106TH CONGRESS
1ST SESSION

S. 1678

To amend title XVIII of the Social Security Act to modify the provisions of the Balanced Budget Act of 1997.

IN THE SENATE OF THE UNITED STATES

OCTOBER 1, 1999

Mr. DASCHLE (for himself, Mr. MOYNIHAN, Mr. ROCKEFELLER, Mr. KENNEDY, Mr. KERRY, Mr. BAUCUS, Mr. BINGAMAN, Ms. MIKULSKI, Mr. DURBIN, Mr. REID, Mr. KERREY, Mr. TORRICELLI, Mr. CLELAND, Mrs. BOXER, Mr. JOHNSON, Mr. REED, Mrs. MURRAY, Mr. SCHUMER, Mr. BREAUX, Mr. DODD, Mr. LEVIN, Mr. SARBANES, Mr. LEAHY, Mr. WELLSTONE, Mr. BRYAN, Mr. DORGAN, Mr. LAUTENBERG, Mr. BYRD, Mr. HARKIN, Mrs. FEINSTEIN, Mrs. LINCOLN, Mr. ROBB, Mr. INOUYE, Mr. HOLLINGS and Mr. EDWARDS) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend title XVIII of the Social Security Act to modify the provisions of the Balanced Budget Act of 1997.

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 ''Medicare Beneficiary Access to Care 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 of this Act is as follows:

TITLE I—HOSPITALS

SEC. 101. MULTIYEAR TRANSITION TO PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) IN GENERAL.—Section 1833(t) (42 U.S.C. 1395(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) that the Secretary determines is necessary to ensure that the payment to cost ratio of the hospital for the transition year equals 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 part 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 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 affect-

ing 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) SPECIAL RULE FOR RURAL AND CANCER HOSPITALS.—Section 1833(t) (42 U.S.C. 1395(t)), as amended by subsection (a), is amended by adding at the end the following:

''(11) SPECIAL RULE FOR RURAL AND CANCER HOSPITALS.—

''(A) IN GENERAL.—For each year (or portion thereof), beginning in 2000, in the case of covered OPD services furnished by a medicare-dependent, small rural hospital (as defined in section 1886(d)(5)(G)(iv)), a sole community hospital (as defined in section 1886(d)(5)(D)(iii)), or in a hospital described in section 1886(d)(1)(B)(v), the Secretary shall increase the payments for such services under the prospective payment system established

under this subsection by the amount (if any) that the Secretary determines is necessary to ensure that the payment to cost ratio of the hospital (as determined pursuant to paragraph (10)(B)) for the year equals the payment to cost ratio of the hospital for 1996 (as calculated under clause (ii) of such paragraph).

''(B) INTERIM PAYMENTS.—

''(i) IN GENERAL.—The Secretary shall make interim payments to a hospital during any 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 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).

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

''(D) APPLICATION WITHOUT REGARD TO BUDGET NEUTRALITY.—The 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.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall 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).

SEC. 102. 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 (II)—

(A) by striking ''fiscal year 1999,'' and inserting ''each of fiscal years 1999, 2000, 2001, and 2002,''; and

(B) by inserting ''and'' after the semicolon;

(2) by striking subclauses (III), (IV), and (V); and

(3) by redesignating subclause (VI) as subclause (III).

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take 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).

SEC. 103. CHANGES TO DSH ALLOTMENTS AND TRANSITION RULE.

(a) CHANGE IN DISPROPORTIONATE SHARE HOSPITAL ALLOTMENTS.—Section 1923(f)(2) (42 U.S.C. 1396r–4(f)(2)) is amended, in the table contained in such section and in the DSH Allotments for fiscal years 2000, 2001, and 2002—

(1) for Minnesota, by striking ''16'' and inserting ''33'';

(2) for New Mexico, by striking ''5'' and inserting ''9''; and

(3) for Wyoming, by striking ''0'' and inserting ''0.1''.

(b) MAKING MEDICAID DSH TRANSITION RULE PERMANENT.—Section 4721(e) of the Balanced Budget Act of 1997 is amended—

(1) in the matter before paragraph (1), by striking ''1923(g)(2)(A)'' and ''1396r–4(g)(2)(A)'' and inserting ''1923(g)(2)'' and ''1396r–4(g)(2)'', respectively;

(2) in paragraphs (1) and (2)—

(A) by striking ", and before July 1, 1999"; and

(B) by striking "in such section" and inserting "in subparagraph (A) of such section"; and

(3) by striking "and" at the end of paragraph (1), by striking the period at the end of paragraph (2) and inserting "; and", and by adding at the end the following:

"(3) effective for State fiscal years that begin on or after July 1, 1999, 'or (b)(1)(B)' were inserted in 1923(g)(2)(B)(ii)(I) after '(b)(1)(A)'.".

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

SEC. 104. REVISION OF CRITERIA FOR DESIGNATION AS A CRITICAL ACCESS HOSPITAL.

(a) CRITERIA FOR DESIGNATION.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395i–4(c)(2)(B)(iii)) is amended by striking "to exceed 96 hours" and all that follows before the semicolon and inserting "to exceed, on average, 96 hours per patient".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect 60 days after the date of enactment of this Act.

SEC. 105. SOLE COMMUNITY HOSPITALS AND MEDICARE DEPENDENT HOSPITALS.

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

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

(2) in subclause (IV)—

(A) by striking ''fiscal year 1996 and each subsequent fiscal year'' and inserting ''fiscal years 1996 through 1999''; and

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

(3) by adding at the end the following:

''(V) for fiscal year 2000 and each subsequent fiscal year, the market basket percentage increase.''.

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

TITLE II—GRADUATE MEDICAL EDUCATION

SEC. 201. REVISION OF MULTIYEAR REDUCTION OF INDIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.

(a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended by striking subclauses (III), (IV), and (V) and inserting the following:

"(III) during each of fiscal years 1999 through 2007, 'c' is equal to 1.6; and

"(IV) on or after October 1, 2007, 'c' is equal to 1.35.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in section 4621 of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 475).

SEC. 202. ACCELERATION OF GME PHASE-IN.

(a) ACCELERATION OF PAYMENT TO HOSPITALS OF INDIRECT AND DIRECT MEDICAL EDUCATION COSTS FOR MEDICARE+CHOICE ENROLLEES.—

(1) IN GENERAL.—Section 1886(h)(3)(D)(ii) (42 U.S.C. 1395ww(h)(3)(D)(ii)) is amended by striking subclauses (IV) and (V) and inserting the following:

''(IV) 100 percent in 2001 and subsequent years.''.

(2) ACCELERATION OF CARVE-OUT.—Section 1853(c)(3)(B)(ii) (42 U.S.C. 1395w–23(c)(3)(B)(ii)) is amended—

(A) in subclause (III), by inserting ''and'' at the end;

(B) by striking subclause (IV); and

(C) by redesignating subclause (V) as subclause (IV).

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

SEC. 203. 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) in subclause (I), by striking ''and'' at the end;

(B) in subclause (II), by striking the period at the end 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) shall 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) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following:

"(V)(i) In determining the amount of payment to a hospital for portions of cost reporting periods 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.

"(ii) The Secretary shall establish rules for applying clause (i) to a hospital reimbursed under a reimbursement system authorized under section 1814(b)(3) in the same

manner as it would apply to the hospital if it were not reimbursed under such section.''.

SEC. 204. ADJUSTMENTS TO LIMITATIONS ON NUMBER OF INTERNS AND RESIDENTS.

(a) INDIRECT GRADUATE MEDICAL EDUCATION ADJUSTMENT.—Section 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is amended—

(1) by striking ''(v) In determining'' and inserting ''(v)(I) Subject to subclause (II), in determining'';

(2) by striking ''in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996'' and inserting ''who were appointed by the hospital's approved medical residency training programs for the hospital's most recent cost reporting period ending on or before December 31, 1996''; and

(3) by adding at the end the following:

''(II) Beginning on or after January 1, 1997, in the case of a hospital that sponsors only 1 allopathic or osteopathic residency program, the limit determined for such hospital under subclause (I) may, at the hospital's discretion, be increased by 1 for each calendar year but shall not exceed a total of 3 more than the limit determined for the hospital under subclause (I).''.

(b) DIRECT GRADUATE MEDICAL EDUCATION ADJUSTMENT.—

(1) LIMITATION ON NUMBER OF RESIDENTS.—Section 1886(h)(4)(F) (42 U.S.C. 1395ww(h)(4)(F)) is amended by inserting ''who were appointed by the hospital's approved medical residency training programs'' after ''may not exceed the number of such full-time equivalent residents''.

(2) FUNDING FOR PROGRAMS.—Section 1886(h)(4)(H)(i) (42 U.S.C. 1395ww(h)(4)(H)(i)) is amended in the second sentence, by inserting '', including facilities that are not located in an underserved rural area but have established separately accredited rural training tracks'' before the period.

(c) GME PAYMENTS FOR CERTAIN INTERNS AND RESIDENTS.—

(1) INDIRECT AND DIRECT MEDICAL EDUCATION.—Each limitation regarding the number of residents or interns for which payment may be made under section 1886 of the Social Security Act (42 U.S.C. 1395ww) is increased by the number of applicable residents (as defined in paragraph (2)).

(2) APPLICABLE RESIDENT DEFINED.—In this subsection, the term ''applicable resident'' means a resident or intern that—

(A) participated in graduate medical education at a facility of the Department of Veterans Affairs;

(B) was subsequently transferred on or after January 1, 1997, and before July 31, 1998, to a hospital and the hospital was not a Department of Veterans Affairs facility; and

(C) was transferred because the approved medical residency program in which the resident or intern participated would lose accreditation by the Accreditation Council on Graduate Medical Education if such program continued to train residents at the Department of Veterans Affairs facility.

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

TITLE III—HOSPICE CARE

SEC. 301. INCREASE IN PAYMENTS FOR HOSPICE CARE.

(a) IN GENERAL.—Section 1814(i)(1)(C)(ii)(VI) (42 U.S.C. 1395f(i)(1)(C)(ii)(VI)) is amended by striking ''through 2002'' and inserting ''and 1999''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the amend-

ments made by section 4441 of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 422).

TITLE IV—SKILLED NURSING FACILITIES

SEC. 401. 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 April 1, 2000, and before the earlier of October 1, 2001, or the date described in subsection (d), 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
RUB	$23.06
RVC	$76.25
RVB	$30.36
RHC	$54.07
RHB	$27.28
RMC	$69.98
RMB	$30.09
SE3	$98.41
SE2	$89.05
SSC	$46.80
SSB	$55.56
SSA	$59.94.

(b) UPDATE.—The Secretary shall update 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) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as permitting the Secretary of Health and Human Services to include any applicable payment add-on determined under subsection (a) in updating the Federal per diem rate under section 1888(e)(4) of the Social Security Act (42 U.S.C. 1395yy(e)(4)).

(d) DATE DESCRIBED.—The date described in this subsection is the date that the Secretary of Health and Human Services—

(1) refines the case mix classification system under section 1888(e)(4)(G)(i) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(G)(i)) to better account for medically complex patients; and

(2) implements such refined system.

SEC. 402. EXCLUSION OF CLINICAL SOCIAL WORKER SERVICES AND SERVICES PERFORMED UNDER A CONTRACT WITH A RURAL HEALTH CLINIC OR FEDERALLY QUALIFIED HEALTH CENTER FROM THE PPS FOR SNFs.

(a) IN GENERAL.—Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended—

(1) in the first sentence, by inserting ''clinical social worker services,'' after ''qualified psychologist services,''; and

(2) by inserting after the first sentence the following: ''Services described in this clause also include services that are provided by a physician, a physician assistant, a nurse practitioner, a qualified psychologist, or a clinical social worker who is employed, or otherwise under contract, with a rural health clinic or a Federally qualified health center.''.

(b) CONFORMING AMENDMENT.—Section 1861(hh)(2) (42 U.S.C. 1395x(hh)(2)) is amended by striking ''and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided on or after the date which is 60 days after the date of enactment of this Act.

SEC. 403. EXCLUSION OF CERTAIN SERVICES FROM THE PPS FOR SNFs.

(a) IN GENERAL.—Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)), as amended by section 402, is amended—

(1) in the first sentence, by inserting ''ambulance services, services identified by HCPCS code in Program Memorandum Transmittal No. A–98–37 issued in November 1998 (but without regard to the setting in which such services are furnished),'' after ''subparagraphs (F) and (O) of section 1861(s)(2),''; and

(2) by inserting after the second sentence the following: ''In addition to the services described in the previous sentences, services described in this clause include chemotherapy items (identified as of July 1, 1999, by HCPCS codes J9000–J9020, J9040–J9151, J9170–J9185, J9200–J9201, J9206–J9208, J9211, J9230–J9245, and J9265–J9600), chemotherapy administration services (identified as of July 1, 1999, by HCPCS codes 36260–36262, 36489, 36530–36535, 36640, 36823, and 96405–96542), radioisotope services (identified as of July 1, 1999, by HCPCS codes 79030–79440), and customized prosthetic devices (identified as of July 1, 1999, by HCPCS codes L5050–L5340, L5500–

L5610, L5613–L5986, L5988, L6050–L6370, L6400–L6880, L6920–L7274, and L7362–L7366).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after the date which is 60 days after the date of enactment of this Act.

SEC. 404. EXCLUSION OF SWING BEDS IN CRITICAL ACCESS HOSPITALS FROM THE PPS FOR SNFs.

(a) IN GENERAL.—Section 1888(e)(7) of the Social Security Act (42 U.S.C. 1395yy(e)(7)) is amended—

(1) in the heading, by striking ''TRANSITION'' and inserting ''SPECIAL RULES'';

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

(3) by adding at the end the following:

''(C) EXEMPTION OF SWING BEDS IN CRITICAL ACCESS HOSPITALS FROM PPS.—The prospective payment system under this subsection shall not apply (and section 1834(g) shall apply) to services provided by a critical access hospital under an agreement described in subparagraph (B).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided on or after October 1, 1999.

TITLE V—OUTPATIENT REHABILITATION SERVICES

SEC. 501. MODIFICATION OF FINANCIAL LIMITATION ON REHABILITATION SERVICES.

(a) 3-YEAR REPEAL.—Section 1833(g) (42 U.S.C. 1395l(g)) is amended by adding at the end the following:

''(4) Subject to paragraph (6), the provisions of paragraphs (1) through (3) shall not apply to 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.

''(5)(A) Notwithstanding the preceding provisions of this subsection and subject to subparagraph (B), with respect to services described in paragraph (4) that are furnished on or after January 1, 2003, the Secretary shall implement, by not later than January 1, 2003, a payment system for such services that takes into account the needs of beneficiaries under this title for differing amounts of therapy based on factors such as diagnosis, functional status, and prior use of services.

''(B) The payment system established under subparagraph (A) shall be designed so that the system shall not result in any increase or decrease in the expenditures under this title on a fiscal year basis, determined as if paragraph (4) had not been enacted.

''(6) If the Secretary for any reason does not implement the payment system described in paragraph (5) on or before January 1, 2003, paragraph (4) shall not apply with respect to services described in such paragraph that are furnished on or after such date and before the date on which the Secretary implements such payment system.''.

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

TITLE VI—PHYSICIANS' SERVICES

SEC. 601. TECHNICAL AMENDMENT TO UPDATE ADJUSTMENT FACTOR AND PHYSICIAN SUSTAINABLE GROWTH RATE.

(a) UPDATE ADJUSTMENT FACTOR.—

(1) CHANGE TO CALENDAR YEAR BASIS.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended—

(A) in paragraph (1), by striking subparagraph (E) and inserting the following:

''(E) PUBLICATION.—The Secretary shall publish in the Federal Register—

''(i) not later than November 1 of each year (beginning with 1999), the conversion factor that will apply to physicians' services for the succeeding year and the update determined under paragraph (3) for such year; and

''(ii) not later than November 1 of 1999—

''(I) the special update for the year 2000 under paragraph (3)(E)(i); and

''(II) the estimated special adjustments for years 2001 through 2006 under paragraph (3)(E)(ii).''; and

(B) in paragraph (3)(C)—

(i) in the matter preceding clause (i), by striking ''the 12-month period ending with March 31 of'';

(ii) in clause (i)—

(I) by striking ''1997'' and inserting ''1996,''; and

(II) by striking ''such 12-month period'' and inserting ''1996''; and

(iii) in clause (ii)—

(I) by inserting a comma after ''subsequent year''; and

(II) by striking ''fiscal year which begins during such 12-month period'' and inserting ''year involved''.

(2) FORMULA FOR DETERMINING THE UPDATE ADJUSTMENT FACTOR.—Section 1848(d)(3) (42 U.S.C. 1395w–4(d)(3)) is amended—

(A) in subparagraph (A)—

(i) in clause (ii), by striking ''(divided by 100),'' and inserting a period; and

(ii) by striking the matter following clause (ii);

(B) in subparagraph (B)—

(i) in the matter preceding clause (i), by inserting ''the sum of'' after ''Secretary) to''; and

(ii) by striking clauses (i) and (ii) and inserting the following:

''(i) the figure arrived at by—

''(I) determining the difference between the allowed expenditures for physicians' services for the prior year (as determined under subparagraph (C)) and the actual expenditures for such services for that year;

''(II) dividing that difference by the actual expenditures for such services in that year; and

''(III) multiplying that quotient by 0.75; and

''(ii) the figure arrived at by—

''(I) determining the difference between the allowed expenditures for physicians' services (as determined under subparagraph (C)) from 1996 through the prior year and the actual expenditures for such services during that period, corrected with the best available data;

''(II) dividing that difference by actual expenditures for such services for the prior year as increased by the sustainable growth rate under subsection (f) for the year whose update

adjustment factor is to be determined; and

''(III) multiplying that quotient by 0.33.''; and

(C) by amending subparagraph (D) to read as follows:

''(D) RESTRICTION ON UPDATE ADJUSTMENT FACTOR.—The update adjustment factor determined under subparagraph (B) for a year may not be less than negative 0.07 or greater than 0.03.''.

(3) SPECIAL PROVISIONS.—Section 1848(d)(3) (42 U.S.C. 1395w–4(d)(3)) is amended—

(A) in subparagraph (A), in the matter preceding clause (i), by striking ''subparagraph (D)'' and inserting ''subparagraphs (D) and (E)''; and

(B) by adding at the end the following:

''(E) SPECIAL UPDATE AND ADJUSTMENTS.—

''(i) YEAR 2000.—For the year 2000, the update under this paragraph shall be the percentage that the Secretary estimates will, without regard to any otherwise applicable restriction, result in expendi-

tures equal to the expenditures that would have occurred in that year in the absence of the amendments made by section 601 of the Medicare Beneficiary Access to Care Act of 1999.

''(ii) YEARS 2001–2006.—For each of the years 2001 through 2006, the Secretary shall make that adjustment to the update for that year which the Secretary estimates will, without regard to any otherwise applicable restriction, result in expenditures equal to the expenditures that would have occurred for that year in the absence of the amendments made by section 601 of the Medicare Beneficiary Access to Care Act of 1999.''.

(b) SUSTAINABLE GROWTH RATE.—Section 1848(f) (42 U.S.C. 1395w–4(f)) is amended—

(1) by striking paragraph (1) and inserting the following:

''(1) PUBLICATION.—Not later than November 1 of each year (beginning with 1999), the Secretary shall publish in the Federal Register the sustainable growth rate as determined under this subsection for

the succeeding year, the current year, and each of the preceding 2 years.''; and

(2) in paragraph (2)—

(A) by striking ''fiscal'' each place it appears; and

(B) in the matter preceding subparagraph (A), by striking ''year 1998'' and inserting ''1997''.

(c) DATA TO BE USED IN DETERMINING THE SUSTAINABLE GROWTH RATE.—Section 1848(f) (42 U.S.C. 1395w–4(f)) is amended—

(1) by redesignating paragraph (3) as paragraph (4); and

(2) by inserting after paragraph (2) the following:

''(3) METHODOLOGY.—For purposes of determining the update adjustment factor under subsection (d)(3)(B) and the allowed expenditures under subsection (d)(3)(C) for a year, the sustainable growth rate for each year taken into consideration in the determination under paragraph (2) shall be determined as follows:

''(A) For purposes of such calculations for the year 2000, the sustainable growth rate shall be determined on the basis of the best data

available to the Secretary as of September 1, 1999.

''(B) For purposes of such calculations for each year after the year 2000—

''(i) the sustainable growth rate for such year and each of the 2 preceding years shall be determined on the basis of the best data available to the Secretary as of September 1 of such year; and

''(ii) the sustainable growth rate for each year preceding the years specified in clause (i) shall be the rate used for such year in such calculation for the immediately preceding year.''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by this section shall take effect as if included in the enactment of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 251).

(2) NO EFFECT ON UPDATES FOR 1998 AND 1999.—The amendments made by this section shall have no effect on the updates established by the Secretary for 1998 and 1999, and such established updates may not be changed.

SEC. 602. PUBLICATION OF ESTIMATE OF CONVERSION FACTOR AND MEDPAC REVIEW.

(a) PUBLICATION.—Not later than April 15 of each year (beginning in 2000), the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall publish in the Federal Register—

(1) an estimate of the single conversion factor to be used in the next calendar year for reimbursement of physicians services under section 1848 of the Social Security Act (42 U.S.C. 1395w–4); and

(2) the data on which such estimate is based.

(b) MEDPAC REVIEW AND REPORT.—

(1) REVIEW.—The Medicare Payment Advisory Commission (in this section referred to as ''MedPAC'') shall annually review the estimates and data published by the Secretary pursuant to subsection (a).

(2) REPORT.—Not later than June 30 of each year (beginning in 2000), MedPAC shall submit a report to the Secretary and to the committees of jurisdiction in Congress on the review conducted pursuant to paragraph (1), together with any recommendations as determined appropriate by MedPAC.

TITLE VII—HOME HEALTH

SEC. 701. DELAY IN THE 15 PERCENT REDUCTION IN PAYMENTS UNDER THE PPS FOR HOME HEALTH SERVICES.

(a) CONTINGENCY REDUCTION.—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 by striking ''September 30, 2000'' and inserting ''September 30, 2002''.

(b) PROSPECTIVE PAYMENT SYSTEM.—Section 1895(b)(3)(A) (42 U.S.C. 1395fff(b)(3)(A)), as amended by section 5101 of the Tax and Trade Relief Extension Act of 1998 (contained in division J of Public Law 105–277), is amended by striking clause (i) and inserting the following:

''(i) IN GENERAL.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts) as follows:

''(I) Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the

total amounts payable under the system for fiscal year 2001, shall be equal to the total amount that would have been made if the system had not been in effect;

"(II) For fiscal year 2003 such amount (or amounts), shall be equal to the amount (or amounts) that would have been determined under subclause (I), if the reduction in limits described in clause (ii) had been in effect for fiscal year 2001, and updated under subparagraph (B) for fiscal years 2002 and 2003.

Each such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.".

SEC. 702. INCREASE IN PER VISIT LIMIT.

(a) INTERIM PAYMENT SYSTEM.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)), as amended by section 701(b), 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.''.

(b) ENSURING THE INCREASE IN PER VISIT LIMIT HAS NO EFFECT ON THE PROSPECTIVE PAYMENT SYSTEM.—The second sentence of section 1895(b)(3)(A)(i) (42 U.S.C. 1395fff(b)(3)(A)(i)), as amended by section 5101(c)(1)(B) of the Tax and Trade Relief Extension Act of 1998 (contained in division J of Public Law 105–277) and section 701(b), is amended—

(1) in subclause (I), by inserting ''but if the reference in section 1861(v)(1)(L)(i)(VI) to 112 percent were a reference to 106 percent'' after ''if the system had not been in effect''; and

(2) in subclause (II), by inserting ''and if the reference in section 1861(v)(1)(L)(i)(VI) to 112 per-

cent were a reference to 106 percent'' after ''clause (ii) had been in effect for fiscal year 2001''.

SEC. 703. TREATMENT OF OUTLIERS.

(a) WAIVER OF PER BENEFICIARY LIMITS FOR OUTLIERS.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)), as amended by section 5101 of the Tax and Trade Relief Extension Act of 1998 (contained in division J of Public Law 105–277), is amended—

(1) by redesignating clause (ix) as clause (x); and

(2) by inserting after clause (viii) the following:

''(ix)(I) Notwithstanding the applicable per beneficiary limit under clause (v), (vi), or (viii), but subject to the applicable per visit limit under clause (i), in the case of a provider that demonstrates to the Secretary that with respect to an individual to whom the provider furnished home health services appropriate to the individual's condition (as determined by the Secretary) at a reasonable cost (as determined by the Secretary), and that such reasonable cost significantly exceeded such applicable per beneficiary limit because of unusual variations in the type or amount of medically necessary care required to treat the individual, the Secretary, upon application by the provider, shall pay to such provider for such individual such reasonable cost.

''(II) The total amount of the additional payments made to home health agencies pursuant to subclause (I) in any fiscal year shall not exceed an amount equal to 2 percent of the amounts that would have been paid under this subparagraph in such year if this clause had not been enacted.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date of enactment of this Act, and shall apply to each application for payment of reasonable costs for outliers submitted by any home health agency for cost reporting periods ending on or after October 1, 1999.

SEC. 704. ELIMINATION OF 15-MINUTE BILLING REQUIREMENT.

(a) IN GENERAL.—Section 1895(c) (42 U.S.C. 1395fff(c)) is amended to read as follows:

''(c) REQUIREMENTS FOR PAYMENT INFORMATION.—With respect to home health services furnished on or after October 1, 1998, no claim for such a service may be paid under this title unless the claim has the unique identifier (provided under section 1842(r)) for the physician who prescribed the services or made the certification described in section 1814(a)(2) or 1835(a)(2)(A).''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to claims submitted on or after

the date which is 60 days after the date of enactment of this section.

SEC. 705. RECOUPMENT OF OVERPAYMENTS.

(a) 36-MONTH REPAYMENT PERIOD.—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 ratably over a 36-month period beginning on the date of notification of such overpayment.

(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 of cost reporting periods, beginning on or after the date of the 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) shall apply to debts that are outstanding as of the date of enactment of this Act.

SEC. 706. REFINEMENT OF HOME HEALTH AGENCY CONSOLIDATED BILLING.

(a) IN GENERAL.—Section 1842(b)(6)(F) (42 U.S.C. 1395u(b)(6)(F)) is amended by inserting ''(including medical supplies described in section 1861(m)(5), but excluding durable medical equipment described in such section)'' after ''home health services''.

(b) CONFORMING AMENDMENT.—Section 1862(a)(21) (42 U.S.C. 1395y(a)(21)) is amended by inserting ''(including medical supplies described in section 1861(m)(5), but excluding durable medical equipment described in such section)'' after ''home health services''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take 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).

TITLE VIII—MEDICARE+CHOICE

SEC. 801. DELAY IN ACR DEADLINE UNDER THE MEDICARE+CHOICE PROGRAM.

(a) DELAY IN DEADLINE FOR SUBMISSION OF ADJUSTED COMMUNITY RATES AND RELATED INFORMA-

TION.—Section 1854(a)(1) (42 U.S.C. 1395w–24(a)(1)) is amended by striking ''May 1'' and inserting ''July 1''.

(b) ADJUSTMENT IN INFORMATION DISCLOSURE PROVISIONS.—Section 1851(d)(2)(A)(ii) (42 U.S.C. 1395w–21(d)(2)(A)(ii)) is amended in the first sentence by inserting '', to the extent such information is available at the time of preparation of the material for mailing'' before the period.

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

SEC. 802. CHANGE IN TIME PERIOD FOR EXCLUSION OF MEDICARE+CHOICE ORGANIZATIONS THAT HAVE HAD A CONTRACT TERMINATED.

(a) IN GENERAL.—Section 1857(c)(4) (42 U.S.C. 1395w–27(c)(4)) is amended by striking ''5-year period'' and inserting ''3-year period''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to contract years beginning on or after January 1, 1999.

SEC. 803. ENROLLMENT OF MEDICARE BENEFICIARIES IN ALTERNATIVE MEDICARE+CHOICE PLANS AND MEDIGAP COVERAGE IN CASE OF INVOLUNTARY TERMINATION OF MEDICARE+CHOICE ENROLLMENT.

(a) PERMITTING ENROLLMENT IN ALTERNATIVE PLANS UPON RECEIPT OF NOTICE OF MEDICARE+CHOICE PLAN TERMINATION.—

(1) 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;".

(2) MEDIGAP PLANS.—

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

(i) 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'';

(ii) 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

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

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

(b) GUARANTEED ACCESS FOR CERTAIN MEDICARE BENEFICIARIES TO MEDIGAP POLICIES IN CASE OF INVOLUNTARY TERMINATION OF COVERAGE UNDER A MEDICARE+CHOICE PLAN.—

(1) IN GENERAL.—Section 1882(s)(3)(C)(iii) (42 U.S.C. 1395ss(s)(3)(C)(iii)) is amended by inserting ''or an individual described in clause (ii) or (iii) of subparagraph (B) in the case of circumstances described in section 1851(e)(4)(A)'' after ''subparagraph (B)(vi)''.

(2) EFFECTIVE DATE.—

(A) IN GENERAL.—Subject to subparagraph (B), the amendment made by paragraph (1) shall apply to terminations of coverage effected on or after the date of enactment of this Act.

(B) TRANSITIONAL MEDIGAP OPEN ENROLLMENT PERIOD FOR CERTAIN INDIVIDUALS AFFECTED BY PLAN WITHDRAWALS.—In the case of an individual described in clause (ii) or (iii) of subparagraph (B) of section 1882(s)(3) of the Social Security Act in the case of circumstances described in section 1851(e)(4)(A) of such Act (relating to discontinuation of a plan or organization entirely or in an area), if the termination or discontinuation of coverage occurred after December 31, 1998, and before the date of enactment of this Act, the provisions of subparagraph (A) of section 1882(s)(3)

such Act (in the matter up to and including clause (iii) thereof) shall apply to such an individual who seeks enrollment under a medicare supplemental policy during the 92-day period beginning with the first month that begins more than 30 days after the date of enactment of this Act in the same manner as such provisions apply to an individual described in the matter following such clause (iii).

SEC. 804. APPLYING MEDIGAP AND MEDICARE+CHOICE PROTECTIONS TO DISABLED AND ESRD MEDICARE BENEFICIARIES.

(a) ASSURING AVAILABILITY OF MEDIGAP COVERAGE.—

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

(A) in paragraph (2)(A), by striking ''is 65 years of age or older and is'' and inserting ''is first'';

(B) in paragraph (2)(D), by striking ''who is 65 years of age or older as of the date of issuance and''; and

(C) in paragraph (3)(B)(vi), by striking ''at age 65''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to terminations of coverage effected on or after the date of enactment of this Act, regardless of when the individuals become eligible for benefits under part A or B of title XVIII of the Social Security Act.

(b) PERMITTING ESRD BENEFICIARIES TO ELECT ANOTHER MEDICARE+CHOICE PLAN IN CASE OF PLAN DISCONTINUANCE.—

(1) 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 section 1851(e)(4)(A) the individual will be treated as a 'Medicare+Choice eligible individual' for

purposes of electing to continue enrollment in another Medicare+Choice plan.''.

(2) EFFECTIVE DATE.—

(A) The amendment made by paragraph (1) shall apply to terminations and discontinuations occurring on or after the date of enactment of this Act.

(B) Clause (ii) of section 1851(a)(3)(B) of the Social Security Act (as inserted by such amendment) 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 enactment of this Act. In applying this subparagraph, 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 enactment of this Act.

SEC. 805. EXTENDED MEDICARE+CHOICE DISENROLLMENT WINDOW FOR CERTAIN INVOLUNTARILY TERMINATED ENROLLEES.

(a) PREVIOUS MEDIGAP ENROLLEES.—Section 1882(s)(3)(B)(v)(III) (42 U.S.C. 1395ss(s)(3)(B)(v)(III)) is amended—

(1) by inserting ''(aa)'' after ''(III)'';

(2) by striking the period and inserting ", or"; and

(3) by adding at the end the following:

"(bb) during the 12-month period described in item (aa), is disenrolled under the circumstances described in section 1851(e)(4)(A) from the organization described in subclause (II); enrolls, without an intervening enrollment, with another such organization; and subsequently disenrolls during such period (during which the enrollee is permitted to disenroll under section 1851(e)).".

(b) INITIAL MEDIGAP ENROLLEES.—Section 1882(s)(3)(B)(vi) (42 U.S.C. 1395ss(s)(3)(B)(vi)), as amended by section 804(a)(1)(C), is amended—

(1) by striking "benefits under part A, enrolls" and inserting "benefits under part A—

"(I) enrolls";

(2) by striking the period and inserting ", or"; and

(3) by adding at the end the following:

"(II)(aa) enrolls in a Medicare+Choice plan under part C, which enrollment is terminated or discontinued under the circumstances described in section 1851(e)(4)(A), and

''(bb) subsequently enrolls, without an intervening enrollment, in another Medicare+Choice plan, and disenrolls from such plan by not later than 12 months after the effective date of the enrollment in the Medicare+Choice plan described in item (aa).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to terminations and discontinuations occurring on or after the date of enactment of this Act.

SEC. 806. NONPREEMPTION OF STATE PRESCRIPTION DRUG COVERAGE MANDATES IN CASE OF APPROVED STATE MEDIGAP WAIVERS.

(a) IN GENERAL.—Section 1856(b)(3) (42 U.S.C. 1395w–26(b)(3)) is amended—

(1) in subparagraph (A), by striking ''The standards'' and inserting ''Subject to subparagraph (C), the standards''; and

(2) by adding at the end the following:

''(C) CONTINUATION OF STATE PRESCRIPTION DRUG LAWS.—Subparagraph (A) shall not supersede any State law that requires the comprehensive coverage of prescription drugs or any regulation that carries out such a law, if—

''(i) the State has a waiver in effect under section 1882(p)(6)(A) with respect to requiring such coverage under Medicare supplemental policies; or

''(ii) the Secretary provides for a waiver for the State to impose such a requirement under section 1882(p)(6)(B).''.

(b) MEDIGAP WAIVER.—Section 1882(p)(6) (42 U.S.C. 1395ss(p)(6)) is amended—

(1) by inserting ''(A)'' after ''(6)''; and

(2) by adding at the end the following:

''(B) The Secretary also may waive the application of the standards described in paragraph (1)(A)(i) so that a State may include comprehensive prescription drug coverage among the benefits required for all Medicare supplemental policies.''.

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

SEC. 807. MODIFICATION OF PAYMENT RULES FOR CERTAIN FRAIL ELDERLY MEDICARE BENEFICIARIES.

(a) MODIFICATION OF PAYMENT RULES.—Section 1853 (42 U.S.C. 1395w–23) is amended—

(1) in subsection (a)—

(A) in paragraph (1)(A), by striking ''subsections (e) and (f)'' and inserting ''subsections (e) through (i)'';

(B) in paragraph (3)(D), by inserting ''and paragraph (4)'' after ''section 1859(e)(4)''; and

(C) by adding at the end the following:

''(4) EXEMPTION FROM RISK-ADJUSTMENT SYSTEM FOR FRAIL ELDERLY BENEFICIARIES ENROLLED IN SPECIALIZED PROGRAMS FOR THE FRAIL ELDERLY.—

''(A) IN GENERAL.—During the period described in subparagraph (B), the risk-adjustment described in paragraph (3) shall not apply to a frail elderly Medicare+Choice beneficiary (as defined in subsection (i)(3)) who is enrolled in a Medicare+Choice plan under a specialized program for the frail elderly (as defined in subsection (i)(2)).

''(B) PERIOD OF APPLICATION.—The period described in this subparagraph begins with January 2000, and ends with the first month for which the Secretary certifies to Congress that a comprehensive risk adjustment methodology under paragraph (3)(C) (that takes into

account the types of factors described in subsection (i)(1)) is being fully implemented.''; and

(2) by adding at the end the following:

''(i) SPECIAL RULES FOR FRAIL ELDERLY ENROLLED IN SPECIALIZED PROGRAMS FOR THE FRAIL ELDERLY.—

''(1) DEVELOPMENT AND IMPLEMENTATION OF NEW PAYMENT SYSTEM.—The Secretary shall develop and implement (as soon as possible after the date of enactment of this subsection), during the period described in subsection (a)(4)(B), a payment methodology for frail elderly Medicare+Choice beneficiaries enrolled in a Medicare+Choice plan under a specialized program for the frail elderly (as defined in paragraph (2)(A)). Such methodology shall account for the prevalence, mix, and severity of chronic conditions among such beneficiaries and shall include medical diagnostic factors from all provider settings (including hospital and nursing facility settings). It shall include functional indicators of health status and such other factors as may be necessary to achieve appropriate payments for plans serving such beneficiaries.

''(2) SPECIALIZED PROGRAM FOR THE FRAIL ELDERLY DESCRIBED.—

"(A) IN GENERAL.—For purposes of this part, the term 'specialized program for the frail elderly' means a program which the Secretary determines—

"(i) is offered under this part as a distinct part of a Medicare+Choice plan;

"(ii) primarily enrolls frail elderly Medicare+Choice beneficiaries; and

"(iii) has a clinical delivery system that is specifically designed to serve the special needs of such beneficiaries and to coordinate short-term and long-term care for such beneficiaries through the use of a team described in subparagraph (B) and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

"(B) SPECIALIZED TEAM.—A team described in this subparagraph—

"(i) includes—

"(I) a physician; and

"(II) a nurse practitioner or geriatric care manager, or both; and

"(ii) has as members individuals who have special training and specialize in the

care and management of the frail elderly beneficiaries.

''(3) FRAIL ELDERLY MEDICARE+CHOICE BENEFICIARY DESCRIBED.—For purposes of this part, the term 'frail elderly Medicare+Choice beneficiary' means a Medicare+Choice eligible individual who—

''(A) is residing in a skilled nursing facility or a nursing facility (as defined for purposes of title XIX) for an indefinite period and without any intention of residing outside the facility; and

''(B) has a severity of condition that makes the individual frail (as determined under guidelines approved by the Secretary).''.

(b) CONTINUOUS OPEN ENROLLMENT FOR CERTAIN FRAIL ELDERLY MEDICARE BENEFICIARIES.—

(1) IN GENERAL.—Section 1851(e) (42 U.S.C. 1395w–21(e)) is amended by adding at the end the following:

''(7) SPECIAL RULES FOR FRAIL ELDERLY MEDICARE+CHOICE BENEFICIARIES ENROLLING IN SPECIALIZED PROGRAMS FOR THE FRAIL ELDERLY.—There shall be a continuous open enrollment period for any frail elderly Medicare+Choice beneficiary (as defined in section 1853(i)(3)) who is

seeking to enroll in a Medicare+Choice plan under a specialized program for the frail elderly (as defined in section 1853(i)(2)).''.

(2) CONFORMING AMENDMENTS.—

(A) OPEN ENROLLMENT PERIODS.—Section 1851(e)(6) (42 U.S.C. 1395w–21(e)(6)) is amended—

(i) in subparagraph (A), by striking ''and'' at the end;

(ii) by redesignating subparagraph (B) as subparagraph (C); and

(iii) by inserting after subparagraph (A) the following:

''(B) that is offering a specialized program for the frail elderly (as defined in section 1853(i)(2)), shall accept elections at any time for purposes of enrolling frail elderly Medicare+Choice beneficiaries (as defined in section 1853(i)(3)) in such program; and''.

(B) EFFECTIVENESS OF ELECTIONS.—Section 1851(f)(4) (42 U.S.C. 1395w–21(f)(4)) is amended by striking ''subsection (e)(4)'' and inserting ''paragraph (4) or (7) of subsection (e)''.

(c) DEVELOPMENT OF QUALITY MEASUREMENT PROGRAM FOR SPECIALIZED PROGRAMS FOR THE FRAIL ELDERLY.—Section 1852(e) (42 U.S.C. 1395w–22(e)) is amended by adding at the end the following:

''(5) QUALITY MEASUREMENT PROGRAM FOR SPECIALIZED PROGRAMS FOR THE FRAIL ELDERLY AS PART OF MEDICARE+CHOICE PLANS.—The Secretary shall develop and implement a program to measure the quality of care provided in specialized programs for the frail elderly (as defined in section 1853(i)(2)) in order to reflect the unique health aspects and needs of frail elderly Medicare+Choice beneficiaries (as defined in section 1853(i)(3)). Such quality measurements may include indicators of the prevalence of pressure sores, reduction of iatrogenic disease, use of urinary catheters, use of antianxiety medications, use of advance directives, incidence of pneumonia, and incidence of congestive heart failure.''.

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of enactment of this Act.

(2) DEVELOPMENT OF QUALITY MEASUREMENT PROGRAM FOR SPECIALIZED PROGRAMS FOR THE FRAIL ELDERLY.—The Secretary of Health and Human Services shall first provide for the implementation of the quality measurement program for specialized programs for the frail elderly under the amendment made by subsection (c) by not later than July 1, 2000.

SEC. 808. EXTENSION OF MEDICARE COMMUNITY NURSING ORGANIZATION DEMONSTRATION PROJECTS.

Notwithstanding any other provision of law and in addition to the extension provided under section 4019 of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 347), demonstration projects conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203; 101 Stat. 1330–121) shall be conducted for an additional period of 3 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 IX—CLINICS

SEC. 901. 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 of the center or clinic of 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 pri-

mary 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 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 shall take effect on October 1, 1999.

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