106TH CONGRESS
1ST SESSION

S. 1582

To modify the provisions of the Balanced Budget Act of 1997 relating to the Medicare program under title XVIII of the Social Security Act.

IN THE SENATE OF THE UNITED STATES

SEPTEMBER 14, 1999

Mr. DURBIN introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To modify the provisions of the Balanced Budget Act of 1997 relating to the Medicare program under title XVIII of the Social Security Act.

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; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Care Preservation Act of 1999''.

(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) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

TITLE I—TEACHING HOSPITALS

SEC. 101. TERMINATION OF MULTIYEAR REDUCTION OF INDIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.

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

(1) by adding ''and'' at the end of subclause (II); and

(2) by striking subclauses (III), (IV), and (V) and inserting the following:

"(III) on or after October 1, 1998, 'c' is equal to 1.6.".

SEC. 102. EXCLUSION OF NURSING AND ALLIED HEALTH EDUCATION COSTS IN CALCULATING MEDICARE+CHOICE PAYMENT RATE.

(a) EXCLUDING COSTS IN CALCULATING PAYMENT RATE.—

(1) IN GENERAL.—Section 1853(c)(3)(C)(i) (42 U.S.C. 1395w–23(c)(3)(C)(i)) is amended—

(A) by striking "and" at the end of subclause (I);

(B) by striking the period at the end of subclause (II) and inserting ", and"; and

(C) by adding at the end the following:

"(III) for costs attributable to approved nursing and allied health education programs under section 1861(v).".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) apply in determining the annual per capita rate of payment for years beginning with 2001.

(b) PAYMENT TO HOSPITALS OF NURSING AND ALLIED HEALTH EDUCATION PROGRAM COSTS FOR MEDICARE+CHOICE ENROLLEES.—Section 1861(v)(1) of such Act (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following:

''(V) In determining the amount of payment to a hospital for cost reporting periods (or portions thereof) occurring on or after January 1, 2001, with respect to the reasonable costs for approved nursing and allied health education programs, individuals who are enrolled with a Medicare+Choice organization under part C shall be treated as if they were not so enrolled.''.

TITLE II—RURAL HOSPITALS

SEC. 201. REVISION OF CRITERIA FOR DESIGNATION AS A CRITICAL ACCESS HOSPITAL.

(a) CONVERSION OF DOWNSIZED OR RECENTLY CLOSED HOSPITALS TO CRITICAL ACCESS HOSPITALS.—Section 1820(c)(2) (42 U.S.C. 1395i–4(c)(2)) is amended—

(1) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B), (C), (D), and (E)''; and

(2) by adding at the end the following:

''(C) RECENTLY CLOSED FACILITIES.—A State may designate a facility as a critical access hospital if the facility—

''(i) was a nonprofit or public hospital that ceased operations within the 3-year period ending on the date of enactment of the Health Care Preservation Act of 1999; and

''(ii) as of the effective date of such designation, meets the criteria for designation under subparagraph (B).

''(D) DOWNSIZED FACILITIES.—A State may designate a health clinic or a health center (as defined by the State) as a critical access hospital if such clinic or center—

''(i) is licensed by the State as a health clinic or a health center if the State requires such licensure in order to operate as a health clinic or health center;

''(ii) was a nonprofit or public hospital that was downsized to a health clinic or health center; and

''(iii) as of the effective date of such designation, meets the criteria for designation under subparagraph (B).

''(E) FEDERALLY-QUALIFIED HEALTH CENTER.—A State may designate a Federally-qualified health center (as defined in section 1905(l)(2)(B)) as a critical access hospital if such center—

''(i) operates a laboratory that has in effect a certificate issued under section 353 of the Public Health Service Act that permits such laboratory to perform tests categorized as high complexity;

''(ii) operates a radiology department; and

''(iii) as of the effective date of such designation, meets the criteria for designation under subparagraph (B).''.

(b) REVISION OF CRITERIA FOR DESIGNATION AS A CRITICAL ACCESS HOSPITAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395i–4(c)(2)(B)(iii)) is amended by striking ''not to exceed 96 hours'' and all that follows to the semicolon and inserting ''not to exceed, on average, 96 hours per patient''.

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

SEC. 202. AUTHORITY TO ESTABLISH A PROSPECTIVE PAYMENT SYSTEM FOR RHC SERVICES.

(a) ESTABLISHMENT OF SYSTEM.—Section 1833 (42 U.S.C. 1395l) is amended by adding at the end the following:

''(u) AUTHORITY TO ESTABLISH PROSPECTIVE PAYMENT SYSTEM FOR RURAL HEALTH CLINIC SERVICES.—

''(1) IN GENERAL.—Notwithstanding subsections (a)(3) and (f), the Secretary may establish by regulation a prospective payment system for rural health clinic services (except for such services provided by a rural health clinic located in a rural hospital with less than 50 beds).

''(2) BUDGET NEUTRAL PAYMENTS.—If the Secretary establishes a prospective payment system pursuant to paragraph (1), the Secretary shall establish the initial payment levels under such system in a manner that results in aggregate payments (including payments by individuals to whom services are provided) for the first year, as estimated by the Secretary, approximately equal to the aggregate payments that would have otherwise been made under this part.''.

(b) CONFORMING AMENDMENTS.—

(1) PAYMENT.—Section 1833(a)(3) (42 U.S.C. 1395l(a)(3)) is amended by inserting ''subject to subsection (u),'' before ''in the case''.

(2) LIMITS.—Section 1833(f) (42 U.S.C. 1395l(f)) is amended by striking ''In establishing'' and inserting ''Subject to subsection (u), in establishing''.

(3) REQUIREMENT FOR RURAL HEALTH CLINICS.—Clause (ii) of the second sentence of section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended by inserting ''(and section 1833(u) if the Secretary implements a prospective payment system under that section)'' after ''section 1833''.

SEC. 203. REQUIREMENT TO CONSIDER RURAL ISSUES IN ESTABLISHING FEE SCHEDULE FOR AMBULANCE SERVICES.

(a) IN GENERAL.—Section 1834(l)(2)(C) (42 U.S.C. 1395m(l)(2)(C)) is amended by inserting '', including differences in rural and non-rural areas'' after ''differences''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect as if included in the enactment of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 251).

SEC. 204. STOP-LOSS PROTECTION FOR RURAL HOSPITAL OPD SERVICES.

(a) IN GENERAL.—Section 1833(t)(10)(D)(i) (42 U.S.C. 1395l(t)(10)(D)(i)) (as added by section 402) is amended by adding at the end the following:

> ''The applicable percentage shall be 100 percent with respect to covered OPD services furnished during a transition year in a rural hospital.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect as if included in the amendments made by section 4523 of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 445).

TITLE III—SAFETY NET PROVIDERS

SEC. 301. NEW PROSPECTIVE PAYMENT SYSTEM FOR FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS UNDER THE MEDICAID PROGRAM.

(a) IN GENERAL.—Section 1902(a)(13) (42 U.S.C. 1396a(a)(13)) is amended—

(1) in subparagraph (A), by adding ''and'' at the end;

(2) in subparagraph (B), by striking ''and'' at the end; and

(3) by striking subparagraph (C).

(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 2000 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 2000.—For fiscal year 2000, 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 costs incurred by the center or clinic in furnishing such services during fiscal year 1999 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 in the scope of such services furnished by the center or clinic during fiscal year 2000.

''(3) FISCAL YEAR 2001 AND SUCCEEDING YEARS.—For fiscal year 2001 and each 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 (Medicare economic index) (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 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 October 1, 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 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 in accordance with the regulations and methodology referred to in paragraph (2). 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) of this subsection.

''(5) ADMINISTRATION IN THE CASE OF MANAGED CARE.—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 (at least quarterly) 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.

''(6) ALTERNATIVE PAYMENT SYSTEM.—Notwithstanding any other provision of this section, the State plan may provide for payment in any fiscal year to a Federally-qualified health center (as defined in section 1905(l)(2)(B)) 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 that is in excess of the amount otherwise required to be paid to the center or clinic under this subsection.''.

(c) CONFORMING AMENDMENTS.—

(1) Section 4712 of the Balanced Budget Act of 1997 (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)(E)'' and inserting ''1902(aa)''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 1999.

SEC. 302. CARVING OUT DSH PAYMENTS FROM PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS AND PAYING THE AMOUNTS DIRECTLY TO DSH HOSPITALS ENROLLING MEDICARE+CHOICE ENROLLEES.

(a) IN GENERAL.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)) is amended—

(1) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (D)'';

(2) by redesignating subparagraph (D) as subparagraph (E); and

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

''(D) REMOVAL OF PAYMENTS ATTRIBUTABLE TO DISPROPORTIONATE SHARE PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

''(i) IN GENERAL.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2001), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted, subject to clause (ii), to exclude from the rate the additional payments that

the Secretary estimates were made during 1997 for additional payments described in section 1886(d)(5)(F).

''(ii) TREATMENT OF PAYMENTS COVERED UNDER STATE HOSPITAL REIMBURSEMENT SYSTEM.—To the extent that the Secretary estimates that an annual per capita rate of payment for 1997 described in clause (i) reflects payments to hospitals reimbursed under section 1814(b)(3), the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.''.

(b) ADDITIONAL PAYMENTS FOR MANAGED CARE ENROLLEES.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (ii), by striking ''clause (ix)'' and inserting ''clauses (ix) and (x)''; and

(2) by adding at the end the following:

''(x)(I) For cost reporting periods (or portions thereof) occurring on or after January 1, 2001, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital that is

a disproportionate share hospital (as described in clause (i)).

''(II) For purposes of this clause, the term 'applicable discharge' means the discharge of any individual who is enrolled with a Medicare+Choice organization under part C.

''(III) The amount of the payment under this clause with respect to any applicable discharge shall be equal to the estimated average per discharge amount (as determined by the Secretary) that would otherwise have been paid under this subparagraph if the individual had not been enrolled as described in subclause (II).

''(IV) The Secretary shall establish rules for an additional payment amount for any hospital reimbursed under a reimbursement system authorized under section 1814(b)(3) if such hospital would qualify as a disproportionate share hospital under clause (i) were it not so reimbursed. Such payment shall be determined in the same manner as the amount of payment is determined under this clause for disproportionate share hospitals.''.

SEC. 303. LIMITATION IN REDUCTION OF PAYMENTS TO DISPROPORTIONATE SHARE HOSPITALS.

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

(1) in subclause (IV), by striking ''4'' and inserting ''3''; and

(2) in subclause (V), by striking ''5'' and inserting ''3''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect as if included in the amendments made by section 4403 of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 398).

TITLE IV—OTHER HOSPITAL PROVISIONS

SEC. 401. DELAY OF FINANCIAL LIMITATION ON REHABILITATION SERVICES.

(a) IN GENERAL.—Section 1833(g) (42 U.S.C. 1395l(g)) is amended by adding at the end the following:

''(4) Notwithstanding the preceding provisions of this subsection, for outpatient physical therapy services, outpatient occupational therapy services, and outpatient speech-language pathology services covered under this title and furnished on or after January 1, 2000, and before January 1, 2002, the Secretary shall implement a payment methodology based on the classification of individuals by diagnostic category, functional status, and prior use of services in both inpatient and outpatient settings.''.

(b) BUDGET NEUTRALITY IN IMPLEMENTATION.—The payment methodology implemented under section

1833(g)(4) (42 U.S.C. 1395l(g)(4)), as added by subsection (a), shall be designed so that the methodology, taking into account the increased expenditures resulting from the implementation of such methodology, does not result in any increase or decrease in the expenditures under title XVIII of the Social Security Act on a fiscal year basis.

SEC. 402. MULTIYEAR TRANSITION TO PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) IN GENERAL.—Section 1833(t) (42 U.S.C. 1395l(t)) is amended by adding at the end the following:

"(10) MULTIYEAR TRANSITION.—

"(A) IN GENERAL.—In the case of covered OPD services furnished by a hospital during a transition year, the Secretary shall increase the payments for such services under the prospective payment system established under this subsection by the amount (if any) which the Secretary determines necessary to ensure that the payment to cost ratio of the hospital for the transition year equals a ratio equal to the applicable percentage of the payment to cost ratio of the hospital for 1996.

"(B) PAYMENT TO COST RATIO.—

''(i) IN GENERAL.—The payment to cost ratio of a hospital for any year is the ratio which—

''(I) the hospital's reimbursement under this title for covered OPD services furnished during the year, including through cost-sharing described in subparagraph (D)(ii), bears to

''(II) the cost of such services.

''(ii) CALCULATION OF 1996 PAYMENT TO COST RATIO.—The Secretary shall determine each hospital's payment to cost ratio for 1996 as if the amendments made to this title by the provisions of section 4521 of the Balanced Budget Act of 1997 were in effect in 1996.

''(iii) TRANSITION YEARS.—The Secretary shall estimate each payment to cost ratio of a hospital for any transition year before the beginning of such year.

''(C) INTERIM PAYMENTS.—

''(i) IN GENERAL.—The Secretary shall make interim payments to a hospital during any transition year for which the

Secretary estimates a payment is required under subparagraph (A).

''(ii) ADJUSTMENTS.—If the Secretary makes payments under clause (i) for any transition year, the Secretary shall make retrospective adjustments to each hospital based on its settled cost report so that the amount of any additional payment to a hospital for such year equals the amount described in subparagraph (A).

''(D) DEFINITIONS.—In this paragraph:

''(i) APPLICABLE PERCENTAGE.—The term 'applicable percentage' means, with respect to covered OPD services furnished during—

''(I) the first full year (and any portion of the immediately preceding year) for which the prospective payment system under this subsection is in effect, 95 percent;

''(II) the second full calendar year for which such system is in effect, 90 percent; and

"(III) the third full calendar year for which such system is in effect, 85 percent.

"(ii) COST-SHARING.—The term 'cost-sharing' includes—

"(I) copayment amounts described in paragraph (5);

"(II) coinsurance described in section 1866(a)(2)(A)(ii); and

"(III) the deductible described under section 1833(b).

"(iii) TRANSITION YEAR.—The term 'transition year' means any year (or portion thereof) described in clause (i).

"(E) EFFECT ON COPAYMENTS.—Nothing in this paragraph shall be construed as affecting the unadjusted copayment amount described in paragraph (3)(B).

"(F) APPLICATION WITHOUT REGARD TO BUDGET NEUTRALITY.—The transitional payments made under this paragraph—

"(i) shall not be considered an adjustment under paragraph (2)(E); and

"(ii) shall not be implemented in a budget neutral manner.".

(b) EFFECTIVE DATE.—The amendments made by this section take effect as if included in the amendments made by section 4523 of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 445).

TITLE V—SKILLED NURSING FACILITIES

SEC. 501. MODIFICATION OF CASE MIX CATEGORIES FOR CERTAIN CONDITIONS.

(a) IN GENERAL.—For purposes of applying any formula under paragraph (1) of section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)), for services provided on or after October 1, 1999, and before the earlier of October 1, 2001, or the date described in subsection (c), the Secretary of Health and Human Services shall increase the adjusted Federal per diem rate otherwise determined under paragraph (4) of such section for services provided to any individual during the period in which such individual is in a RUG III category by the applicable payment add-on as determined in accordance with the following table:

RUG III category	Applicable payment add-on
SE3	$75.87
SE2	$65.70
SE1	$58.46
SSC	$57.15
SSB	$54.52
SSA	$53.21
CC2	$56.82
CC1	$52.55
CB2	$49.93
CB1	$47.62

RUG III category	Applicable payment add-on
CA2	$47.30
CA1	$44.67.

(b) UPDATE.—The Secretary shall adjust the applicable payment add-on under subsection (a) for fiscal year 2001 by the skilled nursing facility market basket percentage change (as defined under section 1888(e)(5)(B) of the Social Security Act (42 U.S.C. 1395yy(e)(5)(B))) applicable to such fiscal year.

(c) DATE DESCRIBED.—The date described in this subsection is the date on which the Secretary of Health and Human Services implements a case mix methodology under section 1888(e)(4)(G)(i) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(G)(i)) that takes into account adjustments for the provision of nontherapy ancillary services and supplies such as drugs and respiratory therapy.

SEC. 502. EXCLUSION OF AMBULANCE SERVICES TO AND FROM DIALYSIS TREATMENTS AND PROSTHETIC SERVICES FROM THE PPS FOR SNFs.

(a) IN GENERAL.—The first sentence of section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting ''ambulance services furnished an individual in conjunction with a renal dialysis service, prosthetic and orthotic devices, including testing, fitting, or training in the use of prosthetic and orthotic devices,'' after ''subparagraphs (F) and (O) of section 1861(s)(2),''.

(b) EFFECTIVE DATE.—The amendment made by this section applies to services furnished on or after the date of enactment of this Act.

SEC. 503. WAIVER OF 3-DAY PRIOR HOSPITALIZATION REQUIREMENT FOR COVERAGE OF SKILLED NURSING FACILITY SERVICES.

(a) IN GENERAL.—Not later than October 1, 2000, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall provide for coverage under section 1812(f) of the Social Security Act (42 U.S.C. 1395d(f)) of extended care services (as defined in section 1861(h) of such Act (42 U.S.C. 1395x(h))) for individuals with a condition that is classifiable within a diagnosis-related group identified under subsection (b).

(b) IDENTIFICATION OF DRGS.—For purposes of subsection (a) and subject to subsections (f) through (h), the diagnosis-related groups identified under this subsection are—

(1) diagnosis-related group code 410 (relating to chemotherapy without acute leukemia as secondary diagnosis); and

(2) the diagnosis-related groups described in subsections (c) through (e).

(c) IDENTIFICATION OF DRGS THROUGH A MEDICARE SELECT STUDY AND REPORT.—

(1) IN GENERAL.—The diagnosis related groups described in this subsection are those diagnosis-related groups identified in the report submitted under paragraph (3) and determined to reduce the total of payments made under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (in this section referred to as the ''Medicare program'').

(2) STUDY.—

(A) IN GENERAL.—The Secretary shall conduct a study of extended care services provided in skilled nursing facilities for which coverage is provided under the Medicare select program under section 1882(t) of the Social Security Act (42 U.S.C. 1395ss(t)) to obtain data concerning—

(i) the length of stay of individuals in hospitals; and

(ii) extended care services provided to individuals in skilled nursing facilities.

(B) DRGS IDENTIFIED.—The study conducted under subparagraph (A) shall include the identification of those diagnosis-related groups that are generally treated with less than a 3-day hospital stay under such program.

(3) REPORT.—Not later than January 1, 2001, the Secretary shall submit to the appropriate committees of Congress a report on the study conducted under paragraph (2) that shall include—

(A) a description of each diagnosis-related group identified under subparagraph (B) of such paragraph; and

(B) a determination as to whether waiving the 3-day hospitalization stay requirement with respect to each diagnosis-related group would reduce the total of payments made under the Medicare program.

(d) IDENTIFICATION OF DRGS THROUGH DEMONSTRATION PROGRAMS.—

(1) IN GENERAL.—The diagnosis related groups described in this subsection are those diagnosis-related groups identified in the report submitted under paragraph (3) and determined to reduce the total of payments made under the Medicare program.

(2) DEMONSTRATION PROGRAMS.—

(A) ESTABLISHMENT.—The Secretary shall—

(i) establish demonstration programs under which the Secretary provides for coverage under section 1812(f) of the So-

cial Security Act (42 U.S.C. 1395d(f)) of extended care services for individuals with a condition that is classifiable within a diagnosis-related group identified by the Secretary under subparagraph (B) in the geographic areas selected under subparagraph (C); and

(ii) collect the data described in subparagraph (D).

(B) DRGs IDENTIFIED.—The Secretary shall identify those diagnosis-related groups for which waiver of the 3-day hospitalization stay requirement is likely to reduce the total of payments made under the Medicare program.

(C) SELECTION OF GEOGRAPHIC AREAS.—The geographic areas selected under this subparagraph are those geographic areas that the Secretary expects—

(i) to maximize the provision of appropriate statistically relevant data on the cost of—

(I) extended care services provided in skilled nursing facilities; and

(II) inpatient hospital services (as defined in section 1861(b) of the

Social Security Act (42 U.S.C. 1395x(b))); and

(ii) to minimize regional differences in the practice of medicine.

(D) COLLECTION OF DATA.—The Secretary shall collect appropriate statistically relevant data on the cost of extended care services and inpatient hospital services provided—

(i) in the geographic areas selected under subparagraph (C)—

(I) before the implementation of the demonstration programs under this subsection; and

(II) after the implementation of such programs; and

(ii) in the geographic areas not selected under such subparagraph for the periods described in subclauses (I) and (II) of clause (i).

(3) REPORT.—

(A) IN GENERAL.—Not later than January 1, 2002, the Secretary shall submit to the appropriate committees of Congress a report—

(i) on the demonstration programs conducted under paragraph (2); and

(ii) comparing the effect of the waiver of 3-day prior hospitalization requirement for coverage of extended care services—

(I) among geographic areas; and

(II) before and after the implementation of the programs established under paragraph (2).

(B) CONTENTS.—The report submitted under subparagraph (A) shall contain—

(i) a description of each diagnosis-related group for which a demonstration program is implemented under paragraph (2); and

(ii) a determination as to whether waiving the 3-day hospitalization stay requirement with respect to each diagnosis-related group would reduce the total of payments made under the Medicare program.

(C) CONSIDERATION OF DATA.—In preparing such report, the Secretary shall consider the data collected under paragraph (2)(D).

(e) IDENTIFICATION OF ADDITIONAL DRGS.—The diagnosis related groups described in this subsection are those diagnosis-related groups not otherwise identified

under this section that the Secretary determines would reduce the total of payments made under the Medicare program if such diagnosis-related group were identified under subsection (b).

(f) REQUIREMENT OF HOSPITAL DEDUCTIBLES AND COINSURANCE.—

(1) IN GENERAL.—For purposes of this section, when the requirement for a 3-day hospitalization stay has been waived under this section, the Secretary shall require the application of any deductibles and coinsurance under section 1813 of the Social Security Act (42 U.S.C. 1395e) beginning with the first day of extended care services provided in a skilled nursing facility.

(2) REDUCTION OF AMOUNT.—The Secretary shall reduce the amount of any deductible or coinsurance applied under this subsection based on the best estimate of the Secretary of the difference between the average cost of hospital inpatient services for the individual involved and the average cost of services provided to that individual in a skilled nursing facility.

(g) RECOVERY OF INCREASED PAYMENTS.—If the Secretary determines that the application of this section in a fiscal year has resulted in any increase in the total

of payments made under the Medicare program for the fiscal year above the total of such payments that would have been made in the fiscal year if this section did not apply (taking into account any reduction in the total of payments made under such program as a result of the elimination of or a reduction in the length of hospitalization), the Secretary—

(1) shall, notwithstanding any other provision of law, provide for a reduction in the amounts otherwise payable under part A of such title (42 U.S.C. 1395 et seq.) for post-hospital extended care services (as defined in section 1861(i) of the Social Security Act (42 U.S.C. 1395x(i))) in the following fiscal year by such proportion as will reduce the total of payments made in such fiscal year under such part by the total amount of such an increase in the previous fiscal year; and

(2) may rescind the selection of any diagnosis-related group identified under subsection (b) if the application of this section with respect to such group has resulted in an increase in the total of payments made under the Medicare program.

(h) SPECIAL RULE FOR DUAL ELIGIBLES.—In the case of an individual eligible for assistance for nursing facility services under title XIX of the Social Security Act

(42 U.S.C. 1396 et seq.), the provisions of such title shall apply as if this section had not been enacted.

SEC. 504. EXTENSION OF CERTAIN MEDICARE COMMUNITY NURSING ORGANIZATION DEMONSTRATION PROJECTS.

Notwithstanding any other provision of law, demonstration projects conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987 may be conducted for an additional period of 5 years, and the deadline for any report required relating to the results of such projects shall be not later than 6 months before the end of such additional period.

TITLE VI—COST-EFFICIENT HOME HEALTH PROVIDERS

SEC. 601. DELAY IN CONTINGENCY REDUCTION.

(a) IN GENERAL.—Section 4603(e) of the Balanced Budget Act of 1997 (42 U.S.C. 1395fff note), as amended by section 5101(c)(3) of the Tax and Trade Relief Extension Act of 1998 (contained in division J of Public Law 105–277), is amended—

(1) by striking ''described in subsection (d),'' and inserting ''beginning on or after September 30, 2001''; and

(2) by striking ''September 30, 2000'' and inserting ''September 30, 2001''.

(b) EFFECTIVE DATE.—The amendments made by this section take effect as if included in the enactment of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 251).

SEC. 602. ELIMINATION OF 15-MINUTE REPORTING REQUIREMENT.

(a) IN GENERAL.—Section 1895(c)(2) (42 U.S.C. 1395fff(c)(2)) is amended by striking ", as measured in 15 minute increments".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect as if included in the amendments made by section 4603 of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 467).

SEC. 603. RECOUPMENT OF OVERPAYMENTS.

(a) 36-MONTH REPAYMENT PERIOD.—

(1) IN GENERAL.—Except as provided in paragraph (2), in the case of an overpayment by the Secretary of Health and Human Services to a home health agency for home health services furnished during a cost reporting period beginning on or after October 1, 1997, as a result of payment limitations provided for under clause (v), (vi), or (viii) of section 1861(v)(1)(L) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)), the home health agency may elect to repay the amount of such overpayment over a 36-

month period beginning on the date of notification of such overpayment.

(2) EXCEPTION.—No home health agency may make an election under paragraph (1) if any final adverse action (as defined in section 1128E(g)(1) of such Act (42 U.S.C. 1320a–7e(g)(1))) has been taken against such agency.

(b) NO INTEREST ON OVERPAYMENT AMOUNTS.—In the case of an agency that makes an election under subsection (a), no interest shall accrue on the outstanding balance of the amount of overpayment during such 36-month period.

(c) TERMINATION.—No election under subsection (a) may be made for cost reporting periods (or portions thereof) beginning on or after the date of implementation of the prospective payment system for home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff).

(d) EFFECTIVE DATE.—The provisions of subsection (a) take effect as if included in the enactment of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 251).

SEC. 604. INCREASE IN PER VISIT LIMIT.

Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)), as amended by section 5101(b) of the

Tax and Trade Relief Extension Act of 1998 (contained in division J of Public Law 105–277), is amended—

(1) in subclause (IV), by striking ''or'';

(2) in subclause (V)—

(A) by inserting ''and before October 1, 1999,'' after ''October 1, 1998,''; and

(B) by striking the period and inserting '', or''; and

(3) by adding at the end the following:

''(VI) October 1, 1999, 112 percent of such median.''.

TITLE VII—MEDICARE+CHOICE AND MEDIGAP PROTECTIONS FOR SENIORS AND THE DISABLED

SEC. 701. TWO-YEAR MEDICARE+CHOICE TRIAL PERIOD.

(a) IN GENERAL.—Section 1882(s)(3)(B) (42 U.S.C. 1395ss(s)(3)(B)) is amended—

(1) in clause (v)(III), by striking ''12'' and inserting ''24''; and

(2) in clause (vi), by striking ''12'' and inserting ''24''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to terminations and

discontinuations occurring on or after the date of enactment of this Act.

SEC. 702. PERMITTING ENROLLMENT IN ALTERNATIVE PLANS UPON RECEIPT OF NOTICE OF MEDICARE+CHOICE PLAN TERMINATION.

(a) MEDICARE+CHOICE PLANS.—Section 1851(e)(4) (42 U.S.C. 1395w–21(e)(4)) is amended by striking subparagraph (A) and inserting the following:

"(A)(i) the certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or

"(ii) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuation of such plan;".

(b) MEDIGAP PLANS.—

(1) IN GENERAL.—Section 1882(s)(3)(A) (42 U.S.C. 1395ss(s)(3)(A)) is amended in the matter following clause (iii)—

(A) by inserting "(92 days in the case of a termination or discontinuation of coverage

under the types of circumstances described in section 1851(e)(4)(A))'' after ''63 days'';

(B) by inserting ''(or, if elected by the individual, the date of notification of the individual by the plan or organization of the impending termination or discontinuance of the plan in the area in which the individual resides)'' after ''the date of the termination of enrollment described in such subparagraph''; and

(C) by inserting ''(or date of such notification)'' after ''the date of termination or disenrollment''.

(2) EFFECTIVE DATE.—The amendments made by this subsection apply to notices of intended termination made by group health plans and Medicare+Choice organizations after the date of enactment of this Act.

SEC. 703. GUARANTEED ISSUANCE OF CERTAIN MEDIGAP POLICIES IN CASES OF A SUBSTANTIAL CHANGE IN BENEFITS UNDER A MEDICARE+CHOICE PLAN.

(a) IN GENERAL.—Section 1851(e)(4)(C) (42 U.S.C. 1395w–21(e)(4)(C)) is amended—

(1) in clause (i), by striking ''or'' at the end; and

(2) by adding at the end the following:

''(iii) the organization offering the plan substantially changed the benefits offered under the plan in which the individual enrolled; or''.

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

SEC. 704. GUARANTEED ISSUANCE OF CERTAIN MEDIGAP POLICIES TO DISABLED MEDICARE+CHOICE DISENROLLEES.

(a) IN GENERAL.—Section 1882(s)(3)(C) (42 U.S.C. 1395ss(s)(3)(C)) is amended by adding at the end the following:

''(E) For purposes of this paragraph, in the case of an individual otherwise described in subparagraph (B)(v) except that such individual is under age 65, such individual shall be deemed to be an individual described in such subparagraph''.

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

SEC. 705. ISSUANCE OF SAME MEDIGAP BENEFIT PACKAGE GUARANTEED FOR CERTAIN MEDICARE+CHOICE DISENROLLEES.

(a) IN GENERAL.—Section 1882(s)(3)(C)(ii) (42 U.S.C. 1395ss(s)(3)(C)(ii)) is amended by striking '', if available from the same issuer, or, if not so available,'' and inserting ''or, if not available,''.

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

SEC. 706. PROHIBITION OF ATTAINED-AGE RATING OF PREMIUMS FOR MEDIGAP POLICIES.

Section 1882 (42 U.S.C. 1395ss) is amended by adding at the end the following:

''(v)(1) A Medicare supplemental policy may not be issued or renewed (or otherwise provide coverage after the deadline established under paragraph (2)) in any State unless the premiums for the policy do not increase for an individual under the policy based on the aging of the individual.

''(2) The requirement of paragraph (1) shall apply to premiums for policies under a timetable, recognized by the Secretary, that provides for an appropriate phase-in of such requirement. The Secretary shall recognize as the timetable such timetable as the National Association of

Insurance Commissioners may recommend to the Secretary within 9 months after the date of enactment of this subsection.''.

TITLE VIII—MEDICARE PRESERVATION THROUGH FRAUD PREVENTION

SEC. 801. SITE INSPECTIONS AND BACKGROUND CHECKS.

(a) SITE INSPECTIONS FOR DME SUPPLIERS, COMMUNITY MENTAL HEALTH CENTERS, AND OTHER PROVIDER GROUPS.—Title XVIII (42 U.S.C. 1395 et seq.) is amended by adding at the end the following:

''SITE INSPECTIONS FOR DME SUPPLIERS, COMMUNITY MENTAL HEALTH CENTERS, AND OTHER PROVIDER GROUPS

''SEC. 1897. (a) SITE INSPECTIONS.—

''(1) IN GENERAL.—The Secretary shall conduct a site inspection for each applicable provider (as defined in paragraph (2)) that applies for a provider number in order to provide items or services under this title. Such site inspection shall be in addition to any other site inspection that the Secretary would otherwise conduct with regard to an applicable provider.

''(2) APPLICABLE PROVIDER DEFINED.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), in this section, the term 'applicable provider' means—

"(i) a supplier of durable medical equipment (including items described in section 1834(a)(13));

"(ii) a supplier of prosthetics, orthotics, or supplies (including items described in paragraphs (8) and (9) of section 1861(s));

"(iii) a community mental health center; or

"(iv) any other provider group, as determined by the Secretary.

"(B) EXCEPTION.—In this section, the term 'applicable provider' does not include—

"(i) a physician that provides durable medical equipment (as so described) or prosthetics, orthotics, or supplies (as so described) to an individual as incident to an office visit by such individual; or

"(ii) a hospital that provides durable medical equipment (as described in subparagraph (A)(i)) or prosthetics, orthotics, or supplies (as described in subparagraph

(A)(ii)) to an individual as incident to an emergency room visit by such individual.

''(b) STANDARDS AND REQUIREMENTS.—In conducting the site inspection pursuant to subsection (a), the Secretary shall ensure that the site being inspected is in full compliance with all the conditions and standards of participation and requirements for obtaining Medicare billing privileges under this title.

''(c) TIME.—The Secretary shall conduct the site inspection for an applicable provider prior to the issuance of a provider number to such provider.

''(d) TIMELY REVIEW.—The Secretary shall provide for procedures to ensure that the site inspection required under this section does not unreasonably delay the issuance of a provider number to an applicable provider.''.

(b) BACKGROUND CHECKS.—Title XVIII (42 U.S.C. 1395 et seq.) (as amended by subsection (a)) is amended by adding at the end the following:

''BACKGROUND CHECKS

''SEC. 1898. (a) BACKGROUND CHECK REQUIRED.—Except as provided in subsection (b), the Secretary shall conduct a background check on any individual or entity that applies to the Secretary for a provider number for the purpose of furnishing any item or service under this title. In performing the background check, the Secretary shall—

''(1) conduct the background check before issuing a provider number to an individual or entity;

''(2) include a search of criminal records in the background check; and

''(3) provide for procedures that ensure the background check does not unreasonably delay the issuance of a provider number to an eligible individual or entity.

''(b) USE OF STATE LICENSING PROCEDURE.—The Secretary may use the results of a State licensing procedure as a background check under subsection (a) if the State licensing procedure meets the requirements of subsection (a).

''(c) ATTORNEY GENERAL REQUIRED TO PROVIDE INFORMATION.—

''(1) IN GENERAL.—Upon request of the Secretary, the Attorney General shall provide the criminal background check information referred to in subsection (a)(2) to the Secretary.

''(2) RESTRICTION ON USE OF DISCLOSED INFORMATION.—The Secretary may only use the information disclosed under subsection (a) for the purpose of carrying out the Secretary's responsibilities under this title.

''(d) REFUSAL TO ISSUE PROVIDER NUMBER.—

''(1) AUTHORITY.—In addition to any other remedy available to the Secretary, the Secretary may refuse to issue a provider number to an individual or entity if the Secretary determines, after a background check conducted under this section, that such individual or entity has a history of acts that indicate issuance of a provider number to such individual or entity would be detrimental to the best interests of the program or program beneficiaries. Such acts may include, but are not limited to—

''(A) any bankruptcy;

''(B) any act resulting in a civil judgment against such individual or entity; or

''(C) any felony conviction under Federal or State law.

''(2) REPORTING OF REFUSAL TO ISSUE PROVIDER NUMBER TO THE HEALTH INTEGRITY PROTECTION DATABASE (HIPDB).—A determination to refuse to issue a provider number to an individual or entity as a result of a background check conducted under this section shall be reported to the health integrity protection database established under section 1128E in accordance with the procedures for reporting final adverse actions taken

against a health care provider, supplier, or practitioner under that section.''.

(c) REGULATIONS; EFFECTIVE DATE.—

(1) REGULATIONS.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate such regulations as are necessary to implement the amendments made by subsections (a) and (b).

(2) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) apply to applications received by the Secretary of Health and Human Services on or after January 1, 2000.

(d) USE OF MEDICARE INTEGRITY PROGRAM FUNDS.—The Secretary of Health and Human Services may use funds appropriated or transferred for purposes of carrying out the Medicare integrity program established under section 1893 of the Social Security Act (42 U.S.C. 1395ddd) to carry out the provisions of sections 1897 and 1898 of that Act (as added by subsections (a) and (b)).

SEC. 802. REGISTRATION OF BILLING AGENCIES.

(a) REGISTRATION OF BILLING AGENCIES AND INDIVIDUALS.—Title XVIII (42 U.S.C. 1395 et seq.) (as amended by section 801(b)) is amended by adding at the end the following:

''REGISTRATION OF BILLING AGENCIES AND INDIVIDUALS

''SEC. 1899. (a) REGISTRATION.—The Secretary shall establish procedures for the registration of all applicable persons.

''(b) REQUIRED APPLICATION.—Each applicable person shall submit a registration application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require.

''(c) IDENTIFICATION NUMBER.—If the Secretary approves an application submitted under subsection (b), the Secretary shall assign a unique identification number to the applicable person.

''(d) REQUIREMENT.—Every claim for reimbursement under this title that is compiled and submitted by an applicable person shall contain the identification number that is assigned to the applicable person pursuant to subsection (c).

''(e) TIMELY REVIEW.—The Secretary shall provide for procedures that ensure the timely consideration and determination regarding approval of applications under this section.

''(f) DEFINITION OF APPLICABLE PERSON.—In this section, the term 'applicable person' means an individual or an entity that compiles and submits claims for reim-

bursement under this title to the Secretary on behalf of any individual or entity.''.

(b) PERMISSIVE EXCLUSION.—Section 1128(b) (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following:

''(16) FRAUD BY APPLICABLE PERSON.—An applicable person (as defined in section 1899(f)) that the Secretary determines knowingly submitted or caused to be submitted a claim for reimbursement under title XVIII that the applicable person knows or should know is false or fraudulent.''.

(c) REGULATIONS; EFFECTIVE DATE.—

(1) REGULATIONS.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate such regulations as are necessary to implement the amendments made by subsections (a) and (b).

(2) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) take effect on January 1, 2000.

SEC. 803. EXPANDED ACCESS TO THE HEALTH INTEGRITY PROTECTION DATABASE (HIPDB).

(a) IN GENERAL.—Section 1128E(d)(1) (42 U.S.C. 1320a–7e(d)(1)) is amended to read as follows:

''(1) AVAILABILITY.—The information in the database maintained under this section shall be available to—

''(A) Federal and State government agencies and health plans, and any health care provider, supplier, or practitioner entering an employment or contractual relationship with an individual or entity who could potentially be the subject of a final adverse action, in any case in which the contract involves the furnishing of items or services reimbursed by 1 or more Federal health care programs (regardless of whether the individual or entity is paid by the programs directly, or whether the items or services are reimbursed directly or indirectly through the claims of a direct provider); and

''(B) utilization and quality control peer review organizations and accreditation entities as defined by the Secretary, including but not limited to organizations described in part B of this title and in section 1154(a)(4)(C).''.

(b) CRIMINAL PENALTY FOR MISUSE OF INFORMATION.—Section 1128B(b) (42 U.S.C. 1320a–7b(b)) is amended by adding at the end the following:

''(4) Whoever knowingly uses information maintained in the health integrity protection database maintained in accordance with section 1128E for a purpose other than a purpose authorized under that section shall be imprisoned for not more than 3 years or fined under title 18, United States Code, or both.''.

(c) EFFECTIVE DATES.—

(1) AVAILABILITY.—The amendment made by subsection (a) takes effect on the date of enactment of this Act.

(2) CRIMINAL PENALTY FOR MISUSE OF INFORMATION.—The amendment made by subsection (b) takes effect on the date of enactment of this Act and applies to acts committed on or after the date of enactment of this Act.

SEC. 804. LIABILITY OF MEDICARE CARRIERS AND FISCAL INTERMEDIARIES FOR CLAIMS SUBMITTED BY EXCLUDED PROVIDERS.

(a) REIMBURSEMENT TO THE SECRETARY FOR AMOUNTS PAID TO EXCLUDED PROVIDERS.—

(1) REQUIREMENTS FOR FISCAL INTERMEDIARIES.—

(A) IN GENERAL.—Section 1816 (42 U.S.C. 1395h) is amended by adding at the end the following:

''(m) An agreement with an agency or organization under this section shall require that such agency or organization reimburse the Secretary for any amounts paid by the agency or organization for a service under this title which is furnished by an individual or entity during any period for which the individual or entity is excluded, pursuant to section 1128, 1128A, or 1156, from participation in the health care program under this title if the amounts are paid to the individual or entity excluded from participation—

''(1) after the 60-day period beginning on the date the Secretary provides notice of the exclusion to the agency or organization, unless the payment was made as a result of incorrect information provided by the Secretary; or

''(2) which has concealed or altered their identity.''.

(B) CONFORMING AMENDMENT.—Section 1816(i) (42 U.S.C. 1395h(i)) is amended by adding at the end the following:

''(4) Nothing in this subsection shall be construed to prohibit reimbursement by an agency or organization pursuant to subsection (m).''.

(2) REQUIREMENTS FOR CARRIERS.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(A) by striking ''and'' at the end of subparagraph (I); and

(B) by inserting after subparagraph (I) the following:

''(J) will reimburse the Secretary for any amounts paid by the carrier for an item or service under this part which is furnished by an individual or entity during any period for which the individual or entity is excluded, pursuant to section 1128, 1128A, or 1156, from participation in the health care program under this title if the amounts are paid to the individual or entity excluded from participation—

''(1) after the 60-day period beginning on the date the Secretary provides notice of the exclusion to the agency or organization, unless the payment was made as a result of incorrect information provided by the Secretary; or

''(2) which has concealed or altered their identity; and''.

(b) CONFORMING REPEAL OF MANDATORY PAYMENT RULE.—Section 1862(e) (42 U.S.C. 1395y(e)) is amended—

(1) in paragraph (1)(B), by striking ''and when the person'' and all that follows through ''person)''; and

(2) by amending paragraph (2) to read as follows:

''(2) No individual or entity may bill (or collect any amount from) any individual for any item or service for which payment is denied under paragraph (1). No individual is liable for payment of any amounts billed for such an item or service in violation of the preceding sentence.''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section apply to claims for payment submitted on or after the date of enactment of this Act.

(2) CONTRACT MODIFICATION.—The Secretary of Health and Human Services shall take such steps as may be necessary to modify contracts and agreements entered into, renewed, or extended prior to the date of enactment of this Act to conform such contracts or agreements to the provisions of this section.

SEC. 805. COMMUNITY MENTAL HEALTH CENTERS.

(a) IN GENERAL.—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) provides the community mental health services specified in paragraph (1) of section 1913(c) of the Public Health Service Act;

''(ii) meets applicable certification or licensing requirements for community mental health centers in the State in which it is located;

''(iii) provides a significant share of its services to individuals who are not eligible for benefits under this title; and

''(iv) meets such additional standards or requirements for obtaining Medicare billing privileges as the Secretary may specify to ensure—

''(I) the health and safety of beneficiaries receiving such services; or

''(II) the furnishing of such services in an effective and efficient manner.''.

(b) RESTRICTION.—Section 1861(ff)(3)(A) (42 U.S.C. 1395x(ff)(3)(A)) is amended by inserting ''other than in an individual's home or in an inpatient or residential setting'' before the period.

(c) EFFECTIVE DATE.—The amendments made by this section apply to items and services furnished after the

sixth month that begins after the date of enactment of this Act.

SEC. 806. LIMITING THE DISCHARGE OF DEBTS IN BANKRUPTCY PROCEEDINGS IN CASES WHERE A HEALTH CARE PROVIDER OR A SUPPLIER ENGAGES IN FRAUDULENT ACTIVITY.

(a) IN GENERAL.—

(1) CIVIL MONETARY PENALTIES.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended by adding at the end the following: ''Notwithstanding any other provision of law, amounts made payable under this section are not dischargeable under section 727, 1141, 1228 (a) or (b), or 1328 of title 11, United States Code, or any other provision of such title.''.

(2) RECOVERY OF OVERPAYMENT TO PROVIDERS OF SERVICES UNDER PART A OF MEDICARE.—Section 1815(d) (42 U.S.C. 1395g(d)) is amended—

(A) by inserting ''(1)'' after ''(d)''; and

(B) by adding at the end the following:

''(2) Notwithstanding any other provision of law, amounts due to the Secretary under this section are not dischargeable under section 727, 1141, 1228 (a) or (b), or 1328 of title 11, United States Code, or any other pro-

vision of such title if the overpayment was the result of fraudulent activity, as may be defined by the Secretary.''.

(3) RECOVERY OF OVERPAYMENT OF BENEFITS UNDER PART B OF MEDICARE.—Section 1833(j) (42 U.S.C. 1395l(j)) is amended—

(A) by inserting ''(1)'' after ''(j)''; and

(B) by adding at the end the following:

''(2) Notwithstanding any other provision of law, amounts due to the Secretary under this section are not dischargeable under section 727, 1141, 1228 (a) or (b), or 1328 of title 11, United States Code, or any other provision of such title if the overpayment was the result of fraudulent activity, as may be defined by the Secretary.''.

(4) COLLECTION OF PAST-DUE OBLIGATIONS ARISING FROM BREACH OF SCHOLARSHIP AND LOAN CONTRACT.—Section 1892(a) (42 U.S.C. 1395ccc(a)) is amended by adding at the end the following:

''(5) Notwithstanding any other provision of law, amounts due to the Secretary under this section are not dischargeable under section 727, 1141, 1228 (a) or (b), or 1328 of title 11, United States Code, or any other provision of such title.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to bankruptcy petitions filed after the date of enactment of this Act.

SEC. 807. ILLEGAL DISTRIBUTION OF A MEDICARE OR MEDICAID BENEFICIARY IDENTIFICATION OR PROVIDER NUMBER.

(a) IN GENERAL.—Section 1128B(b) (42 U.S.C. 1320a–7b(b)), as amended by section 803(b), is amended by adding at the end the following:

''(5) Whoever knowingly, intentionally, and with the intent to defraud purchases, sells or distributes, or arranges for the purchase, sale, or distribution of 2 or more Medicare or Medicaid beneficiary identification numbers or provider numbers shall be imprisoned for not more than 3 years or fined under title 18, United States Code (or, if greater, an amount equal to the monetary loss to the Federal and any State government as a result of such acts), or both.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on the date of enactment of this Act and applies to acts committed on or after the date of enactment of this Act.

SEC. 808. TREATMENT OF CERTAIN SOCIAL SECURITY ACT CRIMES AS FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—Section 24(a) of title 18, United States Code, is amended—

(1) by striking the period at the end of paragraph (2) and inserting ''; or''; and

(2) by adding at the end the following:

''(3) section 1128B of the Social Security Act (42 U.S.C. 1320a–7b).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on the date of enactment of this Act and applies to acts committed on or after the date of enactment of this Act.

SEC. 809. AUTHORITY OF OFFICE OF INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(a) AUTHORITY.—Notwithstanding any other provision of law, upon designation by the Inspector General of the Department of Health and Human Services, any criminal investigator of the Office of Inspector General of such department may, in accordance with guidelines issued by the Secretary of Health and Human Services and approved by the Attorney General, while engaged in activities within the lawful jurisdiction of such Inspector General—

(1) obtain and execute any warrant or other process issued under the authority of the United States;

(2) make an arrest without a warrant for—

(A) any offense against the United States committed in the presence of such investigator; or

(B) any felony offense against the United States, if such investigator has reasonable cause to believe that the person to be arrested has committed or is committing that felony offense; and

(3) exercise any other authority necessary to carry out the authority described in paragraphs (1) and (2).

(b) FUNDS.—The Office of Inspector General of the Department of Health and Human Services may receive and expend funds that represent the equitable share from the forfeiture of property in investigations in which the Office of Inspector General participated, and that are transferred to the Office of Inspector General by the Department of Justice, the Department of the Treasury, or the United States Postal Service. Such equitable sharing funds shall be deposited in a separate account and shall remain available until expended.

SEC. 810. UNIVERSAL PRODUCT NUMBERS ON CLAIMS FORMS FOR REIMBURSEMENT UNDER THE MEDICARE PROGRAM.

(a) UPNs ON CLAIMS FORMS FOR REIMBURSEMENT UNDER THE MEDICARE PROGRAM.—

(1) ACCOMMODATION OF UPNS ON MEDICARE CLAIMS FORMS.—Not later than February 1, 2001, all claims forms developed or used by the Secretary of Health and Human Services for reimbursement under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) shall accommodate the use of universal product numbers for a UPN covered item.

(2) REQUIREMENT FOR PAYMENT OF CLAIMS.—Title XVIII (42 U.S.C. 1395 et seq.) (as amended by section 802(a)) is amended by adding at the end the following:

''USE OF UNIVERSAL PRODUCT NUMBERS

''SEC. 1899A. (a) IN GENERAL.—No payment shall be made under this title for any claim for reimbursement for any UPN covered item unless the claim contains the universal product number of the UPN covered item.

''(b) DEFINITIONS.—In this section:

''(1) UPN COVERED ITEM.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'UPN covered item' means—

"(i) a covered item (as defined in section 1834(a)(13));

"(ii) an item described in paragraph (8) or (9) of section 1861(s);

"(iii) an item described in paragraph (5) of section 1861(s); and

"(iv) any other item for which payment is made under this title that the Secretary determines to be appropriate.

"(B) EXCLUSION.—The term 'UPN covered item' does not include a customized item for which payment is made under this title.

"(2) UNIVERSAL PRODUCT NUMBER.—The term 'universal product number' means a number that is—

"(A) affixed by the manufacturer to each individual UPN covered item that uniquely identifies the item at each packaging level; and

"(B) based on commercially acceptable identification standards, such as standards established by the Uniform Code Council-International Article Numbering System or the

Health Industry Business Communication Council.''.

(3) DEVELOPMENT AND IMPLEMENTATION OF PROCEDURES.—

(A) INFORMATION INCLUDED IN UPN.—The Secretary of Health and Human Services, in consultation with manufacturers and entities with appropriate expertise, shall determine the relevant descriptive information appropriate for inclusion in a universal product number for a UPN covered item.

(B) REVIEW OF PROCEDURE.—From the information obtained by the use of universal product numbers on claims for reimbursement under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), the Secretary of Health and Human Services, in consultation with interested parties, shall periodically review the UPN covered items billed under the Health Care Financing Administration Common Procedure Coding System and adjust such coding system to ensure that functionally equivalent UPN covered items are billed and reimbursed under the same codes.

(4) EFFECTIVE DATE.—The amendment made by paragraph (2) applies to claims for reimbursement submitted on and after February 1, 2002.

(b) STUDY AND REPORTS TO CONGRESS.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study on the results of the implementation of the provisions in paragraphs (1) and (3) of subsection (a) and the amendment to the Social Security Act in paragraph (2) of that subsection.

(2) REPORTS.—

(A) PROGRESS REPORT.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress that contains a detailed description of the progress of the matters studied pursuant to paragraph (1).

(B) IMPLEMENTATION.—Not later than 18 months after the date of enactment of this Act, and annually thereafter for 3 years, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress that contains a detailed description of the results of the study conducted pursuant to

paragraph (1), together with the Secretary's recommendations regarding the use of universal product numbers and the use of data obtained from the use of such numbers.

(c) DEFINITIONS.—In this section:

(1) UPN COVERED ITEM.—The term ''UPN covered item'' has the meaning given such term in section 1899A(b)(1) of the Social Security Act (as added by subsection (a)(2)).

(2) UNIVERSAL PRODUCT NUMBER.—The term ''universal product number'' has the meaning given such term in section 1899A(b)(2) of the Social Security Act (as added by subsection (a)(2)).

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for the purpose of carrying out the provisions in paragraphs (1) and (3) of subsection (a), subsection (b), and section 1899A of the Social Security Act (as added by subsection (a)(2)).

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