106TH CONGRESS
2D SESSION

S. 3077

To amend the Social Security Act to make corrections and refinements in the Medicare, Medicaid, and SCHIP health insurance programs, as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes.

IN THE SENATE OF THE UNITED STATES

SEPTEMBER 20, 2000

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

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A BILL

To amend the Social Security Act to make corrections and refinements in the Medicare, Medicaid, and SCHIP health insurance programs, as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes.

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

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

(a) SHORT TITLE.—This Act may be cited as the ''Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 2000''.

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

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

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

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

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

TITLE I—PROVISIONS RELATING TO PART A

Subtitle A—Skilled Nursing Facilities

SEC. 101. ELIMINATING REDUCTION IN SKILLED NURSING FACILITY (SNF) MARKET BASKET UPDATE.

(a) ELIMINATION OF REDUCTION.—Section 1888(e)(4)(E)(ii) (42 U.S.C. 1395yy(e)(4)(E)(ii)) is amended—

(1) in subclause (I), by adding ''and'' at the end;

(2) by striking subclause (II); and

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

(b) SPECIAL RULE FOR PAYMENT FOR SKILLED NURSING FACILITY SERVICES FOR FISCAL YEAR 2001.—Notwithstanding the amendments made by subsection (a), for purposes of making payments for covered skilled nursing facility services under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) for fiscal year 2001,

the Federal per diem rate referred to in paragraph (4)(E)(ii) of such section—

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

(2) for the period beginning on April 1, 2001, and ending on September 30, 2001, shall be the rate computed for fiscal year 2000 pursuant to subclause (I) of such paragraph increased by the skilled nursing facility market basket percentage change for fiscal year 2001 plus 1 percentage point.

SEC. 102. REVISION OF BBRA INCREASE FOR SKILLED NURSING FACILITIES IN FISCAL YEARS 2001 AND 2002.

(a) REVISION.—Section 101(d) of BBRA (113 Stat. 1501A–325) is amended—

(1) in paragraph (1)—

(A) by striking ''4.0 percent for each such fiscal year'' and inserting ''the applicable percent (as defined in paragraph (3)) for each such fiscal year (or portion of such year)''; and

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

''(3) APPLICABLE PERCENT DEFINED.—For purposes of this subsection, the term 'applicable percent' means, with respect to services provided during—

''(A) the period beginning on October 1, 2000, and ending on March 31, 2001, 4.0 percent;

''(B) the period beginning on April 1, 2001, and ending on September 30, 2001, 8.0 percent; and

''(C) fiscal year 2002, 6.0 percent.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in the enactment of section 101 of BBRA (113 Stat. 1501A–324).

SEC. 103. MEDPAC STUDY ON PAYMENT UPDATES FOR SKILLED NURSING FACILITIES; AUTHORITY OF SECRETARY TO MAKE ADJUSTMENTS.

(a) STUDY.—The Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) (in this section referred to as ''MedPAC'') shall conduct a study of nursing home costs to determine the adequacy of payment rates (including updates to such rates) under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.) (in this section referred to as the ''medicare program'')

for items and services furnished by skilled nursing facilities. In conducting such study, MedPAC shall use data on actual costs and cost increases.

(b) REPORT.—Not later than 12 months after the date of enactment of this Act, MedPAC shall submit a report to the Secretary of Health and Human Services and Congress on the study conducted under subsection (a), including a description of the methodology and calculations used by the Health Care Financing Administration to establish the original payment level under the prospective payment system for skilled nursing facility services under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) and to annually update payments under the medicare program for items and services furnished by skilled nursing facilities, together with recommendations regarding methods to ensure that all input variables, including the labor costs, the intensity of services, and the changes in science and technology that are specific to such facilities, are adequately accounted for.

(c) AUTHORITY OF SECRETARY TO MAKE ADJUSTMENTS.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may make adjustments to payments under the prospective payment system under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) for covered skilled nursing facility serv-

ices to reflect any necessary adjustments to such payments as is appropriate as a result of the study conducted under subsection (a).

(d) PUBLICATION.—

(1) IN GENERAL.—Not later than April 1, 2002, the Secretary of Health and Human Services shall publish for public comment a description of—

(A) whether the Secretary will make any adjustments pursuant to subsection (c); and

(B) if so, the form of such adjustments.

(2) FINAL FORM.—Not later than August 1, 2002, the Secretary of Health and Human Services shall publish the description described in paragraph (1) in final form.

Subtitle B—PPS Hospitals

SEC. 111. REVISION OF REDUCTION OF INDIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.

(a) REVISION.—

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

(A) in subclause (IV), by adding ''and'' at the end; and

(B) by striking subclauses (V) and (VI) and inserting the following new subclause:

"(V) on or after October 1, 2000, 'c' is equal to 1.6.".

(2) TECHNICAL AMENDMENTS.—Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)), as amended by paragraph (1), is amended—

(A) by realigning the left margins of clauses (ii) and (v) so as to align with the left margin of clause (i); and

(B) by realigning the left margins of subclauses (I) through (V) of clause (ii) appropriately.

(b) SPECIAL ADJUSTMENT FOR PURPOSES OF MAINTAINING 6.5 PERCENT IME PAYMENT FOR FISCAL YEAR 2001.—Notwithstanding paragraph (5)(B)(ii)(V) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(ii)(V)), as amended by subsection (a), for purposes of making payments for subsection (d) hospitals (as defined in paragraph (1)(B) of such section) with indirect costs of medical education, the indirect teaching adjustment factor referred to in paragraph (5)(B)(ii) of such section shall be determined—

(1) for discharges occurring on or after October 1, 2000, and before April 1, 2001, pursuant to such paragraph as in effect on the day before the date of enactment of this Act; and

(2) for discharges occurring on or after April 1, 2001, and before October 1, 2001, by substituting ''1.66'' for ''1.6'' in subclause (V) of such paragraph (as so amended).

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

(1) by inserting a comma after ''Balanced Budget Act of 1997''; and

(2) by inserting '', or any payment under such paragraph resulting from the application of section 111(b) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 2000'' after ''Balanced Budget Refinement Act of 1999''.

SEC. 112. ELIMINATING REDUCTION IN PPS HOSPITAL PAYMENT UPDATE.

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

(1) in subclause (XV), by adding ''and'' at the end;

(2) by striking subclauses (XVI) and (XVII);

(3) by redesignating subclause (XVIII) as subclause (XVI); and

(4) in subclause (XVI), as so redesignated, by striking ''fiscal year 2003'' and inserting ''fiscal year 2001''.

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

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

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

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

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

SEC. 113. ELIMINATING REDUCTION IN DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

(a) ELIMINATION OF REDUCTION.—

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

(A) in subclause (III), by striking ''during each of fiscal years 2000 and 2001'' and inserting ''during fiscal year 2000'';

(B) by striking subclause (IV);

(C) by redesignating subclause (V) as subclause (IV); and

(D) in subclause (IV), as so redesignated, by striking ''during fiscal year 2003'' and inserting ''during fiscal year 2001''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to discharges occurring on or after October 1, 2000.

(b) SPECIAL RULE FOR DSH PAYMENT FOR FISCAL YEAR 2001.—Notwithstanding the amendments made by subsection (a)(1), for purposes of making disproportionate share payments for subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) for fiscal year 2001, the addi-

tional payment amount otherwise determined under clause (ii) of section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F))—

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

(2) for discharges occurring on or after April 1, 2001, and before October 1, 2001, shall be increased by 3 percent.

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

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

(2) by inserting '', or the enactment of section 113(b) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 2000'' after ''Omnibus Budget Reconciliation Act of 1990''.

SEC. 114. EQUALIZING THE THRESHOLD AND UPDATING PAYMENT FORMULAS FOR DISPROPORTIONATE SHARE HOSPITALS.

(a) APPLICATION OF UNIFORM 15 PERCENT THRESHOLD.—Section 1886(d)(5)(F)(v) (42 U.S.C. 1395ww(d)(5)(F)(v)) is amended by striking ''exceeds—'' and all that follows and inserting ''exceeds 15 percent.''.

(b) CHANGE IN PAYMENT PERCENTAGE FORMULAS.—Section 1886(d)(5)(F)(viii) (42 U.S.C. 1395ww(d)(5)(F)(viii)) is amended to read as follows:

''(viii) The formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in subclause (II), (III), or (IV) of clause (iv) is—

''(I) in the case of such a hospital with a disproportionate patient percentage (as defined in clause (vi)) that does not exceed 20.2, (P–15)(.65) + 2.5;

''(II) in the case of such a hospital with a disproportionate patient percentage (as so defined) that exceeds 20.2 but does not exceed 25.2, (P–20.2)(.825) + 5.88;

''(III) except as provided in subclause (IV), in the case of such a hospital with a disproportionate patient percentage (as so defined) that exceeds 25.2,

the disproportionate share adjustment percentage = 10; and

''(IV) in the case of such a hospital with a disproportionate patient percentage (as so defined) that exceeds 30.0 and that is described in clause (iv)(III), (P–30)(.6) + 10;

where 'P' is the hospital's disproportionate patient percentage (as so defined).''.

(c) CONFORMING AMENDMENTS.—Section 1886(d)(5)(F)(iv) (42 U.S.C. 1395ww(d)(5)(F)(iv)) is amended—

(1) in subclause (I), by striking ''is described in the second sentence of clause (v)'' and inserting ''is located in a rural area and has 500 or more beds'';

(2) by amending subclause (II) to read as follows:

''(II) is located in an urban area and has less than 100 beds, or is located in a rural area and has less than 500 beds and is not described in subclause (III) or (IV), is equal to the percent determined in accordance with the applicable formula described in clause (viii);'';

(3) by striking subclauses (III) and (IV);

(4) by redesignating subclauses (V) and (VI) as subclauses (III) and (IV), respectively;

(5) in subclause (III) (as so redesignated), by striking ''and is not classified as a sole community hospital under subparagraph (D),''; and

(6) in subclause (IV) (as so redesignated), by striking ''10 percent'' and inserting ''equal to the percent determined in accordance with the applicable formula described in clause (viii)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after April 1, 2001.

SEC. 115. CARE FOR LOW-INCOME PATIENTS.

(a) FREEZE IN MEDICAID DSH ALLOTMENTS.—

(1) IN GENERAL.—Section 1923(f) (42 U.S.C. 1396r–4(f)) is amended—

(A) by redesignating paragraph (4) as paragraph (5); and

(B) by inserting after paragraph (3), the following new paragraph:

''(4) SPECIAL RULE FOR FISCAL YEARS 2001 THROUGH 2008.—With respect to each of fiscal years 2001 through 2008—

''(A) paragraph (2) shall be applied—

''(i) by substituting—

''(I) in the heading, '2001' for '2002';

"(II) in the matter preceding the table, '2001 (and the DSH allotment for a State for fiscal year 2001 is the same as the DSH allotment for the State for fiscal year 2000, as determined under the following table)' for '2002'; and

"(ii) without regard to the columns in the table relating to FY 01 and FY 02 (fiscal years 2001 and 2002); and

"(B) paragraph (3) shall be applied by substituting—

"(i) in the heading, '2002' for '2003';

"(ii) in subparagraph (A), '2002' for '2003'.".

(2) REPEAL; APPLICABILITY.—Effective October 1, 2008, the amendments made by paragraph (1) are repealed and section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) shall be applied and administered as if such amendments had not been enacted.

(b) INCREASE IN DSH ALLOTMENTS FOR THE DISTRICT OF COLUMBIA.—

(1) IN GENERAL.—Each of the entries in the table in section 1923(f)(2) (42 U.S.C. 1396r–

4(f)(2)) relating to the District of Columbia for FY 98 (fiscal year 1998), for FY 99 (fiscal year 1999), for FY 00 (fiscal year 2000), for FY 01 (fiscal year 2001), and for FY 02 (fiscal year 2002) are amended by striking the amount otherwise specified and inserting ''43.4''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect as if included in the enactment of section 4721(a) of BBA (111 Stat. 511).

(c) OPTIONAL ELIGIBILITY OF CERTAIN ALIEN PREGNANT WOMEN AND CHILDREN FOR MEDICAID AND SCHIP.—

(1) MEDICAID.—Section 1903(v) (42 U.S.C. 1396b(v)) is amended—

(A) in paragraph (1), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (4)''; and

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

''(4)(A) A State may elect (in a plan amendment under this title) to provide medical assistance under this title, notwithstanding sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, for aliens who are lawfully re-

siding in the United States (including battered aliens described in section 431(c) of such Act) and who are otherwise eligible for such assistance, within any of the following eligibility categories:

''(i) PREGNANT WOMEN.—Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

''(ii) CHILDREN.—Children (as defined under such plan), including optional targeted low-income children described in section 1905(u)(2)(B).

''(B) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no action may be brought under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such category.''.

(2) SCHIP.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is amended by adding at the end the following new subparagraph:

''(D) Section 1903(v)(4)(A)(ii) (relating to optional coverage of permanent resident alien children), but only if the State has in effect an election under that same eligibility category for purposes of title XIX.''.

(3) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2000, and

apply to medical assistance and child health assistance furnished on or after such date.

SEC. 116. MODIFICATION OF PAYMENT RATE FOR PUERTO RICO HOSPITALS.

(a) MODIFICATION OF PAYMENT RATE.—Section 1886(d)(9)(A) (42 U.S.C. 1395ww(d)(9)(A)) is amended—

(1) in clause (i), by striking ''October 1, 1997, 50 percent ('' and inserting ''October 1, 2000, 25 percent (for discharges between October 1, 1997, and September 30, 2000, 50 percent,''; and

(2) in clause (ii), in the matter preceding subclause (I), by striking ''after October 1, 1997, 50 percent ('' and inserting ''after October 1, 2000, 75 percent (for discharges between October 1, 1997, and September 30, 2000, 50 percent,''.

(b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR 2001.—

(1) IN GENERAL.—Notwithstanding the amendment made by subsection (a), for purposes of making payments for the operating costs of inpatient hospital services of a section 1886(d) Puerto Rico hospital for fiscal year 2001, the amount referred to in the matter preceding clause (i) of section

1886(d)(9)(A) of the Social Security Act (42 U.S.C. 1395ww(d)(9)(A))—

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

(B) for discharges occurring on or after April 1, 2001, and before October 1, 2001, shall be determined—

(i) using 0 percent of the Puerto Rico adjusted DRG prospective payment rate referred to in clause (i) of such section; and

(ii) using 100 percent of the discharge-weighted average referred to in clause (ii) of such section.

(2) SECTION 1886(d) PUERTO RICO HOSPITAL.—For purposes of this subsection, the term ''section 1886(d) Puerto Rico hospital'' has the meaning given the term ''subsection (d) Puerto Rico hospital'' in the last sentence of section 1886(d)(9)(A) of the Social Security Act (42 U.S.C. 1395ww(d)(9)(A)).

SEC. 117. MEDPAC STUDY ON HOSPITAL AREA WAGE INDEXES.

(a) STUDY.—

(1) IN GENERAL.—The Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) (in this section referred to as ''MedPAC'') shall conduct a study on the hospital area wage indexes used in making payments to hospitals under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), including an assessment of the accuracy of those indexes in reflecting geographic differences in wage and wage-related costs of hospitals.

(2) CONSIDERATIONS.—In conducting the study under paragraph (1), MedPAC shall consider—

(A) the appropriate method for determining hospital area wage indexes;

(B) the appropriate portion of hospital payments that should be adjusted by the applicable area wage index;

(C) the appropriate method for adjusting the wage index by occupational mix; and

(D) the feasibility and impact of making changes (as determined appropriate by MedPAC) to the methods used to determine

such indexes, including the need for a data system required to implement such changes.

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

Subtitle C—PPS Exempt Hospitals

SEC. 121. TREATMENT OF CERTAIN CANCER HOSPITALS.

(a) IN GENERAL.—Section 1886(d)(1)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(v)) is amended—

(1) in subclause (I), by striking ''or'' at the end;

(2) in subclause (II), by striking the semicolon at the end and inserting '', or''; and

(3) by adding at the end the following:

''(III) a hospital that was recognized as a clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of February 18, 1998, that has never been reimbursed for inpatient hospital services pursuant to a reimbursement system under a demonstration project under section 1814(b), that is a freestanding facility

organized primarily for treatment of and research on cancer and is not a unit of another hospital, that as of the date of enactment of this subclause, is licensed for 162 acute care beds, and that demonstrates for the 4-year period ending on June 30, 1999, that at least 50 percent of its total discharges have a principal finding of neoplastic disease, as defined in subparagraph (E);''.

(b) CONFORMING AMENDMENT.—Section 1886(d)(1)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(E)) is amended by striking ''For purposes of subparagraph (B)(v)(II)'' and inserting ''For purposes of subclauses (II) and (III) of subparagraph (B)(v)''.

(c) PAYMENT.—

(1) APPLICATION TO COST REPORTING PERIODS.—Any classification by reason of section 1886(d)(1)(B)(v)(III) of the Social Security Act (as added by subsection (a)) shall apply to 12-month cost reporting periods beginning on or after July 1, 1999.

(2) BASE YEAR.—Notwithstanding the provisions of section 1886(b)(3)(E) of such Act (42 U.S.C. 1395ww(b)(3)(E)) or other provisions to the contrary, the base cost reporting period for purposes of determining the target amount for any hospital

classified by reason of section 1886(d)(1)(B)(v)(III) of such Act (as added by subsection (a)) shall be the 12-month cost reporting period beginning on July 1, 1995.

(3) DEADLINE FOR PAYMENTS.—Any payments owed to a hospital by reason of this subsection shall be made expeditiously, but in no event later than 1 year after the date of enactment of this Act.

SEC. 122. PAYMENT ADJUSTMENT FOR INPATIENT SERVICES IN REHABILITATION HOSPITALS.

(a) OPTION TO APPLY PROSPECTIVE PAYMENT SYSTEM DURING TRANSITION PERIOD.—Section 1886(j)(1)(A) (42 U.S.C. 1395ww(j)(1)(A)) is amended in the matter preceding subclause (i) by inserting ''the greater of the prospective payment rate determined in paragraph (3)(A) or'' after ''is equal to''.

(b) INCREASE IN PROSPECTIVE PAYMENT PERCENTAGE DURING TRANSITION PERIOD.—Section 1886(j)(1)(A)(ii)(I) (42 U.S.C. 1395ww(j)(1)(A)(ii)(I)) is amended by inserting ''102 percent of'' before ''the per unit''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 4421 of BBA (111 Stat. 410).

Subtitle D—Hospice Care

SEC. 131. REVISION IN PAYMENTS FOR HOSPICE CARE.

(a) INCREASE.—Section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)) is amended—

(1) in clause (i), by adding at the end the following new sentence: ''With respect to routine home care and other services included in hospice care furnished during fiscal year 2001, the payment rates for such care and services for such fiscal year shall be 110 percent of such rates as would otherwise be in effect for such fiscal year (taking into account the increase under clause (ii) but not taking into account the increase under section 131 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999), and such payment rates shall be used in determining payments for such care and services furnished in a subsequent fiscal year under clause (ii).''; and

(2) in clause (ii), by striking ''during a subsequent fiscal year'' and inserting ''during a fiscal year beginning after September 30, 1990''.

(b) ELIMINATING REDUCTION IN UPDATE.—Section 1814(i)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)(ii)) is amended—

(1) in subclause (VI), by striking ''through 2002'' and inserting ''through 2000''; and

(2) in subclause (VII), by striking ''for a subsequent fiscal year'' and inserting ''for fiscal year 2001 and each subsequent fiscal year''.

(c) SPECIAL RULE FOR PAYMENT FOR HOSPICE CARE FOR FISCAL YEAR 2001.—Notwithstanding the amendments made by subsections (a) and (b), for purposes of making payments under section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)) for routine home care and other services included in hospice care furnished during fiscal year 2001, such payment rates shall be determined—

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

(2) for the period beginning on April 1, 2001, and ending on September 30, 2001—

(A) by substituting ''120 percent'' for ''110 percent'' in the second sentence of clause (i) of such section (as added by subsection (a)(1)); and

(B) as if the increase under subclause (ii)(VII) (as amended by subsection (b)) for fis-

cal year 2001 was equal to the market basket increase for the fiscal year plus 1.0 percentage point.

Subtitle E—Other Provisions

SEC. 141. HOSPITALS REQUIRED TO COMPLY WITH BLOODBORNE PATHOGENS STANDARD.

(a) AGREEMENTS WITH HOSPITALS.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (R), by striking ''and'' at the end;

(2) in subparagraph (S), by striking the period at the end and inserting '', and''; and

(3) by inserting after subparagraph (S) the following new subparagraph:

''(T) in the case of hospitals that are not otherwise subject to regulation by the Occupational Safety and Health Administration, to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to agreements in effect on or after the date that is 1 year after the date of enactment of this Act.

SEC. 142. INFORMATICS AND DATA SYSTEMS GRANT PROGRAM.

(a) GRANTS TO HOSPITALS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a program to make grants to hospitals that have submitted applications in accordance with subsection (c) to assist such hospitals in offsetting the costs related to—

(A) developing and implementing standardized clinical health care informatics systems designed to improve medical care and reduce adverse events and health care complications resulting from medication errors; and

(B) establishing data systems to comply with the administrative simplification requirements under part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.).

(2) COSTS.—For purposes of paragraph (1), the term ''costs'' shall include costs associated with—

(A) purchasing computer software and hardware; and

(B) providing education and training to hospital staff on computer information systems.

(3) DURATION.—The authority of the Secretary to make grants under this section shall terminate on September 30, 2011.

(4) LIMITATION.—A hospital that has received a grant under section 1611 of the Public Health Service Act (as added by section 447 of this Act) is not eligible to receive a grant under this section.

(b) SPECIAL CONSIDERATION FOR LARGE URBAN HOSPITALS.—In awarding grants under this section, the Secretary shall give special consideration to hospitals located in large urban areas (as defined for purposes of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)).

(c) APPLICATION.—A hospital seeking a grant under this section shall submit an application to the Secretary at such time and in such form and manner as the Secretary specifies.

(d) REPORTS.—

(1) INFORMATION.—A hospital receiving a grant under this section shall furnish the Secretary with such information as the Secretary may require to—

(A) evaluate the project for which the grant is made; and

(B) ensure that the grant is expended for the purposes for which it is made.

(2) TIMING OF SUBMISSION.—

(A) INTERIM REPORTS.—The Secretary shall report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate at least annually on the grant program established under this section, including in such report information on the number of grants made, the nature of the projects involved, the geographic distribution of grant recipients, and such other matters as the Secretary deems appropriate.

(B) FINAL REPORT.—The Secretary shall submit a final report to such committees not later than 180 days after the completion of all of the projects for which a grant is made under this section.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) $25,000,000 for each of the fiscal years 2001 through 2011 for the purposes of making grants under this section.

SEC. 143. RELIEF FROM MEDICARE PART A LATE ENROLLMENT PENALTY FOR GROUP BUY-IN FOR STATE AND LOCAL RETIREES.

Section 1818(d) (42 U.S.C. 1395i–2(d)) is amended by adding at the end the following new paragraph:

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

''(B) For purposes of this paragraph, the term 'qualified State or local government retiree group' means all of the individuals who retire prior to a

specified date that is before January 1, 2002, from employment in 1 or more occupations or other broad classes of employees of—

''(i) the State;

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

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

Subtitle F—Transitional Provisions

SEC. 151. RECLASSIFICATION OF CERTAIN COUNTIES AND AREAS FOR PURPOSES OF REIMBURSEMENT UNDER THE MEDICARE PROGRAM.

(a) FISCAL YEARS 2002 THROUGH 2004.—Notwithstanding any other provision of law, effective for discharges occurring during fiscal years 2002, 2003, and 2004, for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d))—

(1) Iredell County, North Carolina is deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina-South Carolina Metropolitan Statistical Area; and

(2) the large urban area of New York, New York is deemed to include Orange County, New York (including hospitals that have been reclassified into such county).

For purposes of that section, any reclassification under this subsection shall be treated as a decision of the Medicare Geographic Classification Review Board under paragraph (10) of that section.

(b) FISCAL YEARS 2001 THROUGH 2003.—Notwithstanding any other provision of law, effective for discharges occurring during fiscal years 2001, 2002, and 2003, for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d))—

(1) the Jackson, Michigan Metropolitan Statistical Area is deemed to be located in the Ann Arbor, Michigan Metropolitan Statistical Area;

(2) Tangipahoa Parish, Louisiana is deemed to be located in the New Orleans, Louisiana Metropolitan Statistical Area; and

(3) the large urban area of New York, New York is deemed to include Duchess County, New York.

For purposes of that section, any reclassification under this subsection shall be treated as a decision of the Medicare Geographic Classification Review Board under paragraph (10) of that section.

(c) TECHNICAL CORRECTION TO BBRA.—

(1) IN GENERAL.—Section 152 of BBRA (113 Stat. 1501A–334) is amended—

(A) in subsection (a)(2), by inserting ''(including hospitals that have been reclassified into such county)'' after ''such county''; and

(B) in subsection (b)(2), by inserting ''(including hospitals that have been reclassified into such county)'' after ''Orange County, New York''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect as if included in the enactment of section 152 of BBRA (113 Stat. 1501A–334).

SEC. 152. CALCULATION AND APPLICATION OF WAGE INDEX FLOOR FOR A CERTAIN AREA.

Notwithstanding any other provision of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), for discharges occurring during fiscal year 2000, the Secretary of Health and Human Services shall calculate and apply the wage index for the Barnstable-Yarmouth Metropolitan Statistical Area under that section as if the Jordan Hospital were classified in such area for purposes of payment under that section for such fiscal year. Such recalculation shall not affect the wage index for any other area.

TITLE II—PROVISIONS RELATING TO PART B

Subtitle A—Hospital Outpatient Services

SEC. 201. REDUCTION OF EFFECTIVE HOPD COINSURANCE RATE TO 20 PERCENT BY 2019.

Section 1833(t)(3)(B)(ii) (42 U.S.C. 1395l(t)(3)(B)(ii)) is amended—

(1) by striking ''If the'' and inserting:

''(I) IN GENERAL.—If the''; and

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

''(II) ACCELERATED PHASE-IN.—The Secretary shall estimate, prior to January 1, 2002, the unadjusted copayment amount for each such service (or groups of such services). If the Secretary estimates such unadjusted copayment amount to be greater than 20 percent for any such service (or group of such services) on or after January 1, 2019, the Secretary shall, for services furnished beginning on or after January 1, 2002, reduce the unadjusted copayment amount for

such service (or group of such services) in equal increments each year, from the amount applicable in 2001, by an amount estimated by the Secretary such that the unadjusted copayment amount shall equal 20 percent beginning on or after January 1, 2019.''.

SEC. 202. APPLICATION OF TRANSITIONAL CORRIDOR TO CERTAIN HOSPITALS THAT DID NOT SUBMIT A 1996 COST REPORT.

(a) IN GENERAL.—Section 1833(t)(7)(F)(ii)(I) (42 U.S.C. 1395l(t)(7)(F)(ii)(I)) is amended by inserting ''(or, in the case of a hospital that did not submit a cost report for such period, during the first cost reporting period ending in a year after 1996 and before 2001 for which the hospital submitted a cost report)'' after ''1996''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of section 202 of BBRA.

SEC. 203. PERMANENT GUARANTEE OF PRE-BBA PAYMENT LEVELS FOR OUTPATIENT SERVICES FURNISHED BY CHILDREN'S HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D) (42 U.S.C. 1395l(t)(7)(D)), as amended by section 432, is amended—

(1) in the heading, by inserting ", CHILDREN'S," after "SMALL RURAL"; and

(2) by striking "section 1886(d)(1)(B)(v)" and inserting "clause (iii) or (v) of section 1886(d)(1)(B)".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services provided on or after the date that is 1 year after the date of enactment of this Act.

Subtitle B—Provisions Relating to Physicians

SEC. 211. LOAN DEFERMENT FOR RESIDENTS.

(a) FAIRNESS IN MEDICAL STUDENT LOAN FINANCING.—

(1) ELIGIBILITY REQUIREMENTS.—Section 427(a)(2)(C)(iii) of the Higher Education Act of 1965 (20 U.S.C. 1077(a)(2)(C)(iii)) is amended by inserting before the semicolon the following: ", except that for a medical student such period shall not exceed the full initial residency period".

(2) INSURANCE PROGRAM AGREEMENTS.—Section 428(b)(1)(M)(iii) of the Higher Education Act of 1965 (20 U.S.C. 1078(b)(1)(M)(iii)) is amended by inserting before the semicolon the following: ", except that for a medical student such period shall not exceed the full initial residency period".

(3) DEFERMENT ELIGIBILITY.—Section 455(f)(2)(C) of the Higher Education Act of 1965 (20 U.S.C. 1087e(f)(2)(C)) is amended by inserting before the period the following: ", except that for a medical student such period shall not exceed the full initial residency period".

(4) CONTENTS OF LOAN AGREEMENT.—Section 464(c)(2)(A)(iii) of the Higher Education Act of 1965 (20 U.S.C. 1087dd(c)(2)(A)(iii)) is amended by inserting before the semicolon the following: ", except that for a medical student such period shall not exceed the full initial residency period".

(b) FAIRNESS IN ECONOMIC HARDSHIP DETERMINATION.—Section 435(o)(1)(B) of the Higher Education Act of 1965 (20 U.S.C. 1085(o)(1)(B)) is amended to read as follows:

"(B) such borrower is working full time and has a Federal educational debt burden that equals or exceeds 20 percent of such borrower's

adjusted gross income, and the difference between such borrower's adjusted gross income minus such burden is less than 250 percent of the greater of—

"(i) the annual earnings of an individual earning the minimum wage under section 6 of the Fair Labor Standards Act of 1938; or

"(ii) the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Community Service Block Grant Act) applicable to a family of 2; or".

SEC. 212. GAO STUDIES AND REPORTS ON MEDICARE PAYMENTS.

(a) GAO STUDY ON HCFA POST-PAYMENT AUDIT PROCESS.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study of the post-payment audit process 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") as such process applies to physicians, including the proper level of resources

that the Health Care Financing Administration should devote to educating physicians regarding—

(A) coding and billing;

(B) documentation requirements; and

(C) the calculation of overpayments.

(2) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General shall submit a report to the Secretary of Health and Human Services and Congress on the study conducted under paragraph (1) together with specific recommendations for changes or improvements in the post-payment audit process described in such paragraph.

(b) GAO STUDY ON ADMINISTRATION AND OVERSIGHT.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the aggregate effects of regulatory, audit, oversight, and paperwork burdens on physicians and other health care providers participating in the medicare program.

(2) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General shall submit a report to the Secretary of Health and Human Services and Congress on the

study conducted under paragraph (1) together with recommendations regarding any area in which—

(A) a reduction in paperwork, an ease of administration, or an appropriate change in oversight and review may be accomplished; or

(B) additional payments or education are needed to assist physicians and other health care providers in understanding and complying with any legal or regulatory requirements.

SEC. 213. MEDPAC STUDY ON THE RESOURCE-BASED PRACTICE EXPENSE SYSTEM.

(a) STUDY.—The Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) (in this section referred to as ''MedPAC'') shall conduct a study of the refinements to the practice expense relative value units during the transition to a resource-based practice expense system for physician payments under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (in this section referred to as the ''medicare program'').

(b) REPORT.—Not later than July 1, 2001, MedPAC shall submit a report to the Secretary of Health and Human Services and Congress on the study conducted

under subsection (a) together with recommendations regarding—

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

(2) the appropriateness of payments to physicians.

Subtitle C—Ambulance Services

SEC. 221. ELECTION TO FOREGO PHASE-IN OF FEE SCHEDULE FOR AMBULANCE SERVICES.

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

''(8) ELECTION TO FOREGO PHASE-IN OF FEE SCHEDULE.—

''(A) IN GENERAL.—If the Secretary provides for a phase-in of the fee schedule established under this subsection, a supplier of ambulance services may make an election to receive payments based only on such fee schedule at any time during such phase-in, and the Secretary shall begin to make payments to the supplier based only on such fee schedule not later than the date that is 60 days after the date on which the supplier notifies the Secretary of such election.

''(B) WAIVER OF BUDGET NEUTRALITY.—The Secretary shall apply paragraph (3)(A) as if this paragraph had not been enacted.''.

SEC. 222. PRUDENT LAYPERSON STANDARD FOR EMERGENCY AMBULANCE SERVICES.

(a) IN GENERAL.—Section 1861(s)(7) (42 U.S.C. 1395x(s)(7)) is amended by inserting before the semicolon at the end the following: '', except that such regulations shall not fail to treat ambulance services as medical and other health services solely because the ultimate diagnosis of the individual receiving the ambulance services results in a conclusion that ambulance services were not necessary, as long as the request for ambulance services is made after the sudden onset of a medical condition that would be classified as an emergency medical condition (as defined in section 1852(d)(3)(B))''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to ambulance services provided on or after October 1, 2000.

SEC. 223. ELIMINATION OF REDUCTION IN INFLATION ADJUSTMENTS FOR AMBULANCE SERVICES.

Subparagraphs (A) and (B) of section 1834(l)(3) (42 U.S.C. 1395m(l)(3)(A)) are each amended by striking ''reduced in the case of 2001 and 2002 by 1.0 percentage

points'' and inserting ''increased in the case of 2001 by 1.0 percentage point''.

SEC. 224. STUDY AND REPORT ON THE COSTS OF RURAL AMBULANCE SERVICES.

(a) STUDY.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), in consultation with the Office of Rural Health Policy, shall conduct a study of the means by which rural areas with low population densities can be identified for the purpose of designating areas in which the cost of providing ambulance services would be expected to be higher than similar services provided in more heavily populated areas because of low usage. Such study shall also include an analysis of the additional costs of providing ambulance services in areas designated under the previous sentence.

(b) REPORT.—Not later than June 30, 2001, the Secretary shall submit a report to Congress on the study conducted under subsection (a), together with a regulation based on that study which adjusts the fee schedule payment rates for ambulance services provided in low density rural areas based on the increased cost of providing such services in such areas.

SEC. 225. INTERIM PAYMENTS FOR RURAL GROUND AMBULANCE SERVICES UNTIL REGULATION IMPLEMENTED.

(a) INTERIM PAYMENTS.—Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 221, is amended by adding at the end the following new paragraph:

"(9) INTERIM PAYMENTS FOR RURAL GROUND AMBULANCE SERVICES.—Until such time as the fee schedule established under this subsection is modified by the regulation described in section 224(b) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 2000, the amount of payment under this subsection for ground ambulance services provided in a rural area (as defined in section 1886(d)(2)(D)) shall be the greater of—

"(A) the amount determined under the fee schedule established under this subsection (without regard to any phase-in established pursuant to paragraph (2)(E)); or

"(B) the amount that would have been paid for such services if the amendments made by section 4531(b) of the Balanced Budget Act of 1997 had not been enacted;

as adjusted for inflation in the manner described in paragraph (3)(B). For purposes of this paragraph, an ambulance trip shall be considered to have been

provided in a rural area only if the transportation of the patient originated in a rural area.''.

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

(1) in subparagraph (R)—

(A) by inserting ''except as provided in subparagraph (T),'' before ''with respect''; and

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

(2) in subparagraph (S), by striking the semicolon at the end and inserting '', and (T) with respect to ambulance services described in section 1834(l)(9), the amount paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined under such section;''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services provided on and after January 1, 2001.

SEC. 226. GAO STUDY AND REPORT ON THE COSTS OF EMERGENCY AND MEDICAL TRANSPORTATION SERVICES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of the costs of providing emergency and medical transportation services across the range of acuity levels of conditions for which such transportation services are provided.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General shall submit a report to the Secretary of Health and Human Services and Congress on the study conducted under subsection (a), together with recommendations for any changes in methodology or payment level necessary to fairly compensate suppliers of emergency and medical transportation services and to ensure the access of beneficiaries under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such services.

Subtitle D—Preventive Services

SEC. 231. ELIMINATION OF DEDUCTIBLES AND COINSURANCE FOR PREVENTIVE BENEFITS.

(a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l) is amended by inserting after subsection (o) the following new subsection:

"(p) DEDUCTIBLES AND COINSURANCE WAIVED FOR PREVENTIVE BENEFITS.—The Secretary may not require the payment of any deductible or coinsurance under subsection (a) or (b) of any individual enrolled for coverage under this part for any of the following preventive health care items and services:

''(1) Blood-testing strips, lancets, and blood glucose monitors for individuals with diabetes described in section 1861(n).

''(2) Diabetes outpatient self-management training services (as defined in section 1861(qq)(1)).

''(3) Pneumococcal, influenza, and hepatitis B vaccines and administration described in section 1861(s)(10).

''(4) Screening mammography (as defined in section 1861(jj)).

''(5) Screening pap smear and screening pelvic exam (as defined in paragraphs (1) and (2) of section 1861(nn), respectively).

''(6) Bone mass measurement (as defined in section 1861(rr)(1)).

''(7) Prostate cancer screening test (as defined in section 1861(oo)(1)).

''(8) Colorectal cancer screening test (as defined in section 1861(pp)(1)).''.

(b) WAIVER OF COINSURANCE.—Section 1833(a)(1)(B) (42 U.S.C. 1395l(a)(1)(B)) is amended to read as follows: ''(B) with respect to preventive health care items and services described in subsection (p), the amounts paid shall be 100 percent of the fee schedule or other basis of payment under this title,''.

(c) WAIVER OF DEDUCTIBLE.—Section 1833(b)(1) (42 U.S.C. 1395l(b)(1)) is amended to read as follows: ''(1) such deductible shall not apply with respect to preventive health care items and services described in subsection (p),''.

(d) ADDING ''LANCET'' TO DEFINITION OF DME.—Section 1861(n) (42 U.S.C. 1395x(n)) is amended by striking ''blood-testing strips and blood glucose monitors'' and inserting ''blood-testing strips, lancets, and blood glucose monitors''.

(e) CONFORMING AMENDMENTS.—

(1) ELIMINATION OF COINSURANCE FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.—Paragraphs (1)(D)(i) and (2)(D)(i) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended—

(A) by striking ''basis or which'' and inserting ''basis, which''; and

(B) by inserting '', or which are described in subsection (p)'' after ''critical access hospital''.

(2) ELIMINATION OF COINSURANCE FOR CERTAIN DME.—Section 1834(a)(1)(A) (42 U.S.C. 1395m(a)(1)(A)) is amended by inserting ''(or 100 percent, in the case of such an item described in section 1833(p))'' after ''80 percent''.

(3) ELIMINATION OF COINSURANCE FOR SCREENING MAMMOGRAPHY.—Section 1834(c)(1)(C) (42 U.S.C. 1395m(c)(1)(C)) is amended by striking ''80 percent'' and inserting ''100 percent''.

(4) ELIMINATION OF DEDUCTIBLES AND COINSURANCE FOR COLORECTAL CANCER SCREENING TESTS.—Section 1834(d) (42 U.S.C. 1395m(d)) is amended—

(A) in paragraph (2)(C)—

(i) by striking clause (ii);

(ii) by striking ''FACILITY PAYMENT LIMIT.—'' and all that follows through ''Notwithstanding'' and inserting ''FACILITY PAYMENT LIMIT.—Notwithstanding''; and

(iii) by redesignating subclauses (I) and (II) as clauses (i) and (ii), respectively; and

(B) in paragraph (3)(C)—

(i) by striking clause (ii); and

(ii) by striking ''FACILITY PAYMENT LIMIT.—'' and all that follows through ''Notwithstanding'' and inserting ''FACILITY PAYMENT LIMIT.—Notwithstanding''.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after July 1, 2001.

SEC. 232. COUNSELING FOR CESSATION OF TOBACCO USE.

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

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

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

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

''(U) counseling for cessation of tobacco use (as defined in subsection (uu)) for individuals who have a history of tobacco use;''.

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

''Counseling for Cessation of Tobacco Use

''(uu)(1) Except as provided in paragraph (2), the term 'counseling for cessation of tobacco use' means diagnostic, therapy, and counseling services for cessation of tobacco use which are furnished—

''(A) by or under the supervision of a physician; or

''(B) by any other health care professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.

''(2) The term 'counseling for cessation of tobacco use' does not include coverage for drugs or biologicals that are not otherwise covered under this title.''.

(c) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)), as amended by section 225(b), is amended—

(A) by striking ''and'' before ''(T)''; and

(B) by inserting before the semicolon at the end the following: '', and (U) with respect to counseling for cessation of tobacco use (as defined in section 1861(uu)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended—

(A) by striking ''and'' before ''(6)''; and

(B) by inserting before the period the following: '', and (7) such deductible shall not apply with respect to counseling for cessation of tobacco use (as defined in section 1861(uu))''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after July 1, 2001.

SEC. 233. COVERAGE OF GLAUCOMA DETECTION TESTS.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by section 232, is amended—

(1) in subsection (s)(2)—

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

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

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

''(V) glaucoma detection tests (as defined in subsection (vv));''; and

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

''Glaucoma Detection Tests

''(vv) The term 'glaucoma detection test' means all of the following conducted for the purpose of early detection of glaucoma:

''(1) A dilated eye examination with an intraocular pressure measurement.

''(2) Direct ophthalmoscopy or slit-lamp biomicroscopic examination.''.

(b) LIMITATION ON ELIGIBILITY AND FREQUENCY.—Section 1834 (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(m) LIMITATION ON COVERAGE OF GLAUCOMA DETECTION TESTS.—

''(1) IN GENERAL.—Notwithstanding any other provision of this part, with respect to expenses incurred for glaucoma detection tests (as defined in section 1861(vv)), payment may be made only for glaucoma detection tests conducted—

''(A) for individuals described in paragraph (2); and

''(B) consistent with the frequency permitted under paragraph (3).

''(2) INDIVIDUALS ELIGIBLE FOR BENEFIT.—Individuals described in this paragraph are as follows:

"(A) Individuals who are 60 years of age or older and who have a family history of glaucoma.

"(B) Other individuals who are at high risk (as determined by the Secretary) of developing glaucoma.

"(3) FREQUENCY LIMIT.—

"(A) IN GENERAL.—Subject to subparagraph (B), payment may not be made under this part for a glaucoma detection test performed for an individual within 23 months following the month in which a glaucoma detection test was performed under this part for the individual.

"(B) EXCEPTION.—The Secretary may permit a glaucoma detection test to be covered on a more frequent basis than that provided under subparagraph (A) under such circumstances as the Secretary determines to be appropriate.".

(c) NO APPLICATION OF DEDUCTIBLE.—Section 1833(b)(5) (42 U.S.C. 1395l(b)(5)) is amended by inserting "or with respect to glaucoma detection tests (as defined in section 1861(vv))" after "1861(jj))".

(d) CONFORMING AMENDMENTS.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

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

(B) in subparagraph (I), by striking the semicolon at the end and inserting '', and''; and

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

''(J) in the case of glaucoma detection tests (as defined in section 1861(vv)), which are furnished to an individual not described in paragraph (2) of section 1834(m) or which are performed more frequently than is covered under paragraph (3) of such section;''; and

(2) in paragraph (7), by striking ''or (H)'' and inserting ''(H), or (I)''.

(e) EFFECTIVE DATE.—The amendments made by this section apply to tests provided on or after July 1, 2001.

SEC. 234. MEDICAL NUTRITION THERAPY SERVICES FOR BENEFICIARIES WITH DIABETES, A CARDIOVASCULAR DISEASE, OR A RENAL DISEASE.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by section 233(a), is amended—

(1) in subparagraph (U) by striking ''and'' at the end;

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

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

''(W) medical nutrition therapy services (as defined in subsection (ww)(1)) in the case of a beneficiary with diabetes, a cardiovascular disease (including congestive heart failure, arteriosclerosis, hyperlipidemia, hypertension, and hypercholesterolemia), or a renal disease;''.

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x), as amended by section 233(a), is amended by adding at the end the following new subsection:

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

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

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

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

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

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

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

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

in which medical nutrition therapy services are performed.''.

(c) PAYMENT.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)), as amended by section 232(c)(1), is amended—

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

(2) by inserting before the semicolon at the end the following: '', and (V) with respect to medical nutrition therapy services (as defined in section 1861(ww)), the amount paid shall be 85 percent of the lesser of the actual charge for the services or the amount determined under the fee schedule established under section 1848(b) for the same services if furnished by a physician''.

(d) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after July 1, 2001.

SEC. 235. STUDIES ON PREVENTIVE INTERVENTIONS IN PRIMARY CARE FOR OLDER AMERICANS.

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

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

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

SEC. 236. INSTITUTE OF MEDICINE 5-YEAR MEDICARE PREVENTION BENEFIT STUDY AND REPORT.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall contract with the Institute of Medicine of the National Academy of Sciences to conduct a comprehensive study of current literature and best practices in the field of health promotion and disease prevention among medicare beneficiaries including the issues described in paragraph (2) and to submit the report described in subsection (b).

(2) ISSUES STUDIED.—The study required under paragraph (1) shall include an assessment of—

(A) whether each covered benefit is—

(i) medically effective; and

(ii) a cost-effective benefit or a cost-saving benefit;

(B) utilization of covered benefits (including any barriers to or incentives to increase utilization); and

(C) quality of life issues associated with both health promotion and disease prevention benefits covered under the medicare program and those that are not covered under such program that would affect all medicare beneficiaries.

(b) REPORT.—

(1) IN GENERAL.—Not later than 5 years after the date of enactment of this section, and every fifth year thereafter, the Institute of Medicine of the National Academy of Sciences shall submit to the President a report that contains a detailed statement of the findings and conclusions of the study conducted under subsection (a) and the recommendations for legislation described in paragraph (2).

(2) RECOMMENDATIONS FOR LEGISLATION.—The Institute of Medicine of the National Academy

of Sciences, in consultation with the Partnership for Prevention, shall develop recommendations in legislative form that—

(A) prioritize the preventive benefits under the medicare program; and

(B) modify preventive benefits offered under the medicare program based on the study conducted under subsection (a).

(c) TRANSMISSION TO CONGRESS.—

(1) IN GENERAL.—On the day on which the report described in subsection (b) is submitted to the President, the President shall transmit the report and recommendations in legislative form described in subsection (b)(2) to Congress.

(2) DELIVERY.—Copies of the report and recommendations in legislative form required to be transmitted to Congress under paragraph (1) shall be delivered—

(A) to both Houses of Congress on the same day;

(B) to the Clerk of the House of Representatives if the House is not in session; and

(C) to the Secretary of the Senate if the Senate is not in session.

(d) DEFINITIONS.—In this section:

(1) COST-EFFECTIVE BENEFIT.—The term ''cost-effective benefit'' means a benefit or technique that has—

(A) been subject to peer review;

(B) been described in scientific journals; and

(C) demonstrated value as measured by unit costs relative to health outcomes achieved.

(2) COST-SAVING BENEFIT.—The term ''cost-saving benefit'' means a benefit or technique that has—

(A) been subject to peer review;

(B) been described in scientific journals; and

(C) caused a net reduction in health care costs for medicare beneficiaries.

(3) MEDICALLY EFFECTIVE.—The term ''medically effective'' means, with respect to a benefit or technique, that the benefit or technique has been—

(A) subject to peer review;

(B) described in scientific journals; and

(C) determined to achieve an intended goal under normal programmatic conditions.

(4) MEDICARE BENEFICIARY.—The term ''medicare beneficiary'' means any individual who is

entitled to benefits under part A or enrolled under part B of the medicare program, including any individual enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization under part C of such program.

(5) MEDICARE PROGRAM.—The term ''medicare program'' means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

SEC. 237. FAST-TRACK CONSIDERATION OF PREVENTION BENEFIT LEGISLATION.

(a) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This section is enacted by Congress—

(1) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and is deemed a part of the rules of each House of Congress, but—

(A) is applicable only with respect to the procedure to be followed in that House of Congress in the case of an implementing bill (as defined in subsection (d)); and

(B) supersedes other rules only to the extent that such rules are inconsistent with this section; and

(2) with full recognition of the constitutional right of either House of Congress to change the rules (so far as relating to the procedure of that House of Congress) at any time, in the same manner and to the same extent as in the case of any other rule of that House of Congress.

(b) INTRODUCTION AND REFERRAL.—

(1) INTRODUCTION.—

(A) IN GENERAL.—Subject to paragraph (2), on the day on which the President transmits the report pursuant to section 236(c) to the House of Representatives and the Senate, the recommendations in legislative form transmitted by the President with respect to such report shall be introduced as a bill (by request) in the following manner:

(i) HOUSE OF REPRESENTATIVES.—In the House of Representatives, by the Majority Leader, for himself and the Minority Leader, or by Members of the House of Representatives designated by the Majority Leader and Minority Leader.

(ii) SENATE.—In the Senate, by the Majority Leader, for himself and the Minority Leader, or by Members of the Sen-

ate designated by the Majority Leader and Minority Leader.

(B) SPECIAL RULE.—If either House of Congress is not in session on the day on which such recommendations in legislative form are transmitted, the recommendations in legislative form shall be introduced as a bill in that House of Congress, as provided in subparagraph (A), on the first day thereafter on which that House of Congress is in session.

(2) REFERRAL.—Such bills shall be referred by the presiding officers of the respective Houses to the appropriate committee, or, in the case of a bill containing provisions within the jurisdiction of 2 or more committees, jointly to such committees for consideration of those provisions within their respective jurisdictions.

(c) CONSIDERATION.—After the recommendations in legislative form have been introduced as a bill and referred under subsection (b), such implementing bill shall be considered in the same manner as an implementing bill is considered under subsections (d), (e), (f), and (g) of section 151 of the Trade Act of 1974 (19 U.S.C. 2191).

(d) IMPLEMENTING BILL DEFINED.—In this section, the term ''implementing bill'' means only the recommenda-

tions in legislative form of the Institute of Medicine of the National Academy of Sciences described in section 236(b)(2), transmitted by the President to the House of Representatives and the Senate under section 236(c), and introduced and referred as provided in subsection (b) as a bill of either House of Congress.

(e) COUNTING OF DAYS.—For purposes of this section, any period of days referred to in section 151 of the Trade Act of 1974 shall be computed by excluding—

(1) the days on which either House of Congress is not in session because of an adjournment of more than 3 days to a day certain or an adjournment of Congress sine die; and

(2) any Saturday and Sunday, not excluded under paragraph (1), when either House is not in session.

Subtitle E—Other Services

SEC. 241. REVISION OF MORATORIUM IN CAPS FOR THERAPY SERVICES.

(a) EXTENSION OF MORATORIUM.—Section 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended by striking ''during 2000 and 2001'' and inserting ''during the period beginning on January 1, 2000, and ending on the date that is 18 months after the date the Secretary sub-

mits the report required under section 4541(d)(2) of the Balanced Budget Act of 1997 to Congress''.

(b) EXTENSION OF REPORTING DATE.—Section 4541(d)(2) of BBA (42 U.S.C. 1395l note), as amended by section 221(c) of BBRA (113 Stat. 1501A–351), is amended by striking ''January 1, 2001'' and inserting ''January 1, 2002''.

SEC. 242. REVISION OF COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.

(a) REVISION.—

(1) IN GENERAL.—Section 1861(s)(2)(J) (42 U.S.C. 1395x(s)(2)(J)) is amended to read as follows:

''(J) prescription drugs used in immunosuppressive therapy furnished—

''(i) on or after the date of enactment of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 2000 and before January 1, 2004, to an individual who has received an organ transplant; and

''(ii) on or after January 1, 2004, to an individual who receives an organ transplant for which payment is made under this title, but only in the case of drugs furnished within 36

months after the date of the transplant procedure.''.

(2) CONFORMING AMENDMENTS.—

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

(i) by striking subsection (b); and

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

(B) PASS-THROUGH; REPORT.—Subsections (c) and (d) of section 227 of BBRA (113 Stat. 1501A–355) are repealed.

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

(b) EXTENSION OF CERTAIN SECONDARY PAYER REQUIREMENTS.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended by adding at the end the following: ''With regard to immunosuppressive drugs furnished on or after the date of enactment of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 2000 and before January 1, 2004, this subparagraph shall be applied without regard to any time limitation.''.

SEC. 243. STATE ACCREDITATION OF DIABETES SELF-MANAGEMENT TRAINING PROGRAMS.

Section 1861(qq)(2) of the Social Security Act (42 U.S.C. 1395xx(qq)(2)) is amended—

(1) in the matter preceding subparagraph (A), by striking ''paragraph (1)—'' and inserting ''paragraph (1):'';

(2) in subparagraph (A)—

(A) by striking ''a 'certified provider' '' and inserting ''A 'certified provider' ''; and

(B) by striking ''; and'' and inserting a period; and

(3) in subparagraph (B)—

(A) by striking ''a physician, or such other individual'' and inserting ''(i) A physician, or such other individual'';

(B) by inserting ''(I)'' before ''meets applicable standards'';

(C) by inserting ''(II)'' before ''is recognized'';

(D) by inserting '', or by a program described in clause (ii),'' after ''recognized by an organization that represents individuals (including individuals under this title) with diabetes''; and

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

''(ii) Notwithstanding any reference to 'a national accreditation body' in section 1865(b), for purposes of clause (i), a program described in this clause is a program operated by a State for the purposes of accrediting diabetes self-management training programs, if the Secretary determines that such State program has established quality standards that meet or exceed the standards established by the Secretary under clause (i) or the standards originally established by the National Diabetes Advisory Board and subsequently revised as described in clause (i).''.

SEC. 244. ELIMINATION OF REDUCTION IN PAYMENT AMOUNTS FOR DURABLE MEDICAL EQUIPMENT AND OXYGEN AND OXYGEN EQUIPMENT.

(a) UPDATE FOR COVERED ITEMS.—Section 1834(a)(14)(C) (42 U.S.C. 1395m(a)(14)(C)) is amended by striking ''through 2002'' and inserting ''through 2000''.

(b) ORTHOTICS AND PROSTHETICS.—Section 1834(h)(4)(A)(v) (42 U.S.C. 1395m(h)(4)(A)(v)) is

amended by striking ''through 2002'' and inserting ''through 2000''.

(c) PARENTERAL AND ENTERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT.—Section 4551(b) of BBA (42 U.S.C. 1395m note) is amended by striking ''through 2002'' and inserting ''through 2000''.

(d) OXYGEN AND OXYGEN EQUIPMENT.—Section 1834(a)(9)(B) (42 U.S.C. 1395m(a)(9)(B)) is amended—

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

(2) in clause (vi)—

(A) by striking ''each subsequent year'' and inserting ''2000''; and

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

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

''(vii) for 2001 and each subsequent year, the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year.''.

(e) CONFORMING AMENDMENT.—Section 228 of BBRA (113 Stat. 1501A–356) is repealed.

SEC. 245. STANDARDS REGARDING PAYMENT FOR CERTAIN ORTHOTICS AND PROSTHETICS.

(a) STANDARDS.—

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

''(F) ESTABLISHMENT OF STANDARDS FOR CERTAIN ITEMS.—

''(i) IN GENERAL.—No payment shall be made for an applicable item unless such item is provided by a qualified practitioner or a qualified supplier under the system established by the Secretary under clause (iii). For purposes of the preceding sentence, if a qualified practitioner or a qualified supplier contracts with an entity to provide an applicable item, then no payment shall be made for such item unless the entity is also a qualified supplier.

''(ii) DEFINITIONS.—In this subparagraph—

''(I) APPLICABLE ITEM.—The term 'applicable item' means orthotics and prosthetics that require education, training, and experience to custom fabricate such item. Such

term does not include shoes and shoe inserts.

"(II) QUALIFIED PRACTITIONER.—The term 'qualified practitioner' means a physician or health professional who meets any of the following requirements:

"(aa) The physician or health professional is specifically trained and educated to provide or manage the provision of custom-designed, fabricated, modified, and fitted orthotics and prosthetics, and is either certified by the American Board for Certification in Orthotics and Prosthetics, Inc., certified by the Board for Orthotist/Prosthetist Certification, or credentialed and approved by a program that the Secretary determines, in consultation with appropriate experts in orthotics and prosthetics, has training and education stand-

ards that are necessary to provide applicable items.

''(bb) The physician or health professional is licensed in orthotics or prosthetics by the State in which the applicable item is supplied, but only if the Secretary determines that the mechanisms used by the State to provide such licensure meet standards determined appropriate by the Secretary.

''(cc) The physician or health professional has completed at least 10 years practice in the provision of applicable items. A physician or health professional may not qualify as a qualified practitioner under the preceding sentence with respect to an applicable item if the item was provided on or after January 1, 2005.

"(III) QUALIFIED SUPPLIER.—The term 'qualified supplier' means any entity that is—

"(aa) accredited by the American Board for Certification in Orthotics and Prosthetics, Inc. or the Board for Orthotist/Prosthetist Certification; or

"(bb) accredited and approved by a program that the Secretary determines has accreditation and approval standards that are essentially equivalent to those of such Board.

"(iii) SYSTEM.—The Secretary, in consultation with appropriate experts in orthotics and prosthetics, shall establish a system under which the Secretary shall—

"(I) determine which items are applicable items and formulate a list of such items;

"(II) review the applicable items billed under the coding system established under this title; and

''(III) limit payment for applicable items pursuant to clause (i).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items provided on or after January 1, 2003.

(b) REVISION OF DEFINITION OF ORTHOTICS.—

(1) IN GENERAL.—Section 1861(s)(9) (42 U.S.C. 1395x(s)(9)) is amended by inserting ''(including such braces that are used in conjunction with, or as components of, other medical or nonmedical equipment when provided by a qualified practitioner (as defined in subclause (II) of section 1834(h)(1)(F))) or a qualified supplier (as defined in subclause (III) of such section)'' after ''braces''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items provided on or after January 1, 2003.

SEC. 246. NATIONAL LIMITATION AMOUNT EQUAL TO 100 PERCENT OF NATIONAL MEDIAN FOR NEW PAP SMEAR TECHNOLOGIES AND OTHER NEW CLINICAL LABORATORY TEST TECHNOLOGIES.

Section 1833(h)(4)(B)(viii) (42 U.S.C. 1395l(h)(4)(B)(viii)) is amended by inserting before the period at the end the following: ''(or 100 percent of such

median in the case of a clinical diagnostic laboratory test performed on or after January 1, 2001, that the Secretary determines is a new test for which no limitation amount has previously been established under this subparagraph)''.

SEC. 247. INCREASED MEDICARE PAYMENTS FOR CERTIFIED NURSE-MIDWIFE SERVICES.

(a) AMOUNT OF PAYMENT.—Section 1833(a)(1)(K) (42 U.S.C. 1395l(a)(1)(K)) is amended by striking ''65 percent of the prevailing charge that would be allowed for the same service performed by a physician, or, for services furnished on or after January 1, 1992, 65 percent'' and inserting ''85 percent''.

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

SEC. 248. PAYMENT FOR ADMINISTRATION OF DRUGS.

(a) REVIEW OF CHEMOTHERAPY ADMINISTRATION PRACTICE EXPENSES RVUS.—The Secretary of Health and Human Services shall review the resource-based practice expense component of relative value units under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for chemotherapy administration services to determine if such units should be increased.

(b) MORE ACCURATE CHEMOTHERAPY DRUG PAYMENTS TIED TO INCREASES IN CHEMOTHERAPY ADMINISTRATION PAYMENTS.—If the Secretary of Health and Human Services determines, as a result of the review under subsection (a), that the resource-based practice expense relative value units for chemotherapy administration services should be increased, the Secretary—

(1) may implement such increases for such services, but only if the Secretary simultaneously implements more accurate average wholesale prices for chemotherapy drugs (but in no case shall such simultaneous implementation occur prior to January 1, 2002); and

(2) if the Secretary implements such increases for such services, shall do so without taking into account the requirement under the physician fee schedule under section 1848(c)(2)(B)(ii)(II) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)(ii)(II)).

(c) BLOOD CLOTTING DRUG-RELATED ACTIVITIES.—

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

(A) by striking ''and'' after ''supervision,''; and

(B) by inserting the following before the semicolon: ", and the costs (pursuant to section 1834(n)) incurred by suppliers of such factors".

(2) PAYMENTS.—Section 1834 (42 U.S.C. 1395m), as amended by section 233(b), is amended by adding at the end the following new subsection:

"(n) PAYMENT FOR BLOOD CLOTTING DRUG-RELATED ACTIVITIES.—

"(1) IN GENERAL.—The Secretary shall make payments in accordance with paragraph (2) to suppliers of blood clotting factors (as described in section 1861(s)(2)(I)) to cover the costs (such as shipping, storage, inventory control, or other costs specified by the Secretary) incurred by such suppliers in furnishing such factors to individuals enrolled under this part.

"(2) PAYMENT AMOUNT.—The amount of payment for furnishing such blood clotting factors (as so described) shall be an amount equal to 80 percent of the lesser of—

"(A) the actual charge for the furnishing of such factors; or

"(B) an amount equal to 10 cents (or such other amount determined appropriate by the Secretary) per unit of such factor furnished.".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to blood clotting factors (as described in section 1861(s)(2)(I) of the Social Security Act (42 U.S.C. 1395x(s)(2)(I))) furnished on or after the date that the Secretary of Health and Human Services implements more accurate average wholesale prices for such factors.

SEC. 249. MEDPAC STUDY ON IN-HOME INFUSION THERAPY NURSING SERVICES.

(a) STUDY.—The Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) (in this section referred to as ''MedPAC'') shall conduct a study on the provision of in-home infusion therapy nursing services, including a review of any documentation of clinical efficacy for those services and any costs associated with providing those services.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, MedPAC shall submit a report to the Secretary of Health and Human Services and Congress on the study and review conducted under subsection (a) together with recommendations regarding the establishment of a payment methodology for in-home infusion therapy nursing services that ensures the continuing access of beneficiaries under the medicare program under

title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to those services.

TITLE III—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

SEC. 301. ELIMINATION OF 15 PERCENT REDUCTION IN PAYMENT RATES UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1895(b)(3)(A) (42 U.S.C. 1395fff(b)(3)(A)) is amended to read as follows:

"(A) INITIAL BASIS.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts). 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 the 12-month period beginning on the date the Secretary implements the system shall be equal to the total amount that would have been made if the system had not been in effect and if section 1861(v)(1)(L)(ix) had not been enacted. Each such amount shall be standardized in a manner

that eliminates the effect of variations in relative case mix and area wage adjustments 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.''.

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

SEC. 302. EXCLUSION OF CERTAIN NONROUTINE MEDICAL SUPPLIES UNDER THE PPS FOR HOME HEALTH SERVICES.

(a) EXCLUSION.—

(1) IN GENERAL.—Section 1895 (42 U.S.C. 1395fff) is amended by adding at the end the following new subsection:

''(e) EXCLUSION OF NONROUTINE MEDICAL SUPPLIES.—

''(1) IN GENERAL.—Notwithstanding the preceding provisions of this section, in the case of all nonroutine medical supplies (as defined by the Secretary) furnished by a home health agency during a

year (beginning with 2001) for which payment is otherwise made on the basis of the prospective payment amount under this section, payment under this section shall be based instead on the lesser of—

''(A) the actual charge for the nonroutine medical supply; or

''(B) the amount determined under the fee schedule established by the Secretary for purposes of making payment for such items under part B for nonroutine medical supplies furnished during that year.

''(2) BUDGET NEUTRALITY ADJUSTMENT.—The Secretary shall provide for an appropriate proportional reduction in payments under this section so that beginning with fiscal year 2001, the aggregate amount of such reductions is equal to the aggregate increase in payments attributable to the exclusion effected under paragraph (1).''.

(2) CONFORMING AMENDMENT.—Section 1895(b)(1) of the Social Security Act (42 U.S.C. 1395fff(b)(1)) is amended by striking ''The Secretary'' and inserting ''Subject to subsection (e), the Secretary''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to supplies furnished on or after January 1, 2001.

(b) EXCLUSION FROM CONSOLIDATED BILLING.—

(1) IN GENERAL.—For items provided during the applicable period, the Secretary of Health and Human Services shall administer the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as if—

(A) section 1842(b)(6)(F) of such Act (42 U.S.C. 1395u(b)(6)(F)) was amended by striking ''(including medical supplies described in section 1861(m)(5), but excluding durable medical equipment to the extent provided for in such section)'' and inserting ''(excluding medical supplies and durable medical equipment described in section 1861(m)(5))''; and

(B) section 1862(a)(21) of such Act (42 U.S.C. 1395y(a)(21)) was amended by striking ''(including medical supplies described in section 1861(m)(5), but excluding durable medical equipment to the extent provided for in such section)'' and inserting ''(excluding medical supplies and durable medical equipment described in section 1861(m)(5))''.

(2) APPLICABLE PERIOD DEFINED.—For purposes of paragraph (1), the term ''applicable period'' means the period beginning on January 1, 2001, and ending on the later of—

(A) the date that is 18 months after the date of enactment of this Act; or

(B) the date determined appropriate by the Secretary of Health and Human Services.

(c) STUDY ON EXCLUSION OF CERTAIN NONROUTINE MEDICAL SUPPLIES UNDER THE PPS FOR HOME HEALTH SERVICES.—

(1) STUDY.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall conduct a study to identify any nonroutine medical supply that may be appropriately and cost-effectively excluded from the prospective payment system for home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff). Specifically, the Secretary shall consider whether wound care and ostomy supplies should be excluded from such prospective payment system.

(2) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to the committees of jurisdiction of the

House of Representatives and the Senate a report on the study conducted under paragraph (1), including a list of any nonroutine medical supplies that should be excluded from the prospective payment system for home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff).

(d) EXCLUSION OF OTHER NONROUTINE MEDICAL SUPPLIES.—Upon submission of the report under subsection (c)(2), the Secretary shall (if necessary) revise the definition of nonroutine medical supply, as defined for purposes of section 1895(e) (as added by subsection (a)), based on the list of nonroutine medical supplies included in such report.

SEC. 303. PERMITTING HOME HEALTH PATIENTS WITH ALZHEIMER'S DISEASE OR A RELATED DEMENTIA TO ATTEND ADULT DAY-CARE.

(a) IN GENERAL.—Sections 1814(a) and 1835(a) of the Social Security Act (42 U.S.C. 1395f(a); 1395n(a)) are each amended in the last sentence by inserting ''(including regularly participating, for the purpose of therapeutic treatment for Alzheimer's disease or a related dementia, in an adult day-care program that is licensed, certified, or accredited by a State to furnish adult day-care services in the State)'' before the period.

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

SEC. 304. STANDARDS FOR HOME HEALTH BRANCH OFFICES.

(a) IN GENERAL.—Section 1861(o) (42 U.S.C. 1395x(o)) is amended by adding at the end the following new sentences: ''For purposes of this subsection, a home health agency may provide services through a single site or through a branch office. For purposes of the preceding sentence, the term 'branch office' means a service site for home health services that is controlled and supervised by a home health agency.''.

(b) ESTABLISHMENT OF STANDARDS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall establish, using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code, standards for the operation of a branch office (as defined in the last sentence of section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)), as added by subsection (a)).

(2) REQUIREMENTS.—In establishing standards under paragraph (1), the Secretary shall—

(A) provide for the special treatment of any home health agency or branch office—

(i) that is located in a frontier area; or

(ii) with any other special circumstance that the Secretary determines is appropriate; and

(B) allow the use of technology used by the home health agency to supervise the branch office.

(3) CONSULTATION.—The Secretary shall establish the regulations under this subsection in consultation with representatives of the home health industry.

SEC. 305. TREATMENT OF HOME HEALTH SERVICES PROVIDED IN CERTAIN COUNTIES.

(a) IN GENERAL.—Notwithstanding any other provision of law, effective for home health services provided under the prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff) during fiscal year 2001 in an applicable county, the geographic adjustment factors applicable in such year to hospitals physically located in such county under section 1886(d) of such Act (42 U.S.C. 1395ww(d)) (including the factors applicable to such hospitals by reason of any reclassification or

deemed reclassification) shall be deemed to apply to such services instead of the area wage adjustment factors that would otherwise be applicable to such services under section 1895(b)(4)(C) of such Act (42 U.S.C. 1395fff(b)(4)(C)).

(b) APPLICABLE COUNTY DEFINED.—For purposes of subsection (a), the term ''applicable county'' means any of the following counties:

(1) Duchess County, New York.

(2) Orange County, New York.

(3) Clinton County, New York.

(4) Ulster County, New York.

(5) Otsego County, New York.

(6) Cayuga County, New York.

(7) St. Jefferson County, New York.

Subtitle B—Direct Graduate Medical Education

SEC. 311. NOT COUNTING CERTAIN GERIATRIC RESIDENTS AGAINST GRADUATE MEDICAL EDUCATION LIMITATIONS.

For cost reporting periods beginning on or after October 1, 2000, and before October 1, 2005, in applying the limitations regarding the total number of full-time equivalent interns and residents in the field of allopathic or osteopathic medicine under subsections (d)(5)(B)(v)

and (h)(4)(F) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) for a hospital, the Secretary of Health and Human Services shall not take into account a maximum of 3 interns or residents in the field of geriatric medicine to the extent the hospital increases the number of geriatric interns or residents above the number of such interns or residents for the hospital's most recent cost reporting period ending before October 1, 2000.

SEC. 312. PROGRAM OF PAYMENTS TO CHILDREN'S HOSPITALS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.

Part A of title XI (42 U.S.C. 1301 et seq.) is amended by adding after section 1150 the following new section:

''PROGRAM OF PAYMENTS TO CHILDREN'S HOSPITALS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS

''SEC. 1150A. (a) PAYMENTS.—The Secretary shall make 2 payments under this section to each children's hospital for each of fiscal years 2002 through 2005, 1 for the direct expenses and the other for the indirect expenses associated with operating approved graduate medical residency training programs.

''(b) AMOUNT OF PAYMENTS.—

''(1) IN GENERAL.—Subject to paragraph (2), the amounts payable under this section to a children's hospital for an approved graduate medical

residency training program for a fiscal year are each of the following amounts:

"(A) DIRECT EXPENSE AMOUNT.—The amount determined under subsection (c) for direct expenses associated with operating approved graduate medical residency training programs.

"(B) INDIRECT EXPENSE AMOUNT.—The amount determined under subsection (d) for indirect expenses associated with the treatment of more severely ill patients and the additional costs relating to teaching residents in such programs.

"(2) CAPPED AMOUNT.—

"(A) IN GENERAL.—The total of the payments made to children's hospitals under subparagraph (A) or (B) of paragraph (1) in a fiscal year shall not exceed the funds appropriated under paragraph (1) or (2), respectively, of subsection (f) for such payments for that fiscal year.

"(B) PRO RATA REDUCTIONS OF PAYMENTS FOR DIRECT EXPENSES.—If the Secretary determines that the amount of funds appropriated under subsection (f)(1) for a fiscal

year is insufficient to provide the total amount of payments otherwise due for such periods under paragraph (1)(A), the Secretary shall reduce the amounts so payable on a pro rata basis to reflect such shortfall.

''(c) AMOUNT OF PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION.—

''(1) IN GENERAL.—The amount determined under this subsection for payments to a children's hospital for direct graduate expenses relating to approved graduate medical residency training programs for a fiscal year is equal to the product of—

''(A) the updated per resident amount for direct graduate medical education, as determined under paragraph (2); and

''(B) the average number of full-time equivalent residents in the hospital's graduate approved medical residency training programs (as determined under section 1886(h)(4)) during the fiscal year.

''(2) UPDATED PER RESIDENT AMOUNT FOR DIRECT GRADUATE MEDICAL EDUCATION.—The updated per resident amount for direct graduate medical education for a hospital for a fiscal year is an amount determined as follows:

''(A) DETERMINATION OF HOSPITAL SINGLE PER RESIDENT AMOUNT.—The Secretary shall compute for each hospital operating an approved graduate medical education program (regardless of whether or not it is a children's hospital) a single per resident amount equal to the average (weighted by number of full-time equivalent residents) of the primary care per resident amount and the non-primary care per resident amount computed under section 1886(h)(2) for cost reporting periods ending during fiscal year 1997.

''(B) DETERMINATION OF WAGE AND NON-WAGE-RELATED PROPORTION OF THE SINGLE PER RESIDENT AMOUNT.—The Secretary shall estimate the average proportion of the single per resident amounts computed under subparagraph (A) that is attributable to wages and wage-related costs.

''(C) STANDARDIZING PER RESIDENT AMOUNTS.—The Secretary shall establish a standardized per resident amount for each such hospital—

''(i) by dividing the single per resident amount computed under subparagraph (A)

into a wage-related portion and a non-wage-related portion by applying the proportion determined under subparagraph (B);

"(ii) by dividing the wage-related portion by the factor applied under section 1886(d)(3)(E) for discharges occurring during fiscal year 1999 for the hospital's area; and

"(iii) by adding the non-wage-related portion to the amount computed under clause (ii).

"(D) DETERMINATION OF NATIONAL AVERAGE.—The Secretary shall compute a national average per resident amount equal to the average of the standardized per resident amounts computed under subparagraph (C) for such hospitals, with the amount for each hospital weighted by the average number of full-time equivalent residents at such hospital.

"(E) APPLICATION TO INDIVIDUAL HOSPITALS.—The Secretary shall compute for each such hospital that is a children's hospital a per resident amount—

"(i) by dividing the national average per resident amount computed under subparagraph (D) into a wage-related portion and a non-wage-related portion by applying the proportion determined under subparagraph (B);

"(ii) by multiplying the wage-related portion by the factor described in subparagraph (C)(ii) for the hospital's area; and

"(iii) by adding the non-wage-related portion to the amount computed under clause (ii).

"(F) UPDATING RATE.—The Secretary shall update such per resident amount for each such children's hospital by the estimated percentage increase in the Consumer Price Index for all urban consumers (U.S. city average) during the period beginning October 1997, and ending with the midpoint of the Federal fiscal year for which payments are made.

"(d) AMOUNT OF PAYMENT FOR INDIRECT MEDICAL EDUCATION.—

"(1) IN GENERAL.—The amount determined under this subsection for payments to a children's hospital for indirect expenses associated with the

treatment of more severely ill patients and the additional costs related to the teaching of residents for a fiscal year is equal to an amount determined appropriate by the Secretary.

''(2) FACTORS.—In determining the amount under paragraph (1), the Secretary shall—

''(A) take into account variations in case mix and regional wage levels among children's hospitals and the number of full-time equivalent residents in the hospitals' approved graduate medical residency training programs; and

''(B) assure that the aggregate of the payments for indirect expenses associated with the treatment of more severely ill patients and the additional costs related to the teaching of residents under this section in a fiscal year are equal to the amount appropriated for such expenses for the fiscal year involved under subsection (f)(2).

''(e) MAKING OF PAYMENTS.—

''(1) INTERIM PAYMENTS.—The Secretary shall determine, before the beginning of each fiscal year involved for which payments may be made for a hospital under this section, the amounts of the payments for direct graduate medical education and in-

direct medical education for such fiscal year and shall (subject to paragraph (2)) make the payments of such amounts in 26 equal interim installments during such period. Such interim payments to each individual hospital shall be based on the number of residents reported in the hospital's most recently filed medicare cost report prior to the application date for the Federal fiscal year for which the interim payment amounts are established.

''(2) WITHHOLDING.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall withhold 25 percent from each interim installment for direct and indirect graduate medical education paid under paragraph (1).

''(B) REDUCTION OF WITHHOLDING.—The Secretary shall reduce the percent withheld from each installment pursuant to subparagraph (A) if the Secretary determines that such reduced percent will provide the Secretary with a reasonable level of assurance that most hospitals will not be overpaid on an interim basis.

''(3) RECONCILIATION.—Prior to the end of each fiscal year, the Secretary shall determine any changes to the number of residents reported by a

hospital and shall use that number of residents to determine the final amount payable to the hospital for the current fiscal year for both direct expense and indirect expense amounts. Based on such determination, the Secretary shall recoup any overpayments made or pay any balance due to the extent possible. In the event that a hospital's interim payments were greater than the final amount to which it is entitled, the Secretary shall have the option of recouping that excess amount in determining the amount to be paid in the subsequent year to that hospital. The final amount so determined shall be considered a final intermediary determination for purposes of applying section 1878 and shall be subject to review under that section in the same manner as the amount of payment under section 1886(d) is subject to review under such section.

''(f) AUTHORIZATION OF APPROPRIATIONS.—

''(1) DIRECT GRADUATE MEDICAL EDUCATION.—

''(A) IN GENERAL.—There are appropriated, out of any money in the Treasury not otherwise appropriated, for payments under subsection (b)(1)(A) for each of fiscal years 2002 through 2005, $95,000,000.

''(B) CARRYOVER OF EXCESS.—The amounts appropriated under subparagraph (A) for each fiscal year shall remain available for obligation through the end of the subsequent fiscal year.

''(2) INDIRECT MEDICAL EDUCATION.—There are appropriated, out of any money in the Treasury not otherwise appropriated, for payments under subsection (b)(1)(A) for each of fiscal years 2002 through 2005, $190,000,000.

''(g) DEFINITIONS.—In this section:

''(1) APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAM.—The term 'approved graduate medical residency training program' has the meaning given the term 'approved medical residency training program' in section 1886(h)(5)(A).

''(2) CHILDREN'S HOSPITAL.—The term 'children's hospital' means a hospital with a medicare payment agreement and which is excluded from the medicare inpatient prospective payment system pursuant to section 1886(d)(1)(B)(iii) and its accompanying regulations.

''(3) DIRECT GRADUATE MEDICAL EDUCATION COSTS.—The term 'direct graduate medical edu-

cation costs' has the meaning given such term in section 1886(h)(5)(C).''.

SEC. 313. AUTHORITY TO INCLUDE COSTS OF TRAINING OF CLINICAL PSYCHOLOGISTS IN PAYMENTS TO HOSPITALS.

Effective for cost reporting periods beginning on or after October 1, 1999, for purposes of payments to hospitals under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for costs of approved educational activities (as defined in section 413.85 of title 42 of the Code of Federal Regulations), such approved educational activities shall include the clinical portion of professional educational training programs, recognized by the Secretary, for clinical psychologists.

SEC. 314. TREATMENT OF CERTAIN NEWLY ESTABLISHED RESIDENCY PROGRAMS IN COMPUTING MEDICARE PAYMENTS FOR THE COSTS OF MEDICAL EDUCATION.

(a) IN GENERAL.—Section 1886(h)(4)(H) (42 U.S.C. 1395ww(h)(4)(H)) is amended by adding at the end the following new clause:

''(v) TREATMENT OF CERTAIN NEWLY ESTABLISHED PROGRAMS.—Any hospital that has received payments under this subsection for a cost reporting period ending

before January 1, 1995, and that operates an approved medical residency training program established on or after August 5, 1997, shall be treated as meeting the requirements for an adjustment under the rules prescribed pursuant to clause (i) with respect to such program if—

''(I) such program received accreditation from the American Council of Graduate Medical Education not later than August 5, 1998;

''(II) such program was in operation (with 1 or more residents in training) as of January 1, 2000;

''(III) such hospital is located in an area that is contiguous to a rural area and serves individuals from such rural area; and

''(IV) such hospital serves a medical service area with a population that is less than 500,000.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of section 4623 of BBA (111 Stat. 477).

Subtitle C—Miscellaneous Provisions

SEC. 321. WAIVER OF 24-MONTH WAITING PERIOD FOR MEDICARE COVERAGE OF INDIVIDUALS DISABLED WITH AMYOTROPHIC LATERAL SCLEROSIS (ALS).

(a) IN GENERAL.—Section 226 (42 U.S.C. 426) is amended—

(1) by redesignating subsection (h) as subsection (j) and by moving such subsection to the end of the section; and

(2) by inserting after subsection (g) the following new subsection:

''(h) For purposes of applying this section in the case of an individual medically determined to have amyotrophic lateral sclerosis (ALS), the following special rules apply:

''(1) Subsection (b) shall be applied as if there were no requirement for any entitlement to benefits, or status, for a period longer than 1 month.

''(2) The entitlement under such subsection shall begin with the first month (rather than twenty-fifth month) of entitlement or status.

''(3) Subsection (f) shall not be applied.''.

(b) CONFORMING AMENDMENT.—Section 1837 (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

''(j) In applying this section in the case of an individual who is entitled to benefits under part A pursuant to the operation of section 226(h), the following special rules apply:

''(1) The initial enrollment period under subsection (d) shall begin on the first day of the first month in which the individual satisfies the requirement of section 1836(1).

''(2) In applying subsection (g)(1), the initial enrollment period shall begin on the first day of the first month of entitlement to disability insurance benefits referred to in such subsection.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits for months beginning after the date of enactment of this Act.

TITLE IV—RURAL PROVIDER PROVISIONS

Subtitle A—Critical Access Hospitals

SEC. 401. PAYMENTS TO CRITICAL ACCESS HOSPITALS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) PAYMENT ON COST BASIS WITHOUT BENEFICIARY COST-SHARING.—

(1) IN GENERAL.—Section 1833(a)(6) (42 U.S.C. 1395l(a)(6)) is amended by inserting ''(including clinical diagnostic laboratory services furnished by a critical access hospital)'' after ''outpatient critical access hospital services''.

(2) NO BENEFICIARY COST-SHARING.—

(A) IN GENERAL.—Section 1834(g) (42 U.S.C. 1395m(g)) is amended by inserting ''(except that in the case of clinical diagnostic laboratory services furnished by a critical access hospital the amount of payment shall be equal to 100 percent of the reasonable costs of the critical access hospital in providing such services)'' before the period at the end.

(B) BBRA AMENDMENT.—Section 1834(g) (42 U.S.C. 1395m(g)), as amended by section

403(d) of BBRA (113 Stat. 1501A–371), is amended—

(i) in paragraph (1), by inserting ''(except that in the case of clinical diagnostic laboratory services furnished by a critical access hospital the amount of payment shall be equal to 100 percent of the reasonable costs of the critical access hospital in providing such services)'' after ''such services''; and

(ii) in paragraph (2)(A), by inserting ''(except that in the case of clinical diagnostic laboratory services furnished by a critical access hospital the amount of payment shall be equal to 100 percent of the reasonable costs of the critical access hospital in providing such services)'' before the period at the end.

(b) CONFORMING AMENDMENTS.—Paragraphs (1)(D)(i) and (2)(D)(i) of section 1833(a) (42 U.S.C. 1395l(a)(1)(D)(i); 1395l(a)(2)(D)(i)) are each amended by striking ''or which are furnished on an outpatient basis by a critical access hospital''.

(c) TECHNICAL AMENDMENT.—Section 403(d)(2) of BBRA (113 Stat. 1501A–371) is amended by striking ''subsection (a)'' and inserting ''paragraph (1)''.

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to services furnished on or after November 29, 1999.

(2) BBRA AND TECHNICAL AMENDMENTS.—The amendments made by subsections (a)(2)(B) and (c) shall take effect as if included in the enactment of section 403(d) of BBRA (113 Stat. 1501A–371).

SEC. 402. REVISION OF PAYMENT FOR PROFESSIONAL SERVICES PROVIDED BY A CRITICAL ACCESS HOSPITAL.

(a) IN GENERAL.—Section 1834(g)(2)(B) (42 U.S.C. 1395m(g)(2)(B)), as amended by section 403(d) of BBRA (113 Stat. 1501A–371), is amended by inserting ''120 percent of'' after ''hospital services,''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of section 403(d) of BBRA (113 Stat. 1501A–371).

SEC. 403. PERMITTING CRITICAL ACCESS HOSPITALS TO OPERATE PPS EXEMPT DISTINCT PART PSYCHIATRIC AND REHABILITATION UNITS.

(a) 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 inserting ''excluding any psychiatric or rehabilitation unit of the facility which is a distinct part of the facility,'' before ''provides not''.

(b) DEFINITION OF PPS EXEMPT DISTINCT PART PSYCHIATRIC AND REHABILITATION UNITS.—Section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended by inserting before the last sentence the following new sentence: ''In establishing such definition, the Secretary may not exclude from such definition a psychiatric or rehabilitation unit of a critical access hospital which is a distinct part of such hospital solely because such hospital is exempt from the prospective payment system under this section.''.

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

Subtitle B—Medicare Dependent, Small Rural Hospital Program

SEC. 411. MAKING THE MEDICARE DEPENDENT, SMALL RURAL HOSPITAL PROGRAM PERMANENT.

(a) PAYMENT METHODOLOGY.—Section 1886(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(1) in clause (i), by striking ''and before October 1, 2006,''; and

(2) in clause (ii)(II), by striking ''and before October 1, 2006,''.

(b) CONFORMING AMENDMENTS.—

(1) TARGET AMOUNT.—Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking ''and before October 1, 2006,''; and

(B) in clause (iv), by striking ''through fiscal year 2005,'' and inserting ''or any subsequent fiscal year,''.

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note), as amended by section 404(b)(2) of BBRA (113 Stat. 1501A–372), is amended by striking ''or fiscal year 2000 through fiscal year 2005''

and inserting ''fiscal year 2000, or any subsequent fiscal year,''.

SEC. 412. OPTION TO BASE ELIGIBILITY FOR MEDICARE DEPENDENT, SMALL RURAL HOSPITAL PROGRAM ON DISCHARGES DURING ANY OF THE 3 MOST RECENT AUDITED COST REPORTING PERIODS.

(a) IN GENERAL.—Section 1886(d)(5)(G)(iv)(IV) (42 U.S.C. 1395ww(d)(5)(G)(iv)(IV)) is amended by inserting '', or any of the 3 most recent audited cost reporting periods,'' after ''1987''.

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

Subtitle C—Sole Community Hospitals

SEC. 421. EXTENSION OF OPTION TO USE REBASED TARGET AMOUNTS TO ALL SOLE COMMUNITY HOSPITALS.

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

(1) in the matter preceding subclause (I)—

(A) by striking ''that for its cost reporting period beginning during 1999 is paid on the

basis of the target amount applicable to the hospital under subparagraph (C) and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital''; and

(B) by striking ''substituted for such target amount'' and inserting ''substituted, if such substitution results in a greater payment under this section for such hospital, for the amount otherwise determined under subsection (d)(5)(D)(i)'';

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

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

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

SEC. 422. DEEMING A CERTAIN HOSPITAL AS A SOLE COMMUNITY HOSPITAL.

Notwithstanding any other provision of law, for purposes of discharges occurring on or after October 1, 2000, the Greensville Memorial Hospital located in Emporia, Virginia shall be deemed to have satisfied the travel and time criteria under section 1886(d)(5)(D)(iii)(II) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(D)(iii)(II)) for classification as a sole community hospital.

Subtitle D—Other Rural Hospital Provisions

SEC. 431. EXEMPTION OF HOSPITAL SWING-BED PROGRAM FROM THE PPS FOR SKILLED NURSING FACILITIES.

(a) EXEMPTION FOR MEDICARE SWING-BED HOSPITALS.—

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

(A) in the heading, by striking ''TRANSITION'' and inserting ''EXEMPTION'';

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

''(A) IN GENERAL.—The prospective payment system under this subsection shall not apply to items and services provided by a facility described in subparagraph (B).''; and

(C) in subparagraph (B), by striking ", for which payment" and all that follows before the period.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect as if included in the enactment of section 4432 of BBA (111 Stat. 414).

(b) CHANGE IN EFFECTIVE DATE OF BBRA AMENDMENTS.—

(1) IN GENERAL.—Section 408(c) of BBRA (113 Stat. 1501A–375) is amended by striking "the date that is" and all that follows and inserting "January 1, 2001.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect as if included in the enactment of section 408 of BBRA (113 Stat. 1501A–375).

SEC. 432. PERMANENT GUARANTEE OF PRE-BBA PAYMENT LEVELS FOR OUTPATIENT SERVICES FURNISHED BY RURAL HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D), as amended by section 203, is amended to read as follows:

"(D) HOLD HARMLESS PROVISIONS FOR SMALL RURAL AND CANCER HOSPITALS.—In the case of a hospital located in a rural area

and that has not more than 100 beds or a hospital described in section 1886(d)(1)(B)(v), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of section 202 of BBRA (111 Stat. 1501A–342).

SEC. 433. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

(a) IN GENERAL.—Section 1848(i) (42 U.S.C. 1395w–4(i)) is amended by adding at the end the following new paragraph:

''(4) TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.—

''(A) IN GENERAL.—Notwithstanding any other provision of law, when an independent laboratory furnishes the technical component of a physician pathology service with respect to a fee-for-service medicare beneficiary who is a patient of a grandfathered hospital, such component shall be treated as a service for which pay-

ment shall be made to the laboratory under this section and not as—

"(i) an inpatient hospital service for which payment is made to the hospital under section 1886(d); or

"(ii) a hospital outpatient service for which payment is made to the hospital under the prospective payment system under section 1834(t).

"(B) DEFINITIONS.—In this paragraph:

"(i) GRANDFATHERED HOSPITAL.—The term 'grandfathered hospital' means a hospital that had an arrangement with an independent laboratory—

"(I) that was in effect as of July 22, 1999; and

"(II) under which the laboratory furnished the technical component of physician pathology services with respect to patients of the hospital and submitted a claim for payment for such component to a carrier with a contract under section 1842 (and not to the hospital).

"(ii) FEE-FOR-SERVICE MEDICARE BENEFICIARY.—The term 'fee-for-service medicare beneficiary' means an individual who is not enrolled—

"(I) in a Medicare+Choice plan under part C;

"(II) in a plan offered by an eligible organization under section 1876;

"(III) with a PACE provider under section 1894;

"(IV) in a medicare managed care demonstration project; or

"(V) in the case of a service furnished to an individual on an outpatient basis, in a health care prepayment plan under section 1833(a)(1)(A).".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services furnished on or after January 1, 2001.

Subtitle E—Other Rural Provisions

SEC. 441. REVISION OF BONUS PAYMENTS FOR SERVICES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.

(a) EXPANSION OF BONUS PAYMENTS TO INCLUDE PHYSICIAN ASSISTANT AND NURSE PRACTITIONER SERVICES.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended—

(1) by inserting ''(or services furnished by a physician assistant or nurse practitioner that would be physicians' services if furnished by a physician)'' after ''physicians' services'';

(2) by inserting '', physician assistant (in the case of a physician assistant described in subparagraph (C)(ii) of section 1842(b)(6)), or nurse practitioner'' after ''physician''; and

(3) by striking ''clause (A) of section 1842(b)(6)'' and inserting ''subparagraphs (A) and (C)(i) of such section''.

(b) ELIMINATION OF REQUIREMENT TO MAKE BONUS PAYMENTS ON MONTHLY OR QUARTERLY BASIS.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended by striking ''(on a monthly or quarterly basis)''.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by subsection (a) shall apply to services furnished on or after July 1, 2001.

(2) MONTHLY OR QUARTERLY PAYMENTS.—The amendment made by subsection (b) shall apply to services furnished on or after the first day of the first calendar quarter beginning at least 240 days after the date of enactment of this Act.

SEC. 442. PROVIDER-BASED RURAL HEALTH CLINIC CAP EXEMPTION.

(a) IN GENERAL.—The matter in section 1833(f) (42 U.S.C. 1395l(f)) preceding paragraph (1) is amended by striking ''with less than 50 beds'' and inserting ''with an average daily patient census that does not exceed 50''.

(b) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to services furnished on or after January 1, 2001.

SEC. 443. PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT SERVICES.

(a) PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT SERVICES.—Section 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is amended by striking ''for such services provided before January 1, 2003,''.

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

SEC. 444. BONUS PAYMENTS FOR RURAL HOME HEALTH AGENCIES IN 2001 AND 2002.

(a) INCREASE IN PAYMENT RATES FOR RURAL AGENCIES IN 2001 AND 2002.—Section 1895(b) (42 U.S.C. 1395fff(b)) is amended by adding at the end the following new paragraph:

''(7) ADDITIONAL PAYMENT AMOUNT FOR SERVICES FURNISHED IN RURAL AREAS IN 2001 AND 2002.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D)) during 2001 or 2002, the Secretary shall provide for an addition or adjustment to the payment amount otherwise made under this section for services furnished in a rural area in an amount equal to 10 percent of the amount otherwise determined under this subsection.''.

(b) WAIVING BUDGET NEUTRALITY.—Section 1895(b)(3) (42 U.S.C. 1395fff(b)(3)) is amended by adding at the end the following new subparagraph:

''(D) NO ADJUSTMENT FOR ADDITIONAL PAYMENTS FOR RURAL SERVICES.—The Secretary shall not reduce the standard prospective

payment amount (or amounts) under this paragraph applicable to home health services furnished during a period to offset the increase in payments resulting from the application of paragraph (7) (relating to services furnished in rural areas).''.

SEC. 445. 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 certified nurse midwife, 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) 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. 446. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES PROVIDED IN RURAL HEALTH CLINICS.

(a) COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES.—

(1) PROVISION OF SERVICES IN RURAL HEALTH CLINICS.—Section 1861(aa)(1)(B) (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking ''Secretary)'' and inserting ''Secretary), by a marriage and family therapist (as defined in subsection (xx)(2)),''.

(2) MARRIAGE AND FAMILY THERAPIST SERVICES DEFINED.—Section 1861 (42 U.S.C. 1395x), as amended by section 234(b), is amended by adding at the end the following new subsection:

''Marriage and Family Therapist Services

''(xx)(1) The term 'marriage and family therapist services' means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform

under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(2) The term 'marriage and family therapist' means an individual who—

''(A) possesses a master's or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law;

''(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

''(C)(i) is licensed or certified as a marriage and family therapist in the State in which marriage and family therapist services are performed; or

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

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

SEC. 447. CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM.

(a) IN GENERAL.—Part A of title XVI of the Public Health Service Act (42 U.S.C. 300q et seq.) is amended by adding at the end the following new section:

''CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM

''SEC. 1603. (a) AUTHORITY TO MAKE AND GUARANTEE LOANS.—

''(1) AUTHORITY TO MAKE LOANS.—The Secretary may make loans from the fund established under section 1602(d) to any rural entity for projects for capital improvements, including—

''(A) the acquisition of land necessary for the capital improvements;

''(B) the renovation or modernization of any building;

''(C) the acquisition or repair of fixed or major movable equipment; and

''(D) such other project expenses as the Secretary determines appropriate.

''(2) AUTHORITY TO GUARANTEE LOANS.—

''(A) IN GENERAL.—The Secretary may guarantee the payment of principal and interest for loans to rural entities for projects for capital improvements described in paragraph (1) to non-Federal lenders.

''(B) INTEREST SUBSIDIES.—In the case of a guarantee of any loan to a rural entity under subparagraph (A)(i), the Secretary may pay to the holder of such loan and for and on behalf of the project for which the loan was made, amounts sufficient to reduce by not more than 3 percentage points of the net effective interest rate otherwise payable on such loan.

''(b) AMOUNT OF LOAN.—The principal amount of a loan directly made or guaranteed under subsection (a) for a project for capital improvement may not exceed $5,000,000.

''(c) FUNDING LIMITATIONS.—

''(1) GOVERNMENT CREDIT SUBSIDY EXPOSURE.—The total of the Government credit subsidy exposure under the Credit Reform Act of 1990 scoring protocol with respect to the loans outstanding at any time with respect to which guarantees have been issued, or which have been directly made, under subsection (a) may not exceed $50,000,000 per year.

''(2) TOTAL AMOUNTS.—Subject to paragraph (1), the total of the principal amount of all loans directly made or guaranteed under subsection (a) may not exceed $250,000,000 per year.

''(d) ADDITIONAL ASSISTANCE.—

''(1) NONREPAYABLE GRANTS.—Subject to paragraph (2), the Secretary may make a grant to a rural entity, in an amount not to exceed $50,000, for purposes of capital assessment and business planning.

''(2) LIMITATION.—The cumulative total of grants awarded under this subsection may not exceed $2,500,000 per year.

''(e) TERMINATION OF AUTHORITY.—The Secretary may not directly make or guarantee any loan under subsection (a) or make a grant under subsection (d) after September 30, 2005.''.

(b) RURAL ENTITY DEFINED.—Section 1624 of the Public Health Service Act (42 U.S.C. 300s–3) is amended by adding at the end the following new paragraph:

''(15)(A) The term 'rural entity' includes—

''(i) a rural health clinic, as defined in section 1861(aa)(2) of the Social Security Act;

''(ii) any medical facility with at least 1, but less than 50, beds that is located in—

''(I) a county that is not part of a metropolitan statistical area; or

''(II) a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the

Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725));

''(iii) a hospital that is classified as a rural, regional, or national referral center under section 1886(d)(5)(C) of the Social Security Act; and

''(iv) a hospital that is a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of the Social Security Act).

''(B) For purposes of subparagraph (A), the fact that a clinic, facility, or hospital has been geographically reclassified under the medicare program under title XVIII of the Social Security Act shall not preclude a hospital from being considered a rural entity under clause (i) or (ii) of subparagraph (A).''.

(c) CONFORMING AMENDMENTS.—Section 1602 of the Public Health Service Act (42 U.S.C. 300q–2) is amended—

(1) in subsection (b)(2)(D), by inserting ''or 1603(a)(2)(B)'' after ''1601(a)(2)(B)''; and

(2) in subsection (d)—

(A) in paragraph (1)(C), by striking ''section 1601(a)(2)(B)'' and inserting ''sections 1601(a)(2)(B) and 1603(a)(2)(B)''; and

(B) in paragraph (2)(A), by inserting ''or 1603(a)(2)(B)'' after ''1601(a)(2)(B)''.

SEC. 448. GRANTS FOR UPGRADING DATA SYSTEMS.

(a) IN GENERAL.—Part B of title XVI of the Public Health Service Act (42 U.S.C. 300r et seq.) is amended by adding at the end the following new section:

''GRANTS FOR UPGRADING DATA SYSTEMS

''SEC. 1611. (a) GRANTS TO HOSPITALS.—

''(1) IN GENERAL.—The Secretary shall establish a program to make grants to hospitals that have submitted applications in accordance with subsection (c) to assist eligible small rural hospitals in offsetting the costs of establishing data systems—

''(A) required to—

''(i) implement prospective payment systems under title XVIII of the Social Security Act; and

''(ii) comply with the administrative simplification requirements under part C of title XI of such Act; or

''(B) to reduce medication errors.

''(2) COSTS.—For purposes of paragraph (1), the term 'costs' shall include costs associated with—

''(A) purchasing computer software and hardware; and

''(B) providing education and training to hospital staff on computer information systems.

''(3) LIMITATION.—A hospital that has received a grant under section 142 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 2000 is not eligible to receive a grant under this section.

''(b) ELIGIBLE SMALL RURAL HOSPITAL DEFINED.—For purposes of this section, the term 'eligible small rural hospital' means a non-Federal, short-term general acute care hospital that—

''(1) is located in a rural area, as defined for purposes of section 1886(d) of the Social Security Act; and

''(2) has less than 50 beds.

''(c) APPLICATION.—A hospital seeking a grant under this section shall submit an application to the Secretary at such time and in such form and manner as the Secretary specifies.

''(d) AMOUNT OF GRANT.—A grant to a hospital under this section may not exceed $100,000.

''(e) REPORTS.—

''(1) INFORMATION.—A hospital receiving a grant under this section shall furnish the Secretary

with such information as the Secretary may require to—

"(A) evaluate the project for which the grant is made; and

"(B) ensure that the grant is expended for the purposes for which it is made.

"(2) TIMING OF SUBMISSION.—

"(A) INTERIM REPORTS.—The Secretary shall report to the Committee on Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate at least annually on the grant program established under this section, including in such report information on the number of grants made, the nature of the projects involved, the geographic distribution of grant recipients, and such other matters as the Secretary deems appropriate.

"(B) FINAL REPORT.—The Secretary shall submit a final report to such committees not later than 180 days after the completion of all of the projects for which a grant is made under this section.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for grants under this section.''.

(b) CONFORMING AMENDMENT.—Section 1820(g)(3) (42 U.S.C. 1395i–4(g)(3)) is repealed.

SEC. 449. RELIEF FOR FINANCIALLY DISTRESSED RURAL HOSPITALS.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by inserting after section 330D the following new section:

''SEC. 330E. RELIEF FOR FINANCIALLY DISTRESSED RURAL HOSPITALS.

''(a) GRANTS TO SMALL RURAL HOSPITALS.—The Secretary, acting through the Health Resources and Services Administration, may award grants to eligible small rural hospitals that have submitted applications in accordance with subsection (c) to provide relief for financial distress that has a negative impact on access to care for beneficiaries under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) that reside in a rural area.

''(b) ELIGIBLE SMALL RURAL HOSPITAL DEFINED.—For purposes of this paragraph, the term 'eligible small rural hospital' means a non-Federal, short-term general acute care hospital that—

''(1) is located in a rural area (as defined for purposes of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d))); and

''(2) has less than 50 beds.

''(c) APPLICATION AND APPROVAL.—

''(1) APPLICATION.—Each eligible small rural hospital that desires to receive a grant under this paragraph shall submit an application to the Secretary, at such time, in such form and manner, and accompanied by such additional information as the Secretary may reasonably require.

''(2) APPROVAL.—The Secretary shall approve applications submitted under paragraph (1) based on a methodology developed by the Secretary in consultation with the Office of Rural Health Policy.

''(d) AMOUNT OF GRANT.—A grant to an eligible small rural hospital under this paragraph may not exceed $250,000.

''(e) USE OF FUNDS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), an eligible small rural hospital may use amounts received under a grant under this section to temporarily offset financial operating losses, with emphasis on those losses attributable to reimbursement formula changes that resulted from the Bal-

anced Budget Act of 1997, in order to ensure continued operation and short-term sustainability or to address emergency physical capital needs that might otherwise result in closure.

''(2) PROHIBITED USES.—A hospital may not use funds received under a grant under this section for new construction, the purchase of medical equipment, or for computer software or hardware.

''(f) REPORT.—

''(1) INFORMATION.—A hospital receiving a grant under this section shall furnish the Secretary with such information as the Secretary may require to evaluate the project for which the grant is made and to ensure that the grant is expended for the purposes for which it is made.

''(2) REPORTING.—

''(A) ANNUAL REPORTS.—

''(i) IN GENERAL.—Not later than December 31 of each year (beginning with 2001), the Secretary shall submit a report to the committees of jurisdiction of the House of Representatives and the Senate on the grant program established under this section.

''(ii) INFORMATION INCLUDED.—The report submitted under clause (i) shall include information on the number of grants made, the nature of the projects involved, the geographic distribution of grant recipients, and such other information as the Secretary determines is appropriate.

''(B) FINAL REPORT.—Not later than 180 days after the completion of all of the projects for which a grant is made under this section, the Secretary shall submit a final report on the grant program established under this section to the committees described in subparagraph (A).

''(g) APPROPRIATIONS.—There are appropriated, out of any money in the Treasury not otherwise appropriated, for making grants under this section $25,000,000 for each of the fiscal years 2001 through 2005.''.

SEC. 450. REFINEMENT OF MEDICARE REIMBURSEMENT FOR TELEHEALTH SERVICES.

(a) REVISION OF TELEHEALTH PAYMENT METHODOLOGY AND ELIMINATION OF FEE-SHARING REQUIREMENT.—Section 4206(b) of the Balanced Budget Act of 1997 (42 U.S.C. 1395l note) is amended to read as follows:

''(b) METHODOLOGY FOR DETERMINING AMOUNT OF PAYMENTS.—

''(1) IN GENERAL.—The Secretary shall pay to—

''(A) the physician or practitioner at a distant site that provides an item or service under subsection (a) an amount equal to the amount that such physician or provider would have been paid had the item or service been provided without the use of a telecommunications system; and

''(B) the originating site a facility fee for facility services furnished in connection with such item or service.

''(2) APPLICATION OF PART B COINSURANCE AND DEDUCTIBLE.—Any payment made under this section shall be subject to the coinsurance and deductible requirements under subsections (a)(1) and (b) of section 1833 of the Social Security Act (42 U.S.C. 1395l).

''(3) DEFINITIONS.—In this subsection:

''(A) DISTANT SITE.—The term 'distant site' means the site at which the physician or practitioner is located at the time the item or

service is provided via a telecommunications system.

''(B) FACILITY FEE.—The term 'facility fee' means an amount equal to—

''(i) for 2000 and 2001, $20; and

''(ii) for a subsequent year, the facility fee under this subsection for the previous year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for such subsequent year.

''(C) ORIGINATING SITE.—

''(i) IN GENERAL.—The term 'originating site' means the site described in clause (ii) at which the eligible telehealth beneficiary under the medicare program is located at the time the item or service is provided via a telecommunications system.

''(ii) SITES DESCRIBED.—The sites described in this paragraph are as follows:

''(I) On or before January 1, 2002, the office of a physician or a practitioner, a critical access hospital, a rural health clinic, and a Federally qualified health center.

''(II) On or before January 1, 2003, a hospital, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a renal dialysis facility, an ambulatory surgical center, an Indian Health Service facility, and a community mental health center.''.

(b) ELIMINATION OF REQUIREMENT FOR TELEPRESENTER.—Section 4206 of the Balanced Budget Act of 1997 (42 U.S.C. 1395l note) is amended—

(1) in subsection (a), by striking '', notwithstanding that the individual physician'' and all that follows before the period at the end; and

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

''(e) TELEPRESENTER NOT REQUIRED.—Nothing in this section shall be construed as requiring an eligible telehealth beneficiary to be presented by a physician or practitioner for the provision of an item or service via a telecommunications system.''.

(c) REIMBURSEMENT FOR MEDICARE BENEFICIARIES WHO DO NOT RESIDE IN A HPSA.—Section 4206(a) of the Balanced Budget Act of 1997 (42 U.S.C. 1395l note), as amended by subsection (b), is amended—

(1) by striking ''IN GENERAL.—Not later than'' and inserting the following: ''TELEHEALTH SERVICES REIMBURSED.—

''(1) IN GENERAL.—Not later than'';

(2) by striking ''furnishing a service for which payment'' and all that follows before the period and inserting ''to an eligible telehealth beneficiary''; and

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

''(2) ELIGIBLE TELEHEALTH BENEFICIARY DEFINED.—In this section, the term 'eligible telehealth beneficiary' means a beneficiary under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) that resides in—

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

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

''(C) an inner-city area that is medically underserved (as defined in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3))).''.

(d) TELEHEALTH COVERAGE FOR DIRECT PATIENT CARE.—

(1) IN GENERAL.—Section 4206 of the Balanced Budget Act of 1997 (42 U.S.C. 1395l note), as amended by subsection (c), is amended—

(A) in subsection (a)(1), by striking ''professional consultation via telecommunications systems with a physician'' and inserting ''items and services for which payment may be made under such part that are furnished via a telecommunications system by a physician''; and

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

''(f) COVERAGE OF ITEMS AND SERVICES.—Payment for items and services provided pursuant to subsection (a) shall include payment for professional consultations, office visits, office psychiatry services, including any service identified as of July 1, 2000, by HCPCS codes 99241–99275, 99201–99215, 90804–90815, and 90862.''.

(2) STUDY AND REPORT REGARDING ADDITIONAL ITEMS AND SERVICES.—

(A) STUDY.—The Secretary of Health and Human Services shall conduct a study to identify items and services in addition to those described in section 4206(f) of the Balanced

Budget Act of 1997 (as added by paragraph (1)) that would be appropriate to provide payment under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

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

(e) ALL PHYSICIANS AND PRACTITIONERS ELIGIBLE FOR TELEHEALTH REIMBURSEMENT.—Section 4206(a) of the Balanced Budget Act of 1997 (42 U.S.C. 1395l note), as amended by subsection (d), is amended—

(1) in paragraph (1), by striking ''(described in section 1842(b)(18)(C) of such Act (42 U.S.C. 1395u(b)(18)(C))''; and

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

''(3) PRACTITIONER DEFINED.—For purposes of paragraph (1), the term 'practitioner' includes—

''(A) a practitioner described in section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)); and

''(B) a physical, occupational, or speech therapist.''.

(f) TELEHEALTH SERVICES PROVIDED USING STORE-AND-FORWARD TECHNOLOGIES.—Section 4206(a)(1) of the Balanced Budget Act of 1997 (42 U.S.C. 1395l note), as amended by subsection (e), is amended by adding at the end the following new paragraph:

''(4) USE OF STORE-AND-FORWARD TECHNOLOGIES.—For purposes of paragraph (1), in the case of any Federal telemedicine demonstration program in Alaska or Hawaii, the term 'telecommunications system' includes store-and-forward technologies that provide for the asynchronous transmission of health care information in single or multimedia formats.''.

(g) CONSTRUCTION RELATING TO HOME HEALTH SERVICES.—Section 4206(a) of the Balanced Budget Act of 1997 (42 U.S.C. 1395l note), as amended by subsection (f), is amended by adding at the end the following new paragraph:

''(5) CONSTRUCTION RELATING TO HOME HEALTH SERVICES.—

''(A) IN GENERAL.—Nothing in this section or in section 1895 of the Social Security

Act (42 U.S.C. 1395fff) shall be construed as preventing a home health agency that is receiving payment under the prospective payment system described in such section from furnishing a home health service via a telecommunications system.

''(B) LIMITATION.—The Secretary shall not consider a home health service provided in the manner described in subparagraph (A) to be a home health visit for purposes of—

''(i) determining the amount of payment to be made under the prospective payment system established under section 1895 of the Social Security Act (42 U.S.C. 1395fff); or

''(ii) any requirement relating to the certification of a physician required under section 1814(a)(2)(C) of such Act (42 U.S.C. 1395f(a)(2)(C)).''.

(h) FIVE-YEAR APPLICATION.—The amendments made by this section shall apply to items and services provided on or after April 1, 2001, and before April 1, 2006.

SEC. 451. MEDPAC STUDY ON LOW-VOLUME, ISOLATED RURAL HEALTH CARE PROVIDERS.

(a) STUDY.—The Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) (in this section referred to as ''MedPAC'') shall conduct a study on the effect of low patient and procedure volume on the financial status of low-volume, isolated rural health care providers participating in the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

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

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

(2) whether the status as a low-volume, isolated rural health care provider should be designated under the medicare program and any criteria that should be used to qualify for such a status; and

(3) any changes in the payment methodologies described in subsection (c) that are necessary to pro-

vide appropriate reimbursement under the medicare program to low-volume, isolated rural health care providers (as designated pursuant to paragraph (2)).

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

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

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

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

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

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

TITLE V—PROVISIONS RELATING TO PART C (MEDICARE+CHOICE PROGRAM) AND OTHER MEDICARE MANAGED CARE PROVISIONS

SEC. 501. RESTORING EFFECTIVE DATE OF ELECTIONS AND CHANGES OF ELECTIONS OF MEDICARE+CHOICE PLANS.

(a) OPEN ENROLLMENT.—Section 1851(f)(2) (42 U.S.C. 1395w–21(f)(2)) is amended by striking '', except that if such election or change is made after the 10th day of any calendar month, then the election or change shall not take effect until the first day of the second calendar month following the date on which the election or change is made''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to elections and changes of coverage made on or after January 1, 2001.

SEC. 502. SPECIAL MEDIGAP ENROLLMENT ANTIDISCRIMINATION PROVISION FOR CERTAIN BENEFICIARIES.

(a) DISENROLLMENT WINDOW IN ACCORDANCE WITH BENEFICIARY'S CIRCUMSTANCE.—Section 1882(s)(3) (42 U.S.C. 1395ss(s)(3)) is amended—

(1) in subparagraph (A), in the matter following clause (iii), by striking ", subject to subparagraph (E), seeks to enroll under the policy not later than 63 days after the date of termination of enrollment described in such subparagraph" and inserting "seeks to enroll under the policy during the period specified in subparagraph (E)"; and

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

"(E) For purposes of subparagraph (A), the time period specified in this subparagraph is—

"(i) in the case of an individual described in subparagraph (B)(i), the period beginning on the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if no such notice is received, notice that a claim has been denied because of such a termination or cessation) and ending on the date that is 63 days after the applicable notice;

"(ii) in the case of an individual described in clause (ii), (iii), (v), or (vi) of subparagraph (B) whose enrollment is terminated involuntarily, the period beginning on the date that the individual receives a notice of termination and ending on the

date that is 63 days after the date the applicable coverage is terminated;

''(iii) in the case of an individual described in subparagraph (B)(iv)(I), the period beginning on the earlier of (I) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice, if any, and (II) the date that the applicable coverage is terminated, and ending on the date that is 63 days after the date the coverage is terminated;

''(iv) in the case of an individual described in clause (ii), (iii), (iv)(II), (iv)(III), (v), or (vi) of subparagraph (B) who disenrolls voluntarily, the period beginning on the date that is 60 days before the effective date of the disenrollment and ending on the date that is 63 days after such effective date; and

''(v) in the case of an individual described in subparagraph (B) but not described in the preceding provisions of this subparagraph, the period beginning on the effective date of the disenrollment and ending on the date that is 63 days after such effective date.''.

(b) EXTENDED MEDIGAP ACCESS FOR INTERRUPTED TRIAL PERIODS.—Section 1882(s)(3) (42 U.S.C.

1395ss(s)(3)), as amended by subsection (a), is amended by adding at the end the following new subparagraph:

''(F) For purposes of this paragraph—

''(i) in the case of an individual described in subparagraph (B)(v) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with an organization or provider described in subclause (II) of such subparagraph is involuntarily terminated within the first 12 months of such enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, such subsequent enrollment shall be deemed to be an initial enrollment described in such subparagraph; and

''(ii) in the case of an individual described in clause (vi) of subparagraph (B) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with a plan or in a program described in clause (v)(II) of such subparagraph is involuntarily terminated within the first 12 months of such enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, such subsequent enrollment shall be deemed to be an initial enrollment described in clause (vi) of such subparagraph.''.

SEC. 503. INCREASE IN NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE IN 2001 AND 2002.

Section 1853(c)(6)(B) of the Social Security Act (42 U.S.C. 1395w–23(c)(6)(B)) is amended—

(1) in clause (iv), by striking ''for 2001, 0.5 percentage points'' and inserting ''for 2001, 0 percentage points''; and

(2) in clause (v), by striking ''for 2002, 0.3 percentage points'' and inserting ''for 2002, 0 percentage points''.

SEC. 504. ALLOWING MOVEMENT TO 50:50 PERCENT BLEND IN 2002.

Section 1853(c)(2) of the Social Security Act (42 U.S.C. 1395w–23(c)(2)) is amended—

(1) by striking the period at the end of subparagraph (F) and inserting a semicolon; and

(2) by adding after and below subparagraph (F) the following:

''except that a Medicare+Choice organization may elect to apply subparagraph (F) (rather than subparagraph (E)) for 2002.''.

SEC. 505. DELAY FROM JULY TO NOVEMBER 2000, IN DEADLINE FOR OFFERING AND WITHDRAWING MEDICARE+CHOICE PLANS FOR 2001.

Notwithstanding any other provision of law, the deadline for a Medicare+Choice organization to withdraw the offering of a Medicare+Choice plan under part C of title XVIII of the Social Security Act (or otherwise to submit information required for the offering of such a plan) for 2001 is delayed from July 1, 2000, to November 1, 2000, and any such organization that provided notice of withdrawal of such a plan during 2000 before the date of enactment of this Act may rescind such withdrawal at any time before November 1, 2000.

SEC. 506. AMOUNTS IN MEDICARE TRUST FUNDS AVAILABLE FOR SECRETARY'S SHARE OF MEDICARE+CHOICE EDUCATION AND ENROLLMENT-RELATED COSTS.

(a) RELOCATION OF PROVISIONS.—Section 1857(e)(2) (42 U.S.C. 1395w–27(e)(2)) is amended to read as follows:

''(2) COST-SHARING IN ENROLLMENT-RELATED COSTS.—A Medicare+Choice organization shall pay the fee established by the Secretary under section 1851(j)(3)(A).''.

(b) FUNDING FOR EDUCATION AND ENROLLMENT ACTIVITIES.—Section 1851 (42 U.S.C. 1395w–21) is

amended by adding at the end the following new subsection:

"(j) FUNDING FOR BENEFICIARY EDUCATION AND ENROLLMENT ACTIVITIES.—

"(1) SECRETARY'S ESTIMATE OF TOTAL COSTS.—The Secretary shall annually estimate the total cost for a fiscal year of carrying out this section, section 4360 of the Omnibus Budget Reconciliation Act of 1990 (relating to the health insurance counseling and assistance program), and related activities.

"(2) TOTAL AMOUNT AVAILABLE.—The total amount available to the Secretary for a fiscal year for the costs of the activities described in paragraph (1) shall be equal to the lesser of—

"(A) the amount estimated for such fiscal year under paragraph (1); or

"(B) for—

"(i) fiscal year 2001, $130,000,000; and

"(ii) fiscal year 2002 and each subsequent fiscal year, the amount for the previous fiscal year, adjusted to account for inflation, any change in the number of

beneficiaries under this title, and any other relevant factors.

"(3) COST-SHARING IN ENROLLMENT-RELATED COSTS.—

"(A) AMOUNTS FROM MEDICARE+CHOICE ORGANIZATIONS.—

"(i) IN GENERAL.—The Secretary is authorized to charge a fee to each Medicare+Choice organization with a contract under this part that is equal to the organization's pro rata share (as determined by the Secretary) of the Medicare+Choice portion (as defined in clause (ii)) of the total amount available under paragraph (2) for a fiscal year. Any amounts collected shall be available without further appropriation to the Secretary for the costs of the activities described in paragraph (1).

"(ii) MEDICARE+CHOICE PORTION DEFINED.—For purposes of clause (i), the term 'Medicare+Choice portion' means, for a fiscal year, the ratio, as estimated by the Secretary, of—

''(I) the average number of individuals enrolled in Medicare+Choice plans during the fiscal year; to

''(II) the average number of individuals entitled to benefits under parts A, and enrolled under part B, during the fiscal year.

''(B) SECRETARY'S SHARE.—

''(i) AMOUNTS AVAILABLE FROM TRUST FUNDS.—The Secretary's share of expenses shall be payable from funds in the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, in such proportion as the Secretary shall deem to be fair and equitable after taking into consideration the expenses attributable to the administration of this part with respect to part A and B. The Secretary shall make such transfers of moneys between such Trust Funds as may be appropriate to settle accounts between the Trust Funds in cases where expenses properly payable from one such Trust Fund have been paid from the other such Trust Fund.

''(ii) SECRETARY'S SHARE OF EXPENSES DEFINED.—For purposes of clause (i), the term 'Secretary's share of expenses' means, for a fiscal year, an amount equal to—

''(I) the total amount available to the Secretary under paragraph (2) for the fiscal year; less

''(II) the amount collected under subparagraph (A) for the fiscal year.''.

SEC. 507. REVISED TERMS AND CONDITIONS FOR EXTENSION OF MEDICARE COMMUNITY NURSING ORGANIZATION (CNO) DEMONSTRATION PROJECT.

(a) IN GENERAL.—Section 532 of BBRA (42 U.S.C. 1395mm note) is amended—

(1) in subsection (a), by striking the second sentence; and

(2) by striking subsection (b) and inserting the following new subsections:

''(b) TERMS AND CONDITIONS.—

''(1) JANUARY THROUGH SEPTEMBER 2000.—For the 9-month period beginning with January 2000, any such demonstration project shall be con-

ducted under the same terms and conditions as applied to such demonstration during 1999.

''(2) OCTOBER 2000 THROUGH DECEMBER 2001.—For the 15-month period beginning with October 2000, any such demonstration project shall be conducted under the same terms and conditions as applied to such demonstration during 1999, except that the following modifications shall apply:

''(A) BASIC CAPITATION RATE.—The basic capitation rate paid for services covered under the project (other than case management services) per enrollee per month shall be basic capitation rate paid for such services for 1999, reduced by 10 percent in the case of the demonstration sites located in Arizona, Minnesota, and Illinois, and 15 percent for the demonstration site located in New York.

''(B) TARGETED CASE MANAGEMENT FEE.—A case management fee shall be paid only for enrollees who are classified as 'moderate' or 'at risk' through a baseline health assessment (as required for Medicare+Choice plans under section 1852(e) of the Social Security Act (42 U.S.C. 1395ww–22(e)).

"(C) GREATER UNIFORMITY IN CLINICAL FEATURES AMONG SITES.—Each project shall implement for each site—

"(i) protocols for periodic telephonic contact with enrollees based on—

"(I) the results of such standardized written health assessment; and

"(II) the application of appropriate care planning approaches;

"(ii) disease management programs for targeted diseases (such as congestive heart failure, arthritis, diabetes, and hypertension) that are highly prevalent in the enrolled populations;

"(iii) systems and protocols to track enrollees through hospitalizations, including pre-admission planning, concurrent management during inpatient hospital stays, and post-discharge assessment, planning, and follow-up; and

"(iv) standardized patient educational materials for specified diseases and health conditions.

"(D) QUALITY IMPROVEMENT.—Each project shall implement at each site once during the 15-month period—

"(i) enrollee satisfaction surveys; and

"(ii) reporting on specified quality indicators for the enrolled population.

"(c) EVALUATION.—

"(1) PRELIMINARY REPORT.—Not later than July 1, 2001, the Secretary of Health and Human Services shall submit to the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate a preliminary report that—

"(A) evaluates such demonstration projects for the period beginning July 1, 1997, and ending December 31, 1999, on a site-specific basis with respect to the impact on per beneficiary spending, specific health utilization measures, and enrollee satisfaction; and

"(B) includes a similar evaluation of such projects for the portion of the extension period that occurs after September 30, 2000.

"(2) FINAL REPORT.—Not later than July 1, 2002, the Secretary shall submit a final report to such Committees on such demonstration projects.

Such report shall include the same elements as the preliminary report required by paragraph (1), but for the period after December 31, 1999.

''(3) METHODOLOGY FOR SPENDING COMPARISONS.—Any evaluation of the impact of the demonstration projects on per beneficiary spending included in such reports shall be based on a comparison of—

''(A) data for all individuals who—

''(i) were enrolled in such demonstration projects as of the first day of the period under evaluation; and

''(ii) were enrolled for a minimum of 6 months thereafter; with

''(B) data for a matched sample of individuals who are enrolled under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) and who are not enrolled in such a project, in a Medicare+Choice plan under part C of such title (42 U.S.C. 1395w–21 et seq.), a plan offered by an eligible organization under section 1876 of such Act (42 U.S.C. 1395mm), or a health care prepayment plan under section 1833(a)(1)(A) of such Act (42 U.S.C. 1395l(a)(1)(A)).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall be effective as if included in the enactment of section 532 of BBRA (42 U.S.C. 1395mm note).

SEC. 508. 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), (g), and (i)'' and inserting ''subsections (e), (g), (i), and (j)'';

(B) in paragraph (3)(D), by inserting ''paragraph (4) and'' after ''Subject to''; and

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

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

''(A) IN GENERAL.—In applying the risk-adjustment factors established under paragraph (3) during the period described in subparagraph (B), the limitation under paragraph (3)(C)(ii)(I) shall apply to a frail elderly Medicare+Choice beneficiary (as defined in

subsection (j)(3)) who is enrolled in a Medicare+Choice plan under a specialized program for the frail elderly (as defined in subsection (j)(2)) during the entire period.

''(B) PERIOD OF APPLICATION.—The period described in this subparagraph begins with January 2001, 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 factors described in subsection (j)(1)(B) is being fully implemented.''; and

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

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

''(1) DEVELOPMENT AND IMPLEMENTATION OF NEW PAYMENT SYSTEM.—

''(A) IN GENERAL.—The Secretary shall develop and implement (as soon as possible after the date of enactment of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 2000), 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)).

''(B) FACTORS DESCRIBED.—The methodology developed and implemented under subparagraph (A) shall take into account the prevalence, mix, and severity of chronic conditions among frail elderly Medicare+Choice beneficiaries and shall include—

''(i) medical diagnostic factors from all provider settings (including hospital and nursing facility settings);

''(ii) functional indicators of health status; and

''(iii) such other factors as may be necessary to achieve appropriate payments for plans serving such beneficiaries.

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

''(A) IN GENERAL.—In this part, the term 'specialized program for the frail elderly' means a program that 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 DESCRIBED.—A team described in this subparagraph—

"(i) includes—

"(I) a physician; and

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

"(ii) has as members individuals who—

"(I) have special training in the care and management of the frail elderly beneficiaries; and

"(II) specialize in the care and management of such beneficiaries.

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

''(A) is residing in a skilled nursing facility (as defined in section 1819(a)) or a nursing facility (as defined in section 1919(a)) 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) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act.

TITLE VI—PROVISIONS RELATING TO INDIVIDUALS WITH END-STAGE RENAL DISEASE

SEC. 601. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.

(a) IN GENERAL.—The last sentence of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by striking '', and for such services'' and all that follows before the period at the end and inserting the following: '', for such services furnished during 2001, by 2.4 percent above such composite rate payment amounts for such services

furnished on December 31, 2000, for such services furnished during 2002 and 2003, by the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year above such composite rate payment amounts for such services furnished on December 31 of the previous year, and for such services furnished during a subsequent year, by the ESRD market basket percentage increase above such composite rate payment amounts for such services furnished on December 31 of the previous year''.

(b) ESRD MARKET BASKET PERCENTAGE INCREASE DEFINED.—Section 1881(b) (42 U.S.C. 1395rr(b)) is amended by adding at the end the following new paragraph:

''(12)(A) For purposes of this title, the term 'ESRD market basket percentage increase' means, with respect to a calendar year, the percentage (estimated by the Secretary before the beginning of such year) by which—

''(i) the cost of the mix of goods and services included in the provision of dialysis services (which may include the costs described in subparagraph (D) as determined appropriate by the Secretary) that is determined based on an index of appropriately weighted indicators of changes in wages and prices

which are representative of the mix of goods and services included in such dialysis services for the calendar year; exceeds

''(ii) the cost of such mix of goods and services for the preceding calendar year.

''(B) In determining the percentage under subparagraph (A), the Secretary may take into account any increase in the costs of furnishing the mix of goods and services described in such subparagraph resulting from—

''(i) the adoption of scientific and technological innovations used to provide dialysis services; and

''(ii) changes in the manner or method of delivering dialysis services.

''(C) The Secretary shall periodically review and update (as necessary) the items and services included in the mix of goods and services used to determine the percentage under subparagraph (A).

''(D) The costs described in this subparagraph include—

''(i) labor, including direct patient care costs and administrative labor costs, vacation and holiday pay, payroll taxes, and employee benefits;

''(ii) other direct costs, including drugs, supplies, and laboratory fees;

''(iii) overhead, including medical director fees, temporary services, general and administrative costs, interest expenses, and bad debt;

''(iv) capital, including rent, real estate taxes, depreciation, utilities, repairs, and maintenance; and

''(v) such other allowable costs as the Secretary may specify.''.

SEC. 602. REVISION OF PAYMENT RATES FOR ESRD PATIENTS ENROLLED IN MEDICARE+CHOICE PLANS.

(a) IN GENERAL.—Section 1853(a)(1)(B) (42 U.S.C. 1395w–23(a)(1)(B)) is amended by adding at the end the following: ''In establishing such rates the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including any risk-adjustment associated with such rate) of the social health maintenance organization end-stage renal disease demonstrations established by section 2355 of the Deficit Reduction Act of 1984 (Public Law 98–369; 98 Stat. 1103), as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66; 107 Stat. 608), and shall compute such rates by not taking into account individuals with kidney transplants and individuals in which the program under this title is a secondary payer

to another payer (or payers) pursuant to section 1862(b).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to payments for months beginning with January 2002.

(c) PUBLICATION.—The Secretary of Health and Human Services, not later than 6 months after the date of enactment of this Act, shall publish for public comment a description of the appropriate adjustments described in the last sentence of section 1853(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B)), as added by subsection (a). The Secretary shall publish in final form such adjustments by not later than July 1, 2001, so that the amendment made by subsection (a) is implemented on a timely basis consistent with subsection (b).

SEC. 603. PERMITTING ESRD BENEFICIARIES TO ENROLL IN ANOTHER MEDICARE+CHOICE PLAN IF THE PLAN IN WHICH THEY ARE ENROLLED IS TERMINATED.

(a) IN GENERAL.—Section 1851(a)(3)(B) (42 U.S.C. 1395w–21(a)(3)(B)) is amended by striking ''except that'' and all that follows and inserting the following: ''except that—

''(i) an individual who develops end-stage renal disease while enrolled in a

Medicare+Choice plan may continue to be enrolled in that plan; and

''(ii) in the case of such an individual who is enrolled in a Medicare+Choice plan under clause (i) (or subsequently under this clause), if the enrollment is discontinued under circumstances described in section 1851(e)(4)(A) then the individual will be treated as a 'Medicare+Choice eligible individual' for purposes of electing to continue enrollment in another Medicare+Choice plan.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall apply to terminations and discontinuations occurring on or after the date of enactment of this Act.

(2) APPLICATION TO PRIOR PLAN TERMINATIONS.—Clause (ii) of section 1851(a)(3)(B) of the Social Security Act (as inserted by subsection (a)) also shall apply to individuals whose enrollment in a Medicare+Choice plan was terminated or discontinued after December 31, 1997, and before the date of enactment of this Act. In applying this paragraph, such an individual shall be treated, for pur-

poses 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. 604. COVERAGE OF CERTAIN VASCULAR ACCESS SERVICES FOR ESRD BENEFICIARIES PROVIDED BY AMBULATORY SURGICAL CENTERS.

(a) IN GENERAL.—The matter following subparagraph (B) of section 1833(i)(1) (42 U.S.C. 1395l(i)(1)) is amended by adding at the end the following new sentence: ''Such lists shall include the procedures identified as of July 30, 1999, by vascular access codes 34101, 34111, 34490, 35190, 35458, 35460, 35475, 35476, 35903, 36005, 36010, 36011, 36120, 36140, 36145, 36215–36218, 36831–36834, 37201, 37204–37208, 37250, 37251, and 49423.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to vascular access services furnished on or after January 1, 2000.

SEC. 605. COLLECTION AND ANALYSIS OF INFORMATION ON THE SATISFACTION OF ESRD BENEFICIARIES WITH THE QUALITY OF AND ACCESS TO HEALTH CARE UNDER THE MEDICARE PROGRAM.

(a) COLLECTION OF INFORMATION.—The Secretary shall collect information on the satisfaction of each ESRD

medicare beneficiary with the quality of health care under the original fee-for-service medicare program and the Medicare+Choice program, and the access of each beneficiary to that care.

(b) ANALYSIS OF COLLECTED INFORMATION.—

(1) IN GENERAL.—The Secretary shall conduct an analysis of the information collected under subsection (a) to determine—

(A) the kinds of health care that each non-dialysis health care provider provides to each ESRD medicare beneficiary for the treatment of end-stage renal disease and each comorbidity;

(B) the effect of the availability of supplemental insurance on the use by beneficiary of health care;

(C) the perceptions of each beneficiary regarding the access of that beneficiary to health care; and

(D) the quality of health care provided to each ESRD medicare beneficiary enrolled under the Medicare+Choice program compared to each beneficiary enrolled under the original fee-for-service medicare program.

(2) CONSIDERATIONS.—In conducting the analysis under paragraph (1), the Secretary shall consider—

(A) the feasibility of routinely collecting information on the satisfaction of each ESRD medicare beneficiary with dialysis and non-dialysis health care;

(B) whether to collect information using disease specific questions or generic questions (similar to those used in conducting the Medicare Current Beneficiary Survey);

(C) how well collected information detects access problems within each specific group of ESRD medicare beneficiaries, including beneficiaries without supplemental insurance and beneficiaries that reside in a rural area; and

(D) each obstacle that a health care provider may face in offering each type of dialysis service.

(c) AVAILABILITY OF INFORMATION AND ANALYSIS.—Not later than January 1 of each year (beginning in 2002) the Secretary shall make the information collected under subsection (a) and the analysis conducted under subsection (b) available to the public.

(d) DEFINITIONS.—In this section:

(1) ESRD MEDICARE BENEFICIARY.—The term ''ESRD medicare beneficiary'' means an individual eligible for benefits under the medicare program that has end-stage renal disease (including an individual enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization under the Medicare+Choice program).

(2) MEDICARE+CHOICE PROGRAM.—The term ''Medicare+Choice program'' means the program established under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.).

(3) ORIGINAL FEE-FOR-SERVICE MEDICARE PROGRAM.—The term ''original fee-for-service medicare program'' means the health benefits program under parts A and B title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services, acting through the Administrator of the Health Care Financing Administration.

TITLE VII—ACCESS TO CARE IMPROVEMENTS THROUGH MEDICAID AND SCHIP

SEC. 701. NEW PROSPECTIVE PAYMENT SYSTEM FOR FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.

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

(1) in paragraph (13)—

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

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

(C) by striking subparagraph (C); and

(2) by inserting after paragraph (14) the following new paragraph:

''(15) for payment for services described in subparagraph (B) or (C) of section 1905(a)(2) under the plan in accordance with subsection (aa);''.

(b) NEW PROSPECTIVE PAYMENT SYSTEM.—Section 1902 (42 U.S.C. 1396a) is amended by adding at the end the following:

''(aa) PAYMENT FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.—

''(1) IN GENERAL.—Beginning with fiscal year 2001 and each succeeding fiscal year, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by a Federally-qualified health center and services described in section 1905(a)(2)(B) furnished by a rural health clinic in accordance with the provisions of this subsection.

''(2) FISCAL YEAR 2001.—Subject to paragraph (4), for services furnished during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of the center or clinic of furnishing such services during fiscal year 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under section 1833(a)(3), adjusted to take into account any increase in the scope of such services furnished by the center or clinic during fiscal year 2001.

''(3) FISCAL YEAR 2002 AND SUCCEEDING FISCAL YEARS.—Subject to paragraph (4), for services

furnished during fiscal year 2002 or a succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this subsection for the preceding fiscal year—

''(A) increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) for that fiscal year; and

''(B) adjusted to take into account any increase in the scope of such services furnished by the center or clinic during that fiscal year.

''(4) ESTABLISHMENT OF INITIAL YEAR PAYMENT AMOUNT FOR NEW CENTERS OR CLINICS.—In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after fiscal year 2000, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by the center or services described in section 1905(a)(2)(B) furnished by the clinic in the first fiscal year in which the center or clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year 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).

''(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 METHODOLOGIES.—Notwithstanding any other provision of this section, the State plan may provide for payment in any fiscal year to a Federally-qualified health center for services described in section 1905(a)(2)(C) or to a rural health clinic for services described in section

1905(a)(2)(B) in an amount which is determined under an alternative payment methodology that—

''(A) is agreed to by the State and the center or clinic; and

''(B) results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under this section.''.

(c) CONFORMING AMENDMENTS.—

(1) Section 4712 of BBA (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(a)(15), 1902(aa),''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2000, and apply to services furnished on or after such date.

SEC. 702. TRANSITIONAL MEDICAL ASSISTANCE.

(a) MAKING PROVISION PERMANENT.—

(1) IN GENERAL.—Subsection (f) of section 1925 (42 U.S.C. 1396r–6) is repealed.

(2) CONFORMING AMENDMENT.—Section 1902(e)(1) (42 U.S.C. 1396a(e)(1)) is repealed.

(b) STATE OPTION OF INITIAL 12-MONTH ELIGIBILITY.—Section 1925 (42 U.S.C. 1396r–6) is amended—

(1) in subsection (a), by adding at the end the following new paragraph:

''(5) OPTION OF 12-MONTH INITIAL ELIGIBILITY PERIOD.—A State may elect to treat any reference in this subsection to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months). In the case of such an election, subsection (b) shall not apply.''; and

(2) in subsection (b)(1), by inserting ''and subsection (a)(5)'' after ''paragraph (3)''.

(c) SIMPLIFICATION OPTIONS.—

(1) REMOVAL OF ADMINISTRATIVE REPORTING REQUIREMENTS FOR ADDITIONAL 6-MONTH EXTENSION.—Section 1925(b) (42 U.S.C. 1396r–6(b)) is amended—

(A) in paragraph (2)—

(i) in the heading, by striking ''AND REPORTING'';

(ii) by striking subparagraph (B);

(iii) in subparagraph (A)(i)—

(I) by striking ''(I)'' and all that follows through ''(II)'' and inserting ''(i)'';

(II) by striking '', and (III)'' and inserting ''and (ii)''; and

(III) by redesignating such subparagraph as subparagraph (A) (with appropriate indentation); and

(iv) in subparagraph (A)(ii)—

(I) by striking ''notify the family of the reporting requirement under subparagraph (B)(ii) and a statement of'' and inserting ''provide the family with notification of''; and

(II) by redesignating such subparagraph as subparagraph (B) (with appropriate indentation);

(B) in paragraph (3)(A)—

(i) in clause (iii)—

(I) in the heading, by striking ''REPORTING AND TEST'';

(II) by striking subclause (I); and

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

(ii) by striking the last 3 sentences; and

(C) in paragraph (3)(B), by striking ''subparagraph (A)(iii)(II)'' and inserting ''subparagraph (A)(iii)(I)''.

(2) EXEMPTION FOR STATES COVERING NEEDY FAMILIES UP TO 185 PERCENT OF POVERTY.—Section 1925 (42 U.S.C. 1396r–6), as amended by subsection (a), is amended—

(A) in each of subsections (a)(1) and (b)(1), by inserting ''but subject to subsection (f),'' after ''Notwithstanding any other provision of this title,''; and

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

''(f) EXEMPTION FOR STATE COVERING NEEDY FAMILIES UP TO 185 PERCENT OF POVERTY.—At State option, the provisions of this section shall not apply to a State that uses the authority under section 1931(b)(2)(C) to make medical assistance available under the State plan under this title, at a minimum, to all individuals described in section 1931(b)(1) in families with gross incomes (de-

termined without regard to work-related child care expenses of such individuals) at or below 185 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.''.

(3) STATE OPTION TO ELECT SHORTER PERIOD FOR REQUIREMENT FOR RECEIPT OF MEDICAL ASSISTANCE AS A CONDITION OF ELIGIBILITY FOR TRANSITIONAL MEDICAL ASSISTANCE.—Section 1925(a)(1) (42 U.S.C. 1396r–6(a)(1)) is amended by inserting ''(or such shorter period as the State may elect)'' after ''3''.

(d) APPLICATION OF NOTICE OF ELIGIBILITY TO ALL FAMILIES LEAVING WELFARE.—Section 1925(a) (42 U.S.C. 1396r–6(a)), as amended by subsection (b)(1), is amended by adding at the end the following new paragraph:

''(6) NOTICE OF ELIGIBILITY FOR MEDICAL ASSISTANCE TO ALL FAMILIES LEAVING TANF.—Each State shall notify each family which was receiving assistance under the State program funded under part A of title IV and which is no longer eligible for such assistance, of the potential eligibility of the

family and any individual members of such family for medical assistance under this title or child health assistance under title XXI. Such notice shall include a statement that the family does not have to be receiving assistance under the State program funded under part A of title IV in order to be eligible for such medical assistance or child health assistance.''.

(e) ENROLLMENT DATA.—Section 1925 (42 U.S.C. 1396r–6), as amended by subsection (c)(2)(B), is amended by adding at the end the following new subsection:

''(g) ENROLLMENT DATA.—The Secretary annually shall obtain from each State with a State plan approved under this title enrollment data regarding—

''(1) the number of adults and children who—

''(A) receive medical assistance under this title based on eligibility under section 1931;

''(B) at the time they were first determined to be eligible for such medical assistance, also received cash assistance under the State program funded under part A of title IV; and

''(C) subsequently ceased to receive assistance under such State program due to increased earnings or increased child support income;

''(2) the percentage of the adults and children described in paragraph (1) who receive transitional medical assistance under this section or otherwise remain enrolled in the program under this title; and

''(3) the percentage of such adults and children that receive such transitional medical assistance for more than 6 months or that remain enrolled in the program under this title for more than 6 months after such adults or children ceased to receive assistance under the State program funded under part A of title IV.''.

(f) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2000.

SEC. 703. APPLICATION OF SIMPLIFIED SCHIP PROCEDURES UNDER THE MEDICAID PROGRAM.

(a) COORDINATION WITH MEDICAID.—

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

(A) in paragraph (3), by inserting ''subject to paragraph (5)'', after ''Notwithstanding subsection (a)(17),''; and

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

''(5) With respect to determining the eligibility of individuals under 19 years of age for medical assistance

under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), (a)(10)(A)(ii)(IX), or (a)(10)(A)(ii)(XIV), notwithstanding any other provision of this title, if the State has established a State child health plan under title XXI, or expanded coverage beyond the income eligibility standards required for such individuals under this title under a waiver granted under section 1115—

''(A) the State may not apply a resource standard if the State does not apply such a standard under such child health plan or section 1115 waiver with respect to such individuals;

''(B) the State shall use the same simplified eligibility form (including, if applicable, permitting application other than in person) as the State uses under such State child health plan or section 1115 waiver with respect to such individuals;

''(C) the State shall provide for initial eligibility determinations and redeterminations of eligibility using the same verification policies, forms, and frequency as the State uses for such purposes under such State child health plan or section 1115 waiver with respect to such individuals; and

''(D) the State shall not require a face-to-face interview for purposes of initial eligibility determina-

tions and redeterminations unless the State required such an interview for such purposes under such child health plan or section 1115 waiver with respect to such individuals.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) take effect on October 1, 2000, and apply to eligibility determinations and redeterminations made on or after such date.

(b) AUTOMATIC REASSESSMENT OF ELIGIBILITY FOR TITLE XXI AND MEDICAID BENEFITS FOR CHILDREN LOSING MEDICAID OR TITLE XXI ELIGIBILITY.—

(1) LOSS OF MEDICAID ELIGIBILITY.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(A) by striking the period at the end of paragraph (65) and inserting ''; and'', and

(B) by inserting after paragraph (65) the following new paragraph:

''(66) provide, by not later than the first day of the first month that begins more than 1 year after the date of the enactment of this paragraph and in the case of a State with a State child health plan under title XXI, that before medical assistance to a child (or a parent of a child) is discontinued under this title, a determination of whether the child (or

parent) is eligible for benefits under title XXI shall be made and, if determined to be so eligible, the child (or parent) shall be automatically enrolled in the program under such title without the need for a new application and without being asked to provide any information that is already available to the State.''.

(2) LOSS OF TITLE XXI ELIGIBILITY.—Section 2102(b)(3) (42 U.S.C. 1397bb(b)(3)) is amended by redesignating subparagraphs (D) and (E) as subparagraphs (E) and (F), respectively, and by inserting after subparagraph (C) the following new subparagraph:

''(D) that before health assistance to a child (or a parent of a child) is discontinued under this title, a determination of whether the child (or parent) is eligible for benefits under title XIX is made and, if determined to be so eligible, the child (or parent) is automatically enrolled in the program under such title without the need for a new application and without being asked to provide any information that is already available to the State;''.

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) apply to individuals who

lose eligibility under the medicaid program under title XIX, or under a State child health insurance plan under title XXI, respectively, of the Social Security Act (42 U.S.C. 1396 et seq.; 1397aa et seq.) on or after the date that is 60 days after the date of the enactment of this Act.

SEC. 704. PRESUMPTIVE ELIGIBILITY.

(a) ADDITIONAL ENTITIES QUALIFIED TO DETERMINE PRESUMPTIVE ELIGIBILITY FOR LOW-INCOME CHILDREN.—

(1) MEDICAID.—Section 1920A(b)(3)(A)(i) (42 U.S.C. 1396r–1a(b)(3)(A)(i)) is amended—

(A) by striking ''or (II)'' and inserting '', (II)''; and

(B) by inserting ''eligibility of a child for medical assistance under the State plan under this title, or eligibility of a child for child health assistance under the program funded under title XXI, (III) is an elementary school or secondary school, as such terms are defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801), an elementary or secondary school operated or supported by the Bureau of Indian Affairs, a State

child support enforcement agency, a child care resource and referral agency, an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act, or a State office or entity involved in enrollment in the program under this title, under part A of title IV, under title XXI, or that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437 et seq.), or (IV) any other entity the State so deems, as approved by the Secretary'' before the semicolon.

(2) APPLICATION UNDER SCHIP.—

(A) IN GENERAL.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is amended by adding at the end the following new subparagraph:

''(D) Section 1920A (relating to presumptive eligibility).''.

(B) EXCEPTION FROM LIMITATION ON ADMINISTRATIVE EXPENSES.—Section 2105(c)(2)

(42 U.S.C. 1397ee(c)(2)) is amended by adding at the end the following new subparagraph:

''(C) EXCEPTION FOR PRESUMPTIVE ELIGIBILITY EXPENDITURES.—The limitation under subparagraph (A) on expenditures shall not apply to expenditures attributable to the application of section 1920A (pursuant to section 2107(e)(1)(D)), regardless of whether the child is determined to be ineligible for the program under this title or title XIX.''.

(3) TECHNICAL AMENDMENTS.—Section 1920A (42 U.S.C. 1396r–1a) is amended—

(A) in subsection (b)(3)(A)(ii), by striking ''paragraph (1)(A)'' and inserting ''paragraph (2)(A)''; and

(B) in subsection (c)(2), in the matter preceding subparagraph (A), by striking ''subsection (b)(1)(A)'' and inserting ''subsection (b)(2)(A)''.

(b) ELIMINATION OF SCHIP FUNDING OFFSET FOR EXERCISE OF PRESUMPTIVE ELIGIBILITY OPTION.—

(1) IN GENERAL.—Section 2104(d) (42 U.S.C. 1397dd(d)) is amended by striking ''the sum of—'' and all that follows through ''(2)'' and conforming the margins of all that remains accordingly.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect October 1, 2000, and applies to allotments under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) for fiscal year 2001 and each succeeding fiscal year thereafter.

SEC. 705. IMPROVEMENTS TO THE MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT.

(a) INCREASE IN AUTHORIZATION OF APPROPRIATIONS.—Section 501(a) (42 U.S.C. 701(a)) is amended in the matter preceding paragraph (1) by striking ''$705,000,000 for fiscal year 1994'' and inserting ''$1,000,000,000 for fiscal year 2001''.

(b) COORDINATION WITH MEDICAID AND SCHIP.—

(1) SCHIP.—Section 505(a)(5)(F) (42 U.S.C. 705(a)(5)(F)) is amended—

(A) in clause (ii), by inserting ''and in the coordination of the administration of the State program under title XXI with the care and services available under this title, as required under subsections (b)(3)(G) and (c)(2) of section 2102'' before the comma; and

(B) in clause (iv), by striking ''and infants who are eligible for medical assistance under subparagraph (A) or (B) of section 1902(l)(1)''

and inserting ", infants, and children who are eligible for medical assistance under section 1902(l)(1), and children who are eligible for child health assistance under the State program under title XXI".

(2) CONFORMING AMENDMENTS TO SCHIP.—Section 2102(b)(3) (42 U.S.C. 1397bb(b)(3)), as amended by section 703(b)(2), is amended—

(A) by striking "and" at the end of subparagraph (E);

(B) by striking the period at the end of subparagraph (F) and inserting "; and"; and

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

"(G) that operations and activities under this title are developed and implemented in consultation and coordination with the program operated by the State under title V with respect to outreach and enrollment, benefits and services, service delivery standards, public health and social service agency relationships, and quality assurance and data reporting.".

(c) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2000.

SEC. 706. IMPROVING ACCESS TO MEDICARE COST-SHARING ASSISTANCE FOR LOW-INCOME BENEFICIARIES.

(a) INCREASE IN SLMB ELIGIBILITY.—

(1) IN GENERAL.—Section 1902(a)(10)(E) (42 U.S.C. 1396a(a)(10)(E)) is amended—

(A) in clause (iii), by striking ''and 120 percent in 1995'' and inserting '', 120 percent in 1995 through 2000, and 135 percent in 2001''; and

(B) in clause (iv), by striking ''2002)—'' and all that follows through ''(II) for'' and inserting ''2002) for''.

(2) CONFORMING AMENDMENT.—Section 1933(c)(2)(A) (42 U.S.C. 1396u–3(c)(2)(A)) is amended by striking ''sum of—'' and all that follows through ''(ii) the''''.

(3) EFFECTIVE DATE.—The amendments made by this subsection take effect on January 1, 2001, and with respect to the amendment made by paragraph (2), applies to allocations determined under section 1933(c) of the Social Security Act (42 U.S.C. 1396u–3(c)) for the last 3 quarters of fiscal year 2001 and all of fiscal year 2002.

(b) INDEX OF ASSETS TEST TO INFLATION.—Section 1905(p)(1)(C) (42 U.S.C. 1396d(p)(1)(C)) is amended by

inserting ‘‘, increased (beginning with 2001 and each year thereafter) by the percentage increase (if any) in the Consumer Price Index for All Urban Consumers (United States city average)’’ before the period.

(c) INCREASED EFFORT TO PROVIDE MEDICARE BENEFICIARIES WITH MEDICARE COST-SHARING UNDER THE MEDICAID PROGRAM.—

(1) IN GENERAL.—Section 1902(a) (42 U.S.C. 1396a(a)), as amended by section 703(b)(1)(A), is amended—

(A) in paragraph (65), by striking ‘‘and’’ at the end;

(B) in paragraph (66), by striking the period and inserting ‘‘; and’’; and

(C) by inserting after paragraph (66) the following new paragraph:

‘‘(67) provide for the determination of eligibility for medicare cost-sharing (as defined in section 1905(p)(3)) for individuals described in paragraph (10)(E) and, if eligible for such medicare cost-sharing, for the enrollment of such individuals at any hospital, clinic, or similar entity at which State or local agency personnel are stationed for the purpose of determining the eligibility of individuals for medical assistance under the State plan or providing

outreach services to eligible or potentially eligible individuals.''.

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

(d) PRESUMPTIVE ELIGIBILITY OF CERTAIN LOW-INCOME INDIVIDUALS FOR MEDICARE COST-SHARING UNDER THE QMB OR SLMB PROGRAM.—Title XIX (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920A the following new section:

''PRESUMPTIVE ELIGIBILITY OF CERTAIN LOW-INCOME INDIVIDUALS

''SEC. 1920B. (a) A State plan approved under section 1902 shall provide for making medical assistance with respect to medicare cost-sharing covered under the State plan available to a low-income individual on the date the low-income individual becomes entitled to benefits under part A of title XVIII during a presumptive eligibility period.

''(b) For purposes of this section:

''(1) The term 'low-income individual' means an individual who at the age of 65 years is described—

''(A) in section 1902(a)(10)(E)(i), or

''(B) in section 1902(a)(10)(E)(iii).

''(2) The term 'medicare cost-sharing'—

"(A) with respect to an individual described in paragraph (1)(A), has the meaning given such term in section 1905(p)(3); and

"(B) with respect to an individual described in paragraph (1)(B), has the meaning given such term in section 1905(p)(3)(A).

"(3) The term 'presumptive eligibility period' means, with respect to a low-income individual, the period that—

"(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the income and resources of the individual do not exceed the applicable income and resource level of eligibility under the State plan, and

"(B) ends with (and includes) the earlier of—

"(i) the day on which a determination is made with respect to the eligibility of the low-income individual for medical assistance for medical cost-sharing under the State plan, or

"(ii) in the case of a low-income individual on whose behalf an application is not filed by the last day of the month fol-

lowing the month during which the entity makes the determination referred to in subparagraph (A), such last day.

''(4)(A) Subject to subparagraph (B), the term 'qualified entity' means any of the following:

''(i) Qualified individuals within the Social Security Administration.

''(ii) An entity determined by the State agency to be capable of making determinations of the type described in paragraph (3).

''(B) The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

''(c)(1) The State agency, after consultation with the Secretary, shall provide qualified entities with—

''(A) such forms as are necessary for an application to be made on behalf of a low-income individual for medical assistance for medical cost-sharing under the State plan, and

''(B) information on how to assist low-income individuals and other persons in completing and filing such forms.

''(2) A qualified entity that determines under subsection (b)(2)(A) that a low-income individual is presump-

tively eligible for medical assistance for medical cost-sharing under a State plan shall—

''(A) notify the State agency of the determination within 5 working days after the date on which the determination is made, and

''(B) inform the low-income individual at the time the determination is made that an application for medical assistance for medical cost-sharing under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

''(3) In the case of a low-income individual who is determined by a qualified entity to be presumptively eligible for medical assistance for medical cost-sharing under a State plan, the low-income individual shall make application for medical assistance for medical cost-sharing under such plan by not later than the last day of the month following the month during which the determination is made.

''(d) Notwithstanding any other provision of this title, medical assistance for medicare cost-sharing that—

''(1) is furnished to a low-income individual during a presumptive eligibility period under the State plan; and

''(2) is included in the services covered by a State plan;

shall be treated as medical assistance provided by such plan for purposes of section 1903.''.

SEC. 707. BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(A) in subclause (XVI), by striking ''or'' at the end;

(B) in subclause (XVII), by adding ''or'' at the end; and

(C) by adding at the end the following:

''(XVIII) who are described in subsection (aa) (relating to certain breast or cervical cancer patients);''.

(2) GROUP DESCRIBED.—Section 1902 (42 U.S.C. 1396a) is amended by adding at the end the following:

''(aa) Individuals described in this subsection are individuals who—

''(1) are not described in subsection (a)(10)(A)(i);

''(2) have not attained age 65;

''(3) have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention breast and cervical cancer early detection program established under title XV of the Public Health Service Act (42 U.S.C. 300k et seq.) in accordance with the requirements of section 1504 of that Act (42 U.S.C. 300n) and need treatment for breast or cervical cancer; and

''(4) are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)).''.

(3) LIMITATION ON BENEFITS.—Section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G)—

(A) by striking ''and (XIII)'' and inserting ''(XIII)''; and

(B) by inserting '', and (XIV) the medical assistance made available to an individual described in subsection (aa) who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer'' before the semicolon.

(4) CONFORMING AMENDMENTS.—Section 1905(a) (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(A) in clause (xi), by striking ''or'' at the end;

(B) in clause (xii), by adding ''or'' at the end; and

(C) by inserting after clause (xii) the following:

''(xiii) individuals described in section 1902(aa),''.

(b) PRESUMPTIVE ELIGIBILITY.—

(1) IN GENERAL.—Title XIX (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920A the following:

''PRESUMPTIVE ELIGIBILITY FOR CERTAIN BREAST OR CERVICAL CANCER PATIENTS

''SEC. 1920B. (a) STATE OPTION.—A State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(aa) (relating to certain breast or cervical cancer patients) during a presumptive eligibility period.

''(b) DEFINITIONS.—For purposes of this section:

''(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The term 'presumptive eligibility period' means, with re-

spect to an individual described in subsection (a), the period that—

''(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(aa); and

''(B) ends with (and includes) the earlier of—

''(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

''(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

''(2) QUALIFIED ENTITY.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'qualified entity' means any entity that—

''(i) is eligible for payments under a State plan approved under this title; and

''(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

''(B) REGULATIONS.—The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

''(C) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed under subparagraph (B).

''(c) ADMINISTRATION.—

''(1) IN GENERAL.—The State agency shall provide qualified entities with—

''(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

''(B) information on how to assist such individuals in completing and filing such forms.

''(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection

(a) is presumptively eligible for medical assistance under a State plan shall—

"(A) notify the State agency of the determination within 5 working days after the date on which the determination is made; and

"(B) inform such individual at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

"(3) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made.

"(d) PAYMENT.—Notwithstanding any other provision of this title, medical assistance that—

"(1) is furnished to an individual described in subsection (a)—

''(A) during a presumptive eligibility period; and

''(B) by a entity that is eligible for payments under the State plan; and

''(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(47) (42 U.S.C. 1396a(a)(47)) is amended by inserting before the semicolon at the end the following: ''and provide for making medical assistance available to individuals described in subsection (a) of section 1920B during a presumptive eligibility period in accordance with such section''.

(B) Section 1903(u)(1)(D)(v) (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

(i) by striking ''or for'' and inserting '', for''; and

(ii) by inserting before the period the following: '', or for medical assistance provided to an individual described in subsection (a) of section 1920B during a pre-

sumptive eligibility period under such section''.

(c) ENHANCED MATCH.—The first sentence of section 1905(b) (42 U.S.C. 1396d(b)) is amended—

(1) by striking ''and'' before ''(3)''; and

(2) by inserting before the period at the end the following: '', and (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 2105(b) with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XVIII)''.

(d) EFFECTIVE DATE.—The amendments made by this section apply to medical assistance for items and services furnished on or after October 1, 2000, without regard to whether final regulations to carry out such amendments have been promulgated by such date.

TITLE VIII—OTHER PROVISIONS

SEC. 801. APPROPRIATIONS FOR RICKY RAY HEMOPHILIA RELIEF FUND.

Section 101(e) of the Ricky Ray Hemophilia Relief Fund Act of 1998 (42 U.S.C. 300c–22 note) is amended by adding at the end the following: ''There is appropriated to the Fund $475,000,000 for fiscal year 2001, to remain available until expended.''.

SEC. 802. INCREASE IN APPROPRIATIONS FOR SPECIAL DIABETES PROGRAMS FOR CHILDREN WITH TYPE I DIABETES AND INDIANS.

(a) SPECIAL DIABETES PROGRAMS FOR CHILDREN WITH TYPE I DIABETES.—Section 330B(b) of the Public Health Service Act (42 U.S.C. 254c–2(b)) is amended—

(1) by striking ''Notwithstanding'' and inserting the following:

''(1) TRANSFERRED FUNDS.—Notwithstanding''; and

(2) by adding at the end the following:

''(2) APPROPRIATIONS.—For the purpose of making grants under this section, there are appropriated, out of any money in the Treasury not otherwise appropriated—

''(A) $70,000,000 for each of fiscal years 2001 and 2002 (which shall be combined with amounts transferred under paragraph (1) for each such fiscal years); and

''(B) $100,000,000 for each of fiscal years 2003 through 2005.''.

(b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—Section 330C(c) of the Public Health Service Act (42 U.S.C. 254c–3(c)) is amended—

(1) by striking ''Notwithstanding'' and inserting the following:

''(1) TRANSFERRED FUNDS.—Notwithstanding'';

(2) by adding at the end the following:

''(2) APPROPRIATIONS.—For the purpose of making grants under this section, there are appropriated, out of any money in the Treasury not otherwise appropriated—

''(A) $70,000,000 for each of fiscal years 2001 and 2002 (which shall be combined with amounts transferred under paragraph (1) for each such fiscal years); and

''(B) $100,000,000 for each of fiscal years 2003 through 2005.''.

SEC. 803. DEMONSTRATION GRANTS TO IMPROVE OUTREACH, ENROLLMENT, AND COORDINATION OF PROGRAMS AND SERVICES TO HOMELESS INDIVIDUALS AND FAMILIES.

(a) AUTHORITY.—The Secretary of Health and Human Services may award demonstration grants to not more than 7 States (or other qualified entities) to conduct innovative programs that are designed to improve outreach to homeless individuals and families under the programs described in subsection (b) with respect to enrollment of such individuals and families under such pro-

grams and the provision of services (and coordinating the provision of such services) under such programs.

(b) PROGRAMS FOR HOMELESS DESCRIBED.—The programs described in this subsection are as follows:

(1) MEDICAID.—The program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(2) SCHIP.—The program under title XXI of such Act (42 U.S.C. 1397aa et seq.).

(3) TANF.—The program under part A of title IV of such Act (42 U.S.C. 601 et seq.).

(4) MATERNAL AND CHILD HEALTH BLOCK GRANTS.—The program under title V of the Social Security Act (42 U.S.C. 701 et seq.).

(5) MENTAL HEALTH AND SUBSTANCE ABUSE BLOCK GRANTS.—The program under part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–1 et seq.).

(6) HIV/AIDS CARE GRANTS.—The program under part B of title XXVI of the Public Health Service Act (42 U.S.C. 300ff–21 et seq.).

(7) FOOD STAMP PROGRAM.—The program under the Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.).

(8) WORKFORCE INVESTMENT ACT.—The program under the Workforce Investment Act of 1999 (29 U.S.C. 2801 et seq.).

(9) WELFARE-TO-WORK.—The welfare-to-work program under section 403(a)(5) of the Social Security Act (42 U.S.C. 603(a)(5)).

(10) OTHER PROGRAMS.—Other public and private benefit programs that serve low-income individuals.

(c) APPROPRIATIONS.—For the purposes of carrying out this section, there are appropriated, out of any funds in the Treasury not otherwise appropriated, $10,000,000, to remain available until expended.

SEC. 804. PROTECTION OF AN HMO ENROLLEE TO RECEIVE CONTINUING CARE AT A FACILITY SELECTED BY THE ENROLLEE.

(a) AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following new section:

"SEC. 714. ENSURING CHOICE FOR CONTINUING CARE.

''(a) IN GENERAL.—With respect to health insurance coverage provided to participants or beneficiaries through a managed care organization under a group health plan, or through a health insurance issuer providing health insurance coverage in connection with a group health plan, such plan or issuer may not deny coverage for services provided to such participant or beneficiary by a continuing care retirement community, skilled nursing facility, or other qualified facility in which the participant or beneficiary resided prior to a hospitalization, regardless of whether such organization is under contract with such community or facility if the requirements described in subsection (b) are met.

''(b) REQUIREMENTS.—The requirements of this subsection are that—

''(1) the service involved is a service for which the managed care organization involved would be required to provide or pay for under its contract with the participant or beneficiary if the continuing care retirement community, skilled nursing facility, or other qualified facility were under contract with the organization;

''(2) the participant or beneficiary involved—

''(A) resided in the continuing care retirement community, skilled nursing facility, or

other qualified facility prior to being hospitalized;

''(B) had a contractual or other right to return to the facility after hospitalization; and

''(C) elects to return to the facility after hospitalization, whether or not the residence of the participant or beneficiary after returning from the hospital is the same part of the facility in which the beneficiary resided prior to hospitalization;

''(3) the continuing care retirement community, skilled nursing facility, or other qualified facility has the capacity to provide the services the participant or beneficiary needs; and

''(4) the continuing care retirement community, skilled nursing facility, or other qualified facility is willing to accept substantially similar payment under the same terms and conditions that apply to similarly situated health care facility providers under contract with the organization involved.

''(c) SERVICES TO PREVENT HOSPITALIZATION.—A group health plan or health insurance issuer to which this section applies may not deny payment for a skilled nursing service provided to a participant or beneficiary by a continuing care retirement community, skilled nursing facil-

ity, or other qualified facility in which the participant or beneficiary resides, without a preceding hospital stay, regardless of whether the organization is under contract with such community or facility, if—

''(1) the plan or issuer has determined that the service is necessary to prevent the hospitalization of the participant or beneficiary; and

''(2) the service to prevent hospitalization is provided as an additional benefit as described in section 417.594 of title 42, Code of Federal Regulations, and would otherwise be covered as provided for in subsection (b)(1).

''(d) RIGHTS OF SPOUSES.—A group health plan or health insurance issuer to which this section applies shall not deny payment for services provided by a skilled nursing facility for the care of a participant or beneficiary, regardless of whether the plan or issuer is under contract with such facility, if the spouse of the participant or beneficiary is already a resident of such facility and the requirements described in subsection (b) are met.

''(e) EXCEPTIONS.—Subsection (a) shall not apply—

''(1) where the attending acute care provider and the participant or beneficiary (or a designated representative of the participant or beneficiary where the participant or beneficiary is physically or men-

tally incapable of making an election under this paragraph) do not elect to pursue a course of treatment necessitating continuing care; or

''(2) unless the community or facility involved—

''(A) meets all applicable licensing and certification requirements of the State in which it is located; and

''(B) agrees to reimbursement for the care of the participant or beneficiary at a rate similar to the rate negotiated by the managed care organization with similar providers of care for similar services.

''(f) PROHIBITIONS.—A group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan may not—

''(1) deny to an individual eligibility, or continued eligibility, to enroll or to renew coverage with a managed care organization under the plan, solely for the purpose of avoiding the requirements of this section;

''(2) provide monetary payments or rebates to enrollees to encourage such enrollees to accept less than the minimum protections available under this section;

''(3) penalize or otherwise reduce or limit the reimbursement of an attending physician because such physician provided care to a participant or beneficiary in accordance with this section; or

''(4) provide incentives (monetary or otherwise) to an attending physician to induce such physician to provide care to a participant or beneficiary in a manner inconsistent with this section.

''(g) RULES OF CONSTRUCTION.—

''(1) HMO NOT OFFERING BENEFITS.—This section shall not apply with respect to any managed care organization under a group health plan, or through a health insurance issuer providing health insurance coverage in connection with a group health plan, that does not provide benefits for stays in a continuing care retirement community, skilled nursing facility, or other qualified facility.

''(2) COST-SHARING.—Nothing in this section shall be construed as preventing a managed care organization under a group health plan, or through a health insurance issuer providing health insurance coverage in connection with a group health plan, from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for care in a continuing care facility.

''(h) PREEMPTION; EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

''(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage to the extent that a State law (as defined in section 2723(d)(1) of the Public Health Service Act) applies to such coverage and is described in any of the following subparagraphs:

''(A) Such State law requires such coverage to provide for referral to a continuing care retirement community, skilled nursing facility, or other qualified facility in a manner that is more protective of participants or beneficiaries than the provisions of this section.

''(B) Such State law expands the range of services or facilities covered under this section and is otherwise more protective of the rights of participants or beneficiaries than the provisions of this section.

''(2) CONSTRUCTION.—Section 731(a)(1) shall not be construed to provide that any requirement of this section applies with respect to health insurance coverage, to the extent that a State law described in paragraph (1) applies to such coverage.

''(i) PENALTIES.—A participant or beneficiary may enforce the provisions of this section in an appropriate Federal district court. An action for injunctive relief or damages may be commenced on behalf of the participant or beneficiary by the participant's or beneficiary's legal representative. The court may award reasonable attorneys' fees to the prevailing party. If a beneficiary dies before conclusion of an action under this section, the action may be maintained by a representative of the participant's or beneficiary's estate.

''(j) DEFINITIONS.—In this section:

''(1) ATTENDING ACUTE CARE PROVIDER.—The term 'attending acute care provider' means anyone licensed or certified under State law to provide health care services who is operating within the scope of such license and who is primarily responsible for the care of the enrollee.

''(2) CONTINUING CARE RETIREMENT COMMUNITY.—The term 'continuing care retirement community' means an organization that provides or arranges for the provision of housing and health-related services to an older person under an agreement effective for the life of the person or for a specified period greater than 1 year.

''(3) MANAGED CARE ORGANIZATION.—The term 'managed care organization' means an organization that provides comprehensive health services to participants or beneficiaries, directly or under contract or other agreement, on a prepayment basis to such individuals. For purposes of this section, the following shall be considered as managed care organizations:

''(A) A Medicare+Choice plan authorized under section 1851(a) of the Social Security Act (42 U.S.C. 1395w–21(a)).

''(B) Any other entity that manages the cost, utilization, and delivery of health care through the use of predetermined periodic payments to health care providers employed by or under contract or other agreement, directly or indirectly, with the entity.

''(4) OTHER QUALIFIED FACILITY.—The term 'other qualified facility' means any facility that can provide the services required by the participant or beneficiary consistent with State and Federal law.

''(5) SKILLED NURSING FACILITY.—The term 'skilled nursing facility' means a facility that meets the requirements of section 1819 of the Social Security Act (42 U.S.C. 1395i–3).''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the items relating to subpart B of part 7 of subtitle B of title I the following new item:

''Sec. 714. Ensuring choice for continuing care.''.

(3) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2001.

(b) AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.—

(1) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–4 et seq.) is amended by adding at the end the following new section:

''SEC. 2707. ENSURING CHOICE FOR CONTINUING CARE.

''(a) IN GENERAL.—With respect to health insurance coverage provided to enrollees through a managed care organization under a group health plan, or through a health insurance issuer providing health insurance coverage in connection with a group health plan, such plan or issuer may not deny coverage for services provided to such enrollee by a continuing care retirement community, skilled nursing facility, or other qualified facility in which the enrollee resided prior to a hospitalization, regardless of whether such organization is under contract with such

community or facility if the requirements described in subsection (b) are met.

''(b) REQUIREMENTS.—The requirements of this subsection are that—

''(1) the service involved is a service for which the managed care organization involved would be required to provide or pay for under its contract with the enrollee if the continuing care retirement community, skilled nursing facility, or other qualified facility were under contract with the organization;

''(2) the enrollee involved—

''(A) resided in the continuing care retirement community, skilled nursing facility, or other qualified facility prior to being hospitalized;

''(B) had a contractual or other right to return to the facility after hospitalization; and

''(C) elects to return to the facility after hospitalization, whether or not the residence of the enrollee after returning from the hospital is the same part of the facility in which the beneficiary resided prior to hospitalization;

''(3) the continuing care retirement community, skilled nursing facility, or other qualified facility has

the capacity to provide the services the enrollee needs; and

''(4) the continuing care retirement community, skilled nursing facility, or other qualified facility is willing to accept substantially similar payment under the same terms and conditions that apply to similarly situated health care facility providers under contract with the organization involved.

''(c) SERVICES TO PREVENT HOSPITALIZATION.—A group health plan or health insurance issuer to which this section applies may not deny payment for a skilled nursing service provided to an enrollee by a continuing care retirement community, skilled nursing facility, or other qualified facility in which the enrollee resides, without a preceding hospital stay, regardless of whether the plan or issuer is under contract with such community or facility, if—

''(1) the plan or issuer has determined that the service is necessary to prevent the hospitalization of the enrollee; and

''(2) the service to prevent hospitalization is provided as an additional benefit as described in section 417.594 of title 42, Code of Federal Regulations, and would be covered as provided for in subsection (b)(1).

''(d) RIGHTS OF SPOUSES.—A group health plan or health insurance issuer to which this section applies shall not deny payment for services provided by a skilled nursing facility for the care of an enrollee, regardless of whether the plan or issuer is under contract with such facility, if the spouse of the enrollee is already a resident of such facility and the requirements described in subsection (b) are met.

''(e) EXCEPTIONS.—Subsection (a) shall not apply—

''(1) where the attending acute care provider and the enrollee (or a designated representative of the enrollee where the enrollee is physically or mentally incapable of making an election under this paragraph) do not elect to pursue a course of treatment necessitating continuing care; or

''(2) unless the community or facility involved—

''(A) meets all applicable licensing and certification requirements of the State in which it is located; and

''(B) agrees to reimbursement for the care of the enrollee at a rate similar to the rate negotiated by the managed care organization with similar providers of care for similar services.

''(f) PROHIBITIONS.—A group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan may not—

''(1) deny to an individual eligibility, or continued eligibility, to enroll or to renew coverage with a managed care organization under the plan, solely for the purpose of avoiding the requirements of this section;

''(2) provide monetary payments or rebates to enrollees to encourage such enrollees to accept less than the minimum protections available under this section;

''(3) penalize or otherwise reduce or limit the reimbursement of an attending physician because such physician provided care to an enrollee in accordance with this section; or

''(4) provide incentives (monetary or otherwise) to an attending physician to induce such physician to provide care to an enrollee in a manner inconsistent with this section.

''(g) RULES OF CONSTRUCTION.—

''(1) HMO NOT OFFERING BENEFITS.—This section shall not apply with respect to any managed care organization under a group health plan, or through a health insurance issuer providing health

insurance coverage in connection with a group health plan, that does not provide benefits for stays in a continuing care retirement community, skilled nursing facility, or other qualified facility.

''(2) COST-SHARING.—Nothing in this section shall be construed as preventing a managed care organization under a group health plan, or through a health insurance issuer providing health insurance coverage in connection with a group health plan, from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for care in a continuing care facility.

''(h) PREEMPTION; EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

''(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage to the extent that a State law (as defined in section 2723(d)(1)) applies to such coverage and is described in any of the following subparagraphs:

''(A) Such State law requires such coverage to provide for referral to a continuing care retirement community, skilled nursing facility, or other qualified facility in a manner

that is more protective of the enrollee than the provisions of this section.

''(B) Such State law expands the range of services or facilities covered under this section and is otherwise more protective of enrollee rights than the provisions of this section.

''(2) CONSTRUCTION.—Section 2723(a)(1) shall not be construed to provide that any requirement of this section applies with respect to health insurance coverage, to the extent that a State law described in paragraph (1) applies to such coverage.

''(i) PENALTIES.—An enrollee may enforce the provisions of this section in an appropriate Federal district court. An action for injunctive relief or damages may be commenced on behalf of the enrollee by the enrollee's legal representative. The court may award reasonable attorneys' fees to the prevailing party. If a beneficiary dies before conclusion of an action under this section, the action may be maintained by a representative of the enrollee's estate.

''(j) DEFINITIONS.—In this section:

''(1) ATTENDING ACUTE CARE PROVIDER.—The term 'attending acute care provider' means anyone licensed or certified under State law to provide health care services who is operating within the

scope of such license and who is primarily responsible for the care of the enrollee.

''(2) CONTINUING CARE RETIREMENT COMMUNITY.—The term 'continuing care retirement community' means an organization that provides or arranges for the provision of housing and health-related services to an older person under an agreement effective for the life of the person or for a specified period greater than 1 year.

''(3) MANAGED CARE ORGANIZATION.—The term 'managed care organization' means an organization that provides comprehensive health services to enrollees, directly or under contract or other agreement, on a prepayment basis to such individuals. For purposes of this section, the following shall be considered as managed care organizations:

''(A) A Medicare+Choice plan authorized under section 1851(a) of the Social Security Act (42 U.S.C. 1395w–21(a)).

''(B) Any other entity that manages the cost, utilization, and delivery of health care through the use of predetermined periodic payments to health care providers employed by or under contract or other agreement, directly or indirectly, with the entity.

''(4) OTHER QUALIFIED FACILITY.—The term 'other qualified facility' means any facility that can provide the services required by the enrollee consistent with State and Federal law.

''(5) SKILLED NURSING FACILITY.—The term 'skilled nursing facility' means a facility that meets the requirements of section 1819 of the Social Security Act (42 U.S.C. 1395i–3).''.

(2) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 2001.

(c) AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE INDIVIDUAL MARKET.—

(1) IN GENERAL.—The first subpart 3 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–51 et seq.) (relating to other requirements) is amended—

(A) by redesignating such subpart as subpart 2; and

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

''SEC. 2753. ENSURING CHOICE FOR CONTINUING CARE.

''The provisions of section 2707 shall apply to health maintenance organization coverage offered by a health in-

surance issuer in the individual market in the same manner as they apply to such coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.''.

(2) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 2001.

SEC. 805. GRANTS TO DEVELOP AND ESTABLISH REAL CHOICE SYSTEMS CHANGE INITIATIVES.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall award grants described in subsection (b) to States to support real choice systems change initiatives that establish specific action steps and specific timetables to achieve enduring system improvements and to provide consumer-responsive long-term services and supports to eligible individuals in the most integrated setting appropriate based on the unique strengths and needs of the individual, the priorities and concerns of the individual (or, as appropriate, the individual's representative), and the

individual's desires with regard to participation in community life.

(2) ELIGIBILITY.—To be eligible for a grant under this section, a State shall—

(A) establish a Consumer Task Force in accordance with subsection (d); and

(B) submit an application at such time, in such manner, and containing such information as the Secretary may determine. The application shall be jointly developed and signed by the designated State official and the chairperson of such Task Force, acting on behalf of and at the direction of the Task Force.

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

(b) GRANTS FOR REAL CHOICE SYSTEMS CHANGE INITIATIVES.—

(1) IN GENERAL.—From funds appropriated under subsection (f), the Secretary shall award grants to States to—

(A) support the establishment, implementation, and operation of the State real choice systems change initiatives described in subsection (a); and

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

(2) DETERMINATION OF AWARDS; STATE ALLOTMENTS.—The Secretary shall develop a formula for the distribution of funds to States for each fiscal year under subsection (a). Such formula shall give preference to States that have a higher need for assistance, as determined by the Secretary, based on indicators such as a relatively higher proportion of long-term services and supports furnished to individuals in an institutional setting but who have a plan described in an application submitted under subsection (a)(2).

(c) AUTHORIZED ACTIVITIES.—A State that receives a grant under this section shall use the funds made available through the grant to accomplish the purposes described in subsection (a) and, in accomplishing such purposes, may carry out any of the following systems change activities:

(1) NEEDS ASSESSMENT AND DATA GATHERING.—The State may use funds to conduct a

statewide needs assessment that may be based on data in existence on the date on which the assessment is initiated and may include information about the number of individuals within the State who are receiving long-term services and supports in unnecessarily segregated settings, the nature and extent to which current programs respond to the preferences of individuals with disabilities to receive services in home and community-based settings as well as in institutional settings, and the expected change in demand for services provided in home and community settings as well as institutional settings.

(2) INSTITUTIONAL BIAS: REMEDIES AND PROMOTION OF COMMUNITY PARTICIPATION.—The State may use funds to identify, develop, and implement strategies for modifying policies, practices, and procedures that unnecessarily bias the provision of long-term services and supports toward institutional settings and away from home and community-based settings, including policies, practices, and procedures governing statewideness, comparability in amount, duration, and scope of services, financial eligibility, individualized functional assessments and screenings (including individual and family involvement), knowledge about service options, and promotion of self-di-

rection of services and community-integrated living and service arrangements that facilitate participation in community life to the fullest extent possible and desired by the individual.

(3) OVER MEDICALIZATION OF SERVICES.—The State may use funds to identify, develop, and implement strategies for modifying policies, practices, and procedures that unnecessarily bias the provision of long-term services and supports by health care professionals to the extent that quality services and supports can be provided by other qualified individuals, including policies, practices, and procedures governing service authorization, case management, and service coordination, service delivery options, quality controls, and supervision and training.

(4) INTERAGENCY COORDINATION; SINGLE POINT OF ENTRY.—The State may support activities to identify and coordinate Federal and State policies, resources, and services, relating to the provision of long-term services and supports, including the convening of interagency work groups and the entering into of interagency agreements that provide for a single point of entry with one-stop access for long-term support services and the design and implementation of a coordinated screening and assessment

system for all persons eligible for long-term services and supports.

(5) TRAINING AND TECHNICAL ASSISTANCE.—The State may carry out directly, or may provide support to a public or private entity to carry out training and technical assistance activities that are provided for individuals with disabilities, and, as appropriate, their representatives, attendants, and other personnel (including professionals, paraprofessionals, volunteers, and other members of the community).

(6) PUBLIC AWARENESS.—The State may support a public awareness program that is designed to provide information relating to the availability of choices available to individuals with disabilities for receiving long-term services and support in the most integrated setting appropriate.

(7) TRANSITIONAL COSTS.—The State may use funds to provide transitional costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from an institutional facility to a community-based home setting where the individual resides.

(8) TASK FORCE.—The State may use funds to support the operation of the Consumer Task Force established under subsection (d).

(9) DEMONSTRATIONS OF NEW APPROACHES.—The State may use funds to conduct, on a time-limited basis, the demonstration of new approaches to accomplishing the purposes described in subsection (a)(1).

(10) IMPROVEMENT IN THE QUALITY OF SERVICES AND SUPPORTS.—The State may use funds to improve the quality of services and supports provided to individuals with disabilities and their families.

(11) OTHER ACTIVITIES.—The State may use funds for any systems change activities that are not described in any of the preceding paragraphs of this subsection and that are necessary for developing, implementing, or evaluating the comprehensive statewide system of community-integrated long-term services and supports.

(d) CONSUMER TASK FORCE.—

(1) ESTABLISHMENT AND DUTIES.—To be eligible to receive a grant under this section, each State shall establish a Consumer Task Force (referred to in this section as the ''Task Force'') to as-

sist the State in the development, implementation, and evaluation of real choice systems change initiatives.

(2) APPOINTMENT.—Members of the Task Force shall be appointed by the Chief Executive Officer of the State in accordance with the requirements of paragraph (3), after the solicitation of recommendations from representatives of organizations representing a broad range of individuals with disabilities and organizations interested in individuals with disabilities.

(3) COMPOSITION.—

(A) IN GENERAL.—The Task Force shall represent a broad range of individuals with disabilities from diverse backgrounds and shall include representatives from Developmental Disabilities Councils, Mental Health Councils, State Independent Living Centers and Councils, Commissions on Aging, organizations that provide services to individuals with disabilities and consumers of long-term services and supports.

(B) INDIVIDUALS WITH DISABILITIES.—A majority of the members of the Task Force shall be individuals with disabilities or the representatives of such individuals.

(C) LIMITATION.—The Task Force shall not include employees of any State agency providing services to individuals with disabilities other than employees of agencies described in the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6000 et seq.) or the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10801 et seq.).

(e) AVAILABILITY OF FUNDS.—

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

(2) FUNDS NOT ALLOTTED TO STATES.—Funds not allotted to States in the fiscal year for which they are appropriated shall remain available in succeeding fiscal years for allotment by the Secretary using the allotment formula established by the Secretary under subsection (b)(2).

(f) ANNUAL REPORT.—A State that receives a grant under this section shall submit an annual report to the Secretary on the use of funds provided under the grant. Each report shall include the number and percentage increase in the number of eligible individuals in the State

who receive long-term services and supports in the most integrated setting appropriate, including through community attendant services and supports and other community-based settings.

(g) FUNDING.—

(1) FISCAL YEAR 2001.—For the purpose of making grants under this section, there are appropriated, out of any funds in the Treasury not otherwise appropriated, $50,000,000 for fiscal year 2001.

(2) FISCAL YEAR 2002 AND THEREAFTER.—There is authorized to be appropriated such sums as may be necessary to carry out this section for fiscal year 2002 and each fiscal year thereafter.

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