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H. R. 3075

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AN ACT

To amend titles XVIII, XIX, and XXI of the Social Security Act to make corrections and refinements in the Medicare, Medicaid, and State children's health insurance programs, as revised by the Balanced Budget Act of 1997.

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

1 **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECUR-**
 2 **RITY ACT; REFERENCES TO BBA; TABLE OF**
 3 **CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
 5 “Medicare, Medicaid, and SCHIP Balanced Budget Re-
 6 finement Act of 1999”.

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

13 (c) REFERENCES TO BALANCED BUDGET ACT OF
 14 1997.—In this Act, the term “BBA” means the Balanced
 15 Budget Act of 1997 (Public Law 105–33).

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

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

TITLE I—PROVISIONS RELATING TO PART A

Subtitle A—PPS Hospitals

Sec. 101. One-year delay in transition for indirect medical education (IME)
 percentage adjustment.

Sec. 102. Decrease in reductions for disproportionate share hospitals; data col-
 lection requirements.

Subtitle B—PPS Exempt Hospitals

Sec. 111. Wage adjustment of percentile cap for PPS-exempt hospitals.

Sec. 112. Enhanced payments for long-term care and psychiatric hospitals until
 development of prospective payment systems for those hos-
 pitals.

Sec. 113. Per discharge prospective payment system for long-term care hos-
 pitals.

- Sec. 114. Per diem prospective payment system for psychiatric hospitals.
- Sec. 115. Refinement of prospective payment system for inpatient rehabilitation services.

Subtitle C—Adjustments to PPS Payments for Skilled Nursing Facilities

- Sec. 121. Temporary increase in payment for certain high cost patients.
- Sec. 122. Market basket increase.
- Sec. 123. Authorizing facilities to elect immediate transition to Federal rate.
- Sec. 124. Part A pass-through payment for certain ambulance services, prostheses, and chemotherapy drugs.
- Sec. 125. Provision for part B add-ons for facilities participating in the NHCMQ demonstration project.
- Sec. 126. Special consideration for facilities serving specialized patient populations.
- Sec. 127. MedPAC study on special payment for facilities located in Hawaii and Alaska.

Subtitle D—Other

- Sec. 131. Part A BBA technical corrections.

TITLE II—PROVISIONS RELATING TO PART B

Subtitle A—Adjustments to Physician Payment Updates

- Sec. 201. Modification of update adjustment factor provisions to reduce update oscillations and require estimate revisions.
- Sec. 202. Use of data collected by organizations and entities in determining practice expense relative values.
- Sec. 203. GAO study on resources required to provide safe and effective outpatient cancer therapy.

Subtitle B—Hospital Outpatient Services

- Sec. 211. Outlier adjustment and transitional pass-through for certain medical devices, drugs, and biologicals.
- Sec. 212. Establishing a transitional corridor for application of OPD PPS.
- Sec. 213. Delay in application of prospective payment system to cancer center hospitals.
- Sec. 214. Limitation on outpatient hospital copayment for a procedure to the hospital deductible amount.

Subtitle C—Other

- Sec. 221. Application of separate caps to physical and speech therapy services.
- Sec. 222. Transitional outlier payments for therapy services for certain high acuity patients.
- Sec. 223. Update in renal dialysis composite rate.
- Sec. 224. Temporary update in durable medical equipment and oxygen rates.
- Sec. 225. Requirement for new proposed rulemaking for implementation of inherent reasonableness policy.
- Sec. 226. Increase in reimbursement for pap smears.
- Sec. 227. Refinement of ambulance services demonstration project.
- Sec. 228. Phase-in of PPS for ambulatory surgical centers.
- Sec. 229. Extension of Medicare benefits for immunosuppressive drugs.
- Sec. 230. Additional studies.

TITLE III—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

- Sec. 301. Adjustment to reflect administrative costs not included in the interim payment system.
- Sec. 302. Delay in application of 15 percent reduction in payment rates for home health services until 1 year after implementation of prospective payment system.
- Sec. 303. Clarification of surety bond requirements.
- Sec. 304. Technical amendment clarifying applicable market basket increase for PPS.

Subtitle B—Direct Graduate Medical Education

- Sec. 311. Use of national average payment methodology in computing direct graduate medical education (DGME) payments.
- Sec. 312. Initial residency period for child neurology residency training programs.

Subtitle C—Other

- Sec. 321. GAO study on geographic reclassification.
- Sec. 322. MedPAC study on Medicare payment for non-physician health professional clinical training in hospitals.

TITLE IV—RURAL PROVIDER PROVISIONS

- Sec. 401. Permitting reclassification of certain urban hospitals as rural hospitals.
- Sec. 402. Update of standards applied for geographic reclassification for certain hospitals.
- Sec. 403. Improvements in the critical access hospital (CAH) program.
- Sec. 404. Five-year extension of Medicare dependent hospital (MDH) program.
- Sec. 405. Rebasing for certain sole community hospitals.
- Sec. 406. Increased flexibility in providing graduate physician training in rural areas.
- Sec. 407. Elimination of certain restrictions with respect to hospital swing bed program.
- Sec. 408. Grant program for rural hospital transition to prospective payment.
- Sec. 409. MedPAC study of rural providers.
- Sec. 410. Expansion of access to paramedic intercept services in rural areas.

TITLE V—PROVISIONS RELATING TO PART C
(MEDICARE+CHOICE PROGRAM)

Subtitle A—Medicare+Choice

- Sec. 501. Phase-in of new risk adjustment methodology.
- Sec. 502. Encouraging offering of Medicare+Choice plans in areas without plans.
- Sec. 503. Modification of 5-year re-entry rule for contract terminations.
- Sec. 504. Continued computation and publication of AAPCC data.
- Sec. 505. Changes in Medicare+Choice enrollment rules.
- Sec. 506. Allowing variation in premium waivers within a service area if Medicare+Choice payment rates vary within the area.
- Sec. 507. Delay in deadline for submission of adjusted community rates and related information.

- Sec. 508. Two-year extension of Medicare cost contracts.
- Sec. 509. Medicare+Choice nursing and allied health professional education payments.
- Sec. 510. Reduction in adjustment in national per capita Medicare+Choice growth percentage for 2002.
- Sec. 511. Deeming of Medicare+Choice organization to meet requirements.
- Sec. 512. Miscellaneous changes and studies.
- Sec. 513. MedPAC report on Medicare MSA (medical savings account) plans.
- Sec. 514. Clarification of nonapplicability of certain provisions of discharge planning process to Medicare+Choice plans.

Subtitle B—Managed Care Demonstration Projects

- Sec. 521. Extension of social health maintenance organization demonstration (SHMO) project authority.
- Sec. 522. Extension of Medicare community nursing organization demonstration project.
- Sec. 523. Medicare+Choice competitive bidding demonstration project.
- Sec. 524. Extension of Medicare municipal health services demonstration projects.
- Sec. 525. Medicare coordinated care demonstration project.

TITLE VI—MEDICAID

- Sec. 601. Making Medicaid DSH transition rule permanent.
- Sec. 602. Increase in DSH allotment for certain States and the District of Columbia.
- Sec. 603. New prospective payment system for Federally-qualified health centers and rural health clinics.
- Sec. 604. Parity in reimbursement for certain utilization and quality control services.

TITLE VII—STATE CHILDREN’S HEALTH INSURANCE PROGRAM (SCHIP)

- Sec. 701. Stabilizing the SCHIP allotment formula.
- Sec. 702. Increased allotments for territories under the State children’s health insurance program.

1 **TITLE I—PROVISIONS RELATING**
2 **TO PART A**

3 **Subtitle A—PPS Hospitals**

4 **SEC. 101. ONE-YEAR DELAY IN TRANSITION FOR INDIRECT**
5 **MEDICAL EDUCATION (IME) PERCENTAGE**
6 **ADJUSTMENT.**

7 (a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42
8 U.S.C. 1395ww(d)(5)(B)(ii)), as amended by section
9 4621(a)(1) of BBA, is amended—

10 (1) in subclause (IV), by inserting “and 2001”
11 after “2000”; and

12 (2) by striking “2000” in subclause (V) and in-
13 serting “2001”.

14 (b) CONFORMING AMENDMENT RELATING TO DE-
15 TERMINATION OF STANDARDIZED AMOUNT.—Section
16 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)), as
17 amended by section 4621(a)(2) of BBA, is amended by
18 inserting “or any additional payments under such para-
19 graph resulting from the amendment made by section
20 101(a) of Medicare, Medicaid, and SCHIP Balanced
21 Budget Refinement Act of 1999” after “Balanced Budget
22 Act of 1997”.

1 **SEC. 102. DECREASE IN REDUCTIONS FOR DISPROPOR-**
 2 **TIONATE SHARE HOSPITALS; DATA COLLEC-**
 3 **TION REQUIREMENTS.**

4 (a) IN GENERAL.—Section 1886(d)(5)(F)(ix) (42
 5 U.S.C. 1395ww(d)(5)(F)(ix)), as added by section 4403(a)
 6 of BBA, is amended—

7 (1) in subclause (III), by striking “during fiscal
 8 year 2000” and inserting “during each of fiscal
 9 years 2000 and 2001”;

10 (2) by striking subclause (IV);

11 (3) by redesignating subclauses (V) and (VI)
 12 and subclauses (IV) and (V), respectively; and

13 (4) in subclause (IV), as so redesignated, by
 14 striking “reduced by 5 percent” and inserting “re-
 15 duced by 4 percent”.

16 (b) DATA COLLECTION.—

17 (1) IN GENERAL.—The Secretary of Health and
 18 Human Services shall require any subsection (d)
 19 hospital (as defined in section 1886(d)(1)(B) of the
 20 Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) to
 21 submit to the Secretary, in the cost reports sub-
 22 mitted to the Secretary by such hospital for dis-
 23 charges occurring during a fiscal year, data on the
 24 costs incurred by the hospital for providing inpatient
 25 and outpatient hospital services for which the hos-
 26 pital is not compensated, including non-Medicare

1 bad debt, charity care, and charges for Medicaid an
 2 indigent care.

3 (2) EFFECTIVE DATE.—The Secretary shall re-
 4 quire the submission of the data described in para-
 5 graph (1) in cost reports for cost reporting periods
 6 beginning on or after the date of the enactment of
 7 this Act.

8 **Subtitle B—PPS-Exempt Hospitals**

9 **SEC. 111. WAGE ADJUSTMENT OF PERCENTILE CAP FOR** 10 **PPS-EXEMPT HOSPITALS.**

11 (a) IN GENERAL.—Section 1886(b)(3)(H) (42 U.S.C.
 12 1395ww(b)(3)(H)), as amended by section 4414 of BBA,
 13 is amended—

14 (1) in clause (i), by inserting “, as adjusted
 15 under clause (iii)” before the period;

16 (2) in clause (ii), by striking “clause (i)” and
 17 “such clause” and inserting “subclause (I)” and
 18 “such subclause” respectively;

19 (3) by striking “(H)(i)” and inserting “(ii)(I)”;

20 (4) by redesignating clauses (ii) and (iii) as
 21 subclauses (II) and (III);

22 (5) by inserting after clause (ii), as so redesign-
 23 nated, the following new clause:

24 “(iii) In applying clause (ii)(I) in the case of a hos-
 25 pital or unit, the Secretary shall provide for an appro-

1 puate adjustment to the labor-related portion of the
 2 amount determined under such subparagraph to take into
 3 account differences between average wage-related costs in
 4 the area of the hospital and the national average of such
 5 costs within the same class of hospital.”; and

6 (6) by inserting before clause (ii), as so redesign-
 7 nated, the following new clause:

8 “(H)(i) In the case of a hospital or unit that is within
 9 a class of hospital described in clause (iv), for a cost re-
 10 porting period beginning during fiscal years 1998 through
 11 2002, the target amount for such a hospital or unit may
 12 not exceed the amount as updated up to or for such cost
 13 reporting period under clause (ii).”.

14 (b) EFFECTIVE DATE.—The amendments made by
 15 subsection (a) apply to cost reporting periods beginning
 16 on or after October 1, 1999.

17 **SEC. 112. ENHANCED PAYMENTS FOR LONG-TERM CARE**
 18 **AND PSYCHIATRIC HOSPITALS UNTIL DEVEL-**
 19 **OPMENT OF PROSPECTIVE PAYMENT SYS-**
 20 **TEMS FOR THOSE HOSPITALS.**

21 Section 1886(b)(2) (42 U.S.C. 1395ww(b)(2)), as
 22 added by section 4415(b) of BBA, is amended—

23 (1) in subparagraph (A), by striking “In addi-
 24 tion to” and inserting “Except as provided in sub-
 25 paragraph (E), in addition to”; and

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

3 “(E)(i) In the case of an eligible hospital that is a
4 hospital or unit that is within a class of hospital described
5 in clause (ii) with a 12-month cost reporting period begin-
6 ning before the enactment of this subparagraph, in deter-
7 mining the amount of the increase under subparagraph
8 (A), the Secretary shall substitute for the percentage of
9 the target amount applicable under subparagraph
10 (A)(ii)—

11 “(I) for a cost reporting period beginning on or
12 after October 1, 2000, and before September 30,
13 2001, 1.5 percent; and

14 “(II) for a cost reporting period beginning on
15 or after October 1, 2001, and before September 30,
16 2002, 2 percent.

17 “(ii) For purposes of clause (i), each of the fol-
18 lowing shall be treated as a separate class of hos-
19 pital:

20 “(I) Hospitals described in clause (i) of
21 subsection (d)(1)(B) and psychiatric units de-
22 scribed in the matter following clause (v) of
23 such subsection.

24 “(II) Hospitals described in clause (iv) of
25 such subsection.”.

1 **SEC. 113. PER DISCHARGE PROSPECTIVE PAYMENT SYS-**
2 **TEM FOR LONG-TERM CARE HOSPITALS.**

3 (a) DEVELOPMENT OF SYSTEM.—

4 (1) IN GENERAL.—The Secretary of Health and
5 Human Services shall develop a per discharge pro-
6 spective payment system for payment for inpatient
7 hospital services of long-term care hospitals de-
8 scribed in section 1886(d)(1)(B)(iv) of the Social Se-
9 curity Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under
10 the Medicare program. Such system shall include an
11 adequate patient classification system that is based
12 on diagnosis-related groups (DRGs) and that re-
13 flects the differences in patient resource use and
14 costs, and shall maintain budget neutrality.

15 (2) COLLECTION OF DATA AND EVALUATION.—

16 In developing the system described in paragraph (1),
17 the Secretary may require such long-term care hos-
18 pitals to submit such information to the Secretary as
19 the Secretary may require to develop the system.

20 (b) REPORT.—Not later than October 1, 2001, the
21 Secretary shall submit to the appropriate committees of
22 Congress a report that includes a description of the system
23 developed under subsection (a)(1).

24 (c) IMPLEMENTATION OF PROSPECTIVE PAYMENT
25 SYSTEM.—Notwithstanding section 1886(b)(3) of the So-
26 cial Security Act (42 U.S.C. 1395ww(b)(3)), the Secretary

1 shall provide, for cost reporting periods beginning on or
2 after October 1, 2002, for payments for inpatient hospital
3 services furnished by long-term care hospitals under title
4 XVIII of the Social Security Act (42 U.S.C. 1395 et seq.)
5 in accordance with the system described in subsection (a).

6 **SEC. 114. PER DIEM PROSPECTIVE PAYMENT SYSTEM FOR**
7 **PSYCHIATRIC HOSPITALS.**

8 (a) DEVELOPMENT OF SYSTEM.—

9 (1) IN GENERAL.—The Secretary of Health and
10 Human Services shall develop a per diem prospective
11 payment system for payment for inpatient hospital
12 services of psychiatric hospitals and units (as de-
13 fined in paragraph (3)) under the Medicare pro-
14 gram. Such system shall include an adequate patient
15 classification system that reflects the differences in
16 patient resource use and costs among such hospitals
17 and shall maintain budget neutrality.

18 (2) COLLECTION OF DATA AND EVALUATION.—

19 In developing the system described in paragraph (1),
20 the Secretary may require such psychiatric hospitals
21 and units to submit such information to the Sec-
22 retary as the Secretary may require to develop the
23 system.

24 (3) DEFINITION.—In this section, the term
25 “psychiatric hospitals and units” means a psy-

(b) REPORT.—Not later than October 1, 2001, the Secretary shall submit to the appropriate committees of Congress a report that includes a description of the system developed under subsection (a)(1).

(c) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Notwithstanding section 1886(b)(3) of the Social Security Act (42 U.S.C. 1395ww(b)(3)), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2002, for payments for inpatient hospital services furnished by psychiatric hospitals and units under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) in accordance with the prospective payment system established by the Secretary under this section in a budget neutral manner.

19 SEC. 115. REFINEMENT OF PROSPECTIVE PAYMENT SYS-
20 TEM FOR INPATIENT REHABILITATION SERV-
21 ICES.

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

1 (1) IN GENERAL.—Paragraph (1) of section
 2 1886(j) (42 U.S.C. 1395ww(j)), as added by section
 3 4421(a) of BBA, is amended—

4 (A) in subparagraph (C), by inserting
 5 “subject to subparagraph (E),” after “subpara-
 6 graph (A),”; and

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

9 “(E) ELECTION TO APPLY FULL PROSPEC-
 10 TIVE PAYMENT SYSTEM.—A rehabilitation facil-
 11 ity may elect for either or both cost reporting
 12 periods described in subparagraph (C) to have
 13 the TEFRA percentage and prospective pay-
 14 ment percentage set at 0 percent and 100 per-
 15 cent, respectively, for the facility.”.

16 (2) BUDGET NEUTRALITY IN APPLICATION.—
 17 Paragraph (3)(B) of such section is amended by in-
 18 serting “and taking into account the election per-
 19 mitted under paragraph (1)(E)” after “in the Sec-
 20 retary’s estimation”.

21 (3) CASE MIX CREEP ADJUSTMENT.—Paragraph
 22 (2)(C) of such section is amended by adding at the end
 23 the following new clauses:

24 “(iii) EXAMINATION OF CHANGES IN
 25 CASE MIX.—The Secretary, upon obtaining

1 substantially complete data from fiscal
2 year 2001, shall analyze the extent to
3 which the changes in case mix during that
4 fiscal year are attributable to changes in
5 coding and classification and do not reflect
6 real changes in case mix.

7 “(iv) INITIAL ADJUSTMENT OF RATES
8 IN FISCAL YEAR 2004.—Based on the anal-
9 ysis performed under clause (iii) in deter-
10 mining the amount of case mix change due
11 merely to changes in coding or classifica-
12 tion, the Secretary shall adjust the pro-
13 spective payment amounts for fiscal year
14 2004 by 150 percent of the Secretary’s es-
15 timate of the percentage adjustment to the
16 prospective payment rate under this para-
17 graph that would have achieved budget
18 neutrality in fiscal year 2001 if it had ap-
19 plied in setting the rates for that fiscal
20 year.

21 “(v) FINAL ADJUSTMENT OF RATES
22 IN FISCAL YEAR 2005.—In the case that
23 the adjustment under clause (iv) resulted
24 in—

1 “(I) a percentage decrease in
2 rates, the Secretary shall increase the
3 prospective payment amounts for fis-
4 cal year 2005 by a percentage equal
5 to $\frac{1}{3}$ of such percentage decrease; or

6 “(II) a percentage increase in
7 rates, the Secretary shall decrease the
8 prospective payment amounts for fis-
9 cal year 2005 by a percentage equal
10 to $\frac{1}{3}$ of such percentage increase.”.

11 (b) USE OF DISCHARGE AS PAYMENT UNIT.—

12 (1) IN GENERAL.—Paragraph (1)(D) of such
13 section is amended by striking “, day of inpatient
14 hospital services, or other unit of payment defined
15 by the Secretary”.

16 (2) CONFORMING AMENDMENT TO CLASSIFICA-
17 TION.—Paragraph (2)(A) of such section is amended
18 by amending clause (i) of to read as follows:

19 “(i) classes of patient discharges of
20 rehabilitation facilities by functional-re-
21 lated groups (each in this subsection re-
22 ferred to as a ‘case mix group’), based on
23 impairment, age, comorbidities, and func-
24 tional capability of the patient and such
25 other factors as the Secretary deems ap-

1 appropriate to improve the explanatory power
2 of functional independence measure-function
3 related groups; and”.

4 (3) CONSTRUCTION RELATING TO TRANSFER
5 AUTHORITY.—Paragraph (1) of such section, as
6 amended by subsection (a)(1), is further amended by
7 adding at the end the following new subparagraph:

8 “(F) CONSTRUCTION RELATING TO TRANS-
9 FER AUTHORITY.—Nothing in this subsection
10 shall be construed as preventing the Secretary
11 from providing for an adjustment to payments
12 to take into account the early transfer of a pa-
13 tient from a rehabilitation facility to another
14 site of care.”.

15 (c) STUDY ON IMPACT OF IMPLEMENTATION OF PRO-
16 SPECTIVE PAYMENT SYSTEM.—

17 (1) STUDY.—The Secretary of Health and
18 Human Services shall conduct a study of the impact
19 on utilization and beneficiary access to services of
20 the implementation of the Medicare prospective pay-
21 ment system for inpatient hospital services or reha-
22 bilitation facilities under section 1886(j) of the So-
23 cial Security Act (as added by section 4421(a) of
24 BBA).

1 (2) REPORT.—Not later than 3 years after the
 2 date such system is first implemented, the Secretary
 3 shall submit to Congress a report on such study.

4 (d) EFFECTIVE DATE.—The amendments made by
 5 subsections (a) and (b) are effective as if included in the
 6 enactment of section 4421(a) of BBA.

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

10 **SEC. 121. TEMPORARY INCREASE IN PAYMENT FOR CER-**
 11 **TAIN HIGH COST PATIENTS.**

12 (a) ADJUSTMENT FOR MEDICALLY COMPLEX PA-
 13 TIENTS UNTIL ESTABLISHMENT OF REFINED CASE-MIX
 14 ADJUSTMENT.—For purposes of computing payments for
 15 covered skilled nursing facility services under paragraph
 16 (1) of section 1888(e) of the Social Security Act (42
 17 U.S.C. 1395yy(e)), as added by section 4432(a) of BBA,
 18 for such services furnished on or after April 1, 2000, and
 19 before October 1, 2000, the Secretary of Health and
 20 Human Services shall increase by 10 percent the adjusted
 21 Federal per diem rate otherwise determined under para-
 22 graph (4) of such section (but for this section) for covered
 23 skilled nursing facility services for RUG–III groups de-
 24 scribed in subsection (b) furnished to an individual during

1 the period in which such individual is classified in such
 2 a RUG–III category.

3 (b) GROUPS DESCRIBED.—The RUG–III groups for
 4 which the adjustment described in subsection (a) applies
 5 are SE3, SE2, SE1, SSC, SSB, SSA, CC2, CC1, CB2,
 6 CB1, CA2, and CA1, as specified in Tables 3 and 4 of
 7 the final rule published in the Federal Register by the
 8 Health Care Financing Administration on July 30, 1999
 9 (64 Fed. Reg. 41684).

10 **SEC. 122. MARKET BASKET INCREASE.**

11 Section 1888(e)(4)(E)(ii) (42 U.S.C.
 12 1395yy(e)(4)(E)(ii)) is amended—

13 (1) by redesignating subclause (III) as sub-
 14 clause (IV); and

15 (2) by striking subclause (II) and inserting
 16 after subclause (I) the following:

17 “(II) for fiscal year 2001, the
 18 rate computed for fiscal year 2000
 19 (determined without regard to section
 20 121 of the Medicare, Medicaid, and
 21 SCHIP Balanced Budget Refinement
 22 Act of 1999) increased by the skilled
 23 nursing facility market basket per-
 24 centage change for the fiscal year in-
 25 volved plus 0.8 percentage point;

1 “(III) for fiscal year 2002, the
 2 rate computed for the previous fiscal
 3 year increased by the skilled nursing
 4 facility market basket percentage
 5 change for the fiscal year involved
 6 minus 1 percentage point; and”.

7 **SEC. 123. AUTHORIZING FACILITIES TO ELECT IMMEDIATE**
 8 **TRANSITION TO FEDERAL RATE.**

9 (a) IN GENERAL.—Section 1888(e) (42 U.S.C.
 10 1395yy(e)), as added by section 4432(a) of BBA, is
 11 amended—

12 (1) in paragraph (1), in the matter preceding
 13 subparagraph (A), by striking “paragraph (7)” and
 14 inserting “paragraphs (7) and (11)”; and

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

17 “(11) PERMITTING FACILITIES TO WAIVE 3-
 18 YEAR TRANSITION.—Notwithstanding paragraph
 19 (1)(A), a facility may elect to have the amount of
 20 the payment for all costs of covered skilled nursing
 21 facility services for each day of such services fur-
 22 nished in cost reporting periods beginning after the
 23 date of such election determined pursuant to sub-
 24 paragraph (B) of paragraph (1).”.

1 (b) EFFECTIVE DATE.—The amendments made by
 2 subsection (a) shall apply to elections made more than 60
 3 days after the date of the enactment of this Act.

4 **SEC. 124. PART A PASS-THROUGH PAYMENT FOR CERTAIN**
 5 **AMBULANCE SERVICES, PROSTHESES, AND**
 6 **CHEMOTHERAPY DRUGS.**

7 (a) IN GENERAL.—Section 1888(e) (42 U.S.C.
 8 1395yy(e)), as added by section 4432(a) of BBA, is
 9 amended—

10 (1) in paragraph (2)(A)(i)(II), by striking
 11 “services described in clause (ii)” and inserting
 12 “items and services described in clauses (ii) and
 13 (iii)”;

14 (2) by adding at the end of paragraph (2)(A)
 15 the following new clause:

16 “(iii) EXCLUSION OF CERTAIN ADDI-
 17 TIONAL ITEMS.—Items described in this
 18 clause are the following:

19 “(I) Ambulance services fur-
 20 nished to an individual in conjunction
 21 with renal dialysis services described
 22 in section 1861(s)(2)(F).

23 “(II) Chemotherapy items (iden-
 24 tified as of July 1, 1999, by HCPCS
 25 codes J9000–J9020; J9040–J9151;

J9170–J9185; J9200–J9201; J9206–
J9208; J9211; J9230–J9245; and
J9265–J9600 (and as subsequently
modified by the Secretary)).

“(III) Chemotherapy administra-
tion services (identified as of July 1,
1999, by HCPCS codes 36260–
36262; 36489; 36530–36535; 36640;
36823; and 96405–96542 (and as
subsequently modified by the Sec-
retary)).

“(IV) Radioisotope services
(identified as of July 1, 1999, by
HCPCS codes 79030–79440 (and as
subsequently modified by the Sec-
retary)).

“(V) Customized prosthetic de-
vices (commonly known as artificial
limbs or components or artificial
limbs) under the following HCPCS
codes (as of July 1, 1999 (and as sub-
sequently modified by the Secretary))
if delivered to an inpatient for use
during the stay in the skilled nursing
facility and intended to be used by the

1 individual after discharge from the fa-
 2 cility: L5050–L5340; L5500–L5610;
 3 L5613–L5986; L5988; L6050–
 4 L6370; L6400–L6880; L6920–
 5 L7274; and L7362–7366.”; and

6 (3) by adding at the end of paragraph (9) the
 7 following: “In the case of an item or service de-
 8 scribed in clause (iii) of paragraph (2)(A) that would
 9 be payable under part A but for the exclusion of
 10 such item or service under such clause, payment
 11 shall be made for the item or service, in an amount
 12 otherwise determined under part B of this title for
 13 such item or service, from the Federal Hospital In-
 14 surance Trust Fund under section 1817 (rather
 15 than from the Federal Supplementary Medical In-
 16 surance Trust Fund under section 1841).”.

17 (b) CONFORMING FOR BUDGET NEUTRALITY BEGIN-
 18 NING WITH FISCAL YEAR 2001.—Section 1888(e)(4)(G)
 19 (42 U.S.C. 1395yy(e)(4)(G)) is amended by adding at the
 20 end the following new clause:

21 “(iii) ADJUSTMENT FOR EXCLUSION
 22 OF CERTAIN ADDITIONAL ITEMS.—The
 23 Secretary shall provide for an appropriate
 24 proportional reduction in payments so that
 25 beginning with fiscal year 2001, the aggre-

1 gate amount of such reductions is equal to
 2 the aggregate increase in payments attrib-
 3 utable to the exclusion effected under
 4 clause (iii) of paragraph (2)(A).”.

5 (c) EFFECTIVE DATE.—The amendments made by
 6 subsection (a) shall apply to payments made for items fur-
 7 nished on or after April 1, 2000.

8 **SEC. 125. PROVISION FOR PART B ADD-ONS FOR FACILI-**
 9 **TIES PARTICIPATING IN THE NHCMQ DEM-**
 10 **ONSTRATION PROJECT.**

11 (a) IN GENERAL.—Section 1888(e)(3) (42 U.S.C.
 12 1395yy(e)(3)), as added by section 4432(a) of BBA, is
 13 amended—

14 (1) in subparagraph (A)—

15 (A) in clause (i), by inserting “or, in the
 16 case of a facility participating in the Nursing
 17 Home Case-Mix and Quality Demonstration
 18 (RUGS–III), the RUGS–III rate received by
 19 the facility during the cost reporting period be-
 20 ginning in 1997” after “to non-settled cost re-
 21 ports”; and

22 (B) in clause (ii), by striking “furnished
 23 during such period” and inserting “furnished
 24 during the applicable cost reporting period de-
 25 scribed in clause (i)”; and

1 (2) by amending subparagraph (B) to read as
 2 follows:

3 “(B) UPDATE TO FIRST COST REPORTING
 4 PERIOD.—The Secretary shall update the
 5 amount determined under subparagraph (A),
 6 for each cost reporting period after the applica-
 7 ble cost reporting period described in subpara-
 8 graph (A)(i) and up to the first cost reporting
 9 period by a factor equal to the skilled nursing
 10 facility market basket percentage increase
 11 minus 1 percentage point (except that for the
 12 cost reporting period beginning in fiscal year
 13 2001, the factor shall be equal to such market
 14 basket percentage plus 0.8 percentage point).”.

15 (b) EFFECTIVE DATE.—The amendments made by
 16 subsection (a) shall be effective as if included in the enact-
 17 ment of section 4432(a) of BBA.

18 **SEC. 126. SPECIAL CONSIDERATION FOR FACILITIES SERV-**
 19 **ING SPECIALIZED PATIENT POPULATIONS.**

20 (a) IN GENERAL.—Section 1888(e) (42 U.S.C.
 21 1395yy(e)), as amended by section 123(a)(1), is further
 22 amended—

23 (1) in paragraph (1), by striking “subject to
 24 paragraphs (7) and (11)” and inserting “subject to
 25 paragraphs (7), (11), and (12)”; and

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

3 “(12) PAYMENT RULE FOR CERTAIN FACILI-
4 TIES.—

5 “(A) IN GENERAL.—In the case of a quali-
6 fied acute skilled nursing facility described in
7 subparagraph (B), the per diem amount of pay-
8 ment shall be determined by applying the non-
9 Federal percentage and Federal percentage
10 specified in paragraph (2)(C)(ii).

11 “(B) FACILITY DESCRIBED.—For purposes
12 of subparagraph (A), a qualified acute skilled
13 nursing facility is a facility that—

14 “(i) was certified by the Secretary as
15 a skilled nursing facility eligible to furnish
16 services under this title before July 1,
17 1992;

18 “(ii) is a hospital-based facility; and

19 “(iii) for the cost reporting period be-
20 ginning in fiscal year 1998, the facility had
21 more than 60 percent of total patient days
22 comprised of patients who are described in
23 subparagraph (C).

24 “(C) DESCRIPTION OF PATIENTS.—For
25 purposes of subparagraph (B), a patient de-

1 scribed in this subparagraph is an individual
2 who—

3 “(i) is entitled to benefits under part
4 A; and

5 “(ii) is immuno-compromised sec-
6 ondary to an infectious disease, with spe-
7 cific diagnoses as specified by the Sec-
8 retary.”.

9 (b) EFFECTIVE DATE.—The amendments made by
10 subsection (a) shall apply for the period beginning on the
11 date on which after the date of the enactment of this Act
12 the first cost reporting period of the facility begins and
13 ending on September 30, 2001, and applies to skilled
14 nursing facilities furnishing covered skilled nursing facility
15 services on the date of the enactment of this Act for which
16 payment is made under title XVIII of the Social Security
17 Act.

18 (c) REPORT TO CONGRESS.—By not later than 1 year
19 after the date of the enactment of this Act, the Secretary
20 of Health and Human Services shall assess the resource
21 use of patients of skilled nursing facilities furnishing serv-
22 ices under the Medicare program who are immuno-com-
23 promised secondary to an infectious disease, with specific
24 diagnoses as specified by the Secretary (under paragraph
25 (12)(C), as added by subsection (a), of section 1888(e)

1 of the Social Security Act (42 U.S.C. 1395yy(e))) to deter-
 2 mine whether any permanent adjustments are needed to
 3 the RUGs to take into account the resource uses and costs
 4 of these patients.

5 **SEC. 127. MEDPAC STUDY ON SPECIAL PAYMENT FOR FA-**
 6 **CILITIES LOCATED IN HAWAII AND ALASKA.**

7 (a) IN GENERAL.—The Medicare Payment Advisory
 8 Commission shall conduct a study on skilled nursing facili-
 9 ties furnishing covered skilled nursing facility services (as
 10 defined in section 1888(e)(2)(A) of the Social Security Act
 11 (42 U.S.C. 1395yy(e)(2)(A)) to determine the need for an
 12 additional payment amount under section 1888(e)(4)(G)
 13 of such Act (42 U.S.C. 1395yy(e)(4)(G)) to take into ac-
 14 count the unique circumstances of skilled nursing facilities
 15 located in Alaska and Hawaii.

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

20 **Subtitle D—Other**

21 **SEC. 131. PART A BBA TECHNICAL CORRECTIONS.**

22 (a) SECTION 4201.—Section 1820(c)(2)(B)(i) (42
 23 U.S.C. 1395i–4(c)(2)(B)(i)), as amended by section
 24 4201(a) of BBA, is amended by striking “and is located
 25 in a county (or equivalent unit of local government) in a

1 rural area (as defined in section 1886(d)(2)(D)) that” and
 2 inserting “that is located in a county (or equivalent unit
 3 of local government) in a rural area (as defined in section
 4 1886(d)(2)(D)), and that”.

5 (b) SECTION 4204.—(1) Section 1886(d)(5)(G) (42
 6 U.S.C. 1395ww(d)(5)(G)), as amended by section
 7 4204(a)(1) of BBA, is amended—

8 (A) in clause (i), by striking “or beginning on
 9 or after October 1, 1997, and before October 1,
 10 2001,” and inserting “or discharges on or after Oc-
 11 tober 1, 1997, and before October 1, 2001,”; and

12 (B) in clause (ii)(II), by striking “or beginning
 13 on or after October 1, 1997, and before October 1,
 14 2001,” and inserting “or discharges on or after Oc-
 15 tober 1, 1997, and before October 1, 2001,”.

16 (2) Section 1886(b)(3)(D) (42 U.S.C.
 17 1395ww(b)(3)(D)), as amended by section 4204(a)(2) of
 18 BBA, is amended in the matter preceding clause (i) by
 19 striking “and for cost reporting periods beginning on or
 20 after October 1, 1997, and before October 1, 2001,” and
 21 inserting “and for discharges beginning on or after Octo-
 22 ber 1, 1997, and before October 1, 2001,”.

23 (c) SECTION 4319.—Section 1847(b)(2) (42 U.S.C.
 24 1395w-3(b)(2)), as added by section 4319 of BBA, is

1 amended by inserting “and” after “specified by the Sec-
2 retary”.

3 (d) SECTION 4401.—Section 4401(b)(1)(B) of BBA
4 (42 U.S.C. 1395ww note) is amended by striking “section
5 1886(b)(3)(B)(i)(XIII) of the Social Security Act (42
6 U.S.C. 1395ww(b)(3)(B)(i)(XIII))” and inserting “section
7 1886(b)(3)(B)(i)(XIV) of the Social Security Act (42
8 U.S.C. 1395ww(b)(3)(B)(i)(XIV))”.

9 (e) SECTION 4402.—The last sentence of section
10 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)), as added by
11 section 4402 of BBA, is amended by striking “September
12 30, 2002,” and inserting “October 1, 2002,”.

13 (f) SECTION 4419.—The first sentence of section
14 1886(b)(4)(A)(i) (42 U.S.C. 1395ww(b)(4)(A)(i)), as
15 amended by section 4419(a)(1) of BBA, by striking “or
16 unit”.

17 (g) SECTION 4442.—Section 4442(b) of BBA (42
18 U.S.C. 1395f note) is amended by striking “applies to cost
19 reporting periods beginning” and inserting “applies to
20 items and services furnished”.

21 (h) EFFECTIVE DATE.—The amendments made by
22 this section shall take effect as if included in the enact-
23 ment of BBA.

**TITLE II—PROVISIONS
RELATING TO PART B
Subtitle A—Adjustments to
Physician Payment Updates**

SEC. 201. MODIFICATION OF UPDATE ADJUSTMENT FACTOR PROVISIONS TO REDUCE UPDATE OSCILLATIONS AND REQUIRE ESTIMATE REVISIONS.

(a) UPDATE ADJUSTMENT FACTOR.—

(1) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w-4(d)) is amended—

(A) in paragraph (3)—

(i) in the heading, by inserting “FOR 1999 AND 2000” after “UPDATE”;

(ii) in subparagraph (A), by striking “a year beginning with 1999” and inserting “1999 and 2000”; and

(iii) in subparagraph (C), by inserting “and paragraph (4)” after “For purposes of this paragraph”; and

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

“(4) UPDATE FOR YEARS BEGINNING WITH 2001.—

“(A) IN GENERAL.—Unless otherwise provided by law, subject to the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii) and subject to adjustment under subparagraph (F), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 2001 is equal to the product of—

“(i) 1 plus the Secretary’s estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year (divided by 100); and

“(ii) 1 plus the Secretary’s estimate of the update adjustment factor under subparagraph (B) for the year.

“(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), subject to subparagraph (D), the ‘update adjustment factor’ for a year is equal (as estimated by the Secretary) to the sum of the following:

“(i) PRIOR YEAR ADJUSTMENT COMPONENT.—An amount determined by—

“(I) computing the difference (which may be positive or negative) between the amount of the allowed ex-

penditures for physicians' services for the prior year (as determined under subparagraph (C)) and the amount of the actual expenditures for such services for that year;

“(II) dividing that difference by the amount of the actual expenditures for such services for that year; and

“(III) multiplying that quotient by 0.75.

“(ii) CUMULATIVE ADJUSTMENT COMPONENT.—An amount determined by—

“(I) computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services (as determined under subparagraph (C)) from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for such services during that period;

“(II) dividing that difference by actual expenditures for such services for the prior year as increased by the sustainable growth rate under sub-

1 section (f) for the year for which the
2 update adjustment factor is to be de-
3 termined; and

4 “(III) multiplying that quotient
5 by 0.33.

6 “(C) DETERMINATION OF ALLOWED EX-
7 PENDITURES.—For purposes of this paragraph:

8 “(i) PERIOD UP TO APRIL 1, 1999.—
9 The allowed expenditures for physicians’
10 services for a period before April 1, 1999,
11 shall be the amount of the allowed expendi-
12 tures for such period as determined under
13 paragraph (3)(C).

14 “(ii) TRANSITION TO CALENDAR YEAR
15 ALLOWED EXPENDITURES.—Subject to
16 subparagraph (E), the allowed expendi-
17 tures for—

18 “(I) the 9-month period begin-
19 ning April 1, 1999, shall be the Sec-
20 retary’s estimate of the amount of the
21 allowed expenditures that would be
22 permitted under paragraph (3)(C) for
23 such period; and

24 “(II) the year of 1999, shall be
25 the Secretary’s estimate of the

1 amount of the allowed expenditures
2 that would be permitted under para-
3 graph (3)(C) for such year.

4 “(iii) YEARS BEGINNING WITH 2000.—

5 The allowed expenditures for a year (be-
6 ginning with 2000) is equal to the allowed
7 expenditures for physicians’ services for
8 the previous year, increased by the sustain-
9 able growth rate under subsection (f) for
10 the year involved.

11 “(D) RESTRICTION ON UPDATE ADJUST-
12 MENT FACTOR.—The update adjustment factor
13 determined under subparagraph (B) for a year
14 may not be less than -0.07 or greater than
15 0.03 .

16 “(E) RECALCULATION OF ALLOWED EX-
17 PENDITURES FOR UPDATES BEGINNING WITH
18 2001.—For purposes of determining the update
19 adjustment factor for a year beginning with
20 2001, the Secretary shall recompute the allowed
21 expenditures for previous periods beginning on
22 or after April 1, 1999, consistent with sub-
23 section (f)(3).

24 “(F) TRANSITIONAL ADJUSTMENT DE-
25 SIGNED TO PROVIDE FOR BUDGET NEU-

1 TRALITY.—Under this subparagraph the Sec-
 2 retary shall provide for an adjustment to the
 3 update under subparagraph (A)—

4 “(i) for each of 2001, 2002, 2003,
 5 and 2004, of -0.2 percent; and

6 “(ii) for 2005 of $+0.8$ percent.”.

7 (2) PUBLICATION CHANGE.—

8 (A) IN GENERAL.—Section 1848(d)(1)(E)
 9 (42 U.S.C. 1395w-4(d)(1)(E)) is amended to
 10 read as follows:

11 “(E) PUBLICATION AND DISSEMINATION
 12 OF INFORMATION.—The Secretary shall—

13 “(i) cause to have published in the
 14 Federal Register not later than November
 15 1 of each year (beginning with 2000) the
 16 conversion factor which will apply to physi-
 17 cians’ services for the succeeding year, the
 18 update determined under paragraph (4)
 19 for such succeeding year, and the allowed
 20 expenditures under such paragraph for
 21 such succeeding year; and

22 “(ii) make available to the Medicare
 23 Payment Advisory Commission and the
 24 public by March 1 of each year (beginning
 25 with 2000) an estimate of the sustainable

1 growth rate and of the conversion factor
2 which will apply to physicians' services for
3 the succeeding year and data used in mak-
4 ing such estimate.”.

5 (B) MEDPAC REVIEW OF CONVERSION
6 FACTOR ESTIMATES.—Section 1805(b)(1)(D)
7 (42 U.S.C. 1395b–6(b)(1)(D)) is amended by
8 inserting “and including a review of the esti-
9 mate of the conversion factor submitted under
10 section 1848(d)(1)(E)(ii)” before the period at
11 the end.

12 (C) ONE-TIME PUBLICATION OF INFORMA-
13 TION ON TRANSITION.—The Secretary of
14 Health and Human Services shall cause to have
15 published in the Federal Register, not later
16 than 90 days after the date of the enactment of
17 this section, the Secretary's determination,
18 based upon the best available data, of—

19 (i) the allowed expenditures under
20 subclauses (I) and (II) of section
21 1848(d)(4)(C)(ii) of the Social Security
22 Act, as added by subsection (a)(1)(B), for
23 the 9-month period beginning on April 1,
24 1999, and for 1999;

1 (ii) the estimated actual expenditures
 2 described in section 1848(d) of such Act
 3 for 1999; and

4 (iii) the sustainable growth rate under
 5 section 1848(f) of such Act (42 U.S.C.
 6 1395w-4(f)) for 2000.

7 (3) CONFORMING AMENDMENTS.—

8 (A) Section 1848 (42 U.S.C. 1395w-4) is
 9 amended—

10 (i) in subsection (d)(1)(A), by insert-
 11 ing “(for years before 2001) and, for years
 12 beginning with 2001, multiplied by the up-
 13 date (established under paragraph (4)) for
 14 the year involved” after “for the year in-
 15 volved”; and

16 (ii) in subsection (f)(2)(D), by insert-
 17 ing “or (d)(4)(B), as the case may be”
 18 after “(d)(3)(B)”.

19 (B) Section 1833(l)(4)(A)(i)(VII) (42
 20 U.S.C. 1395l(l)(4)(A)(i)(VII)) is amended by
 21 striking “1848(d)(3)” and inserting “1848(d)”.

22 (b) SUSTAINABLE GROWTH RATES.—Section 1848(f)
 23 (42 U.S.C. 1395w-4(f)) is amended—

24 (1) by amending paragraph (1) to read as fol-
 25 lows:

1 “(1) PUBLICATION.—The Secretary shall cause
2 to have published in the Federal Register not later
3 than—

4 “(A) November 1, 2000, the sustainable
5 growth rate for 2000 and 2001; and

6 “(B) November 1 of each succeeding year
7 the sustainable growth rate for such succeeding
8 year and each of the preceding 2 years.”;

9 (2) in paragraph (2)—

10 (A) in the matter before subparagraph (A),
11 by striking “fiscal year 1998)” and inserting
12 “fiscal year 1998 and ending with fiscal year
13 2000) and a year beginning with 2000”; and

14 (B) in subparagraphs (A) through (D), by
15 striking “fiscal year” and inserting “applicable
16 period” each place it appears;

17 (3) in paragraph (3), by adding at the end the
18 following new subparagraph:

19 “(C) APPLICABLE PERIOD.—The term ‘ap-
20 plicable period’ means—

21 “(i) a fiscal year, in the case of fiscal
22 year 1998, fiscal year 1999, and fiscal year
23 2000; or

24 “(ii) a calendar year with respect to a
25 year beginning with 2000,

1 as the case may be.”;

2 (4) by redesignating paragraph (3) as para-
3 graph (4); and

4 (5) by inserting after paragraph (2) the fol-
5 lowing new paragraph:

6 “(3) DATA TO BE USED.—For purposes of de-
7 termining the update adjustment factor under sub-
8 section (d)(4)(B) for a year beginning with 2001,
9 the sustainable growth rates taken into consideration
10 in the determination under paragraph (2) shall be
11 determined as follows:

12 “(A) FOR 2001.—For purposes of such cal-
13 culations for 2001, the sustainable growth rates
14 for fiscal year 2000 and the years 2000 and
15 2001 shall be determined on the basis of the
16 best data available to the Secretary as of Sep-
17 tember 1, 2000.

18 “(B) FOR 2002.—For purposes of such cal-
19 culations for 2002, the sustainable growth rates
20 for fiscal year 2000 and for years 2000, 2001,
21 and 2002 shall be determined on the basis of
22 the best data available to the Secretary as of
23 September 1, 2001.

1 “(C) FOR 2003 AND SUCCEEDING YEARS.—

2 For purposes of such calculations for a year
3 after 2002—

4 “(i) the sustainable growth rates for
5 that year and the preceding 2 years shall
6 be determined on the basis of the best data
7 available to the Secretary as of September
8 1 of the year preceding the year for which
9 the calculation is made; and

10 “(ii) the sustainable growth rate for
11 any year before a year described in clause
12 (i) shall be the rate as most recently deter-
13 mined for that year under this subsection.

14 Nothing in this paragraph shall be construed as af-
15 fecting the sustainable growth rates established for
16 fiscal year 1998 or fiscal year 1999.”.

17 (c) EFFECTIVE DATE.—The amendments made by
18 this section shall be effective in determining the conversion
19 factor under section 1848(d) of the Social Security Act
20 (42 U.S.C. 1395w–4(d)) for years beginning with 2001
21 and shall not apply to or affect any update (or any update
22 adjustment factor) for any year before 2001.

1 **SEC. 202. USE OF DATA COLLECTED BY ORGANIZATIONS**
2 **AND ENTITIES IN DETERMINING PRACTICE**
3 **EXPENSE RELATIVE VALUES.**

4 (a) IN GENERAL.—The Secretary of Health and
5 Human Services shall establish by regulation (after notice
6 and opportunity for public comment) a process (including
7 data collection standards) under which the Secretary will
8 accept for use and will use, to the maximum extent prac-
9 ticable consistent with sound data practices, data collected
10 or developed by entities and organizations (other than the
11 Department of Health and Human Services) to supple-
12 ment the data normally collected by that department in
13 determining the practice expense component under section
14 1848(c)(2)(C)(ii) of the Social Security Act (42 U.S.C.
15 1395w–4(c)(2)(C)(ii)) for purposes of determining relative
16 values for payment for physicians’ services under the fee
17 schedule under section 1848 of such Act (42 U.S.C.
18 1395w–4). The Secretary shall first promulgate such regu-
19 lation on an interim final basis in a manner that permits
20 the submission and use of data in the computation of prac-
21 tice expense relative value units for payment rates for
22 2001.

23 (b) PUBLICATION OF INFORMATION.—The Secretary
24 shall include, in the publication of the estimated and final
25 updates under section 1848(c) of such Act (42 U.S.C.
26 1395w–4(c)) for payments for 2001 and for 2002, a de-

1 scription of the process established under subsection (a)
2 for the use of external data in making adjustments in rel-
3 ative value units and the extent to which the Secretary
4 has used such external data in making such adjustments
5 for each such year, particularly in cases in which the data
6 otherwise used are inadequate because they are not based
7 upon a large enough sample size to be statistically reliable.

8 **SEC. 203. GAO STUDY ON RESOURCES REQUIRED TO PRO-**
9 **VIDE SAFE AND EFFECTIVE OUTPATIENT**
10 **CANCER THERAPY.**

11 (a) STUDY .—The Comptroller General of the United
12 States shall conduct a nationwide study to determine the
13 physician and non-physician clinical resources necessary to
14 provide safe outpatient cancer therapy services and the ap-
15 propriate payment rates for such services under the Medi-
16 care program. In making such determination, the Comp-
17 troller General shall—

18 (1) determine the adequacy of practice expense
19 relative value units associated with the utilization of
20 those clinical resources;

21 (2) determine the adequacy of work units in the
22 practice expense formula; and

23 (3) assess various standards to assure the pro-
24 vision of safe outpatient cancer therapy services.

1 (b) REPORT TO CONGRESS.—The Comptroller Gen-
 2 eral shall submit to Congress a report on the study con-
 3 ducted under subsection (a). The report shall include rec-
 4 ommendations regarding practice expense adjustments to
 5 the payment methodology under part B of the Medicare
 6 program, including the development and inclusion of ade-
 7 quate work units to assure the adequacy of payment
 8 amounts for safe outpatient cancer therapy services. The
 9 study shall also include an estimate of the cost of imple-
 10 menting such recommendations.

11 **Subtitle B—Hospital Outpatient** 12 **Services**

13 **SEC. 211. OUTLIER ADJUSTMENT AND TRANSITIONAL PASS-** 14 **THROUGH FOR CERTAIN MEDICAL DEVICES,** 15 **DRUGS, AND BIOLOGICALS.**

16 (a) OUTLIER ADJUSTMENT.—Section 1833(t) (42
 17 U.S.C. 1395l(t)), as added by section 4523(a) of BBA,
 18 is amended—

19 (1) by redesignating paragraphs (5) through
 20 (9) as paragraphs (7) through (11), respectively;
 21 and

22 (2) by inserting after paragraph (4) the fol-
 23 lowing new paragraph:

24 “(5) OUTLIER ADJUSTMENT.—

1 “(A) IN GENERAL.—The Secretary shall
2 provide for an additional payment for each cov-
3 ered OPD service (or group of services) for
4 which a hospital’s charges, adjusted to cost,
5 exceed—

6 “(i) a fixed multiple of the sum of—

7 “(I) the applicable Medicare
8 OPD fee schedule amount determined
9 under paragraph (3)(D), as adjusted
10 under paragraph (4)(A) (other than
11 for adjustments under this paragraph
12 or paragraph (6)); and

13 “(II) any transitional pass-
14 through payment under paragraph
15 (6); and

16 “(ii) at the option of the Secretary,
17 such fixed dollar amount as the Secretary
18 may establish.

19 “(B) AMOUNT OF ADJUSTMENT.—The
20 amount of the additional payment under sub-
21 paragraph (A) shall be determined by the Sec-
22 retary and shall approximate the marginal cost
23 of care beyond the applicable cutoff point under
24 such subparagraph.

1 “(C) LIMIT ON AGGREGATE OUTLIER AD-
2 JUSTMENTS.—

3 “(i) IN GENERAL.—The total of the
4 additional payments made under this para-
5 graph for covered OPD services furnished
6 in a year (as projected or estimated by the
7 Secretary before the beginning of the year)
8 may not exceed the applicable percentage
9 (specified in clause (ii)) of the total pro-
10 gram payments projected or estimated to
11 be made under this subsection for all cov-
12 ered OPD services furnished in that year.
13 If this paragraph is first applied to less
14 than a full year, the previous sentence
15 shall apply only to the portion of such
16 year.

17 “(ii) APPLICABLE PERCENTAGE.—For
18 purposes of clause (i), the term ‘applicable
19 percentage’ means a percentage specified
20 by the Secretary up to (but not to ex-
21 ceed)—

22 “(I) for a year (or portion of a
23 year) before 2004, 2.5 percent; and

24 “(II) for 2004 and thereafter,
25 3.0 percent.”.

1 (b) TRANSITIONAL PASS-THROUGH FOR ADDITIONAL
2 COSTS OF INNOVATIVE MEDICAL DEVICES, DRUGS, AND
3 BIOLOGICALS.—Such section is further amended by in-
4 serting after paragraph (5) the following new paragraph:

5 “(6) TRANSITIONAL PASS-THROUGH FOR ADDI-
6 TIONAL COSTS OF INNOVATIVE MEDICAL DEVICES,
7 DRUGS, AND BIOLOGICALS.—

8 “(A) IN GENERAL.—The Secretary shall
9 provide for an additional payment under this
10 paragraph for any of the following that are pro-
11 vided as part of a covered OPD service (or
12 group of services):

13 “(i) CURRENT ORPHAN DRUGS.—A
14 drug or biological that is used for a rare
15 disease or condition with respect to which
16 the drug or biological has been designated
17 as an orphan drug under section 526 of
18 the Federal Food, Drug and Cosmetic Act
19 if payment for the drug or biological as an
20 outpatient hospital service under this part
21 was being made on the first date that the
22 system under this subsection is imple-
23 mented.

24 “(ii) CURRENT CANCER THERAPY
25 DRUGS AND BIOLOGICALS.—A drug or bio-

1 logical that is used in cancer therapy, in-
2 cluding (but not limited to) a
3 chemotherapeutic agent, antiemetic,
4 hematopoietic growth factor, colony stimu-
5 lating factor, a biological response modi-
6 fier, and a bisphosphonate, or
7 brachytherapy, if payment for such drug,
8 biological, or device as an outpatient hos-
9 pital service under this part was being
10 made on such first date.

11 “(iii) NEW MEDICAL DEVICES, DRUGS,
12 AND BIOLOGICALS.—A medical device,
13 drug, or biological not described in clause
14 (i) or (ii) if—

15 “(I) payment for the device,
16 drug, or biological as an outpatient
17 hospital service under this part was
18 not being made as of December 31,
19 1996; and

20 “(II) the cost of the device, drug,
21 or biological is not insignificant in re-
22 lation to the OPD fee schedule
23 amount (as calculated under para-
24 graph (3)(D)) payable for the service
25 (or group of services) involved.

1 “(B) LIMITED PERIOD OF PAYMENT.—The
2 payment under this paragraph with respect to
3 a medical device, drug, or biological shall only
4 apply during a period of at least 2 years, but
5 not more than 3 years, that begins—

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

14 “(ii) in the case of a device, drug, or
15 biological described in subparagraph
16 (A)(iii) not described in clause (i), on the
17 first date on which payment is made under
18 this part for the device, drug, or biological
19 as an outpatient hospital service.

20 “(C) AMOUNT OF ADDITIONAL PAY-
21 MENT.—Subject to subparagraph (D)(iii), the
22 amount of the payment under this paragraph
23 with respect to a device, drug, or biological pro-
24 vided as part of a covered OPD service is—

1 “(i) in the case of a drug or biological,
2 the amount by which the amount deter-
3 mined under section 1842(o) for the drug
4 or biological exceeds the portion of the oth-
5 erwise applicable Medicare OPD fee sched-
6 ule that the Secretary determines is associ-
7 ated with the drug or biological; or

8 “(ii) in the case of a medical device,
9 the amount by which the hospital’s charges
10 for the device, adjusted to cost, exceeds the
11 portion of the otherwise applicable Medi-
12 care OPD fee schedule that the Secretary
13 determines is associated with the device.

14 “(D) LIMIT ON AGGREGATE ANNUAL AD-
15 JUSTMENT.—

16 “(i) IN GENERAL.—The total of the
17 additional payments made under this para-
18 graph for covered OPD services furnished
19 in a year (as projected or estimated by the
20 Secretary before the beginning of the year)
21 may not exceed the applicable percentage
22 (specified in clause (ii)) of the total pro-
23 gram payments projected or estimated to
24 be made under this subsection for all cov-
25 ered OPD services furnished in that year.

1 If this paragraph is first applied to less
2 than a full year, the previous sentence
3 shall apply only to the portion of such
4 year.

5 “(ii) APPLICABLE PERCENTAGE.—For
6 purposes of clause (i), the term ‘applicable
7 percentage’ means—

8 “(I) for a year (or portion of a
9 year) before 2004, 2.5 percent; and

10 “(II) for 2004 and thereafter, a
11 percentage specified by the Secretary
12 up to (but not to exceed) 2.0 percent.

13 “(iii) UNIFORM PROSPECTIVE REDUC-
14 TION IF AGGREGATE LIMIT PROJECTED TO
15 BE EXCEEDED.—If the Secretary projects
16 or estimates before the beginning of a year
17 that the amount of the additional pay-
18 ments under this paragraph for the year
19 (or portion thereof) as determined under
20 clause (i) without regard to this clause)
21 will exceed the limit established under such
22 clause, the Secretary shall reduce pro rata
23 the amount of each of the additional pay-
24 ments under this paragraph for that year
25 (or portion thereof) in order to ensure that

1 the aggregate additional payments under
 2 this paragraph (as so projected or esti-
 3 mated) do not exceed such limit.”.

4 (c) APPLICATION OF NEW ADJUSTMENTS ON A
 5 BUDGET NEUTRAL BASIS.—Section 1833(t)(2)(E) (42
 6 U.S.C. 1395l(t)(2)(E)) is amended by striking “other ad-
 7 justments, in a budget neutral manner, as determined to
 8 be necessary to ensure equitable payments, such a outlier
 9 adjustments or” and inserting “, in a budget neutral man-
 10 ner, outlier adjustments under paragraph (5) and transi-
 11 tional pass-through payments under paragraph (6) and
 12 other adjustments as determined to be necessary to ensure
 13 equitable payments, such as”.

14 (d) LIMITATION ON JUDICIAL REVIEW FOR NEW AD-
 15 JUSTMENTS.—Section 1833(t)(11), as redesignated by
 16 subsection (a)(1), is amended—

17 (1) by striking “and” at the end of subpara-
 18 graph (C);

19 (2) by striking the period at the end of sub-
 20 paragraph (D) and inserting “; and”; and

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

22 “(E) the determination of the fixed mul-
 23 tiple, or a fixed dollar cutoff amount, the mar-
 24 ginal cost of care, or applicable percentage
 25 under paragraph (5) or the determination of in-

1 significance of cost, the duration of the addi-
 2 tional payments (consistent with paragraph
 3 (6)(B)), the portion of the Medicare OPD fee
 4 schedule amount associated with particular de-
 5 vices, drugs, or biologicals, and the application
 6 of any pro rata reduction under paragraph
 7 (6).”.

8 (e) INCLUSION OF MEDICAL DEVICES UNDER SYS-
 9 TEM.—Section 1833(t) (42 U.S.C. 1395l(t)) is amended—

10 (1) in paragraph (1)(B)(ii), by striking “clause
 11 (iii)” and inserting “clause (iv)” and by striking
 12 “but”;

13 (2) by redesignating clause (iii) of paragraph
 14 (1)(B) as clause (iv) and inserting after clause (ii)
 15 of such paragraph the following new clause:

16 “(iii) includes medical devices (such
 17 as implantable medical devices); but”; and

18 (3) in paragraph (2)(B), by inserting after “re-
 19 sources” the following: “and so that a device is clas-
 20 sified to the group that includes the service to which
 21 the device relates”.

22 (f) AUTHORIZING PAYMENT WEIGHTS BASED ON
 23 MEAN HOSPITAL COSTS.—Section 1833(t)(2)(C) (42
 24 U.S.C. 1395l(t)(2)(C)) is amended by inserting “(or, at
 25 the election of the Secretary, mean)” after “median”.

1 (g) LIMITING VARIATION OF COSTS OF SERVICES
2 CLASSIFIED WITH A GROUP.—Section 1833(t)(2) (42
3 U.S.C. 1395l(t)(2)) is amended by adding at the end the
4 following new flush sentence:

5 “For purposes of subparagraph (B), items and serv-
6 ices within a group shall not be treated as ‘com-
7 parable with respect to the use of resources’ if the
8 highest median cost (or mean cost, if elected by the
9 Secretary under subparagraph (C)) for an item or
10 service within the group is more than two times
11 greater than the lowest median cost (or mean cost,
12 if so elected) for an item or service within the group;
13 except that the Secretary may make exceptions in
14 unusual cases, such as low volume items and serv-
15 ices, but may not make such an exception in the
16 case of a drug or biological has been designated as
17 an orphan drug under section 526 of the Federal
18 Food, Drug and Cosmetic Act.”.

19 (h) ANNUAL REVIEW OF OPD PPS COMPONENTS.—

20 (1) IN GENERAL.—Section 1833(t)(8)(A) (42
21 U.S.C. 1395l(t)(8)(A)), as redesignated by sub-
22 section (a), is amended—

23 (A) by striking “may periodically review”
24 and inserting “shall review not less often than
25 annually”; and

1 (B) by adding at the end the following:

2 “The Secretary shall consult with an expert
3 outside advisory panel composed of an appro-
4 priate selection of representatives of providers
5 to review (and advise the Secretary concerning)
6 the clinical integrity of the groups and weights.
7 Such panel may use data collected or developed
8 by entities and organizations (other than the
9 Department of Health and Human Services) in
10 conducting such review.”.

11 (2) EFFECTIVE DATES.—The Secretary of
12 Health and Human Services shall first conduct the
13 annual review under the amendment made by para-
14 graph (1)(A) in 2001 for application in 2002 and
15 the amendment made by paragraph (1)(B) takes ef-
16 fect on the date of the enactment of this Act.

17 (i) NO IMPACT ON COPAYMENT.—Section 1833(t)(7)
18 (42 U.S.C. 1395l(t)(7)), as redesignated by subsection (a),
19 is amended by adding at the end the following new sub-
20 paragraph:

21 “(D) COMPUTATION IGNORING OUTLIER
22 AND PASS-THROUGH ADJUSTMENTS.—The co-
23 payment amount shall be computed under sub-
24 paragraph (A) as if the adjustments under
25 paragraphs (5) and (6) (and any adjustment

1 made under paragraph (2)(E) in relation to
2 such adjustments) had not occurred.”.

3 (j) TECHNICAL CORRECTION IN REFERENCE RELAT-
4 ING TO HOSPITAL-BASED AMBULANCE SERVICES.—Sec-
5 tion 1833(t)(9) (42 U.S.C. 1395l(t)(9)), as redesignated
6 by subsection (a), is amended by striking “the matter in
7 subsection (a)(1) preceding subparagraph (A)” and insert-
8 ing “section 1861(v)(1)(U)”.

9 (k) EFFECTIVE DATE.—Except as provided in this
10 section, the amendments made by this section shall be ef-
11 fective as if included in the enactment of BBA.

12 (l) STUDY OF DELIVERY OF INTRAVENOUS IMMUNE
13 GLOBULIN (IVIG) OUTSIDE HOSPITALS AND PHYSICIANS’
14 OFFICES.—

15 (1) STUDY.—The Secretary of Health and
16 Human Services shall conduct a study of the extent
17 to which intravenous immune globulin (IVIG) could
18 be delivered and reimbursed under the Medicare pro-
19 gram outside of a hospital or physician’s office. In
20 conducting the study, the Secretary shall—

21 (A) consider the sites of service that other
22 payors, including Medicare+Choice plans, use
23 for these drugs and biologicals;

24 (B) determine whether covering the deliv-
25 ery of these drugs and biologicals in a Medicare

1 patient's home raises any additional safety and
2 health concerns for the patient;

3 (C) determine whether covering the deliv-
4 ery of these drugs and biologicals in a patient's
5 home can reduce overall spending under the
6 Medicare program; and

7 (D) determine whether changing the site of
8 setting for these services would affect bene-
9 ficiary access to care.

10 (2) REPORT.—The Secretary shall submit a re-
11 port on such study to the Committees on Way and
12 Means and Commerce of the House of Representa-
13 tives and the Committee on Finance of the Senate
14 within 1 year after the date of the enactment of this
15 Act. The Secretary shall include in the report rec-
16 ommendations regarding on the appropriate manner
17 and settings under which the Medicare program
18 should pay for these drugs and biologicals delivered
19 outside of a hospital or physician's office.

20 **SEC. 212. ESTABLISHING A TRANSITIONAL CORRIDOR FOR**
21 **APPLICATION OF OPD PPS.**

22 (a) IN GENERAL.—Section 1833(t) (42 U.S.C.
23 1395l(t)), as amended by section 211(a), is further
24 amended—

1 (1) in paragraph (4), in the matter before sub-
2 paragraph (A), by inserting “, subject to paragraph
3 (7),” after “is determined”; and

4 (2) by redesignating paragraphs (7) through
5 (11) as paragraphs (8) through (12), respectively;
6 and

7 (3) by inserting after paragraph (6), as inserted
8 by section 211(b), the following new paragraph:

9 “(7) TRANSITIONAL ADJUSTMENT TO LIMIT DE-
10 CLINE IN PAYMENT.—

11 “(A) BEFORE 2002.—Subject to subpara-
12 graph (D), for covered OPD services furnished
13 before January 1, 2002, for which the PPS
14 amount (as defined in subparagraph (E)) is—

15 “(i) at least 90 percent, but less than
16 100 percent, of the pre-BBA amount (as
17 defined in subparagraph (F)), the amount
18 of payment under this subsection shall be
19 increased by 80 percent of the amount of
20 such difference;

21 “(ii) at least 80 percent, but less than
22 90 percent, of the pre-BBA amount, the
23 amount of payment under this subsection
24 shall be increased by the amount by which
25 (I) the product of 0.71 and the pre-BBA

1 amount, exceeds (II) the product of 0.70
2 and the PPS amount;

3 “(iii) at least 70 percent, but less
4 than 80 percent, of the pre-BBA amount,
5 the amount of payment under this sub-
6 section shall be increased by the amount
7 by which (I) the product of 0.63 and the
8 pre-BBA amount, exceeds (II) the product
9 of 0.60 and the PPS amount;

10 “(iv) less than 70 percent of the pre-
11 BBA amount, the amount of payment
12 under this subsection shall be increased by
13 21 percent of the pre-BBA amount.

14 “(B) 2002.—Subject to subparagraph (D),
15 for covered OPD services furnished during
16 2002, for which the PPS amount is—

17 “(i) at least 90 percent, but less than
18 100 percent, of the pre-BBA amount, the
19 amount of payment under this subsection
20 shall be increased by 70 percent of the
21 amount of such difference;

22 “(ii) at least 80 percent, but less than
23 90 percent, of the pre-BBA amount, the
24 amount of payment under this subsection
25 shall be increased by the amount by which

1 (I) the product of 0.61 and the pre-BBA
2 amount, exceeds (II) the product of 0.60
3 and the PPS amount;

4 “(iii) less than 80 percent of the pre-
5 BBA amount, the amount of payment
6 under this subsection shall be increased by
7 13 percent of the pre-BBA amount.

8 “(C) 2003.—Subject to subparagraph (D),
9 for covered OPD services furnished during
10 2003, for which the PPS amount is—

11 “(i) at least 90 percent, but less than
12 100 percent, of the pre-BBA amount, the
13 amount of payment under this subsection
14 shall be increased by 60 percent of the
15 amount of such difference; or

16 “(ii) less than 90 percent of the pre-
17 BBA amount, the amount of payment
18 under this subsection shall be increased by
19 6 percent of the pre-BBA amount.

20 “(D) SPECIAL RULE FOR SMALL RURAL
21 HOSPITALS.—In the case of a hospital located
22 in a rural area and that has not more than 100
23 beds, for covered OPD services furnished before
24 January 1, 2004, for which the PPS amount is
25 less than the pre-BBA amount, the amount of

1 payment under this subsection shall be in-
2 creased by 100 percent of the amount of such
3 difference.

4 “(E) PPS AMOUNT DEFINED.—In this
5 paragraph, the term ‘PPS amount’ means, with
6 respect to covered OPD services, the amount
7 payable under this title for such services (deter-
8 mined without regard to this paragraph), in-
9 cluding amounts payable as copayment under
10 paragraph (5), coinsurance under section
11 1866(a)(2)(A)(ii), and the deductible under sec-
12 tion 1833(b).

13 “(F) PRE-BBA AMOUNT DEFINED.—

14 “(i) IN GENERAL.—In this paragraph,
15 the ‘pre-BBA amount’ means, with respect
16 to covered OPD services furnished by a
17 hospital in a year, an amount equal to the
18 product of the reasonable cost of the hos-
19 pital for such services for the portions of
20 the hospital’s cost reporting period (or pe-
21 riods) occurring in the year and the base
22 OPD payment-to-cost ratio for the hospital
23 (as defined in clause (ii)).

24 “(ii) BASE PAYMENT-TO-COST-RATIO
25 DEFINED.—For purposes of this subpara-

graph, the ‘base payment-to-cost ratio’ for
a hospital means the ratio of—

“(I) the hospital’s reimbursement
under this part for covered OPD serv-
ices furnished during the cost report-
ing period ending in 1996, including
any reimbursement for such services
through cost-sharing described in sub-
paragraph (D), to

“(II) the reasonable cost of such
services for such period.

“(G) NO EFFECT ON COPAYMENTS.—

Nothing in this paragraph shall be construed to
affect the unadjusted copayment amount de-
scribed in paragraph (3)(B) or the copayment
amount under paragraph (8).

“(H) APPLICATION WITHOUT REGARD TO

BUDGET NEUTRALITY.—The additional pay-
ments made under this paragraph—

“(i) shall not be considered an adjust-
ment under paragraph (2)(E); and

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

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall be effective as if included in the enact-
3 ment of BBA.

4 (c) REPORT ON RURAL HOSPITALS.—Not later than
5 July 1, 2002, the Secretary of Health and Human Serv-
6 ices shall submit to Congress a report and recommenda-
7 tions on whether the prospective payment system for cov-
8 ered outpatient services furnished under title XVIII of the
9 Social Security Act should apply to the following providers
10 of services furnishing outpatient items and services for
11 which payment is made under such title:

12 (1) Medicare-dependent, small rural hospitals
13 (as defined in section 1886(d)(5)(G)(iv) of such Act
14 (42 U.S.C. 1395ww(d)(5)(G)(iv))).

15 (2) Sole community hospitals (as defined in sec-
16 tion 1886(d)(5)(D)(iii) of such Act (42 U.S.C.
17 1395ww(d)(5)(D)(iii))).

18 (3) Rural health clinics (as defined in section
19 1861(aa)(2) of such Act (42 U.S.C. 1395x(aa)(2))).

20 (4) Rural referral centers (as so classified
21 under section 1886(d)(5)(C) of such Act (42 U.S.C.
22 1395ww(d)(5)(C))).

23 (5) Any other rural hospital with not more than
24 100 beds.

1 (6) Any other rural hospital that the Secretary
2 determines appropriate.

3 **SEC. 213. DELAY IN APPLICATION OF PROSPECTIVE PAY-**
4 **MENT SYSTEM TO CANCER CENTER HOS-**
5 **PITALS.**

6 Section 1833(t)(11)(A) (42 U.S.C. 1395l(t)(11)(A)),
7 as redesignated by section 212(a), is amended by striking
8 “January 1, 2000” and inserting “the first day of the first
9 year that begins 2 years after the date the prospective pay-
10 ment system under this section is first implemented”.

11 **SEC. 214. LIMITATION ON OUTPATIENT HOSPITAL COPAY-**
12 **MENT FOR A PROCEDURE TO THE HOSPITAL**
13 **DEDUCTIBLE AMOUNT.**

14 (a) IN GENERAL.—Section 1833(t)(8) (42 U.S.C.
15 1395l(t)(8)), as redesignated by sections 212(a)(1) and
16 212(a)(2), is amended—

17 (1) in subparagraph (A), by striking “subpara-
18 graph (B)” and inserting “subparagraphs (B) and
19 (C)”;

20 (2) by redesignating subparagraphs (C) and
21 (D) as subparagraphs (D) and (E), respectively; and

22 (3) by inserting after subparagraph (B) the fol-
23 lowing new subparagraph:

24 “(C) LIMITING COPAYMENT AMOUNT TO
25 INPATIENT HOSPITAL DEDUCTIBLE AMOUNT.—

1 In no case shall the copayment amount for a
 2 procedure performed in a year exceed the
 3 amount of the inpatient hospital deductible es-
 4 tablished under section 1813(b) for that year.”.

5 (b) INCREASE IN PAYMENT TO REFLECT REDUCTION
 6 IN COPAYMENT.—Section 1833(t)(4)(C) (42 U.S.C.
 7 1395l(t)(4)(C)) is amended by inserting “, plus the
 8 amount of any reduction in the copayment amount attrib-
 9 utable to paragraph (5)(C)” before the period at the end.

10 (c) EFFECTIVE DATE.—The amendments made by
 11 this section apply as if included in the enactment of BBA
 12 and shall only apply to procedures performed for which
 13 payment is made on the basis of the prospective payment
 14 system under section 1833(t) of the Social Security Act.

15 **Subtitle C—Other**

16 **SEC. 221. APPLICATION OF SEPARATE CAPS TO PHYSICAL** 17 **AND SPEECH THERAPY SERVICES.**

18 (a) IN GENERAL.—Section 1833(g) (42 U.S.C.
 19 1395l(g)) is amended—

20 (1) in paragraph (1)—

21 (A) by inserting “(A)” after “(g)(1)”; and

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

24 “(B) Subparagraph (A) shall be applied separately
 25 for speech-language pathology services described in the

1 fourth sentence of section 1861(p) and for other out-
2 patient physical therapy services.”; and

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

5 “(4) The limitations of this subsection apply to the
6 services involved on a per beneficiary, per facility (or pro-
7 vider) basis.”.

8 (b) TECHNICAL AMENDMENT RELATING TO BEING
9 UNDER THE CARE OF A PHYSICIAN.—Section 1861 (42
10 U.S.C. 1395x) is amended—

11 (1) in subsection (p)(1), by striking “or (3)”
12 and inserting “, (3), or (4)”;

13 (2) in subsection (r)(4), by inserting “for pur-
14 poses of subsection (p)(1) and” after “but only”.

15 (c) EFFECTIVE DATE.—The amendments made by
16 this section apply to services furnished on or after Janu-
17 ary 1, 2000.

18 **SEC. 222. TRANSITIONAL OUTLIER PAYMENTS FOR THER-**
19 **APY SERVICES FOR CERTAIN HIGH ACUITY**
20 **PATIENTS.**

21 Section 1833(g) (42 U.S.C. 1395l(g)), as amended
22 by section 221, is further amended by adding at the end
23 the following new paragraph:

24 “(5)(A) The Secretary shall establish a process under
25 which a facility or provider that is providing therapy serv-

ices to which the limitation of this subsection applies to a beneficiary may apply to the Secretary for an increase in such limitation under this paragraph for services furnished in 2000 or in 2001.

“(B) Such process shall take into account the clinical diagnosis and shall provide that the aggregate amount of additional payments resulting from the application of this paragraph—

“(i) during fiscal year 2000 may not exceed \$40,000,000;

“(ii) during fiscal year 2001 may not exceed \$60,000,000; and

“(iii) during fiscal year 2002 may not exceed \$20,000,000.”.

SEC. 223. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.

(a) IN GENERAL.—Section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by adding at the end the following new flush sentence:

“The Secretary shall increase the amount of each composite rate payment for dialysis services furnished on or after January 1, 2000, and on or before December 31, 2000, by 1.2 percent above such composite rate payment amounts for such services furnished on December 31, 1999, and for such services furnished on or after January 1, 2001, by 1.2 percent above such composite rate pay-

1 ment amounts for such services furnished on December
2 31, 2000.”.

3 (b) CONFORMING AMENDMENT.—

4 (1) IN GENERAL.—Section 9335(a) of the Om-
5 nibus Budget Reconciliation Act of 1986 (42 U.S.C.
6 1395rr note) is amended by striking paragraph (1).

7 (2) EFFECTIVE DATE.—The amendment made
8 by paragraph (1) shall take effect on January 1,
9 2000.

10 (c) STUDY ON PAYMENT LEVEL FOR HOME HEMO-
11 DIALYSIS.—The Medicare Payment Advisory Commission
12 shall conduct a study on the appropriateness of the dif-
13 ferential in payment under the Medicare program for
14 hemodialysis services furnished in a facility and such serv-
15 ices furnished in a home. Not later than 18 months after
16 the date of the enactment of this Act, the Commission
17 shall submit to Congress a report on such study and shall
18 include recommendations regarding changes in Medicare
19 payment policy in response to the study.

20 **SEC. 224. TEMPORARY UPDATE IN DURABLE MEDICAL**
21 **EQUIPMENT AND OXYGEN RATES.**

22 (a) DURABLE MEDICAL EQUIPMENT AND OXYGEN.—
23 Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)), as
24 amended by section 4551(a)(1) of BBA, is amended—

1 (1) by redesignating subparagraph (D) as sub-
2 paragraph (E); and

3 (2) by striking subparagraph (C) and inserting
4 the following:

5 “(C) for each of the years 1998 through
6 2000, 0 percentage points;

7 “(D) for each of the years 2001 and 2002,
8 the percentage increase in the consumer price
9 index for all urban consumers (United States
10 city average) for the 12-month period ending
11 with June of the previous year minus 2 percent-
12 age points; and”.

13 (b) CONFORMING AMENDMENTS.—Section
14 1834(a)(9)(B) (42 U.S.C. 1395m(a)(9)(B)), as amended
15 by section 4552(a) of BBA, is amended—

16 (1) by striking “and” at the end of clause (v);

17 (2) in clause (vi), by striking “and each subse-
18 quent year” and inserting “and 2000” and by strik-
19 ing the period at the end and inserting “; and”; and

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

22 “(vii) for 2001 and each subsequent
23 year, the amount determined under this
24 subparagraph for the preceding year in-

1 creased by the covered item update for
2 such subsequent year.”.

3 **SEC. 225. REQUIREMENT FOR NEW PROPOSED RULE-**
4 **MAKING FOR IMPLEMENTATION OF INHER-**
5 **ENT REASONABLENESS POLICY.**

6 The Secretary of Health and Human Services shall
7 not exercise inherent reasonableness authority provided
8 under section 1842(b)(8) of the Social Security Act (42
9 U.S.C. 1395u(b)(8)) before such time as—

10 (1) the Secretary has published in the Federal
11 Register a new notice of proposed rulemaking to im-
12 plement subparagraph (A) of such section;

13 (2) has provided for a period of not less than
14 60 days for public comment on such proposed rule;
15 and

16 (3) the Secretary has published in the Federal
17 Register a final rule which takes into account com-
18 ments received during such period.

19 **SEC. 226. INCREASE IN REIMBURSEMENT FOR PAP SMEARS.**

20 (a) **PAP SMEAR PAYMENT INCREASE.**—Section
21 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at
22 the end the following new paragraph:

23 “(7) Notwithstanding paragraphs (1) and (4), the
24 Secretary shall establish a minimum payment amount
25 under this subsection for all areas for a diagnostic or

1 screening pap smear laboratory test (including all cervical
2 cancer screening technologies that have been approved by
3 the Food and Drug Administration) of not less than
4 \$14.60.”.

5 (b) SENSE OF THE CONGRESS.—It is the sense of
6 the Congress that—

7 (1) the Health Care Financing Administration
8 has been slow to incorporate or provide incentives
9 for providers to use new screening diagnostic health
10 care technologies in the area of cervical cancer;

11 (2) some new technologies have been developed
12 which optimize the effectiveness of pap smear
13 screening; and

14 (3) the Health Care Financing Administration
15 should institute an appropriate increase in the pay-
16 ment rate for new cervical cancer screening tech-
17 nologies that have been approved by the Food and
18 Drug Administration as significantly more effective
19 than a conventional pap smear.

20 (c) EFFECTIVE DATE.—The amendments made by
21 subsection (a) apply to services items and furnished on
22 or after January 1, 2000.

1 **SEC. 227. REFINEMENT OF AMBULANCE SERVICES DEM-**
2 **ONSTRATION PROJECT.**

3 Effective as if included in the enactment of BBA, sec-
4 tion 4532 of BBA is amended—

5 (1) in subsection (a), by adding at the end the
6 following: “The Secretary shall publish by not later
7 than July 1, 2000, a request for proposals for such
8 projects.”; and

9 (2) by amending paragraph (2) of subsection
10 (b) to read as follows:

11 “(2) CAPITATED PAYMENT RATE DEFINED.—In
12 this subsection, the ‘capitated payment rate’ means,
13 with respect to a demonstration project—

14 “(A) in its first year, a rate established for
15 the project by the Secretary, using the most
16 current available data, in a manner that en-
17 sures that aggregate payments under the
18 project will not exceed the aggregate payment
19 that would have been made for ambulance serv-
20 ices under part B of title XVIII of the Social
21 Security Act in the local area of government’s
22 jurisdiction; and

23 “(B) in a subsequent year, the capitated
24 payment rate established for the previous year
25 increased by an appropriate inflation adjust-
26 ment factor.”.

1 **SEC. 228. PHASE-IN OF PPS FOR AMBULATORY SURGICAL**
2 **CENTERS.**

3 If the Secretary of Health and Human Services im-
4 plements a revised prospective payment system for serv-
5 ices of ambulatory surgical facilities under part B of title
6 XVIII of the Social Security Act, prior to incorporating
7 data from the 1999 Medicare cost survey, such system
8 shall be implemented in a manner so that—

9 (1) in the first year of its implementation, only
10 a proportion (specified by the Secretary and not to
11 exceed $\frac{1}{3}$) of the payment for such services shall be
12 made in accordance with such system and the re-
13 mainder shall be made in accordance with current
14 regulations; and

15 (2) in the following year a proportion (specified
16 by the Secretary and not to exceed $\frac{2}{3}$) of the pay-
17 ment for such services shall be made under such sys-
18 tem and the remainder shall be made in accordance
19 with current regulations.

20 **SEC. 229. EXTENSION OF MEDICARE BENEFITS FOR IM-**
21 **MUNOSUPPRESSIVE DRUGS.**

22 (a) IN GENERAL.—The Secretary of Health and
23 Human Services shall provide under this section for an
24 extension of the period of coverage of immunosuppressive
25 drugs under section 1861(s)(2)(J) of the Social Security
26 Act (42 U.S.C. 1395x(s)(2)(J)) to individuals described

1 in such section under terms and conditions specified by
2 the Secretary consistent with subsection (c) and the
3 objectives—

4 (1) of improving health outcomes by decreasing
5 transplant rejection rates that are attributable to
6 failure to comply with immunosuppressive drug regi-
7 mens; and

8 (2) of achieving cost saving to the Medicare
9 program by decreasing the need for secondary trans-
10 plants and other care relating to post-transplant
11 complications.

12 (b) AUTHORITY.—In carrying out this section—

13 (1) the Secretary shall provide priority in eligi-
14 bility to those Medicare beneficiaries who, because of
15 income or other factors, would be less likely to main-
16 tain an immunosuppressive drug regimen in the ab-
17 sence of such an extension; and

18 (2) the Secretary is authorized to vary the ben-
19 eficiary cost-sharing otherwise applicable in order to
20 promote the objectives described in subsection (a).

21 (c) LIMITATIONS.—The total amount expended by
22 the Secretary under title XVIII of the Social Security Act
23 to carry out this section shall not exceed \$200,000,000,
24 and with respect to expenditures in fiscal year 2000 shall
25 not exceed \$40,000,000. The Secretary shall not provide

1 an extension of coverage under this section for immuno-
2 suppressive drugs furnished after September 30, 2004.

3 (d) REPORT.—Not later than 36 months after the
4 first month in which the Secretary provides for extended
5 benefits under this section, the Secretary shall submit to
6 Congress a report on the operation of this section. The
7 report shall include—

8 (1) an analysis of the impact of this section on
9 meeting the objectives described in subsection (a);
10 and

11 (2) recommendations regarding an appropriate
12 cost-effective method for extending coverage of im-
13 munosuppressive drugs under the Medicare program
14 on a permanent basis.

15 **SEC. 230. ADDITIONAL STUDIES.**

16 (a) MEDPAC STUDY ON POSTSURGICAL RECOVERY
17 CARE CENTER SERVICES.—

18 (1) IN GENERAL.—The Medicare Payment Ad-
19 visory Commission shall conduct a study on the cost-
20 effectiveness and efficacy of covering under the
21 Medicare program services of a post-surgical recov-
22 ery care center (that provides an intermediate level
23 of recovery care following surgery). In conducting
24 such study, the Commission shall consider data on
25 these centers gathered in demonstration projects.

1 (2) REPORT.—Not later than 1 year after the
2 date of the enactment of this Act, the Commission
3 shall submit to Congress a report on such study and
4 shall include in the report recommendations on the
5 feasibility, costs, and savings of covering such serv-
6 ices under the Medicare program.

7 (b) ACHPR STUDY ON EFFECT OF CREDENTIALING
8 OF TECHNOLOGISTS AND SONOGRAPHERS ON QUALITY OF
9 ULTRASOUND AND IMAGING SERVICES.—

10 (1) STUDY.—The Administrator for Health
11 Care Policy and Research shall provide for a study
12 that compares the differences in quality of
13 ultrasound and other imaging services (including
14 error rates and resulting complications) furnished
15 under the Medicare and Medicaid programs between
16 such services furnished by individuals who are
17 credentialed by private entities or organizations and
18 by those who are not so credentialed. Such study
19 shall examine and evaluate differences in error rates
20 and patient outcomes as a result of the differences
21 in credentialing. In designing the study, the Admin-
22 istrator shall consult with organizations nationally
23 recognized for their expertise in ultrasound proce-
24 dures.

1 (2) REPORT.—By not later than 2 years after
2 the date of the enactment of this Act, the Adminis-
3 trator shall submit a report to Congress on the
4 study conducted under paragraph (1).

5 (c) MEDPAC STUDY ON THE COMPLEXITY OF THE
6 MEDICARE PROGRAM AND THE LEVELS OF BURDENS
7 PLACED ON PROVIDERS THROUGH FEDERAL REGULA-
8 TIONS.—

9 (1) STUDY.—The Medicare Payment Advisory
10 Commission shall undertake a comprehensive study
11 to review the regulatory burdens placed on all class-
12 es of health care providers under parts A and B of
13 the Medicare program under title XVIII of the So-
14 cial Security Act and to determine the costs these
15 burdens impose on the nation's health care system.
16 The study shall also examine the complexity of the
17 current regulatory system and its impact on pro-
18 viders.

19 (2) REPORT.—not later than December 31,
20 2001, the Commission shall submit to Congress a re-
21 port on the study conducted under paragraph (1).
22 The report shall include recommendations
23 regarding—

1 (A) how the Health Care Financing Ad-
2 ministration can reduce the regulatory burdens
3 placed on patients and providers; and

4 (B) legislation that may be appropriate to
5 reduce the complexity of the Medicare program,
6 including improvement of the rules regarding
7 billing, compliance, and fraud and abuse.

8 (d) GAO CONTINUED MONITORING OF DEPARTMENT
9 OF JUSTICE APPLICATION OF GUIDELINES ON USE OF
10 FALSE CLAIMS ACT IN CIVIL HEALTH CARE MATTERS.—

11 The Comptroller General of the United States shall—

12 (1) continue the monitoring, begun under sec-
13 tion 118 of the Department of Justice Appropria-
14 tions Act, 1999 (included in Public Law 105–277)
15 of the compliance of the Department of Justice and
16 all United States Attorneys with the “Guidance on
17 the Use of the False Claims Act in Civil Health
18 Care Matters” issued by the Department of Justice
19 on June 3, 1998, including any revisions to that
20 guidance; and

21 (2) not later than April 1, 2000, and of each
22 of the two succeeding years, submit a report on such
23 compliance to the appropriate committees of Con-
24 gress.

1 **TITLE III—PROVISIONS**
2 **RELATING TO PARTS A AND B**
3 **Subtitle A—Home Health Services**

4 **SEC. 301. ADJUSTMENT TO REFLECT ADMINISTRATIVE**
5 **COSTS NOT INCLUDED IN THE INTERIM PAY-**
6 **MENT SYSTEM; GAO REPORT ON COSTS OF**
7 **COMPLIANCE WITH OASIS DATA COLLECTION**
8 **REQUIREMENTS.**

9 (a) ADJUSTMENT TO REFLECT ADMINISTRATIVE
10 COSTS.—

11 (1) IN GENERAL.—In the case of a home health
12 agency that furnishes home health services to a
13 Medicare beneficiary, for each such beneficiary to
14 whom the agency furnished such services during the
15 agency's cost reporting period beginning in fiscal
16 year 2000, the Secretary of Health Services shall
17 pay the agency, in addition to any amount of pay-
18 ment made under subsection (v)(1)(L) of such sec-
19 tion for the beneficiary and only for such cost re-
20 porting period, an aggregate amount of \$10 to de-
21 fray costs incurred by the agency attributable to
22 data collection and reporting requirements under the
23 Outcome and Assessment Information Set (OASIS)
24 required by reason of section 4602(e) of the Bal-
25 anced Budget Act of 1997 (42 U.S.C. 1395fff note).

1 (2) PAYMENT SCHEDULE.—

2 (A) MIDYEAR PAYMENT.—By not later
3 than April 1, 2000, the Secretary shall pay to
4 a home health agency an amount that the Sec-
5 retary estimates to be 50 percent of the aggre-
6 gate amount payable to the agency by reason of
7 this subsection.

8 (B) UPON SETTLED COST REPORT.—The
9 Secretary shall pay the balance of amounts pay-
10 able to an agency under this subsection on the
11 date that the cost report submitted by the agen-
12 cy for the cost reporting period beginning in fis-
13 cal year 2000 is settled.

14 (3) PAYMENT FROM TRUST FUNDS.—Payments
15 under this subsection shall be made, in appropriate
16 part as specified by the Secretary, from the Federal
17 Hospital Insurance Trust Fund and from the Fed-
18 eral Supplementary Medical Insurance Trust Fund.

19 (4) DEFINITIONS.—in this subsection:

20 (A) HOME HEALTH AGENCY.—The term
21 “home health agency” has the meaning given
22 that term under section 1861(o) of the Social
23 Security Act (42 U.S.C. 1395x(o)).

24 (B) HOME HEALTH SERVICES.—The term
25 “home health services” has the meaning given

1 that term under section 1861(m) of such Act
2 (42 U.S.C. 1395x(m)).

3 (C) MEDICARE BENEFICIARY.—The term
4 “Medicare beneficiary” means a beneficiary de-
5 scribed in section 1861(v)(1)(L)(vi)(II) of the
6 Social Security Act (42 U.S.C.
7 1395x(v)(1)(L)(vi)(II)).

8 (b) GAO REPORT ON COSTS OF COMPLIANCE WITH
9 OASIS DATA COLLECTION REQUIREMENTS.—

10 (1) REPORT TO CONGRESS.—

11 (A) IN GENERAL.—Not later than 180
12 days after the date of the enactment of this
13 Act, the Comptroller General of the United
14 States shall submit a report to Congress on
15 matters described in subparagraph (B) with re-
16 spect to the data collection requirement of pa-
17 tients of such agencies under the Outcome and
18 Assessment Information Set (OASIS) standard
19 as part of the comprehensive assessment of pa-
20 tients.

21 (B) MATTERS STUDIED.—For purposes of
22 subparagraph (A), the matters described in this
23 subparagraph include the following:

24 (i) An assessment of the costs in-
25 curred by Medicare home health agencies

1 in complying with such data collection re-
2 quirement.

3 (ii) An analysis of the effect of such
4 data collection requirement on the privacy
5 interests of patients from whom data is
6 collected.

7 (C) AUDIT.—The Comptroller General
8 shall conduct an independent audit of the costs
9 described in subparagraph (B)(i). Not later
10 than 180 days after receipt of the report under
11 subparagraph (A), the Comptroller General
12 shall submit to Congress a report describing the
13 Comptroller General’s findings with respect to
14 such audit, and shall include comments on the
15 report submitted to Congress by the Secretary
16 of Health and Human Services under subpara-
17 graph (A).

18 (2) DEFINITIONS.—In this subsection:

19 (A) COMPREHENSIVE ASSESSMENT OF PA-
20 TIENTS.—The term “comprehensive assessment
21 of patients” means the rule published by the
22 Health Care Financing Administration that re-
23 quires, as a condition of participation in the
24 Medicare program, a home health agency to
25 provide a patient-specific comprehensive assess-

ment that accurately reflects the patient’s current status and that incorporates the Outcome and Assessment Information Set (OASIS).

(B) OUTCOME AND ASSESSMENT INFORMATION SET.—The term “Outcome and Assessment Information Set” means the standard provided under the rule relating to data items that must be used in conducting a comprehensive assessment of patients.

SEC. 302. DELAY IN APPLICATION OF 15 PERCENT REDUCTION IN PAYMENT RATES FOR HOME HEALTH SERVICES UNTIL 1 YEAR AFTER IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.

(a) CONTINGENCY REDUCTION.—Section 4603(e) of the Balanced Budget Act of 1997 (42 U.S.C. 1395fff note) (as amended by section 5101(c)(3) of the Tax and Trade Relief Extension Act of 1998 (contained in division J of Public Law 105–277)) is amended by striking “September 30, 2000” and inserting “on the date that is 12 months after the date the Secretary implements such system”.

(b) PROSPECTIVE PAYMENT SYSTEM.—Section 1895(b)(3)(A)(i) (42 U.S.C. 1395fff(b)(3)(A)(i)) (as amended by section 5101 of the Tax and Trade Relief Ex-

1 tension Act of 1998 (contained in division J of Public Law
2 105–277)) is amended to read as follows:

3 “(i) IN GENERAL.—Under such sys-
4 tem the Secretary shall provide for com-
5 putation of a standard prospective pay-
6 ment amount (or amounts). Such amount
7 (or amounts) shall initially be based on the
8 most current audited cost report data
9 available to the Secretary and shall be
10 computed in a manner so that the total
11 amounts payable under the system—

12 “(I) for the 12-month period be-
13 ginning on the date the Secretary im-
14 plements the system, shall be equal to
15 the total amount that would have
16 been made if the system had not been
17 in effect; and

18 “(II) for periods beginning after
19 the period described in subclause (I),
20 shall be equal to the total amount
21 that would have been made for fiscal
22 year 2001 if the system had not been
23 in effect but if the reduction in limits
24 described in clause (ii) had been in ef-

1 fect, and updated under subparagraph
2 (B).

3 Each such amount shall be standardized in
4 a manner that eliminates the effect of vari-
5 ations in relative case mix and wage levels
6 among different home health agencies in a
7 budget neutral manner consistent with the
8 case mix and wage level adjustments pro-
9 vided under paragraph (4)(A). Under the
10 system, the Secretary may recognize re-
11 gional differences or differences based
12 upon whether or not the services or agency
13 are in an urbanized area.”.

14 (c) REPORT.—

15 (1) IN GENERAL.—The Secretary of Health and
16 Human Services shall submit to Congress a report
17 analyzing the need for the 15 percent reduction
18 under section 1895(b)(3)(A)(ii) of the Social Secu-
19 rity Act (42 U.S.C. 1395fff(b)(3)(A)(ii)), or for any
20 reduction, in the computation of the base payment
21 amounts under the prospective payment system for
22 home health services under section 1895 of such Act
23 (42 U.S.C. 1395w–29).

24 (2) DEADLINE.—The Secretary shall submit to
25 Congress the report described in paragraph (1) by

1 not later than the date that is 6 months after the
2 date the Secretary implements the prospective pay-
3 ment system for home health services under such
4 section 1895.

5 **SEC. 303. CLARIFICATION OF SURETY BOND REQUIRE-**
6 **MENTS.**

7 (a) HOME HEALTH AGENCIES.—Section 1861(o)(7)
8 (42 U.S.C. 1395x(o)(7)) is amended to read as follows:

9 “(7) provides the Secretary with a surety
10 bond—

11 “(A) effective for a period of 4 years (as
12 specified by the Secretary) or in the case of a
13 change in the ownership or control of the agen-
14 cy (as determined by the Secretary) during or
15 after such 4-year period, an additional period of
16 time that the Secretary determines appropriate,
17 such additional period not to exceed 4 years
18 from the date of such change in ownership or
19 control;

20 “(B) in a form specified by the Secretary;
21 and

22 “(C) for a year in the period described in
23 subparagraph (A) in an amount that is equal to
24 the lesser of \$50,000 or 10 percent of the ag-
25 gregate amount of payments to the agency

1 under this title and title XIX for that year, as
 2 estimated by the Secretary; and”.

3 (b) COORDINATION OF SURETY BONDS.—Part A of
 4 title XI is amended by adding at the end the following
 5 new section:

6 “COORDINATION OF MEDICARE AND MEDICAID SURETY
 7 BOND PROVISIONS

8 “SEC. 1148. In the case of a home health agency that
 9 is subject to a surety bond under title XVIII and title
 10 XIX, the surety bond provided to satisfy the requirement
 11 under one such title shall satisfy the requirement under
 12 the other such title so long as the bond applies to guar-
 13 antee return of overpayments under both such titles.”.

14 (c) EFFECTIVE DATE.—The amendments made by
 15 this section take effect on the date of the enactment of
 16 this Act and in applying section 1861(o)(7) of the Social
 17 Security Act, as amended by subsection (a), the Secretary
 18 of Health and Human Services may take into account the
 19 previous period for which a home health agency had a sur-
 20 ety bond in effect under such section before such date.

21 **SEC. 304. TECHNICAL AMENDMENT CLARIFYING APPLICA-**
 22 **BLE MARKET BASKET INCREASE FOR PPS.**

23 Section 1895(b)(3)(B)(ii)(I) (42 U.S.C.
 24 1395fff(b)(3)(B)(ii)(I)), as added by section 4603 of BBA
 25 (as amended by section 5101(d)(2) of the Tax and Trade
 26 Relief Extension Act of 1998 (contained in division J of

1 Public Law 105–277)) is amended by striking “fiscal year
2 2002 or 2003” and inserting “each of fiscal years 2002
3 and 2003”.

4 **Subtitle B—Direct Graduate** 5 **Medical Education**

6 **SEC. 311. USE OF NATIONAL AVERAGE PAYMENT METHOD-**
7 **LOGY IN COMPUTING DIRECT GRADUATE**
8 **MEDICAL EDUCATION (DGME) PAYMENTS.**

9 Section 1886(h) (42 U.S.C. 1395ww(h)) is
10 amended—

11 (1) by amending clause (i) of paragraph (3)(B)
12 to read as follows:

13 “(i)(I) for a cost reporting period be-
14 ginning before October 1, 2000, the hos-
15 pital’s approved FTE resident amount (de-
16 termined under paragraph (2)) for that pe-
17 riod;

18 “(II) for a cost reporting period be-
19 ginning on or after October 1, 2000, and
20 before October 1, 2004, the national aver-
21 age per resident amount determined under
22 paragraph (7) or, if greater, the sum of
23 the hospital-specific percentage (as defined
24 in subparagraph (E)) of the hospital’s ap-
25 proved FTE resident amount (determined

1 under paragraph (2)) for the period and
2 the national percentage (as defined in such
3 subparagraph) of the national average per
4 resident amount determined under para-
5 graph (7); and

6 “(III) for a cost reporting period be-
7 ginning on or after October 1, 2004, the
8 national average per resident amount de-
9 termined under paragraph (7); and”;

10 (2) in paragraph (3), by adding at the end the
11 following new subparagraph:

12 “(E) TRANSITION TO NATIONAL AVERAGE
13 PER RESIDENT PAYMENT SYSTEM.—For pur-
14 poses of subparagraph (B)(i)(II), for the cost
15 reporting period of a hospital beginning—

16 “(i) during fiscal year 2001, the hos-
17 pital-specific percentage is 80 percent and
18 the national percentage is 20 percent;

19 “(ii) during fiscal year 2002, the hos-
20 pital-specific percentage is 60 percent and
21 the national percentage is 40 percent;

22 “(iii) during fiscal year 2003, the hos-
23 pital-specific percentage is 40 percent and
24 the national percentage is 60 percent; and

1 “(iv) during fiscal year 2004, the hos-
2 pital-specific percentage is 20 percent and
3 the national percentage is 80 percent.”;
4 and

5 (3) by adding at the end the following new
6 paragraph:

7 “(7) NATIONAL AVERAGE PER RESIDENT
8 AMOUNT.—The national average per resident
9 amount for a hospital for a cost reporting period be-
10 ginning in a fiscal year is an amount determined as
11 follows:

12 “(A) DETERMINATION OF HOSPITAL SIN-
13 GLE PER RESIDENT AMOUNT.—The Secretary
14 shall compute for each hospital operating an
15 approved graduate medical education program a
16 single per resident amount equal to the average
17 (weighted by number of full-time equivalent
18 residents) of the primary care per resident
19 amount and the non-primary care per resident
20 amount computed under paragraph (2) for cost
21 reporting periods ending during fiscal year
22 1997.

23 “(B) DETERMINATION OF WAGE AND NON-
24 WAGE-RELATED PROPORTION OF THE SINGLE
25 PER RESIDENT AMOUNT.—The Secretary shall

1 estimate the average proportion of the single
2 per resident amounts computed under subpara-
3 graph (A) that is attributable to wages and
4 wage-related costs.

5 “(C) STANDARDIZING PER RESIDENT
6 AMOUNTS.—The Secretary shall establish a
7 standardized per resident amount for each such
8 hospital—

9 “(i) by dividing the single per resident
10 amount computed under subparagraph (A)
11 into a wage-related portion and a non-
12 wage-related portion by applying the pro-
13 portion determined under subparagraph
14 (B);

15 “(ii) by dividing the wage-related por-
16 tion by the factor applied under subsection
17 (d)(3)(E) for discharges occurring during
18 fiscal year 1999 for the hospital’s area;
19 and

20 “(iii) by adding the non-wage-related
21 portion to the amount computed under
22 clause (ii).

23 “(D) DETERMINATION OF NATIONAL AV-
24 ERAGE.—The Secretary shall compute a na-
25 tional average per resident amount equal to the

1 average of the standardized per resident
2 amounts computed under subparagraph (C) for
3 such hospitals, with the amount for each hos-
4 pital weighted by the average number of full-
5 time equivalent residents at such hospital.

6 “(E) APPLICATION TO INDIVIDUAL HOS-
7 PITALS.—The Secretary shall compute for each
8 such hospital a per resident amount—

9 “(i) by dividing the national average
10 per resident amount computed under sub-
11 paragraph (D) into a wage-related portion
12 and a non-wage-related portion by applying
13 the proportion determined under subpara-
14 graph (B);

15 “(ii) by multiplying the wage-related
16 portion by the factor described in subpara-
17 graph (C)(ii) for the hospital’s area; and

18 “(iii) by adding the non-wage-related
19 portion to the amount computed under
20 clause (ii).

21 In applying clause (ii) for a cost reporting pe-
22 riod beginning before October 1, 2004, the fac-
23 tor described in such clause shall be deemed to
24 be 1 for a hospital if the national average per
25 resident amount computed under subparagraph

1 (D) is less than the hospital's approved FTE
2 resident amount (determined under paragraph
3 (2)) for the period involved and the factor de-
4 scribed in subparagraph (C)(ii) for the hos-
5 pital's area is less than 1.

6 “(F) INITIAL UPDATING RATE.—The Sec-
7 retary shall update such per resident amount
8 for the hospital's cost reporting period that be-
9 gins during fiscal year 2001 for each such hos-
10 pital by the estimated percentage increase in
11 the consumer price index for all urban con-
12 sumers during the period beginning October
13 1997 and ending with the midpoint of the hos-
14 pital's cost reporting period that begins during
15 fiscal year 2001.

16 “(G) SUBSEQUENT UPDATING.—For each
17 subsequent cost reporting period, subject to
18 subparagraph (H), the national average per
19 resident amount for a hospital is equal to the
20 amount determined under this paragraph for
21 the previous cost reporting period updated,
22 through the midpoint of the period, by pro-
23 jecting the estimated percentage change in the
24 consumer price index during the 12-month pe-
25 riod ending at that midpoint, with appropriate

1 adjustments to reflect previous under-or over-
2 estimations under this subparagraph in the pro-
3 jected percentage change in the consumer price
4 index.

5 “(H) TRANSITIONAL BUDGET NEUTRALITY
6 ADJUSTMENT.—

7 “(i) IN GENERAL.—If the Secretary
8 estimates that, as a result of the amend-
9 ments made by section 311 of the Medi-
10 care, Medicaid, and SCHIP Balanced
11 Budget Refinement Act of 1999, the post-
12 MBBRA expenditures for fiscal year 2005
13 will be greater or less than the pre-
14 MBBRA expenditures for that fiscal
15 year—

16 “(I) the Secretary shall adjust
17 the update applied under subpara-
18 graph (G) in determining the national
19 average per resident amount for cost
20 reporting periods beginning during
21 fiscal year 2005 so that the amount of
22 the post-MBBRA expenditures for
23 those cost reporting periods is equal
24 to the amount of the pre-MBBRA ex-
25 penditures for such periods; and

1 “(II) the Secretary shall, taking
2 into account the adjustment made
3 under subclause (I), adjust the na-
4 tional average per resident amount, as
5 applied for the portion of a cost re-
6 porting period beginning during fiscal
7 year 2004 that occur in fiscal year
8 2005, so that the amount of the post-
9 MBBRA expenditures made during
10 fiscal year 2005 is equal to the
11 amount of the pre-MBBRA expendi-
12 tures during such fiscal year.

13 “(ii) DEFINITIONS.—In this subpara-
14 graph:

15 “(I) AGGREGATE SUBSECTION
16 (h)-RELATED EXPENDITURES.—The
17 term ‘aggregate subsection (h)-related
18 expenditures’ means, with respect to
19 cost reporting periods beginning dur-
20 ing a fiscal year or with respect to a
21 fiscal year, the aggregate expenditures
22 under this title for such periods or fis-
23 cal year, respectively, which are at-
24 tributable to the operation of this sub-
25 section.

1 “(II) PRE-MBBRA EXPENDI-
 2 TURES.—The term ‘pre-MBBRA ex-
 3 penditures’ means aggregate sub-
 4 section (h)-related expenditures deter-
 5 mined as if the amendments made by
 6 section 311 of the Medicare, Medicaid,
 7 and SCHIP Balanced Budget Refine-
 8 ment Act of 1999 had not been en-
 9 acted.

10 “(III) POST-MBBRA EXPENDI-
 11 TURES.—The term ‘post-MBBRA ex-
 12 penditures’ means aggregate sub-
 13 section (h)-related expenditures deter-
 14 mined taking into account the amend-
 15 ments made by section 311 of the
 16 Medicare, Medicaid, and SCHIP Bal-
 17 anced Budget Refinement Act of
 18 1999.”.

19 **SEC. 312. INITIAL RESIDENCY PERIOD FOR CHILD NEU-**
 20 **ROLOGY RESIDENCY TRAINING PROGRAMS.**

21 (a) IN GENERAL.—Section 1886(h)(5)(F) (42 U.S.C.
 22 1395ww(h)(5)(F)) is amended—

23 (1) in clause (i) by striking “clause (ii)” and in-
 24 serting “clause (ii) or (iii)”;

25 (2) in clause (i), by striking “and” at the end;

1 (3) in clause (ii), by striking the period at the
2 end and inserting “, and”; and

3 (4) by inserting after clause (ii), the following
4 new clause:

5 “(iii) a period, of not more than three
6 years, during which an individual is in a
7 child neurology residency program, shall be
8 treated as part of the initial residency pe-
9 riod, but shall not be counted against any
10 limitation on the initial residency period.”.

11 (b) EFFECTIVE DATE.—The amendments made by
12 subsection (a) apply on and after July 1, 2000, to resi-
13 dency programs that began before, on, or after the date
14 of the enactment of this Act.

15 (c) MEDPAC REPORT.—The Medicare Payment Ad-
16 visory Commission shall include in its report submitted to
17 Congress in March of 2001 recommendations on whether
18 there should be an extension of the initial residency period
19 under section 1886(h)(5)(F) of the Social Security Act
20 (42 U.S.C. 1395ww(h)(5)(F)) for other residency training
21 programs in a specialty requiring preliminary years of
22 study in another specialty.

Subtitle C—Other

2 SEC. 321. GAO STUDY ON GEOGRAPHIC RECLASSIFICATION.

3 (a) IN GENERAL.—The Comptroller General of the
4 United States shall conduct a study of the current laws
5 and regulations for geographic reclassification of hospitals
6 to determine whether such reclassification is appropriate
7 for purposes of applying wage indices under the Medicare
8 program and whether it results in more accurate payments
9 for all hospitals. Such study shall examine data on the
10 number of hospitals that are reclassified and their special
11 designation status in determining payments under the
12 Medicare program. The study shall evaluate—

13 (1) the magnitude of the effect of geographic
14 reclassification on rural hospitals that do not reclass-
15 sify;

16 (2) whether the current thresholds used in geo-
17 graphic reclassification reclassify hospitals to the ap-
18 propriate labor markets;

19 (3) the effect of eliminating geographic reclassi-
20 fication through use of the occupational mix data;

21 (4) the group reclassification policy;

22 (5) changes in the number of reclassifications
23 and the compositions of the groups;

24 (6) the effect of State-specific budget neutrality
25 compared to national budget neutrality; and

1 (7) whether there are sufficient controls over
2 the intermediary evaluation of the wage data re-
3 ported by hospitals.

4 (b) REPORT.—Not later than 18 months after the
5 date of the enactment of this Act, the Comptroller General
6 of the United States shall submit to Congress a report
7 on the study conducted under subsection (a).

8 **SEC. 322. MEDPAC STUDY ON MEDICARE PAYMENT FOR**
9 **NON-PHYSICIAN HEALTH PROFESSIONAL**
10 **CLINICAL TRAINING IN HOSPITALS.**

11 (a) IN GENERAL.—The Medicare Payment Advisory
12 Commission shall conduct a study on Medicare payment
13 policy with respect to professional clinical training of dif-
14 ferent classes of non-physician health care professionals
15 (such as nurses, nurse practitioners, allied health profes-
16 sionals, physician assistants, and psychologists) and the
17 basis for any differences in treatment among such classes.

18 (b) REPORT.—The Commission shall submit a report
19 to Congress on the study conducted under subsection (a)
20 not later than 18 months after the date of the enactment
21 of this Act.

**TITLE IV—RURAL PROVIDER
PROVISIONS**

**SEC. 401. PERMITTING RECLASSIFICATION OF CERTAIN
URBAN HOSPITALS AS RURAL HOSPITALS.**

(a) IN GENERAL.—Section 1886(d)(8) (42 U.S.C. 1395ww(d)(8)) is amended by adding at the end the following new subparagraph:

“(E)(i) For purposes of this subsection, not later than 60 days after the receipt of an application from a subsection (d) hospital described in clause (ii), the Secretary shall treat the hospital as being located in the rural area (as defined in such paragraph (2)(D)) of the State in which the hospital is located.

“(ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:

“(I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the Goldsmith Modification, as published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

“(II) The hospital is located in an area designated by any law or regulation of such State as a

1 rural area (or is designated by such State as a rural
2 hospital).

3 “(III) The hospital would qualify as a rural or
4 regional or national referral center under paragraph
5 (5)(C) or as a sole community hospital under para-
6 graph (5)(D) if the hospital were located in a rural
7 area.

8 “(IV) The hospital meets such other criteria as
9 the Secretary may specify.”.

10 (b) CONFORMING CHANGES.—(1) Section 1833(t)
11 (42 U.S.C. 1395l(t)), as amended by sections 211 and
12 212, is further amended by adding at the end the following
13 new paragraph:

14 “(13) MISCELLANEOUS PROVISIONS.—

15 “(A) APPLICATION OF RECLASSIFICATION
16 OF CERTAIN HOSPITALS.—If a hospital is being
17 treated as being located a rural under section
18 1886(d)(8)(E), that hospital shall be treated
19 under this subsection as being located in that
20 rural area.”.

21 (2) Section 1820(c)(2)(B)(i) (42 U.S.C. 1395i–
22 4(c)(2)(B)(i)) is amended by inserting “or is treated as
23 being located in a rural area pursuant to section
24 1886(d)(8)(E)” after “section 1886(d)(2)(D))”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall become effective on January 1, 2000.

3 **SEC. 402. UPDATE OF STANDARDS APPLIED FOR GEO-**
4 **GRAPHIC RECLASSIFICATION FOR CERTAIN**
5 **HOSPITALS.**

6 (a) IN GENERAL.—Section 1886(d)(8)(B) (42 U.S.C.
7 1395ww(d)(8)(B)) is amended—

8 (1) by inserting “(i)” after “(B)”;

9 (2) by striking “published in the Federal Reg-
10 ister on January 3, 1980” and inserting “described
11 in clause (ii)”;

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

14 “(ii) The standards described in this clause for cost
15 reporting periods beginning in a fiscal year—

16 “(I) before fiscal year 2003, are the standards
17 published in the Federal Register on January 3,
18 1980, or, at the election of the hospital with respect
19 to fiscal years 2001 and 2002, standards so pub-
20 lished on March 30, 1990; and

21 “(II) after fiscal year 2002, are the standards
22 published in the Federal Register by the Director of
23 the Office of Management and Budget based on the
24 most recent available decennial population data.

1 Subparagraphs (C) and (D) shall not apply with respect
 2 to the application of subclause (I).”.

3 (b) EFFECTIVE DATE.—The amendments made by
 4 subsection (a) apply with respect to discharges occurring
 5 during cost reporting periods beginning on or after Octo-
 6 ber 1, 1999.

7 **SEC. 403. IMPROVEMENTS IN THE CRITICAL ACCESS HOS-**
 8 **PITAL (CAH) PROGRAM.**

9 (a) APPLYING 96-HOUR LIMIT ON A AVERAGE AN-
 10 NUAL BASIS.—

11 (1) IN GENERAL.—Section 1820(c)(2)(B)(iii)
 12 (42 U.S.C. 1395i–4(c)(2)(B)(iii)), as added by sec-
 13 tion 4201(a) of BBA, is amended by striking “for
 14 a period not to exceed 96 hours” and all that follows
 15 and inserting “for a period that does not exceed, as
 16 determined on an annual, average basis, 96 hours
 17 per patient;”.

18 (2) EFFECTIVE DATE.—The amendment made
 19 by paragraph (1) takes effect on the date of the en-
 20 actment of this Act.

21 (b) PERMITTING FOR-PROFIT HOSPITALS TO QUAL-
 22 IFY FOR DESIGNATION AS A CRITICAL ACCESS HOS-
 23 PITAL.—Section 1820(c)(2)(B)(i) (42 U.S.C. 1395i–
 24 4(c)(2)(B)(i)), as added by section 4201(a) of BBA, is

1 amended in the matter preceding subclause (I), by striking
 2 “nonprofit or public hospital” and inserting “hospital”.

3 (c) ALLOWING CLOSED OR DOWNSIZED HOSPITALS
 4 TO CONVERT TO CRITICAL ACCESS HOSPITALS.—Section
 5 1820(c)(2) (42 U.S.C. 1395i–4(c)(2)), as added by section
 6 4201(a) of BBA, is amended—

7 (1) in subparagraph (A), by striking “subpara-
 8 graph (B)” and inserting “subparagraphs (B), (C),
 9 and (D)”; and

10 (2) by adding at the end the following new sub-
 11 paragraphs:

12 “(C) RECENTLY CLOSED FACILITIES.—A
 13 State may designate a facility as a critical ac-
 14 cess hospital if the facility—

15 “(i) was a hospital that ceased oper-
 16 ations on or after the date that is 10 years
 17 before the date of the enactment of this
 18 subparagraph; and

19 “(ii) as of the effective date of such
 20 designation, meets the criteria for designa-
 21 tion under subparagraph (B).

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

1 “(i) is licensed by the State as a
2 health clinic or a health center;

3 “(ii) was a hospital that was
4 downsized to a health clinic or health cen-
5 ter; and

6 “(iii) as of the effective date of such
7 designation, meets the criteria for designa-
8 tion under subparagraph (B).”.

9 (d) ALL-INCLUSIVE PAYMENT OPTION FOR OUT-
10 PATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

11 (1) IN GENERAL.—Section 1834(g) (42 U.S.C.
12 1395m(g)), as added by section 4201(c)(5) of BBA,
13 is amended to read as follows:

14 “(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS
15 HOSPITAL SERVICES.—

16 “(1) ELECTION OF CAH.—At the election of a
17 critical access hospital, the amount of payment for
18 outpatient critical access hospital services under this
19 part shall be determined under paragraph (2) or (3),
20 such amount determined under either paragraph
21 without regard to the amount of the customary or
22 other charge.

23 “(2) COST-BASED HOSPITAL OUTPATIENT SERV-
24 ICE PAYMENT PLUS FEE SCHEDULE FOR PROFES-
25 SIONAL SERVICES.—If a hospital elects this para-

1 graph to apply, there shall be paid amounts equal to
2 the sum of the following, less the amount that such
3 hospital may charge as described in section
4 1866(a)(2)(A):

5 “(A) FACILITY FEE.—With respect to fa-
6 cility services, not including any services for
7 which payment may be made under subpara-
8 graph (B), the reasonable costs of the critical
9 access hospital in providing such services.

10 “(B) FEE SCHEDULE FOR PROFESSIONAL
11 SERVICES.—With respect to professional serv-
12 ices otherwise included within outpatient critical
13 access hospital services, such amounts as would
14 otherwise be paid under this part if such serv-
15 ices were not included in outpatient critical ac-
16 cess hospital services.

17 “(3) ALL-INCLUSIVE RATE.—If a hospital elects
18 this paragraph to apply, with respect to both facility
19 services and professional services, there shall be paid
20 amounts equal to the reasonable costs of the critical
21 access hospital in providing such services, less the
22 amount that such hospital may charge as described
23 in section 1866(a)(2)(A).”.

1 (2) EFFECTIVE DATE.—The amendment made
2 by subsection (a) shall apply for cost reporting peri-
3 ods beginning on or after October 1, 1999.

4 (e) ELIMINATION OF COINSURANCE FOR CLINICAL
5 DIAGNOSTIC LABORATORY TESTS FURNISHED BY A CRIT-
6 ICAL ACCESS HOSPITAL ON AN OUTPATIENT BASIS.—

7 (1) IN GENERAL.—Section 1833(a)(1)(D) (42
8 U.S.C. 1395l(a)(1)(D)) is amended by inserting “or
9 which are furnished on an outpatient basis by a crit-
10 ical access hospital” after “on an assignment-related
11 basis”.

12 (2) EFFECTIVE DATE.—The amendment made
13 by paragraph (1) shall apply to services furnished on
14 or after the date of the enactment of this Act.

15 (f) PARTICIPATION IN SWING BED PROGRAM.—Sec-
16 tion 1883 (42 U.S.C. 1395tt) is amended—

17 (1) in subsection (a)(1), by striking “(other
18 than a hospital which has in effect a waiver under
19 subparagraph (A) of the last sentence of section
20 1861(e))”; and

21 (2) in subsection (c), by striking “, or during
22 which there is in effect for the hospital a waiver
23 under subparagraph (A) of the last sentence of sec-
24 tion 1861(e)”.

1 **SEC. 404. FIVE-YEAR EXTENSION OF MEDICARE DEPEND-**
2 **ENT HOSPITAL (MDH) PROGRAM.**

3 (a) EXTENSION OF PAYMENT METHODOLOGY.—Sec-
4 tion 1886(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(G)), as
5 amended by section 4204(a)(1) of BBA, is amended—

6 (1) in clause (i), by striking “and before Octo-
7 ber 1, 2001,” and inserting “and before October 1,
8 2006”; and

9 (2) in clause (ii)(II), by striking “and before
10 October 1, 2001,” and inserting “and before Octo-
11 ber 1, 2006”.

12 (b) CONFORMING AMENDMENTS.—

13 (1) EXTENSION OF TARGET AMOUNT.—Section
14 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)), as
15 amended by section 4204(a)(2) of BBA, is
16 amended—

17 (A) in the matter preceding clause (i), by
18 striking “and before October 1, 2001,” and in-
19 serting “and before October 1, 2006”; and

20 (B) in clause (iv), by striking “during fis-
21 cal year 1998 through fiscal year 2000” and in-
22 serting “during fiscal year 1998 through fiscal
23 year 2005”.

24 (2) PERMITTING HOSPITALS TO DECLINE RE-
25 CLASSIFICATION.—Section 13501(e)(2) of Omnibus
26 Budget Reconciliation Act of 1993 (42 U.S.C.

1 1395ww note), as amended by section 4204(a)(3) of
2 BBA, is amended by striking “or fiscal year 2000”
3 and inserting “or fiscal year 2000 through fiscal
4 year 2005”.

5 **SEC. 405. REBASING FOR CERTAIN SOLE COMMUNITY HOS-**
6 **PITALS.**

7 Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)), as
8 amended by sections 4413 and 4414 of BBA, is
9 amended—

10 (1) in subparagraph (C), by inserting “subject
11 to subparagraph (I)” before “the term ‘target
12 amount’ means”; and

13 (2) by adding at the end the following new sub-
14 paragraph:

15 “(I)(i) For cost reporting periods beginning on or
16 after October 1, 2000, in the case of a sole community
17 hospital that for its cost reporting period beginning during
18 1999 is paid on the basis of the target amount applicable
19 to the hospital under subparagraph (C) and that elects
20 (in a form and manner determined by the Secretary) this
21 subparagraph to apply to the hospital, there shall be sub-
22 stituted for the base cost reporting period described in
23 subparagraph (C) the rebased target amount determined
24 under this subparagraph.

1 “(ii) For purposes of clause (i), the rebased target
2 amount applicable to a hospital making an election under
3 this subparagraph is equal to the sum of the following:

4 “(I) With respect to discharges occurring in fis-
5 cal year 2001, 75 percent of the target amount ap-
6 plicable to the hospital under subparagraph (C)
7 (hereinafter in this subparagraph referred to as the
8 ‘subparagraph (C) target amount’) and 25 percent
9 of the amount of the allowable operating costs of in-
10 patient hospital services (as defined in subsection
11 (a)(4)) recognized under this title for the hospital
12 for the 12-month cost reporting period beginning
13 during fiscal year 1996 (hereinafter in this subpara-
14 graph referred to as the ‘rebased target amount’),
15 increased by the applicable percentage increase
16 under subparagraph (B)(iv).

17 “(II) With respect to discharges occurring in
18 fiscal year 2002, 50 percent of the subparagraph (C)
19 target amount and 50 percent of the rebased target
20 amount, increased by the applicable percentage in-
21 crease under subparagraph (B)(iv).

22 “(III) With respect to discharges occurring in
23 fiscal year 2003, 25 percent of the subparagraph (C)
24 target amount and 75 percent of the rebased target

1 amount, increased by the applicable percentage in-
 2 crease under subparagraph (B)(iv).

3 “(IV) With respect to discharges occurring in
 4 fiscal year 2003 or any subsequent fiscal year, 100
 5 percent of the rebased target amount, increased by
 6 the applicable percentage increase under subpara-
 7 graph (B)(iv).”.

8 **SEC. 406. INCREASED FLEXIBILITY IN PROVIDING GRAD-**
 9 **UATE PHYSICIAN TRAINING IN RURAL AREAS.**

10 (a) PERMITTING 30 PERCENT EXPANSION IN CUR-
 11 RENT GME TRAINING PROGRAMS FOR HOSPITALS LO-
 12 CATED IN RURAL AREAS.—

13 (1) PAYMENT FOR DIRECT GRADUATE MEDICAL
 14 EDUCATION COSTS.—Section 1886(h)(4)(F) (42
 15 U.S.C. 1395ww(h)(4)(F)), as added by section 4623
 16 of BBA, is amended by inserting “(or, 130 percent
 17 of such number in the case of a hospital located in
 18 a rural area)” after “may not exceed the number”.

19 (2) PAYMENT FOR INDIRECT GRADUATE MED-
 20 ICAL EDUCATION COSTS.—Section 1886(d)(5)(B)(v)
 21 (42 U.S.C. 1395ww(d)(5)(B)(v)), as added by sec-
 22 tion 4621(b)(1) of BBA, is amended by inserting
 23 “(or, 130 percent of such number in the case of a
 24 hospital located in a rural area)” after “may not ex-
 25 ceed the number”.

1 (3) EFFECTIVE DATES.—(A) The amendment
2 made by paragraph (1) applies to cost reporting pe-
3 riods beginning on or after October 1, 1999.

4 (B) The amendment made by paragraph (2) ap-
5 plies to discharges occurring on or after October 1,
6 1999.

7 (b) SPECIAL RULE FOR NON-RURAL FACILITIES
8 SERVING RURAL AREAS.—

9 (1) IN GENERAL.—Section 1886(h)(4)(H) (42
10 U.S.C. 1395ww(h)(4)(H)), as added by section 4623
11 of BBA, is amended by adding at the end the fol-
12 lowing new clause:

13 “(iv) NON-RURAL HOSPITALS OPER-
14 ATING TRAINING PROGRAMS IN UNDER-
15 SERVED RURAL AREAS.—In the case of a
16 hospital that is not located in a rural area
17 but establishes separately accredited ap-
18 proved medical residency training pro-
19 grams (or rural tracks) in an underserved
20 rural area or has an accredited training
21 program with an integrated rural track,
22 the Secretary shall adjust the limitation
23 under subparagraph (F) in an appropriate
24 manner insofar as it applies to such pro-
25 grams in such underserved rural areas in

1 order to encourage the training of physi-
2 cians in underserved rural areas.”.

3 (2) EFFECTIVE DATE.—The amendment made
4 by paragraph (1) applies with respect to—

5 (A) payments to hospitals under section
6 1886(h) of the Social Security Act (42 U.S.C.
7 1395ww(h)) for cost reporting periods begin-
8 ning on or after October 1, 1999; and

9 (B) payments to hospitals under section
10 1886(d)(5)(B)(v) of such Act (42 U.S.C.
11 1395ww(d)(5)(B)(v)) for discharges occurring
12 on or after October 1, 1999.

13 **SEC. 407. ELIMINATION OF CERTAIN RESTRICTIONS WITH**
14 **RESPECT TO HOSPITAL SWING BED PRO-**
15 **GRAM.**

16 (a) ELIMINATION OF REQUIREMENT FOR STATE
17 CERTIFICATE OF NEED.—Section 1883(b) (42 U.S.C.
18 1395tt(b)) is amended to read as follows:

19 “(b) The Secretary may not enter into an agreement
20 under this section with any hospital unless, except as pro-
21 vided under subsection (g), the hospital is located in a
22 rural area and has less than 100 beds.”.

23 (b) ELIMINATION OF SWING BED RESTRICTIONS ON
24 CERTAIN HOSPITALS WITH MORE THAN 49 BEDS.—Sec-
25 tion 1883(d) (42 U.S.C. 1395tt(d)) is amended—

1 (1) by striking paragraphs (2) and (3); and

2 (2) by striking “(d)(1)” and inserting “(d)”.

3 (c) EFFECTIVE DATE.—The amendments made by
4 this section take effect on the date that is the first day
5 after the expiration of the transition period under section
6 1888(e)(2)(E) of the Social Security Act (42 U.S.C.
7 1395yy(e)(2)(E)), as added by section 4432(a) of BBA,
8 for payments for covered skilled nursing facility services
9 under the Medicare program.

10 **SEC. 408. GRANT PROGRAM FOR RURAL HOSPITAL TRANSI-**
11 **TION TO PROSPECTIVE PAYMENT.**

12 Section 1820(g) (42 U.S.C. 1395i–4(g)), as added by
13 section 4201(a) of BBA, is amended by adding at the end
14 the following new paragraph:

15 “(3) UPGRADING DATA SYSTEMS.—

16 “(A) GRANTS TO HOSPITALS.—The Sec-
17 retary may award grants to hospitals that have
18 submitted applications in accordance with sub-
19 paragraph (C) to assist eligible small rural hos-
20 pitals in meeting the costs of implementing data
21 systems required to meet requirements estab-
22 lished under the Medicare program pursuant to
23 amendments made by the Balanced Budget Act
24 of 1997.

1 “(B) ELIGIBLE SMALL RURAL HOSPITAL
2 DEFINED.—For purposes of this paragraph, the
3 term ‘eligible small rural hospital’ means a non-
4 Federal, short-term general acute care hospital
5 that—

6 “(i) is located in a rural area (as de-
7 fined for purposes of section 1886(d)); and

8 “(ii) has less than 50 beds.

9 “(C) APPLICATION.—A hospital seeking a
10 grant under this paragraph shall submit an ap-
11 plication to the Secretary on or before such
12 date and in such form and manner as the Sec-
13 retary specifies.

14 “(D) AMOUNT OF GRANT.—A grant to a
15 hospital under this paragraph may not exceed
16 \$50,000.

17 “(E) USE OF FUNDS.—A hospital receiving
18 a grant under this paragraph may use the
19 funds for the purchase of computer software
20 and hardware and for the education and train-
21 ing of hospital staff on computer information
22 systems and costs related to the implementation
23 of prospective payment systems.

24 “(F) REPORT.—

1 “(i) INFORMATION.—A hospital re-
2 ceiving a grant under this section shall fur-
3 nish the Secretary with such information
4 as the Secretary may require to evaluate
5 the project for which the grant is made
6 and to ensure that the grant is expended
7 for the purposes for which it is made.

8 “(ii) REPORTING.—

9 “(I) INTERIM REPORTS.—The
10 Secretary shall report to the Com-
11 mittee on Ways and Means of the
12 House of Representatives and the
13 Committee on Finance of the Senate
14 at least annually on the grant pro-
15 gram established under this section,
16 including in such report information
17 on the number of grants made, the
18 nature of the projects involved, the ge-
19 ographic distribution of grant recipi-
20 ents, and such other matters as the
21 Secretary deems appropriate.

22 “(II) FINAL REPORT.—The Sec-
23 retary shall submit a final report to
24 such committees not later than 180
25 days after the completion of all of the

1 projects for which a grant is made
2 under this section.”.

3 **SEC. 409. MEDPAC STUDY OF RURAL PROVIDERS.**

4 (a) STUDY.—The Medicare Payment Advisory Com-
5 mission shall conduct a study on rural providers fur-
6 nishing items and services for which payment is made
7 under title XVIII of the Social Security Act. Such study
8 shall examine and evaluate the adequacy and appropriate-
9 ness of the categories of special payments (and payment
10 methodologies) established for rural hospitals under the
11 Medicare program, and their impact on beneficiary access
12 and quality of health care services.

13 (b) REPORT.—By not later than 18 months after the
14 date of the enactment of this Act, the Medicare Payment
15 Advisory Commission shall submit to Congress a report
16 on the study conducted under subsection (a).

17 **SEC. 410. EXPANSION OF ACCESS TO PARAMEDIC INTER-**
18 **CEPT SERVICES IN RURAL AREAS.**

19 (a) EXPANSION OF PAYMENT AREAS.—Section
20 4531(c) of BBA (42 U.S.C. 1395x(s)(7) note; 111 Stat.
21 452) is amended by adding at the end the following flush
22 sentence:

23 “For purposes of this subsection, an area shall be treated
24 as a rural area if it is designated as a rural area by any
25 law or regulation of the State or if it is located in a rural

1 census tract of a metropolitan statistical area (as deter-
 2 mined under the Goldsmith Modification, as published in
 3 the Federal Register on February 27, 1992 (57 Fed. Reg.
 4 6725)).”.

5 (b) EFFECTIVE DATE.—The amendment made by
 6 subsection (a) takes effect on January 1, 2000, and ap-
 7 plies to paramedic intercept services furnished on or after
 8 such date.

9 **TITLE V—PROVISIONS RELAT-**
 10 **ING TO PART C**
 11 **(MEDICARE+CHOICE PRO-**
 12 **GRAM)**

13 **Subtitle A—Medicare+Choice**

14 **SEC. 501. PHASE-IN OF NEW RISK ADJUSTMENT METHOD-**
 15 **LOGY.**

16 Section 1853(a)(3)(C) (42 U.S.C. 1395w-
 17 23(a)(3)(C)) is amended—

18 (1) by redesignating the first sentence as clause
 19 (i) with the heading “IN GENERAL.—” and appro-
 20 priate indentation; and

21 (2) by adding at the end the following new
 22 clause:

23 “(ii) PHASE-IN.—Such risk adjust-
 24 ment methodology shall be implemented in
 25 a phased-in manner so that the method-

1 ology insofar as it makes adjustments for
2 health status based on clinical data applies
3 to—

4 “(I) not more than 10 percent of
5 the payment amount in 2000 and
6 2001;

7 “(II) not more than 20 percent
8 of such amount in 2002;

9 “(III) not more than 30 percent
10 of such amount in 2003; and

11 “(IV) 100 percent of such
12 amount in any subsequent year (at
13 which time the risk adjustment meth-
14 odology should reflect data from mul-
15 tiple settings).”.

16 **SEC. 502. ENCOURAGING OFFERING OF MEDICARE+CHOICE**
17 **PLANS IN AREAS WITHOUT PLANS.**

18 Section 1853 (42 U.S.C. 1395w-23) is amended—

19 (1) in subsection (a)(1), by striking “sub-
20 sections (e) and (f)” and inserting “subsections (e),
21 (g), and (i)”;

22 (2) in subsection (c)(5), by inserting “(other
23 than those attributable to subsection (i))” after
24 “payments under this part”; and

1 (3) by adding at the end the following new sub-
2 section:

3 “(i) NEW ENTRY BONUS.—

4 “(1) IN GENERAL.—Subject to paragraphs (2)
5 and (3), in the case of Medicare+Choice payment
6 area in which a Medicare+Choice plan has not been
7 offered since 1997 (or in which all organizations
8 that offered a plan since such date have filed notice
9 with the Secretary, as of October 13, 1999, that
10 they will not be offering such a plan as of January
11 1, 2000), the amount of the monthly payment other-
12 wise made under this subsection shall be increased—

13 “(A) only for the first 12 months in which
14 any Medicare+Choice plan is offered in the
15 area, by 5 percent of the total monthly payment
16 otherwise computed for such payment area; and

17 “(B) only for the subsequent 12 months,
18 by 3 percent of the total monthly payment oth-
19 erwise computed for such payment area.

20 “(2) PERIOD OF APPLICATION.—Paragraph (1)
21 shall only apply to payment for Medicare+Choice
22 plans which are first offered in a Medicare+Choice
23 payment area during the 2-year period beginning
24 with January 1, 2000.

1 “(3) LIMITATION TO ORGANIZATION OFFERING
 2 FIRST PLAN IN AN AREA.—Paragraph (1) shall only
 3 apply to payment to the first Medicare+Choice orga-
 4 nization that offers a Medicare+Choice plan in each
 5 Medicare+Choice payment area, except that if more
 6 than one such organization first offers such a plan
 7 in an area on the same date, paragraph (1) shall
 8 apply to payment for such organizations.

9 “(4) CONSTRUCTION.—Nothing in paragraph
 10 (1) shall be construed as affecting the calculation of
 11 the annual Medicare+Choice capitation rate for any
 12 payment area under subsection (c) or as applying to
 13 payment for any period not described in such para-
 14 graph.

15 “(5) OFFERED DEFINED.—In this subsection,
 16 the term ‘offered’ means, with respect to a
 17 Medicare+Choice plan as of a date, that a
 18 Medicare+Choice eligible individual may enroll with
 19 the plan on that date, regardless of when the enroll-
 20 ment takes effect or the individual obtain benefits
 21 under the plan.”.

22 **SEC. 503. MODIFICATION OF 5-YEAR RE-ENTRY RULE FOR**
 23 **CONTRACT TERMINATIONS.**

24 (a) IN GENERAL.—Section 1857(c)(4) (42 U.S.C.
 25 1395w-27(c)(4)) is amended—

1 (1) by inserting “as provided in paragraph (2)
2 and except” after “except”;

3 (2) by redesignating the first sentence as a sub-
4 paragraph (A) with an appropriate indentation and
5 the heading “IN GENERAL.—”; and

6 (3) by adding at the end the following new sub-
7 paragraph:

8 “(B) EARLIER RE-ENTRY PERMITTED
9 WHERE CHANGE IN PAYMENT POLICY AND NO
10 MORE THAN ONE OTHER PLAN AVAILABLE.—
11 Subparagraph (A) shall not apply with respect
12 to the offering by a Medicare+Choice organiza-
13 tion of a Medicare+Choice plan in a
14 Medicare+Choice payment area if—

15 “(i) during the 6-month period begin-
16 ning on the date the organization notified
17 the Secretary of the intention to terminate
18 the most recent previous contract, there
19 was a legislative change enacted (or a reg-
20 ulatory change adopted) that has the effect
21 of increasing payment rates under section
22 1853 for that Medicare+Choice payment
23 area; and

24 “(ii) at the time the organization noti-
25 fies the Secretary of its intent to enter into

1 a contract to offer such a plan in the area,
2 there is no more than one
3 Medicare+Choice plan offered in the
4 area.”.

5 (b) EFFECTIVE DATE.—The amendments made by
6 subsection (a) shall apply to contract terminations occur-
7 ring before, on, or after the date of the enactment of this
8 Act.

9 **SEC. 504. CONTINUED COMPUTATION AND PUBLICATION**
10 **OF AAPCC DATA.**

11 (a) IN GENERAL.—Section 1853(b) (42 U.S.C.
12 1395w-23(b)) is amended by adding at the end the fol-
13 lowing new paragraph:

14 “(4) CONTINUED COMPUTATION AND PUBLICA-
15 TION OF COUNTY-SPECIFIC PER CAPITA FEE-FOR-
16 SERVICE EXPENDITURE INFORMATION.—The Sec-
17 retary, through the Chief Actuary of the Health
18 Care Financing Administration, shall provide for the
19 computation and publication, on an annual basis at
20 the time of publication of the annual
21 Medicare+Choice capitation rates, of information on
22 the level of the average annual per capita costs (de-
23 scribed in section 1876(a)(4)) for each
24 Medicare+Choice payment area.”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall take effect on the date of the enact-
3 ment of this Act and apply to publications of the annual
4 Medicare+Choice capitation rates made on or after such
5 date.

6 **SEC. 505. CHANGES IN MEDICARE+CHOICE ENROLLMENT**
7 **RULES.**

8 (a) PERMITTING ENROLLMENT IN ALTERNATIVE
9 MEDICARE+CHOICE PLANS AND MEDIGAP COVERAGE IN
10 CASE OF INVOLUNTARY TERMINATION OF
11 MEDICARE+CHOICE ENROLLMENT.—

12 (1) IN GENERAL.—Section 1851(e)(4) (42
13 U.S.C. 1395w–21(e)(4)) is amended by striking sub-
14 paragraph (A) and inserting the following:

15 “(A)(i) the certification of the organization
16 or plan under this part has been terminated, or
17 the organization or plan has notified the indi-
18 vidual or the Secretary of an impending termi-
19 nation of such certification; or

20 “(ii) the organization has terminated or
21 otherwise discontinued providing the plan in the
22 area in which the individual resides, or has no-
23 tified the individual or Secretary of an impend-
24 ing termination or discontinuation of such
25 plan;”.

1 (2) CONFORMING MEDIGAP AMENDMENT.—Sec-
2 tion 1882(s)(3) (42 U.S.C. 1395ss(s)(3)) is
3 amended—

4 (A) in subparagraph (A), by inserting “,
5 subject to subparagraph (E),” after “in the
6 case of an individual described in subparagraph
7 (B) who”; and

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

10 “(E)(i) An individual described in subparagraph
11 (B)(ii) may elect to apply subparagraph (A) by sub-
12 stituting, for the date of termination of enrollment, the
13 date on which the individual or Secretary was notified by
14 the Medicare+Choice organization of the impending ter-
15 mination or discontinuance of the Medicare+Choice plan
16 in the area in which the individual resides, but only if the
17 individual disenrolls from the plan as a result of such noti-
18 fication.

19 “(ii) In the case of an individual making such an elec-
20 tion, the issuer involved shall accept the application of the
21 individual submitted before the date of termination of en-
22 rollment, but the coverage under subparagraph (A) shall
23 only become effective upon termination of coverage under
24 the Medicare+Choice plan involved.”.

1 (3) EFFECTIVE DATE.—The amendments made
 2 by this subsection shall apply to notices of impend-
 3 ing terminations or discontinuances made on or
 4 after the date of the enactment of this Act.

5 (b) CONTINUOUS OPEN ENROLLMENT FOR INSTITU-
 6 TIONALIZED INDIVIDUALS.—Section 1851(e)(2) (42
 7 U.S.C. 1395w–21(e)(2)) is amended—

8 (1) in subparagraph (B)(i), by inserting “and
 9 subparagraph (D)” after “clause (ii)”;

10 (2) in subparagraph (C)(i), by inserting “and
 11 subparagraph (D)” after “clause (ii)”; and

12 (3) by adding at the end the following new sub-
 13 paragraph:

14 “(D) CONTINUOUS OPEN ENROLLMENT
 15 FOR INSTITUTIONALIZED INDIVIDUALS.—At
 16 any time after 2001 in the case of a
 17 Medicare+Choice eligible individual who is in-
 18 stitutionalized, the individual may change the
 19 election under subsection (a)(1).”.

20 (c) CONTINUING ENROLLMENT FOR CERTAIN EN-
 21 ROLLEES.—Section 1851(b)(1) (42 U.S.C. 1395w–
 22 21(b)(1)) is amended—

23 (1) in subparagraph (A), by inserting “and ex-
 24 cept as provided in subparagraph (C)” after “may
 25 otherwise provide”; and

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

3 “(C) CONTINUATION OF ENROLLMENT
4 PERMITTED WHERE SERVICE CHANGED.—Not-
5 withstanding subparagraph (B), if a
6 Medicare+Choice organization eliminates from
7 its service area a geographic area that was pre-
8 viously within its service area, the organization
9 may elect to offer individuals residing in all or
10 portions of the affected geographic area who
11 would otherwise be ineligible to continue enroll-
12 ment the option to continue enrollment in a
13 Medicare+Choice plan it offers so long as—

14 “(i) the enrollee agrees to receive the
15 full range of basic benefits (excluding
16 emergency and urgently needed care) ex-
17 clusively at facilities designated by the or-
18 ganization within the plan service area;
19 and

20 “(ii) there is no other
21 Medicare+Choice plan offered in the area
22 in which the enrollee resides at the time of
23 the organization’s election.”.

24 (d) EFFECTIVE DATE.—The amendments made by
25 subsections (b) and (c) apply as if included in the enact-

1 ment of BBA and the amendments made by subsection
 2 (c) apply to eliminations of geographic areas from a serv-
 3 ice area that occur before, on, or after the date of the
 4 enactment of this Act.

5 **SEC. 506. ALLOWING VARIATION IN PREMIUM WAIVERS**
 6 **WITHIN A SERVICE AREA IF**
 7 **MEDICARE+CHOICE PAYMENT RATES VARY**
 8 **WITHIN THE AREA.**

9 (a) IN GENERAL.—Section 1854(c) (42 U.S.C.
 10 1395w–24(c)) is amended—

11 (1) by striking “The” and inserting “Subject to
 12 paragraph (2), the”;

13 (2) by redesignating the first sentence as a
 14 paragraph (1) with an appropriate indentation and
 15 the heading “IN GENERAL.—”; and

16 (3) by adding at the end the following new
 17 paragraph:

18 “(2) VARIATION IN PREMIUM WAIVER PER-
 19 MITTED.—A Medicare+Choice organization may
 20 waive part or all of a premium described in para-
 21 graph (1) for one or more Medicare+Choice pay-
 22 ment areas within its service area if the annual
 23 Medicare+Choice capitation rates under section
 24 1853(c) vary between such payment area and other
 25 payment areas within such service area.”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) apply to premiums for contract years begin-
3 ning on or after January 1, 2001.

4 **SEC. 507. DELAY IN DEADLINE FOR SUBMISSION OF AD-**
5 **JUSTED COMMUNITY RATES AND RELATED**
6 **INFORMATION.**

7 (a) DELAY IN DEADLINE FOR SUBMISSION OF AD-
8 JUSTED COMMUNITY RATES AND RELATED INFORMA-
9 TION.—Section 1854(a)(1) (42 U.S.C. 1395w–24(a)(1)) is
10 amended by striking “May 1” and inserting “July 1”.

11 (b) ADJUSTMENT IN INFORMATION DISCLOSURE
12 PROVISIONS.—Section 1851(d)(2)(A)(ii) (42 U.S.C.
13 1395w–21(d)(2)(A)(ii)) is amended by inserting after “in-
14 formation described in paragraph (4) concerning such
15 plans” the following: “, to the extent such information is
16 available at the time of preparation of the material for
17 mailing”.

18 (c) EFFECTIVE DATE.—The amendments made by
19 this section apply with respect to information submitted
20 by Medicare+Choice organizations (and provided to bene-
21 ficiaries) for years beginning with 1999.

1 **SEC. 508. TWO-YEAR EXTENSION OF MEDICARE COST CON-**
2 **TRACTS.**

3 Section 1876(h)(5)(B) (42 U.S.C.
4 1395mm(h)(5)(B)) is amended by striking “2002” and in-
5 serting “2004”.

6 **SEC. 509. MEDICARE+CHOICE NURSING AND ALLIED**
7 **HEALTH PROFESSIONAL EDUCATION PAY-**
8 **MENTS.**

9 Section 1886(d)(11) (42 U.S.C. 1395ww(d)(11)) is
10 amended—

11 (1) in subparagraph (A)—

12 (A) by designating the portion following
13 “IN GENERAL.—” as a clause (i) with the head-
14 ing “GRADUATE MEDICAL TRAINING.—” and
15 appropriate indentation; and

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

18 “(ii) NURSING AND ALLIED HEALTH
19 TRAINING.—For portions of cost reporting
20 periods occurring on or after January 1,
21 2000, the Secretary shall provide for an
22 additional payment amount for each appli-
23 cable discharge of any subsection (d) hos-
24 pital that has direct costs of approved edu-
25 cation activities for nurse and allied health
26 professional training.”;

1 (2) in subparagraph (C)—

2 (A) designating the portion following “DE-
3 TERMINATION OF AMOUNT.—” as a clause (i)
4 with the heading “GRADUATE MEDICAL TRAIN-
5 ING.—” and appropriate indentation;

6 (B) by striking “under this paragraph”
7 and inserting “under subparagraph (A)(i)”;

8 (C) by inserting “the DGME portion (as
9 defined in clause (iii)) of” after “shall be equal
10 to”; and

11 (D) by adding at the end the following new
12 clauses:

13 “(ii) NURSING AND ALLIED HEALTH
14 TRAINING.—The amount of the payment
15 under subparagraph (A)(ii) with respect to
16 any applicable discharge shall be equal to
17 an amount specified by the Secretary in a
18 manner consistent with the following:

19 “(I) The total payments under
20 such subparagraph in a year shall
21 bear the same ratio to the Secretary’s
22 estimate of the total payments under
23 subparagraph (A)(i) in the year as the
24 ratio (as estimated by the Secretary)
25 of the total payments under this title

1 for direct costs described in subpara-
2 graph (A)(ii) in the year bear to the
3 total payments under section 1886(h)
4 in the year; but in no case shall the
5 total payments under subparagraph
6 (A)(ii) exceed \$60,000,000 in a year.

7 “(II) The payments to different
8 hospitals are proportional to the direct
9 costs of each hospital described in
10 subparagraph (A)(ii).

11 “(iii) DGME PORTION DEFINED.—
12 For purposes of this subparagraph, the
13 ‘DGME portion’ means, for a year, the
14 ratio of—

15 “(I) the amount by which (aa)
16 the Secretary’s estimate of the total
17 additional payments that would be
18 payable under this paragraph for the
19 year if subparagraph (A)(ii) and
20 clause (ii) of this subparagraph did
21 not apply, exceeds (bb) the total pay-
22 ments in the year under subparagraph
23 (A)(ii), to

1 “(II) the total additional pay-
 2 ments estimated under subclause
 3 (I)(aa) for the year.”.

4 **SEC. 510. REDUCTION IN ADJUSTMENT IN NATIONAL PER**
 5 **CAPITA MEDICARE+CHOICE GROWTH PER-**
 6 **CENTAGE FOR 2002.**

7 Section 1853(c)(6)(B)(iv) (42 U.S.C. 1395w-
 8 23(c)(6)(B)(iv)) is amended by striking “0.5 percentage
 9 points” and inserting “0.3 percentage points”.

10 **SEC. 511. DEEMING OF MEDICARE+CHOICE ORGANIZATION**
 11 **TO MEET REQUIREMENTS.**

12 Section 1852(e)(4) (42 U.S.C. 1395w-22(e)(4)) is
 13 amended to read as follows:

14 “(4) TREATMENT OF ACCREDITATION.—The
 15 Secretary shall provide that a Medicare+Choice or-
 16 ganization is deemed to meet requirements of para-
 17 graphs (1) and (2) of this subsection and subsection
 18 (h) (relating to confidentiality and accuracy of en-
 19 rollee records) if the organization is accredited (and
 20 periodically reaccredited) by a private accrediting or-
 21 ganization under a process that the Secretary has
 22 determined assures that the accrediting organization
 23 applies standards that meet or exceed the standards
 24 established under section 1856 to carry out the re-
 25 spective requirements. The Secretary shall deter-

1 mine, within 210 days after the date the Secretary
 2 receives an application by a private accrediting orga-
 3 nization, whether the process of the private accred-
 4 iting organization meets the requirements of the pre-
 5 ceding sentence using the criteria specified in section
 6 1865(b)(2). The Secretary shall, using the process
 7 described in section 1865(b), deem a
 8 Medicare+Choice organization that is so accredited
 9 as meeting the requirements of paragraphs (1) and
 10 (2) of this subsection and subsection (h).”

11 **SEC. 512. MISCELLANEOUS CHANGES AND STUDIES.**

12 (a) PERMITTING RELIGIOUS FRATERNAL BENEFIT
 13 SOCIETIES TO OFFER A RANGE OF MEDICARE+CHOICE
 14 PLANS.—Section 1859(e)(2) (42 U.S.C. 1395w–29(e)(2))
 15 is amended in the matter preceding subparagraph (A) by
 16 striking “section 1851(a)(2)(A)” and inserting “section
 17 1851(a)(2)”.

18 (b) STUDY OF ACCOUNTING FOR VA AND DOD EX-
 19 PENDITURES FOR MEDICARE BENEFICIARIES.—The Sec-
 20 retary of Health and Human Services, jointly with the
 21 Secretaries of Defense and of Veterans Affairs, shall sub-
 22 mit to Congress not later than 1 year after the date of
 23 the enactment of this Act a report on the estimated use
 24 of health care services furnished by the Departments of
 25 Defense and of Veterans Affairs to Medicare beneficiaries,

1 including both beneficiaries under the original Medicare
2 fee-for-service program and under the Medicare+Choice
3 program. The report shall include an analysis of how best
4 to properly account for expenditures for such services in
5 the computation of Medicare+Choice capitation rates.

6 (c) PROMOTING PROMPT IMPLEMENTATION OF
7 INFORMATICS, TELEMEDICINE, AND EDUCATION DEM-
8 ONSTRATION PROJECT.—Section 4207 of BBA is
9 amended—

10 (1) in subsection (a)(1), by adding at the end
11 the following: “The Secretary shall make an award
12 for such project not later than 3 months after the
13 date of the enactment of the Medicare, Medicaid,
14 and SCHIP Balanced Budget Refinement Act of
15 1999. The Secretary shall accept the proposal ad-
16 judged to be the best technical proposal as of such
17 date of the enactment without the need for addi-
18 tional review or resubmission of proposals.”;

19 (2) in subsection (a)(2)(A), by inserting before
20 the period at the end the following: “that qualify as
21 Federally designated medically underserved areas or
22 health professional shortage areas at the time of en-
23 rollment of beneficiaries under the project”;

1 (3) in subsection (c)(2), by striking “and the
2 source and amount of non-Federal funds used in the
3 project”;

4 (4) in subsection (d)(2)(A), by striking “at a
5 rate of 50 percent of the costs that are reasonable
6 and” and inserting “for the costs that are related”;

7 (5) in subsection (d)(2)(B)(i), by striking “(but
8 only in the case of patients located in medically un-
9 derserved areas)” and inserting “or at sites pro-
10 viding health care to patients located in medically
11 underserved areas”;

12 (6) in subsection (d)(2)(C)(i), by striking “to
13 deliver medical informatics services under” and in-
14 serting “for activities related to”; and

15 (7) by amending paragraph (4) of subsection
16 (d) to read as follows:

17 “(4) COST-SHARING.—The project may not im-
18 pose cost sharing on a Medicare beneficiary for the
19 receipt of services under the project. Project costs
20 will cover all costs to patients and providers related
21 to participation in the project.”.

22 **SEC. 513. MEDPAC REPORT ON MEDICARE MSA (MEDICAL**
23 **SAVINGS ACCOUNT) PLANS.**

24 Not later than 1 year after the date of the enactment
25 of this Act, the Medicare Payment Advisory Commission

1 shall submit to Congress a report on specific legislative
 2 changes that should be made to make MSA plans a viable
 3 option under the Medicare+Choice program.

4 **SEC. 514. CLARIFICATION OF NONAPPLICABILITY OF CER-**
 5 **TAIN PROVISIONS OF DISCHARGE PLANNING**
 6 **PROCESS TO MEDICARE+CHOICE PLANS.**

7 (a) IN GENERAL.—Section 1861(ee)(2)(H) (42
 8 U.S.C. 1395x(ee)(2)(H)), as added by section 4431 of
 9 BBA, is amended—

10 (1) in clause (i)—

11 (A) by striking “not specify” and inserting
 12 “subject to clause (iii), not specify”; and

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

14 (2) in clause (ii), by striking the period at the
 15 end and inserting “, and”; and

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

18 “(iii) for individuals enrolled under a
 19 Medicare+Choice plan, under a contract with
 20 the Secretary under section 1857, for whom a
 21 hospital furnishes inpatient hospital services,
 22 the hospital may specify with respect to such
 23 individual the provider of post-hospital home
 24 health services or other post-hospital services
 25 under the plan.”.

**Subtitle B—Managed Care
Demonstration Projects**

SEC. 521. EXTENSION OF SOCIAL HEALTH MAINTENANCE

ORGANIZATION DEMONSTRATION (SHMO)

PROJECT AUTHORITY.

(a) EXTENSION.—Section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203), as amended by section 4014(a)(1) of BBA, is amended—

(1) in paragraph (1), by striking “December 31, 2000” and inserting “the date that is 18 months after the date that the Secretary submits to Congress the report described in section 4014(c) of the Balanced Budget Act of 1997”; and

(2) by adding at the end of paragraph (4) the following: “Not later than 6 months after the date the Secretary submits such final report, the Medicare Payment Advisory Commission shall submit to Congress a report containing recommendations regarding such project.”.

(b) SUBSTITUTION OF AGGREGATE CAP.—Section 13567(c) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), as amended by section 4014(b) of BBA, is amended to read as follows:

“(c) AGGREGATE LIMIT ON NUMBER OF MEMBERS.—The Secretary of Health and Human Services

1 may not impose a limit on the number of individuals that
2 may participate in a project conducted under section 2355
3 of the Deficit Reduction Act of 1984, other than an aggre-
4 gate limit of not less than 324,000 for all sites.”.

5 **SEC. 522. EXTENSION OF MEDICARE COMMUNITY NURSING**
6 **ORGANIZATION DEMONSTRATION PROJECT.**

7 (a) EXTENSION.—Notwithstanding any other provi-
8 sion of law, any demonstration project conducted under
9 section 4079 of the Omnibus Budget Reconciliation Act
10 of 1987 (Public Law 100–123) and conducted for the ad-
11 ditional period of 2 years as provided for under section
12 4019 of BBA, shall be conducted for an additional period
13 of 2 years.

14 (b) REPORT.—By not later than July 1, 2001, the
15 Secretary of Health and Human Services shall submit to
16 Congress a report describing the results of any demonstra-
17 tion project conducted under section 4079 of the Omnibus
18 Budget Reconciliation Act of 1987, and describing the
19 data collected by the Secretary relevant to the analysis of
20 the results of such project, including the most recently
21 available data through the end of 2000.

22 **SEC. 523. MEDICARE+CHOICE COMPETITIVE BIDDING DEM-**
23 **ONSTRATION PROJECT.**

24 Section 4011 of BBA is amended—

25 (1) in subsection (a)—

1 (A) by striking “The Secretary” and in-
2 serting the following:

3 “(1) IN GENERAL.—Subject to the succeeding
4 provisions of this subsection, the Secretary”; and

5 (B) by adding at the end the following:

6 “(2) DELAY IN IMPLEMENTATION.—The Sec-
7 retary shall not implement the project until January
8 1, 2002, or, if later, 6 months after the date the
9 Competitive Pricing Advisory Committee has sub-
10 mitted to Congress a report on each of the following
11 topics:

12 “(A) INCORPORATION OF ORIGINAL FEE-
13 FOR-SERVICE MEDICARE PROGRAM INTO
14 PROJECT.—What changes would be required in
15 the project to feasibly incorporate the original
16 fee-for-service Medicare program into the
17 project in the areas in which the project is oper-
18 ational.

19 “(B) QUALITY ACTIVITIES.—The nature
20 and extent of the quality reporting and moni-
21 toring activities that should be required of plans
22 participating in the project, the estimated costs
23 that plans will incur as a result of these re-
24 quirements, and the current ability of the
25 Health Care Financing Administration to col-

1 lect and report comparable data, sufficient to
2 support comparable quality reporting and moni-
3 toring activities with respect to beneficiaries en-
4 rolled in the original fee-for-service Medicare
5 program generally.

6 “(C) RURAL PROJECT.—The current via-
7 bility of initiating a project site in a rural area,
8 given the site specific budget neutrality require-
9 ments of the project, and insofar as the Com-
10 mittee decides that the addition of such a site
11 is not viable, recommendations on how the
12 project might best be changed so that such a
13 site is viable.

14 “(D) BENEFIT STRUCTURE.—The nature
15 and extent of the benefit structure that should
16 be required of plans participating in the project,
17 the rationale for such benefit structure, the po-
18 tential implications that any benefit standard-
19 ization requirement may have on the number of
20 plan choices available to a beneficiary in an
21 area designated under the project, the potential
22 implications of requiring participating plans to
23 offer variations on any standardized benefit
24 package the committee might recommend, such
25 that a beneficiary could elect to pay a higher

1 percentage of out-of-pocket costs in exchange
2 for a lower premium (or premium rebate as the
3 case may be), and the potential implications of
4 expanding the project (in conjunction with the
5 potential inclusion of the original fee-for-service
6 Medicare program) to require Medicare supple-
7 mental insurance plans operating in an area
8 designated under the project to offer a coordi-
9 nated and comparable standardized benefit
10 package.

11 “(3) CONFORMING DEADLINES.—Any dates
12 specified in the succeeding provisions of this section
13 shall be delayed (as specified by the Secretary) in a
14 manner consistent with the delay effected under
15 paragraph (2).”; and

16 (2) in subsection (c)(1)(A)—

17 (A) by striking “and” at the end of clause
18 (i); and

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

21 “(iii) establish beneficiary premiums
22 for plans offered in such area in a manner
23 such that a beneficiary who enrolls in an
24 offered plan with a below average price (as
25 established by the competitive pricing

methodology established for such area) may, at the plan's election, be offered a rebate of some or all of the Medicare part B premium that such individual must otherwise pay in order to participate in a Medicare+Choice plan under the Medicare+Choice program; and”.

SEC. 524. EXTENSION OF MEDICARE MUNICIPAL HEALTH SERVICES DEMONSTRATION PROJECTS.

Section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended by section 6135 of the Omnibus Budget Reconciliation Act of 1989, section 13557 of the Omnibus Budget Reconciliation Act of 1993, and section 4017 of BBA, is amended by striking “December 31, 2000” and inserting “December 31, 2001”.

SEC. 525. MEDICARE COORDINATED CARE DEMONSTRATION PROJECT.

Section 4016(e)(1)(A)(ii) of the Balanced Budget Act of 1997 (42 U.S.C. 1395b–1 note) is amended to read as follows:

“(ii) CANCER HOSPITAL.—In the case of the project described in subsection (b)(2)(C), the Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund and the Federal Sup-

1 plementary Insurance Trust Fund under
 2 title XVIII of the Social Security Act (42
 3 U.S.C. 1395i, 1395t), in such proportions
 4 as the Secretary determines to be appro-
 5 priate, of such funds as are necessary to
 6 cover costs of the project, including costs
 7 for information infrastructure and recur-
 8 ring costs of case management services,
 9 flexible benefits, and program manage-
 10 ment.”.

11 **TITLE VI—MEDICAID**

12 **SEC. 601. MAKING MEDICAID DSH TRANSITION RULE PER-** 13 **MANENT.**

14 (a) IN GENERAL.—Section 4721(e) of the Balanced
 15 Budget Act of 1997 (42 U.S.C. 1396r–4 note) is
 16 amended—

17 (1) in the matter before paragraph (1), by
 18 striking “1923(g)(2)(A)” and “1396r–4(g)(2)(A)”
 19 and inserting “1923(g)(2)” and “1396r–4(g)(2)”,
 20 respectively;

21 (2) in paragraphs (1) and (2)—

22 (A) by striking “, and before July 1,
 23 1999”; and

1 (B) by striking “in such section” and in-
2 serting “in subparagraph (A) of such section”;
3 and

4 (3) by striking “and” at the end of paragraph
5 (1), by striking the period at the end of paragraph
6 (2) and inserting “; and”, and by adding at the end
7 the following new paragraph:

8 “(3) effective for State fiscal years that begin
9 on or after July 1, 1999, ‘or (b)(1)(B)’ were in-
10 serted in section 1923(g)(2)(B)(ii)(I) after
11 ‘(b)(1)(A)’.”.

12 (b) EFFECTIVE DATE.—The amendments made by
13 subsection (a) shall take effect as if included in the enact-
14 ment of section 4721(e) of the Balanced Budget Act of
15 1997 (Public Law 105–33; 110 Stat. 514).

16 **SEC. 602. INCREASE IN DSH ALLOTMENT FOR CERTAIN**
17 **STATES AND THE DISTRICT OF COLUMBIA.**

18 (a) IN GENERAL.—The table in section 1923(f)(2)
19 (42 U.S.C. 1396r–4(f)(2)) is amended under each of the
20 columns for FY 00, FY 01, and FY 02—

21 (1) in the entry for the District of Columbia, by
22 striking “23” and inserting “32”;

23 (2) in the entry for Minnesota, by striking “16”
24 and inserting “33”;

1 (3) in the entry for New Mexico, by striking
2 “5” and inserting “9”; and

3 (4) in the entry for Wyoming, by striking “0”
4 and inserting “.100”.

5 (b) EFFECTIVE DATE.—The amendments made by
6 subsection (a) take effect on October 1, 1999, and applies
7 to expenditures made on or after such date.

8 **SEC. 603. NEW PROSPECTIVE PAYMENT SYSTEM FOR FED-**
9 **ERALLY-QUALIFIED HEALTH CENTERS AND**
10 **RURAL HEALTH CLINICS.**

11 (a) IN GENERAL.—Section 1902(a) of the Social Se-
12 curity Act (42 U.S.C. 1396a(a)) is amended—

13 (1) in paragraph (13)—

14 (A) in subparagraph (A), by adding “and”
15 at the end;

16 (B) in subparagraph (B), by striking
17 “and” at the end; and

18 (C) by striking subparagraph (C); and

19 (2) by inserting after paragraph (14) the fol-
20 lowing new paragraph:

21 “(15) for payment for services described in
22 clause (B) or (C) of section 1905(a)(2) under the
23 plan in accordance with subsection (aa);”.

1 (b) NEW PROSPECTIVE PAYMENT SYSTEM.—Section
2 1902 of the Social Security Act (42 U.S.C. 1396a) is
3 amended by adding at the end the following:

4 “(aa) PAYMENT FOR SERVICES PROVIDED BY FED-
5 ERALLY-QUALIFIED HEALTH CENTERS AND RURAL
6 HEALTH CLINICS.—

7 “(1) IN GENERAL.—Beginning with fiscal year
8 2000 and each succeeding fiscal year, the State plan
9 shall provide for payment for services described in
10 section 1905(a)(2)(C) furnished by a Federally-
11 qualified health center and services described in sec-
12 tion 1905(a)(2)(B) furnished by a rural health clinic
13 in accordance with the provisions of this subsection.

14 “(2) FISCAL YEAR 2000.—Subject to paragraph
15 (4), for services furnished during fiscal year 2000,
16 the State plan shall provide for payment for such
17 services in an amount (calculated on a per visit
18 basis) that is equal to 100 percent of the costs of
19 the center or clinic of furnishing such services dur-
20 ing fiscal year 1999 which are reasonable and re-
21 lated to the cost of furnishing such services, or
22 based on such other tests of reasonableness as the
23 Secretary prescribes in regulations under section
24 1833(a)(3), or, in the case of services to which such
25 regulations do not apply, the same methodology used

1 under section 1833(a)(3), adjusted to take into ac-
2 count any increase in the scope of such services fur-
3 nished by the center or clinic during fiscal year
4 2000.

5 “(3) FISCAL YEAR 2001 AND SUCCEEDING FIS-
6 CAL YEARS.—Subject to paragraph (4), for services
7 furnished during fiscal year 2001 or a succeeding
8 fiscal year, the State plan shall provide for payment
9 for such services in an amount (calculated on a per
10 visit basis) that is equal to the amount calculated for
11 such services under this subsection for the preceding
12 fiscal year—

13 “(A) increased by the percentage increase
14 in the MEI (as defined in section 1842(i)(3))
15 applicable to primary care services (as defined
16 in section 1842(i)(4)) for that fiscal year; and

17 “(B) adjusted to take into account any in-
18 crease in the scope of such services furnished by
19 the center or clinic during that fiscal year.

20 “(4) ESTABLISHMENT OF INITIAL YEAR PAY-
21 MENT AMOUNT FOR NEW CENTERS OR CLINICS.—In
22 any case in which an entity first qualifies as a Fed-
23 erally-qualified health center or rural health clinic
24 after fiscal year 1999, the State plan shall provide
25 for payment for services described in section

1 1905(a)(2)(C) furnished by the center or services
2 described in section 1905(a)(2)(B) furnished by the
3 clinic in the first fiscal year in which the center or
4 clinic so qualifies in an amount (calculated on a per
5 visit basis) that is equal to 100 percent of the costs
6 of furnishing such services during such fiscal year in
7 accordance with the regulations and methodology re-
8 ferred to in paragraph (2). For each fiscal year fol-
9 lowing the fiscal year in which the entity first quali-
10 fies as a Federally-qualified health center or rural
11 health clinic, the State plan shall provide for the
12 payment amount to be calculated in accordance with
13 paragraph (3).

14 “(5) ADMINISTRATION IN THE CASE OF MAN-
15 AGED CARE.—In the case of services furnished by a
16 Federally-qualified health center or rural health clin-
17 ic pursuant to a contract between the center or clinic
18 and a managed care entity (as defined in section
19 1932(a)(1)(B)), the State plan shall provide for pay-
20 ment to the center or clinic (at least quarterly) by
21 the State of a supplemental payment equal to the
22 amount (if any) by which the amount determined
23 under paragraphs (2), (3), and (4) of this subsection
24 exceeds the amount of the payments provided under
25 the contract.

1 “(6) ALTERNATIVE PAYMENT METHODOLO-
2 GIES.—Notwithstanding any other provision of this
3 section, the State plan may provide for payment in
4 any fiscal year to a Federally-qualified health center
5 for services described in section 1905(a)(2)(C) or to
6 a rural health clinic for services described in section
7 1905(a)(2)(B) in an amount which is determined
8 under an alternative payment methodology that—

9 “(A) is agreed to by the State and the cen-
10 ter or clinic; and

11 “(B) results in payment to the center or
12 clinic of an amount which is at least equal to
13 the amount otherwise required to be paid to the
14 center or clinic under this section.”.

15 (c) CONFORMING AMENDMENTS.—

16 (1) Section 4712 of the Balanced Budget Act
17 of 1997 (Public Law 105–33; 111 Stat. 508) is
18 amended by striking subsection (c).

19 (2) Section 1915(b) of the Social Security Act
20 (42 U.S.C. 1396n(b)) is amended by striking
21 “1902(a)(13)(E)” and inserting “1902(a)(15),
22 1902(aa),”.

23 (d) EFFECTIVE DATE.—The amendments made by
24 this section take effect on October 1, 1999, and apply to
25 services furnished on or after such date.

1 **SEC. 604. PARITY IN REIMBURSEMENT FOR CERTAIN UTILI-**
2 **ZATION AND QUALITY CONTROL SERVICES.**

3 (a) IN GENERAL.—Section 1903(a)(3)(C)(i) (42
4 U.S.C. 1396b(a)(3)(C)(i)) is amended—

5 (1) by inserting “(other than a review described
6 in clause (ii))” after “quality review”; and

7 (2) by inserting “(or under a contract with the
8 State that sets forth standards of performance
9 equivalent to those under section 1902(d))” before
10 the semicolon.

11 (b) EFFECTIVE DATE.—The amendments made by
12 subsection (a) apply to expenditures made on and after
13 the date of the enactment of this Act.

14 **TITLE VII—STATE CHILDREN’S**
15 **HEALTH INSURANCE PRO-**
16 **GRAM (SCHIP)**

17 **SEC. 701. STABILIZING THE SCHIP ALLOTMENT FORMULA.**

18 (a) IN GENERAL.—Section 2104(b) (42 U.S.C.
19 1397dd(b)) is amended—

20 (1) in paragraph (2)(A)—

21 (A) in clause (i), by striking “through
22 2000” and inserting “and 1999”; and

23 (B) in clause (ii), by striking “2001” and
24 inserting “2000”;

25 (2) by amending paragraph (4) to read as fol-
26 lows:

1 “(4) FLOORS AND CEILINGS IN STATE ALLOT-
2 MENTS.—

3 “(A) IN GENERAL.—The proportion of the
4 allotment under this subsection for a subsection
5 (b) State (as defined in subparagraph (D)) for
6 fiscal year 2000 and each fiscal year thereafter
7 shall be subject to the following floors and ceil-
8 ings:

9 “(i) FLOOR OF \$2,000,000.—A floor
10 equal to \$2,000,000 divided by the total of
11 the amount available under this subsection
12 for all such allotments for the fiscal year.

13 “(ii) ANNUAL FLOOR OF 10 PERCENT
14 BELOW PRECEDING FISCAL YEAR’S PRO-
15 PORTION.—A floor of 90 percent of the
16 proportion for the State for the preceding
17 fiscal year.

18 “(iii) CUMULATIVE FLOOR OF 30 PER-
19 CENT BELOW THE FY 1999 PROPORTION.—
20 A floor of 70 percent of the proportion for
21 the State for fiscal year 1999.

22 “(iv) CUMULATIVE CEILING OF 45
23 PERCENT ABOVE FY 1999 PROPORTION.—A
24 ceiling of 145 percent of the proportion for
25 the State for fiscal year 1999.

“(B) RECONCILIATION.—

“(i) ELIMINATION OF ANY DEFICIT BY ESTABLISHING A PERCENTAGE INCREASE CEILING FOR STATES WITH HIGHEST ANNUAL PERCENTAGE INCREASES.—To the extent that the application of subparagraph (A) would result in the sum of the proportions of the allotments for all subsection (b) States exceeding 1.0, the Secretary shall establish a maximum percentage increase in such proportions for all subsection (b) States for the fiscal year in a manner so that such sum equals 1.0.

“(ii) ALLOCATION OF SURPLUS THROUGH PRO RATA INCREASE.—To the extent that the application of subparagraph (A) would result in the sum of the proportions of the allotments for all subsection (b) States being less than 1.0, the proportions of such allotments (as computed before the application of floors under clauses (i), (ii), and (iii) of subparagraph (A)) for all subsection (b) States shall be increased in a pro rata manner (but not to exceed the ceiling established under sub-

1 paragraph (A)(iv)) so that (after the appli-
2 cation of such floors and ceiling) such sum
3 equals 1.0.

4 “(C) CONSTRUCTION.—This paragraph
5 shall not be construed as applying to (or taking
6 into account) amounts of allotments redistrib-
7 uted under subsection (f).

8 “(D) DEFINITIONS.—In this paragraph:

9 “(i) PROPORTION OF ALLOTMENT.—
10 The term ‘proportion’ means, with respect
11 to the allotment of a subsection (b) State
12 for a fiscal year, the amount of the allot-
13 ment of such State under this subsection
14 for the fiscal year divided by the total of
15 the amount available under this subsection
16 for all such allotments for the fiscal year.

17 “(ii) SUBSECTION (b) STATE.—The
18 term ‘subsection (b) State’ means one of
19 the 50 States or the District of Colum-
20 bia.”;

21 (3) in paragraph (2)(B), by striking “the fiscal
22 year” and inserting “the calendar year in which
23 such fiscal year begins”; and

1 (4) in paragraph (3)(B), by striking “the fiscal
2 year involved” and inserting “the calendar year in
3 which such fiscal year begins”.

4 (b) EFFECTIVE DATE.—The amendments made by
5 this section apply to allotments determined under title
6 XXI of the Social Security Act (42 U.S.C. 1397aa et seq.)
7 for fiscal year 2000 and each fiscal year thereafter.

8 **SEC. 702. INCREASED ALLOTMENTS FOR TERRITORIES**
9 **UNDER THE STATE CHILDREN’S HEALTH IN-**
10 **SURANCE PROGRAM.**

11 Section 2104(c)(4)(B) (42 U.S.C. 1397dd(c)(4)(B))
12 is amended by inserting “, \$34,200,000 for each of fiscal
13 years 2000 and 2001, \$25,200,000 for each of fiscal years
14 2002 through 2004, \$32,400,000 for each of fiscal years
15 2005 and 2006, and \$40,000,000 for fiscal year 2007”
16 before the period.

 Passed the House of Representatives November 5,
1999.

Attest:

JEFF TRANDAHL,

Clerk.