL OF MARKETING MATERIAL**
18 **THAT FOLLOWS MODEL MARKETING LAN-**
19 **GUAGE.**

20 (a) IN GENERAL.—Section 1851(h) (42 U.S.C.
21 1395w–21(h)) is amended—

22 (1) in paragraph (1)(A), by inserting “(or 10
23 days in the case described in paragraph (5))” after
24 “45 days”; and

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

1 “(5) SPECIAL TREATMENT OF MARKETING MA-
2 TERIAL FOLLOWING MODEL MARKETING LAN-
3 GUAGE.—In the case of marketing material of an or-
4 ganization that uses, without modification, proposed
5 model language specified by the Secretary, the pe-
6 riod specified in paragraph (1)(A) shall be reduced
7 from 45 days to 10 days.”.

8 (b) EFFECTIVE DATE.—The amendments made by
9 subsection (a) apply to marketing material submitted on
10 or after January 1, 2001.

11 **SEC. 614. AVOIDING DUPLICATIVE REGULATION.**

12 (a) IN GENERAL.—Section 1856(b)(3)(B) (42 U.S.C.
13 1395w-26(b)(3)(B)) is amended—

14 (1) in clause (i), by inserting “(including cost-
15 sharing requirements)” after “Benefit require-
16 ments”; and

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

19 “(iv) Requirements relating to mar-
20 keting materials and summaries and sched-
21 ules of benefits regarding a
22 Medicare+Choice plan.”.

23 (b) EFFECTIVE DATE.—The amendments made by
24 subsection (a) take effect on the date of the enactment
25 of this Act.

1 **SEC. 615. ELECTION OF UNIFORM LOCAL COVERAGE POL-**
2 **ICY FOR MEDICARE+CHOICE PLAN COVERING**
3 **MULTIPLE LOCALITIES.**

4 Section 1852(a)(2) (42 U.S.C. 1395w–22(a)(2)) is
5 amended by adding at the end the following new subpara-
6 graph:

7 “(C) ELECTION OF UNIFORM COVERAGE
8 POLICY.—In the case of a Medicare+Choice or-
9 ganization that offers a Medicare+Choice plan
10 in an area in which more than one local cov-
11 erage policy is applied with respect to different
12 parts of the area, the organization may elect to
13 have the local coverage policy for the part of
14 the area that is most beneficial to
15 Medicare+Choice enrollees (as identified by the
16 Secretary) apply with respect to all
17 Medicare+Choice enrollees enrolled in the
18 plan.”.

19 **SEC. 616. ELIMINATING HEALTH DISPARITIES IN**
20 **MEDICARE+CHOICE PROGRAM.**

21 (a) QUALITY ASSURANCE PROGRAM FOCUS ON RA-
22 CIAL AND ETHNIC MINORITIES.—Subparagraphs (A) and
23 (B) of section 1852(e)(2) (42 U.S.C. 1395w–22(e)(2)) are
24 each amended by adding at the end the following:

25 “Such program shall include a separate focus
26 (with respect to all the elements described in

1 this subparagraph) on racial and ethnic minori-
2 ties.”.

3 (b) REPORT.—Section 1852(e) (42 U.S.C. 1395w-
4 22(e)) is amended by adding at the end the following new
5 paragraph:

6 “(5) REPORT TO CONGRESS.—

7 “(A) IN GENERAL.—Not later than 2 years
8 after the date of the enactment of this para-
9 graph, and biennially thereafter, the Secretary
10 shall submit to Congress a report regarding
11 how quality assurance programs conducted
12 under this subsection focus on racial and ethnic
13 minorities.

14 “(B) CONTENTS OF REPORT.—Each such
15 report shall include the following:

16 “(i) A description of the means by
17 which such programs focus on such racial
18 and ethnic minorities.

19 “(ii) An evaluation of the impact of
20 such programs on eliminating health dis-
21 parities and on improving health outcomes,
22 continuity and coordination of care, man-
23 agement of chronic conditions, and con-
24 sumer satisfaction.

1 “(iii) Recommendations on ways to re-
2 duce clinical outcome disparities among ra-
3 cial and ethnic minorities.”.

4 **SEC. 617. MEDICARE+CHOICE PROGRAM COMPATIBILITY**
5 **WITH EMPLOYER OR UNION GROUP HEALTH**
6 **PLANS.**

7 (a) IN GENERAL.—Section 1857 (42 U.S.C. 1395w-
8 27) is amended by adding at the end the following new
9 subsection:

10 “(i) MEDICARE+CHOICE PROGRAM COMPATIBILITY
11 WITH EMPLOYER OR UNION GROUP HEALTH PLANS.—
12 To facilitate the offering of Medicare+Choice plans under
13 contracts between Medicare+Choice organizations and
14 employers, labor organizations, or the trustees of a fund
15 established by 1 or more employers or labor organizations
16 (or combination thereof) to furnish benefits to the entity’s
17 employees, former employees (or combination thereof) or
18 members or former members (or combination thereof) of
19 the labor organizations, the Secretary may waive or mod-
20 ify requirements that hinder the design of, the offering
21 of, or the enrollment in such Medicare+Choice plans.”.

22 (b) EFFECTIVE DATE.—The amendment made by
23 subsection (a) applies with respect to years beginning with
24 2001.

1 **SEC. 618. SPECIAL MEDIGAP ENROLLMENT ANTIDISCRIMI-**
2 **NATION PROVISION FOR CERTAIN BENE-**
3 **FICIARIES.**

4 (a) DISENROLLMENT WINDOW IN ACCORDANCE
5 WITH BENEFICIARY'S CIRCUMSTANCE.—Section
6 1882(s)(3) (42 U.S.C. 1395ss(s)(3)) is amended—

7 (1) in subparagraph (A), in the matter fol-
8 lowing clause (iii), by striking “, subject to subpara-
9 graph (E), seeks to enroll under the policy not later
10 than 63 days after the date of the termination of en-
11 rollment described in such subparagraph” and in-
12 serting “seeks to enroll under the policy during the
13 period specified in subparagraph (E)”; and

14 (2) by striking subparagraph (E) and inserting
15 the following new subparagraph:

16 “(E) For purposes of subparagraph (A), the time pe-
17 riod specified in this subparagraph is—

18 “(i) in the case of an individual described in
19 subparagraph (B)(i), the period beginning on the
20 date the individual receives a notice of termination
21 or cessation of all supplemental health benefits (or,
22 if no such notice is received, notice that a claim has
23 been denied because of such a termination or ces-
24 sation) and ending on the date that is 63 days after
25 the applicable notice;

1 “(ii) in the case of an individual described in
2 clause (ii), (iii), (v), or (vi) of subparagraph (B)
3 whose enrollment is terminated involuntarily, the pe-
4 riod beginning on the date that the individual re-
5 ceives a notice of termination and ending on the
6 date that is 63 days after the date the applicable
7 coverage is terminated;

8 “(iii) in the case of an individual described in
9 subparagraph (B)(iv)(I), the period beginning on the
10 earlier of (I) the date that the individual receives a
11 notice of termination, a notice of the issuer’s bank-
12 ruptcy or insolvency, or other such similar notice, if
13 any, and (II) the date that the applicable coverage
14 is terminated, and ending on the date that is 63
15 days after the date the coverage is terminated;

16 “(iv) in the case of an individual described in
17 clause (ii), (iii), (iv)(II), (iv)(III), (v), or (vi) of sub-
18 paragraph (B) who disenrolls voluntarily, the period
19 beginning on the date that is 60 days before the ef-
20 fective date of the disenrollment and ending on the
21 date that is 63 days after such effective date; and

22 “(v) in the case of an individual described in
23 subparagraph (B) but not described in the preceding
24 provisions of this subparagraph, the period begin-
25 ning on the effective date of the disenrollment and

1 ending on the date that is 63 days after such effective date.”.

3 (b) EXTENDED MEDIGAP ACCESS FOR INTERRUPTED
4 TRIAL PERIODS.—Section 1882(s)(3) (42 U.S.C.
5 1395ss(s)(3)), as amended by subsection (a), is further
6 amended by adding at the end the following new subpara-
7 graph:

8 “(F)(i) Subject to clause (ii), for purposes of this
9 paragraph—

10 “(I) in the case of an individual described in
11 subparagraph (B)(v) (or deemed to be so described,
12 pursuant to this subparagraph) whose enrollment
13 with an organization or provider described in sub-
14 clause (II) of such subparagraph is involuntarily ter-
15 minated within the first 12 months of such enroll-
16 ment, and who, without an intervening enrollment,
17 enrolls with another such organization or provider,
18 such subsequent enrollment shall be deemed to be an
19 initial enrollment described in such subparagraph;
20 and

21 “(II) in the case of an individual described in
22 clause (vi) of subparagraph (B) (or deemed to be so
23 described, pursuant to this subparagraph) whose en-
24 rollment with a plan or in a program described in
25 such clause is involuntarily terminated within the

1 first 12 months of such enrollment, and who, with-
2 out an intervening enrollment, enrolls in another
3 such plan or program, such subsequent enrollment
4 shall be deemed to be an initial enrollment described
5 in such clause.

6 “(ii) For purposes of clauses (v) and (vi) of subpara-
7 graph (B), no enrollment of an individual with an organi-
8 zation or provider described in clause (v)(II), or with a
9 plan or in a program described in clause (vi), may be
10 deemed to be an initial enrollment under this clause after
11 the 2-year period beginning on the date on which the indi-
12 vidual first enrolled with such an organization, provider,
13 plan, or program.”.

14 **SEC. 619. RESTORING EFFECTIVE DATE OF ELECTIONS AND**
15 **CHANGES OF ELECTIONS OF**
16 **MEDICARE+CHOICE PLANS.**

17 (a) OPEN ENROLLMENT.—Section 1851(f)(2) (42
18 U.S.C. 1395w-21(f)(2)) is amended by striking “, except
19 that if such election or change is made after the 10th day
20 of any calendar month, then the election or change shall
21 not take effect until the first day of the second calendar
22 month following the date on which the election or change
23 is made”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 this section shall apply to elections and changes of cov-
3 erage made on or after January 1, 2001.

4 **SEC. 620. PERMITTING ESRD BENEFICIARIES TO ENROLL**
5 **IN ANOTHER MEDICARE+CHOICE PLAN IF**
6 **THE PLAN IN WHICH THEY ARE ENROLLED IS**
7 **TERMINATED.**

8 (a) IN GENERAL.—Section 1851(a)(3)(B) (42 U.S.C.
9 1395w-21(a)(3)(B)) is amended by striking “except that”
10 and all that follows and inserting the following: “except
11 that—

12 “(i) an individual who develops end-
13 stage renal disease while enrolled in a
14 Medicare+Choice plan may continue to be
15 enrolled in that plan; and

16 “(ii) in the case of such an individual
17 who is enrolled in a Medicare+Choice plan
18 under clause (i) (or subsequently under
19 this clause), if the enrollment is discon-
20 tinued under circumstances described in
21 section 1851(e)(4)(A), then the individual
22 will be treated as a ‘Medicare+Choice eli-
23 gible individual’ for purposes of electing to
24 continue enrollment in another
25 Medicare+Choice plan.”.

1 (b) EFFECTIVE DATE.—

2 (1) IN GENERAL.—The amendment made by
3 subsection (a) shall apply to terminations and
4 discontinuations occurring on or after the date of
5 the enactment of this Act.

6 (2) APPLICATION TO PRIOR PLAN TERMI-
7 NATIONS.—Clause (ii) of section 1851(a)(3)(B) of
8 the Social Security Act (as inserted by subsection
9 (a)) also shall apply to individuals whose enrollment
10 in a Medicare+Choice plan was terminated or dis-
11 continued after December 31, 1998, and before the
12 date of the enactment of this Act. In applying this
13 paragraph, such an individual shall be treated, for
14 purposes of part C of title XVIII of the Social Secu-
15 rity Act, as having discontinued enrollment in such
16 a plan as of the date of the enactment of this Act.

17 **SEC. 621. PROVIDING CHOICE FOR SKILLED NURSING FA-**
18 **CILITY SERVICES UNDER THE**
19 **MEDICARE+CHOICE PROGRAM.**

20 (a) IN GENERAL.—Section 1852 (42 U.S.C. 1395w–
21 22) is amended by adding at the end the following new
22 subsection:

23 “(1) RETURN TO HOME SKILLED NURSING FACILI-
24 TIES FOR COVERED POST-HOSPITAL EXTENDED CARE
25 SERVICES.—

1 “(1) ENSURING RETURN TO HOME SNF.—

2 “(A) IN GENERAL.—In providing coverage
3 of post-hospital extended care services, a
4 Medicare+Choice plan shall provide for such
5 coverage through a home skilled nursing facility
6 if the following conditions are met:

7 “(i) ENROLLEE ELECTION.—The en-
8 rollee elects to receive such coverage
9 through such facility.

10 “(ii) SNF AGREEMENT.—The facility
11 has a contract with the Medicare+Choice
12 organization for the provision of such serv-
13 ices, or the facility agrees to accept sub-
14 stantially similar payment under the same
15 terms and conditions that apply to simi-
16 larly situated skilled nursing facilities that
17 are under contract with the
18 Medicare+Choice organization for the pro-
19 vision of such services and through which
20 the enrollee would otherwise receive such
21 services.

22 “(B) MANNER OF PAYMENT TO HOME
23 SNF.—The organization shall provide payment
24 to the home skilled nursing facility consistent

1 with the contract or the agreement described in
2 subparagraph (A)(ii), as the case may be.

3 “(2) NO LESS FAVORABLE COVERAGE.—The
4 coverage provided under paragraph (1) (including
5 scope of services, cost-sharing, and other criteria of
6 coverage) shall be no less favorable to the enrollee
7 than the coverage that would be provided to the en-
8 rollee with respect to a skilled nursing facility the
9 post-hospital extended care services of which are
10 otherwise covered under the Medicare+Choice plan.

11 “(3) RULE OF CONSTRUCTION.—Nothing in
12 this subsection shall be construed to do the fol-
13 lowing:

14 “(A) To require coverage through a skilled
15 nursing facility that is not otherwise qualified
16 to provide benefits under part A for medicare
17 beneficiaries not enrolled in a Medicare+Choice
18 plan.

19 “(B) To prevent a skilled nursing facility
20 from refusing to accept, or imposing conditions
21 upon the acceptance of, an enrollee for the re-
22 ceipt of post-hospital extended care services.

23 “(4) DEFINITIONS.—In this subsection:

24 “(A) HOME SKILLED NURSING FACIL-
25 ITY.—The term ‘home skilled nursing facility’

1 means, with respect to an enrollee who is enti-
2 tled to receive post-hospital extended care serv-
3 ices under a Medicare+Choice plan, any of the
4 following skilled nursing facilities:

5 “(i) SNF RESIDENCE AT TIME OF AD-
6 MISSION.—The skilled nursing facility in
7 which the enrollee resided at the time of
8 admission to the hospital preceding the re-
9 ceipt of such post-hospital extended care
10 services.

11 “(ii) SNF IN CONTINUING CARE RE-
12 TIREMENT COMMUNITY.—A skilled nursing
13 facility that is providing such services
14 through a continuing care retirement com-
15 munity (as defined in subparagraph (B))
16 which provided residence to the enrollee at
17 the time of such admission.

18 “(iii) SNF RESIDENCE OF SPOUSE AT
19 TIME OF DISCHARGE.—The skilled nursing
20 facility in which the spouse of the enrollee
21 is residing at the time of discharge from
22 such hospital.

23 “(B) CONTINUING CARE RETIREMENT
24 COMMUNITY.—The term ‘continuing care retire-
25 ment community’ means, with respect to an en-

1 rollee in a Medicare+Choice plan, an arrange-
2 ment under which housing and health-related
3 services are provided (or arranged) through an
4 organization for the enrollee under an agree-
5 ment that is effective for the life of the enrollee
6 or for a specified period.”.

7 (b) EFFECTIVE DATE.—The amendment made by
8 subsection (a) applies with respect to contracts entered
9 into or renewed on or after the date of the enactment of
10 this Act.

11 (c) MEDPAC STUDY.—

12 (1) STUDY.—The Medicare Payment Advisory
13 Commission shall conduct a study analyzing the ef-
14 fects of the amendment made by subsection (a) on
15 Medicare+Choice organizations. In conducting such
16 study, the Commission shall examine the effects (if
17 any) such amendment has had on—

18 (A) the scope of additional benefits pro-
19 vided under the Medicare+Choice program;

20 (B) the administrative and other costs in-
21 curred by Medicare+Choice organizations;

22 (C) the contractual relationships between
23 such organizations and skilled nursing facilities.

24 (2) REPORT.—Not later than 2 years after the
25 date of the enactment of this Act, the Commission

1 shall submit to Congress a report on the study con-
2 ducted under paragraph (1).

3 **SEC. 622. PROVIDING FOR ACCOUNTABILITY OF**
4 **MEDICARE+CHOICE PLANS.**

5 (a) MANDATORY REVIEW OF ACR SUBMISSIONS BY
6 THE CHIEF ACTUARY OF THE HEALTH CARE FINANCING
7 ADMINISTRATION.—Section 1854(a)(5)(A) (42 U.S.C.
8 1395w-24(a)(5)(A)) is amended—

9 (1) by striking “value” and inserting “values”;
10 and

11 (2) by adding at the end the following: “The
12 Chief Actuary of the Health Care Financing Admin-
13 istration shall review the actuarial assumptions and
14 data used by the Medicare+Choice organization with
15 respect to such rates, amounts, and values so sub-
16 mitted to determine the appropriateness of such as-
17 sumptions and data.”.

18 (b) EFFECTIVE DATE.—The amendment made by
19 subsection (a) applies to submissions made on or after
20 January 1, 2001.

1 **Subtitle C—Other Managed Care**
2 **Reforms**

3 **SEC. 631. 1-YEAR EXTENSION OF SOCIAL HEALTH MAINTENANCE ORGANIZATION (SHMO) DEMONSTRATION PROJECT.**

6 Section 4018(b)(1) of the Omnibus Budget Reconciliation Act of 1987, as amended by section 531(a)(1) of BBRA (113 Stat. 1501A–388), is amended by striking
7
8
9 “18 months” and inserting “30 months”.

10 **SEC. 632. REVISED TERMS AND CONDITIONS FOR EXTENSION OF MEDICARE COMMUNITY NURSING ORGANIZATION (CNO) DEMONSTRATION PROJECT.**

14 (a) IN GENERAL.—Section 532 of BBRA (113 Stat. 1501A–388) is amended—

16 (1) in subsection (a), by striking the second
17 sentence; and

18 (2) by striking subsection (b) and inserting the
19 following new subsection:

20 “(b) TERMS AND CONDITIONS.—

21 “(1) JANUARY THROUGH SEPTEMBER 2000.—

22 For the 9-month period beginning with January
23 2000, any such demonstration project shall be conducted under the same terms and conditions as applied to such demonstration during 1999.
24
25

1 “(2) OCTOBER 2000 THROUGH DECEMBER
2 2001.—For the 15-month period beginning with Oc-
3 tober 2000, any such demonstration project shall be
4 conducted under the same terms and conditions as
5 applied to such demonstration during 1999, except
6 that the following modifications shall apply:

7 “(A) BASIC CAPITATION RATE.—The basic
8 capitation rate paid for services covered under
9 the project (other than case management serv-
10 ices) per enrollee per month and furnished
11 during—

12 “(i) the period beginning with October
13 1, 2000, and ending with December 31,
14 2000, shall be determined by actuarially
15 adjusting the actual capitation rate paid
16 for such services in 1999 for inflation, uti-
17 lization, and other changes to the CNO
18 service package, and by reducing such ad-
19 justed capitation rate by 10 percent in the
20 case of the demonstration sites located in
21 Arizona, Minnesota, and Illinois, and 15
22 percent for the demonstration site located
23 in New York; and

24 “(ii) 2001 shall be determined by ac-
25 tuarily adjusting the capitation rate de-

1 terminated under clause (i) for inflation, uti-
2 lization, and other changes to the CNO
3 service package.

4 “(B) TARGETED CASE MANAGEMENT
5 FEE.—Effective October 1, 2000—

6 “(i) the case management fee per en-
7 rollee per month for—

8 “(I) the period described in sub-
9 paragraph (A)(i) shall be determined
10 by actuarially adjusting the case man-
11 agement fee for 1999 for inflation;
12 and

13 “(II) 2001 shall be determined
14 by actuarially adjusting the amount
15 determined under subclause (I) for in-
16 flation; and

17 “(ii) such case management fee shall
18 be paid only for enrollees who are classified
19 as moderately frail or frail pursuant to cri-
20 teria established by the Secretary.

21 “(C) GREATER UNIFORMITY IN CLINICAL
22 FEATURES AMONG SITES.—Each project shall
23 implement for each site—

24 “(i) protocols for periodic telephonic
25 contact with enrollees based on—

1 “(I) the results of such standard-
2 ized written health assessment; and

3 “(II) the application of appro-
4 priate care planning approaches;

5 “(ii) disease management programs
6 for targeted diseases (such as congestive
7 heart failure, arthritis, diabetes, and hy-
8 pertension) that are highly prevalent in the
9 enrolled populations;

10 “(iii) systems and protocols to track
11 enrollees through hospitalizations, includ-
12 ing pre-admission planning, concurrent
13 management during inpatient hospital
14 stays, and post-discharge assessment, plan-
15 ning, and follow-up; and

16 “(iv) standardized patient educational
17 materials for specified diseases and health
18 conditions.

19 “(D) QUALITY IMPROVEMENT.—Each
20 project shall implement at each site once during
21 the 15-month period—

22 “(i) enrollee satisfaction surveys; and

23 “(ii) reporting on specified quality in-
24 dicators for the enrolled population.

25 “(c) EVALUATION.—

1 “(1) PRELIMINARY REPORT.—Not later than
2 July 1, 2001, the Secretary of Health and Human
3 Services shall submit to the Committees on Ways
4 and Means and Commerce of the House of Rep-
5 resentatives and the Committee on Finance of the
6 Senate a preliminary report that—

7 “(A) evaluates such demonstration projects
8 for the period beginning July 1, 1997, and end-
9 ing December 31, 1999, on a site-specific basis
10 with respect to the impact on per beneficiary
11 spending, specific health utilization measures,
12 and enrollee satisfaction; and

13 “(B) includes a similar evaluation of such
14 projects for the portion of the extension period
15 that occurs after September 30, 2000.

16 “(2) FINAL REPORT.—The Secretary shall sub-
17 mit a final report to such Committees on such dem-
18 onstration projects not later than July 1, 2002.
19 Such report shall include the same elements as the
20 preliminary report required by paragraph (1), but
21 for the period after December 31, 1999.

22 “(3) METHODOLOGY FOR SPENDING COMPARI-
23 SONS.—Any evaluation of the impact of the dem-
24 onstration projects on per beneficiary spending in-

1 onciliation Act of 1989, section 13557 of the Omnibus
2 Budget Reconciliation Act of 1993, section 4017 of BBA,
3 and section 534 of BBRA (113 Stat. 1501A–390), is
4 amended by striking “December 31, 2002” and inserting
5 “December 31, 2004”.

6 **SEC. 634. SERVICE AREA EXPANSION FOR MEDICARE COST**
7 **CONTRACTS DURING TRANSITION PERIOD.**

8 Section 1876(h)(5) (42 U.S.C. 1395mm(h)(5)) is
9 amended—

10 (1) by redesignating subparagraph (B) as sub-
11 paragraph (C); and

12 (2) by inserting after subparagraph (A), the fol-
13 lowing new subparagraph:

14 “(B) Subject to subparagraph (C), the Secretary
15 shall approve an application for a modification to a rea-
16 sonable cost contract under this section in order to expand
17 the service area of such contract if—

18 “(i) such application is submitted to the Sec-
19 retary on or before September 1, 2003; and

20 “(ii) the Secretary determines that the organi-
21 zation with the contract continues to meet the re-
22 quirements applicable to such organizations and con-
23 tracts under this section.”.

TITLE VII—MEDICAID

SEC. 701. DSH PAYMENTS.

(a) MODIFICATIONS TO DSH ALLOTMENTS.—

(1) INCREASED ALLOTMENTS FOR FISCAL YEARS 2001 AND 2002.—

(A) IN GENERAL.—Section 1923(f) (42 U.S.C. 1396r-4(f)) is amended—

(i) in paragraph (2), by striking “The DSH allotment” and inserting “Subject to paragraph (4), the DSH allotment”;

(ii) by redesignating paragraph (4) as paragraph (6); and

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

“(4) SPECIAL RULE FOR FISCAL YEARS 2001 AND 2002.—

“(A) IN GENERAL.—Notwithstanding paragraph (2), the DSH allotment for any State for—

“(i) fiscal year 2001, shall be the DSH allotment determined under paragraph (2) for fiscal year 2000 increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the consumer price index for all urban con-

1 consumers (all items; U.S. city average) for
2 fiscal year 2000; and

3 “(ii) fiscal year 2002, shall be the
4 DSH allotment determined under clause
5 (i) increased, subject to subparagraph (B)
6 and paragraph (5), by the percentage
7 change in the consumer price index for all
8 urban consumers (all items; U.S. city aver-
9 age) for fiscal year 2001.

10 “(B) LIMITATION.—Subparagraph (B) of
11 paragraph (3) shall apply to subparagraph (A)
12 of this paragraph in the same manner as that
13 subparagraph (B) applies to paragraph (3)(A).

14 “(C) NO APPLICATION TO ALLOTMENTS
15 AFTER FISCAL YEAR 2002.—The DSH allotment
16 for any State for fiscal year 2003 or any suc-
17 ceeding fiscal year shall be determined under
18 paragraph (3) without regard to the DSH allot-
19 ments determined under subparagraph (A) of
20 this paragraph.”.

21 (2) SPECIAL RULE FOR MEDICAID DSH ALLOT-
22 MENT FOR EXTREMELY LOW DSH STATES.—

23 (A) IN GENERAL.—Section 1923(f) (42
24 U.S.C. 1396r-4(f)), as amended by paragraph

1 (1), is amended by inserting after paragraph
2 (4) the following new paragraph:

3 “(5) SPECIAL RULE FOR EXTREMELY LOW DSH
4 STATES.—In the case of a State in which the total
5 expenditures under the State plan (including Federal
6 and State shares) for disproportionate share hospital
7 adjustments under this section for fiscal year 1999,
8 as reported to the Administrator of the Health Care
9 Financing Administration as of August 31, 2000, is
10 greater than 0 but less than 1 percent of the State’s
11 total amount of expenditures under the State plan
12 for medical assistance during the fiscal year, the
13 DSH allotment for fiscal year 2001 shall be in-
14 creased to 1 percent of the State’s total amount of
15 expenditures under such plan for such assistance
16 during such fiscal year. In subsequent fiscal years,
17 such increased allotment is subject to an increase for
18 inflation as provided in paragraph (3)(A).”.

19 (B) CONFORMING AMENDMENT.—Section
20 1923(f)(3)(A) (42 U.S.C. 1396r-4(f)(3)(A)) is
21 amended by inserting “and paragraph (5)”
22 after “subparagraph (B)”.

23 (3) EFFECTIVE DATE.—The amendments made
24 by paragraphs (1) and (2) take effect on the date
25 the final regulation required under section 705(a)

1 (relating to the application of an aggregate upper
2 payment limit test for State medicaid spending for
3 inpatient hospital services, outpatient hospital serv-
4 ices, nursing facility services, intermediate care facil-
5 ity services for the mentally retarded, and clinic
6 services provided by government facilities that are
7 not State-owned or operated facilities) is published
8 in the Federal Register.

9 (b) ASSURING IDENTIFICATION OF MEDICAID MAN-
10 AGED CARE PATIENTS.—

11 (1) IN GENERAL.—Section 1932 (42 U.S.C.
12 1396u-2) is amended by adding at the end the fol-
13 lowing new subsection:

14 “(g) IDENTIFICATION OF PATIENTS FOR PURPOSES
15 OF MAKING DSH PAYMENTS.—Each contract with a
16 managed care entity under section 1903(m) or under sec-
17 tion 1905(t)(3) shall require the entity either—

18 “(1) to report to the State information nec-
19 essary to determine the hospital services provided
20 under the contract (and the identity of hospitals pro-
21 viding such services) for purposes of applying sec-
22 tions 1886(d)(5)(F) and 1923; or

23 “(2) to include a sponsorship code in the identi-
24 fication card issued to individuals covered under this

1 title in order that a hospital may identify a patient
2 as being entitled to benefits under this title.”.

3 (2) CLARIFICATION OF COUNTING MANAGED
4 CARE MEDICAID PATIENTS.—Section 1923 (42
5 U.S.C. 1396r-4) is amended—

6 (A) in subsection (a)(2)(D), by inserting
7 after “the proportion of low-income and med-
8 icaid patients” the following: “(including such
9 patients who receive benefits through a man-
10 aged care entity)”;

11 (B) in subsection (b)(2), by inserting after
12 “a State plan approved under this title in a pe-
13 riod” the following: “(regardless of whether
14 such patients receive medical assistance on a
15 fee-for-service basis or through a managed care
16 entity)”;

17 (C) in subsection (b)(3)(A)(i), by inserting
18 after “under a State plan under this title” the
19 following: “(regardless of whether the services
20 were furnished on a fee-for-service basis or
21 through a managed care entity)”.

22 (3) EFFECTIVE DATES.—

23 (A) The amendment made by paragraph
24 (1) applies to contracts as of January 1, 2001.

1 (B) The amendments made by paragraph
2 (2) apply to payments made on or after Janu-
3 ary 1, 2001.

4 (c) APPLICATION OF MEDICAID DSH TRANSITION
5 RULE TO PUBLIC HOSPITALS IN ALL STATES.—

6 (1) IN GENERAL.—During the period described
7 in paragraph (3), with respect to a State, section
8 4721(e) of the Balanced Budget Act of 1997 (Public
9 Law 105–33; 111 Stat. 514), as amended by section
10 607 of BBRA (113 Stat. 1501A–321) shall be ap-
11 plied as though—

12 (A) “September 30, 2002” were sub-
13 stituted for “July 1, 1997” each place it ap-
14 pears;

15 (B) “hospitals owned or operated by a
16 State (as defined for purposes of title XIX of
17 such Act), or by an instrumentality or a unit of
18 government within a State (as so defined)”
19 were substituted for “the State of California”;

20 (C) paragraph (3) were redesignated as
21 paragraph (4);

22 (D) “and” were omitted from the end of
23 paragraph (2); and

24 (E) the following new paragraph were in-
25 serted after paragraph (2):

1 “(3) ‘(as defined in subparagraph (B) but with-
2 out regard to clause (ii) of that subparagraph and
3 subject to subsection (d))’ were substituted for ‘(as
4 defined in subparagraph (B))’ in subparagraph (A)
5 of such section; and”.

6 (2) SPECIAL RULE.—With respect to California,
7 section 4721(e) of the Balanced Budget Act of 1997
8 (Public Law 105–33; 111 Stat. 514) shall be applied
9 without regard to paragraph (1).

10 (3) PERIOD DESCRIBED.—The period described
11 in this paragraph is the period that begins, with re-
12 spect to a State, on the first day of the first State
13 fiscal year that begins after September 30, 2002,
14 and ends on the last day of the succeeding State fis-
15 cal year.

16 (4) APPLICATION TO WAIVERS.—With respect
17 to a State operating under a waiver of the require-
18 ments of title XIX of the Social Security Act (42
19 U.S.C. 1396 et seq.) under section 1115 of such Act
20 (42 U.S.C. 1315), the amount by which any pay-
21 ment adjustment made by the State under title XIX
22 of such Act (42 U.S.C. 1396 et seq.), after the ap-
23 plication of section 4721(e) of the Balanced Budget
24 Act of 1997 under paragraph (1) to such State, ex-
25 ceeds the costs of furnishing hospital services pro-

1 vided by hospitals described in such section shall be
2 fully reflected as an increase in the baseline expendi-
3 ture limit for such waiver.

4 (d) ASSISTANCE FOR CERTAIN PUBLIC HOS-
5 PITALS.—

6 (1) IN GENERAL.—Beginning with fiscal year
7 2002, notwithstanding section 1923(f) of the Social
8 Security Act (42 U.S.C. 1396r–4(f)) and subject to
9 paragraph (3), with respect to a State, payment ad-
10 justments made under title XIX of the Social Secu-
11 rity Act (42 U.S.C. 1396 et seq.) to a hospital de-
12 scribed in paragraph (2) shall be made without re-
13 gard to the DSH allotment limitation for the State
14 determined under section 1923(f) of that Act (42
15 U.S.C. 1396r–4(f)).

16 (2) HOSPITAL DESCRIBED.—A hospital is de-
17 scribed in this paragraph if the hospital—

18 (A) is owned or operated by a State (as de-
19 fined for purposes of title XIX of the Social Se-
20 curity Act), or by an instrumentality or a unit
21 of government within a State (as so defined);

22 (B) as of October 1, 2000—

23 (i) is in existence and operating as a
24 hospital described in subparagraph (A);
25 and

1 (ii) is not receiving disproportionate
2 share hospital payments from the State in
3 which it is located under title XIX of such
4 Act; and

5 (C) has a low-income utilization rate (as
6 defined in section 1923(b)(3) of the Social Se-
7 curity Act (42 U.S.C. 1396r-4(b)(3))) in excess
8 of 65 percent.

9 (3) LIMITATION ON EXPENDITURES.—

10 (A) IN GENERAL.—With respect to any fis-
11 cal year, the aggregate amount of Federal fi-
12 nancial participation that may be provided for
13 payment adjustments described in paragraph
14 (1) for that fiscal year for all States may not
15 exceed the amount described in subparagraph
16 (B) for the fiscal year.

17 (B) AMOUNT DESCRIBED.—The amount
18 described in this subparagraph for a fiscal year
19 is as follows:

20 (i) For fiscal year 2002, \$15,000,000.

21 (ii) For fiscal year 2003,
22 \$176,000,000.

23 (iii) For fiscal year 2004,
24 \$269,000,000.

1 (iv) For fiscal year 2005,
2 \$330,000,000.

3 (v) For fiscal year 2006 and each fis-
4 cal year thereafter, \$375,000,000.

5 (e) DSH PAYMENT ACCOUNTABILITY STANDARDS.—
6 Not later than September 30, 2002, the Secretary of
7 Health and Human Services shall implement account-
8 ability standards to ensure that Federal funds provided
9 with respect to disproportionate share hospital adjust-
10 ments made under section 1923 of the Social Security Act
11 (42 U.S.C. 1396r-4) are used to reimburse States and
12 hospitals eligible for such payment adjustments for pro-
13 viding uncompensated health care to low-income patients
14 and are otherwise made in accordance with the require-
15 ments of section 1923 of that Act.

16 **SEC. 702. NEW PROSPECTIVE PAYMENT SYSTEM FOR FED-**
17 **ERALLY-QUALIFIED HEALTH CENTERS AND**
18 **RURAL HEALTH CLINICS.**

19 (a) IN GENERAL.—Section 1902(a) (42 U.S.C.
20 1396a(a)) is amended—

21 (1) in paragraph (13)—

22 (A) in subparagraph (A), by adding “and”
23 at the end;

24 (B) in subparagraph (B), by striking
25 “and” at the end; and

1 (C) by striking subparagraph (C); and

2 (2) by inserting after paragraph (14) the fol-
3 lowing new paragraph:

4 “(15) provide for payment for services de-
5 scribed in clause (B) or (C) of section 1905(a)(2)
6 under the plan in accordance with subsection (aa);”.

7 (b) NEW PROSPECTIVE PAYMENT SYSTEM.—Section
8 1902 (42 U.S.C. 1396a) is amended by adding at the end
9 the following:

10 “(aa) PAYMENT FOR SERVICES PROVIDED BY FED-
11 ERALLY-QUALIFIED HEALTH CENTERS AND RURAL
12 HEALTH CLINICS.—

13 “(1) IN GENERAL.—Beginning with fiscal year
14 2001 and each succeeding fiscal year, the State plan
15 shall provide for payment for services described in
16 section 1905(a)(2)(C) furnished by a Federally-
17 qualified health center and services described in sec-
18 tion 1905(a)(2)(B) furnished by a rural health clinic
19 in accordance with the provisions of this subsection.

20 “(2) FISCAL YEAR 2001.—Subject to paragraph
21 (4), for services furnished during fiscal year 2001,
22 the State plan shall provide for payment for such
23 services in an amount (calculated on a per visit
24 basis) that is equal to 100 percent of the average of
25 the costs of the center or clinic of furnishing such

1 services during fiscal years 1999 and 2000 which
2 are reasonable and related to the cost of furnishing
3 such services, or based on such other tests of reason-
4 ableness as the Secretary prescribes in regulations
5 under section 1833(a)(3), or, in the case of services
6 to which such regulations do not apply, the same
7 methodology used under section 1833(a)(3), ad-
8 justed to take into account any increase or decrease
9 in the scope of such services furnished by the center
10 or clinic during fiscal year 2001.

11 “(3) FISCAL YEAR 2002 AND SUCCEEDING FIS-
12 CAL YEARS.—Subject to paragraph (4), for services
13 furnished during fiscal year 2002 or a succeeding
14 fiscal year, the State plan shall provide for payment
15 for such services in an amount (calculated on a per
16 visit basis) that is equal to the amount calculated for
17 such services under this subsection for the preceding
18 fiscal year—

19 “(A) increased by the percentage increase
20 in the MEI (as defined in section 1842(i)(3))
21 applicable to primary care services (as defined
22 in section 1842(i)(4)) for that fiscal year; and

23 “(B) adjusted to take into account any in-
24 crease or decrease in the scope of such services

1 furnished by the center or clinic during that fis-
2 cal year.

3 “(4) ESTABLISHMENT OF INITIAL YEAR PAY-
4 MENT AMOUNT FOR NEW CENTERS OR CLINICS.—In
5 any case in which an entity first qualifies as a Fed-
6 erally-qualified health center or rural health clinic
7 after fiscal year 2000, the State plan shall provide
8 for payment for services described in section
9 1905(a)(2)(C) furnished by the center or services
10 described in section 1905(a)(2)(B) furnished by the
11 clinic in the first fiscal year in which the center or
12 clinic so qualifies in an amount (calculated on a per
13 visit basis) that is equal to 100 percent of the costs
14 of furnishing such services during such fiscal year
15 based on the rates established under this subsection
16 for the fiscal year for other such centers or clinics
17 located in the same or adjacent area with a similar
18 case load or, in the absence of such a center or clin-
19 ic, in accordance with the regulations and method-
20 ology referred to in paragraph (2) or based on such
21 other tests of reasonableness as the Secretary may
22 specify. For each fiscal year following the fiscal year
23 in which the entity first qualifies as a Federally-
24 qualified health center or rural health clinic, the

1 State plan shall provide for the payment amount to
2 be calculated in accordance with paragraph (3).

3 “(5) ADMINISTRATION IN THE CASE OF MAN-
4 AGED CARE.—

5 “(A) IN GENERAL.—In the case of services
6 furnished by a Federally-qualified health center
7 or rural health clinic pursuant to a contract be-
8 tween the center or clinic and a managed care
9 entity (as defined in section 1932(a)(1)(B)), the
10 State plan shall provide for payment to the cen-
11 ter or clinic by the State of a supplemental pay-
12 ment equal to the amount (if any) by which the
13 amount determined under paragraphs (2), (3),
14 and (4) of this subsection exceeds the amount
15 of the payments provided under the contract.

16 “(B) PAYMENT SCHEDULE.—The supple-
17 mental payment required under subparagraph
18 (A) shall be made pursuant to a payment
19 schedule agreed to by the State and the Feder-
20 ally-qualified health center or rural health clin-
21 ic, but in no case less frequently than every 4
22 months.

23 “(6) ALTERNATIVE PAYMENT METHODOLO-
24 GIES.—Notwithstanding any other provision of this
25 section, the State plan may provide for payment in

1 any fiscal year to a Federally-qualified health center
2 for services described in section 1905(a)(2)(C) or to
3 a rural health clinic for services described in section
4 1905(a)(2)(B) in an amount which is determined
5 under an alternative payment methodology that—

6 “(A) is agreed to by the State and the cen-
7 ter or clinic; and

8 “(B) results in payment to the center or
9 clinic of an amount which is at least equal to
10 the amount otherwise required to be paid to the
11 center or clinic under this section.”.

12 (c) CONFORMING AMENDMENTS.—

13 (1) Section 4712 of the BBA (Public Law 105–
14 33; 111 Stat. 508) is amended by striking sub-
15 section (c).

16 (2) Section 1915(b) (42 U.S.C. 1396n(b)) is
17 amended by striking “1902(a)(13)(C)” and inserting
18 “1902(a)(15), 1902(aa),”.

19 (d) GAO STUDY OF FUTURE REBASING.—The
20 Comptroller General of the United States shall provide for
21 a study on the need for, and how to, rebase or refine costs
22 for making payment under the medicaid program for serv-
23 ices provided by Federally-qualified health centers and
24 rural health clinics (as provided under the amendments
25 made by this section). The Comptroller General shall pro-

1 vide for submittal of a report on such study to Congress
2 by not later than 4 years after the date of the enactment
3 of this Act.

4 (e) EFFECTIVE DATE.—The amendments made by
5 this section take effect on October 1, 2000, and apply to
6 services furnished on or after such date.

7 **SEC. 703. STREAMLINED APPROVAL OF CONTINUED STATE-**
8 **WIDE SECTION 1115 MEDICAID WAIVERS.**

9 (a) IN GENERAL.—Section 1115 (42 U.S.C. 1315)
10 is amended by adding at the end the following new sub-
11 section:

12 “(f) An application by the chief executive officer of
13 a State for an extension of a waiver project the State is
14 operating under an extension under subsection (e) (in this
15 subsection referred to as the ‘waiver project’) shall be sub-
16 mitted and approved or disapproved in accordance with
17 the following:

18 “(1) The application for an extension of the
19 waiver project shall be submitted to the Secretary at
20 least 120 days prior to the expiration of the current
21 period of the waiver project.

22 “(2) Not later than 45 days after the date such
23 application is received by the Secretary, the Sec-
24 retary shall notify the State if the Secretary intends
25 to review the terms and conditions of the waiver

1 project. A failure to provide such notification shall
2 be deemed to be an approval of the application.

3 “(3) Not later than 45 days after the date a no-
4 tification is made in accordance with paragraph (2),
5 the Secretary shall inform the State of proposed
6 changes in the terms and conditions of the waiver
7 project. A failure to provide such information shall
8 be deemed to be an approval of the application.

9 “(4) During the 30-day period that begins on
10 the date information described in paragraph (3) is
11 provided to a State, the Secretary shall negotiate re-
12 vised terms and conditions of the waiver project with
13 the State.

14 “(5)(A) Not later than 120 days after the date
15 an application for an extension of the waiver project
16 is submitted to the Secretary (or such later date
17 agreed to by the chief executive officer of the State),
18 the Secretary shall—

19 “(i) approve the application subject to such
20 modifications in the terms and conditions—

21 “(I) as have been agreed to by the
22 Secretary and the State; or

23 “(II) in the absence of such agree-
24 ment, as are determined by the Secretary
25 to be reasonable, consistent with the over-

1 all objectives of the waiver project, and not
2 in violation of applicable law; or

3 “(ii) disapprove the application.

4 “(B) A failure by the Secretary to approve or
5 disapprove an application submitted under this sub-
6 section in accordance with the requirements of sub-
7 paragraph (A) shall be deemed to be an approval of
8 the application subject to such modifications in the
9 terms and conditions as have been agreed to (if any)
10 by the Secretary and the State.

11 “(6) An approval of an application for an exten-
12 sion of a waiver project under this subsection shall
13 be for a period not to exceed 3 years.

14 “(7) An extension of a waiver project under this
15 subsection shall be subject to the final reporting and
16 evaluation requirements of paragraphs (4) and (5)
17 of subsection (e) (taking into account the extension
18 under this subsection with respect to any timing re-
19 quirements imposed under those paragraphs).”.

20 (b) EFFECTIVE DATE.—The amendment made by
21 subsection (a) applies to requests for extensions of dem-
22 onstration projects pending or submitted on or after the
23 date of the enactment of this Act.

1 **SEC. 704. MEDICAID COUNTY-ORGANIZED HEALTH SYS-**
2 **TEMS.**

3 (a) IN GENERAL.—Section 9517(c)(3)(C) of the
4 Comprehensive Omnibus Budget Reconciliation Act of
5 1985 is amended by striking “10 percent” and inserting
6 “14 percent”.

7 (b) EFFECTIVE DATE.—The amendment made by
8 subsection (a) takes effect on the date of the enactment
9 of this Act.

10 **SEC. 705. DEADLINE FOR ISSUANCE OF FINAL REGULATION**
11 **RELATING TO MEDICAID UPPER PAYMENT**
12 **LIMITS.**

13 (a) IN GENERAL.—Not later than December 31,
14 2000, the Secretary of Health and Human Services (in
15 this section referred to as the “Secretary”), notwith-
16 standing any requirement of the Administrative Proce-
17 dures Act under chapter 5 of title 5, United States Code,
18 or any other provision of law, shall issue under sections
19 447.272, 447.304, and 447.321 of title 42, Code of Fed-
20 eral Regulations (and any other section of part 447 of title
21 42, Code of Federal Regulations that the Secretary deter-
22 mines is appropriate), a final regulation based on the pro-
23 posed rule announced on October 5, 2000, that—

24 (1) modifies the upper payment limit test ap-
25 plied to State medicaid spending for inpatient hos-
26 pital services, outpatient hospital services, nursing

1 facility services, intermediate care facility services
2 for the mentally retarded, and clinic services by ap-
3 plying an aggregate upper payment limit to pay-
4 ments made to government facilities that are not
5 State-owned or operated facilities; and

6 (2) provides for a transition period in accord-
7 ance with subsection (b).

8 (b) TRANSITION PERIOD.—

9 (1) IN GENERAL.—The final regulation required
10 under subsection (a) shall provide that, with respect
11 to a State described in paragraph (3), the State
12 shall be considered to be in compliance with the final
13 regulation required under subsection (a) so long as,
14 for each State fiscal year during the period de-
15 scribed in paragraph (4), the State reduces pay-
16 ments under a State medicaid plan payment provi-
17 sion or methodology described in paragraph (3), or
18 reduces the actual dollar payment levels described in
19 paragraph (3)(B), so that the amount of the pay-
20 ments that would otherwise have been made under
21 such provision, methodology, or payment levels by
22 the State for any State fiscal year during such pe-
23 riod is reduced by 15 percent in the first such State
24 fiscal year, and by an additional 15 percent in each
25 of next 5 State fiscal years.

1 (2) REQUIREMENT.—Notwithstanding para-
2 graph (1), the final regulation required under sub-
3 section (a) shall provide that, for any period (or por-
4 tion of a period) that occurs on or after October 1,
5 2008, medicaid payments made by a State described
6 in paragraph (3) shall comply with such final regula-
7 tion.

8 (3) STATE DESCRIBED.—A State described in
9 this paragraph is a State with a State medicaid plan
10 payment provision or methodology which—

11 (A) was approved, deemed to have been ap-
12 proved, or was in effect on or before October 1,
13 1992 (including any subsequent amendments or
14 successor provisions or methodologies and
15 whether or not a State plan amendment was
16 made to carry out such provision or method-
17 ology after such date) or under which claims for
18 Federal financial participation were filed and
19 paid on or before such date; and

20 (B) provides for payments that are in ex-
21 cess of the upper payment limit test established
22 under the final regulation required under sub-
23 section (a) (or which would be noncompliant
24 with such final regulation if the actual dollar
25 payment levels made under the payment provi-

1 sion or methodology in the State fiscal year
2 which begins during 1999 were continued).

3 (4) PERIOD DESCRIBED.—The period described
4 in this paragraph is the period that begins on the
5 first State fiscal year that begins after September
6 30, 2002, and ends on September 30, 2008.

7 **SEC. 706. ALASKA FMAP.**

8 Notwithstanding the first sentence of section 1905(b)
9 of the Social Security Act (42 U.S.C. 1396d(b)), only with
10 respect to each of fiscal years 2001 through 2005, for pur-
11 poses of titles XIX and XXI of the Social Security Act,
12 the State percentage used to determine the Federal med-
13 ical assistance percentage for Alaska shall be that percent-
14 age which bears the same ratio to 45 percent as the square
15 of the adjusted per capita income of Alaska (determined
16 by dividing the State's 3-year average per capita income
17 by 1.05) bears to the square of the per capita income of
18 the 50 States.

19 **TITLE VIII—STATE CHILDREN'S**
20 **HEALTH INSURANCE PROGRAM**

21 **SEC. 801. SPECIAL RULE FOR REDISTRIBUTION AND AVAIL-**
22 **ABILITY OF UNUSED FISCAL YEAR 1998 AND**
23 **1999 SCHIP ALLOTMENTS.**

24 (a) CHANGE IN RULES FOR REDISTRIBUTION AND
25 RETENTION OF UNUSED SCHIP ALLOTMENTS FOR FIS-

1 CAL YEARS 1998 AND 1999.—Section 2104 (42 U.S.C.
2 1397dd) is amended by adding at the end the following
3 new subsection:

4 “(g) RULE FOR REDISTRIBUTION AND EXTENDED
5 AVAILABILITY OF FISCAL YEARS 1998 AND 1999 ALLOT-
6 MENTS.—

7 “(1) AMOUNT REDISTRIBUTED.—

8 “(A) IN GENERAL.—In the case of a State
9 that expends all of its allotment under sub-
10 section (b) or (c) for fiscal year 1998 by the
11 end of fiscal year 2000, or for fiscal year 1999
12 by the end of fiscal year 2001, the Secretary
13 shall redistribute to the State under subsection
14 (f) (from the fiscal year 1998 or 1999 allot-
15 ments of other States, respectively, as deter-
16 mined by the application of paragraphs (2) and
17 (3) with respect to the respective fiscal year))
18 the following amount:

19 “(i) STATE.—In the case of 1 of the
20 50 States or the District of Columbia, with
21 respect to—

22 “(I) the fiscal year 1998 allot-
23 ment, the amount by which the
24 State’s expenditures under this title in
25 fiscal years 1998, 1999, and 2000 ex-

1 ceed the State's allotment for fiscal
2 year 1998 under subsection (b); or

3 “(II) the fiscal year 1999 allot-
4 ment, the amount by which the
5 State's expenditures under this title in
6 fiscal years 1999, 2000, and 2001 ex-
7 ceed the State's allotment for fiscal
8 year 1999 under subsection (b).

9 “(ii) TERRITORY.—In the case of a
10 commonwealth or territory described in
11 subsection (c)(3), an amount that bears
12 the same ratio to 1.05 percent of the total
13 amount described in paragraph (2)(B)(i)(I)
14 as the ratio of the commonwealth's or ter-
15 ritory's fiscal year 1998 or 1999 allotment
16 under subsection (c) (as the case may be)
17 bears to the total of all such allotments for
18 such fiscal year under such subsection.

19 “(B) EXPENDITURE RULES.—An amount
20 redistributed to a State under this paragraph
21 with respect to fiscal year 1998 or 1999—

22 “(i) shall not be included in the deter-
23 mination of the State's allotment for any
24 fiscal year under this section;

1 “(ii) notwithstanding subsection (e),
2 shall remain available for expenditure by
3 the State through the end of fiscal year
4 2002; and

5 “(iii) shall be counted as being ex-
6 pended with respect to a fiscal year allot-
7 ment in accordance with applicable regula-
8 tions of the Secretary.

9 “(2) EXTENSION OF AVAILABILITY OF PORTION
10 OF UNEXPENDED FISCAL YEARS 1998 AND 1999 AL-
11 LOTMENTS.—

12 “(A) IN GENERAL.—Notwithstanding sub-
13 section (e):

14 “(i) FISCAL YEAR 1998 ALLOTMENT.—
15 Of the amounts allotted to a State pursu-
16 ant to this section for fiscal year 1998 that
17 were not expended by the State by the end
18 of fiscal year 2000, the amount specified in
19 subparagraph (B) for fiscal year 1998 for
20 such State shall remain available for ex-
21 penditure by the State through the end of
22 fiscal year 2002.

23 “(ii) FISCAL YEAR 1999 ALLOT-
24 MENT.—Of the amounts allotted to a State
25 pursuant to this subsection for fiscal year

1 1999 that were not expended by the State
2 by the end of fiscal year 2001, the amount
3 specified in subparagraph (B) for fiscal
4 year 1999 for such State shall remain
5 available for expenditure by the State
6 through the end of fiscal year 2002.

7 “(B) AMOUNT REMAINING AVAILABLE FOR
8 EXPENDITURE.—The amount specified in this
9 subparagraph for a State for a fiscal year is
10 equal to—

11 “(i) the amount by which (I) the total
12 amount available for redistribution under
13 subsection (f) from the allotments for that
14 fiscal year, exceeds (II) the total amounts
15 redistributed under paragraph (1) for that
16 fiscal year; multiplied by

17 “(ii) the ratio of the amount of such
18 State’s unexpended allotment for that fis-
19 cal year to the total amount described in
20 clause (i)(I) for that fiscal year.

21 “(C) USE OF UP TO 10 PERCENT OF RE-
22 TAINED 1998 ALLOTMENTS FOR OUTREACH AC-
23 TIVITIES.—Notwithstanding section
24 2105(c)(2)(A), with respect to any State de-
25 scribed in subparagraph (A)(i), the State may

1 use up to 10 percent of the amount specified in
2 subparagraph (B) for fiscal year 1998 for ex-
3 penditures for outreach activities approved by
4 the Secretary.

5 “(3) DETERMINATION OF AMOUNTS.—For pur-
6 poses of calculating the amounts described in para-
7 graphs (1) and (2) relating to the allotment for fis-
8 cal year 1998 or fiscal year 1999, the Secretary
9 shall use the amounts reported by the States not
10 later than November 30, 2000, or November 30,
11 2001, respectively, on HCFA Form 64 or HCFA
12 Form 21, as approved by the Secretary.”.

13 (b) EFFECTIVE DATE.—The amendments made by
14 this section shall take effect as if included in the enact-
15 ment of section 4901 of BBA (111 Stat. 552).

16 **SEC. 802. AUTHORITY TO PAY MEDICAID EXPANSION SCHIP**
17 **COSTS FROM TITLE XXI APPROPRIATION.**

18 (a) AUTHORITY TO PAY MEDICAID EXPANSION
19 SCHIP COSTS FROM TITLE XXI APPROPRIATION.—Sec-
20 tion 2105(a) (42 U.S.C. 1397ee(a)) is amended—

21 (1) by redesignating subparagraphs (A) through
22 (D) of paragraph (2) as clauses (i) through (iv), re-
23 spectively, and indenting appropriately;

24 (2) by redesignating paragraph (1) as subpara-
25 graph (C), and indenting appropriately;

1 (3) by redesignating paragraph (2) as subpara-
2 graph (D), and indenting appropriately;

3 (4) by striking “(a) IN GENERAL.—” and the
4 remainder of the text that precedes subparagraph
5 (C), as so redesignated, and inserting the following:
6 “(a) PAYMENTS.—

7 “(1) IN GENERAL.—Subject to the succeeding
8 provisions of this section, the Secretary shall pay to
9 each State with a plan approved under this title,
10 from its allotment under section 2104, an amount
11 for each quarter equal to the enhanced FMAP (or,
12 in the case of expenditures described in subpara-
13 graph (B), the Federal medical assistance percent-
14 age (as defined in the first sentence of section
15 1905(b))) of expenditures in the quarter—

16 “(A) for child health assistance under the
17 plan for targeted low-income children in the
18 form of providing medical assistance for which
19 payment is made on the basis of an enhanced
20 FMAP under the fourth sentence of section
21 1905(b);

22 “(B) for the provision of medical assist-
23 ance on behalf of a child during a presumptive
24 eligibility period under section 1920A;”); and

1 (5) by adding after subparagraph (D), as so re-
2 designated, the following new paragraph:

3 “(2) ORDER OF PAYMENTS.—Payments under
4 paragraph (1) from a State’s allotment shall be
5 made in the following order:

6 “(A) First, for expenditures for items de-
7 scribed in paragraph (1)(A).

8 “(B) Second, for expenditures for items
9 described in paragraph (1)(B).

10 “(C) Third, for expenditures for items de-
11 scribed in paragraph (1)(C).

12 “(D) Fourth, for expenditures for items
13 described in paragraph (1)(D).”.

14 (b) ELIMINATION OF REQUIREMENT TO REDUCE
15 TITLE XXI ALLOTMENT BY MEDICAID EXPANSION
16 SCHIP COSTS.—Section 2104 (42 U.S.C. 1397dd) is
17 amended by striking subsection (d).

18 (c) AUTHORITY TO TRANSFER TITLE XXI APPRO-
19 PRIATIONS TO TITLE XIX APPROPRIATION ACCOUNT AS
20 REIMBURSEMENT FOR MEDICAID EXPENDITURES FOR
21 MEDICAID EXPANSION SCHIP SERVICES.—Notwith-
22 standing any other provision of law, all amounts appro-
23 priated under title XXI and allotted to a State pursuant
24 to subsection (b) or (c) of section 2104 of the Social Secu-
25 rity Act (42 U.S.C. 1397dd) for fiscal years 1998 through

1 2000 (including any amounts that, but for this provision,
2 would be considered to have expired) and not expended
3 in providing child health assistance or related services for
4 which payment may be made pursuant to subparagraph
5 (C) or (D) of section 2105(a)(1) of such Act (42 U.S.C.
6 1397ee(a)(1)) (as amended by subsection (a)), shall be
7 available to reimburse the Grants to States for Medicaid
8 account in an amount equal to the total payments made
9 to such State under section 1903(a) of such Act (42
10 U.S.C. 1396b(a)) for expenditures in such years for med-
11 ical assistance described in subparagraphs (A) and (B) of
12 section 2105(a)(1) of such Act (42 U.S.C. 1397ee(a)(1)
13 (as so amended).

14 (d) CONFORMING AMENDMENTS.—

15 (1) Section 1905(b) (42 U.S.C. 1396d(b)) is
16 amended in the fourth sentence by striking “the
17 State’s allotment under section 2104 (not taking
18 into account reductions under section 2104(d)(2))
19 for the fiscal year reduced by the amount of any
20 payments made under section 2105 to the State
21 from such allotment for such fiscal year” and insert-
22 ing “the State’s available allotment under section
23 2104”.

1 (2) Section 1905(u)(1)(B) (42 U.S.C.
2 1396d(u)(1)(B)) is amended by striking “and sec-
3 tion 2104(d)”.

4 (3) Section 2104 (42 U.S.C. 1397dd), as
5 amended by subsection (b), is further amended—

6 (A) in subsection (b)(1), by striking “and
7 subsection (d)”;

8 (B) in subsection (c)(1), by striking “sub-
9 ject to subsection (d),”.

10 (4) Section 2105(c) (42 U.S.C. 1397ee(c)) is
11 amended—

12 (A) in paragraph (2)(A), by striking all
13 that follows “Except as provided in this para-
14 graph,” and inserting “the amount of payment
15 that may be made under subsection (a) for a
16 fiscal year for expenditures for items described
17 in paragraph (1)(D) of such subsection shall
18 not exceed 10 percent of the total amount of ex-
19 penditures for which payment is made under
20 subparagraphs (A), (C), and (D) of paragraph
21 (1) of such subsection.”;

22 (B) in paragraph (2)(B), by striking “de-
23 scribed in subsection (a)(2)” and inserting “de-
24 scribed in subsection (a)(1)(D)”;

1 (C) in paragraph (6)(B), by striking “Ex-
2 cept as otherwise provided by law,” and insert-
3 ing “Except as provided in subparagraph (A) or
4 (B) of subsection (a)(1) or any other provision
5 of law,”.

6 (5) Section 2110(a) (42 U.S.C. 1397jj(a)) is
7 amended by striking “section 2105(a)(2)(A)” and
8 inserting “section 2105(a)(1)(D)(i)”.

9 (e) TECHNICAL AMENDMENT.—Section
10 2105(d)(2)(B)(ii) (42 U.S.C. 1397ee(d)(2)(B)(ii)) is
11 amended by striking “enhanced FMAP under section
12 1905(u)” and inserting “enhanced FMAP under the
13 fourth sentence of section 1905(b)”.

14 (f) EFFECTIVE DATE.—The amendments made by
15 this section shall be effective as if included in the enact-
16 ment of section 4901 of the BBA (111 Stat. 552).

17 **TITLE IX—OTHER PROVISIONS**

18 **Subtitle A—PACE Program**

19 **SEC. 901. EXTENSION OF TRANSITION FOR CURRENT WAIV-** 20 **ERS.**

21 Section 4803(d)(2) of BBA is amended—

22 (1) in subparagraph (A), by striking “24
23 months” and inserting “36 months”;

1 (2) in subparagraph (A), by striking “the initial
2 effective date of regulations described in subsection
3 (a)” and inserting “July 1, 2000”; and

4 (3) in subparagraph (B), by striking “3 years”
5 and inserting “4 years”.

6 **SEC. 902. CONTINUING OF CERTAIN OPERATING ARRANGE-**
7 **MENTS PERMITTED.**

8 (a) IN GENERAL.—Section 1894(f)(2) (42 U.S.C.
9 1395eee(f)(2)) is amended by adding at the end the fol-
10 lowing new subparagraph:

11 “(C) CONTINUATION OF MODIFICATIONS
12 OR WAIVERS OF OPERATIONAL REQUIREMENTS
13 UNDER DEMONSTRATION STATUS.—If a PACE
14 program operating under demonstration author-
15 ity has contractual or other operating arrange-
16 ments which are not otherwise recognized in
17 regulation and which were in effect on July 1,
18 2000, the Secretary (in close consultation with,
19 and with the concurrence of, the State admin-
20 istering agency) shall permit any such program
21 to continue such arrangements so long as such
22 arrangements are found by the Secretary and
23 the State to be reasonably consistent with the
24 objectives of the PACE program.”.

1 (b) CONFORMING AMENDMENT.—Section 1934(f)(2)
2 (42 U.S.C. 1396u–4(f)(2)) is amended by adding at the
3 end the following new subparagraph:

4 “(C) CONTINUATION OF MODIFICATIONS
5 OR WAIVERS OF OPERATIONAL REQUIREMENTS
6 UNDER DEMONSTRATION STATUS.—If a PACE
7 program operating under demonstration author-
8 ity has contractual or other operating arrange-
9 ments which are not otherwise recognized in
10 regulation and which were in effect on July 1
11 2000, the Secretary (in close consultation with,
12 and with the concurrence of, the State admin-
13 istering agency) shall permit any such program
14 to continue such arrangements so long as such
15 arrangements are found by the Secretary and
16 the State to be reasonably consistent with the
17 objectives of the PACE program.”.

18 (c) EFFECTIVE DATE.—The amendments made by
19 this section shall be effective as included in the enactment
20 of BBA.

21 **SEC. 903. FLEXIBILITY IN EXERCISING WAIVER AUTHORITY.**

22 In applying sections 1894(f)(2)(B) and
23 1934(f)(2)(B) of the Social Security Act (42 U.S.C.
24 1395eee(f)(2)(B), 1396u–4(f)(2)(B)), the Secretary of
25 Health and Human Services—

1 (1) shall approve or deny a request for a modi-
 2 fication or a waiver of provisions of the PACE pro-
 3 tocol not later than 90 days after the date the Sec-
 4 retary receives the request; and

5 (2) may exercise authority to modify or waive
 6 such provisions in a manner that responds promptly
 7 to the needs of PACE programs relating to areas of
 8 employment and the use of community-based pri-
 9 mary care physicians.

10 **Subtitle B—Outreach to Eligible**
 11 **Low-Income Medicare Bene-**
 12 **ficiaries**

13 **SEC. 911. OUTREACH ON AVAILABILITY OF MEDICARE**
 14 **COST-SHARING ASSISTANCE TO ELIGIBLE**
 15 **LOW-INCOME MEDICARE BENEFICIARIES.**

16 (a) OUTREACH.—

17 (1) IN GENERAL.—Title XI (42 U.S.C. 1301 et
 18 seq.) is amended by inserting after section 1143 the
 19 following new section:

20 “OUTREACH EFFORTS TO INCREASE AWARENESS OF THE
 21 AVAILABILITY OF MEDICARE COST-SHARING

22 “SEC. 1144. (a) OUTREACH.—

23 “(1) IN GENERAL.—The Commissioner of So-
 24 cial Security (in this section referred to as the ‘Com-
 25 missioner’) shall conduct outreach efforts to—

1 “(A) identify individuals entitled to bene-
2 fits under the medicare program under title
3 XVIII who may be eligible for medical assist-
4 ance for payment of the cost of medicare cost-
5 sharing under the medicaid program pursuant
6 to sections 1902(a)(10)(E) and 1933; and

7 “(B) notify such individuals of the avail-
8 ability of such medical assistance under such
9 sections.

10 “(2) CONTENT OF NOTICE.—Any notice fur-
11 nished under paragraph (1) shall state that eligi-
12 bility for medicare cost-sharing assistance under
13 such sections is conditioned upon—

14 “(A) the individual providing to the State
15 information about income and resources (in the
16 case of an individual residing in a State that
17 imposes an assets test for such eligibility); and

18 “(B) meeting the applicable eligibility cri-
19 teria.

20 “(b) COORDINATION WITH STATES.—

21 “(1) IN GENERAL.—In conducting the outreach
22 efforts under this section, the Commissioner shall—

23 “(A) furnish the agency of each State re-
24 sponsible for the administration of the medicaid
25 program and any other appropriate State agen-

1 cy with information consisting of the name and
2 address of individuals residing in the State that
3 the Commissioner determines may be eligible
4 for medical assistance for payment of the cost
5 of medicare cost-sharing under the medicaid
6 program pursuant to sections 1902(a)(10)(E)
7 and 1933; and

8 “(B) update any such information not less
9 frequently than once per year.

10 “(2) INFORMATION IN PERIODIC UPDATES.—

11 The periodic updates described in paragraph (1)(B)
12 shall include information on individuals who are or
13 may be eligible for the medical assistance described
14 in paragraph (1)(A) because such individuals have
15 experienced reductions in benefits under title II.”.

16 (2) AMENDMENT TO TITLE XIX.—Section

17 1905(p) (42 U.S.C. 1396d(p)) is amended by adding
18 at the end the following new paragraph:

19 “(5) For provisions relating to outreach efforts to in-
20 crease awareness of the availability of medicare cost-shar-
21 ing, see section 1144.”.

22 (b) GAO REPORT.—The Comptroller General of the
23 United States shall conduct a study of the impact of sec-
24 tion 1144 of the Social Security Act (as added by sub-
25 section (a)(1)) on the enrollment of individuals for medi-

1 care cost-sharing under the medicaid program. Not later
2 than 18 months after the date that the Commissioner of
3 Social Security first conducts outreach under section 1144
4 of such Act, the Comptroller General shall submit to Con-
5 gress a report on such study. The report shall include such
6 recommendations for legislative changes as the Comp-
7 troller General deems appropriate.

8 (c) EFFECTIVE DATE.—The amendments made by
9 subsections (a) shall take effect one year after the date
10 of the enactment of this Act.

11 **Subtitle C—Maternal and Child**
12 **Health Block Grant**

13 **SEC. 921. INCREASE IN AUTHORIZATION OF APPROPRIA-**
14 **TIONS FOR THE MATERNAL AND CHILD**
15 **HEALTH SERVICES BLOCK GRANT.**

16 (a) IN GENERAL.—Section 501(a) (42 U.S.C.
17 701(a)) is amended in the matter preceding paragraph (1)
18 by striking “\$705,000,000 for fiscal year 1994” and in-
19 serting “\$850,000,000 for fiscal year 2001”.

20 (b) EFFECTIVE DATE.—The amendment made by
21 subsection (a) takes effect on October 1, 2000.

1 (1) by striking “Notwithstanding” and insert-
2 ing the following:

3 “(1) TRANSFERRED FUNDS.—Notwith-
4 standing”; and

5 (2) by adding at the end the following:

6 “(2) APPROPRIATIONS.—For the purpose of
7 making grants under this section, there is appro-
8 priated, out of any money in the Treasury not other-
9 wise appropriated—

10 “(A) \$70,000,000 for each of fiscal years
11 2001 and 2002 (which shall be combined with
12 amounts transferred under paragraph (1) for
13 each such fiscal years); and

14 “(B) \$100,000,000 for fiscal year 2003.”.

15 (c) EXTENSION OF FINAL REPORT ON GRANT PRO-
16 GRAMS.—Section 4923(b)(2) of BBA is amended by strik-
17 ing “2002” and inserting “2003”.

18 **SEC. 932. APPROPRIATIONS FOR RICKY RAY HEMOPHILIA**

19 **RELIEF FUND.**

20 Section 101(e) of the Ricky Ray Hemophilia Relief
21 Fund Act of 1998 (42 U.S.C. 300c–22 note) is amended
22 by adding at the end the following: “There is appropriated
23 to the Fund \$475,000,000 for fiscal year 2001, to remain
24 available until expended.”.

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