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106TH CONGRESS
2D 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. BLILEY, 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

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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.

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

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO OTHER ACTS; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000''.

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

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

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

(2) MEDICARE, MEDICAID, AND SCHIP BALANCED BUDGET REFINEMENT ACT OF 1999.—The term ''BBRA'' means the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Appendix F, 113 Stat. 1501A–321), as enacted into law by section 1000(a)(6) of Public Law 106–113.

(d) TABLE OF CONTENTS.—The table of contents of 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 MANAGED 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.

TITLE I—MEDICARE BENEFICIARY IMPROVEMENTS

Subtitle A—Improved Preventive Benefits

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

(a) IN GENERAL.—

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

(2) BIENNIAL SCREENING PELVIC EXAM.—Section 1861(nn)(2) (42 U.S.C. 1395x(nn)(2)) is amended by striking ''3 years'' and inserting ''2 years''.

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

SEC. 102. COVERAGE OF SCREENING FOR GLAUCOMA.

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

(1) by striking ''and'' at the end of subparagraph (S);

(2) by inserting ''and'' at the end of subparagraph (T); and

(3) by adding at the end the following:

''(U) screening for glaucoma (as defined in subsection (uu)) for individuals determined to be at high risk for glaucoma, individuals with a family history of glaucoma and individuals with diabetes;''.

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

''Screening for Glaucoma

''(uu) The term 'screening for glaucoma' means a dilated eye examination with an intraocular pressure measurement, and a direct ophthalmoscopy or a slit-lamp biomicroscopic examination for the early detection of glaucoma which is furnished by or under the direct supervision of an optometrist or ophthalmologist who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident

to a physician's professional service, if the individual involved has not had such an examination in the preceding year.''.

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

(1) by striking ''and,''; and

(2) by adding at the end the following: ''and, in the case of screening for glaucoma, which is performed more frequently than is provided under section 1861(uu),''.

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

SEC. 103. COVERAGE OF SCREENING COLONOSCOPY FOR AVERAGE RISK INDIVIDUALS.

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

(1) in paragraph (1)(C), by striking ''In the case of an individual at high risk for colorectal cancer, screening colonoscopy'' and inserting ''Screening colonoscopy''; and

(2) in paragraph (2), by striking ''In paragraph (1)(C), an'' and inserting ''An''.

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

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

(2) in paragraph (3)—

(A) in the heading by striking ''FOR INDIVIDUALS AT HIGH RISK FOR COLORECTAL CANCER'';

(B) in subparagraph (A), by striking ''for individuals at high risk for colorectal cancer (as defined in section 1861(pp)(2))'';

(C) in subparagraph (E), by inserting before the period at the end the following: ''or for other individuals if the procedure is performed within the 119 months after a previous screening colonoscopy or within 47 months after a previous screening flexible sigmoidoscopy''.

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

SEC. 104. MODERNIZATION OF SCREENING MAMMOGRAPHY BENEFIT.

(a) INCLUSION IN PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(13),'' after ''(4),''.

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

''(c) PAYMENT AND STANDARDS FOR SCREENING MAMMOGRAPHY.—

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

''(A) for screening mammography conducted consistent with the frequency permitted under paragraph (2); and

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

''(2) FREQUENCY COVERED.—

''(A) IN GENERAL.—Subject to revision by the Secretary under subparagraph (B)—

''(i) no payment may be made under this part for screening mammography performed on a woman under 35 years of age;

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

''(iii) in the case of a woman over 39 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.

''(B) REVISION OF FREQUENCY.—

''(i) REVIEW.—The Secretary, in consultation with the Director of the National Cancer Institute, shall review periodically the appropriate frequency for performing screening mammography, based on age and such other factors as the Secretary believes to be pertinent.

''(ii) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which screening mammography may be paid for under this subsection.''.

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

(d) PAYMENT FOR NEW TECHNOLOGIES.—

(1) TESTS FURNISHED IN 2001.—

(A) SCREENING.—For a screening mammography (as defined in section 1861(jj) of the Social Security Act (42 U.S.C. 1395(jj))) furnished during the period beginning on April 1, 2001, and ending on December 31, 2001, that uses a new technology, payment for such screening mammography shall be made as follows:

(i) In the case of a technology which directly takes a digital image (without involving film) and subsequently analyzes such resulting image with software to identify possible problem areas, in an amount equal to 150 percent of the amount of payment under section 1848 of such Act (42 U.S.C. 1395w–4) for a bilateral diagnostic mammography (under HCPCS code 76091) for such year.

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

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

(B) BILATERAL DIAGNOSTIC MAMMOGRAPHY.—For a bilateral diagnostic mammography (under HCPCS code 76091) furnished during the period beginning on April 1, 2001, and ending on December 31, 2001, that uses a new technology described in subparagraph (A)(i), payment for such mammography shall be the amount of payment provided for under such subparagraph.

The Secretary of Health and Human Services may implement the provisions of this paragraph by program memorandum or otherwise.

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

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

(3) NEW TECHNOLOGY DESCRIBED.—For purposes of this subsection, a new technology with respect to a screening mammography is an advance in technology with respect to the test or equipment that results in the following:

(A) A significant increase or decrease in the resources used in the test or in the manufacture of the equipment.

(B) A significant improvement in the performance of the test or equipment.

(C) A significant advance in medical technology that is expected to significantly improve the treatment of medicare beneficiaries.

(4) HCPCS CODE DEFINED.—The term ''HCPCS code'' means an alphanumeric code under the Health Care Financing Administration Common Procedure Coding System (HCPCS).

SEC. 105. COVERAGE OF MEDICAL NUTRITION THERAPY SERVICES FOR BENEFICIARIES WITH DIABETES OR A RENAL DISEASE.

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

(1) in subparagraph (T), by striking ''and'' at the end;

(2) in subparagraph (U), by inserting ''and'' at the end; and

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

''(V) medical nutrition therapy services (as defined in subsection (vv)(1)) in the case of a beneficiary with diabetes or a renal disease who—

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

''(ii) meets such other criteria determined by the Secretary after consideration of protocols established by dietitian or nutrition professional organizations;''.

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x), as amended by section 102(b), is amended by adding at the end the following:

''Medical Nutrition Therapy Services; Registered Dietitian or Nutrition Professional

''(vv)(1) The term 'medical nutrition therapy services' means nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional (as defined in paragraph (2)) pursuant to a referral by a physician (as defined in subsection (r)(1)).

''(2) Subject to paragraph (3), the term 'registered dietitian or nutrition professional' means an individual who—

''(A) holds a baccalaureate or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized by the Secretary for this purpose;

''(B) has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional; and

''(C)(i) is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed; or

''(ii) in the case of an individual in a State that does not provide for such licensure or certification, meets such other criteria as the Secretary establishes.

''(3) Subparagraphs (A) and (B) of paragraph (2) shall not apply in the case of an individual who, as of the date of the enactment of this subsection, is licensed or certified as a dietitian or nutrition professional by the State in which medical nutrition therapy services are performed.''.

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

(1) by striking ''and'' before ''(S)''; and

(2) by inserting before the semicolon at the end the following: '', and (T) with respect to medical nutrition therapy services (as defined in section 1861(vv)), the amount paid shall be 80 percent of the lesser of the actual charge for the services or 85 percent of the amount determined under the fee schedule established under section 1848(b) for the same services if furnished by a physician''.

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

''(vi) A registered dietitian or nutrition professional.''.

(e) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after January 1, 2002.

(f) STUDY.—Not later than July 1, 2003, the Secretary of Health and Human Services shall submit to Congress a report that contains recommendations with respect to the expansion to other medicare beneficiary populations of the medical nutrition therapy services benefit (furnished under the amendments made by this section).

Subtitle B—Other Beneficiary Improvements

SEC. 111. ACCELERATION OF REDUCTION OF BENEFICIARY COPAYMENT FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

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

(1) IN GENERAL.—Section 1833(t)(8)(C) (42 U.S.C. 1395l(t)(8)(C)) is amended to read as follows:

''(C) LIMITATION ON COPAYMENT AMOUNT.—

''(i) TO INPATIENT HOSPITAL DEDUCTIBLE AMOUNT.—In no case shall the

copayment amount for a procedure performed in a year exceed the amount of the inpatient hospital deductible established under section 1813(b) for that year.

"(ii) TO SPECIFIED PERCENTAGE.—The Secretary shall reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed the following percentage:

"(I) For procedures performed in 2001, 60 percent.

"(II) For procedures performed in 2002 or 2003, 55 percent.

"(III) For procedures performed in 2004, 50 percent.

"(IV) For procedures performed in 2005, 45 percent.

"(V) For procedures performed in 2006 and thereafter, 40 percent.".

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

(b) CONSTRUCTION REGARDING LIMITING INCREASES IN COST-SHARING.—Nothing in this Act or the Social Security Act shall be construed as preventing a hospital from waiving the amount of any coinsurance for outpatient hospital services under the medicare program under title XVIII of the Social Security Act that may have been increased as a result of the implementation of the prospective payment system under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)).

(c) GAO STUDY OF REDUCTION IN MEDIGAP PREMIUM LEVELS RESULTING FROM REDUCTIONS IN COINSURANCE.—The Comptroller General of the United States shall work, in concert with the National Association of Insurance Commissioners, to evaluate the extent to which the premium levels for medicare supplemental policies reflect the reductions in coinsurance resulting from the amendment made by subsection (a). Not later than April 1, 2004, the Comptroller General shall submit to Congress a report on such evaluation and the extent to which the reductions in beneficiary coinsurance effected by such amendment have resulted in actual savings to medicare beneficiaries.

SEC. 112. PRESERVATION OF COVERAGE OF DRUGS AND BIOLOGICALS UNDER PART B OF THE MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended, in each of subparagraphs (A) and (B), by striking ''(including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered)'' and inserting ''(including drugs and biologicals which are not usually self-administered by the patient)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to drugs and biologicals administered on or after the date of the enactment of this Act.

SEC. 113. ELIMINATION OF TIME LIMITATION ON MEDICARE BENEFITS FOR IMMUNOSUPPRESSIVE DRUGS.

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

(b) CONFORMING AMENDMENTS.—

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

(A) by striking subsection (b); and

(B) by redesignating subsection (c) as subsection (b).

(2) PASS-THROUGH; REPORT.—Section 227 of BBRA is amended by striking subsection (d).

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to drugs furnished on or after the date of the enactment of this Act.

SEC. 114. IMPOSITION OF BILLING LIMITS ON PRESCRIPTION DRUGS.

(a) IN GENERAL.—Section 1842(o) (42 U.S.C. 1395u(o)) is amended by adding at the end the following new paragraph:

''(3)(A) Payment for a charge for any drug or biological for which payment may be made under this part may be made under this part only on an assignment-related basis.

''(B) The provisions of subsection (b)(18)(B) shall apply to charges for such drugs or biologicals in the same manner as they apply to services furnished by a practitioner described in subsection (b)(18)(C).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items furnished on or after January 1, 2001.

Subtitle C—Demonstration Projects and Studies

SEC. 121. DEMONSTRATION PROJECT FOR DISEASE MANAGEMENT FOR SEVERELY CHRONICALLY ILL MEDICARE BENEFICIARIES.

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

(b) VOLUNTARY PARTICIPATION.—

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

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

(B) their physicians approve of participation in the project; and

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

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

(A) for disease management services related to their chronic health condition; and

(B) for payment for all costs for prescription drugs without regard to whether or not they relate to the chronic health condition, except that the project may provide for modest cost-sharing with respect to prescription drug coverage.

(c) CONTRACTS WITH DISEASE MANAGEMENT ORGANIZATIONS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall carry out the project through contracts with up to three disease management organizations. The Secretary shall not enter into such a contract with an organization unless the organization demonstrates that it can produce improved health outcomes and reduce aggregate medicare expenditures consistent with paragraph (2).

(2) CONTRACT PROVISIONS.—Under such contracts—

(A) such an organization shall be required to provide for prescription drug coverage described in subsection (b)(2)(B);

(B) such an organization shall be paid a fee negotiated and established by the Secretary in a manner so that (taking into account savings in expenditures under parts A and B of the medicare program under title XVIII of the Social Security Act) there will be a net reduction in expenditures under the medicare program as a result of the project; and

(C) such an organization shall guarantee, through an appropriate arrangement with a reinsurance company or otherwise, the net reduction in expenditures described in subparagraph (B).

(3) PAYMENTS.—Payments to such organizations shall be made in appropriate proportion from the Trust Funds established under title XVIII of the Social Security Act.

(d) APPLICATION OF MEDIGAP PROTECTIONS TO DEMONSTRATION PROJECT ENROLLEES.—(1) Subject to paragraph (2), the provisions of section 1882(s)(3) (other than clauses (i) through (iv) of subparagraph (B)) and 1882(s)(4) of the Social Security Act shall apply to enrollment (and termination of enrollment) in the demonstration project under this section, in the same manner as they apply to enrollment (and termination of enrollment) with

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

(2) In applying paragraph (1)—

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

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

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

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

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

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

SEC. 122. CANCER PREVENTION AND TREATMENT DEMONSTRATION FOR ETHNIC AND RACIAL MINORITIES.

(a) DEMONSTRATION.—

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

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

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

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

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

(2) TARGET INDIVIDUAL DEFINED.—In this section, the term ''target individual'' means an individual of a racial and ethnic minority group, as defined by section 1707 of the Public Health Service Act, who is entitled to benefits under part A, and enrolled under part B, of title XVIII of the Social Security Act.

(b) PROGRAM DESIGN.—

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

(2) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall implement at least 9 demonstration projects, including the following:

(A) 2 projects for each of the 4 major racial and ethnic minority groups (American Indians (including Alaska Natives, Eskimos, and Aleuts); Asian Americans and Pacific Islanders; Blacks; and Hispanics. The 2 projects must target different ethnic subpopulations.

(B) 1 project within the Pacific Islands.

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

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

(A) reduce expenditures under the medicare program under title XVIII of the Social Security Act; or

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

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

(c) REPORT TO CONGRESS.—

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

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

(A) A description of the demonstration projects.

(B) An evaluation of—

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

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

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

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

(d) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act to such extent and for such period as

the Secretary determines is necessary to conduct demonstration projects.

(e) FUNDING.—

(1) DEMONSTRATION PROJECTS.—

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

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

(2) LIMITATION.—In conducting demonstration projects, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the sum of the amount which the Secretary would have paid under the program for the prevention and

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

SEC. 123. STUDY ON MEDICARE COVERAGE OF ROUTINE THYROID SCREENING.

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

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit a report on the findings of the study conducted under subsection (a) to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate.

SEC. 124. MEDPAC STUDY ON CONSUMER COALITIONS.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study that examines the use of

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

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

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

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

(4) how such coalitions should be funded.

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

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

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

(1) provides information to medicare beneficiaries about their health care options under the medicare program; and

(2) negotiates benefits and premiums for medicare beneficiaries who are members or otherwise affiliated with the group of organizations with Medicare+Choice organizations offering Medicare+Choice plans, issuers of medicare supplemental policies, issuers of long-term care coverage, and pharmacy benefit managers.

SEC. 125. STUDY ON LIMITATION ON STATE PAYMENT FOR MEDICARE COST-SHARING AFFECTING ACCESS TO SERVICES FOR QUALIFIED MEDICARE BENEFICIARIES.

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

Security Act (42 U.S.C. 1396a(n)). As part of such study, the Secretary shall analyze the effect of such payment limitation on providers who serve a disproportionate share of such beneficiaries.

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

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.

(a) STUDY.—The Secretary of Health and Human Services shall enter into a contract with the Institute of Medicine to conduct a study that examines the appropriateness of waiving the 24-month waiting period for eligibility for benefits under the medicare program under title XVIII of the Social Security Act applicable under section 226(b) of such Act (42 U.S.C. 426(b)) for individuals with a devastating disease. For purposes of this section, the term ''devastating disease'' means amyotrophic lateral

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

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

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

(a) STUDIES.—The Secretary of Health and Human Services, acting through the United States Preventive Services Task Force, shall conduct a series of studies designed to identify preventive interventions that can be delivered in the primary care setting and that are most valuable to older Americans.

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

(c) REPORT.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter, the Secretary of Health and Human Services shall submit to Congress a report on the conclusions of the studies conducted under subsection (a), together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

SEC. 128. MEDPAC STUDY AND REPORT ON MEDICARE COVERAGE OF CARDIAC AND PULMONARY REHABILITATION THERAPY SERVICES.

(a) STUDY.—

(1) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study on coverage of cardiac and pulmonary rehabilitation therapy services under the medicare program under title XVIII of the Social Security Act.

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

(A) qualifying diagnoses required for coverage of cardiac and pulmonary rehabilitation therapy services;

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

(C) level of reimbursement for such services.

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

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.

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

''(4) NO BENEFICIARY COST-SHARING FOR CLINICAL DIAGNOSTIC LABORATORY SERVICES.—No coinsurance, deductible, copayment, or other cost-sharing otherwise applicable under this part shall apply with respect to clinical diagnostic laboratory services furnished as an outpatient critical access hospital service. Nothing in this title shall be construed as providing for payment for clinical diagnostic laboratory services furnished as part of outpatient critical access hospital services, other than on the basis described in this subsection.''.

(b) TECHNICAL AND CONFORMING AMENDMENTS.—

(1) Paragraphs (1)(D)(i) and (2)(D)(i) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended

by striking ''or which are furnished on an outpatient basis by a critical access hospital''.

(2) Section 403(d)(2) of BBRA (113 Stat. 1501A–371) is amended by striking ''The amendment made by subsection (a) shall apply'' and inserting ''Paragraphs (1) through (3) of section 1834(g) of the Social Security Act (as amended by paragraph (1)) apply''.

(c) EFFECTIVE DATES.—The amendment made—

(1) by subsection (a) applies to services furnished on or after the date of the enactment of BBRA;

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

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

SEC. 202. ASSISTANCE WITH FEE SCHEDULE PAYMENT FOR PROFESSIONAL SERVICES UNDER ALL-INCLUSIVE RATE.

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

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

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

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

(1) in the heading, by striking ''TRANSITION FOR'' and inserting ''TREATMENT OF'';

(2) in subparagraph (A), by striking ''IN GENERAL.—The'' and inserting ''TRANSITION.—Subject to subparagraph (C), the'';

(3) in subparagraph (A), by inserting ''(other than critical access hospitals)'' after ''facilities described in subparagraph (B)'';

(4) in subparagraph (B), by striking '', for which payment'' and all that follows before the period; and

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

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

hospital pursuant to an agreement under section 1883.''.

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

(1) in paragraph (2)(A), by inserting ''(other than a critical access hospital)'' after ''any hospital''; and

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

''(3) Notwithstanding any other provision of this title, a critical access hospital shall be paid for covered skilled nursing facility services furnished under an agreement entered into under this section on the basis of the reasonable costs of such services (as determined under section 1861(v)).''.

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

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

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

amended by adding at the end the following new paragraph:

"(5) COVERAGE OF COSTS FOR EMERGENCY ROOM ON-CALL PHYSICIANS.—In determining the reasonable costs of outpatient critical access hospital services under paragraphs (1) and (2)(A), the Secretary shall recognize as allowable costs, amounts (as defined by the Secretary) for reasonable compensation and related costs for emergency room physicians who are on-call (as defined by the Secretary) but who are not present on the premises of the critical access hospital involved, and are not otherwise furnishing physicians' services and are not on-call at any other provider or facility.".

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

SEC. 205. TREATMENT OF AMBULANCE SERVICES FURNISHED BY CERTAIN CRITICAL ACCESS HOSPITALS.

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

"(8) SERVICES FURNISHED BY CRITICAL ACCESS HOSPITALS.—Notwithstanding any other provi-

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

"(A) by a critical access hospital (as defined in —section 1861(mm)(1)), or

"(B) by an entity that is owned and operated by a —critical access hospital,

but only if the critical access hospital or entity is the –only provider or supplier of ambulance services that is located within a 35-mile drive of such critical access hospital.".

(b) CONFORMING AMENDMENT.—Section 1833(a)(1)(R) (42 U.S.C. 1395l(a)(1)(R)) is amended—

(1) by striking "ambulance service," and inserting "ambulance services, (i)"; and

(2) by inserting before the comma at the end the –following: "and (ii) with respect to ambulance services described in section 1834(l)(8), the amounts paid shall be the amounts determined under section 1834(g) for outpatient critical access hospital services".

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

SEC. 206. GAO STUDY ON CERTAIN ELIGIBILITY REQUIREMENTS FOR CRITICAL ACCESS HOSPITALS.

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

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

(2) the effect of seasonal variations in patient admissions on critical access hospital eligibility requirements with respect to limitations on average annual length of stay and number of beds.

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

(1) whether distinct part units should be permitted as part of a critical access hospital under the medicare program;

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

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

(4) any adjustments to such eligibility requirements to account for seasonal variations in patient admissions.

Subtitle B—Other Rural Hospitals Provisions

SEC. 211. EQUITABLE TREATMENT FOR RURAL DISPROPORTIONATE SHARE HOSPITALS.

(a) APPLICATION OF UNIFORM THRESHOLD.—Section 1886(d)(5)(F)(v) (42 U.S.C. 1395ww(d)(5)(F)(v)) is amended—

(1) in subclause (II), by inserting ''(or 15 percent, for discharges occurring on or after April 1, 2001)'' after ''30 percent'';

(2) in subclause (III), by inserting ''(or 15 percent, for discharges occurring on or after April 1, 2001)'' after ''40 percent''; and

(3) in subclause (IV), by inserting ''(or 15 percent, for discharges occurring on or after April 1, 2001)'' after ''45 percent''.

(b) ADJUSTMENT OF PAYMENT FORMULAS.—

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

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

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

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

''(I) is less than 17.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P–15)(.65) + 2.5;

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

''(III) is equal to or exceeds 30, such adjustment percentage is equal to 10 percent,

where 'P' is the hospital's disproportionate patient percentage (as defined in clause (vi)).''.

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

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

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

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

''(I) is less than 17.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P–15)(.65) + 2.5;

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

''(III) is equal to or exceeds 30, such adjustment percentage is determined in accordance with the following formula: (P–30)(.6) + 4,

where 'P' is the hospital's disproportionate patient percentage (as defined in clause (vi)).''.

(3) SMALL RURAL HOSPITALS GENERALLY.—Such section is further amended—

(A) in clause (iv)(III), by inserting after ''4 percent'' the following: ''or, for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xii)''; and

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

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

''(I) is less than 17.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P–15)(.65) + 2.5;

''(II) is equal to or exceeds 17.3, such adjustment percentage is equal to 4 percent,

where 'P' is the hospital's disproportionate patient percentage (as defined in clause (vi)).''.

(4) HOSPITALS THAT ARE BOTH SOLE COMMUNITY HOSPITALS AND RURAL REFERRAL CENTERS.—Such section is further amended, in clause (iv)(IV), by inserting after ''clause (viii)'' the following: ''or, for discharges occurring on or after April 1, 2001, the greater of the percentages determined under clause (x) or (xi)''.

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

(A) in clause (iv)(II), by inserting after ''5 percent'' the following: ''or, for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xiii)''; and

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

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

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

cordance with the following formula: (P–15)(.65) + 2.5;

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

''(III) is equal to or exceeds 40, such adjustment percentage is equal to 5 percent,

where 'P' is the hospital's disproportionate patient percentage (as defined in clause (vi)).''.

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.

(a) IN GENERAL.—Section 1886(d)(5)(G)(iv)(IV) (42 U.S.C. 1395ww(d)(5)(G)(iv)(IV)) is amended by inserting '', or 2 of the 3 most recently audited cost reporting periods for which the Secretary has a settled cost report,'' after ''1987''.

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

SEC. 213. EXTENSION OF OPTION TO USE REBASED TARGET AMOUNTS TO ALL SOLE COMMUNITY HOSPITALS.

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

(1) in the matter preceding subclause (I), by striking ''that for its cost reporting period beginning during 1999'' and all that follows through ''for such target amount'' and inserting ''there shall be substituted for the amount otherwise determined under subsection (d)(5)(D)(i), if such substitution results in a greater amount of payment under this section for the hospital'';

(2) in subclause (I), by striking ''target amount otherwise applicable'' and all that follows through ''target amount')'' and inserting ''the amount otherwise applicable to the hospital under subsection (d)(5)(D)(i) (referred to in this clause as the 'subsection (d)(5)(D)(i) amount')''; and

(3) in each of subclauses (II) and (III), by striking ''subparagraph (C) target amount'' and inserting ''subsection (d)(5)(D)(i) amount''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 405 of BBRA (113 Stat. 1501A–372).

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

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

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

(2) in its report under subsection (b) of such section a recommendation on whether special treatment for such hospitals may be warranted.

Subtitle C—Other Rural Provisions

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

(a) TRANSITIONAL ASSISTANCE IN CERTAIN MILEAGE RATES.—Section 1834(l) (42 U.S.C. 1395m(l)) is amended by adding at the end the following new paragraph:

''(8) TRANSITIONAL ASSISTANCE FOR RURAL PROVIDERS.—In the case of ground ambulance services furnished on or after the date on which the Secretary implements the fee schedule under this subsection and before January 1, 2004, for which the transportation originates in a rural area (as defined in section 1886(d)(2)(D)) or in a rural census tract

of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)), the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 17 miles, and up to 50 miles, the rate otherwise established shall be increased by not less than ½ of the additional payment per mile established for the first 17 miles of such a trip originating in a rural area.''.

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

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

(2) MATTERS DESCRIBED.—The matters referred to in paragraph (1) are the following:

(A) The cost of efficiently providing ambulance services for trips originating in rural areas, with special emphasis on collection of cost data from rural providers.

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

cost of providing ambulance services would be expected to be higher than similar services provided in more heavily populated areas because of low usage. Such study shall also include an analysis of the additional costs of providing ambulance services in areas designated under the previous sentence.

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

(c) ADJUSTMENT IN RURAL RATES.—In providing for adjustments under subparagraph (D) of section 1834(l)(2) of the Social Security Act (42 U.S.C. 1395m(l)(2)) for years beginning with 2004, the Secretary of Health and Human Services shall take into consideration the recommendations contained in the report under subsection (b)(2) and shall adjust the fee schedule payment rates under such section for ambulance services provided in low density rural areas based on the increased cost (if any) of providing such services in such areas.

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

date the Secretary implements the fee schedule under section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)). In applying such amendment to services furnished on or after such date and before January 1, 2002, the amount of the rate increase provided under such amendment shall be equal to $1.25 per mile.

SEC. 222. PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT SERVICES.

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

(1) by striking ''for such services provided before January 1, 2003,''; and

(2) by striking the semicolon at the end and inserting a comma.

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

SEC. 223. REVISION OF MEDICARE REIMBURSEMENT FOR TELEHEALTH SERVICES.

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

(b) EXPANSION OF MEDICARE PAYMENT FOR TELEHEALTH SERVICES.—Section 1834 (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

"(m) PAYMENT FOR TELEHEALTH SERVICES.—

"(1) IN GENERAL.—The Secretary shall pay for telehealth services that are furnished via a telecommunications system by a physician (as defined in section 1861(r)) or a practitioner (described in section 1842(b)(18)(C)) to an eligible telehealth individual enrolled under this part notwithstanding that the individual physician or practitioner providing the telehealth service is not at the same location as the beneficiary. For purposes of the preceding sentence, in the case of any Federal telemedicine demonstration program conducted in Alaska or Hawaii, the term 'telecommunications system' includes store-and-forward technologies that provide for the asynchronous transmission of health care information in single or multimedia formats.

"(2) PAYMENT AMOUNT.—

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

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

''(B) FACILITY FEE FOR ORIGINATING SITE.—With respect to a telehealth service, subject to section 1833(a)(1)(U), there shall be paid to the originating site a facility fee equal to—

''(i) for the period beginning on July 1, 2001, and ending on December 31, 2001, and for 2002, $20; and

''(ii) for a subsequent year, the facility fee specified in clause (i) or this clause for the preceding year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for such subsequent year.

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

medically necessary (as determined by the physician or practitioner at the distant site).

''(3) LIMITATION ON BENEFICIARY CHARGES.—

''(A) PHYSICIAN AND PRACTITIONER.—The provisions of section 1848(g) and subparagraphs (A) and (B) of section 1842(b)(18) shall apply to a physician or practitioner receiving payment under this subsection in the same manner as they apply to physicians or practitioners under such sections.

''(B) ORIGINATING SITE.—The provisions of section 1842(b)(18) shall apply to originating sites receiving a facility fee in the same manner as they apply to practitioners under such section.

''(4) DEFINITIONS.—For purposes of this subsection:

''(A) DISTANT SITE.—The term 'distant site' means the site at which the physician or practitioner is located at the time the service is provided via a telecommunications system.

''(B) ELIGIBLE TELEHEALTH INDIVIDUAL.—The term 'eligible telehealth individual' means an individual enrolled under this

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

''(C) ORIGINATING SITE.—

''(i) IN GENERAL.—The term 'originating site' means only those sites described in clause (ii) at which the eligible telehealth individual is located at the time the service is furnished via a telecommunications system and only if such site is located—

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

''(II) in a county that is not included in a Metropolitan Statistical Area; or

''(III) from an entity that participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000.

''(ii) SITES DESCRIBED.—The sites referred to in clause (i) are the following sites:

''(I) The office of a physician or practitioner.

''(II) A critical access hospital (as defined in section 1861(mm)(1)).

''(III) A rural health clinic (as defined in section 1861(aa)(s)).

''(IV) A Federally qualified health center (as defined in section 1861(aa)(4)).

''(V) A hospital (as defined in section 1861(e)).

''(D) PHYSICIAN.—The term ''physician'' has the meaning given that term in section 1861(r).

''(E) PRACTITIONER.—The term 'practitioner' has the meaning given that term in section 1842(b)(18)(C).

''(F) TELEHEALTH SERVICE.—

''(i) IN GENERAL.—The term 'telehealth service' means professional consultations, office visits, and office psychiatry services (identified as of July 1, 2000,

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

''(ii) YEARLY UPDATE.—The Secretary shall establish a process that provides, on an annual basis, for the addition or deletion of services (and HCPCS codes), as appropriate, to those specified in clause (i) for authorized payment under paragraph (1).''.

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

(1) by striking ''and (T)'' and inserting ''(T)''; and

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

(d) STUDY AND REPORT ON ADDITIONAL COVERAGE.—

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

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

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

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

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislation that the Secretary determines are appropriate.

(e) EFFECTIVE DATE.—The amendments made by subsections (b) and (c) shall be effective for services furnished on or after July 1, 2001.

SEC. 224. EXPANDING ACCESS TO RURAL HEALTH CLINICS.

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

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

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

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the effect of low patient and procedure volume on the financial status of low-volume, isolated rural health care providers participating in the medicare program under title XVIII of the Social Security Act.

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

(1) whether low-volume, isolated rural health care providers are having, or may have, significantly decreased medicare margins or other financial difficulties resulting from any of the payment methodologies described in subsection (c);

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

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

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

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

(1) The prospective payment system for hospital outpatient department services under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)).

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

(3) The prospective payment system for inpatient hospital services under section 1886 of such Act (42 U.S.C. 1395ww).

(4) The prospective payment system for routine service costs of skilled nursing facilities under section 1888(e) of such Act (42 U.S.C. 1395yy(e)).

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

TITLE III—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

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

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

(1) in subclause (XVI), by striking ''minus 1.1 percentage points for hospitals (other than sole community hospitals) in all areas, and the market basket percentage increase for sole community hospitals,'' and inserting ''for hospitals in all areas,'';

(2) in subclause (XVII)—

(A) by striking ''minus 1.1 percentage points'' and inserting ''minus 0.55 percentage points; and

(B) by striking ''and'' at the end;

(3) by redesignating subclause (XVIII) as subclause (XIX);

(4) in subclause (XIX), as so redesignated, by striking ''fiscal year 2003'' and inserting ''fiscal year 2004''; and

(5) by inserting after subclause (XVII) the following new subclause:

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

(b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR 2001.—Notwithstanding the amendment made by subsection (a), for purposes of making payments for fiscal year 2001 for inpatient hospital services furnished by subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)), the ''applicable percentage increase'' referred to in section 1886(b)(3)(B)(i) of such Act (42 U.S.C. 1395ww(b)(3)(B)(i))—

(1) for discharges occurring on or after October 1, 2000, and before April 1, 2001, shall be determined in accordance with subclause (XVI) of such section as in effect on the day before the date of the enactment of this Act; and

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

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

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

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

(d) MEDPAC STUDY AND REPORT REGARDING CERTAIN HOSPITAL COSTS.—

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

(A) any increased costs incurred by subsection (d) hospitals (as defined in paragraph (1)(B) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d))) in providing inpatient hospital services to medicare beneficiaries under title XVIII of such Act during the period

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

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

(ii) providing such services using new technologies;

(B) the extent to which the prospective payment system for such services under such section provides adequate and timely recognition of such increased costs;

(C) the prospects for (and to the extent practicable, the magnitude of) cost increases that hospitals will incur in providing such services that are attributable to complying with new blood safety measure requirements and providing such services using new technologies during the 10 years after the date of the enactment of this Act; and

(D) the feasibility and advisability of establishing mechanisms under such payment system to provide for more timely and accurate recognition of such cost increases in the future.

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

with representatives of the blood community, including—

(A) hospitals;

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

(C) organizations involved in the development of new blood safety technologies.

(3) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislation and administrative action as the Commission determines appropriate.

(e) ADJUSTMENT FOR INPATIENT CASE MIX CHANGES.—

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

''(vi) Insofar as the Secretary determines that the adjustments under paragraph (4)(C)(i) for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in the coding or classification of discharges

that do not reflect real changes in case mix, the Secretary may adjust the average standardized amounts computed under this paragraph for subsequent fiscal years so as to eliminate the effect of such coding or classification changes.''.

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

SEC. 302. ADDITIONAL MODIFICATION IN TRANSITION FOR INDIRECT MEDICAL EDUCATION (IME) PERCENTAGE ADJUSTMENT.

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

(1) in subclause (V) by striking ''and'' at the end;

(2) by redesignating subclause (VI) as subclause (VII);

(3) in subclause (VII) as so redesignated, by striking ''2001'' and inserting ''2002''; and

(4) by inserting after subclause (V) the following new subclause:

''(VI) during fiscal year 2002, 'c' is equal to 1.57; and''.

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

tion 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(ii)(V)), for purposes of making payments for subsection (d) hospitals (as defined in paragraph (1)(B) of such section) with indirect costs of medical education, the indirect teaching adjustment factor referred to in paragraph (5)(B)(ii) of such section shall be determined, for discharges occurring on or after April 1, 2001, and before October 1, 2001, as if ''c'' in paragraph (5)(B)(ii)(V) of such section equalled 1.66 rather than 1.54.

(c) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by inserting ''or of section 302 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000'' after ''Balanced Budget Refinement Act of 1999''.

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

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

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

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

SEC. 303. DECREASE IN REDUCTIONS FOR DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

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

(1) in subclause (III), by striking ''each of'' and by inserting ''and 2 percent, respectively'' after ''3 percent''; and

(2) in subclause (IV), by striking ''4 percent'' and inserting ''3 percent''.

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

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

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

(c) CONFORMING AMENDMENTS RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)), is amended—

(1) by striking ''1989 or'' and inserting ''1989,''; and

(2) by inserting '', or the enactment of section 303 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000'' after ''Omnibus Budget Reconciliation Act of 1990''.

(d) TECHNICAL AMENDMENT.—

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

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) is effective as if included in the enactment of BBA.

(e) REFERENCE TO CHANGES IN DSH FOR RURAL HOSPITALS.—For additional changes in the DSH program for rural hospitals, see section 211.

SEC. 304. WAGE INDEX IMPROVEMENTS.

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

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

''(vi) Such guidelines shall provide that, in making decisions on applications for reclassification for the purposes described in clause (v) for fiscal year 2003 and any succeeding fiscal year, the Board shall base any comparison of the average hourly wage for the hospital with the average hourly wage for hospitals in an area on—

''(I) an average of the average hourly wage amount for the hospital from the most recently published hospital wage survey data of the Secretary (as

of the date on which the hospital applies for reclassification) and such amount from each of the two immediately preceding surveys; and

''(II) an average of the average hourly wage amount for hospitals in such area from the most recently published hospital wage survey data of the Secretary (as of the date on which the hospital applies for reclassification) and such amount from each of the two immediately preceding surveys.''.

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

(1) IN GENERAL.—The Secretary of Health and Human Services shall establish a process (based on the voluntary process utilized by the Secretary of Health and Human Services under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for purposes of computing and applying a statewide geographic wage index) under which an appropriate statewide entity may apply to have all the geographic areas in a State treated as a single geographic area for purposes of computing and applying the area wage index under section 1886(d)(3)(E) of such Act (42 U.S.C. 1395ww(d)(3)(E)). Such process shall be established by October 1, 2001, for reclassifications beginning in fiscal year 2003.

(2) PROHIBITION ON INDIVIDUAL HOSPITAL RECLASSIFICATION.—Notwithstanding any other provision of law, if the Secretary applies a statewide geographic wage index under paragraph (1) with respect to a State, any application submitted by a hospital in that State under section 1886(d)(10) of the Social Security Act (42 U.S.C. 1395ww(d)(10)) for geographic reclassification shall not be considered.

(c) COLLECTION OF INFORMATION ON OCCUPATIONAL MIX.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall provide for the collection of data every 3 years on occupational mix for employees of each subsection (d) hospital (as defined in section 1886(d)(1)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(D))) in the provision of inpatient hospital services, in order to construct an occupational mix adjustment in the hospital area wage index applied under section 1886(d)(3)(E) of such Act (42 U.S.C. 1395ww(d)(3)(E)).

(2) APPLICATION.—The third sentence of section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is amended by striking ''To the extent determined feasible by the Secretary, such survey shall measure'' and inserting ''Not less often than once every 3

years the Secretary (through such survey or otherwise) shall measure''.

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

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

(B) the measurement under the third sentence of section 1886(d)(3)(E), as amended by paragraph (2).

SEC. 305. PAYMENT FOR INPATIENT SERVICES OF REHABILITATION HOSPITALS.

(a) ASSISTANCE WITH ADMINISTRATIVE COSTS ASSOCIATED WITH COMPLETION OF PATIENT ASSESSMENT.—Section 1886(j)(3)(B) (42 U.S.C. 1395ww(j)(3)(B)) is amended by striking ''98 percent'' and inserting ''98 percent for fiscal year 2001 and 100 percent for fiscal year 2002''.

(b) ELECTION TO APPLY FULL PROSPECTIVE PAYMENT RATE WITHOUT PHASE-IN.—

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

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

subparagraph (F)'' before ''in a cost reporting period'';

(B) in subparagraph (B), by inserting ''or, in the case of a facility making an election under subparagraph (F), for any cost reporting period described in such subparagraph,'' after ''2002,''; and

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

''(F) ELECTION TO APPLY FULL PROSPECTIVE PAYMENT SYSTEM.—A rehabilitation facility may elect, not later than 30 days before its first cost reporting period for which the payment methodology under this subsection applies to the facility, to have payment made to the facility under this subsection under the provisions of subparagraph (B) (rather than subparagraph (A)) for each cost reporting period to which such payment methodology applies.''.

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

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

SEC. 306. PAYMENT FOR INPATIENT SERVICES OF PSYCHIATRIC HOSPITALS.

With respect to hospitals described in clause (i) of section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) and psychiatric units described in the matter following clause (v) of such section, in making incentive payments to such hospitals under section 1886(b)(1)(A) of such Act (42 U.S.C. 1395ww(b)(1)(A)) for cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001, the Secretary of Health and Human Services, in clause (ii) of such section, shall substitute ''3 percent'' for ''2 percent''.

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

(a) INCREASED TARGET AMOUNTS AND CAPS FOR LONG-TERM CARE HOSPITALS BEFORE IMPLEMENTATION OF THE PROSPECTIVE PAYMENT SYSTEM.—

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

(A) in subparagraph (H)(ii)(III), by inserting ''subject to subparagraph (J),'' after ''2002,''; and

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

''(J) For cost reporting periods beginning during fiscal year 2001, for a hospital described in subsection (d)(1)(B)(iv)—

''(i) the limiting or cap amount otherwise determined under subparagraph (H) shall be increased by 2 percent; and

''(ii) the target amount otherwise determined under subparagraph (A) shall be increased by 25 percent (subject to the limiting or cap amount determined under subparagraph (H), as increased by clause (i)).''.

(2) APPLICATION.—The amendments made by subsection (a) and by section 122 of BBRA (113 Stat. 1501A–331) shall not be taken into account in the development and implementation of the prospective payment system under section 123 of BBRA (113 Stat. 1501A–331).

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

(1) MODIFICATION OF REQUIREMENT.—In developing the prospective payment system for payment for inpatient hospital services provided in long-term care hospitals described in section

1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under the medicare program under title XVIII of such Act required under section 123 of BBRA, the Secretary of Health and Human Services shall examine the feasibility and the impact of basing payment under such a system on the use of existing (or refined) hospital diagnosis-related groups (DRGs) that have been modified to account for different resource use of long-term care hospital patients as well as the use of the most recently available hospital discharge data. The Secretary shall examine and may provide for appropriate adjustments to the long-term hospital payment system, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and a disproportionate share adjustment consistent with section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)).

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

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

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.

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

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

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

(A) by striking ''each of fiscal years 2001 and 2002'' and inserting ''each of fiscal years 2002 and 2003''; and

(B) by striking ''minus 1 percentage point'' and inserting ''minus 0.5 percentage points''; and

(3) by inserting after subclause (I) the following new subclause:

''(II) for fiscal year 2001, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year;''.

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

(1) for the period beginning on October 1, 2000, and ending on March 31, 2001, shall be the rate determined in accordance with the law as in effect on the day before the date of the enactment of this Act; and

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

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

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

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

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study of the different systems for categorizing patients in medicare skilled nursing facilities in a manner that accounts for the relative resource utilization of different patient types.

(2) REPORT.—Not later than January 1, 2005, the Secretary shall submit to Congress a report on the study conducted under subsection (a). Such report shall include such recommendations regarding changes in law as may be appropriate.

SEC. 312. INCREASE IN NURSING COMPONENT OF PPS FEDERAL RATE.

(a) IN GENERAL.—The Secretary of Health and Human Services shall increase by 16.66 percent the nursing component of the case-mix adjusted Federal prospective payment rate specified in Tables 3 and 4 of the final rule published in the Federal Register by the Health Care Financing Administration on July 31, 2000 (65 Fed. Reg. 46770), effective for services furnished on or after April 1, 2001, and before October 1, 2002.

(b) GAO AUDIT OF NURSING STAFF RATIOS.—

(1) AUDIT.—The Comptroller General of the United States shall conduct an audit of nursing staffing ratios in a representative sample of medicare skilled nursing facilities. Such sample shall cover selected States and shall include broad representation with respect to size, ownership, location, and medicare volume. Such audit shall include an examination of payroll records and medicaid cost reports of individual facilities.

(2) REPORT.—Not later than August 1, 2002, the Comptroller General shall submit to Congress a report on the audits conducted under paragraph (1). Such report shall include an assessment of the impact of the increased payments under this subtitle on increased nursing staff ratios and shall make recommendations as to whether increased payments under subsection (a) should be continued.

SEC. 313. APPLICATION OF SNF CONSOLIDATED BILLING REQUIREMENT LIMITED TO PART A COVERED STAYS.

(a) IN GENERAL.—Section 1862(a)(18) (42 U.S.C. 1395y(a)(18)) is amended by striking ''or of a part of a facility that includes a skilled nursing facility (as determined under regulations),'' and inserting ''during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1861(s)(2)(D), which are furnished to such an individual without regard to such period),''.

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

(A) by inserting ''by, or under arrangements made by, a skilled nursing facility'' after ''furnished'';

(B) by striking ''or of a part of a facility that includes a skilled nursing facility (as determined under regulations)''; and

(C) by striking ''(without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise)''.

(2) Section 1842(t) (42 U.S.C. 1395u(t)) is amended by striking ''by a physician'' and ''or of a part of a facility that includes a skilled nursing facility (as determined under regulations),''.

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

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

(d) OVERSIGHT.—The Secretary of Health and Human Services, through the Office of the Inspector General in the Department of Health and Human Services

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

SEC. 314. ADJUSTMENT OF REHABILITATION RUGS TO CORRECT ANOMALY IN PAYMENT RATES.

(a) ADJUSTMENT FOR REHABILITATION RUGS.—

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

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

(b) CORRECTION WITH RESPECT TO REHABILITATION RUGS.—

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

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

(c) REVIEW BY OFFICE OF INSPECTOR GENERAL.—The Inspector General of the Department of Health and Human Services shall review the medicare payment structure for services classified within rehabilitation resource utilization groups (RUGs) (as in effect after the date of the enactment of the BBRA) to assess whether payment incentives exist for the delivery of inadequate care. Not

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

SEC. 315. ESTABLISHMENT OF PROCESS FOR GEOGRAPHIC RECLASSIFICATION.

(a) IN GENERAL.—The Secretary of Health and Human Services may establish a procedure for the geographic reclassification of a skilled nursing facility for purposes of payment for covered skilled nursing facility services under the prospective payment system established under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)). Such procedure may be based upon the method for geographic reclassifications for inpatient hospitals established under section 1886(d)(10) of the Social Security Act (42 U.S.C. 1395ww(d)(10)).

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

Subtitle C—Hospice Care

SEC. 321. FULL MARKET BASKET INCREASE FOR 2001.

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

(1) by redesignating subclause (VII) as subclause (IX);

(2) in subclause (VI)—

(A) by striking ''through 2002'' and inserting ''through 2000''; and

(B) by striking ''and'' at the end; and

(3) by inserting after subclause (VI) the following new subclauses:

''(VII) for fiscal year 2001, the market basket percentage increase for the fiscal year;

''(VIII) for fiscal year 2002, the market basket percentage increase for the fiscal year minus 0.25 percentage points; and''.

(b) TRANSITION DURING FISCAL YEAR 2001.—Notwithstanding the amendments made by subsection (a), for purposes of making payments for hospice care under section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) for fiscal year 2001, the payment rates referred to in paragraph (1)(C) of such section—

(1) for the period beginning on October 1, 2000, and ending on March 31, 2001, shall be the rate determined in accordance with the law as in effect on the day before the date of the enactment of this Act; and

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

(c) CONFORMING AMENDMENTS TO BBRA.—

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

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

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

SEC. 322. CLARIFICATION OF PHYSICIAN CERTIFICATION.

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

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

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

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

(b) STUDY AND REPORT ON PHYSICIAN CERTIFICATION REQUIREMENT FOR HOSPICE BENEFITS.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study to examine the appropriateness of the certification regarding terminal illness of an individual under section 1814(a)(7) of the Social Security Act (42 U.S.C. 1395f(a)(7)) that is required in order for such individual to receive hospice benefits under the medicare program under title XVIII of such Act. In conducting such study, the Secretary shall take into account the effect of the amendment made by subsection (a).

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the study conducted under paragraph (1), together with any recommendations for legislation that the Secretary deems appropriate.

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

(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study to examine the factors affecting the use of hospice benefits under the medicare program under title XVIII of the Social Security Act, including a delay in the time (relative to death) of entry into a hospice program, and differences in such use between urban and rural hospice programs and based upon the presenting condition of the patient.

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

Subtitle D—Other Provisions

SEC. 331. RELIEF FROM MEDICARE PART A LATE ENROLLMENT PENALTY FOR GROUP BUY-IN FOR STATE AND LOCAL RETIREES.

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

(1) in subsection (c)(6), by inserting before the semicolon at the end the following: ''and shall be subject to reduction in accordance with subsection (d)(6)''; and

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

''(6)(A) In the case where a State, a political subdivision of a State, or an agency or instrumentality of a State or political subdivision thereof determines to pay, for the life of each individual, the monthly premiums due under paragraph (1) on behalf of each of the individuals in a qualified State or local government retiree group who meets the conditions of subsection (a), the amount of any increase otherwise applicable under section 1839(b) (as applied and modified by subsection (c)(6) of this section) with respect to the monthly premium for benefits under this part for an individual who is a member of such group shall be reduced by the total amount of taxes paid under section 3101(b) of the Internal Revenue Code of 1986 by such individual and under section 3111(b) by the employers of such individual on behalf of such individual with respect to employment (as defined in section 3121(b) of such Code).

''(B) For purposes of this paragraph, the term 'qualified State or local government retiree group' means all of the individuals who retire prior to a specified date that is before January 1, 2002, from employment in 1 or more occupations or other broad classes of employees of—

''(i) the State;

''(ii) a political subdivision of the State; or

''(iii) an agency or instrumentality of the State or political subdivision of the State.''.

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

SEC. 332. POSTING OF INFORMATION ON NURSING FACILITY STAFFING.

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

''(8) INFORMATION ON NURSE STAFFING.—

''(A) IN GENERAL.—A skilled nursing facility shall post daily for each shift the current number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. The information shall be displayed in a uniform manner (as specified by the Secretary) and in a clearly visible place.

''(B) PUBLICATION OF DATA.—A skilled nursing facility shall, upon request, make available to the public the nursing staff data described in subparagraph (A).''.

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

''(8) INFORMATION ON NURSE STAFFING.—

''(A) IN GENERAL.—A nursing facility shall post daily for each shift the current number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. The information shall be displayed in a uniform manner (as specified by the Secretary) and in a clearly visible place.

''(B) PUBLICATION OF DATA.—A nursing facility shall, upon request, make available to the public the nursing staff data described in subparagraph (A).''.

TITLE IV—PROVISIONS RELATING TO PART B

Subtitle A—Hospital Outpatient Services

SEC. 401. REVISION OF HOSPITAL OUTPATIENT PPS PAYMENT UPDATE.

(a) IN GENERAL.—Section 1833(t)(3)(C)(iii) (42 U.S.C. 1395l(t)(3)(C)(iii)) is amended by striking ''in each of 2000, 2001, and 2002'' and inserting ''in each of 2000 and 2002''.

(b) ADJUSTMENT FOR CASE MIX CHANGES.—

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

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

(B) by inserting after clause (ii) the following new clause:

''(iii) ADJUSTMENT FOR SERVICE MIX CHANGES.—Insofar as the Secretary determines that the adjustments for service mix under paragraph (2) for a previous year (or estimates that such adjustments for a future year) did (or are likely to) result in a change in aggregate payments under this subsection during the year that are a result of changes in the coding or classification of covered OPD services that do not reflect real changes in service mix, the Secretary may adjust the conversion factor computed under this subparagraph for subsequent years so as to eliminate the effect of such coding or classification changes.''.

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

SEC. 402. CLARIFYING PROCESS AND STANDARDS FOR DETERMINING ELIGIBILITY OF DEVICES FOR PASS-THROUGH PAYMENTS UNDER HOSPITAL OUTPATIENT PPS.

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

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

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

"(B) USE OF CATEGORIES IN DETERMINING ELIGIBILITY OF A DEVICE FOR PASS-THROUGH PAYMENTS.—The following provisions apply for purposes of determining whether a medical device qualifies for additional payments under clause (ii) or (iv) of subparagraph (A):

"(i) ESTABLISHMENT OF INITIAL CATEGORIES.—The Secretary shall initially establish under this clause categories of medical devices based on type of device by April 1, 2001. Such categories shall be es-

tablished in a manner such that each medical device that meets the requirements of clause (ii) or (iv) of subparagraph (A) as of as of January 1, 2001, is included in such a category and no such device is included in more than one category. For purposes of the preceding sentence, whether a medical device meets such requirements as of such date shall be determined on the basis of the program memoranda issued before such date or if the Secretary determines the medical device would have been included in the program memoranda but for the requirement of subparagraph (A)(iv)(I). The categories may be established under this clause by program memorandum or otherwise, after consultation with groups representing hospitals, manufacturers of medical devices, and other affected parties.

''(ii) ESTABLISHING CRITERIA FOR ADDITIONAL CATEGORIES.—

''(I) IN GENERAL.—The Secretary shall establish criteria that will be used for creation of additional cat-

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

''(II) STANDARD.—Such categories shall be established under this clause in a manner such that no medical device is described by more than one category. Such criteria shall include a test of whether the average cost of devices that would be included in a category and are in use at the time the category is established is not insignificant, as described in subparagraph (A)(iv)(II).

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

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

vice that meets the requirements of subparagraph (A)(iv) and for which none of the categories in effect (or that were previously in effect) is appropriate.

''(iii) PERIOD FOR WHICH CATEGORY IS IN EFFECT.—A category of medical devices established under clause (i) or clause (ii) shall be in effect for a period of at least 2 years, but not more than 3 years, that begins—

''(I) in the case of a category established under clause (i), on the first date on which payment was made under this paragraph for any device described by such category (including payments made during the period before April 1, 2001); and

''(II) in the case of any other category, on the first date on which payment is made under this paragraph for any medical device that is described by such category.

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

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

"(I) the device is described by a category established and in effect under clause (i); or

"(II) the device is described by a category established and in effect under clause (ii) and an application under section 515 of the Federal Food, Drug, and Cosmetic Act has been approved with respect to the device, or the device has been cleared for market under section 510(k) of such Act, or the device is exempt from the requirements of section 510(k) of such Act pursuant to subsection (l) or (m) of section 510 of such Act or section 520(g) of such Act.

Nothing in this clause shall be construed as requiring an application or prior approval (other than that described in subclause (II)) in order for a covered device to qualify for payment under this paragraph.

"(C) LIMITED PERIOD OF PAYMENT.—

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

"(I) on the first date this subsection is implemented in the case of a drug or biological described in clause (i), (ii), or (iii) of subparagraph (A) and in the case of a drug or biological described in subparagraph (A)(iv) and for which payment under this part is made as an outpatient hospital service before such first date; or

"(II) in the case of a drug or biological described in subparagraph (A)(iv) not described in subclause (I), on the first date on which payment is made under this part for the drug or biological as an outpatient hospital service.

"(ii) MEDICAL DEVICES.—Payment shall be made under this paragraph with

respect to a medical device only if such device—

''(I) is described by a category of medical devices established and in effect under subparagraph (B); and

''(II) is provided as part of a service (or group of services) paid for under this subsection and provided during the period for which such category is in effect under such subparagraph.''.

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

(1) in paragraph (6)(A)(iv)(II), by striking ''the cost of the device, drug, or biological'' and inserting ''the cost of the drug or biological or the average cost of the category of devices'';

(2) in paragraph (6)(D) (as redesignated by subsection (a)(1)), by striking ''subparagraph (D)(iii)'' in the matter preceding clause (i) and inserting ''subparagraph (E)(iii)''; and

(3) in paragraph (12)(E), by striking ''additional payments (consistent with paragraph (6)(B))'' and inserting ''additional payments, the determination and deletion of initial and new categories (con-

sistent with subparagraphs (B) and (C) of paragraph (6))''.

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

(d) TRANSITION.—

(1) IN GENERAL.—In the case of a medical device provided as part of a service (or group of services) furnished during the period before initial categories are implemented under subparagraph (B)(i) of section 1833(t)(6) of the Social Security Act (as amended by subsection (a)), payment shall be made for such device under such section in accordance with the provisions in effect before the date of the enactment of this Act, except that, beginning on the date that is 30 days after the date of the enactment of this Act, payment shall also be made for such a device that is not included in a program memorandum described in such subparagraph if the Secretary of Health and Human Services determines that the device is likely to be described by such an initial category or would have been included in such program memoranda but for the requirement of subparagraph (A)(iv)(I) of that section.

(2) APPLICATION OF CURRENT PROCESS.—Notwithstanding any other provision of law, the Secretary shall continue to accept applications with respect to medical devices under the process established pursuant to paragraph (6) of section 1833(t) of the Social Security Act (as in effect on the day before the date of the enactment of this Act) through December 1, 2000, and any device—

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

(B) that meets the requirements of clause (ii) or (iv) of subparagraph (A) of such paragraph (as determined pursuant to such process),

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

SEC. 403. APPLICATION OF OPD PPS TRANSITIONAL CORRIDOR PAYMENTS TO CERTAIN HOSPITALS THAT DID NOT SUBMIT A 1996 COST REPORT.

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

for such period, during the first subsequent cost reporting period ending before 2001 for which the hospital submitted a cost report)'' after ''1996''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of BBRA.

SEC. 404. APPLICATION OF RULES FOR DETERMINING PROVIDER-BASED STATUS FOR CERTAIN ENTITIES.

(a) GRANDFATHER.—Notwithstanding any other provision of law, for purposes of making determinations of provider-based status under title XVIII of the Social Security Act on or after October 1, 2000, any facility or organization that is treated as provider-based in relation to a hospital or critical access hospital under such title as of October 1, 2000—

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

(2) the requirements, limitations, and exclusions specified in paragraphs (d), (e), (f), and (h) of section 413.65 of title 42, Code of Federal Regulations shall not apply to such facility or organization

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

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

(1) a facility or organization for which a determination of provider-based status in relation to a hospital or critical access hospital is requested on or after October 1, 2000, and before October 1, 2002, may not be treated as not having provider-based status in relation to such a hospital for any period before a determination is made with respect to such status pursuant to such request; and

(2) in making a determination with respect to such status for any facility or organization in relationship to such a hospital on or after October 1, 2000, the following rules apply:

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

(i) satisfies the requirements of section 413.65(d)(7) of title 42, Code of Federal Regulations; or

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

(B) The facility or organization shall be treated as satisfying any of the requirements and standards for geographic location in relation to such a hospital if the facility or organization is owned and operated by a hospital or critical access hospital that—

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

(ii) has a disproportionate share adjustment percentage (as determined under

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

(c) DEFINITIONS.—For purposes of this section, the terms ''hospital'' and ''critical access hospital'' have the meanings given such terms in subsections (e) and (mm)(1), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

SEC. 405. TREATMENT OF CHILDREN'S HOSPITALS UNDER PROSPECTIVE PAYMENT SYSTEM.

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

(1) in the heading of paragraph (7)(D)(ii), by inserting ''AND CHILDREN'S HOSPITALS'' after ''CANCER HOSPITALS''; and

(2) in paragraphs (7)(D)(ii) and (11), by striking ''section 1886(d)(1)(B)(v)'' and inserting ''clause (iii) or (v) of section 1886(d)(1)(B)''.

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

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

(a) IN GENERAL.—Section 1833(t)(6)(A)(ii) (42 U.S.C. 1395l(t)(6)(A)(ii)) is amended by inserting ''or temperature monitored cryoablation'' after ''device of brachytherapy''.

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

Subtitle B—Provisions Relating to Physicians' Services

SEC. 411. GAO STUDIES RELATING TO PHYSICIANS' SERVICES.

(a) STUDY OF SPECIALIST PHYSICIANS' SERVICES FURNISHED IN PHYSICIANS' OFFICES AND HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to examine the appropriateness of furnishing in physicians' offices specialist physicians' services (such as gastrointestinal endoscopic physicians' services) which are ordinarily furnished in hospital outpatient departments. In conducting this study, the Comptroller General shall—

(A) review available scientific and clinical evidence about the safety of performing procedures in physicians' offices and hospital outpatient departments;

(B) assess whether resource-based practice expense relative values established by the Secretary of Health and Human Services under the medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for such specialist physicians' services furnished in physicians' offices and hospital outpatient departments create an incentive to furnish such services in physicians' offices instead of hospital outpatient departments; and

(C) assess the implications for access to care for medicare beneficiaries if the medicare program were not to cover such services in physicians' offices.

(2) REPORT.—Not later than July 1, 2001, the Comptroller General shall submit to Congress a report on such study and include such recommendations as the Comptroller General determines to be appropriate.

(b) STUDY OF THE RESOURCE-BASED PRACTICE EXPENSE SYSTEM.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the refinements to the practice expense relative value units during the transition to a resource-based practice expense system for physician payments under the medicare program under title XVIII of the Social Security Act. Such study shall examine how the Secretary of Health and Human Services has accepted and used the practice expense data submitted under section 212 of BBRA (113 Stat. 1501A–350).

(2) REPORT.—Not later than July 1, 2001, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) together with recommendations regarding—

(A) improvements in the process for acceptance and use of practice expense data under section 212 of BBRA;

(B) any change or adjustment that is appropriate to ensure full access to a spectrum of care for beneficiaries under the medicare program; and

(C) the appropriateness of payments to physicians.

SEC. 412. PHYSICIAN GROUP PRACTICE DEMONSTRATION.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1866 the following new sections:

''DEMONSTRATION OF APPLICATION OF PHYSICIAN VOLUME INCREASES TO GROUP PRACTICES

''SEC. 1866A. (a) DEMONSTRATION PROGRAM AUTHORIZED.—

''(1) IN GENERAL.—The Secretary shall conduct demonstration projects to test and, if proven effective, expand the use of incentives to health care groups participating in the program under this title that—

''(A) encourage coordination of the care furnished to individuals under the programs under parts A and B by institutional and other providers, practitioners, and suppliers of health care items and services;

''(B) encourage investment in administrative structures and processes to ensure efficient service delivery; and

''(C) reward physicians for improving health outcomes.

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

''(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1866B.

''(3) DEFINITIONS.—For purposes of this section, terms have the following meanings:

''(A) PHYSICIAN.—Except as the Secretary may otherwise provide, the term 'physician' means any individual who furnishes services which may be paid for as physicians' services under this title.

''(B) HEALTH CARE GROUP.—The term 'health care group' means a group of physicians (as defined in subparagraph (A)) organized at least in part for the purpose of providing physicians' services under this title. As the Secretary finds appropriate, a health care group may include a hospital and any other individual or entity furnishing items or services for which payment may be made under this title that is affiliated with the health care group under an arrangement structured so that such individual or entity participates in a demonstration under this section and will share in any bonus earned under subsection (d).

''(b) ELIGIBILITY CRITERIA.—

''(1) IN GENERAL.—The Secretary is authorized to establish criteria for health care groups eligible to participate in a demonstration under this section, including criteria relating to numbers of health care professionals in, and of patients served by, the group, scope of services provided, and quality of care.

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

''(A) to be paid on a fee-for-service basis; and

''(B) that payment with respect to all such services furnished by members of the health care group to such beneficiaries shall (where determined appropriate by the Secretary) be made to a single entity.

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

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

''(c) PATIENTS WITHIN SCOPE OF DEMONSTRATION.—

''(1) IN GENERAL.—The Secretary shall specify, in accordance with this subsection, the criteria for identifying those patients of a health care group who shall be considered within the scope of the demonstration under this section for purposes of application of subsection (d) and for assessment of the effectiveness of the group in achieving the objectives of this section.

''(2) OTHER CRITERIA.—The Secretary may establish additional criteria for inclusion of beneficiaries within a demonstration under this section, which may include frequency of contact with physicians in the group or other factors or criteria that the Secretary finds to be appropriate.

''(3) NOTICE REQUIREMENTS.—In the case of each beneficiary determined to be within the scope of a demonstration under this section with respect to a specific health care group, the Secretary shall ensure that such beneficiary is notified of the incentives, and of any waivers of coverage or payment

rules, applicable to such group under such demonstration.

''(d) INCENTIVES.—

''(1) PERFORMANCE TARGET.—The Secretary shall establish for each health care group participating in a demonstration under this section—

''(A) a base expenditure amount, equal to the average total payments under parts A and B for patients served by the health care group on a fee-for-service basis in a base period determined by the Secretary; and

''(B) an annual per capita expenditure target for patients determined to be within the scope of the demonstration, reflecting the base expenditure amount adjusted for risk and expected growth rates.

''(2) INCENTIVE BONUS.—The Secretary shall pay to each participating health care group (subject to paragraph (4)) a bonus for each year under the demonstration equal to a portion of the medicare savings realized for such year relative to the performance target.

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

on evidence the Secretary determines to be sufficient, the Secretary shall also pay to a participating health care group (subject to paragraph (4)) an additional bonus for a year, equal to such portion as the Secretary may designate of the saving to the program under this title resulting from process improvements made by and patient outcome improvements attributable to activities of the group.

''(4) LIMITATION.—The Secretary shall limit bonus payments under this section as necessary to ensure that the aggregate expenditures under this title (inclusive of bonus payments) with respect to patients within the scope of the demonstration do not exceed the amount which the Secretary estimates would be expended if the demonstration projects under this section were not implemented.

''PROVISIONS FOR ADMINISTRATION OF DEMONSTRATION PROGRAM

''SEC. 1866B. (a) GENERAL ADMINISTRATIVE AUTHORITY.—

''(1) BENEFICIARY ELIGIBILITY.—Except as otherwise provided by the Secretary, an individual shall only be eligible to receive benefits under the program under section 1866A (in this section referred to as the 'demonstration program') if such individual—

"(A) is enrolled in under the program under part B and entitled to benefits under part A; and

"(B) is not enrolled in a Medicare+Choice plan under part C, an eligible organization under a contract under section 1876 (or a similar organization operating under a demonstration project authority), an organization with an agreement under section 1833(a)(1)(A), or a PACE program under section 1894.

"(2) SECRETARY'S DISCRETION AS TO SCOPE OF PROGRAM.—The Secretary may limit the implementation of the demonstration program to—

"(A) a geographic area (or areas) that the Secretary designates for purposes of the program, based upon such criteria as the Secretary finds appropriate;

"(B) a subgroup (or subgroups) of beneficiaries or individuals and entities furnishing items or services (otherwise eligible to participate in the program), selected on the basis of the number of such participants that the Secretary finds consistent with the effective and efficient implementation of the program;

"(C) an element (or elements) of the program that the Secretary determines to be suitable for implementation; or

"(D) any combination of any of the limits described in subparagraphs (A) through (C).

"(3) VOLUNTARY RECEIPT OF ITEMS AND SERVICES.—Items and services shall be furnished to an individual under the demonstration program only at the individual's election.

"(4) AGREEMENTS.—The Secretary is authorized to enter into agreements with individuals and entities to furnish health care items and services to beneficiaries under the demonstration program.

"(5) PROGRAM STANDARDS AND CRITERIA.—The Secretary shall establish performance standards for the demonstration program including, as applicable, standards for quality of health care items and services, cost-effectiveness, beneficiary satisfaction, and such other factors as the Secretary finds appropriate. The eligibility of individuals or entities for the initial award, continuation, and renewal of agreements to provide health care items and services under the program shall be conditioned, at a minimum, on performance that meets or exceeds such standards.

''(6) ADMINISTRATIVE REVIEW OF DECISIONS AFFECTING INDIVIDUALS AND ENTITIES FURNISHING SERVICES.—An individual or entity furnishing services under the demonstration program shall be entitled to a review by the program administrator (or, if the Secretary has not contracted with a program administrator, by the Secretary) of a decision not to enter into, or to terminate, or not to renew, an agreement with the entity to provide health care items or services under the program.

''(7) SECRETARY'S REVIEW OF MARKETING MATERIALS.—An agreement with an individual or entity furnishing services under the demonstration program shall require the individual or entity to guarantee that it will not distribute materials that market items or services under the program without the Secretary's prior review and approval.

''(8) PAYMENT IN FULL.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), an individual or entity receiving payment from the Secretary under a contract or agreement under the demonstration program shall agree to accept such payment as payment in full, and such payment shall be in lieu of any payments to which the individual or

entity would otherwise be entitled under this title.

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

''(b) CONTRACTS FOR PROGRAM ADMINISTRATION.—

''(1) IN GENERAL.—The Secretary may administer the demonstration program through a contract with a program administrator in accordance with the provisions of this subsection.

''(2) SCOPE OF PROGRAM ADMINISTRATOR CONTRACTS.—The Secretary may enter into such contracts for a limited geographic area, or on a regional or national basis.

''(3) ELIGIBLE CONTRACTORS.—The Secretary may contract for the administration of the program with—

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

''(B) any other entity with substantial experience in managing the type of program concerned.

''(4) CONTRACT AWARD, DURATION, AND RENEWAL.—

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

''(B) NONCOMPETITIVE AWARD AND RENEWAL FOR ENTITIES ADMINISTERING PART A OR PART B PAYMENTS.—The Secretary may enter or renew a contract under this subsection with an entity described in paragraph (3)(A) without regard to the requirements of section 5 of title 41, United States Code.

''(5) APPLICABILITY OF FEDERAL ACQUISITION REGULATION.—The Federal Acquisition Regulation shall apply to program administration contracts under this subsection.

''(6) PERFORMANCE STANDARDS.—The Secretary shall establish performance standards for the program administrator including, as applicable, standards for the quality and cost-effectiveness of the program administered, and such other factors as the Secretary finds appropriate. The eligibility of entities for the initial award, continuation, and renewal of program administration contracts shall be condi-

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

''(7) FUNCTIONS OF PROGRAM ADMINISTRATOR.—A program administrator shall perform any or all of the following functions, as specified by the Secretary:

''(A) AGREEMENTS WITH ENTITIES FURNISHING HEALTH CARE ITEMS AND SERVICES.—Determine the qualifications of entities seeking to enter or renew agreements to provide services under the demonstration program, and as appropriate enter or renew (or refuse to enter or renew) such agreements on behalf of the Secretary.

''(B) ESTABLISHMENT OF PAYMENT RATES.—Negotiate or otherwise establish, subject to the Secretary's approval, payment rates for covered health care items and services.

''(C) PAYMENT OF CLAIMS OR FEES.—Administer payments for health care items or services furnished under the program.

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

(c)(2)(A)(ii) to entities furnishing items or services for which payment may be made under the program.

''(E) OVERSIGHT.—Monitor the compliance of individuals and entities with agreements under the program with the conditions of participation.

''(F) ADMINISTRATIVE REVIEW.—Conduct reviews of adverse determinations specified in subsection (a)(6).

''(G) REVIEW OF MARKETING MATERIALS.—Conduct a review of marketing materials proposed by an entity furnishing services under the program.

''(H) ADDITIONAL FUNCTIONS.—Perform such other functions as the Secretary may specify.

''(8) LIMITATION OF LIABILITY.—The provisions of section 1157(b) shall apply with respect to activities of contractors and their officers, employees, and agents under a contract under this subsection.

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

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

''(c) RULES APPLICABLE TO BOTH PROGRAM AGREEMENTS AND PROGRAM ADMINISTRATION CONTRACTS.—

''(1) RECORDS, REPORTS, AND AUDITS.—The Secretary is authorized to require entities with agreements to provide health care items or services under the demonstration program, and entities with program administration contracts under subsection (b), to maintain adequate records, to afford the Secretary access to such records (including for audit purposes), and to furnish such reports and other materials (including audited financial statements and performance data) as the Secretary may require for purposes of implementation, oversight, and evaluation of the program and of individuals' and entities' effectiveness in performance of such agreements or contracts.

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

(B)(ii), the Secretary may make bonus payments under the demonstration program from the Federal Health Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in amounts that do not exceed the amounts authorized under the program in accordance with the following:

''(A) PAYMENTS TO PROGRAM ADMINISTRATORS.—The Secretary may make bonus payments under the program to program administrators.

''(B) PAYMENTS TO ENTITIES FURNISHING SERVICES.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary may make bonus payments to individuals or entities furnishing items or services for which payment may be made under the demonstration program, or may authorize the program administrator to make such bonus payments in accordance with such guidelines as the Secretary shall establish and subject to the Secretary's approval.

''(ii) LIMITATIONS.—The Secretary may condition such payments on the achievement of such standards related to

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

''(3) ANTIDISCRIMINATION LIMITATION.—The Secretary shall not enter into an agreement with an entity to provide health care items or services under the demonstration program, or with an entity to administer the program, unless such entity guarantees that it will not deny, limit, or condition the coverage or provision of benefits under the program, for individuals eligible to be enrolled under such program, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(d) LIMITATIONS ON JUDICIAL REVIEW.—The following actions and determinations with respect to the demonstration program shall not be subject to review by a judicial or administrative tribunal:

''(1) Limiting the implementation of the program under subsection (a)(2).

''(2) Establishment of program participation standards under subsection (a)(5) or the denial or termination of, or refusal to renew, an agreement with an entity to provide health care items and services under the program.

''(3) Establishment of program administration contract performance standards under subsection (b)(6), the refusal to renew a program administration contract, or the noncompetitive award or renewal of a program administration contract under subsection (b)(4)(B).

''(5) Establishment of payment rates, through negotiation or otherwise, under a program agreement or a program administration contract.

''(6) A determination with respect to the program (where specifically authorized by the program authority or by subsection (c)(2))—

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

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

''(e) APPLICATION LIMITED TO PARTS A AND B.—None of the provisions of this section or of the demonstration program shall apply to the programs under part C.

''(f) REPORTS TO CONGRESS.—Not later than two years after the date of the enactment of this section, and biennially thereafter for six years, the Secretary shall report to Congress on the use of authorities under the demonstration program. Each report shall address the impact

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

(b) GAO REPORT.—Not later than 2 years after the date on which the demonstration project under section 1866A of the Social Security Act, as added by subsection (a), is implemented, the Comptroller General of the United States shall submit to Congress a report on such demonstration project. The report shall include such recommendations with respect to changes to the demonstration project that the Comptroller General determines appropriate.

SEC. 413. STUDY ON ENROLLMENT PROCEDURES FOR GROUPS THAT RETAIN INDEPENDENT CONTRACTOR PHYSICIANS.

(a) IN GENERAL.—The Comptroller General of the United States shall conduct a study of the current medicare enrollment process for groups that retain independent contractor physicians with particular emphasis on hospital-based physicians, such as emergency department staffing groups. In conducting the evaluation, the Comptroller General shall consult with groups that retain independent contractor physicians and shall—

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

(2) review direct and indirect costs associated with the current process incurred by the medicare program and groups that retain independent contractor physicians;

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

(4) develop suggested procedures for the enrollment of these groups.

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

Subtitle C—Other Services

SEC. 421. 1-YEAR EXTENSION OF MORATORIUM ON THERAPY CAPS; REPORT ON STANDARDS FOR SUPERVISION OF PHYSICAL THERAPY ASSISTANTS.

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

(b) CONFORMING AMENDMENT TO CONTINUE FOCUSED MEDICAL REVIEWS OF CLAIMS DURING MORATORIUM PERIOD.—Section 221(a)(2) of BBRA (113 Stat.

1501A–351) is amended by striking ''(under the amendment made by paragraph (1)(B))''.

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

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

(A) of eliminating the ''in the room'' supervision requirement for medicare payment for services of physical therapy assistants who are supervised by physical therapists; and

(B) of such requirement on the cap imposed under section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) on physical therapy services.

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

SEC. 422. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.

(a) UPDATE.—

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

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

(2) PROHIBITION ON EXEMPTIONS.—

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

(B) SPECIAL RULES FOR 2000.—

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

(ii) RESUBMISSION OF CERTAIN APPLICATIONS.—In the case of an application for an exemption rate under such section that was filed by a facility during 2000 that was not approved by the Secretary of Health and Human Services, the facility may submit an application for an exemption rate for that year by not later than July 1, 2001.

(b) DEVELOPMENT OF ESRD MARKET BASKET.—

(1) DEVELOPMENT.—The Secretary of Health and Human Services shall collect data and develop an ESRD market basket whereby the Secretary can estimate, before the beginning of a year, the percentage by which the costs for the year of the mix of labor and nonlabor goods and services included in the ESRD composite rate under section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)) will exceed the costs of such mix of goods and services for the preceding year. In developing such index, the Secretary may take into account measures of changes in—

(A) technology used in furnishing dialysis services;

(B) the manner or method of furnishing dialysis services; and

(C) the amounts by which the payments under such section for all services billed by a facility for a year exceed the aggregate allowable audited costs of such services for such facility for such year.

(2) REPORT.—The Secretary of Health and Human Services shall submit to Congress a report on the index developed under paragraph (1) no later

than July 1, 2002, and shall include in the report recommendations on the appropriateness of an annual or periodic update mechanism for renal dialysis services under the medicare program under title XVIII of the Social Security Act based on such index.

(c) INCLUSION OF ADDITIONAL SERVICES IN COMPOSITE RATE.—

(1) DEVELOPMENT.—The Secretary of Health and Human Services shall develop a system which includes, to the maximum extent feasible, in the composite rate used for payment under section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)), payment for clinical diagnostic laboratory tests and drugs (including drugs paid under section 1881(b)(11)(B) of such Act (42 U.S.C. 1395rr(b)(11)(B)) that are routinely used in furnishing dialysis services to medicare beneficiaries but which are currently separately billable by renal dialysis facilities.

(2) REPORT.—The Secretary shall include, as part of the report submitted under subsection (b)(2), a report on the system developed under paragraph (1) and recommendations on the appropriateness of

incorporating the system into medicare payment for renal dialysis services.

(d) GAO STUDY ON ACCESS TO SERVICES.—

(1) STUDY.—The Comptroller General of the United States shall study access of medicare beneficiaries to renal dialysis services. Such study shall include whether there is a sufficient supply of facilities to furnish needed renal dialysis services, whether medicare payment levels are appropriate, taking into account audited costs of facilities for all services furnished, to ensure continued access to such services, and improvements in access (and quality of care) that may result in the increased use of long nightly and short daily hemodialysis modalities.

(2) REPORT.—Not later than January 1, 2003, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 423. PAYMENT FOR AMBULANCE SERVICES.

(a) RESTORATION OF FULL CPI INCREASE FOR 2001.—Section 1834(l)(3) (42 U.S.C. 1395m(l)(3)) is amended by striking ''reduced in the case of 2001 and 2002'' each place it appears and inserting ''reduced in the case of 2002''.

(b) MILEAGE PAYMENTS.—Section 1834(l)(2)(E) (42 U.S.C. 1395m(l)(2)(E)) is amended by inserting be-

fore the period at the end the following: ‘‘, except that, beginning on the date on which the Secretary implements such fee schedule, such phase-in shall provide for full payment of any national mileage rate for ambulance services provided by suppliers that are paid by carriers in any of the 50 States where payment by a carrier for such services for all such suppliers in such State did not, prior to the implementation of the fee schedule, include a separate amount for all mileage within the county from which the beneficiary is transported’’.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) applies to services furnished on or after the date on which the Secretary of Health and Human Services implements the fee schedule under section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)).

SEC. 424. AMBULATORY SURGICAL CENTERS.

(a) DELAY IN IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—The Secretary of Health and Human Services may not implement a revised prospective payment system for services of ambulatory surgical facilities under section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i)) before January 1, 2002.

(b) EXTENDING PHASE-IN TO 4 YEARS.—Section 226 of the BBRA (113 Stat. 1501A–354) is amended by

striking paragraphs (1) and (2) and inserting the following:

''(1) in the first year of its implementation, only a proportion (specified by the Secretary and not to exceed ¼) of the payment for such services shall be made in accordance with such system and the remainder shall be made in accordance with current regulations; and

''(2) in each of the following 2 years a proportion (specified by the Secretary and not to exceed ½, and ¾, respectively) of the payment for such services shall be made under such system and the remainder shall be made in accordance with current regulations.''.

(c) DEADLINE FOR USE OF 1999 OR LATER COST SURVEYS.—Section 226 of BBRA (113 Stat. 1501A–354) is amended by adding at the end the following:

''By not later than January 1, 2003, the Secretary shall incorporate data from a 1999 medicare cost survey or a subsequent cost survey for purposes of implementing or revising such system.''.

SEC. 425. FULL UPDATE FOR DURABLE MEDICAL EQUIPMENT.

(a) IN GENERAL.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

(1) by redesignating subparagraph (D) as subparagraph (F);

(2) in subparagraph (C)—

(A) by striking ''through 2002'' and inserting ''through 2000''; and

(B) by striking ''and'' at the end; and

(3) by inserting after subparagraph (C) the following new subparagraphs:

''(D) for 2001, the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average) for the 12-month period ending with June 2000;

''(E) for 2002, 0 percentage points; and''.

(b) CONFORMING AMENDMENTS TO BBRA.—Subsection (a) of section 228 of BBRA (113 Stat. 1501A–356) is amended—

(1) in the matter preceding paragraph (1), by striking ''for such items'';

(2) in paragraph (1), by inserting ''oxygen and oxygen equipment for'' after ''(1)''; and

(3) in paragraph (2), by inserting ''all such covered items for'' after ''(2)''.

(c) EFFECTIVE DATE.—The amendments made by subsection (b) shall take effect as if included in the enactment of BBRA.

SEC. 426. FULL UPDATE FOR ORTHOTICS AND PROSTHETICS.

Section 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A)) is amended—

(1) by redesignating clause (vi) as clause (viii);

(2) in clause (v)—

(A) by striking ''through 2002'' and inserting ''through 2000''; and

(B) by striking ''and'' at the end; and

(3) by inserting after clause (v) the following new clause:

''(vi) for 2001, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June 2000;

''(vii) for 2002, 1 percent; and''.

SEC. 427. ESTABLISHMENT OF SPECIAL PAYMENT PROVISIONS AND REQUIREMENTS FOR PROSTHETICS AND CERTAIN CUSTOM FABRICATED ORTHOTIC ITEMS.

(a) IN GENERAL.—Section 1834(h)(1) (42 U.S.C. 1395m(h)(1)) is amended by adding at the end the following:

"(F) SPECIAL PAYMENT RULES FOR CERTAIN PROSTHETICS AND CUSTOM FABRICATED ORTHOTICS.—

"(i) IN GENERAL.—No payment shall be made under this subsection for an item of custom fabricated orthotics described in clause (ii) or for an item of prosthetics unless such item is—

"(I) furnished by a qualified practitioner; and

"(II) fabricated by a qualified practitioner or a qualified supplier at a facility that meets such criteria as the Secretary determines appropriate.

"(ii) DESCRIPTION OF CUSTOM FABRICATED ITEM.—

"(I) IN GENERAL.—An item described in this clause is an item of custom fabricated orthotics that requires education, training, and experience to custom fabricate and that is included in a list established by the Secretary in subclause (II). Such an item does not include shoes and shoe inserts.

''(II) LIST OF ITEMS.—The Secretary, in consultation with appropriate experts in orthotics (including national organizations representing manufacturers of orthotics), shall establish and update as appropriate a list of items to which this subparagraph applies. No item may be included in such list unless the item is individually fabricated for the patient over a positive model of the patient.

''(iii) QUALIFIED PRACTITIONER DEFINED.—In this subparagraph, the term 'qualified practitioner' means a physician or other individual who—

''(I) is a qualified physical therapist or a qualified occupational therapist;

''(II) in the case of a State that provides for the licensing of orthotics and prosthetics, is licensed in orthotics or prosthetics by the State in which the item is supplied; or

''(III) in the case of a State that does not provide for the licensing of

orthotics and prosthetics, is specifically trained and educated to provide or manage the provision of prosthetics and custom-designed or fabricated orthotics, and is certified by the American Board for Certification in Orthotics and Prosthetics, Inc. or by the Board for Orthotist/Prosthetist Certification, or is credentialed and approved by a program that the Secretary determines, in consultation with appropriate experts in orthotics and prosthetics, has training and education standards that are necessary to provide such prosthetics and orthotics.

''(iv) QUALIFIED SUPPLIER DEFINED.—In this subparagraph, the term 'qualified supplier' means any entity that is accredited by the American Board for Certification in Orthotics and Prosthetics, Inc. or by the Board for Orthotist/Prosthetist Certification, or accredited and approved by a program that the Secretary determines has accreditation and approval

standards that are essentially equivalent to those of such Board.''.

(b) EFFECTIVE DATE.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall promulgate revised regulations to carry out the amendment made by subsection (a) using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code.

(c) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on HCFA Ruling 96–1, issued on September 1, 1996, with respect to distinguishing orthotics from durable medical equipment under the medicare program under title XVIII of the Social Security Act. The study shall assess the following matters:

(A) The compliance of the Secretary of Health and Human Services with the Administrative Procedures Act (under chapter 5 of title 5, United States Code) in making such ruling.

(B) The potential impact of such ruling on the health care furnished to medicare beneficiaries under the medicare program, especially those beneficiaries with degenerative musculoskeletal conditions.

(C) The potential for fraud and abuse under the medicare program if payment were provided for orthotics used as a component of durable medical equipment only when made under the special payment provision for certain prosthetics and custom fabricated orthotics under section 1834(h)(1)(F) of the Social Security Act, as added by subsection (a) and furnished by qualified practitioners under that section.

(D) The impact on payments under titles XVIII and XIX of the Social Security Act if such ruling were overturned.

(2) REPORT.—Not later than 6 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 428. REPLACEMENT OF PROSTHETIC DEVICES AND PARTS.

(a) IN GENERAL.—Section 1834(h)(1) (42 U.S.C. 1395m(h)(1)), as amended by section 427(a), is further amended by adding at the end the following new subparagraph:

''(G) REPLACEMENT OF PROSTHETIC DEVICES AND PARTS.—

''(i) IN GENERAL.—Payment shall be made for the replacement of prosthetic devices which are artificial limbs, or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions if an ordering physician determines that the provision of a replacement device, or a replacement part of such a device, is necessary because of any of the following:

''(I) A change in the physiological condition of the patient.

''(II) An irreparable change in the condition of the device, or in a part of the device.

''(III) The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

''(ii) CONFIRMATION MAY BE REQUIRED IF REPLACEMENT DEVICE OR PART IS LESS THAN 3 YEARS OLD.—If a

physician determines that a replacement device, or a replacement part, is necessary pursuant to clause (i)—

"(I) such determination shall be controlling; and

"(II) such replacement device or part shall be deemed to be reasonable and necessary for purposes of section 1862(a)(1)(A);

except that if the device, or part, being replaced is less than 3 years old (calculated from the date on which the beneficiary began to use the device or part), the Secretary may also require confirmation of necessity of the replacement device, or, as the case may be, the replacement part.".

(b) PREEMPTION OF RULE.—The provisions of section 1834(h)(1)(G) as added by subsection (a) shall supersede any rule that as of the date of the enactment of this Act may have applied a 5-year replacement rule with regard to prosthetic devices.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items replaced on or after April 1, 2001.

SEC. 429. REVISED PART B PAYMENT FOR DRUGS AND BIOLOGICALS AND RELATED SERVICES.

(a) RECOMMENDATIONS FOR REVISED PAYMENT METHODOLOGY FOR DRUGS AND BIOLOGICALS.—

(1) STUDY.—

(A) IN GENERAL.—The Comptroller General of the United States shall conduct a study on the reimbursement for drugs and biologicals under the current medicare payment methodology (provided under section 1842(o) of the Social Security Act (42 U.S.C. 1395u(o)) and for related services under part B of title XVIII of such Act. In the study, the Comptroller General shall—

(i) identify the average prices at which such drugs and biologicals are acquired by physicians and other suppliers;

(ii) quantify the difference between such average prices and the reimbursement amount under such section; and

(iii) determine the extent to which (if any) payment under such part is adequate to compensate physicians, providers of services, or other suppliers of such drugs and biologicals for costs incurred in the ad-

ministration, handling, or storage of such drugs or biologicals.

(B) CONSULTATION.—In conducting the study under subparagraph (A), the Comptroller General shall consult with physicians, providers of services, and suppliers of drugs and biologicals under the medicare program under title XVIII of such Act, as well as other organizations involved in the distribution of such drugs and biologicals to such physicians, providers of services, and suppliers.

(2) REPORT.—Not later than 9 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress and to the Secretary of Health and Human Services a report on the study conducted under this subsection, and shall include in such report recommendations for revised payment methodologies described in paragraph (3).

(3) RECOMMENDATIONS FOR REVISED PAYMENT METHODOLOGIES.—

(A) IN GENERAL.—The Comptroller General shall provide specific recommendations for revised payment methodologies for reimbursement for drugs and biologicals and for related

services under the medicare program. The Comptroller General may include in the recommendations—

(i) proposals to make adjustments under subsection (c) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for the practice expense component of the physician fee schedule under such section for the costs incurred in the administration, handling, or storage of certain categories of such drugs and biologicals, if appropriate; and

(ii) proposals for new payments to providers of services or suppliers for such costs, if appropriate.

(B) ENSURING PATIENT ACCESS TO CARE.—In making recommendations under this paragraph, the Comptroller General shall ensure that any proposed revised payment methodology is designed to ensure that medicare beneficiaries continue to have appropriate access to health care services under the medicare program.

(C) MATTERS CONSIDERED.—In making recommendations under this paragraph, the Comptroller General shall consider—

(i) the method and amount of reimbursement for similar drugs and biologicals made by large group health plans;

(ii) as a result of any revised payment methodology, the potential for patients to receive inpatient or outpatient hospital services in lieu of services in a physician's office; and

(iii) the effect of any revised payment methodology on the delivery of drug therapies by hospital outpatient departments.

(D) COORDINATION WITH BBRA STUDY.—In making recommendations under this paragraph, the Comptroller General shall conclude and take into account the results of the study provided for under section 213(a) of BBRA (113 Stat. 1501A–350).

(b) IMPLEMENTATION OF NEW PAYMENT METHODOLOGY.—

(1) IN GENERAL.—Notwithstanding any other provision of law, based on the recommendations contained in the report under subsection (a), the Sec-

retary of Health and Human Services, subject to paragraph (2), shall revise the payment methodology under section 1842(o) of the Social Security Act (42 U.S.C. 1395u(o)) for drugs and biologicals furnished under part B of the medicare program. To the extent the Secretary determines appropriate, the Secretary may provide for the adjustments to payments amounts referred to in subsection (a)(3)(A)(i) or additional payments referred to in subsection (a)(2)(A)(ii).

(2) LIMITATION.—In revising the payment methodology under paragraph (1), in no case may the estimated aggregate payments for drugs and biologicals under the revised system (including additional payments referred to in subsection (a)(3)(A)(ii)) exceed the aggregate amount of payment for such drugs and biologicals, as projected by the Secretary, that would have been made under the payment methodology in effect under such section 1842(o).

(c) TEMPORARY INJUNCTION AGAINST REDUCTIONS IN PAYMENT RATES.—Notwithstanding any other provision of law, the Administrator of the Health Care Financing Administration may not directly or indirectly increase or decrease the rates of reimbursement (in effect on Sep-

tember 1, 2000) for drugs and biologicals under the current medicare payment methodology (provided under section 1842(o) of such Act (42 U.S.C. 1395u(o)) until such time as the Secretary has reviewed the report submitted under subsection (a)(2).

SEC. 430. CONTRAST ENHANCED DIAGNOSTIC PROCEDURES UNDER HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

(a) SEPARATE CLASSIFICATION.—Section 1833(t)(2) (42 U.S.C. 1395l(t)(2)) is amended—

(1) by striking ''and'' at the end of subparagraph (E);

(2) by striking the period at the end of subparagraph (F) and inserting ''; and''; and

(3) by inserting after subparagraph (F) the following new subparagraph:

''(G) the Secretary shall create additional groups of covered OPD services that classify separately those procedures that utilize contrast media from those that do not.''.

(b) CONFORMING AMENDMENT.—Section 1861(t)(1) (42 U.S.C. 1395x(t)(1)) is amended by inserting ''(including contrast agents)'' after ''only such drugs''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to items and services furnished on or after January 1, 2001.

SEC. 431. QUALIFICATIONS FOR COMMUNITY MENTAL HEALTH CENTERS.

(a) MEDICARE PROGRAM.—Section 1861(ff)(3)(B) (42 U.S.C. 1395x(ff)(3)(B)) is amended by striking ''entity'' and all that follows and inserting the following: ''entity that—

''(i)(I) provides the mental health services described in section 1913(c)(1) of the Public Health Service Act; or

''(II) in the case of an entity operating in a State that by law precludes the entity from providing itself the service described in subparagraph (E) of such section, provides for such service by contract with an approved organization or entity (as determined by the Secretary);

''(ii) meets applicable licensing or certification requirements for community mental health centers in the State in which it is located; and

''(iii) meets such additional conditions as the Secretary shall specify to ensure (I) the health and safety of individuals being furnished such services, (II) the effective and efficient furnishing of such

services, and (III) the compliance of such entity with the criteria described in section 1931(c)(1) of the Public Health Service Act.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies with respect to community mental health centers with respect to services furnished on or after the first day of the third month beginning after the date of the enactment of this Act.

SEC. 432. MODIFICATION OF MEDICARE BILLING REQUIREMENTS FOR CERTAIN INDIAN PROVIDERS.

(a) IN GENERAL.—Section 1880(a) (42 U.S.C. 1395qq(a)) is amended by adding at the end the following new sentence: ''A hospital or a free-standing ambulatory care clinic (as defined by the Secretary), whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for payments for services for which payment is made pursuant to section 1848, notwithstanding sections 1814(c) and 1835(d), if and for so long as it meets all of the requirements which are applicable generally to such payments, services, hospitals, and clinics.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services furnished on or after January 1, 2001.

SEC. 433. GAO STUDY ON COVERAGE OF SURGICAL FIRST ASSISTING SERVICES OF CERTIFIED REGISTERED NURSE FIRST ASSISTANTS.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the effect on the medicare program under title XVIII of the Social Security Act and on medicare beneficiaries of coverage under the program of surgical first assisting services of certified registered nurse first assistants. The Comptroller General shall consider the following when conducting the study:

(1) Any impact on the quality of care furnished to medicare beneficiaries by reason of such coverage.

(2) Appropriate education and training requirements for certified registered nurse first assistants who furnish such first assisting services.

(3) Appropriate rates of payment under the program to such certified registered nurse first assistants for furnishing such services, taking into account the costs of compensation, overhead, and supervision attributable to certified registered nurse first assistants.

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

SEC. 434. MEDPAC STUDY AND REPORT ON MEDICARE REIMBURSEMENT FOR SERVICES PROVIDED BY CERTAIN PROVIDERS.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the appropriateness of the current payment rates under the medicare program under title XVIII of the Social Security Act for services provided by a—

(1) certified nurse-midwife (as defined in subsection (gg)(2) of section 1861 of such Act (42 U.S.C. 1395x);

(2) physician assistant (as defined in subsection (aa)(5)(A) of such section);

(3) nurse practitioner (as defined in such subsection); and

(4) clinical nurse specialist (as defined in subsection (aa)(5)(B) of such section).

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study conducted under subsection (a), together with any recommendations for legislation that the Commission determines to be appropriate as a result of such study.

SEC. 435. MEDPAC STUDY AND REPORT ON MEDICARE COVERAGE OF SERVICES PROVIDED BY CERTAIN NONPHYSICIAN PROVIDERS.

(a) STUDY.—

(1) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study to determine the appropriateness of providing coverage under the medicare program under title XVIII of the Social Security Act for services provided by a—

(A) surgical technologist;

(B) marriage counselor;

(C) marriage and family therapist;

(D) pastoral care counselor; and

(E) licensed professional counselor of mental health.

(2) COSTS TO PROGRAM.—The study shall consider the short-term and long-term benefits, and costs to the medicare program, of providing the coverage described in paragraph (1).

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study conducted under subsection (a), together with any recommendations for legislation that the Commission determines to be appropriate as a result of such study.

SEC. 436. GAO STUDY AND REPORT ON THE COSTS OF EMERGENCY AND MEDICAL TRANSPORTATION SERVICES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the costs of providing emergency and medical transportation services across the range of acuity levels of conditions for which such transportation services are provided.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a), together with recommendations for any changes in methodology or payment level necessary to fairly compensate suppliers of emergency and medical transportation services and to ensure the access of beneficiaries under the medicare program under title XVIII of the Social Security Act.

SEC. 437. GAO STUDIES AND REPORTS ON MEDICARE PAYMENTS.

(a) GAO STUDY ON HCFA POST-PAYMENT AUDIT PROCESS.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the post-payment audit process under the medicare program under title XVIII of the Social Security Act as such process applies to physicians, including the proper

level of resources that the Health Care Financing Administration should devote to educating physicians regarding—

(A) coding and billing;

(B) documentation requirements; and

(C) the calculation of overpayments.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) together with specific recommendations for changes or improvements in the post-payment audit process described in such paragraph.

(b) GAO STUDY ON ADMINISTRATION AND OVERSIGHT.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the aggregate effects of regulatory, audit, oversight, and paperwork burdens on physicians and other health care providers participating in the medicare program under title XVIII of the Social Security Act.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) together

with recommendations regarding any area in which—

(A) a reduction in paperwork, an ease of administration, or an appropriate change in oversight and review may be accomplished; or

(B) additional payments or education are needed to assist physicians and other health care providers in understanding and complying with any legal or regulatory requirements.

SEC. 438. MEDPAC STUDY ON ACCESS TO OUTPATIENT PAIN MANAGEMENT SERVICES.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the barriers to coverage and payment for outpatient interventional pain medicine procedures under the medicare program under title XVIII of the Social Security Act. Such study shall examine—

(1) the specific barriers imposed under the medicare program on the provision of pain management procedures in hospital outpatient departments, ambulatory surgery centers, and physicians' offices; and

(2) the consistency of medicare payment policies for pain management procedures in those different settings.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study.

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.

(a) IN GENERAL.—Section 1895(b)(3)(A)(i) (42 U.S.C. 1395fff(b)(3)(A)(i)) is amended—

(1) by redesignating subclause (II) as subclause (III);

(2) in subclause (III), as redesignated, by striking ''described in subclause (I)'' and inserting ''described in subclause (II)''; and

(3) by inserting after subclause (I) the following new subclause:

''(II) For the 12-month period beginning after the period described in subclause (I), such amount (or amounts) shall be equal to the amount (or amounts) determined under subclause (I), updated under subparagraph (B).''.

(b) CHANGE IN REPORT.—Section 302(c) of BBRA (113 Stat. 1501A–360) is amended—

(1) by striking ''Not later than'' and all that follows through ''(42 U.S.C. 1395fff)'' and inserting ''Not later than April 1, 2002''; and

(2) by striking ''Secretary'' and inserting ''Comptroller General of the United States''.

(c) CASE MIX ADJUSTMENT CORRECTIONS.—

(1) IN GENERAL.—Section 1895(b)(3)(B) (42 U.S.C. 1395fff(b)(3)(B)) is amended by adding at the end the following new clause:

''(iv) ADJUSTMENT FOR CASE MIX CHANGES.—Insofar as the Secretary determines that the adjustments under paragraph (4)(A)(i) for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in the coding or classification of different units of services that do not reflect real changes in case mix, the Secretary may adjust the standard prospective payment amount (or amounts) under paragraph (3) for subse-

quent fiscal years so as to eliminate the effect of such coding or classification changes.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) applies to episodes concluding on or after October 1, 2001.

SEC. 502. RESTORATION OF FULL HOME HEALTH MARKET BASKET UPDATE FOR HOME HEALTH SERVICES FOR FISCAL YEAR 2001.

(a) IN GENERAL.—Section 1861(v)(1)(L)(x) (42 U.S.C. 1395x(v)(1)(L)(x)) is amended—

(1) by striking ''2001,''; and

(2) by adding at the end the following: ''With respect to cost reporting periods beginning during fiscal year 2001, the update to any limit under this subparagraph shall be the home health market basket index.''.

(b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR 2001 BASED ON ADJUSTED PROSPECTIVE PAYMENT AMOUNTS.—

(1) IN GENERAL.—Notwithstanding the amendments made by subsection (a), for purposes of making payments under section 1895(b) of the Social Security Act (42 U.S.C. 1395fff(b)) for home health

services for fiscal year 2001, the Secretary of Health and Human Services shall—

(A) with respect to episodes and visits ending on or after October 1, 2000, and before April 1, 2001, use the final standardized and budget neutral prospective payment amounts for 60 day episodes and standardized average per visit amounts for fiscal year 2001 as published by the Secretary in Federal Register of the July 3, 2000 (65 Federal Register 41128–41214); and

(B) with respect to episodes and visits ending on or after April 1, 2001, and before October 1, 2001, use such amounts increased by 2.2 percent.

(2) NO EFFECT ON OTHER PAYMENTS OR DETERMINATIONS.—The Secretary shall not take the provisions of paragraph (1) into account for purposes of payments, determinations, or budget neutrality adjustments under section 1895 of the Social Security Act.

SEC. 503. TEMPORARY TWO-MONTH EXTENSION OF PERIODIC INTERIM PAYMENTS.

(a) TEMPORARY EXTENSION.—Notwithstanding subsection (d) of section 4603 of BBA (42 U.S.C. 1395fff

note), as amended by section 5101(c)(2) of the Tax and Trade Relief Extension Act of 1998 (contained in division J of Public Law 105–277)), the amendments made by subsection (b) of such section 4603 shall not take effect until December 1, 2000, in the case of a home health agency that was receiving periodic interim payments under section 1815(e)(2) as of September 30, 2000.

(b) PAYMENT RULE.—The amount of such periodic interim payment made to a home health agency by reason of subsection (a) during each of November and December, 2000, shall be equal to the amount of such payment made to the agency in their last full monthly periodic interim payment. Such amount of payment shall be included in the tentative settlement of the last cost report for the home health agency under the payment system in effect prior to the implementation of the prospective payment system under section 1895(b) of the Social Security Act (42 U.S.C. 1395fff(b)).

SEC. 504. USE OF TELEHEALTH IN DELIVERY OF HOME HEALTH SERVICES.

Section 1895 (42 U.S.C. 1395fff) is amended by adding at the end the following new subsection:

''(e) CONSTRUCTION RELATED TO HOME HEALTH SERVICES.—

''(1) TELECOMMUNICATIONS.—Nothing in this section shall be construed as preventing a home health agency furnishing a home health unit of service for which payment is made under the prospective payment system established by this section for such units of service from furnishing services via a telecommunication system if such services—

''(A) do not substitute for in-person home health services ordered as part of a plan of care certified by a physician pursuant to section 1814(a)(2)(C) or section 1835(a)(2)(A); and

''(B) are not considered a home health visit for purposes of eligibility or payment under this title.

''(2) PHYSICIAN CERTIFICATION.—Nothing in this section shall be construed as waiving the requirement for a physician certification under section 1814(a)(2)(C) or section 1835(a)(2)(A) of such Act (42 U.S.C. 1395f(a)(2)(C), 1395n(a)(2)(A)) for the payment for home health services, whether or not furnished via a telecommunications system.''.

SEC. 505. STUDY ON COSTS TO HOME HEALTH AGENCIES OF PURCHASING NONROUTINE MEDICAL SUPPLIES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on variations in prices paid by home health agencies furnishing home health services under the medicare program under title XVIII of the Social Security Act in purchasing nonroutine medical supplies, including ostomy supplies, and volumes if such supplies used, shall determine the effect (if any) of variations on prices and volumes in the provision of such services.

(b) REPORT.—Not later than October 1, 2001, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a), and shall include in the report recommendations respecting whether payment for nonroutine medical supplies furnished in connection with home health services should be made separately from the prospective payment system for such services.

SEC. 506. TREATMENT OF BRANCH OFFICES; GAO STUDY ON SUPERVISION OF HOME HEALTH CARE PROVIDED IN ISOLATED RURAL AREAS.

(a) TREATMENT OF BRANCH OFFICES.—

(1) IN GENERAL.—Notwithstanding any other provision of law, in determining for purposes of title XVIII of the Social Security Act whether an office

of a home health agency constitutes a branch office or a separate home health agency, neither the time nor distance between a parent office of the home health agency and a branch office shall be the sole determinant of a home health agency's branch office status.

(2) CONSIDERATION OF FORMS OF TECHNOLOGY IN DEFINITION OF SUPERVISION.—The Secretary of Health and Human Services may include forms of technology in determining what constitutes ''supervision'' for purposes of determining a home heath agency's branch office status under paragraph (1).

(b) GAO STUDY.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study of the provision of adequate supervision to maintain quality of home health services delivered under the medicare program under title XVIII of the Social Security Act in isolated rural areas. The study shall evaluate the methods that home health agency branches and subunits use to maintain adequate supervision in the delivery of services to clients residing in those areas, how these methods of supervision compare to requirements that subunits independently meet medi-

care conditions of participation, and the resources utilized by subunits to meet such conditions.

(2) REPORT.—Not later than January 1, 2002, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include recommendations on whether exceptions are needed for subunits and branches of home health agencies under the medicare program to maintain access to the home health benefit or whether alternative policies should be developed to assure adequate supervision and access and recommendations on whether a national standard for supervision is appropriate.

SEC. 507. CLARIFICATION OF THE HOMEBOUND DEFINITION UNDER THE MEDICARE HOME HEALTH BENEFIT.

(a) CLARIFICATION.—

(1) IN GENERAL.—Sections 1814(a) and 1835(a) (42 U.S.C. 1395f(a) and 1395n(a)) are each amended—

(A) in the last sentence, by striking ", and that absences of the individual from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment"; and

(B) by adding at the end the following new sentences: ''Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be 'confined to his home'. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to items and services provided on or after the date of enactment of this Act.

(b) STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct an evaluation of the

effect of the amendment on the cost of and access to home health services under the medicare program under title XVIII of the Social Security Act.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

Subtitle B—Direct Graduate Medical Education

SEC. 511. INCREASE IN FLOOR FOR DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.

Section 1886(h)(2)(D)(iii) (42 U.S.C. 1395ww(h)(2)(D)(iii)) is amended—

(1) in the heading, by striking ''IN FISCAL YEAR 2001 AT 70 PERCENT OF'' and inserting ''FOR''; and

(2) by inserting after ''70 percent'' the following: '', and for the cost reporting period beginning during fiscal year 2002 shall not be less than 85 percent,''.

SEC. 512. CHANGE IN DISTRIBUTION FORMULA FOR MEDICARE+CHOICE-RELATED NURSING AND ALLIED HEALTH EDUCATION COSTS.

(a) IN GENERAL.—Section 1886(l)(2)(C) (42 U.S.C. 1395ww(l)(2)(C)) is amended by striking all that follows

''multiplied by'' and inserting the following: ''the ratio of—

''(i) the product of (I) the Secretary's estimate of the ratio of the amount of payments made under section 1861(v) to the hospital for nursing and allied health education activities for the hospital's cost reporting period ending in the second preceding fiscal year, to the hospital's total inpatient days for such period, and (II) the total number of inpatient days (as established by the Secretary) for such period which are attributable to services furnished to individuals who are enrolled under a risk sharing contract with an eligible organization under section 1876 and who are entitled to benefits under part A or who are enrolled with a Medicare+Choice organization under part C; to

''(ii) the sum of the products determined under clause (i) for such cost reporting periods.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to portions of cost reporting periods occurring on or after January 1, 2001.

Subtitle C—Changes in Medicare Coverage and Appeals Process

SEC. 521. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) CONDUCT OF RECONSIDERATIONS OF DETERMINATIONS BY INDEPENDENT CONTRACTORS.—Section 1869 (42 U.S.C. 1395ff) is amended to read as follows:

''DETERMINATIONS; APPEALS

''SEC. 1869. (a) INITIAL DETERMINATIONS.—

''(1) PROMULGATIONS OF REGULATIONS.—The Secretary shall promulgate regulations and make initial determinations with respect to benefits under part A or part B in accordance with those regulations for the following:

''(A) The initial determination of whether an individual is entitled to benefits under such parts.

''(B) The initial determination of the amount of benefits available to the individual under such parts.

''(C) Any other initial determination with respect to a claim for benefits under such parts, including an initial determination by the Secretary that payment may not be made, or may no longer be made, for an item or service under such parts, an initial determination made by a

utilization and quality control peer review organization under section 1154(a)(2), and an initial determination made by an entity pursuant to a contract (other than a contract under section 1852) with the Secretary to administer provisions of this title or title XI.

''(2) DEADLINES FOR MAKING INITIAL DETERMINATIONS.—

''(A) IN GENERAL.—Subject to subparagraph (B), in promulgating regulations under paragraph (1), initial determinations shall be concluded by not later than the 45-day period beginning on the date the fiscal intermediary or the carrier, as the case may be, receives a claim for benefits from an individual as described in paragraph (1). Notice of such determination shall be mailed to the individual filing the claim before the conclusion of such 45-day period.

''(B) CLEAN CLAIMS.—Subparagraph (A) shall not apply with respect to any claim that is subject to the requirements of section 1816(c)(2) or section 1842(c)(2).

''(3) REDETERMINATIONS.—

''(A) IN GENERAL.—In promulgating regulations under paragraph (1) with respect to ini-

tial determinations, such regulations shall provide for a fiscal intermediary or a carrier to make a redetermination with respect to a claim for benefits that is denied in whole or in part.

''(B) LIMITATIONS.—

''(i) APPEALS RIGHTS.—No initial determination may be reconsidered or appealed under subsection (b) unless the fiscal intermediary or carrier has made a redetermination of that initial determination under this paragraph.

''(ii) DECISION MAKER.—No redetermination may be made by any individual involved in the initial determination.

''(C) DEADLINES.—

''(i) FILING FOR REDETERMINATION.—A redetermination under subparagraph (A) shall be available only if notice is filed with the Secretary to request the redetermination by not later than the end of the 120-day period beginning on the date the individual receives notice of the initial determination under paragraph (2).

''(ii) CONCLUDING REDETERMINATIONS.—Redeterminations shall be concluded by not

later than the 30-day period beginning on the date the fiscal intermediary or the carrier, as the case may be, receives a request for a redetermination. Notice of such determination shall be mailed to the individual filing the claim before the conclusion of such 30-day period.

''(D) CONSTRUCTION.—For purposes of the succeeding provisions of this section a redetermination under this paragraph shall be considered to be part of the initial determination.

''(b) APPEAL RIGHTS.—

''(1) IN GENERAL.—

''(A) RECONSIDERATION OF INITIAL DETERMINATION.—Subject to subparagraph (D), any individual dissatisfied with any initial determination under subsection (a)(1) shall be entitled to reconsideration of the determination, and, subject to subparagraphs (D) and (E), a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). For purposes of the preceding sentence, any reference to the 'Commissioner of Social Security' or the 'Social Security Administration'

in subsection (g) or (l) of section 205 shall be considered a reference to the 'Secretary' or the 'Department of Health and Human Services', respectively.

"(B) REPRESENTATION BY PROVIDER OR SUPPLIER.—

"(i) IN GENERAL.—Sections 206(a), 1102, and 1871 shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this section by a person that furnishes or supplies the individual, directly or indirectly, with services or items, solely on the basis that the person furnishes or supplies the individual with such a service or item.

"(ii) MANDATORY WAIVER OF RIGHT TO PAYMENT FROM BENEFICIARY.—Any person that furnishes services or items to an individual may not represent an individual under this section with respect to the issue described in section 1879(a)(2) unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal.

''(iii) PROHIBITION ON PAYMENT FOR REPRESENTATION.—If a person furnishes services or items to an individual and represents the individual under this section, the person may not impose any financial liability on such individual in connection with such representation.

''(iv) REQUIREMENTS FOR REPRESENTATIVES OF A BENEFICIARY.—The provisions of section 205(j) and section 206 (other than subsection (a)(4) of such section) regarding representation of claimants shall apply to representation of an individual with respect to appeals under this section in the same manner as they apply to representation of an individual under those sections.

''(C) SUCCESSION OF RIGHTS IN CASES OF ASSIGNMENT.—The right of an individual to an appeal under this section with respect to an item or service may be assigned to the provider of services or supplier of the item or service upon the written consent of such individual using a standard form established by the Secretary for such an assignment.

''(D) TIME LIMITS FOR FILING APPEALS.—

''(i) RECONSIDERATIONS.—Reconsideration under subparagraph (A) shall be available only if the individual described in subparagraph (A) files notice with the Secretary to request reconsideration by not later than the end of the 180-day period beginning on the date the individual receives notice of the redetermination under subsection (a)(3), or within such additional time as the Secretary may allow.

''(ii) HEARINGS CONDUCTED BY THE SECRETARY.—The Secretary shall establish in regulations time limits for the filing of a request for a hearing by the Secretary in accordance with provisions in sections 205 and 206.

''(E) AMOUNTS IN CONTROVERSY.—

''(i) IN GENERAL.—A hearing (by the Secretary) shall not be available to an individual under this section if the amount in controversy is less than $100, and judicial review shall not be available to the individual if the amount in controversy is less than $1,000.

''(ii) AGGREGATION OF CLAIMS.—In determining the amount in controversy, the Secretary, under regulations, shall allow two or more appeals to be aggregated if the appeals involve—

''(I) the delivery of similar or related services to the same individual by one or more providers of services or suppliers, or

''(II) common issues of law and fact arising from services furnished to two or more individuals by one or more providers of services or suppliers.

''(F) EXPEDITED PROCEEDINGS.—

''(i) EXPEDITED DETERMINATION.—In the case of an individual who has received notice by a provider of services that the provider of services plans—

''(I) to terminate services provided to an individual and a physician certifies that failure to continue the provision of such services is likely to place the individual's health at significant risk, or

"(II) to discharge the individual from the provider of services,

the individual may request, in writing or orally, an expedited determination or an expedited reconsideration of an initial determination made under subsection (a)(1), as the case may be, and the Secretary shall provide such expedited determination or expedited reconsideration.

"(ii) EXPEDITED HEARING.—In a hearing by the Secretary under this section, in which the moving party alleges that no material issues of fact are in dispute, the Secretary shall make an expedited determination as to whether any such facts are in dispute and, if not, shall render a decision expeditiously.

"(G) REOPENING AND REVISION OF DETERMINATIONS.—The Secretary may reopen or revise any initial determination or reconsidered determination described in this subsection under guidelines established by the Secretary in regulations.

"(c) CONDUCT OF RECONSIDERATIONS BY INDEPENDENT CONTRACTORS.—

''(1) IN GENERAL.—The Secretary shall enter into contracts with qualified independent contractors to conduct reconsiderations of initial determinations made under subparagraphs (B) and (C) of subsection (a)(1). Contracts shall be for an initial term of three years and shall be renewable on a triennial basis thereafter.

''(2) QUALIFIED INDEPENDENT CONTRACTOR.—For purposes of this subsection, the term 'qualified independent contractor' means an entity or organization that is independent of any organization under contract with the Secretary that makes initial determinations under subsection (a)(1), and that meets the requirements established by the Secretary consistent with paragraph (3).

''(3) REQUIREMENTS.—Any qualified independent contractor entering into a contract with the Secretary under this subsection shall meet the all of the following requirements:

''(A) IN GENERAL.—The qualified independent contractor shall perform such duties and functions and assume such responsibilities as may be required by the Secretary to carry out the provisions of this subsection, and shall have sufficient training and expertise in medical

science and legal matters to make reconsiderations under this subsection.

"(B) RECONSIDERATIONS.—

"(i) IN GENERAL.—The qualified independent contractor shall review initial determinations. In the case an initial determination made with respect to whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury (under section 1862(a)(1)(A)), such review shall include consideration of the facts and circumstances of the initial determination by a panel of physicians or other appropriate health care professionals and any decisions with respect to the reconsideration shall be based on applicable information, including clinical experience and medical, technical, and scientific evidence.

"(ii) EFFECT OF NATIONAL AND LOCAL COVERAGE DETERMINATIONS.—

"(I) NATIONAL COVERAGE DETERMINATIONS.—If the Secretary has made a national coverage determination pursuant to the requirements es-

tablished under the third sentence of section 1862(a), such determination shall be binding on the qualified independent contractor in making a decision with respect to a reconsideration under this section.

''(II) LOCAL COVERAGE DETERMINATIONS.—If the Secretary has made a local coverage determination, such determination shall not be binding on the qualified independent contractor in making a decision with respect to a reconsideration under this section. Notwithstanding the previous sentence, the qualified independent contractor shall consider the local coverage determination in making such decision.

''(III) ABSENCE OF NATIONAL OR LOCAL COVERAGE DETERMINATION.—In the absence of such a national coverage determination or local coverage determination, the qualified independent contractor shall make a decision with respect to the reconsider-

ation based on applicable information, including clinical experience and medical, technical, and scientific evidence.

"(C) DEADLINES FOR DECISIONS.—

"(i) RECONSIDERATIONS.—Except as provided in clauses (iii) and (iv), the qualified independent contractor shall conduct and conclude a reconsideration under subparagraph (B), and mail the notice of the decision with respect to the reconsideration by not later than the end of the 30-day period beginning on the date a request for reconsideration has been timely filed.

"(ii) CONSEQUENCES OF FAILURE TO MEET DEADLINE.—In the case of a failure by the qualified independent contractor to mail the notice of the decision by the end of the period described in clause (i) or to provide notice by the end of the period described in clause (iii), as the case may be, the party requesting the reconsideration or appeal may request a hearing before the Secretary, notwithstanding any requirements for a reconsidered determination for

purposes of the party's right to such hearing.

"(iii) EXPEDITED RECONSIDERATIONS.—The qualified independent contractor shall perform an expedited reconsideration under subsection (b)(1)(F) as follows:

"(I) DEADLINE FOR DECISION.—Notwithstanding section 216(j) and subject to clause (iv), not later than the end of the 72-hour period beginning on the date the qualified independent contractor has received a request for such reconsideration and has received such medical or other records needed for such reconsideration, the qualified independent contractor shall provide notice (by telephone and in writing) to the individual and the provider of services and attending physician of the individual of the results of the reconsideration. Such reconsideration shall be conducted regardless of whether the provider of services or supplier will charge the individual for

continued services or whether the individual will be liable for payment for such continued services.

''(II) CONSULTATION WITH BENEFICIARY.—In such reconsideration, the qualified independent contractor shall solicit the views of the individual involved.

''(III) SPECIAL RULE FOR HOSPITAL DISCHARGES.—A reconsideration of a discharge from a hospital shall be conducted under this clause in accordance with the provisions of paragraphs (2), (3), and (4) of section 1154(e) as in effect on the date that precedes the date of the enactment of this subparagraph.

''(iv) EXTENSION.—An individual requesting a reconsideration under this subparagraph may be granted such additional time as the individual specifies (not to exceed 14 days) for the qualified independent contractor to conclude the reconsideration. The individual may request such additional time in orally or in writing.

"(D) LIMITATION ON INDIVIDUAL REVIEWING DETERMINATIONS.—

"(i) PHYSICIANS AND HEALTH CARE PROFESSIONAL.—No physician or health care professional under the employ of a qualified independent contractor may review—

"(I) determinations regarding health care services furnished to a patient if the physician or health care professional was directly responsible for furnishing such services; or

"(II) determinations regarding health care services provided in or by an institution, organization, or agency, if the physician or any member of the family of the physician or health care professional has, directly or indirectly, a significant financial interest in such institution, organization, or agency.

"(ii) FAMILY DESCRIBED.—For purposes of this paragraph, the family of a physician or health care professional includes the spouse (other than a spouse who

is legally separated from the physician or health care professional under a decree of divorce or separate maintenance), children (including stepchildren and legally adopted children), grandchildren, parents, and grandparents of the physician or health care professional.

''(E) EXPLANATION OF DECISION.—Any decision with respect to a reconsideration of a qualified independent contractor shall be in writing, and shall include a detailed explanation of the decision as well as a discussion of the pertinent facts and applicable regulations applied in making such decision, and in the case of a determination of whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury (under section 1862(a)(1)(A)) an explanation of the medical and scientific rational for the decision.

''(F) NOTICE REQUIREMENTS.—Whenever a qualified independent contractor makes a decision with respect to a reconsideration under this subsection, the qualified independent contractor shall promptly notify the entity respon-

sible for the payment of claims under part A or part B of such decision.

"(G) DISSEMINATION OF DECISIONS ON RECONSIDERATIONS.—Each qualified independent contractor shall make available all decisions with respect to reconsiderations of such qualified independent contractors to fiscal intermediaries (under section 1816), carriers (under section 1842), peer review organizations (under part B of title XI), Medicare+Choice organizations offering Medicare+Choice plans under part C, other entities under contract with the Secretary to make initial determinations under part A or part B or title XI, and to the public. The Secretary shall establish a methodology under which qualified independent contractors shall carry out this subparagraph.

"(H) ENSURING CONSISTENCY IN DECISIONS.—Each qualified independent contractor shall monitor its decisions with respect to reconsiderations to ensure the consistency of such decisions with respect to requests for reconsideration of similar or related matters.

"(I) DATA COLLECTION.—

''(i) IN GENERAL.—Consistent with the requirements of clause (ii), a qualified independent contractor shall collect such information relevant to its functions, and keep and maintain such records in such form and manner as the Secretary may require to carry out the purposes of this section and shall permit access to and use of any such information and records as the Secretary may require for such purposes.

''(ii) TYPE OF DATA COLLECTED.—Each qualified independent contractor shall keep accurate records of each decision made, consistent with standards established by the Secretary for such purpose. Such records shall be maintained in an electronic database in a manner that provides for identification of the following:

''(I) Specific claims that give rise to appeals.

''(II) Situations suggesting the need for increased education for providers of services, physicians, or suppliers.

''(III) Situations suggesting the need for changes in national or local coverage policy.

''(IV) Situations suggesting the need for changes in local medical review policies.

''(iii) ANNUAL REPORTING.—Each qualified independent contractor shall submit annually to the Secretary (or otherwise as the Secretary may request) records maintained under this paragraph for the previous year.

''(J) HEARINGS BY THE SECRETARY.—The qualified independent contractor shall (i) prepare such information as is required for an appeal of a decision of the contractor with respect to a reconsideration to the Secretary for a hearing, including as necessary, explanations of issues involved in the decision and relevant policies, and (ii) participate in such hearings as required by the Secretary.

''(4) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—The Secretary shall enter into contracts with not fewer than 12 qualified independent contractors under this subsection.

''(5) LIMITATION ON QUALIFIED INDEPENDENT CONTRACTOR LIABILITY.—No qualified independent contractor having a contract with the Secretary under this subsection and no person who is employed by, or who has a fiduciary relationship with, any such qualified independent contractor or who furnishes professional services to such qualified independent contractor, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this subsection or to a valid contract entered into under this subsection, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) provided due care was exercised in the performance of such duty, function, or activity.

''(d) DEADLINES FOR HEARINGS BY THE SECRETARY.—

''(1) HEARING BY ADMINISTRATIVE LAW JUDGE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), an administrative law judge shall conduct and conclude a hearing on a decision of a qualified independent contractor under subsection (c) and render a decision on such

hearing by not later than the end of the 90-day period beginning on the date a request for hearing has been timely filed.

''(B) WAIVER OF DEADLINE BY PARTY SEEKING HEARING.—The 90-day period under subparagraph (A) shall not apply in the case of a motion or stipulation by the party requesting the hearing to waive such period.

''(2) DEPARTMENTAL APPEALS BOARD REVIEW.—

''(A) IN GENERAL.—The Departmental Appeals Board of the Department of Health and Human Services shall conduct and conclude a review of the decision on a hearing described in paragraph (1) and make a decision or remand the case to the administrative law judge for reconsideration by not later than the end of the 90-day period beginning on the date a request for review has been timely filed.

''(B) DAB HEARING PROCEDURE.—In reviewing a decision on a hearing under this paragraph, the Departmental Appeals Board shall review the case de novo.

''(3) CONSEQUENCES OF FAILURE TO MEET DEADLINES.—

"(A) HEARING BY ADMINISTRATIVE LAW JUDGE.—In the case of a failure by an administrative law judge to render a decision by the end of the period described in paragraph (1), the party requesting the hearing may request a review by the Departmental Appeals Board of the Department of Health and Human Services, notwithstanding any requirements for a hearing for purposes of the party's right to such a review.

"(B) DEPARTMENTAL APPEALS BOARD REVIEW.—In the case of a failure by the Departmental Appeals Board to render a decision by the end of the period described in paragraph (2), the party requesting the hearing may seek judicial review, notwithstanding any requirements for a hearing for purposes of the party's right to such judicial review.

"(e) ADMINISTRATIVE PROVISIONS.—

"(1) LIMITATION ON REVIEW OF CERTAIN REGULATIONS.—A regulation or instruction that relates to a method for determining the amount of payment under part B and that was initially issued before January 1, 1981, shall not be subject to judicial review.

''(2) OUTREACH.—The Secretary shall perform such outreach activities as are necessary to inform individuals entitled to benefits under this title and providers of services and suppliers with respect to their rights of, and the process for, appeals made under this section. The Secretary shall use the toll-free telephone number maintained by the Secretary under section 1804(b) to provide information regarding appeal rights and respond to inquiries regarding the status of appeals.

''(3) CONTINUING EDUCATION REQUIREMENT FOR QUALIFIED INDEPENDENT CONTRACTORS AND ADMINISTRATIVE LAW JUDGES.—The Secretary shall provide to each qualified independent contractor, and, in consultation with the Commissioner of Social Security, to administrative law judges that decide appeals of reconsiderations of initial determinations or other decisions or determinations under this section, such continuing education with respect to coverage of items and services under this title or policies of the Secretary with respect to part B of title XI as is necessary for such qualified independent contractors and administrative law judges to make informed decisions with respect to appeals.

''(4) REPORTS.—

"(A) ANNUAL REPORT TO CONGRESS.—The Secretary shall submit to Congress an annual report describing the number of appeals for the previous year, identifying issues that require administrative or legislative actions, and including any recommendations of the Secretary with respect to such actions. The Secretary shall include in such report an analysis of determinations by qualified independent contractors with respect to inconsistent decisions and an analysis of the causes of any such inconsistencies.

"(B) SURVEY.—Not less frequently than every 5 years, the Secretary shall conduct a survey of a valid sample of individuals entitled to benefits under this title who have filed appeals of determinations under this section, providers of services, and suppliers to determine the satisfaction of such individuals or entities with the process for appeals of determinations provided for under this section and education and training provided by the Secretary with respect to that process. The Secretary shall submit to Congress a report describing the results of the survey, and shall include any rec-

ommendations for administrative or legislative actions that the Secretary determines appropriate.''.

(b) APPLICABILITY OF REQUIREMENTS AND LIMITATIONS ON LIABILITY OF QUALIFIED INDEPENDENT CONTRACTORS TO MEDICARE+CHOICE INDEPENDENT APPEALS CONTRACTORS.—Section 1852(g)(4) (42 U.S.C. 1395w–22(g)(4)) is amended by adding at the end the following: ''The provisions of section 1869(c)(5) shall apply to independent outside entities under contract with the Secretary under this paragraph.''.

(c) CONFORMING AMENDMENT.—Section 1154(e) (42 U.S.C. 1320c–3(e)) is amended by striking paragraphs (2), (3), and (4).

(d) EFFECTIVE DATE.—The amendments made by this section apply with respect to initial determinations made on or after October 1, 2002.

SEC. 522. REVISIONS TO MEDICARE COVERAGE PROCESS.

(a) REVIEW OF DETERMINATIONS.—Section 1869 (42 U.S.C. 1395ff), as amended by section 521, is further amended by adding at the end the following new subsection:

''(f) REVIEW OF COVERAGE DETERMINATIONS.—

''(1) NATIONAL COVERAGE DETERMINATIONS.—

"(A) IN GENERAL.—Review of any national coverage determination shall be subject to the following limitations:

"(i) Such a determination shall not be reviewed by any administrative law judge.

"(ii) Such a determination shall not be held unlawful or set aside on the ground that a requirement of section 553 of title 5, United States Code, or section 1871(b) of this title, relating to publication in the Federal Register or opportunity for public comment, was not satisfied.

"(iii) Upon the filing of a complaint by an aggrieved party, such a determination shall be reviewed by the Departmental Appeals Board of the Department of Health and Human Services. In conducting such a review, the Departmental Appeals Board shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination, if the Board determines that the record is incomplete or lacks adequate information to support the validity of the determination. In reviewing such a

determination, the Departmental Appeals Board shall defer only to the reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

''(iv) A decision of the Departmental Appeals Board constitutes a final agency action and is subject to judicial review.

''(B) DEFINITION OF NATIONAL COVERAGE DETERMINATION.—For purposes of this section, the term 'national coverage determination' means a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under this title, but does not include a determination of what code, if any, is assigned to a particular item or service covered under this title or a determination with respect to the amount of payment made for a particular item or service so covered.

''(2) LOCAL COVERAGE DETERMINATION.—

''(A) IN GENERAL.—Review of any local coverage determination shall be subject to the following limitations:

''(i) Upon the filing of a complaint by an aggrieved party, such a determination

shall be reviewed by an administrative law judge of the Social Security Administration. The administrative law judge shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination, if the administrative law judge determines that the record is incomplete or lacks adequate information to support the validity of the determination. In reviewing such a determination, the administrative law judge shall defer only to the reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

''(ii) Upon the filing of a complaint by an aggrieved party, a decision of an administrative law judge under clause (i) shall be reviewed by the Departmental Appeals Board of the Department of Health and Human Services.

''(iii) A decision of the Departmental Appeals Board constitutes a final agency action and is subject to judicial review.

"(B) DEFINITION OF LOCAL COVERAGE DETERMINATION.—For purposes of this section, the term 'local coverage determination' means a determination by a fiscal intermediary or a carrier under part A or part B, as applicable, respecting whether or not a particular item or service is covered on an intermediary- or carrier-wide basis under such parts, in accordance with section 1862(a)(1)(A).

"(3) NO MATERIAL ISSUES OF FACT IN DISPUTE.—In the case of a determination that may otherwise be subject to review under paragraph (1)(A)(iii) or paragraph (2)(A)(i), where the moving party alleges that—

"(A) there are no material issues of fact in dispute, and

"(B) the only issue of law is the constitutionality of a provision of this title, or that a regulation, determination, or ruling by the Secretary is invalid,

the moving party may seek review by a court of competent jurisdiction without filing a complaint under such paragraph and without otherwise exhausting other administrative remedies.

"(4) PENDING NATIONAL COVERAGE DETERMINATIONS.—

"(A) IN GENERAL.—In the event the Secretary has not issued a national coverage or noncoverage determination with respect to a particular type or class of items or services, an aggrieved person (as described in paragraph (5)) may submit to the Secretary a request to make such a determination with respect to such items or services. By not later than the end of the 90-day period beginning on the date the Secretary receives such a request (notwithstanding the receipt by the Secretary of new evidence (if any) during such 90-day period), the Secretary shall take one of the following actions:

"(i) Issue a national coverage determination, with or without limitations.

"(ii) Issue a national noncoverage determination.

"(iii) Issue a determination that no national coverage or noncoverage determination is appropriate as of the end of such 90-day period with respect to national coverage of such items or services.

"(iv) Issue a notice that states that the Secretary has not completed a review of the request for a national coverage determination and that includes an identification of the remaining steps in the Secretary's review process and a deadline by which the Secretary will complete the review and take an action described in subclause (I), (II), or (III).

"(B) In the case of an action described in clause (i)(IV), if the Secretary fails to take an action referred to in such clause by the deadline specified by the Secretary under such clause, then the Secretary is deemed to have taken an action described in clause (i)(III) as of the deadline.

"(C) When issuing a determination under clause (i), the Secretary shall include an explanation of the basis for the determination. An action taken under clause (i) (other than subclause (IV)) is deemed to be a national coverage determination for purposes of review under subparagraph (A).

"(5) STANDING.—An action under this subsection seeking review of a national coverage deter-

mination or local coverage determination may be initiated only by individuals entitled to benefits under part A, or enrolled under part B, or both, who are in need of the items or services that are the subject of the coverage determination.

''(6) PUBLICATION ON THE INTERNET OF DECISIONS OF HEARINGS OF THE SECRETARY.—Each decision of a hearing by the Secretary with respect to a national coverage determination shall be made public, and the Secretary shall publish each decision on the Medicare Internet site of the Department of Health and Human Services. The Secretary shall remove from such decision any information that would identify any individual, provider of services, or supplier.

''(7) ANNUAL REPORT ON NATIONAL COVERAGE DETERMINATIONS.—

''(A) IN GENERAL.—Not later than December 1 of each year, beginning in 2001, the Secretary shall submit to Congress a report that sets forth a detailed compilation of the actual time periods that were necessary to complete and fully implement national coverage determinations that were made in the previous fiscal year for items, services, or medical devices

not previously covered as a benefit under this title, including, with respect to each new item, service, or medical device, a statement of the time taken by the Secretary to make and implement the necessary coverage, coding, and payment determinations, including the time taken to complete each significant step in the process of making and implementing such determinations.

''(B) PUBLICATION OF REPORTS ON THE INTERNET.—The Secretary shall publish each report submitted under clause (i) on the medicare Internet site of the Department of Health and Human Services.

''(8) CONSTRUCTION.—Nothing in this subsection shall be construed as permitting administrative or judicial review pursuant to this section insofar as such review is explicitly prohibited or restricted under another provision of law.''.

(b) ESTABLISHMENT OF A PROCESS FOR COVERAGE DETERMINATIONS.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended by adding at the end the following new sentence: ''In making a national coverage determination (as defined in paragraph (1)(B) of section 1869(f)) the Secretary shall ensure that the public is afforded no-

tice and opportunity to comment prior to implementation by the Secretary of the determination; meetings of advisory committees established under section 1114(f) with respect to the determination are made on the record; in making the determination, the Secretary has considered applicable information (including clinical experience and medical, technical, and scientific evidence) with respect to the subject matter of the determination; and in the determination, provide a clear statement of the basis for the determination (including responses to comments received from the public), the assumptions underlying that basis, and make available to the public the data (other than proprietary data) considered in making the determination.''.

(c) IMPROVEMENTS TO THE MEDICARE ADVISORY COMMITTEE PROCESS.—Section 1114 (42 U.S.C. 1314) is amended by adding at the end the following new subsection:

''(i)(1) Any advisory committee appointed under subsection (f) to advise the Secretary on matters relating to the interpretation, application, or implementation of section 1862(a)(1) shall assure the full participation of a nonvoting member in the deliberations of the advisory committee, and shall provide such nonvoting member access to all information and data made available to voting

members of the advisory committee, other than information that—

''(A) is exempt from disclosure pursuant to subsection (a) of section 552 of title 5, United States Code, by reason of subsection (b)(4) of such section (relating to trade secrets); or

''(B) the Secretary determines would present a conflict of interest relating to such nonvoting member.

''(2) If an advisory committee described in paragraph (1) organizes into panels of experts according to types of items or services considered by the advisory committee, any such panel of experts may report any recommendation with respect to such items or services directly to the Secretary without the prior approval of the advisory committee or an executive committee thereof.''.

(d) EFFECTIVE DATE.—The amendments made by this section apply with respect to—

(1) a review of any national or local coverage determination filed,

(2) a request to make such a determination made,

(3) a national coverage determination made,

on or after October 1, 2001.

Subtitle D—Improving Access to New Technologies

SEC. 531. REIMBURSEMENT IMPROVEMENTS FOR NEW CLINICAL LABORATORY TESTS AND DURABLE MEDICAL EQUIPMENT.

(a) PAYMENT RULE FOR NEW LABORATORY TESTS.—Section 1833(h)(4)(B)(viii) (42 U.S.C. 1395l(h)(4)(B)(viii)) is amended by inserting before the period at the end the following: ''(or 100 percent of such median in the case of a clinical diagnostic laboratory test performed on or after January 1, 2001, that the Secretary determines is a new test for which no limitation amount has previously been established under this subparagraph)''.

(b) ESTABLISHMENT OF CODING AND PAYMENT PROCEDURES FOR NEW CLINICAL DIAGNOSTIC LABORATORY TESTS AND OTHER ITEMS ON A FEE SCHEDULE.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall establish procedures for coding and payment determinations for the categories of new clinical diagnostic laboratory tests and new durable medical equipment under part B of the title XVIII of the Social Security Act that permit public consultation in a manner consistent with the

procedures established for implementing coding modifications for ICD–9–CM.

(c) REPORT ON PROCEDURES USED FOR ADVANCED, IMPROVED TECHNOLOGIES.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report that identifies the specific procedures used by the Secretary under part B of title XVIII of the Social Security Act to adjust payments for clinical diagnostic laboratory tests and durable medical equipment which are classified to existing codes where, because of an advance in technology with respect to the test or equipment, there has been a significant increase or decrease in the resources used in the test or in the manufacture of the equipment, and there has been a significant improvement in the performance of the test or equipment. The report shall include such recommendations for changes in law as may be necessary to assure fair and appropriate payment levels under such part for such improved tests and equipment as reflects increased costs necessary to produce improved results.

SEC. 532. RETENTION OF HCPCS LEVEL III CODES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall maintain and continue the use of level III codes of the HCPCS coding system (as such sys-

tem was in effect on August 16, 2000) through December 31, 2003, and shall make such codes available to the public.

(b) DEFINITION.—For purposes of this section, the term ''HCPCS Level III codes'' means the alphanumeric codes for local use under the Health Care Financing Administration Common Procedure Coding System (HCPCS).

SEC. 533. RECOGNITION OF NEW MEDICAL TECHNOLOGIES UNDER INPATIENT HOSPITAL PPS.

(a) EXPEDITING RECOGNITION OF NEW TECHNOLOGIES INTO INPATIENT PPS CODING SYSTEM.—

(1) REPORT.—Not later than April 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report on methods of expeditiously incorporating new medical services and technologies into the clinical coding system used with respect to payment for inpatient hospital services furnished under the medicare program under title XVIII of the Social Security Act, together with a detailed description of the Secretary's preferred methods to achieve this purpose.

(2) IMPLEMENTATION.—Not later than October 1, 2001, the Secretary shall implement the preferred

methods described in the report transmitted pursuant to paragraph (1).

(b) ENSURING APPROPRIATE PAYMENTS FOR HOSPITALS INCORPORATING NEW MEDICAL SERVICES AND TECHNOLOGIES.—

(1) ESTABLISHMENT OF MECHANISM.—Section 1886(d)(5) (42 U.S.C. 1395ww(d)(5)) is amended by adding at the end the following new subparagraphs:

''(K)(i) Effective for discharges beginning on or after October 1, 2001, the Secretary shall establish a mechanism to recognize the costs of new medical services and technologies under the payment system established under this subsection. Such mechanism shall be established after notice and opportunity for public comment (in the publications required by subsection (e)(5) for a fiscal year or otherwise).

''(ii) The mechanism established pursuant to clause (i) shall—

''(I) apply to a new medical service or technology if, based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate;

''(II) provide for the collection of data with respect to the costs of a new medical service or technology described in subclause (I) for a period of not less than two years and not more than three years beginning on the date on which an inpatient hospital code is issued with respect to the service or technology;

''(III) subject to paragraph (4)(C)(iii), provide for additional payment to be made under this subsection with respect to discharges involving a new medical service or technology described in subclause (I) that occur during the period described in subclause (II) in an amount that adequately reflects the estimated average cost of such service or technology; and

''(IV) provide that discharges involving such a service or technology that occur after the close of the period described in subclause (II) will be classified within a new or existing diagnosis-related group with a weighting factor under paragraph (4)(B) that is derived from cost data collected with respect to discharges occurring during such period.

''(iii) For purposes of clause (ii)(II), the term 'inpatient hospital code' means any code that is used with respect to inpatient hospital services for which payment may

be made under this subsection and includes an alpha-numeric code issued under the International Classification of Diseases, 9th Revision, Clinical Modification ('ICD–9–CM') and its subsequent revisions.

''(iv) For purposes of clause (ii)(III), the term 'additional payment' means, with respect to a discharge for a new medical service or technology described in clause (ii)(I), an amount that exceeds the prospective payment rate otherwise applicable under this subsection to discharges involving such service or technology that would be made but for this subparagraph.

''(v) The requirement under clause (ii)(III) for an additional payment may be satisfied by means of a new-technology group (described in subparagraph (L)), an add-on payment, a payment adjustment, or any other similar mechanism for increasing the amount otherwise payable with respect to a discharge under this subsection. The Secretary may not establish a separate fee schedule for such additional payment for such services and technologies, by utilizing a methodology established under subsection (a) or (h) of section 1834 to determine the amount of such additional payment, or by other similar mechanisms or methodologies.

''(vi) For purposes of this subparagraph and subparagraph (L), a medical service or technology will be con-

sidered a 'new medical service or technology' if the service or technology meets criteria established by the Secretary after notice and an opportunity for public comment.

''(L)(i) In establishing the mechanism under subparagraph (K), the Secretary may establish new-technology groups into which a new medical service or technology will be classified if, based on the estimated average costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate.

''(ii) Such groups—

''(I) shall not be based on the costs associated with a specific new medical service or technology; but

''(II) shall, in combination with the applicable standardized amounts and the weighting factors assigned to such groups under paragraph (4)(B), reflect such cost cohorts as the Secretary determines are appropriate for all new medical services and technologies that are likely to be provided as inpatient hospital services in a fiscal year.

''(iii) The methodology for classifying specific hospital discharges within a diagnosis-related group under paragraph (4)(A) or a new-technology group shall provide

that a specific hospital discharge may not be classified within both a diagnosis-related group and a new-technology group.''.

(2) PRIOR CONSULTATION.—The Secretary of Health and Human Services shall consult with groups representing hospitals, physicians, and manufacturers of new medical technologies before publishing the notice of proposed rulemaking required by section 1886(d)(5)(K)(i) of the Social Security Act (as added by paragraph (1)).

(3) CONFORMING AMENDMENT.—Section 1886(d)(4)(C)(i) (42 U.S.C. 1395ww(d)(4)(C)(i)) is amended by striking ''technology,'' and inserting ''technology (including a new medical service or technology under paragraph (5)(K)),''.

Subtitle E—Other Provisions

SEC. 541. INCREASE IN REIMBURSEMENT FOR BAD DEBT.

Section 1861(v)(1)(T) (42 U.S.C. 1395x(v)(1)(T)) is amended—

(1) in clause (ii), by striking ''and'' at the end;

(2) in clause (iii)—

(A) by striking ''during a subsequent fiscal year'' and inserting ''during fiscal year 2000''; and

(B) by striking the period at the end and inserting ‘‘, and’’; and

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

‘‘(iv) for cost reporting periods beginning during a subsequent fiscal year, by 30 percent of such amount otherwise allowable.’’.

SEC. 542. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

(a) IN GENERAL.—When an independent laboratory furnishes the technical component of a physician pathology service to a fee-for-service medicare beneficiary who is an inpatient or outpatient of a covered hospital, the Secretary of Health and Human Services shall treat such component as a service for which payment shall be made to the laboratory under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) and not as an inpatient hospital service for which payment is made to the hospital under section 1886(d) of such Act (42 U.S.C. 1395ww(d)) or as an outpatient hospital service for which payment is made to the hospital under section 1833(t) of such Act (42 U.S.C. 1395l(t)).

(b) DEFINITIONS.—For purposes of this section:

(1) COVERED HOSPITAL.—The term ‘‘covered hospital’’ means, with respect to an inpatient or an

outpatient, a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the technical component of physician pathology services to fee-for-service medicare beneficiaries who were hospital inpatients or outpatients, respectively, and submitted claims for payment for such component to a medicare carrier (that has a contract with the Secretary under section 1842 of the Social Security Act, 42 U.S.C. 1395u) and not to such hospital.

(2) FEE-FOR-SERVICE MEDICARE BENEFICIARY.—The term ''fee-for-service medicare beneficiary'' means an individual who—

(A) is entitled to benefits under part A, or enrolled under part B, or both, of such title; and

(B) is not enrolled in any of the following:

(i) A Medicare+Choice plan under part C of such title.

(ii) A plan offered by an eligible organization under section 1876 of such Act (42 U.S.C. 1395mm).

(iii) A program of all-inclusive care for the elderly (PACE) under section 1894 of such Act (42 U.S.C. 1395eee).

(iv) A social health maintenance organization (SHMO) demonstration project established under section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203).

(c) EFFECTIVE DATE.—This section applies to services furnished during the 2-year period beginning on January 1, 2001.

(d) GAO REPORT.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study of the effects of the previous provisions of this section on hospitals and laboratories and access of fee-for-service medicare beneficiaries to the technical component of physician pathology services.

(2) REPORT.—Not later than April 1, 2002, the Comptroller General shall submit to Congress a report on such study. The report shall include recommendations about whether such provisions should be extended after the end of the period specified in subsection (c) for either or both inpatient and outpatient hospital services, and whether the provisions should be extended to other hospitals.

SEC. 543. EXTENSION OF ADVISORY OPINION AUTHORITY.

Section 1128D(b)(6) (42 U.S.C. 1320a–7d(b)(6)) is amended by striking ''and before the date which is 4 years after such date of enactment''.

SEC. 544. CHANGE IN ANNUAL MEDPAC REPORTING.

(a) REVISION OF DEADLINES FOR SUBMISSION OF REPORTS.—

(1) IN GENERAL.—Section 1805(b)(1)(D) (42 U.S.C. 1395b–6(b)(1)(D)) is amended by striking ''June 1 of each year (beginning with 1998),'' and inserting ''June 15 of each year,''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) applies beginning with 2001.

(b) REQUIREMENT FOR ON THE RECORD VOTES ON RECOMMENDATIONS.—Section 1805(b) (42 U.S.C. 1395b–6(b)) is amended by adding at the end the following new paragraph:

''(7) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of the Commission shall vote on the recommendation, and the Commission shall include, by member, the results of that vote in the report containing the recommendation.''.

SEC. 545. DEVELOPMENT OF PATIENT ASSESSMENT INSTRUMENTS.

(a) DEVELOPMENT.—

(1) IN GENERAL.—Not later than January 1, 2005, the Secretary of Health and Human Services shall submit to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate a report on the development of standard instruments for the assessment of the health and functional status of patients, for whom items and services described in subsection (b) are furnished, and include in the report a recommendation on the use of such standard instruments for payment purposes.

(2) DESIGN FOR COMPARISON OF COMMON ELEMENTS.—The Secretary shall design such standard instruments in a manner such that—

(A) elements that are common to the items and services described in subsection (b) may be readily comparable and are statistically compatible;

(B) only elements necessary to meet program objectives are collected; and

(C) the standard instruments supersede any other assessment instrument used before that date.

(3) CONSULTATION.—In developing an assessment instrument under paragraph (1), the Secretary shall consult with the Medicare Payment Advisory Commission, the Agency for Healthcare Research and Quality, and qualified organizations representing providers of services and suppliers under title XVIII.

(b) DESCRIPTION OF SERVICES.—For purposes of subsection (a), items and services described in this subsection are those items and services furnished to individuals entitled to benefits under part A, or enrolled under part B, or both of title XVIII of the Social Security Act for which payment is made under such title, and include the following:

(1) Inpatient and outpatient hospital services.

(2) Inpatient and outpatient rehabilitation services.

(3) Covered skilled nursing facility services.

(4) Home health services.

(5) Physical or occupational therapy or speech-language pathology services.

(6) Items and services furnished to such individuals determined to have end stage renal disease.

(7) Partial hospitalization services and other mental health services.

(8) Any other service for which payment is made under such title as the Secretary determines to be appropriate.

SEC. 546. GAO REPORT ON IMPACT OF THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA) ON HOSPITAL EMERGENCY DEPARTMENTS.

(a) REPORT.—The Comptroller General of the United States shall submit a report to the Committee on Commerce and the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate by May 1, 2001, on the effect of the Emergency Medical Treatment and Active Labor Act on hospitals, emergency physicians, and physicians covering emergency department call throughout the United States.

(b) REPORT REQUIREMENTS.—The report should evaluate—

(1) the extent to which hospitals, emergency physicians, and physicians covering emergency department call provide uncompensated services in relation to the requirements of EMTALA;

(2) the extent to which the regulatory requirements and enforcement of EMTALA have expanded beyond the legislation's original intent;

(3) estimates for the total dollar amount of EMTALA-related care uncompensated costs to emergency physicians, physicians covering emergency department call, hospital emergency departments, and other hospital services;

(4) the extent to which different portions of the United States may be experiencing different levels of uncompensated EMTALA-related care;

(5) the extent to which EMTALA would be classified as an unfunded mandate if it were enacted today;

(6) the extent to which States have programs to provide financial support for such uncompensated care;

(7) possible sources of funds, including medicare hospital bad debt accounts, that are available to hospitals to assist with the cost of such uncompensated care; and

(8) the financial strain that illegal immigration populations, the uninsured, and the underinsured place on hospital emergency departments, other hos-

pital services, emergency physicians, and physicians covering emergency department call.

(c) DEFINITION.—In this section, the terms ''Emergency Medical Treatment and Active Labor Act'' and ''EMTALA'' mean section 1867 of the Social Security Act (42 U.S.C. 1395dd).

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

Subtitle A—Medicare+Choice Payment Reforms

SEC. 601. INCREASE IN MINIMUM PAYMENT AMOUNT.

Section 1853(c)(1)(B)(ii) (42 U.S.C. 1395w–23(c)(1)(B)(ii)) is amended—

(1) by striking ''(ii) For a succeeding year'' and inserting ''(ii)(I) Subject to subclauses (II) and (III), for a succeeding year''; and

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

''(II) For 2001, for any area in a Metropolitan Statistical Area within any of the 50 States and the District of Columbia

with a population of more than 250,000, $525 (and for any other area within any of the 50 States, $475).

''(III) For 2001, for any area in a Metropolitan Statistical Area outside the 50 States and the District of Columbia with a population of more than 250,000, $525 (and for any other area outside the 50 States and the District of Columbia, $475), but not to exceed 120 percent of the amount determined under this subparagraph for such area for 2000.''.

SEC. 602. INCREASE IN MINIMUM PERCENTAGE INCREASE.

Section 1853(c)(1)(C)(ii) (42 U.S.C. 1395w–23(c)(1)(C)(ii)) is amended by inserting ''(or 103 percent in the case of 2001)'' after ''102 percent''.

SEC. 603. 10-YEAR PHASE-IN OF RISK ADJUSTMENT.

Section 1853(a)(3)(C)(ii) (42 U.S.C. 1395w–23(a)(3)(C)(ii)) is amended—

(1) in subclause (I), by striking ''and 2001'' and inserting ''and each succeeding year through the first year in which risk adjustment is based on data from inpatient hospital and ambulatory settings''; and

(2) by amending subclause (II) to read as follows:

"(II) beginning after such first year, insofar as such risk adjustment is based on data from inpatient hospital and ambulatory settings, the methodology shall be phased in equal increments over a 10-year period that begins with such first year.".

SEC. 604. TRANSITION TO REVISED MEDICARE+CHOICE PAYMENT RATES.

(a) ANNOUNCEMENT OF REVISED MEDICARE+CHOICE PAYMENT RATES.—Within 2 weeks after the date of the enactment of this Act, the Secretary of Health and Human Services shall determine, and shall announce (in a manner intended to provide notice to interested parties) Medicare+Choice capitation rates under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for 2001, revised in accordance with the provisions of this Act.

(b) REENTRY INTO PROGRAM PERMITTED FOR MEDICARE+CHOICE PROGRAMS IN 2000.—A Medicare+Choice organization that provided notice to the Secretary of Health and Human Services before the date of the enactment of this Act that it was terminating its

contract under part C of title XVIII of the Social Security Act or was reducing the service area of a Medicare+Choice plan offered under such part shall be permitted to continue participation under such part, or to maintain the service area of such plan, for 2001 if it provides the Secretary with the information described in section 1854(a)(1) of the Social Security Act (42 U.S.C. 1395w–24(a)(1)) within 2 weeks after the date revised rates are announced by the Secretary under subsection (a).

(c) REVISED SUBMISSION OF PROPOSED PREMIUMS AND RELATED INFORMATION.—If—

(1) a Medicare+Choice organization provided notice to the Secretary of Health and Human Services as of July 3, 2000, that it was renewing its contract under part C of title XVIII of the Social Security Act for all or part of the service area or areas served under its current contract, and

(2) any part of the service area or areas addressed in such notice includes a payment area for which the Medicare+Choice capitation rate under section 1853(c) of such Act (42 U.S.C. 1395w–23(c)) for 2001, as determined under subsection (a), is higher than the rate previously determined for such year,

such organization shall revise its submission of the information described in section 1854(a)(1) of the Social Security Act (42 U.S.C. 1395w–24(a)(1)), and shall submit such revised information to the Secretary, within 2 weeks after the date revised rates are announced by the Secretary under subsection (a). In making such submission, the organization may only reduce premiums, cost-sharing, enhance benefits, or utilize the stabilization fund described in section 1854(f)(2) of such Act (42 U.S.C. 1395w–24(f)(2)).

(d) DISREGARD OF NEW RATE ANNOUNCEMENT IN APPLYING PASS-THROUGH FOR NEW NATIONAL COVERAGE DETERMINATIONS.—For purposes of applying section 1852(a)(5) of the Social Security Act (42 U.S.C. 1395w–22(a)(5)), the announcement of revised rates under subsection (a) shall not be treated as an announcement under section 1853(b) of such Act (42 U.S.C. 1395w–23(b)).

SEC. 605. REVISION OF PAYMENT RATES FOR ESRD PATIENTS ENROLLED IN MEDICARE+CHOICE PLANS.

(a) IN GENERAL.—Section 1853(a)(1)(B) (42 U.S.C. 1395w–23(a)(1)(B)) is amended by adding at the end the following: ''In establishing such rates, the Secretary shall provide for appropriate adjustments to increase each rate

to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease capitation demonstrations (established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to payments for months beginning with January 2002.

(c) PUBLICATION.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall publish for public comment a description of the appropriate adjustments described in the last sentence of section 1853(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B)), as added by subsection (a). The Secretary shall publish such adjustments in final form by not later than July 1, 2001, so that the amendment made by subsection (a) is implemented on a timely basis consistent with subsection (b).

SEC. 606. PERMITTING PREMIUM REDUCTIONS AS ADDITIONAL BENEFITS UNDER MEDICARE+CHOICE PLANS.

(a) IN GENERAL.—

(1) AUTHORIZATION OF PART B PREMIUM REDUCTIONS.—Section 1854(f)(1) (42 U.S.C. 1395w–24(f)(1)) is amended—

(A) by redesignating subparagraph (E) as subparagraph (F); and

(B) by inserting after subparagraph (D) the following new subparagraph:

''(E) PREMIUM REDUCTIONS.—

''(i) IN GENERAL.—Subject to clause (ii), as part of providing any additional benefits required under subparagraph (A), a Medicare+Choice organization may elect a reduction in its payments under section 1853(a)(1)(A) with respect to a Medicare+Choice plan and the Secretary shall apply such reduction to reduce the premium under section 1839 of each enrollee in such plan as provided in section 1840(i).

''(ii) AMOUNT OF REDUCTION.—The amount of the reduction under clause (i)

with respect to any enrollee in a Medicare+Choice plan—

"(I) may not exceed 125 percent of the premium described under section 1839(a)(3); and

"(II) shall apply uniformly to each enrollee of the Medicare+Choice plan to which such reduction applies.".

(2) CONFORMING AMENDMENTS.—

(A) ADJUSTMENT OF PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS.—Section 1853(a)(1)(A) (42 U.S.C. 1395w–23(a)(1)(A)) is amended by inserting "reduced by the amount of any reduction elected under section 1854(f)(1)(E) and" after "for that area,".

(B) ADJUSTMENT AND PAYMENT OF PART B PREMIUMS.—

(i) ADJUSTMENT OF PREMIUMS.—Section 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is amended by striking "shall" and all that follows and inserting the following: "shall be the amount determined under paragraph (3), adjusted as required in accordance with subsections

(b), (c), and (f), and to reflect 80 percent of any reduction elected under section 1854(f)(1)(E).''.

(ii) PAYMENT OF PREMIUMS.—Section 1840 (42 U.S.C. 1395s) is amended by adding at the end the following new subsection:

''(i) In the case of an individual enrolled in a Medicare+Choice plan, the Secretary shall provide for necessary adjustments of the monthly beneficiary premium to reflect 80 percent of any reduction elected under section 1854(f)(1)(E). This premium adjustment may be provided directly or as an adjustment to any social security, railroad retirement, and civil service retirement benefits, to the extent which the Secretary determines that such an adjustment is appropriate with the concurrence of the agencies responsible for the administration of such benefits.''.

(C) INFORMATION COMPARING PLAN PREMIUMS UNDER PART C.—Section 1851(d)(4)(B) (42 U.S.C. 1395w–21(d)(4)(B)) is amended—

(i) by striking ''PREMIUMS.—The'' and inserting ''PREMIUMS.—

''(i) IN GENERAL.—The''; and

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

''(ii) REDUCTIONS.—The reduction in part B premiums, if any.''.

(D) TREATMENT OF REDUCTION FOR PURPOSES OF DETERMINING GOVERNMENT CONTRIBUTION UNDER PART B.—Section 1844 (42 U.S.C. 1395w) is amended by adding at the end the following new subsection:

''(c) The Secretary shall determine the Government contribution under subparagraphs (A) and (B) of subsection (a)(1) without regard to any premium reduction resulting from an election under section 1854(f)(1)(E).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to years beginning with 2002.

SEC. 607. FULL IMPLEMENTATION OF RISK ADJUSTMENT FOR CONGESTIVE HEART FAILURE ENROLLEES FOR 2001.

(a) IN GENERAL.—Section 1853(a)(3)(C) (42 U.S.C. 1395w–23(a)(3)(C)) is amended—

(1) in clause (ii), by striking ''Such risk adjustment'' and inserting ''Except as provided in clause (iii), such risk adjustment''; and

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

"(iii) FULL IMPLEMENTATION OF RISK ADJUSTMENT FOR CONGESTIVE HEART FAILURE ENROLLEES FOR 2001.—

"(I) EXEMPTION FROM PHASE-IN.—Subject to subclause (II), the Secretary shall fully implement the risk adjustment methodology described in clause (i) with respect to each individual who has had a qualifying congestive heart failure inpatient diagnosis (as determined by the Secretary under such risk adjustment methodology) during the period beginning on July 1, 1999, and ending on June 30, 2000, and who is enrolled in a coordinated care plan that is the only coordinated care plan offered on January 1, 2001, in the service area of the individual.

"(II) PERIOD OF APPLICATION.—Subclause (I) shall only apply during the 1-year period beginning on January 1, 2001.".

(b) EXCLUSION FROM DETERMINATION OF THE BUDGET NEUTRALITY FACTOR.—Section 1853(c)(5) (42

U.S.C. 1395w–23(c)(5)) is amended by striking ''subsection (i)'' and inserting ''subsections (a)(3)(C)(iii) and (i)''.

SEC. 608. EXPANSION OF APPLICATION OF MEDICARE+CHOICE NEW ENTRY BONUS.

(a) IN GENERAL.—Section 1853(i)(1) (42 U.S.C. 1395w–23(i)(1)) is amended in the matter preceding subparagraph (A) by inserting '', or filed notice with the Secretary as of October 3, 2000, that they will not be offering such a plan as of January 1, 2001'' after ''January 1, 2000''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply as if included in the enactment of BBRA.

SEC. 609. REPORT ON INCLUSION OF CERTAIN COSTS OF THE DEPARTMENT OF VETERANS AFFAIRS AND MILITARY FACILITY SERVICES IN CALCULATING MEDICARE+CHOICE PAYMENT RATES.

The Secretary of Health and Human Services shall report to Congress by not later than January 1, 2003, on a method to phase-in the costs of military facility services furnished by the Department of Veterans Affairs, and the costs of military facility services furnished by the Department of Defense, to medicare-eligible beneficiaries in

the calculation of an area's Medicare+Choice capitation payment. Such report shall include on a county-by-county basis—

(1) the actual or estimated cost of such services to medicare-eligible beneficiaries;

(2) the change in Medicare+Choice capitation payment rates if such costs are included in the calculation of payment rates;

(3) one or more proposals for the implementation of payment adjustments to Medicare+Choice plans in counties where the payment rate has been affected due to the failure to calculate the cost of such services to medicare-eligible beneficiaries; and

(4) a system to ensure that when a Medicare+Choice enrollee receives covered services through a facility of the Department of Veterans Affairs or the Department of Defense there is an appropriate payment recovery to the medicare program under title XVIII of the Social Security Act.

Subtitle B—Other Medicare+Choice Reforms

SEC. 611. PAYMENT OF ADDITIONAL AMOUNTS FOR NEW BENEFITS COVERED DURING A CONTRACT TERM.

(a) IN GENERAL.—Section 1853(c)(7) (42 U.S.C. 1395w–23(c)(7)) is amended to read as follows:

''(7) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If the Secretary makes a determination with respect to coverage under this title or there is a change in benefits required to be provided under this part that the Secretary projects will result in a significant increase in the costs to Medicare+Choice of providing benefits under contracts under this part (for periods after any period described in section 1852(a)(5)), the Secretary shall adjust appropriately the payments to such organizations under this part. Such projection and adjustment shall be based on an analysis by the Chief Actuary of the Health Care Financing Administration of the actuarial costs associated with the new benefits.''.

(b) CONFORMING AMENDMENT.—Section 1852(a)(5) (42 U.S.C. 1395w–22(a)(5)) is amended—

(1) in the heading, by inserting ''AND LEGISLATIVE CHANGES IN BENEFITS'' after ''NATIONAL COVERAGE DETERMINATIONS'';

(2) by inserting ''or legislative change in benefits required to be provided under this part'' after ''national coverage determination'';

(3) in subparagraph (A), by inserting ''or legislative change in benefits'' after ''such determination'';

(4) in subparagraph (B), by inserting ''or legislative change'' after ''if such coverage determination''; and

(5) by adding at the end the following:

''The projection under the previous sentence shall be based on an analysis by the Chief Actuary of the Health Care Financing Administration of the actuarial costs associated with the coverage determination or legislative change in benefits.''.

(c) EFFECTIVE DATE.—The amendments made by this section are effective on the date of the enactment of this Act and apply to national coverage determinations and legislative changes in benefits occurring on or after such date.

SEC. 612. RESTRICTION ON IMPLEMENTATION OF SIGNIFICANT NEW REGULATORY REQUIREMENTS MIDYEAR.

(a) IN GENERAL.—Section 1856(b) (42 U.S.C. 1395w–26(b)) is amended by adding at the end the following new paragraph:

''(4) PROHIBITION OF MIDYEAR IMPLEMENTATION OF SIGNIFICANT NEW REGULATORY REQUIREMENTS.—The Secretary may not implement, other than at the beginning of a calendar year, regulations under this section that impose new, significant regulatory requirements on a Medicare+Choice organization or plan.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on the date of the enactment of this Act.

SEC. 613. TIMELY APPROVAL OF MARKETING MATERIAL THAT FOLLOWS MODEL MARKETING LANGUAGE.

(a) IN GENERAL.—Section 1851(h) (42 U.S.C. 1395w–21(h)) is amended—

(1) in paragraph (1)(A), by inserting ''(or 10 days in the case described in paragraph (5))'' after ''45 days''; and

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

''(5) SPECIAL TREATMENT OF MARKETING MATERIAL FOLLOWING MODEL MARKETING LANGUAGE.—In the case of marketing material of an organization that uses, without modification, proposed model language specified by the Secretary, the period specified in paragraph (1)(A) shall be reduced from 45 days to 10 days.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to marketing material submitted on or after January 1, 2001.

SEC. 614. AVOIDING DUPLICATIVE REGULATION.

(a) IN GENERAL.—Section 1856(b)(3)(B) (42 U.S.C. 1395w–26(b)(3)(B)) is amended—

(1) in clause (i), by inserting ''(including cost-sharing requirements)'' after ''Benefit requirements''; and

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

''(iv) Requirements relating to marketing materials and summaries and schedules of benefits regarding a Medicare+Choice plan.''.

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

SEC. 615. ELECTION OF UNIFORM LOCAL COVERAGE POLICY FOR MEDICARE+CHOICE PLAN COVERING MULTIPLE LOCALITIES.

Section 1852(a)(2) (42 U.S.C. 1395w–22(a)(2)) is amended by adding at the end the following new subparagraph:

''(C) ELECTION OF UNIFORM COVERAGE POLICY.—In the case of a Medicare+Choice organization that offers a Medicare+Choice plan in an area in which more than one local coverage policy is applied with respect to different parts of the area, the organization may elect to have the local coverage policy for the part of the area that is most beneficial to Medicare+Choice enrollees (as identified by the Secretary) apply with respect to all Medicare+Choice enrollees enrolled in the plan.''.

SEC. 616. ELIMINATING HEALTH DISPARITIES IN MEDICARE+CHOICE PROGRAM.

(a) QUALITY ASSURANCE PROGRAM FOCUS ON RACIAL AND ETHNIC MINORITIES.—Subparagraphs (A) and (B) of section 1852(e)(2) (42 U.S.C. 1395w–22(e)(2)) are each amended by adding at the end the following:

''Such program shall include a separate focus (with respect to all the elements described in

this subparagraph) on racial and ethnic minorities.''.

(b) REPORT.—Section 1852(e) (42 U.S.C. 1395w–22(e)) is amended by adding at the end the following new paragraph:

''(5) REPORT TO CONGRESS.—

''(A) IN GENERAL.—Not later than 2 years after the date of the enactment of this paragraph, and biennially thereafter, the Secretary shall submit to Congress a report regarding how quality assurance programs conducted under this subsection focus on racial and ethnic minorities.

''(B) CONTENTS OF REPORT.—Each such report shall include the following:

''(i) A description of the means by which such programs focus on such racial and ethnic minorities.

''(ii) An evaluation of the impact of such programs on eliminating health disparities and on improving health outcomes, continuity and coordination of care, management of chronic conditions, and consumer satisfaction.

''(iii) Recommendations on ways to reduce clinical outcome disparities among racial and ethnic minorities.''.

SEC. 617. MEDICARE+CHOICE PROGRAM COMPATIBILITY WITH EMPLOYER OR UNION GROUP HEALTH PLANS.

(a) IN GENERAL.—Section 1857 (42 U.S.C. 1395w–27) is amended by adding at the end the following new subsection:

''(i) MEDICARE+CHOICE PROGRAM COMPATIBILITY WITH EMPLOYER OR UNION GROUP HEALTH PLANS.—To facilitate the offering of Medicare+Choice plans under contracts between Medicare+Choice organizations and employers, labor organizations, or the trustees of a fund established by 1 or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such Medicare+Choice plans.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies with respect to years beginning with 2001.

SEC. 618. SPECIAL MEDIGAP ENROLLMENT ANTIDISCRIMINATION PROVISION FOR CERTAIN BENEFICIARIES.

(a) DISENROLLMENT WINDOW IN ACCORDANCE WITH BENEFICIARY'S CIRCUMSTANCE.—Section 1882(s)(3) (42 U.S.C. 1395ss(s)(3)) is amended—

(1) in subparagraph (A), in the matter following clause (iii), by striking '', subject to subparagraph (E), seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such subparagraph'' and inserting ''seeks to enroll under the policy during the period specified in subparagraph (E)''; and

(2) by striking subparagraph (E) and inserting the following new subparagraph:

''(E) For purposes of subparagraph (A), the time period specified in this subparagraph is—

''(i) in the case of an individual described in subparagraph (B)(i), the period beginning on the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if no such notice is received, notice that a claim has been denied because of such a termination or cessation) and ending on the date that is 63 days after the applicable notice;

''(ii) in the case of an individual described in clause (ii), (iii), (v), or (vi) of subparagraph (B) whose enrollment is terminated involuntarily, the period beginning on the date that the individual receives a notice of termination and ending on the date that is 63 days after the date the applicable coverage is terminated;

''(iii) in the case of an individual described in subparagraph (B)(iv)(I), the period beginning on the earlier of (I) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice, if any, and (II) the date that the applicable coverage is terminated, and ending on the date that is 63 days after the date the coverage is terminated;

''(iv) in the case of an individual described in clause (ii), (iii), (iv)(II), (iv)(III), (v), or (vi) of subparagraph (B) who disenrolls voluntarily, the period beginning on the date that is 60 days before the effective date of the disenrollment and ending on the date that is 63 days after such effective date; and

''(v) in the case of an individual described in subparagraph (B) but not described in the preceding provisions of this subparagraph, the period beginning on the effective date of the disenrollment and

ending on the date that is 63 days after such effective date.''.

(b) EXTENDED MEDIGAP ACCESS FOR INTERRUPTED TRIAL PERIODS.—Section 1882(s)(3) (42 U.S.C. 1395ss(s)(3)), as amended by subsection (a), is further amended by adding at the end the following new subparagraph:

''(F)(i) Subject to clause (ii), for purposes of this paragraph—

''(I) in the case of an individual described in subparagraph (B)(v) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with an organization or provider described in subclause (II) of such subparagraph is involuntarily terminated within the first 12 months of such enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, such subsequent enrollment shall be deemed to be an initial enrollment described in such subparagraph; and

''(II) in the case of an individual described in clause (vi) of subparagraph (B) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with a plan or in a program described in such clause is involuntarily terminated within the

first 12 months of such enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, such subsequent enrollment shall be deemed to be an initial enrollment described in such clause.

''(ii) For purposes of clauses (v) and (vi) of subparagraph (B), no enrollment of an individual with an organization or provider described in clause (v)(II), or with a plan or in a program described in clause (vi), may be deemed to be an initial enrollment under this clause after the 2-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program.''.

SEC. 619. RESTORING EFFECTIVE DATE OF ELECTIONS AND CHANGES OF ELECTIONS OF MEDICARE+CHOICE PLANS.

(a) OPEN ENROLLMENT.—Section 1851(f)(2) (42 U.S.C. 1395w–21(f)(2)) is amended by striking '', except that if such election or change is made after the 10th day of any calendar month, then the election or change shall not take effect until the first day of the second calendar month following the date on which the election or change is made''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to elections and changes of coverage made on or after January 1, 2001.

SEC. 620. PERMITTING ESRD BENEFICIARIES TO ENROLL IN ANOTHER MEDICARE+CHOICE PLAN IF THE PLAN IN WHICH THEY ARE ENROLLED IS TERMINATED.

(a) IN GENERAL.—Section 1851(a)(3)(B) (42 U.S.C. 1395w–21(a)(3)(B)) is amended by striking ''except that'' and all that follows and inserting the following: ''except that—

''(i) an individual who develops end-stage renal disease while enrolled in a Medicare+Choice plan may continue to be enrolled in that plan; and

''(ii) in the case of such an individual who is enrolled in a Medicare+Choice plan under clause (i) (or subsequently under this clause), if the enrollment is discontinued under circumstances described in section 1851(e)(4)(A), then the individual will be treated as a 'Medicare+Choice eligible individual' for purposes of electing to continue enrollment in another Medicare+Choice plan.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall apply to terminations and discontinuations occurring on or after the date of the enactment of this Act.

(2) APPLICATION TO PRIOR PLAN TERMINATIONS.—Clause (ii) of section 1851(a)(3)(B) of the Social Security Act (as inserted by subsection (a)) also shall apply to individuals whose enrollment in a Medicare+Choice plan was terminated or discontinued after December 31, 1998, and before the date of the enactment of this Act. In applying this paragraph, such an individual shall be treated, for purposes of part C of title XVIII of the Social Security Act, as having discontinued enrollment in such a plan as of the date of the enactment of this Act.

SEC. 621. PROVIDING CHOICE FOR SKILLED NURSING FACILITY SERVICES UNDER THE MEDICARE+CHOICE PROGRAM.

(a) IN GENERAL.—Section 1852 (42 U.S.C. 1395w–22) is amended by adding at the end the following new subsection:

''(l) RETURN TO HOME SKILLED NURSING FACILITIES FOR COVERED POST-HOSPITAL EXTENDED CARE SERVICES.—

''(1) ENSURING RETURN TO HOME SNF.—

''(A) IN GENERAL.—In providing coverage of post-hospital extended care services, a Medicare+Choice plan shall provide for such coverage through a home skilled nursing facility if the following conditions are met:

''(i) ENROLLEE ELECTION.—The enrollee elects to receive such coverage through such facility.

''(ii) SNF AGREEMENT.—The facility has a contract with the Medicare+Choice organization for the provision of such services, or the facility agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated skilled nursing facilities that are under contract with the Medicare+Choice organization for the provision of such services and through which the enrollee would otherwise receive such services.

''(B) MANNER OF PAYMENT TO HOME SNF.—The organization shall provide payment to the home skilled nursing facility consistent

with the contract or the agreement described in subparagraph (A)(ii), as the case may be.

''(2) NO LESS FAVORABLE COVERAGE.—The coverage provided under paragraph (1) (including scope of services, cost-sharing, and other criteria of coverage) shall be no less favorable to the enrollee than the coverage that would be provided to the enrollee with respect to a skilled nursing facility the post-hospital extended care services of which are otherwise covered under the Medicare+Choice plan.

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to do the following:

''(A) To require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under part A for medicare beneficiaries not enrolled in a Medicare+Choice plan.

''(B) To prevent a skilled nursing facility from refusing to accept, or imposing conditions upon the acceptance of, an enrollee for the receipt of post-hospital extended care services.

''(4) DEFINITIONS.—In this subsection:

''(A) HOME SKILLED NURSING FACILITY.—The term 'home skilled nursing facility'

means, with respect to an enrollee who is entitled to receive post-hospital extended care services under a Medicare+Choice plan, any of the following skilled nursing facilities:

"(i) SNF RESIDENCE AT TIME OF ADMISSION.—The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of such post-hospital extended care services.

"(ii) SNF IN CONTINUING CARE RETIREMENT COMMUNITY.—A skilled nursing facility that is providing such services through a continuing care retirement community (as defined in subparagraph (B)) which provided residence to the enrollee at the time of such admission.

"(iii) SNF RESIDENCE OF SPOUSE AT TIME OF DISCHARGE.—The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from such hospital.

"(B) CONTINUING CARE RETIREMENT COMMUNITY.—The term 'continuing care retirement community' means, with respect to an en-

rollee in a Medicare+Choice plan, an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies with respect to contracts entered into or renewed on or after the date of the enactment of this Act.

(c) MEDPAC STUDY.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study analyzing the effects of the amendment made by subsection (a) on Medicare+Choice organizations. In conducting such study, the Commission shall examine the effects (if any) such amendment has had on—

(A) the scope of additional benefits provided under the Medicare+Choice program;

(B) the administrative and other costs incurred by Medicare+Choice organizations;

(C) the contractual relationships between such organizations and skilled nursing facilities.

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Commission

shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 622. PROVIDING FOR ACCOUNTABILITY OF MEDICARE+CHOICE PLANS.

(a) MANDATORY REVIEW OF ACR SUBMISSIONS BY THE CHIEF ACTUARY OF THE HEALTH CARE FINANCING ADMINISTRATION.—Section 1854(a)(5)(A) (42 U.S.C. 1395w–24(a)(5)(A)) is amended—

(1) by striking ''value'' and inserting ''values''; and

(2) by adding at the end the following: ''The Chief Actuary of the Health Care Financing Administration shall review the actuarial assumptions and data used by the Medicare+Choice organization with respect to such rates, amounts, and values so submitted to determine the appropriateness of such assumptions and data.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to submissions made on or after January 1, 2001.

Subtitle C—Other Managed Care Reforms

SEC. 631. 1-YEAR EXTENSION OF SOCIAL HEALTH MAINTENANCE ORGANIZATION (SHMO) DEMONSTRATION PROJECT.

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 ''18 months'' and inserting ''30 months''.

SEC. 632. REVISED TERMS AND CONDITIONS FOR EXTENSION OF MEDICARE COMMUNITY NURSING ORGANIZATION (CNO) DEMONSTRATION PROJECT.

(a) IN GENERAL.—Section 532 of BBRA (113 Stat. 1501A–388) is amended—

(1) in subsection (a), by striking the second sentence; and

(2) by striking subsection (b) and inserting the following new subsection:

''(b) TERMS AND CONDITIONS.—

''(1) JANUARY THROUGH SEPTEMBER 2000.—For the 9-month period beginning with January 2000, any such demonstration project shall be conducted under the same terms and conditions as applied to such demonstration during 1999.

''(2) OCTOBER 2000 THROUGH DECEMBER 2001.—For the 15-month period beginning with October 2000, any such demonstration project shall be conducted under the same terms and conditions as applied to such demonstration during 1999, except that the following modifications shall apply:

''(A) BASIC CAPITATION RATE.—The basic capitation rate paid for services covered under the project (other than case management services) per enrollee per month and furnished during—

''(i) the period beginning with October 1, 2000, and ending with December 31, 2000, shall be determined by actuarially adjusting the actual capitation rate paid for such services in 1999 for inflation, utilization, and other changes to the CNO service package, and by reducing such adjusted capitation rate by 10 percent in the case of the demonstration sites located in Arizona, Minnesota, and Illinois, and 15 percent for the demonstration site located in New York; and

''(ii) 2001 shall be determined by actuarially adjusting the capitation rate de-

termined under clause (i) for inflation, utilization, and other changes to the CNO service package.

''(B) TARGETED CASE MANAGEMENT FEE.—Effective October 1, 2000—

''(i) the case management fee per enrollee per month for—

''(I) the period described in subparagraph (A)(i) shall be determined by actuarially adjusting the case management fee for 1999 for inflation; and

''(II) 2001 shall be determined by actuarially adjusting the amount determined under subclause (I) for inflation; and

''(ii) such case management fee shall be paid only for enrollees who are classified as moderately frail or frail pursuant to criteria established by the Secretary.

''(C) GREATER UNIFORMITY IN CLINICAL FEATURES AMONG SITES.—Each project shall implement for each site—

''(i) protocols for periodic telephonic contact with enrollees based on—

''(I) the results of such standardized written health assessment; and

''(II) the application of appropriate care planning approaches;

''(ii) disease management programs for targeted diseases (such as congestive heart failure, arthritis, diabetes, and hypertension) that are highly prevalent in the enrolled populations;

''(iii) systems and protocols to track enrollees through hospitalizations, including pre-admission planning, concurrent management during inpatient hospital stays, and post-discharge assessment, planning, and follow-up; and

''(iv) standardized patient educational materials for specified diseases and health conditions.

''(D) QUALITY IMPROVEMENT.—Each project shall implement at each site once during the 15-month period—

''(i) enrollee satisfaction surveys; and

''(ii) reporting on specified quality indicators for the enrolled population.

''(e) EVALUATION.—

''(1) PRELIMINARY REPORT.—Not later than July 1, 2001, the Secretary of Health and Human Services shall submit to the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate a preliminary report that—

''(A) evaluates such demonstration projects for the period beginning July 1, 1997, and ending December 31, 1999, on a site-specific basis with respect to the impact on per beneficiary spending, specific health utilization measures, and enrollee satisfaction; and

''(B) includes a similar evaluation of such projects for the portion of the extension period that occurs after September 30, 2000.

''(2) FINAL REPORT.—The Secretary shall submit a final report to such Committees on such demonstration projects not later than July 1, 2002. Such report shall include the same elements as the preliminary report required by paragraph (1), but for the period after December 31, 1999.

''(3) METHODOLOGY FOR SPENDING COMPARISONS.—Any evaluation of the impact of the demonstration projects on per beneficiary spending in-

cluded in such reports shall include a comparison of—

"(A) data for all individuals who—

"(i) were enrolled in such demonstration projects as of the first day of the period under evaluation; and

"(ii) were enrolled for a minimum of 6 months thereafter; with

"(B) data for a matched sample of individuals who are enrolled under part B of title XVIII of the Social Security Act and are not enrolled in such a project, or in a Medicare+Choice plan under part C of such title, a plan offered by an eligible organization under section 1876 of such Act, or a health care prepayment plan under section 1833(a)(1)(A) of such Act.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall be effective as if included in the enactment of section 532 of BBRA (113 Stat. 1501A–388).

SEC. 633. EXTENSION OF MEDICARE MUNICIPAL HEALTH SERVICES DEMONSTRATION PROJECTS.

Section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as amended by section 6135 of the Omnibus Budget Rec-

onciliation Act of 1989, section 13557 of the Omnibus Budget Reconciliation Act of 1993, section 4017 of BBA, and section 534 of BBRA (113 Stat. 1501A–390), is amended by striking ''December 31, 2002'' and inserting ''December 31, 2004''.

SEC. 634. SERVICE AREA EXPANSION FOR MEDICARE COST CONTRACTS DURING TRANSITION PERIOD.

Section 1876(h)(5) (42 U.S.C. 1395mm(h)(5)) is amended—

(1) by redesignating subparagraph (B) as subparagraph (C); and

(2) by inserting after subparagraph (A), the following new subparagraph:

''(B) Subject to subparagraph (C), the Secretary shall approve an application for a modification to a reasonable cost contract under this section in order to expand the service area of such contract if—

''(i) such application is submitted to the Secretary on or before September 1, 2003; and

''(ii) the Secretary determines that the organization with the contract continues to meet the requirements applicable to such organizations and contracts 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-

sumers (all items; U.S. city average) for fiscal year 2000; and

''(ii) fiscal year 2002, shall be the DSH allotment determined under clause (i) increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) for fiscal year 2001.

''(B) LIMITATION.—Subparagraph (B) of paragraph (3) shall apply to subparagraph (A) of this paragraph in the same manner as that subparagraph (B) applies to paragraph (3)(A).

''(C) NO APPLICATION TO ALLOTMENTS AFTER FISCAL YEAR 2002.—The DSH allotment for any State for fiscal year 2003 or any succeeding fiscal year shall be determined under paragraph (3) without regard to the DSH allotments determined under subparagraph (A) of this paragraph.''.

(2) SPECIAL RULE FOR MEDICAID DSH ALLOTMENT FOR EXTREMELY LOW DSH STATES.—

(A) IN GENERAL.—Section 1923(f) (42 U.S.C. 1396r–4(f)), as amended by paragraph

(1), is amended by inserting after paragraph (4) the following new paragraph:

''(5) SPECIAL RULE FOR EXTREMELY LOW DSH STATES.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 1999, as reported to the Administrator of the Health Care Financing Administration as of August 31, 2000, is greater than 0 but less than 1 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2001 shall be increased to 1 percent of the State's total amount of expenditures under such plan for such assistance during such fiscal year. In subsequent fiscal years, such increased allotment is subject to an increase for inflation as provided in paragraph (3)(A).''.

(B) CONFORMING AMENDMENT.—Section 1923(f)(3)(A) (42 U.S.C. 1396r–4(f)(3)(A)) is amended by inserting ''and paragraph (5)'' after ''subparagraph (B)''.

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) take effect on the date the final regulation required under section 705(a)

(relating to the application of an aggregate upper payment limit test for State medicaid spending for inpatient hospital services, outpatient hospital services, nursing facility services, intermediate care facility services for the mentally retarded, and clinic services provided by government facilities that are not State-owned or operated facilities) is published in the Federal Register.

(b) ASSURING IDENTIFICATION OF MEDICAID MANAGED CARE PATIENTS.—

(1) IN GENERAL.—Section 1932 (42 U.S.C. 1396u–2) is amended by adding at the end the following new subsection:

''(g) IDENTIFICATION OF PATIENTS FOR PURPOSES OF MAKING DSH PAYMENTS.—Each contract with a managed care entity under section 1903(m) or under section 1905(t)(3) shall require the entity either—

''(1) to report to the State information necessary to determine the hospital services provided under the contract (and the identity of hospitals providing such services) for purposes of applying sections 1886(d)(5)(F) and 1923; or

''(2) to include a sponsorship code in the identification card issued to individuals covered under this

title in order that a hospital may identify a patient as being entitled to benefits under this title.''.

(2) CLARIFICATION OF COUNTING MANAGED CARE MEDICAID PATIENTS.—Section 1923 (42 U.S.C. 1396r–4) is amended—

(A) in subsection (a)(2)(D), by inserting after ''the proportion of low-income and medicaid patients'' the following: ''(including such patients who receive benefits through a managed care entity)'';

(B) in subsection (b)(2), by inserting after ''a State plan approved under this title in a period'' the following: ''(regardless of whether such patients receive medical assistance on a fee-for-service basis or through a managed care entity)''; and

(C) in subsection (b)(3)(A)(i), by inserting after ''under a State plan under this title'' the following: ''(regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity)''.

(3) EFFECTIVE DATES.—

(A) The amendment made by paragraph (1) applies to contracts as of January 1, 2001.

(B) The amendments made by paragraph (2) apply to payments made on or after January 1, 2001.

(c) APPLICATION OF MEDICAID DSH TRANSITION RULE TO PUBLIC HOSPITALS IN ALL STATES.—

(1) IN GENERAL.—During the period described in paragraph (3), with respect to a State, section 4721(e) of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 514), as amended by section 607 of BBRA (113 Stat. 1501A–321) shall be applied as though—

(A) ''September 30, 2002'' were substituted for ''July 1, 1997'' each place it appears;

(B) ''hospitals owned or operated by a State (as defined for purposes of title XIX of such Act), or by an instrumentality or a unit of government within a State (as so defined)'' were substituted for ''the State of California'';

(C) paragraph (3) were redesignated as paragraph (4);

(D) ''and'' were omitted from the end of paragraph (2); and

(E) the following new paragraph were inserted after paragraph (2):

''(3) '(as defined in subparagraph (B) but without regard to clause (ii) of that subparagraph and subject to subsection (d))' were substituted for '(as defined in subparagraph (B))' in subparagraph (A) of such section; and''.

(2) SPECIAL RULE.—With respect to California, section 4721(e) of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 514) shall be applied without regard to paragraph (1).

(3) PERIOD DESCRIBED.—The period described in this paragraph is the period that begins, with respect to a State, on the first day of the first State fiscal year that begins after September 30, 2002, and ends on the last day of the succeeding State fiscal year.

(4) APPLICATION TO WAIVERS.—With respect to a State operating under a waiver of the requirements of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) under section 1115 of such Act (42 U.S.C. 1315), the amount by which any payment adjustment made by the State under title XIX of such Act (42 U.S.C. 1396 et seq.), after the application of section 4721(e) of the Balanced Budget Act of 1997 under paragraph (1) to such State, exceeds the costs of furnishing hospital services pro-

vided by hospitals described in such section shall be fully reflected as an increase in the baseline expenditure limit for such waiver.

(d) ASSISTANCE FOR CERTAIN PUBLIC HOSPITALS.—

(1) IN GENERAL.—Beginning with fiscal year 2002, notwithstanding section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) and subject to paragraph (3), with respect to a State, payment adjustments made under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to a hospital described in paragraph (2) shall be made without regard to the DSH allotment limitation for the State determined under section 1923(f) of that Act (42 U.S.C. 1396r–4(f)).

(2) HOSPITAL DESCRIBED.—A hospital is described in this paragraph if the hospital—

(A) is owned or operated by a State (as defined for purposes of title XIX of the Social Security Act), or by an instrumentality or a unit of government within a State (as so defined);

(B) as of October 1, 2000—

(i) is in existence and operating as a hospital described in subparagraph (A); and

(ii) is not receiving disproportionate share hospital payments from the State in which it is located under title XIX of such Act; and

(C) has a low-income utilization rate (as defined in section 1923(b)(3) of the Social Security Act (42 U.S.C. 1396r–4(b)(3))) in excess of 65 percent.

(3) LIMITATION ON EXPENDITURES.—

(A) IN GENERAL.—With respect to any fiscal year, the aggregate amount of Federal financial participation that may be provided for payment adjustments described in paragraph (1) for that fiscal year for all States may not exceed the amount described in subparagraph (B) for the fiscal year.

(B) AMOUNT DESCRIBED.—The amount described in this subparagraph for a fiscal year is as follows:

(i) For fiscal year 2002, $15,000,000.

(ii) For fiscal year 2003, $176,000,000.

(iii) For fiscal year 2004, $269,000,000.

(iv) For fiscal year 2005, $330,000,000.

(v) For fiscal year 2006 and each fiscal year thereafter, $375,000,000.

(e) DSH PAYMENT ACCOUNTABILITY STANDARDS.—Not later than September 30, 2002, the Secretary of Health and Human Services shall implement accountability standards to ensure that Federal funds provided with respect to disproportionate share hospital adjustments made under section 1923 of the Social Security Act (42 U.S.C. 1396r–4) are used to reimburse States and hospitals eligible for such payment adjustments for providing uncompensated health care to low-income patients and are otherwise made in accordance with the requirements of section 1923 of that Act.

SEC. 702. NEW PROSPECTIVE PAYMENT SYSTEM FOR FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.

(a) IN GENERAL.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (13)—

(A) in subparagraph (A), by adding ''and'' at the end;

(B) in subparagraph (B), by striking ''and'' at the end; and

(C) by striking subparagraph (C); and

(2) by inserting after paragraph (14) the following new paragraph:

''(15) provide for payment for services described in clause (B) or (C) of section 1905(a)(2) under the plan in accordance with subsection (aa);''.

(b) NEW PROSPECTIVE PAYMENT SYSTEM.—Section 1902 (42 U.S.C. 1396a) is amended by adding at the end the following:

''(aa) PAYMENT FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.—

''(1) IN GENERAL.—Beginning with fiscal year 2001 and each succeeding fiscal year, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by a Federally-qualified health center and services described in section 1905(a)(2)(B) furnished by a rural health clinic in accordance with the provisions of this subsection.

''(2) FISCAL YEAR 2001.—Subject to paragraph (4), for services furnished during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such

services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under section 1833(a)(3), adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001.

''(3) FISCAL YEAR 2002 AND SUCCEEDING FISCAL YEARS.—Subject to paragraph (4), for services furnished during fiscal year 2002 or a succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this subsection for the preceding fiscal year—

''(A) increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) for that fiscal year; and

''(B) adjusted to take into account any increase or decrease in the scope of such services

furnished by the center or clinic during that fiscal year.

''(4) ESTABLISHMENT OF INITIAL YEAR PAYMENT AMOUNT FOR NEW CENTERS OR CLINICS.—In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after fiscal year 2000, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by the center or services described in section 1905(a)(2)(B) furnished by the clinic in the first fiscal year in which the center or clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year based on the rates established under this subsection for the fiscal year for other such centers or clinics located in the same or adjacent area with a similar case load or, in the absence of such a center or clinic, in accordance with the regulations and methodology referred to in paragraph (2) or based on such other tests of reasonableness as the Secretary may specify. For each fiscal year following the fiscal year in which the entity first qualifies as a Federally-qualified health center or rural health clinic, the

State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

''(5) ADMINISTRATION IN THE CASE OF MANAGED CARE.—

''(A) IN GENERAL.—In the case of services furnished by a Federally-qualified health center or rural health clinic pursuant to a contract between the center or clinic and a managed care entity (as defined in section 1932(a)(1)(B)), the State plan shall provide for payment to the center or clinic by the State of a supplemental payment equal to the amount (if any) by which the amount determined under paragraphs (2), (3), and (4) of this subsection exceeds the amount of the payments provided under the contract.

''(B) PAYMENT SCHEDULE.—The supplemental payment required under subparagraph (A) shall be made pursuant to a payment schedule agreed to by the State and the Federally-qualified health center or rural health clinic, but in no case less frequently than every 4 months.

''(6) ALTERNATIVE PAYMENT METHODOLOGIES.—Notwithstanding any other provision of this section, the State plan may provide for payment in

any fiscal year to a Federally-qualified health center for services described in section 1905(a)(2)(C) or to a rural health clinic for services described in section 1905(a)(2)(B) in an amount which is determined under an alternative payment methodology that—

''(A) is agreed to by the State and the center or clinic; and

''(B) results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under this section.''.

(c) CONFORMING AMENDMENTS.—

(1) Section 4712 of the BBA (Public Law 105–33; 111 Stat. 508) is amended by striking subsection (c).

(2) Section 1915(b) (42 U.S.C. 1396n(b)) is amended by striking ''1902(a)(13)(C)'' and inserting ''1902(a)(15), 1902(aa),''.

(d) GAO STUDY OF FUTURE REBASING.—The Comptroller General of the United States shall provide for a study on the need for, and how to, rebase or refine costs for making payment under the medicaid program for services provided by Federally-qualified health centers and rural health clinics (as provided under the amendments made by this section). The Comptroller General shall pro-

vide for submittal of a report on such study to Congress by not later than 4 years after the date of the enactment of this Act.

(e) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2000, and apply to services furnished on or after such date.

SEC. 703. STREAMLINED APPROVAL OF CONTINUED STATEWIDE SECTION 1115 MEDICAID WAIVERS.

(a) IN GENERAL.—Section 1115 (42 U.S.C. 1315) is amended by adding at the end the following new subsection:

''(f) An application by the chief executive officer of a State for an extension of a waiver project the State is operating under an extension under subsection (e) (in this subsection referred to as the 'waiver project') shall be submitted and approved or disapproved in accordance with the following:

''(1) The application for an extension of the waiver project shall be submitted to the Secretary at least 120 days prior to the expiration of the current period of the waiver project.

''(2) Not later than 45 days after the date such application is received by the Secretary, the Secretary shall notify the State if the Secretary intends to review the terms and conditions of the waiver

project. A failure to provide such notification shall be deemed to be an approval of the application.

''(3) Not later than 45 days after the date a notification is made in accordance with paragraph (2), the Secretary shall inform the State of proposed changes in the terms and conditions of the waiver project. A failure to provide such information shall be deemed to be an approval of the application.

''(4) During the 30-day period that begins on the date information described in paragraph (3) is provided to a State, the Secretary shall negotiate revised terms and conditions of the waiver project with the State.

''(5)(A) Not later than 120 days after the date an application for an extension of the waiver project is submitted to the Secretary (or such later date agreed to by the chief executive officer of the State), the Secretary shall—

''(i) approve the application subject to such modifications in the terms and conditions—

''(I) as have been agreed to by the Secretary and the State; or

''(II) in the absence of such agreement, as are determined by the Secretary to be reasonable, consistent with the over-

all objectives of the waiver project, and not in violation of applicable law; or

''(ii) disapprove the application.

''(B) A failure by the Secretary to approve or disapprove an application submitted under this subsection in accordance with the requirements of subparagraph (A) shall be deemed to be an approval of the application subject to such modifications in the terms and conditions as have been agreed to (if any) by the Secretary and the State.

''(6) An approval of an application for an extension of a waiver project under this subsection shall be for a period not to exceed 3 years.

''(7) An extension of a waiver project under this subsection shall be subject to the final reporting and evaluation requirements of paragraphs (4) and (5) of subsection (e) (taking into account the extension under this subsection with respect to any timing requirements imposed under those paragraphs).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to requests for extensions of demonstration projects pending or submitted on or after the date of the enactment of this Act.

SEC. 704. MEDICAID COUNTY-ORGANIZED HEALTH SYSTEMS.

(a) IN GENERAL.—Section 9517(c)(3)(C) of the Comprehensive Omnibus Budget Reconciliation Act of 1985 is amended by striking ''10 percent'' and inserting ''14 percent''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on the date of the enactment of this Act.

SEC. 705. DEADLINE FOR ISSUANCE OF FINAL REGULATION RELATING TO MEDICAID UPPER PAYMENT LIMITS.

(a) IN GENERAL.—Not later than December 31, 2000, the Secretary of Health and Human Services (in this section referred to as the ''Secretary''), notwithstanding any requirement of the Administrative Procedures Act under chapter 5 of title 5, United States Code, or any other provision of law, shall issue under sections 447.272, 447.304, and 447.321 of title 42, Code of Federal Regulations (and any other section of part 447 of title 42, Code of Federal Regulations that the Secretary determines is appropriate), a final regulation based on the proposed rule announced on October 5, 2000, that—

(1) modifies the upper payment limit test applied to State medicaid spending for inpatient hospital services, outpatient hospital services, nursing

facility services, intermediate care facility services for the mentally retarded, and clinic services by applying an aggregate upper payment limit to payments made to government facilities that are not State-owned or operated facilities; and

(2) provides for a transition period in accordance with subsection (b).

(b) TRANSITION PERIOD.—

(1) IN GENERAL.—The final regulation required under subsection (a) shall provide that, with respect to a State described in paragraph (3), the State shall be considered to be in compliance with the final regulation required under subsection (a) so long as, for each State fiscal year during the period described in paragraph (4), the State reduces payments under a State medicaid plan payment provision or methodology described in paragraph (3), or reduces the actual dollar payment levels described in paragraph (3)(B), so that the amount of the payments that would otherwise have been made under such provision, methodology, or payment levels by the State for any State fiscal year during such period is reduced by 15 percent in the first such State fiscal year, and by an additional 15 percent in each of next 5 State fiscal years.

(2) REQUIREMENT.—Notwithstanding paragraph (1), the final regulation required under subsection (a) shall provide that, for any period (or portion of a period) that occurs on or after October 1, 2008, medicaid payments made by a State described in paragraph (3) shall comply with such final regulation.

(3) STATE DESCRIBED.—A State described in this paragraph is a State with a State medicaid plan payment provision or methodology which—

(A) was approved, deemed to have been approved, or was in effect on or before October 1, 1992 (including any subsequent amendments or successor provisions or methodologies and whether or not a State plan amendment was made to carry out such provision or methodology after such date) or under which claims for Federal financial participation were filed and paid on or before such date; and

(B) provides for payments that are in excess of the upper payment limit test established under the final regulation required under subsection (a) (or which would be noncompliant with such final regulation if the actual dollar payment levels made under the payment provi-

sion or methodology in the State fiscal year which begins during 1999 were continued).

(4) PERIOD DESCRIBED.—The period described in this paragraph is the period that begins on the first State fiscal year that begins after September 30, 2002, and ends on September 30, 2008.

SEC. 706. ALASKA FMAP.

Notwithstanding the first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), only with respect to each of fiscal years 2001 through 2005, for purposes of titles XIX and XXI of the Social Security Act, the State percentage used to determine the Federal medical assistance percentage for Alaska shall be that percentage which bears the same ratio to 45 percent as the square of the adjusted per capita income of Alaska (determined by dividing the State's 3-year average per capita income by 1.05) bears to the square of the per capita income of the 50 States.

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.

(a) CHANGE IN RULES FOR REDISTRIBUTION AND RETENTION OF UNUSED SCHIP ALLOTMENTS FOR FIS-

CAL YEARS 1998 AND 1999.—Section 2104 (42 U.S.C. 1397dd) is amended by adding at the end the following new subsection:

"(g) RULE FOR REDISTRIBUTION AND EXTENDED AVAILABILITY OF FISCAL YEARS 1998 AND 1999 ALLOTMENTS.—

"(1) AMOUNT REDISTRIBUTED.—

"(A) IN GENERAL.—In the case of a State that expends all of its allotment under subsection (b) or (c) for fiscal year 1998 by the end of fiscal year 2000, or for fiscal year 1999 by the end of fiscal year 2001, the Secretary shall redistribute to the State under subsection (f) (from the fiscal year 1998 or 1999 allotments of other States, respectively, as determined by the application of paragraphs (2) and (3) with respect to the respective fiscal year)) the following amount:

"(i) STATE.—In the case of 1 of the 50 States or the District of Columbia, with respect to—

"(I) the fiscal year 1998 allotment, the amount by which the State's expenditures under this title in fiscal years 1998, 1999, and 2000 ex-

ceed the State's allotment for fiscal year 1998 under subsection (b); or

"(II) the fiscal year 1999 allotment, the amount by which the State's expenditures under this title in fiscal years 1999, 2000, and 2001 exceed the State's allotment for fiscal year 1999 under subsection (b).

"(ii) TERRITORY.—In the case of a commonwealth or territory described in subsection (c)(3), an amount that bears the same ratio to 1.05 percent of the total amount described in paragraph (2)(B)(i)(I) as the ratio of the commonwealth's or territory's fiscal year 1998 or 1999 allotment under subsection (c) (as the case may be) bears to the total of all such allotments for such fiscal year under such subsection.

"(B) EXPENDITURE RULES.—An amount redistributed to a State under this paragraph with respect to fiscal year 1998 or 1999—

"(i) shall not be included in the determination of the State's allotment for any fiscal year under this section;

"(ii) notwithstanding subsection (e), shall remain available for expenditure by the State through the end of fiscal year 2002; and

"(iii) shall be counted as being expended with respect to a fiscal year allotment in accordance with applicable regulations of the Secretary.

"(2) EXTENSION OF AVAILABILITY OF PORTION OF UNEXPENDED FISCAL YEARS 1998 AND 1999 ALLOTMENTS.—

"(A) IN GENERAL.—Notwithstanding subsection (e):

"(i) FISCAL YEAR 1998 ALLOTMENT.—Of the amounts allotted to a State pursuant to this section for fiscal year 1998 that were not expended by the State by the end of fiscal year 2000, the amount specified in subparagraph (B) for fiscal year 1998 for such State shall remain available for expenditure by the State through the end of fiscal year 2002.

"(ii) FISCAL YEAR 1999 ALLOTMENT.—Of the amounts allotted to a State pursuant to this subsection for fiscal year

1999 that were not expended by the State by the end of fiscal year 2001, the amount specified in subparagraph (B) for fiscal year 1999 for such State shall remain available for expenditure by the State through the end of fiscal year 2002.

''(B) AMOUNT REMAINING AVAILABLE FOR EXPENDITURE.—The amount specified in this subparagraph for a State for a fiscal year is equal to—

''(i) the amount by which (I) the total amount available for redistribution under subsection (f) from the allotments for that fiscal year, exceeds (II) the total amounts redistributed under paragraph (1) for that fiscal year; multiplied by

''(ii) the ratio of the amount of such State's unexpended allotment for that fiscal year to the total amount described in clause (i)(I) for that fiscal year.

''(C) USE OF UP TO 10 PERCENT OF RETAINED 1998 ALLOTMENTS FOR OUTREACH ACTIVITIES.—Notwithstanding section 2105(c)(2)(A), with respect to any State described in subparagraph (A)(i), the State may

use up to 10 percent of the amount specified in subparagraph (B) for fiscal year 1998 for expenditures for outreach activities approved by the Secretary.

''(3) DETERMINATION OF AMOUNTS.—For purposes of calculating the amounts described in paragraphs (1) and (2) relating to the allotment for fiscal year 1998 or fiscal year 1999, the Secretary shall use the amounts reported by the States not later than November 30, 2000, or November 30, 2001, respectively, on HCFA Form 64 or HCFA Form 21, as approved by the Secretary.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 4901 of BBA (111 Stat. 552).

SEC. 802. AUTHORITY TO PAY MEDICAID EXPANSION SCHIP COSTS FROM TITLE XXI APPROPRIATION.

(a) AUTHORITY TO PAY MEDICAID EXPANSION SCHIP COSTS FROM TITLE XXI APPROPRIATION.—Section 2105(a) (42 U.S.C. 1397ee(a)) is amended—

(1) by redesignating subparagraphs (A) through (D) of paragraph (2) as clauses (i) through (iv), respectively, and indenting appropriately;

(2) by redesignating paragraph (1) as subparagraph (C), and indenting appropriately;

(3) by redesignating paragraph (2) as subparagraph (D), and indenting appropriately;

(4) by striking ''(a) IN GENERAL.—'' and the remainder of the text that precedes subparagraph (C), as so redesignated, and inserting the following: ''(a) PAYMENTS.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this section, the Secretary shall pay to each State with a plan approved under this title, from its allotment under section 2104, an amount for each quarter equal to the enhanced FMAP (or, in the case of expenditures described in subparagraph (B), the Federal medical assistance percentage (as defined in the first sentence of section 1905(b))) of expenditures in the quarter—

''(A) for child health assistance under the plan for targeted low-income children in the form of providing medical assistance for which payment is made on the basis of an enhanced FMAP under the fourth sentence of section 1905(b);

''(B) for the provision of medical assistance on behalf of a child during a presumptive eligibility period under section 1920A;''; and

(5) by adding after subparagraph (D), as so redesignated, the following new paragraph:

"(2) ORDER OF PAYMENTS.—Payments under paragraph (1) from a State's allotment shall be made in the following order:

"(A) First, for expenditures for items described in paragraph (1)(A).

"(B) Second, for expenditures for items described in paragraph (1)(B).

"(C) Third, for expenditures for items described in paragraph (1)(C).

"(D) Fourth, for expenditures for items described in paragraph (1)(D).".

(b) ELIMINATION OF REQUIREMENT TO REDUCE TITLE XXI ALLOTMENT BY MEDICAID EXPANSION SCHIP COSTS.—Section 2104 (42 U.S.C. 1397dd) is amended by striking subsection (d).

(c) AUTHORITY TO TRANSFER TITLE XXI APPROPRIATIONS TO TITLE XIX APPROPRIATION ACCOUNT AS REIMBURSEMENT FOR MEDICAID EXPENDITURES FOR MEDICAID EXPANSION SCHIP SERVICES.—Notwithstanding any other provision of law, all amounts appropriated under title XXI and allotted to a State pursuant to subsection (b) or (c) of section 2104 of the Social Security Act (42 U.S.C. 1397dd) for fiscal years 1998 through

2000 (including any amounts that, but for this provision, would be considered to have expired) and not expended in providing child health assistance or related services for which payment may be made pursuant to subparagraph (C) or (D) of section 2105(a)(1) of such Act (42 U.S.C. 1397ee(a)(1)) (as amended by subsection (a)), shall be available to reimburse the Grants to States for Medicaid account in an amount equal to the total payments made to such State under section 1903(a) of such Act (42 U.S.C. 1396b(a)) for expenditures in such years for medical assistance described in subparagraphs (A) and (B) of section 2105(a)(1) of such Act (42 U.S.C. 1397ee(a)(1) (as so amended).

(d) CONFORMING AMENDMENTS.—

(1) Section 1905(b) (42 U.S.C. 1396d(b)) is amended in the fourth sentence by striking ''the State's allotment under section 2104 (not taking into account reductions under section 2104(d)(2)) for the fiscal year reduced by the amount of any payments made under section 2105 to the State from such allotment for such fiscal year'' and inserting ''the State's available allotment under section 2104''.

(2) Section 1905(u)(1)(B) (42 U.S.C. 1396d(u)(1)(B)) is amended by striking ''and section 2104(d)''.

(3) Section 2104 (42 U.S.C. 1397dd), as amended by subsection (b), is further amended—

(A) in subsection (b)(1), by striking ''and subsection (d)''; and

(B) in subsection (c)(1), by striking ''subject to subsection (d),''.

(4) Section 2105(c) (42 U.S.C. 1397ee(c)) is amended—

(A) in paragraph (2)(A), by striking all that follows ''Except as provided in this paragraph,'' and inserting ''the amount of payment that may be made under subsection (a) for a fiscal year for expenditures for items described in paragraph (1)(D) of such subsection shall not exceed 10 percent of the total amount of expenditures for which payment is made under subparagraphs (A), (C), and (D) of paragraph (1) of such subsection.'';

(B) in paragraph (2)(B), by striking ''described in subsection (a)(2)'' and inserting ''described in subsection (a)(1)(D)''; and

(C) in paragraph (6)(B), by striking ''Except as otherwise provided by law,'' and inserting ''Except as provided in subparagraph (A) or (B) of subsection (a)(1) or any other provision of law,''.

(5) Section 2110(a) (42 U.S.C. 1397jj(a)) is amended by striking ''section 2105(a)(2)(A)'' and inserting ''section 2105(a)(1)(D)(i)''.

(e) TECHNICAL AMENDMENT.—Section 2105(d)(2)(B)(ii) (42 U.S.C. 1397ee(d)(2)(B)(ii)) is amended by striking ''enhanced FMAP under section 1905(u)'' and inserting ''enhanced FMAP under the fourth sentence of section 1905(b)''.

(f) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of section 4901 of the BBA (111 Stat. 552).

TITLE IX—OTHER PROVISIONS

Subtitle A—PACE Program

SEC. 901. EXTENSION OF TRANSITION FOR CURRENT WAIVERS.

Section 4803(d)(2) of BBA is amended—

(1) in subparagraph (A), by striking ''24 months'' and inserting ''36 months'';

(2) in subparagraph (A), by striking ''the initial effective date of regulations described in subsection (a)'' and inserting ''July 1, 2000''; and

(3) in subparagraph (B), by striking ''3 years'' and inserting ''4 years''.

SEC. 902. CONTINUING OF CERTAIN OPERATING ARRANGEMENTS PERMITTED.

(a) IN GENERAL.—Section 1894(f)(2) (42 U.S.C. 1395eee(f)(2)) is amended by adding at the end the following new subparagraph:

''(C) CONTINUATION OF MODIFICATIONS OR WAIVERS OF OPERATIONAL REQUIREMENTS UNDER DEMONSTRATION STATUS.—If a PACE program operating under demonstration authority has contractual or other operating arrangements which are not otherwise recognized in regulation and which were in effect on July 1, 2000, the Secretary (in close consultation with, and with the concurrence of, the State administering agency) shall permit any such program to continue such arrangements so long as such arrangements are found by the Secretary and the State to be reasonably consistent with the objectives of the PACE program.''.

(b) CONFORMING AMENDMENT.—Section 1934(f)(2) (42 U.S.C. 1396u–4(f)(2)) is amended by adding at the end the following new subparagraph:

"(C) CONTINUATION OF MODIFICATIONS OR WAIVERS OF OPERATIONAL REQUIREMENTS UNDER DEMONSTRATION STATUS.—If a PACE program operating under demonstration authority has contractual or other operating arrangements which are not otherwise recognized in regulation and which were in effect on July 1 2000, the Secretary (in close consultation with, and with the concurrence of, the State administering agency) shall permit any such program to continue such arrangements so long as such arrangements are found by the Secretary and the State to be reasonably consistent with the objectives of the PACE program.".

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective as included in the enactment of BBA.

SEC. 903. FLEXIBILITY IN EXERCISING WAIVER AUTHORITY.

In applying sections 1894(f)(2)(B) and 1934(f)(2)(B) of the Social Security Act (42 U.S.C. 1395eee(f)(2)(B), 1396u–4(f)(2)(B)), the Secretary of Health and Human Services—

(1) shall approve or deny a request for a modification or a waiver of provisions of the PACE protocol not later than 90 days after the date the Secretary receives the request; and

(2) may exercise authority to modify or waive such provisions in a manner that responds promptly to the needs of PACE programs relating to areas of employment and the use of community-based primary care physicians.

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.

(a) OUTREACH.—

(1) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1143 the following new section:

''OUTREACH EFFORTS TO INCREASE AWARENESS OF THE AVAILABILITY OF MEDICARE COST-SHARING

''SEC. 1144. (a) OUTREACH.—

''(1) IN GENERAL.—The Commissioner of Social Security (in this section referred to as the 'Commissioner') shall conduct outreach efforts to—

"(A) identify individuals entitled to benefits under the medicare program under title XVIII who may be eligible for medical assistance for payment of the cost of medicare cost-sharing under the medicaid program pursuant to sections 1902(a)(10)(E) and 1933; and

"(B) notify such individuals of the availability of such medical assistance under such sections.

"(2) CONTENT OF NOTICE.—Any notice furnished under paragraph (1) shall state that eligibility for medicare cost-sharing assistance under such sections is conditioned upon—

"(A) the individual providing to the State information about income and resources (in the case of an individual residing in a State that imposes an assets test for such eligibility); and

"(B) meeting the applicable eligibility criteria.

"(b) COORDINATION WITH STATES.—

"(1) IN GENERAL.—In conducting the outreach efforts under this section, the Commissioner shall—

"(A) furnish the agency of each State responsible for the administration of the medicaid program and any other appropriate State agen-

cy with information consisting of the name and address of individuals residing in the State that the Commissioner determines may be eligible for medical assistance for payment of the cost of medicare cost-sharing under the medicaid program pursuant to sections 1902(a)(10)(E) and 1933; and

''(B) update any such information not less frequently than once per year.

''(2) INFORMATION IN PERIODIC UPDATES.—The periodic updates described in paragraph (1)(B) shall include information on individuals who are or may be eligible for the medical assistance described in paragraph (1)(A) because such individuals have experienced reductions in benefits under title II.''.

(2) AMENDMENT TO TITLE XIX.—Section 1905(p) (42 U.S.C. 1396d(p)) is amended by adding at the end the following new paragraph:

''(5) For provisions relating to outreach efforts to increase awareness of the availability of medicare cost-sharing, see section 1144.''.

(b) GAO REPORT.—The Comptroller General of the United States shall conduct a study of the impact of section 1144 of the Social Security Act (as added by subsection (a)(1)) on the enrollment of individuals for medi-

care cost-sharing under the medicaid program. Not later than 18 months after the date that the Commissioner of Social Security first conducts outreach under section 1144 of such Act, the Comptroller General shall submit to Congress a report on such study. The report shall include such recommendations for legislative changes as the Comptroller General deems appropriate.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) shall take effect one year after the date of the enactment of this Act.

Subtitle C—Maternal and Child Health Block Grant

SEC. 921. INCREASE IN AUTHORIZATION OF APPROPRIATIONS FOR THE MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT.

(a) IN GENERAL.—Section 501(a) (42 U.S.C. 701(a)) is amended in the matter preceding paragraph (1) by striking ''$705,000,000 for fiscal year 1994'' and inserting ''$850,000,000 for fiscal year 2001''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on October 1, 2000.

Subtitle D—Diabetes

SEC. 931. INCREASE IN APPROPRIATIONS FOR SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES AND INDIANS.

(a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES.—Section 330B(b) of the Public Health Service Act (42 U.S.C. 254c–2(b)) is amended—

(1) by striking ''Notwithstanding'' and inserting the following:

''(1) TRANSFERRED FUNDS.—Notwithstanding''; and

(2) by adding at the end the following:

''(2) APPROPRIATIONS.—For the purpose of making grants under this section, there is appropriated, out of any funds in the Treasury not otherwise appropriated—

''(A) $70,000,000 for each of fiscal years 2001 and 2002 (which shall be combined with amounts transferred under paragraph (1) for each such fiscal years); and

''(B) $100,000,000 for fiscal year 2003.''.

(b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—Section 330C(c) of such Act (42 U.S.C. 254c–3(c)) is amended—

(1) by striking ''Notwithstanding'' and inserting the following:

''(1) TRANSFERRED FUNDS.—Notwithstanding''; and

(2) by adding at the end the following:

''(2) APPROPRIATIONS.—For the purpose of making grants under this section, there is appropriated, out of any money in the Treasury not otherwise appropriated—

''(A) $70,000,000 for each of fiscal years 2001 and 2002 (which shall be combined with amounts transferred under paragraph (1) for each such fiscal years); and

''(B) $100,000,000 for fiscal year 2003.''.

(c) EXTENSION OF FINAL REPORT ON GRANT PROGRAMS.—Section 4923(b)(2) of BBA is amended by striking ''2002'' and inserting ''2003''.

SEC. 932. APPROPRIATIONS FOR RICKY RAY HEMOPHILIA RELIEF FUND.

Section 101(e) of the Ricky Ray Hemophilia Relief Fund Act of 1998 (42 U.S.C. 300c–22 note) is amended by adding at the end the following: ''There is appropriated to the Fund $475,000,000 for fiscal year 2001, to remain available until expended.''.

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