106TH CONGRESS
1ST SESSION

H. R. 3075

IN THE SENATE OF THE UNITED STATES

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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.

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

★**(Star Print)**

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

(a) SHORT TITLE.—This Act may be cited as the ''Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999''.

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

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

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

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.

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

(1) in subclause (IV), by inserting ''and 2001'' after ''2000''; and

(2) by striking ''2000'' in subclause (V) and inserting ''2001''.

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)), as amended by section 4621(a)(2) of BBA, is amended by inserting ''or any additional payments under such paragraph resulting from the amendment made by section 101(a) of Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999'' after ''Balanced Budget Act of 1997''.

SEC. 102. DECREASE IN REDUCTIONS FOR DISPROPORTIONATE SHARE HOSPITALS; DATA COLLECTION REQUIREMENTS.

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

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

(2) by striking subclause (IV);

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

(4) in subclause (IV), as so redesignated, by striking ''reduced by 5 percent'' and inserting ''reduced by 4 percent''.

(b) DATA COLLECTION.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall require any subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) to submit to the Secretary, in the cost reports submitted to the Secretary by such hospital for discharges occurring during a fiscal year, data on the costs incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated, including non-Medicare

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

(2) EFFECTIVE DATE.—The Secretary shall require the submission of the data described in paragraph (1) in cost reports for cost reporting periods beginning on or after the date of the enactment of this Act.

Subtitle B—PPS-Exempt Hospitals

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

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

(1) in clause (i), by inserting ", as adjusted under clause (iii)" before the period;

(2) in clause (ii), by striking "clause (i)" and "such clause" and inserting "subclause (I)" and "such subclause" respectively;

(3) by striking "(H)(i)" and inserting "(ii)(I)";

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

(5) by inserting after clause (ii), as so redesignated, the following new clause:

"(iii) In applying clause (ii)(I) in the case of a hospital or unit, the Secretary shall provide for an appro-

priate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.''; and

(6) by inserting before clause (ii), as so redesignated, the following new clause:

''(H)(i) In the case of a hospital or unit that is within a class of hospital described in clause (iv), for a cost reporting period beginning during fiscal years 1998 through 2002, the target amount for such a hospital or unit may not exceed the amount as updated up to or for such cost reporting period under clause (ii).''.

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

SEC. 112. ENHANCED PAYMENTS FOR LONG-TERM CARE AND PSYCHIATRIC HOSPITALS UNTIL DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEMS FOR THOSE HOSPITALS.

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

(1) in subparagraph (A), by striking ''In addition to'' and inserting ''Except as provided in subparagraph (E), in addition to''; and

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

''(E)(i) In the case of an eligible hospital that is a hospital or unit that is within a class of hospital described in clause (ii) with a 12-month cost reporting period beginning before the enactment of this subparagraph, in determining the amount of the increase under subparagraph (A), the Secretary shall substitute for the percentage of the target amount applicable under subparagraph (A)(ii)—

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

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

''(ii) For purposes of clause (i), each of the following shall be treated as a separate class of hospital:

''(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

''(II) Hospitals described in clause (iv) of such subsection.''.

SEC. 113. PER DISCHARGE PROSPECTIVE PAYMENT SYSTEM FOR LONG-TERM CARE HOSPITALS.

(a) DEVELOPMENT OF SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a per discharge prospective payment system for payment for inpatient hospital services of long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under the Medicare program. Such system shall include an adequate patient classification system that is based on diagnosis-related groups (DRGs) and that reflects the differences in patient resource use and costs, and shall maintain budget neutrality.

(2) COLLECTION OF DATA AND EVALUATION.—In developing the system described in paragraph (1), the Secretary may require such long-term care hospitals to submit such information to the Secretary as the Secretary may require to develop the system.

(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 long-term care hospitals under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) in accordance with the system described in subsection (a).

SEC. 114. PER DIEM PROSPECTIVE PAYMENT SYSTEM FOR PSYCHIATRIC HOSPITALS.

(a) DEVELOPMENT OF SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a per diem prospective payment system for payment for inpatient hospital services of psychiatric hospitals and units (as defined in paragraph (3)) under the Medicare program. Such system shall include an adequate patient classification system that reflects the differences in patient resource use and costs among such hospitals and shall maintain budget neutrality.

(2) COLLECTION OF DATA AND EVALUATION.—In developing the system described in paragraph (1), the Secretary may require such psychiatric hospitals and units to submit such information to the Secretary as the Secretary may require to develop the system.

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

chiatric hospital described in clause (i) of section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) and psychiatric units described in the matter following clause (v) of such section.

(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.

SEC. 115. REFINEMENT OF PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT REHABILITATION SERVICES.

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

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

(A) in subparagraph (C), by inserting ''subject to subparagraph (E),'' after ''subparagraph (A),''; and

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

''(E) ELECTION TO APPLY FULL PROSPECTIVE PAYMENT SYSTEM.—A rehabilitation facility may elect for either or both cost reporting periods described in subparagraph (C) to have the TEFRA percentage and prospective payment percentage set at 0 percent and 100 percent, respectively, for the facility.''.

(2) BUDGET NEUTRALITY IN APPLICATION.—Paragraph (3)(B) of such section is amended by inserting ''and taking into account the election permitted under paragraph (1)(E)'' after ''in the Secretary's estimation''.

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

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

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

''(iv) INITIAL ADJUSTMENT OF RATES IN FISCAL YEAR 2004.—Based on the analysis performed under clause (iii) in determining the amount of case mix change due merely to changes in coding or classification, the Secretary shall adjust the prospective payment amounts for fiscal year 2004 by 150 percent of the Secretary's estimate of the percentage adjustment to the prospective payment rate under this paragraph that would have achieved budget neutrality in fiscal year 2001 if it had applied in setting the rates for that fiscal year.

''(v) FINAL ADJUSTMENT OF RATES IN FISCAL YEAR 2005.—In the case that the adjustment under clause (iv) resulted in—

''(I) a percentage decrease in rates, the Secretary shall increase the prospective payment amounts for fiscal year 2005 by a percentage equal to ⅓ of such percentage decrease; or

''(II) a percentage increase in rates, the Secretary shall decrease the prospective payment amounts for fiscal year 2005 by a percentage equal to ⅓ of such percentage increase.''.

(b) USE OF DISCHARGE AS PAYMENT UNIT.—

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

(2) CONFORMING AMENDMENT TO CLASSIFICATION.—Paragraph (2)(A) of such section is amended by amending clause (i) of to read as follows:

''(i) classes of patient discharges of rehabilitation facilities by functional-related groups (each in this subsection referred to as a 'case mix group'), based on impairment, age, comorbidities, and functional capability of the patient and such other factors as the Secretary deems ap-

propriate to improve the explanatory power of functional independence measure-function related groups; and''.

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

''(F) CONSTRUCTION RELATING TO TRANSFER AUTHORITY.—Nothing in this subsection shall be construed as preventing the Secretary from providing for an adjustment to payments to take into account the early transfer of a patient from a rehabilitation facility to another site of care.''.

(c) STUDY ON IMPACT OF IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study of the impact on utilization and beneficiary access to services of the implementation of the Medicare prospective payment system for inpatient hospital services or rehabilitation facilities under section 1886(j) of the Social Security Act (as added by section 4421(a) of BBA).

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

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

Subtitle C—Adjustments to PPS Payments for Skilled Nursing Facilities

SEC. 121. TEMPORARY INCREASE IN PAYMENT FOR CERTAIN HIGH COST PATIENTS.

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

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

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

SEC. 122. MARKET BASKET INCREASE.

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

(1) by redesignating subclause (III) as subclause (IV); and

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

"(II) for fiscal year 2001, the rate computed for fiscal year 2000 (determined without regard to section 121 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999) increased by the skilled nursing facility market basket percentage change for the fiscal year involved plus 0.8 percentage point;

''(III) for fiscal year 2002, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved minus 1 percentage point; and''.

SEC. 123. AUTHORIZING FACILITIES TO ELECT IMMEDIATE TRANSITION TO FEDERAL RATE.

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

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (11)''; and

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

''(11) PERMITTING FACILITIES TO WAIVE 3-YEAR TRANSITION.—Notwithstanding paragraph (1)(A), a facility may elect to have the amount of the payment for all costs of covered skilled nursing facility services for each day of such services furnished in cost reporting periods beginning after the date of such election determined pursuant to subparagraph (B) of paragraph (1).''.

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

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

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

(1) in paragraph (2)(A)(i)(II), by striking ''services described in clause (ii)'' and inserting ''items and services described in clauses (ii) and (iii)'';

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

''(iii) EXCLUSION OF CERTAIN ADDITIONAL ITEMS.—Items described in this clause are the following:

''(I) Ambulance services furnished to an individual in conjunction with renal dialysis services described in section 1861(s)(2)(F).

''(II) Chemotherapy items (identified as of July 1, 1999, by HCPCS codes J9000–J9020; J9040–J9151;

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

''(III) Chemotherapy administration 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 Secretary)).

''(IV) Radioisotope services (identified as of July 1, 1999, by HCPCS codes 79030–79440 (and as subsequently modified by the Secretary)).

''(V) Customized prosthetic devices (commonly known as artificial limbs or components or artifical limbs) under the following HCPCS codes (as of July 1, 1999 (and as subsequently 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

individual after discharge from the facility: L5050–L5340; L5500–L5610; L5613–L5986; L5988; L6050–L6370; L6400–L6880; L6920–L7274; and L7362–7366.''; and

(3) by adding at the end of paragraph (9) the following: ''In the case of an item or service described in clause (iii) of paragraph (2)(A) that would be payable under part A but for the exclusion of such item or service under such clause, payment shall be made for the item or service, in an amount otherwise determined under part B of this title for such item or service, from the Federal Hospital Insurance Trust Fund under section 1817 (rather than from the Federal Supplementary Medical Insurance Trust Fund under section 1841).''.

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

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

gate amount of such reductions is equal to the aggregate increase in payments attributable to the exclusion effected under clause (iii) of paragraph (2)(A).''.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments made for items furnished on or after April 1, 2000.

SEC. 125. PROVISION FOR PART B ADD-ONS FOR FACILITIES PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT.

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

(1) in subparagraph (A)—

(A) in clause (i), by inserting ''or, in the case of a facility participating in the Nursing Home Case-Mix and Quality Demonstration (RUGS–III), the RUGS–III rate received by the facility during the cost reporting period beginning in 1997'' after ''to non-settled cost reports''; and

(B) in clause (ii), by striking ''furnished during such period'' and inserting ''furnished during the applicable cost reporting period described in clause (i)''; and

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

"(B) UPDATE TO FIRST COST REPORTING PERIOD.—The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the applicable cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase minus 1 percentage point (except that for the cost reporting period beginning in fiscal year 2001, the factor shall be equal to such market basket percentage plus 0.8 percentage point).".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall be effective as if included in the enactment of section 4432(a) of BBA.

SEC. 126. SPECIAL CONSIDERATION FOR FACILITIES SERVING SPECIALIZED PATIENT POPULATIONS.

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

(1) in paragraph (1), by striking "subject to paragraphs (7) and (11)" and inserting "subject to paragraphs (7), (11), and (12)"; and

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

"(12) PAYMENT RULE FOR CERTAIN FACILITIES.—

"(A) IN GENERAL.—In the case of a qualified acute skilled nursing facility described in subparagraph (B), the per diem amount of payment shall be determined by applying the non-Federal percentage and Federal percentage specified in paragraph (2)(C)(ii).

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

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

"(ii) is a hospital-based facility; and

"(iii) for the cost reporting period beginning in fiscal year 1998, the facility had more than 60 percent of total patient days comprised of patients who are described in subparagraph (C).

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

scribed in this subparagraph is an individual who—

"(i) is entitled to benefits under part A; and

"(ii) is immuno-compromised secondary to an infectious disease, with specific diagnoses as specified by the Secretary.".

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

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

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

SEC. 127. MEDPAC STUDY ON SPECIAL PAYMENT FOR FACILITIES LOCATED IN HAWAII AND ALASKA.

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

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

Subtitle D—Other

SEC. 131. PART A BBA TECHNICAL CORRECTIONS.

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

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

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

(A) in clause (i), by striking ''or beginning on or after October 1, 1997, and before October 1, 2001,'' and inserting ''or discharges on or after October 1, 1997, and before October 1, 2001,''; and

(B) in clause (ii)(II), by striking ''or beginning on or after October 1, 1997, and before October 1, 2001,'' and inserting ''or discharges on or after October 1, 1997, and before October 1, 2001,''.

(2) Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)), as amended by section 4204(a)(2) of BBA, is amended in the matter preceding clause (i) by striking ''and for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2001,'' and inserting ''and for discharges beginning on or after October 1, 1997, and before October 1, 2001,''.

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

amended by inserting ''and'' after ''specified by the Secretary''.

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

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

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

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

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

section (f) for the year for which the update adjustment factor is to be determined; and

"(III) multiplying that quotient by 0.33.

"(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph:

"(i) PERIOD UP TO APRIL 1, 1999.—The allowed expenditures for physicians' services for a period before April 1, 1999, shall be the amount of the allowed expenditures for such period as determined under paragraph (3)(C).

"(ii) TRANSITION TO CALENDAR YEAR ALLOWED EXPENDITURES.—Subject to subparagraph (E), the allowed expenditures for—

"(I) the 9-month period beginning April 1, 1999, shall be the Secretary's estimate of the amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such period; and

"(II) the year of 1999, shall be the Secretary's estimate of the

amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such year.

''(iii) YEARS BEGINNING WITH 2000.—The allowed expenditures for a year (beginning with 2000) is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the year involved.

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

''(E) RECALCULATION OF ALLOWED EXPENDITURES FOR UPDATES BEGINNING WITH 2001.—For purposes of determining the update adjustment factor for a year beginning with 2001, the Secretary shall recompute the allowed expenditures for previous periods beginning on or after April 1, 1999, consistent with subsection (f)(3).

''(F) TRANSITIONAL ADJUSTMENT DESIGNED TO PROVIDE FOR BUDGET NEU-

TRALITY.—Under this subparagraph the Secretary shall provide for an adjustment to the update under subparagraph (A)—

''(i) for each of 2001, 2002, 2003, and 2004, of −0.2 percent; and

''(ii) for 2005 of +0.8 percent.''.

(2) PUBLICATION CHANGE.—

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

''(E) PUBLICATION AND DISSEMINATION OF INFORMATION.—The Secretary shall—

''(i) cause to have published in the Federal Register not later than November 1 of each year (beginning with 2000) the conversion factor which will apply to physicians' services for the succeeding year, the update determined under paragraph (4) for such succeeding year, and the allowed expenditures under such paragraph for such succeeding year; and

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

growth rate and of the conversion factor which will apply to physicians' services for the succeeding year and data used in making such estimate.''.

(B) MEDPAC REVIEW OF CONVERSION FACTOR ESTIMATES.—Section 1805(b)(1)(D) (42 U.S.C. 1395b–6(b)(1)(D)) is amended by inserting ''and including a review of the estimate of the conversion factor submitted under section 1848(d)(1)(E)(ii)'' before the period at the end.

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

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

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

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

(3) CONFORMING AMENDMENTS.—

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

(i) in subsection (d)(1)(A), by inserting ''(for years before 2001) and, for years beginning with 2001, multiplied by the update (established under paragraph (4)) for the year involved'' after ''for the year involved''; and

(ii) in subsection (f)(2)(D), by inserting ''or (d)(4)(B), as the case may be'' after ''(d)(3)(B)''.

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

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

(1) by amending paragraph (1) to read as follows:

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

''(A) November 1, 2000, the sustainable growth rate for 2000 and 2001; and

''(B) November 1 of each succeeding year the sustainable growth rate for such succeeding year and each of the preceding 2 years.'';

(2) in paragraph (2)—

(A) in the matter before subparagraph (A), by striking ''fiscal year 1998)'' and inserting ''fiscal year 1998 and ending with fiscal year 2000) and a year beginning with 2000''; and

(B) in subparagraphs (A) through (D), by striking ''fiscal year'' and inserting ''applicable period'' each place it appears;

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

''(C) APPLICABLE PERIOD.—The term 'applicable period' means—

''(i) a fiscal year, in the case of fiscal year 1998, fiscal year 1999, and fiscal year 2000; or

''(ii) a calendar year with respect to a year beginning with 2000,

as the case may be.'';

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

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

''(3) DATA TO BE USED.—For purposes of determining the update adjustment factor under subsection (d)(4)(B) for a year beginning with 2001, the sustainable growth rates taken into consideration in the determination under paragraph (2) shall be determined as follows:

''(A) FOR 2001.—For purposes of such calculations for 2001, the sustainable growth rates for fiscal year 2000 and the years 2000 and 2001 shall be determined on the basis of the best data available to the Secretary as of September 1, 2000.

''(B) FOR 2002.—For purposes of such calculations for 2002, the sustainable growth rates for fiscal year 2000 and for years 2000, 2001, and 2002 shall be determined on the basis of the best data available to the Secretary as of September 1, 2001.

''(C) FOR 2003 AND SUCCEEDING YEARS.—For purposes of such calculations for a year after 2002—

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

''(ii) the sustainable growth rate for any year before a year described in clause (i) shall be the rate as most recently determined for that year under this subsection.

Nothing in this paragraph shall be construed as affecting the sustainable growth rates established for fiscal year 1998 or fiscal year 1999.''.

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

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

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish by regulation (after notice and opportunity for public comment) a process (including data collection standards) under which the Secretary will accept for use and will use, to the maximum extent practicable consistent with sound data practices, data collected or developed by entities and organizations (other than the Department of Health and Human Services) to supplement the data normally collected by that department in determining the practice expense component under section 1848(c)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)(ii)) for purposes of determining relative values for payment for physicians' services under the fee schedule under section 1848 of such Act (42 U.S.C. 1395w–4). The Secretary shall first promulgate such regulation on an interim final basis in a manner that permits the submission and use of data in the computation of practice expense relative value units for payment rates for 2001.

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

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

SEC. 203. GAO STUDY ON RESOURCES REQUIRED TO PROVIDE SAFE AND EFFECTIVE OUTPATIENT CANCER THERAPY.

(a) STUDY .—The Comptroller General of the United States shall conduct a nationwide study to determine the physician and non-physician clinical resources necessary to provide safe outpatient cancer therapy services and the appropriate payment rates for such services under the Medicare program. In making such determination, the Comptroller General shall—

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

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

(3) assess various standards to assure the provision of safe outpatient cancer therapy services.

(b) REPORT TO CONGRESS.—The Comptroller General shall submit to Congress a report on the study conducted under subsection (a). The report shall include recommendations regarding practice expense adjustments to the payment methodology under part B of the Medicare program, including the development and inclusion of adequate work units to assure the adequacy of payment amounts for safe outpatient cancer therapy services. The study shall also include an estimate of the cost of implementing such recommendations.

Subtitle B—Hospital Outpatient Services

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

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

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

(2) by inserting after paragraph (4) the following new paragraph:

''(5) OUTLIER ADJUSTMENT.—

"(A) IN GENERAL.—The Secretary shall provide for an additional payment for each covered OPD service (or group of services) for which a hospital's charges, adjusted to cost, exceed—

"(i) a fixed multiple of the sum of—

"(I) the applicable Medicare OPD fee schedule amount determined under paragraph (3)(D), as adjusted under paragraph (4)(A) (other than for adjustments under this paragraph or paragraph (6)); and

"(II) any transitional pass-through payment under paragraph (6); and

"(ii) at the option of the Secretary, such fixed dollar amount as the Secretary may establish.

"(B) AMOUNT OF ADJUSTMENT.—The amount of the additional payment under subparagraph (A) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the applicable cutoff point under such subparagraph.

''(C) LIMIT ON AGGREGATE OUTLIER ADJUSTMENTS.—

''(i) IN GENERAL.—The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as projected or estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments projected or estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied to less than a full year, the previous sentence shall apply only to the portion of such year.

''(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the term 'applicable percentage' means a percentage specified by the Secretary up to (but not to exceed)—

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

''(II) for 2004 and thereafter, 3.0 percent.''.

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

''(6) TRANSITIONAL PASS-THROUGH FOR ADDITIONAL COSTS OF INNOVATIVE MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—

''(A) IN GENERAL.—The Secretary shall provide for an additional payment under this paragraph for any of the following that are provided as part of a covered OPD service (or group of services):

''(i) CURRENT ORPHAN DRUGS.—A drug or biological that is used for a rare disease or condition with respect to which the drug or biological has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act if payment for the drug or biological as an outpatient hospital service under this part was being made on the first date that the system under this subsection is implemented.

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

logical that is used in cancer therapy, including (but not limited to) a chemotherapeutic agent, antiemetic, hematopoietic growth factor, colony stimulating factor, a biological response modifier, and a bisphosponate, or brachytherapy, if payment for such drug, biological, or device as an outpatient hospital service under this part was being made on such first date.

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

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

''(II) the cost of the device, drug, or biological is not insignificant in relation to the OPD fee schedule amount (as calculated under paragraph (3)(D)) payable for the service (or group of services) involved.

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

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

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

"(C) AMOUNT OF ADDITIONAL PAYMENT.—Subject to subparagraph (D)(iii), the amount of the payment under this paragraph with respect to a device, drug, or biological provided as part of a covered OPD service is—

"(i) in the case of a drug or biological, the amount by which the amount determined under section 1842(o) for the drug or biological exceeds the portion of the otherwise applicable Medicare OPD fee schedule that the Secretary determines is associated with the drug or biological; or

"(ii) in the case of a medical device, the amount by which the hospital's charges for the device, adjusted to cost, exceeds the portion of the otherwise applicable Medicare OPD fee schedule that the Secretary determines is associated with the device.

"(D) LIMIT ON AGGREGATE ANNUAL ADJUSTMENT.—

"(i) IN GENERAL.—The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as projected or estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments projected or estimated to be made under this subsection for all covered OPD services furnished in that year.

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

''(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the term 'applicable percentage' means—

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

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

''(iii) UNIFORM PROSPECTIVE REDUCTION IF AGGREGATE LIMIT PROJECTED TO BE EXCEEDED.—If the Secretary projects or estimates before the beginning of a year that the amount of the additional payments under this paragraph for the year (or portion thereof) as determined under clause (i) without regard to this clause) will exceed the limit established under such clause, the Secretary shall reduce pro rata the amount of each of the additional payments under this paragraph for that year (or portion thereof) in order to ensure that

the aggregate additional payments under this paragraph (as so projected or estimated) do not exceed such limit.''.

(c) APPLICATION OF NEW ADJUSTMENTS ON A BUDGET NEUTRAL BASIS.—Section 1833(t)(2)(E) (42 U.S.C. 1395l(t)(2)(E)) is amended by striking ''other adjustments, in a budget neutral manner, as determined to be necessary to ensure equitable payments, such a outlier adjustments or'' and inserting '', in a budget neutral manner, outlier adjustments under paragraph (5) and transitional pass-through payments under paragraph (6) and other adjustments as determined to be necessary to ensure equitable payments, such as''.

(d) LIMITATION ON JUDICIAL REVIEW FOR NEW ADJUSTMENTS.—Section 1833(t)(11), as redesignated by subsection (a)(1), is amended—

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

(2) by striking the period at the end of subparagraph (D) and inserting ''; and''; and

(3) by adding at the end the following:

''(E) the determination of the fixed multiple, or a fixed dollar cutoff amount, the marginal cost of care, or applicable percentage under paragraph (5) or the determination of in-

significance of cost, the duration of the additional payments (consistent with paragraph (6)(B)), the portion of the Medicare OPD fee schedule amount associated with particular devices, drugs, or biologicals, and the application of any pro rata reduction under paragraph (6).''.

(e) INCLUSION OF MEDICAL DEVICES UNDER SYSTEM.—Section 1833(t) (42 U.S.C. 1395l(t)) is amended—

(1) in paragraph (1)(B)(ii), by striking ''clause (iii)'' and inserting ''clause (iv)'' and by striking ''but'';

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

''(iii) includes medical devices (such as implantable medical devices); but''; and

(3) in paragraph (2)(B), by inserting after ''resources'' the following: ''and so that a device is classified to the group that includes the service to which the device relates''.

(f) AUTHORIZING PAYMENT WEIGHTS BASED ON MEAN HOSPITAL COSTS.—Section 1833(t)(2)(C) (42 U.S.C. 1395l(t)(2)(C)) is amended by inserting ''(or, at the election of the Secretary, mean)'' after ''median''.

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

''For purposes of subparagraph (B), items and services within a group shall not be treated as 'comparable with respect to the use of resources' if the highest median cost (or mean cost, if elected by the Secretary under subparagraph (C)) for an item or service within the group is more than two times greater than the lowest median cost (or mean cost, if so elected) for an item or service within the group; except that the Secretary may make exceptions in unusual cases, such as low volume items and services, but may not make such an exception in the case of a drug or biological has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act.''.

(h) ANNUAL REVIEW OF OPD PPS COMPONENTS.—

(1) IN GENERAL.—Section 1833(t)(8)(A) (42 U.S.C. 1395l(t)(8)(A)), as redesignated by subsection (a), is amended—

(A) by striking ''may periodically review'' and inserting ''shall review not less often than annually''; and

(B) by adding at the end the following: ''The Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise the Secretary concerning) the clinical integrity of the groups and weights. Such panel may use data collected or developed by entities and organizations (other than the Department of Health and Human Services) in conducting such review.''.

(2) EFFECTIVE DATES.—The Secretary of Health and Human Services shall first conduct the annual review under the amendment made by paragraph (1)(A) in 2001 for application in 2002 and the amendment made by paragraph (1)(B) takes effect on the date of the enactment of this Act.

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

''(D) COMPUTATION IGNORING OUTLIER AND PASS-THROUGH ADJUSTMENTS.—The copayment amount shall be computed under subparagraph (A) as if the adjustments under paragraphs (5) and (6) (and any adjustment

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

(j) TECHNICAL CORRECTION IN REFERENCE RELATING TO HOSPITAL-BASED AMBULANCE SERVICES.—Section 1833(t)(9) (42 U.S.C. 1395l(t)(9)), as redesignated by subsection (a), is amended by striking ''the matter in subsection (a)(1) preceding subparagraph (A)'' and inserting ''section 1861(v)(1)(U)''.

(k) EFFECTIVE DATE.—Except as provided in this section, the amendments made by this section shall be effective as if included in the enactment of BBA.

(l) STUDY OF DELIVERY OF INTRAVENOUS IMMUNE GLOBULIN (IVIG) OUTSIDE HOSPITALS AND PHYSICIANS' OFFICES.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study of the extent to which intravenous immune globulin (IVIG) could be delivered and reimbursed under the Medicare program outside of a hospital or physician's office. In conducting the study, the Secretary shall—

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

(B) determine whether covering the delivery of these drugs and biologicals in a Medicare

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

(C) determine whether covering the delivery of these drugs and biologicals in a patient's home can reduce overall spending under the Medicare program; and

(D) determine whether changing the site of setting for these services would affect beneficiary access to care.

(2) REPORT.—The Secretary shall submit a report on such study to the Committees on Way and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate within 1 year after the date of the enactment of this Act. The Secretary shall include in the report recommendations regarding on the appropriate manner and settings under which the Medicare program should pay for these drugs and biologicals delivered outside of a hospital or physician's office.

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

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

(1) in paragraph (4), in the matter before subparagraph (A), by inserting ", subject to paragraph (7)," after "is determined"; and

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

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

"(7) TRANSITIONAL ADJUSTMENT TO LIMIT DECLINE IN PAYMENT.—

"(A) BEFORE 2002.—Subject to subparagraph (D), for covered OPD services furnished before January 1, 2002, for which the PPS amount (as defined in subparagraph (E)) is—

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

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

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

''(iii) at least 70 percent, but less than 80 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.63 and the pre-BBA amount, exceeds (II) the product of 0.60 and the PPS amount;

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

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

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

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

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

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

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

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

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

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

payment under this subsection shall be increased by 100 percent of the amount of such difference.

''(E) PPS AMOUNT DEFINED.—In this paragraph, the term 'PPS amount' means, with respect to covered OPD services, the amount payable under this title for such services (determined without regard to this paragraph), including amounts payable as copayment under paragraph (5), coinsurance under section 1866(a)(2)(A)(ii), and the deductible under section 1833(b).

''(F) PRE-BBA AMOUNT DEFINED.—

''(i) IN GENERAL.—In this paragraph, the 'pre-BBA amount' means, with respect to covered OPD services furnished by a hospital in a year, an amount equal to the product of the reasonable cost of the hospital for such services for the portions of the hospital's cost reporting period (or periods) occurring in the year and the base OPD payment-to-cost ratio for the hospital (as defined in clause (ii)).

''(ii) BASE PAYMENT-TO-COST-RATIO 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 services furnished during the cost reporting period ending in 1996, including any reimbursement for such services through cost-sharing described in subparagraph (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 described in paragraph (3)(B) or the copayment amount under paragraph (8).

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

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

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

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall be effective as if included in the enactment of BBA.

(c) REPORT ON RURAL HOSPITALS.—Not later than July 1, 2002, the Secretary of Health and Human Services shall submit to Congress a report and recommendations on whether the prospective payment system for covered outpatient services furnished under title XVIII of the Social Security Act should apply to the following providers of services furnishing outpatient items and services for which payment is made under such title:

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

(2) Sole community hospitals (as defined in section 1886(d)(5)(D)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(D)(iii)).

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

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

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

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

SEC. 213. DELAY IN APPLICATION OF PROSPECTIVE PAYMENT SYSTEM TO CANCER CENTER HOSPITALS.

Section 1833(t)(11)(A) (42 U.S.C. 1395l(t)(11)(A)), as redesignated by section 212(a), is amended by striking ''January 1, 2000'' and inserting ''the first day of the first year that begins 2 years after the date the prospective payment system under this section is first implemented''.

SEC. 214. LIMITATION ON OUTPATIENT HOSPITAL COPAYMENT FOR A PROCEDURE TO THE HOSPITAL DEDUCTIBLE AMOUNT.

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

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

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

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

''(C) LIMITING COPAYMENT AMOUNT TO INPATIENT HOSPITAL DEDUCTIBLE AMOUNT.—

In no case shall the copayment amount for a procedure performed in a year exceed the amount of the inpatient hospital deductible established under section 1813(b) for that year.''.

(b) INCREASE IN PAYMENT TO REFLECT REDUCTION IN COPAYMENT.—Section 1833(t)(4)(C) (42 U.S.C. 1395l(t)(4)(C)) is amended by inserting '', plus the amount of any reduction in the copayment amount attributable to paragraph (5)(C)'' before the period at the end.

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

Subtitle C—Other

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

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

(1) in paragraph (1)—

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

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

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

fourth sentence of section 1861(p) and for other outpatient physical therapy services.''; and

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

''(4) The limitations of this subsection apply to the services involved on a per beneficiary, per facility (or provider) basis.''.

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

(1) in subsection (p)(1), by striking ''or (3)'' and inserting '', (3), or (4)''; and

(2) in subsection (r)(4), by inserting ''for purposes of subsection (p)(1) and'' after ''but only''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after January 1, 2000.

SEC. 222. TRANSITIONAL OUTLIER PAYMENTS FOR THERAPY SERVICES FOR CERTAIN HIGH ACUITY PATIENTS.

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

''(5)(A) The Secretary shall establish a process under 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-

ment amounts for such services furnished on December 31, 2000.''.

(b) CONFORMING AMENDMENT.—

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

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

(c) STUDY ON PAYMENT LEVEL FOR HOME HEMODIALYSIS.—The Medicare Payment Advisory Commission shall conduct a study on the appropriateness of the differential in payment under the Medicare program for hemodialysis services furnished in a facility and such services furnished in a home. Not later than 18 months after the date of the enactment of this Act, the Commission shall submit to Congress a report on such study and shall include recommendations regarding changes in Medicare payment policy in response to the study.

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

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

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

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

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

''(D) for each of the years 2001 and 2002, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year minus 2 percentage points; and''.

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

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

(2) in clause (vi), by striking ''and each subsequent year'' and inserting ''and 2000'' and by striking the period at the end and inserting ''; and''; and

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

''(vii) for 2001 and each subsequent year, the amount determined under this subparagraph for the preceding year in-

creased by the covered item update for such subsequent year.''.

SEC. 225. REQUIREMENT FOR NEW PROPOSED RULEMAKING FOR IMPLEMENTATION OF INHERENT REASONABLENESS POLICY.

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

(1) the Secretary has published in the Federal Register a new notice of proposed rulemaking to implement subparagraph (A) of such section;

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

(3) the Secretary has published in the Federal Register a final rule which takes into account comments received during such period.

SEC. 226. INCREASE IN REIMBURSEMENT FOR PAP SMEARS.

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

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

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

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

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

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

(3) the Health Care Financing Administration should institute an appropriate increase in the payment rate for new cervical cancer screening technologies that have been approved by the Food and Drug Administration as significantly more effective than a conventional pap smear.

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

SEC. 227. REFINEMENT OF AMBULANCE SERVICES DEMONSTRATION PROJECT.

Effective as if included in the enactment of BBA, section 4532 of BBA is amended—

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

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

''(2) CAPITATED PAYMENT RATE DEFINED.—In this subsection, the 'capitated payment rate' means, with respect to a demonstration project—

''(A) in its first year, a rate established for the project by the Secretary, using the most current available data, in a manner that ensures that aggregate payments under the project will not exceed the aggregate payment that would have been made for ambulance services under part B of title XVIII of the Social Security Act in the local area of government's jurisdiction; and

''(B) in a subsequent year, the capitated payment rate established for the previous year increased by an appropriate inflation adjustment factor.''.

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

If the Secretary of Health and Human Services implements a revised prospective payment system for services of ambulatory surgical facilities under part B of title XVIII of the Social Security Act, prior to incorporating data from the 1999 Medicare cost survey, such system shall be implemented in a manner so that—

(1) in the first year of its implementation, only a proportion (specified by the Secretary and not to exceed ⅓) of the payment for such services shall be made in accordance with such system and the remainder shall be made in accordance with current regulations; and

(2) in the following year a proportion (specified by the Secretary and not to exceed ⅔) of the payment for such services shall be made under such system and the remainder shall be made in accordance with current regulations.

SEC. 229. EXTENSION OF MEDICARE BENEFITS FOR IMMUNOSUPPRESSIVE DRUGS.

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

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

(1) of improving health outcomes by decreasing transplant rejection rates that are attributable to failure to comply with immunosuppressive drug regimens; and

(2) of achieving cost saving to the Medicare program by decreasing the need for secondary transplants and other care relating to post-transplant complications.

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

(1) the Secretary shall provide priority in eligibility to those Medicare beneficiaries who, because of income or other factors, would be less likely to maintain an immunosuppressive drug regimen in the absence of such an extension; and

(2) the Secretary is authorized to vary the beneficiary cost-sharing otherwise applicable in order to promote the objectives described in subsection (a).

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

an extension of coverage under this section for immunosuppressive drugs furnished after September 30, 2004.

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

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

(2) recommendations regarding an appropriate cost-effective method for extending coverage of immunosuppressive drugs under the Medicare program on a permanent basis.

SEC. 230. ADDITIONAL STUDIES.

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

(1) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study on the cost-effectiveness and efficacy of covering under the Medicare program services of a post-surgical recovery care center (that provides an intermediate level of recovery care following surgery). In conducting such study, the Commission shall consider data on these centers gathered in demonstration projects.

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

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

(1) STUDY.—The Administrator for Health Care Policy and Research shall provide for a study that compares the differences in quality of ultrasound and other imaging services (including error rates and resulting complications) furnished under the Medicare and Medicaid programs between such services furnished by individuals who are credentialed by private entities or organizations and by those who are not so credentialed. Such study shall examine and evaluate differences in error rates and patient outcomes as a result of the differences in credentialing. In designing the study, the Administrator shall consult with organizations nationally recognized for their expertise in ultrasound procedures.

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

(c) MEDPAC STUDY ON THE COMPLEXITY OF THE MEDICARE PROGRAM AND THE LEVELS OF BURDENS PLACED ON PROVIDERS THROUGH FEDERAL REGULATIONS.—

(1) STUDY.—The Medicare Payment Advisory Commission shall undertake a comprehensive study to review the regulatory burdens placed on all classes of health care providers under parts A and B of the Medicare program under title XVIII of the Social Security Act and to determine the costs these burdens impose on the nation's health care system. The study shall also examine the complexity of the current regulatory system and its impact on providers.

(2) REPORT.—not later than December 31, 2001, the Commission shall submit to Congress a report on the study conducted under paragraph (1). The report shall include recommendations regarding—

(A) how the Health Care Financing Administration can reduce the regulatory burdens placed on patients and providers; and

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

(d) GAO CONTINUED MONITORING OF DEPARTMENT OF JUSTICE APPLICATION OF GUIDELINES ON USE OF FALSE CLAIMS ACT IN CIVIL HEALTH CARE MATTERS.—The Comptroller General of the United States shall—

(1) continue the monitoring, begun under section 118 of the Department of Justice Appropriations Act, 1999 (included in Public Law 105–277) of the compliance of the Department of Justice and all United States Attorneys with the ''Guidance on the Use of the False Claims Act in Civil Health Care Matters'' issued by the Department of Justice on June 3, 1998, including any revisions to that guidance; and

(2) not later than April 1, 2000, and of each of the two succeeding years, submit a report on such compliance to the appropriate committees of Congress.

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; GAO REPORT ON COSTS OF COMPLIANCE WITH OASIS DATA COLLECTION REQUIREMENTS.

(a) ADJUSTMENT TO REFLECT ADMINISTRATIVE COSTS.—

(1) IN GENERAL.—In the case of a home health agency that furnishes home health services to a Medicare beneficiary, for each such beneficiary to whom the agency furnished such services during the agency's cost reporting period beginning in fiscal year 2000, the Secretary of Health Services shall pay the agency, in addition to any amount of payment made under subsection (v)(1)(L) of such section for the beneficiary and only for such cost reporting period, an aggregate amount of $10 to defray costs incurred by the agency attributable to data collection and reporting requirements under the Outcome and Assessment Information Set (OASIS) required by reason of section 4602(e) of the Balanced Budget Act of 1997 (42 U.S.C. 1395fff note).

(2) PAYMENT SCHEDULE.—

(A) MIDYEAR PAYMENT.—By not later than April 1, 2000, the Secretary shall pay to a home health agency an amount that the Secretary estimates to be 50 percent of the aggregate amount payable to the agency by reason of this subsection.

(B) UPON SETTLED COST REPORT.—The Secretary shall pay the balance of amounts payable to an agency under this subsection on the date that the cost report submitted by the agency for the cost reporting period beginning in fiscal year 2000 is settled.

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

(4) DEFINITIONS.—in this subsection:

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

(B) HOME HEALTH SERVICES.—The term ''home health services'' has the meaning given

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

(C) MEDICARE BENEFICIARY.—The term ''Medicare beneficiary'' means a beneficiary described in section 1861(v)(1)(L)(vi)(II) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(vi)(II)).

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

(1) REPORT TO CONGRESS.—

(A) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Comptroller General of the United States shall submit a report to Congress on matters described in subparagraph (B) with respect to the data collection requirement of patients of such agencies under the Outcome and Assessment Information Set (OASIS) standard as part of the comprehensive assessment of patients.

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

(i) An assessment of the costs incurred by Medicare home health agencies

in complying with such data collection requirement.

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

(C) AUDIT.—The Comptroller General shall conduct an independent audit of the costs described in subparagraph (B)(i). Not later than 180 days after receipt of the report under subparagraph (A), the Comptroller General shall submit to Congress a report describing the Comptroller General's findings with respect to such audit, and shall include comments on the report submitted to Congress by the Secretary of Health and Human Services under subparagraph (A).

(2) DEFINITIONS.—In this subsection:

(A) COMPREHENSIVE ASSESSMENT OF PATIENTS.—The term ''comprehensive assessment of patients'' means the rule published by the Health Care Financing Administration that requires, as a condition of participation in the Medicare program, a home health agency to 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-

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

"(i) IN GENERAL.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts). Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system—

"(I) for the 12-month period beginning on the date the Secretary implements the system, shall be equal to the total amount that would have been made if the system had not been in effect; and

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

fect, and updated under subparagraph (B).

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

(c) REPORT.—

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

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

not later than the date that is 6 months after the date the Secretary implements the prospective payment system for home health services under such section 1895.

SEC. 303. CLARIFICATION OF SURETY BOND REQUIREMENTS.

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

"(7) provides the Secretary with a surety bond—

"(A) effective for a period of 4 years (as specified by the Secretary) or in the case of a change in the ownership or control of the agency (as determined by the Secretary) during or after such 4-year period, an additional period of time that the Secretary determines appropriate, such additional period not to exceed 4 years from the date of such change in ownership or control;

"(B) in a form specified by the Secretary; and

"(C) for a year in the period described in subparagraph (A) in an amount that is equal to the lesser of $50,000 or 10 percent of the aggregate amount of payments to the agency

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

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

''COORDINATION OF MEDICARE AND MEDICAID SURETY BOND PROVISIONS

''SEC. 1148. In the case of a home health agency that is subject to a surety bond under title XVIII and title XIX, the surety bond provided to satisfy the requirement under one such title shall satisfy the requirement under the other such title so long as the bond applies to guarantee return of overpayments under both such titles.''.

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

SEC. 304. TECHNICAL AMENDMENT CLARIFYING APPLICABLE MARKET BASKET INCREASE FOR PPS.

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

Public Law 105–277)) is amended by striking ''fiscal year 2002 or 2003'' and inserting ''each of fiscal years 2002 and 2003''.

Subtitle B—Direct Graduate Medical Education

SEC. 311. USE OF NATIONAL AVERAGE PAYMENT METHODOLOGY IN COMPUTING DIRECT GRADUATE MEDICAL EDUCATION (DGME) PAYMENTS.

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

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

''(i)(I) for a cost reporting period beginning before October 1, 2000, the hospital's approved FTE resident amount (determined under paragraph (2)) for that period;

''(II) for a cost reporting period beginning on or after October 1, 2000, and before October 1, 2004, the national average per resident amount determined under paragraph (7) or, if greater, the sum of the hospital-specific percentage (as defined in subparagraph (E)) of the hospital's approved FTE resident amount (determined

under paragraph (2)) for the period and the national percentage (as defined in such subparagraph) of the national average per resident amount determined under paragraph (7); and

''(III) for a cost reporting period beginning on or after October 1, 2004, the national average per resident amount determined under paragraph (7); and'';

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

''(E) TRANSITION TO NATIONAL AVERAGE PER RESIDENT PAYMENT SYSTEM.—For purposes of subparagraph (B)(i)(II), for the cost reporting period of a hospital beginning—

''(i) during fiscal year 2001, the hospital-specific percentage is 80 percent and the national percentage is 20 percent;

''(ii) during fiscal year 2002, the hospital-specific percentage is 60 percent and the national percentage is 40 percent;

''(iii) during fiscal year 2003, the hospital-specific percentage is 40 percent and the national percentage is 60 percent; and

"(iv) during fiscal year 2004, the hospital-specific percentage is 20 percent and the national percentage is 80 percent."; and

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

"(7) NATIONAL AVERAGE PER RESIDENT AMOUNT.—The national average per resident amount for a hospital for a cost reporting period beginning in a fiscal year is an amount determined as follows:

"(A) DETERMINATION OF HOSPITAL SINGLE PER RESIDENT AMOUNT.—The Secretary shall compute for each hospital operating an approved graduate medical education program a single per resident amount equal to the average (weighted by number of full-time equivalent residents) of the primary care per resident amount and the non-primary care per resident amount computed under paragraph (2) for cost reporting periods ending during fiscal year 1997.

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

estimate the average proportion of the single per resident amounts computed under subparagraph (A) that is attributable to wages and wage-related costs.

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

''(i) by dividing the single per resident amount computed under subparagraph (A) into a wage-related portion and a non-wage-related portion by applying the proportion determined under subparagraph (B);

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

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

''(D) DETERMINATION OF NATIONAL AVERAGE.—The Secretary shall compute a national average per resident amount equal to the

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

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

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

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

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

In applying clause (ii) for a cost reporting period beginning before October 1, 2004, the factor described in such clause shall be deemed to be 1 for a hospital if the national average per resident amount computed under subparagraph

(D) is less than the hospital's approved FTE resident amount (determined under paragraph (2)) for the period involved and the factor described in subparagraph (C)(ii) for the hospital's area is less than 1.

''(F) INITIAL UPDATING RATE.—The Secretary shall update such per resident amount for the hospital's cost reporting period that begins during fiscal year 2001 for each such hospital by the estimated percentage increase in the consumer price index for all urban consumers during the period beginning October 1997 and ending with the midpoint of the hospital's cost reporting period that begins during fiscal year 2001.

''(G) SUBSEQUENT UPDATING.—For each subsequent cost reporting period, subject to subparagraph (H), the national average per resident amount for a hospital is equal to the amount determined under this paragraph for the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index during the 12-month period ending at that midpoint, with appropriate

adjustments to reflect previous under-or over-estimations under this subparagraph in the projected percentage change in the consumer price index.

''(H) TRANSITIONAL BUDGET NEUTRALITY ADJUSTMENT.—

''(i) IN GENERAL.—If the Secretary estimates that, as a result of the amendments made by section 311 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, the post-MBBRA expenditures for fiscal year 2005 will be greater or less than the pre-MBBRA expenditures for that fiscal year—

''(I) the Secretary shall adjust the update applied under subparagraph (G) in determining the national average per resident amount for cost reporting periods beginning during fiscal year 2005 so that the amount of the post-MBBRA expenditures for those cost reporting periods is equal to the amount of the pre-MBBRA expenditures for such periods; and

''(II) the Secretary shall, taking into account the adjustment made under subclause (I), adjust the national average per resident amount, as applied for the portion of a cost reporting period beginning during fiscal year 2004 that occur in fiscal year 2005, so that the amount of the post-MBBRA expenditures made during fiscal year 2005 is equal to the amount of the pre-MBBRA expenditures during such fiscal year.

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

''(I) AGGREGATE SUBSECTION (h)-RELATED EXPENDITURES.—The term 'aggregate subsection (h)-related expenditures' means, with respect to cost reporting periods beginning during a fiscal year or with respect to a fiscal year, the aggregate expenditures under this title for such periods or fiscal year, respectively, which are attributable to the operation of this subsection.

''(II) PRE-MBBRA EXPENDITURES.—The term 'pre-MBBRA expenditures' means aggregate subsection (h)-related expenditures determined as if the amendments made by section 311 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 had not been enacted.

''(III) POST-MBBRA EXPENDITURES.—The term 'post-MBBRA expenditures' means aggregate subsection (h)-related expenditures determined taking into account the amendments made by section 311 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.''.

SEC. 312. INITIAL RESIDENCY PERIOD FOR CHILD NEUROLOGY RESIDENCY TRAINING PROGRAMS.

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

(1) in clause (i) by striking ''clause (ii)'' and inserting ''clause (ii) or (iii)'';

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

(3) in clause (ii), by striking the period at the end and inserting ", and"; and

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

"(iii) a period, of not more than three years, during which an individual is in a child neurology residency program, shall be treated as part of the initial residency period, but shall not be counted against any limitation on the initial residency period.".

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

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

Subtitle C—Other

SEC. 321. GAO STUDY ON GEOGRAPHIC RECLASSIFICATION.

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

(1) the magnitude of the effect of geographic reclassification on rural hospitals that do not reclassify;

(2) whether the current thresholds used in geographic reclassification reclassify hospitals to the appropriate labor markets;

(3) the effect of eliminating geographic reclassification through use of the occupational mix data;

(4) the group reclassification policy;

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

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

(7) whether there are sufficient controls over the intermediary evaluation of the wage data reported by hospitals.

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

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

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

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

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

''(III) The hospital would qualify as a rural or regional or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.

''(IV) The hospital meets such other criteria as the Secretary may specify.''.

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

''(13) MISCELLANEOUS PROVISIONS.—

''(A) APPLICATION OF RECLASSIFICATION OF CERTAIN HOSPITALS.—If a hospital is being treated as being located a rural under section 1886(d)(8)(E), that hospital shall be treated under this subsection as being located in that rural area.''.

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

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

SEC. 402. UPDATE OF STANDARDS APPLIED FOR GEOGRAPHIC RECLASSIFICATION FOR CERTAIN HOSPITALS.

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

(1) by inserting ''(i)'' after ''(B)'';

(2) by striking ''published in the Federal Register on January 3, 1980'' and inserting ''described in clause (ii)''; and

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

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

''(I) before fiscal year 2003, are the standards published in the Federal Register on January 3, 1980, or, at the election of the hospital with respect to fiscal years 2001 and 2002, standards so published on March 30, 1990; and

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

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

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply with respect to discharges occurring during cost reporting periods beginning on or after October 1, 1999.

SEC. 403. IMPROVEMENTS IN THE CRITICAL ACCESS HOSPITAL (CAH) PROGRAM.

(a) APPLYING 96-HOUR LIMIT ON A AVERAGE ANNUAL BASIS.—

(1) IN GENERAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395i–4(c)(2)(B)(iii)), as added by section 4201(a) of BBA, is amended by striking ''for a period not to exceed 96 hours'' and all that follows and inserting ''for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect on the date of the enactment of this Act.

(b) PERMITTING FOR-PROFIT HOSPITALS TO QUALIFY FOR DESIGNATION AS A CRITICAL ACCESS HOSPITAL.—Section 1820(c)(2)(B)(i) (42 U.S.C. 1395i–4(c)(2)(B)(i)), as added by section 4201(a) of BBA, is

amended in the matter preceding subclause (I), by striking ''nonprofit or public hospital'' and inserting ''hospital''.

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

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

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

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

''(i) was a hospital that ceased operations on or after the date that is 10 years before the date of the enactment of this subparagraph; and

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

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

''(i) is licensed by the State as a health clinic or a health center;

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

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

(d) ALL-INCLUSIVE PAYMENT OPTION FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

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

''(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

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

''(2) COST-BASED HOSPITAL OUTPATIENT SERVICE PAYMENT PLUS FEE SCHEDULE FOR PROFESSIONAL SERVICES.—If a hospital elects this para-

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

"(A) FACILITY FEE.—With respect to facility services, not including any services for which payment may be made under subparagraph (B), the reasonable costs of the critical access hospital in providing such services.

"(B) FEE SCHEDULE FOR PROFESSIONAL SERVICES.—With respect to professional services otherwise included within outpatient critical access hospital services, such amounts as would otherwise be paid under this part if such services were not included in outpatient critical access hospital services.

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

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

(e) ELIMINATION OF COINSURANCE FOR CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED BY A CRITICAL ACCESS HOSPITAL ON AN OUTPATIENT BASIS.—

(1) IN GENERAL.—Section 1833(a)(1)(D) (42 U.S.C. 1395l(a)(1)(D)) is amended by inserting ''or which are furnished on an outpatient basis by a critical access hospital'' after ''on an assignment-related basis''.

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

(f) PARTICIPATION IN SWING BED PROGRAM.—Section 1883 (42 U.S.C. 1395tt) is amended—

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

(2) in subsection (c), by striking '', or during which there is in effect for the hospital a waiver under subparagraph (A) of the last sentence of section 1861(e)''.

SEC. 404. FIVE-YEAR EXTENSION OF MEDICARE DEPENDENT HOSPITAL (MDH) PROGRAM.

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

(1) in clause (i), by striking ''and before October 1, 2001,'' and inserting ''and before October 1, 2006''; and

(2) in clause (ii)(II), by striking ''and before October 1, 2001,'' and inserting ''and before October 1, 2006''.

(b) CONFORMING AMENDMENTS.—

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

(A) in the matter preceding clause (i), by striking ''and before October 1, 2001,'' and inserting ''and before October 1, 2006''; and

(B) in clause (iv), by striking ''during fiscal year 1998 through fiscal year 2000'' and inserting ''during fiscal year 1998 through fiscal year 2005''.

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of Omnibus Budget Reconciliation Act of 1993 (42 U.S.C.

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

SEC. 405. REBASING FOR CERTAIN SOLE COMMUNITY HOSPITALS.

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

(1) in subparagraph (C), by inserting ''subject to subparagraph (I)'' before ''the term 'target amount' means''; and

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

''(I)(i) For cost reporting periods beginning on or after October 1, 2000, in the case of a sole community hospital that for its cost reporting period beginning during 1999 is paid on the basis of the target amount applicable to the hospital under subparagraph (C) and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, there shall be substituted for the base cost reporting period described in subparagraph (C) the rebased target amount determined under this subparagraph.

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

''(I) With respect to discharges occurring in fiscal year 2001, 75 percent of the target amount applicable to the hospital under subparagraph (C) (hereinafter in this subparagraph referred to as the 'subparagraph (C) target amount') and 25 percent of the amount of the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period beginning during fiscal year 1996 (hereinafter in this subparagraph referred to as the 'rebased target amount'), increased by the applicable percentage increase under subparagraph (B)(iv).

''(II) With respect to discharges occurring in fiscal year 2002, 50 percent of the subparagraph (C) target amount and 50 percent of the rebased target amount, increased by the applicable percentage increase under subparagraph (B)(iv).

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

amount, increased by the applicable percentage increase under subparagraph (B)(iv).

''(IV) With respect to discharges occurring in fiscal year 2003 or any subsequent fiscal year, 100 percent of the rebased target amount, increased by the applicable percentage increase under subparagraph (B)(iv).''.

SEC. 406. INCREASED FLEXIBILITY IN PROVIDING GRADUATE PHYSICIAN TRAINING IN RURAL AREAS.

(a) PERMITTING 30 PERCENT EXPANSION IN CURRENT GME TRAINING PROGRAMS FOR HOSPITALS LOCATED IN RURAL AREAS.—

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

(2) PAYMENT FOR INDIRECT GRADUATE MEDICAL EDUCATION COSTS.—Section 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)), as added by section 4621(b)(1) of BBA, is amended by inserting ''(or, 130 percent of such number in the case of a hospital located in a rural area)'' after ''may not exceed the number''.

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

(B) The amendment made by paragraph (2) applies to discharges occurring on or after October 1, 1999.

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

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

"(iv) NON-RURAL HOSPITALS OPERATING TRAINING PROGRAMS IN UNDERSERVED RURAL AREAS.—In the case of a hospital that is not located in a rural area but establishes separately accredited approved medical residency training programs (or rural tracks) in an underserved rural area or has an accredited training program with an integrated rural track, the Secretary shall adjust the limitation under subparagraph (F) in an appropriate manner insofar as it applies to such programs in such underserved rural areas in

order to encourage the training of physicians in underserved rural areas.''.

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

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

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

SEC. 407. ELIMINATION OF CERTAIN RESTRICTIONS WITH RESPECT TO HOSPITAL SWING BED PROGRAM.

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

''(b) The Secretary may not enter into an agreement under this section with any hospital unless, except as provided under subsection (g), the hospital is located in a rural area and has less than 100 beds.''.

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

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

(2) by striking ''(d)(1)'' and inserting ''(d)''.

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

SEC. 408. GRANT PROGRAM FOR RURAL HOSPITAL TRANSITION TO PROSPECTIVE PAYMENT.

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

''(3) UPGRADING DATA SYSTEMS.—

''(A) GRANTS TO HOSPITALS.—The Secretary may award grants to hospitals that have submitted applications in accordance with subparagraph (C) to assist eligible small rural hospitals in meeting the costs of implementing data systems required to meet requirements established under the Medicare program pursuant to amendments made by the Balanced Budget Act of 1997.

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

''(i) is located in a rural area (as defined for purposes of section 1886(d)); and

''(ii) has less than 50 beds.

''(C) APPLICATION.—A hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

''(D) AMOUNT OF GRANT.—A grant to a hospital under this paragraph may not exceed $50,000.

''(E) USE OF FUNDS.—A hospital receiving a grant under this paragraph may use the funds for the purchase of computer software and hardware and for the education and training of hospital staff on computer information systems and costs related to the implementation of prospective payment systems.

''(F) REPORT.—

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

''(ii) REPORTING.—

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

''(II) FINAL REPORT.—The Secretary shall submit a final report to such committees not later than 180 days after the completion of all of the

projects for which a grant is made under this section.''.

SEC. 409. MEDPAC STUDY OF RURAL PROVIDERS.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on rural providers furnishing items and services for which payment is made under title XVIII of the Social Security Act. Such study shall examine and evaluate the adequacy and appropriateness of the categories of special payments (and payment methodologies) established for rural hospitals under the Medicare program, and their impact on beneficiary access and quality of health care services.

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

SEC. 410. EXPANSION OF ACCESS TO PARAMEDIC INTERCEPT SERVICES IN RURAL AREAS.

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

''For purposes of this subsection, an area shall be treated as a rural area if it is designated as a rural area by any law or regulation of the State or if it 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)).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on January 1, 2000, and applies to paramedic intercept services furnished on or after such date.

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

Subtitle A—Medicare+Choice

SEC. 501. PHASE-IN OF NEW RISK ADJUSTMENT METHODOLOGY.

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

(1) by redesignating the first sentence as clause (i) with the heading ''IN GENERAL.—'' and appropriate indentation; and

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

''(ii) PHASE-IN.—Such risk adjustment methodology shall be implemented in a phased-in manner so that the method-

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

"(I) not more than 10 percent of the payment amount in 2000 and 2001;

"(II) not more than 20 percent of such amount in 2002;

"(III) not more than 30 percent of such amount in 2003; and

"(IV) 100 percent of such amount in any subsequent year (at which time the risk adjustment methodology should reflect data from multiple settings).".

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

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

(1) in subsection (a)(1), by striking "subsections (e) and (f)" and inserting "subsections (e), (g), and (i)";

(2) in subsection (c)(5), by inserting "(other than those attributable to subsection (i))" after "payments under this part"; and

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

''(i) NEW ENTRY BONUS.—

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

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

''(B) only for the subsequent 12 months, by 3 percent of the total monthly payment otherwise computed for such payment area.

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

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

''(4) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as affecting the calculation of the annual Medicare+Choice capitation rate for any payment area under subsection (c) or as applying to payment for any period not described in such paragraph.

''(5) OFFERED DEFINED.—In this subsection, the term 'offered' means, with respect to a Medicare+Choice plan as of a date, that a Medicare+Choice eligible individual may enroll with the plan on that date, regardless of when the enrollment takes effect or the individual obtain benefits under the plan.''.

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

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

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

(2) by redesignating the first sentence as a subparagraph (A) with an appropriate indentation and the heading ''IN GENERAL.—''; and

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

''(B) EARLIER RE-ENTRY PERMITTED WHERE CHANGE IN PAYMENT POLICY AND NO MORE THAN ONE OTHER PLAN AVAILABLE.—Subparagraph (A) shall not apply with respect to the offering by a Medicare+Choice organization of a Medicare+Choice plan in a Medicare+Choice payment area if—

''(i) during the 6-month period beginning on the date the organization notified the Secretary of the intention to terminate the most recent previous contract, there was a legislative change enacted (or a regulatory change adopted) that has the effect of increasing payment rates under section 1853 for that Medicare+Choice payment area; and

''(ii) at the time the organization notifies the Secretary of its intent to enter into

a contract to offer such a plan in the area, there is no more than one Medicare+Choice plan offered in the area.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to contract terminations occurring before, on, or after the date of the enactment of this Act.

SEC. 504. CONTINUED COMPUTATION AND PUBLICATION OF AAPCC DATA.

(a) IN GENERAL.—Section 1853(b) (42 U.S.C. 1395w–23(b)) is amended by adding at the end the following new paragraph:

''(4) CONTINUED COMPUTATION AND PUBLICATION OF COUNTY-SPECIFIC PER CAPITA FEE-FOR-SERVICE EXPENDITURE INFORMATION.—The Secretary, through the Chief Actuary of the Health Care Financing Administration, shall provide for the computation and publication, on an annual basis at the time of publication of the annual Medicare+Choice capitation rates, of information on the level of the average annual per capita costs (described in section 1876(a)(4)) for each Medicare+Choice payment area.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and apply to publications of the annual Medicare+Choice capitation rates made on or after such date.

SEC. 505. CHANGES IN MEDICARE+CHOICE ENROLLMENT RULES.

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

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

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

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

(2) CONFORMING MEDIGAP AMENDMENT.—Section 1882(s)(3) (42 U.S.C. 1395ss(s)(3)) is amended—

(A) in subparagraph (A), by inserting ", subject to subparagraph (E)," after "in the case of an individual described in subparagraph (B) who"; and

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

"(E)(i) An individual described in subparagraph (B)(ii) may elect to apply subparagraph (A) by substituting, for the date of termination of enrollment, the date on which the individual or Secretary was notified by the Medicare+Choice organization of the impending termination or discontinuance of the Medicare+Choice plan in the area in which the individual resides, but only if the individual disenrolls from the plan as a result of such notification.

"(ii) In the case of an individual making such an election, the issuer involved shall accept the application of the individual submitted before the date of termination of enrollment, but the coverage under subparagraph (A) shall only become effective upon termination of coverage under the Medicare+Choice plan involved.".

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

(b) CONTINUOUS OPEN ENROLLMENT FOR INSTITUTIONALIZED INDIVIDUALS.—Section 1851(e)(2) (42 U.S.C. 1395w–21(e)(2)) is amended—

(1) in subparagraph (B)(i), by inserting ''and subparagraph (D)'' after ''clause (ii)'';

(2) in subparagraph (C)(i), by inserting ''and subparagraph (D)'' after ''clause (ii)''; and

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

''(D) CONTINUOUS OPEN ENROLLMENT FOR INSTITUTIONALIZED INDIVIDUALS.—At any time after 2001 in the case of a Medicare+Choice eligible individual who is institutionalized, the individual may change the election under subsection (a)(1).''.

(c) CONTINUING ENROLLMENT FOR CERTAIN ENROLLEES.—Section 1851(b)(1) (42 U.S.C. 1395w–21(b)(1)) is amended—

(1) in subparagraph (A), by inserting ''and except as provided in subparagraph (C)'' after ''may otherwise provide''; and

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

"(C) CONTINUATION OF ENROLLMENT PERMITTED WHERE SERVICE CHANGED.—Notwithstanding subparagraph (B), if a Medicare+Choice organization eliminates from its service area a geographic area that was previously within its service area, the organization may elect to offer individuals residing in all or portions of the affected geographic area who would otherwise be ineligible to continue enrollment the option to continue enrollment in a Medicare+Choice plan it offers so long as—

"(i) the enrollee agrees to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan service area; and

"(ii) there is no other Medicare+Choice plan offered in the area in which the enrollee resides at the time of the organization's election.".

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

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

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

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

(1) by striking ''The'' and inserting ''Subject to paragraph (2), the'';

(2) by redesignating the first sentence as a paragraph (1) with an appropriate indentation and the heading ''IN GENERAL.—''; and

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

''(2) VARIATION IN PREMIUM WAIVER PERMITTED.—A Medicare+Choice organization may waive part or all of a premium described in paragraph (1) for one or more Medicare+Choice payment areas within its service area if the annual Medicare+Choice capitation rates under section 1853(c) vary between such payment area and other payment areas within such service area.''.

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

SEC. 507. DELAY IN DEADLINE FOR SUBMISSION OF ADJUSTED COMMUNITY RATES AND RELATED INFORMATION.

(a) DELAY IN DEADLINE FOR SUBMISSION OF ADJUSTED COMMUNITY RATES AND RELATED INFORMATION.—Section 1854(a)(1) (42 U.S.C. 1395w–24(a)(1)) is amended by striking ''May 1'' and inserting ''July 1''.

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

(c) EFFECTIVE DATE.—The amendments made by this section apply with respect to information submitted by Medicare+Choice organizations (and provided to beneficiaries) for years beginning with 1999.

SEC. 508. TWO-YEAR EXTENSION OF MEDICARE COST CONTRACTS.

Section 1876(h)(5)(B) (42 U.S.C. 1395mm(h)(5)(B)) is amended by striking ''2002'' and inserting ''2004''.

SEC. 509. MEDICARE+CHOICE NURSING AND ALLIED HEALTH PROFESSIONAL EDUCATION PAYMENTS.

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

(1) in subparagraph (A)—

(A) by designating the portion following ''IN GENERAL.—'' as a clause (i) with the heading ''GRADUATE MEDICAL TRAINING.—'' and appropriate indentation; and

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

''(ii) NURSING AND ALLIED HEALTH TRAINING.—For portions of cost reporting periods occurring on or after January 1, 2000, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital that has direct costs of approved education activities for nurse and allied health professional training.'';

(2) in subparagraph (C)—

(A) designating the portion following ''DETERMINATION OF AMOUNT.—'' as a clause (i) with the heading ''GRADUATE MEDICAL TRAINING.—'' and appropriate indentation;

(B) by striking ''under this paragraph'' and inserting ''under subparagraph (A)(i)'';

(C) by inserting ''the DGME portion (as defined in clause (iii)) of'' after ''shall be equal to''; and

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

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

''(I) The total payments under such subparagraph in a year shall bear the same ratio to the Secretary's estimate of the total payments under subparagraph (A)(i) in the year as the ratio (as estimated by the Secretary) of the total payments under this title

for direct costs described in subparagraph (A)(ii) in the year bear to the total payments under section 1886(h) in the year; but in no case shall the total payments under subparagraph (A)(ii) exceed $60,000,000 in a year.

''(II) The payments to different hospitals are proportional to the direct costs of each hospital described in subparagraph (A)(ii).

''(iii) DGME PORTION DEFINED.—For purposes of this subparagraph, the 'DGME portion' means, for a year, the ratio of—

''(I) the amount by which (aa) the Secretary's estimate of the total additional payments that would be payable under this paragraph for the year if subparagraph (A)(ii) and clause (ii) of this subparagraph did not apply, exceeds (bb) the total payments in the year under subparagraph (A)(ii), to

''(II) the total additional payments estimated under subclause (I)(aa) for the year.''.

SEC. 510. REDUCTION IN ADJUSTMENT IN NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE FOR 2002.

Section 1853(c)(6)(B)(iv) (42 U.S.C. 1395w–23(c)(6)(B)(iv)) is amended by striking ''0.5 percentage points'' and inserting ''0.3 percentage points''.

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

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

''(4) TREATMENT OF ACCREDITATION.—The Secretary shall provide that a Medicare+Choice organization is deemed to meet requirements of paragraphs (1) and (2) of this subsection and subsection (h) (relating to confidentiality and accuracy of enrollee records) if the organization is accredited (and periodically reaccredited) by a private accrediting organization under a process that the Secretary has determined assures that the accrediting organization applies standards that meet or exceed the standards established under section 1856 to carry out the respective requirements. The Secretary shall deter-

mine, within 210 days after the date the Secretary receives an application by a private accrediting organization, whether the process of the private accrediting organization meets the requirements of the preceding sentence using the criteria specified in section 1865(b)(2). The Secretary shall, using the process described in section 1865(b), deem a Medicare+Choice organization that is so accredited as meeting the requirements of paragraphs (1) and (2) of this subsection and subsection (h).''

SEC. 512. MISCELLANEOUS CHANGES AND STUDIES.

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

(b) STUDY OF ACCOUNTING FOR VA AND DOD EXPENDITURES FOR MEDICARE BENEFICIARIES.—The Secretary of Health and Human Services, jointly with the Secretaries of Defense and of Veterans Affairs, shall submit to Congress not later than 1 year after the date of the enactment of this Act a report on the estimated use of health care services furnished by the Departments of Defense and of Veterans Affairs to Medicare beneficiaries,

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

(c) PROMOTING PROMPT IMPLEMENTATION OF INFORMATICS, TELEMEDICINE, AND EDUCATION DEMONSTRATION PROJECT.—Section 4207 of BBA is amended—

(1) in subsection (a)(1), by adding at the end the following: ''The Secretary shall make an award for such project not later than 3 months after the date of the enactment of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999. The Secretary shall accept the proposal adjudged to be the best technical proposal as of such date of the enactment without the need for additional review or resubmission of proposals.'';

(2) in subsection (a)(2)(A), by inserting before the period at the end the following: ''that qualify as Federally designated medically underserved areas or health professional shortage areas at the time of enrollment of beneficiaries under the project'';

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

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

(5) in subsection (d)(2)(B)(i), by striking ''(but only in the case of patients located in medically underserved areas)'' and inserting ''or at sites providing health care to patients located in medically underserved areas'';

(6) in subsection (d)(2)(C)(i), by striking ''to deliver medical informatics services under'' and inserting ''for activities related to''; and

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

''(4) COST-SHARING.—The project may not impose cost sharing on a Medicare beneficiary for the receipt of services under the project. Project costs will cover all costs to patients and providers related to participation in the project.''.

SEC. 513. MEDPAC REPORT ON MEDICARE MSA (MEDICAL SAVINGS ACCOUNT) PLANS.

Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission

shall submit to Congress a report on specific legislative changes that should be made to make MSA plans a viable option under the Medicare+Choice program.

SEC. 514. CLARIFICATION OF NONAPPLICABILITY OF CERTAIN PROVISIONS OF DISCHARGE PLANNING PROCESS TO MEDICARE+CHOICE PLANS.

(a) IN GENERAL.—Section 1861(ee)(2)(H) (42 U.S.C. 1395x(ee)(2)(H)), as added by section 4431 of BBA, is amended—

(1) in clause (i)—

(A) by striking ''not specify'' and inserting ''subject to clause (iii), not specify''; and

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

(2) in clause (ii), by striking the period at the end and inserting '', and''; and

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

''(iii) for individuals enrolled under a Medicare+Choice plan, under a contract with the Secretary under section 1857, for whom a hospital furnishes inpatient hospital services, the hospital may specify with respect to such individual the provider of post-hospital home health services or other post-hospital services 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

may not impose a limit on the number of individuals that may participate in a project conducted under section 2355 of the Deficit Reduction Act of 1984, other than an aggregate limit of not less than 324,000 for all sites.''.

SEC. 522. EXTENSION OF MEDICARE COMMUNITY NURSING ORGANIZATION DEMONSTRATION PROJECT.

(a) EXTENSION.—Notwithstanding any other provision of law, any demonstration project conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–123) and conducted for the additional period of 2 years as provided for under section 4019 of BBA, shall be conducted for an additional period of 2 years.

(b) REPORT.—By not later than July 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report describing the results of any demonstration project conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987, and describing the data collected by the Secretary relevant to the analysis of the results of such project, including the most recently available data through the end of 2000.

SEC. 523. MEDICARE+CHOICE COMPETITIVE BIDDING DEMONSTRATION PROJECT.

Section 4011 of BBA is amended—

(1) in subsection (a)—

(A) by striking ''The Secretary'' and inserting the following:

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary''; and

(B) by adding at the end the following:

''(2) DELAY IN IMPLEMENTATION.—The Secretary shall not implement the project until January 1, 2002, or, if later, 6 months after the date the Competitive Pricing Advisory Committee has submitted to Congress a report on each of the following topics:

''(A) INCORPORATION OF ORIGINAL FEE-FOR-SERVICE MEDICARE PROGRAM INTO PROJECT.—What changes would be required in the project to feasibly incorporate the original fee-for-service Medicare program into the project in the areas in which the project is operational.

''(B) QUALITY ACTIVITIES.—The nature and extent of the quality reporting and monitoring activities that should be required of plans participating in the project, the estimated costs that plans will incur as a result of these requirements, and the current ability of the Health Care Financing Administration to col-

lect and report comparable data, sufficient to support comparable quality reporting and monitoring activities with respect to beneficiaries enrolled in the original fee-for-service Medicare program generally.

''(C) RURAL PROJECT.—The current viability of initiating a project site in a rural area, given the site specific budget neutrality requirements of the project, and insofar as the Committee decides that the addition of such a site is not viable, recommendations on how the project might best be changed so that such a site is viable.

''(D) BENEFIT STRUCTURE.—The nature and extent of the benefit structure that should be required of plans participating in the project, the rationale for such benefit structure, the potential implications that any benefit standardization requirement may have on the number of plan choices available to a beneficiary in an area designated under the project, the potential implications of requiring participating plans to offer variations on any standardized benefit package the committee might recommend, such that a beneficiary could elect to pay a higher

percentage of out-of-pocket costs in exchange for a lower premium (or premium rebate as the case may be), and the potential implications of expanding the project (in conjunction with the potential inclusion of the original fee-for-service Medicare program) to require Medicare supplemental insurance plans operating in an area designated under the project to offer a coordinated and comparable standardized benefit package.

''(3) CONFORMING DEADLINES.—Any dates specified in the succeeding provisions of this section shall be delayed (as specified by the Secretary) in a manner consistent with the delay effected under paragraph (2).''; and

(2) in subsection (c)(1)(A)—

(A) by striking ''and'' at the end of clause (i); and

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

''(iii) establish beneficiary premiums for plans offered in such area in a manner such that a beneficiary who enrolls in an offered plan with a below average price (as 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-

plementary Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t), in such proportions as the Secretary determines to be appropriate, of such funds as are necessary to cover costs of the project, including costs for information infrastructure and recurring costs of case management services, flexible benefits, and program management.''.

TITLE VI—MEDICAID

SEC. 601. MAKING MEDICAID DSH TRANSITION RULE PERMANENT.

(a) IN GENERAL.—Section 4721(e) of the Balanced Budget Act of 1997 (42 U.S.C. 1396r–4 note) is amended—

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

(2) in paragraphs (1) and (2)—

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

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

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

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

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in the enactment of section 4721(e) of the Balanced Budget Act of 1997 (Public Law 105–33; 110 Stat. 514).

SEC. 602. INCREASE IN DSH ALLOTMENT FOR CERTAIN STATES AND THE DISTRICT OF COLUMBIA.

(a) IN GENERAL.—The table in section 1923(f)(2) (42 U.S.C. 1396r–4(f)(2)) is amended under each of the columns for FY 00, FY 01, and FY 02—

(1) in the entry for the District of Columbia, by striking ''23'' and inserting ''32'';

(2) in the entry for Minnesota, by striking ''16'' and inserting ''33'';

(3) in the entry for New Mexico, by striking ''5'' and inserting ''9''; and

(4) in the entry for Wyoming, by striking ''0'' and inserting ''.100''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on October 1, 1999, and applies to expenditures made on or after such date.

SEC. 603. NEW PROSPECTIVE PAYMENT SYSTEM FOR FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (13)—

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

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

(C) by striking subparagraph (C); and

(2) by inserting after paragraph (14) the following new paragraph:

''(15) for payment for services described in clause (B) or (C) of section 1905(a)(2) under the plan in accordance with subsection (aa);''.

(b) NEW PROSPECTIVE PAYMENT SYSTEM.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following:

''(aa) PAYMENT FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.—

''(1) IN GENERAL.—Beginning with fiscal year 2000 and each succeeding fiscal year, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by a Federally-qualified health center and services described in section 1905(a)(2)(B) furnished by a rural health clinic in accordance with the provisions of this subsection.

''(2) FISCAL YEAR 2000.—Subject to paragraph (4), for services furnished during fiscal year 2000, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of the center or clinic of furnishing such services during fiscal year 1999 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used

under section 1833(a)(3), adjusted to take into account any increase in the scope of such services furnished by the center or clinic during fiscal year 2000.

''(3) FISCAL YEAR 2001 AND SUCCEEDING FISCAL YEARS.—Subject to paragraph (4), for services furnished during fiscal year 2001 or a succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this subsection for the preceding fiscal year—

''(A) increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) for that fiscal year; and

''(B) adjusted to take into account any increase in the scope of such services furnished by the center or clinic during that fiscal year.

''(4) ESTABLISHMENT OF INITIAL YEAR PAYMENT AMOUNT FOR NEW CENTERS OR CLINICS.—In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after fiscal year 1999, the State plan shall provide for payment for services described in section

1905(a)(2)(C) furnished by the center or services described in section 1905(a)(2)(B) furnished by the clinic in the first fiscal year in which the center or clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year in accordance with the regulations and methodology referred to in paragraph (2). For each fiscal year following the fiscal year in which the entity first qualifies as a Federally-qualified health center or rural health clinic, the State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

''(5) ADMINISTRATION IN THE CASE OF MANAGED CARE.—In the case of services furnished by a Federally-qualified health center or rural health clinic pursuant to a contract between the center or clinic and a managed care entity (as defined in section 1932(a)(1)(B)), the State plan shall provide for payment to the center or clinic (at least quarterly) by the State of a supplemental payment equal to the amount (if any) by which the amount determined under paragraphs (2), (3), and (4) of this subsection exceeds the amount of the payments provided under the contract.

''(6) ALTERNATIVE PAYMENT METHODOLOGIES.—Notwithstanding any other provision of this section, the State plan may provide for payment in any fiscal year to a Federally-qualified health center for services described in section 1905(a)(2)(C) or to a rural health clinic for services described in section 1905(a)(2)(B) in an amount which is determined under an alternative payment methodology that—

''(A) is agreed to by the State and the center or clinic; and

''(B) results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under this section.''.

(c) CONFORMING AMENDMENTS.—

(1) Section 4712 of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 508) is amended by striking subsection (c).

(2) Section 1915(b) of the Social Security Act (42 U.S.C. 1396n(b)) is amended by striking ''1902(a)(13)(E)'' and inserting ''1902(a)(15), 1902(aa),''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 1999, and apply to services furnished on or after such date.

SEC. 604. PARITY IN REIMBURSEMENT FOR CERTAIN UTILIZATION AND QUALITY CONTROL SERVICES.

(a) IN GENERAL.—Section 1903(a)(3)(C)(i) (42 U.S.C. 1396b(a)(3)(C)(i)) is amended—

(1) by inserting ''(other than a review described in clause (ii))'' after ''quality review''; and

(2) by inserting ''(or under a contract with the State that sets forth standards of performance equivalent to those under section 1902(d))'' before the semicolon.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to expenditures made on and after the date of the enactment of this Act.

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

SEC. 701. STABILIZING THE SCHIP ALLOTMENT FORMULA.

(a) IN GENERAL.—Section 2104(b) (42 U.S.C. 1397dd(b)) is amended—

(1) in paragraph (2)(A)—

(A) in clause (i), by striking ''through 2000'' and inserting ''and 1999''; and

(B) in clause (ii), by striking ''2001'' and inserting ''2000'';

(2) by amending paragraph (4) to read as follows:

"(4) FLOORS AND CEILINGS IN STATE ALLOTMENTS.—

"(A) IN GENERAL.—The proportion of the allotment under this subsection for a subsection (b) State (as defined in subparagraph (D)) for fiscal year 2000 and each fiscal year thereafter shall be subject to the following floors and ceilings:

"(i) FLOOR OF $2,000,000.—A floor equal to $2,000,000 divided by the total of the amount available under this subsection for all such allotments for the fiscal year.

"(ii) ANNUAL FLOOR OF 10 PERCENT BELOW PRECEDING FISCAL YEAR'S PROPORTION.—A floor of 90 percent of the proportion for the State for the preceding fiscal year.

"(iii) CUMULATIVE FLOOR OF 30 PERCENT BELOW THE FY 1999 PROPORTION.—A floor of 70 percent of the proportion for the State for fiscal year 1999.

"(iv) CUMULATIVE CEILING OF 45 PERCENT ABOVE FY 1999 PROPORTION.—A ceiling of 145 percent of the proportion for 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-

paragraph (A)(iv)) so that (after the application of such floors and ceiling) such sum equals 1.0.

''(C) CONSTRUCTION.—This paragraph shall not be construed as applying to (or taking into account) amounts of allotments redistributed under subsection (f).

''(D) DEFINITIONS.—In this paragraph:

''(i) PROPORTION OF ALLOTMENT.—The term 'proportion' means, with respect to the allotment of a subsection (b) State for a fiscal year, the amount of the allotment of such State under this subsection for the fiscal year divided by the total of the amount available under this subsection for all such allotments for the fiscal year.

''(ii) SUBSECTION (b) STATE.—The term 'subsection (b) State' means one of the 50 States or the District of Columbia.'';

(3) in paragraph (2)(B), by striking ''the fiscal year'' and inserting ''the calendar year in which such fiscal year begins''; and

(4) in paragraph (3)(B), by striking ''the fiscal year involved'' and inserting ''the calendar year in which such fiscal year begins''.

(b) EFFECTIVE DATE.—The amendments made by this section apply to allotments determined under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) for fiscal year 2000 and each fiscal year thereafter.

SEC. 702. INCREASED ALLOTMENTS FOR TERRITORIES UNDER THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

Section 2104(c)(4)(B) (42 U.S.C. 1397dd(c)(4)(B)) is amended by inserting '', $34,200,000 for each of fiscal years 2000 and 2001, $25,200,000 for each of fiscal years 2002 through 2004, $32,400,000 for each of fiscal years 2005 and 2006, and $40,000,000 for fiscal year 2007'' before the period.

Passed the House of Representatives November 5, 1999.

Attest: JEFF TRANDAHL,

Clerk.