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106TH CONGRESS
1ST SESSION

H. R. 3426

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.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 17, 1999

Mr. THOMAS introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

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,

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 Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) REFERENCES TO THE 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—Adjustments to PPS Payments for Skilled Nursing Facilities

SEC. 101. 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)) for such services furnished on or after April 1, 2000, and before the date described in subsection (c), the Secretary of Health and Human Services shall increase by 20 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, CA1, RHC, RMC, and RMB 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).

(c) DATE DESCRIBED.—For purposes of subsection (a), the date described in this subsection is the later of—

(1) October 1, 2000; or

(2) the date on which the Secretary implements a refined case mix classification system under section 1888(e)(4)(G)(i) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(G)(i)) to better account for medically complex patients.

(d) INCREASE FOR FISCAL YEARS 2001 AND 2002.—

(1) IN GENERAL.—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)) for covered skilled nursing facility services furnished during fiscal years 2001 and 2002, the Secretary of Health and Human Services shall increase by 4.0 percent for each such fiscal year the adjusted Federal per diem rate otherwise determined under paragraph (4) of such section (but for this section).

(2) ADDITIONAL PAYMENT NOT BUILT INTO THE BASE.—The Secretary of Health and Human Services shall not include any additional payment

made under this subsection in updating the Federal per diem rate under section 1888(e)(4) of that Act (42 U.S.C. 1395yy(e)(4)).

SEC. 102. AUTHORIZING FACILITIES TO ELECT IMMEDIATE TRANSITION TO FEDERAL RATE.

(a) IN GENERAL.—Section 1888(e) (42 U.S.C. 1395yy(e)) 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 no earlier than 30 days before the date of such election determined pursuant to paragraph (1)(B).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to elections made on or after December 15, 1999, except that no election shall be effective under such amendments for a cost reporting period beginning before January 1, 2000.

SEC. 103. 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)) 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 AND SERVICES.—Items and services 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)) and any

additional chemotherapy items identified 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)) and any additional chemotherapy administration services identified by the Secretary.

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

''(V) Customized prosthetic devices (commonly known as artificial limbs or components of artificial limbs) under the following HCPCS codes (as of July 1, 1999 (and as subsequently modified by the Secretary)), and any additional customized pros-

thetic devices identified 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–L5611; 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.—

(1) IN GENERAL.—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 AND SERVICES.—The Secretary shall provide for an appropriate proportional reduction in payments so that beginning with fiscal year 2001, the aggregate amount of such reductions is equal to the aggregate increase in payments attributable to the exclusion effected under clause (iii) of paragraph (2)(A).".

(2) CONFORMING AMENDMENT.—Section 1888(e)(8)(A) (42 U.S.C. 1395yy(e)(8)(A)) is amended by striking "and adjustments for variations in labor-related costs under paragraph (4)(G)(ii)" and inserting "adjustments for variations in labor-related costs under paragraph (4)(G)(ii), and adjustments under paragraph (4)(G)(iii)".

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

SEC. 104. 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)) 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 striking subparagraph (B) and inserting the following new subparagraph:

''(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 1.0 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. 105. SPECIAL CONSIDERATION FOR FACILITIES SERVING SPECIALIZED PATIENT POPULATIONS.

(a) IN GENERAL.—Section 1888(e) (42 U.S.C. 1395yy(e)), as amended by section 102(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 described 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 the first cost reporting period of the facility begins after the date of the enactment of this Act 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.—Not later than March 1, 2001, 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. 106. MEDPAC STUDY ON SPECIAL PAYMENT FOR FACILITIES LOCATED IN HAWAII AND ALASKA.

(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study of 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.—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).

SEC. 107. STUDY AND REPORT REGARDING STATE LICENSURE AND CERTIFICATION STANDARDS AND RESPIRATORY THERAPY COMPETENCY EXAMINATIONS.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study that—

(1) identifies variations in State licensure and certification standards for health care providers (including nursing and allied health professionals) and other individuals providing respiratory therapy in skilled nursing facilities;

(2) examines State requirements relating to respiratory therapy competency examinations for such providers and individuals; and

(3) determines whether regular respiratory therapy competency examinations or certifications should be required under the medicare program

under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for such providers and individuals.

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

Subtitle B—PPS Hospitals

SEC. 111. MODIFICATION 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)) is amended—

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

(2) by redesignating subclause (V) as subclause (VI);

(3) by inserting after subclause (IV) the following new subclause:

''(V) during fiscal year 2001, 'c' is equal to 1.54; and''; and

(4) in subclause (VI), as so redesignated, by striking ''2000'' and inserting ''2001''.

(b) SPECIAL PAYMENTS TO MAINTAIN 6.5 PERCENT IME PAYMENT FOR FISCAL YEAR 2000.—

(1) ADDITIONAL PAYMENT.—In addition to payments made to each subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) under section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B))) which receives payment for the direct costs of medical education for discharges occurring in fiscal year 2000, the Secretary of Health and Human Services shall make one or more payments to each such hospital in an amount which, as estimated by the Secretary, is equal in the aggregate to the difference between the amount of payments to the hospital under such section for such discharges and the amount of payments that would have been paid under such section for such discharges if ''c'' in clause (ii)(IV) of such section equalled 1.6 rather than 1.47. Additional payments made under this subsection shall be made applying the same structure as applies to payments made under section 1886(d)(5)(B) of such Act.

(2) NO EFFECT ON OTHER PAYMENTS OR DETERMINATIONS.—In making such additional payments, the Secretary shall not change payments, determinations, or budget neutrality adjustments made for such period under section 1886(d) of such Act (42 U.S.C. 1395ww(d)).

(c) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by inserting ''or any additional payments under such paragraph resulting from the application of section 111 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999'' after ''Balanced Budget Act of 1997''.

SEC. 112. 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)) 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) as 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 and 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 October 1, 2001.

Subtitle C—PPS-Exempt Hospitals

SEC. 121. 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)) 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 appropriate 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. 122. 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)) 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. 123. 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. 124. 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 pro-

gram. 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 psychiatric 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. 125. REFINEMENT OF PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT REHABILITATION SERVICES.

(a) USE OF DISCHARGE AS PAYMENT UNIT.—

(1) IN GENERAL.—Section 1886(j)(1)(D) (42 U.S.C. 1395ww(j)(1)(D)) is amended by striking ", day of inpatient hospital services, or other unit of payment defined by the Secretary".

(2) CONFORMING AMENDMENT TO CLASSIFICATION.—Section 1886(j)(2)(A)(i) (42 U.S.C. 1395ww(j)(2)(A)(i)) is amended 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 appropriate to improve the explanatory power

of functional independence measure-function related groups; and''.

(3) CONSTRUCTION RELATING TO TRANSFER AUTHORITY.—Section 1886(j)(1) (42 U.S.C. 1395ww(j)(1)) is amended by adding at the end the following new subparagraph:

''(E) 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.''.

(b) 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 (42 U.S.C. 1395ww(j)).

(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.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) are effective as if included in the enactment of section 4421(a) of BBA.

Subtitle D—Hospice Care

SEC. 131. TEMPORARY INCREASE IN PAYMENT FOR HOSPICE CARE.

(a) INCREASE FOR FISCAL YEARS 2001 AND 2002.—For purposes of payments under section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)) for hospice care furnished during fiscal years 2001 and 2002, the Secretary of Health and Human Services shall increase the payment rate in effect (but for this section) for—

(1) fiscal year 2001, by 0.5 percent, and

(2) fiscal year 2002, by 0.75 percent.

(b) ADDITIONAL PAYMENT NOT BUILT INTO THE BASE.—The Secretary of Health and Human Services shall not include any additional payment made under this subsection (a) in updating the payment rate, as increased by the applicable market basket percentage increase for the fiscal year involved under section 1814(i)(1)(C)(ii) of that Act (42 U.S.C. 1395f(i)(1)(C)(ii)).

SEC. 132. STUDY AND REPORT TO CONGRESS REGARDING MODIFICATION OF THE PAYMENT RATES FOR HOSPICE CARE.

(a) STUDY.—The Comptroller General of the United States shall conduct a study to determine the feasibility and advisability of updating the payment rates and the cap amount determined with respect to a fiscal year under section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) for routine home care and other services included in hospice care. Such study shall examine the cost factors used to determine such rates and such amount and shall evaluate whether such factors should be modified, eliminated, or supplemented with additional cost factors.

(b) REPORT.—Not later than one year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a), together with any recommendations for legislation that the Comptroller General determines to be appropriate as a result of such study.

Subtitle E—Other Provisions

SEC. 141. MEDPAC STUDY ON MEDICARE PAYMENT FOR NONPHYSICIAN HEALTH PROFESSIONAL CLINICAL TRAINING IN HOSPITALS.

(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study of medicare payment

policy with respect to professional clinical training of different classes of nonphysician 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.—Not later than 18 months after the date of the enactment of this Act, the Commission shall submit a report to Congress on the study conducted under subsection (a).

Subtitle F—Transitional Provisions

SEC. 151. EXCEPTION TO CMI QUALIFIER FOR ONE YEAR.

Notwithstanding any other provision of law, for purposes of fiscal year 2000, the Northwest Mississippi Regional Medical Center located in Clarksdale, Mississippi shall be deemed to have satisfied the case mix index criteria under section 1886(d)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(C)(ii)) for classification as a rural referral center.

SEC. 152. RECLASSIFICATION OF CERTAIN COUNTIES AND AREAS FOR PURPOSES OF REIMBURSEMENT UNDER THE MEDICARE PROGRAM.

(a) FISCAL YEAR 2000.—Notwithstanding any other provision of law, effective for discharges occurring during fiscal year 2000, for purposes of making payments under

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

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

(2) to hospitals in Orange County, New York, the large urban area of New York, New York is deemed to include such county;

(3) to hospitals in Lake County, Indiana, and to hospitals in Lee County, Illinois, such counties are deemed to be located in the Chicago, Illinois Metropolitan Statistical Area;

(4) to hospitals in Hamilton-Middletown, Ohio, Hamilton-Middletown, Ohio, is deemed to be located in the Cincinnati, Ohio-Kentucky-Indiana Metropolitan Statistical Area;

(5) to hospitals in Brazoria County, Texas, such county is deemed to be located in the Houston, Texas Metropolitan Statistical Area; and

(6) to hospitals in Chittenden County, Vermont, such county is deemed to be located in the Boston-Worcester-Lawrence-Lowell-Brockton, Massachusetts-New Hampshire Metropolitan Statistical Area.

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

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

(2) the large urban area of New York, New York is deemed to include Orange County, New York;

(3) Lake County, Indiana, and Lee County, Illinois, are deemed to be located in the Chicago, Illinois Metropolitan Statistical Area;

(4) Hamilton-Middletown, Ohio, is deemed to be located in the Cincinnati, Ohio-Kentucky-Indiana Metropolitan Statistical Area;

(5) Brazoria County, Texas, is deemed to be located in the Houston, Texas Metropolitan Statistical Area; and

(6) Chittenden County, Vermont is deemed to be located in the Boston-Worcester-Lawrence-Lowell-Brockton, Massachusetts-New Hampshire Metropolitan Statistical Area.

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

SEC. 153. WAGE INDEX CORRECTION.

Notwithstanding any other provision of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), the Secretary of Health and Human Services shall calculate and apply the Hattiesburg, Mississippi Metropolitan Statistical Area wage index under that section for discharges occurring during fiscal year 2000 using fiscal year 1996 wage and hour data for Wesley Medical Center for purposes of payment under that section for that fiscal year. Such recalculation shall not affect the wage index for any other area.

SEC. 154. CALCULATION AND APPLICATION OF WAGE INDEX FLOOR FOR A CERTAIN AREA.

(a) FISCAL YEAR 2000.—Notwithstanding any other provision of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), for discharges occurring during fiscal year 2000, the Secretary of Health and Human Services shall calculate and apply the wage index for the Allentown-Bethlehem-Easton Metropolitan Statistical Area under that section as if the Lehigh Valley Hospital were classified in such area for purposes of payment under that sec-

tion for such fiscal year. Such recalculation shall not affect the wage index for any other area.

(b) FISCAL YEAR 2001.—Notwithstanding any other provision of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), in calculating and applying the wage indices under that section for discharges occurring during fiscal year 2001, Lehigh Valley Hospital shall be treated as being classified in the Allentown-Bethlehem-Easton Metropolitan Statistical Area.

SEC. 155. SPECIAL RULE FOR CERTAIN SKILLED NURSING FACILITIES.

(a) IN GENERAL.—Notwithstanding any provision of section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)), for the cost reporting period beginning in fiscal year 2000 and for the cost reporting period beginning in fiscal year 2001, if a skilled nursing facility which meets the criteria described in subsection (b) elects to be paid in accordance with subsection (c), the Secretary of Health and Human Services shall establish a per diem payment amount for such facility according to the methodology described in subsection (c) for such cost reporting periods in lieu of the payment amount that would otherwise be established for such facility under section 1888(e)(1) of such Act (42 U.S.C. 1395yy(e)(1)).

(b) FACILITY ELIGIBILITY CRITERIA.—For purposes of this subsection, a skilled nursing facility is one—

(1) that began participation in the Medicare program under title XVIII of the Social Security Act before January 1, 1995;

(2) for which at least 80 percent of the total inpatient days of the facility in the cost reporting period beginning in fiscal year 1998 were comprised of individuals entitled to benefits under such title; and

(3) that is located in Baldwin or Mobile County, Alabama.

(c) DETERMINATION OF PER DIEM AMOUNT.—For purposes of subsection (a), the per diem payment amount shall be equal to 100 percent of the amount determined under section 1888(e)(3) of the Social Security Act (42 U.S.C. 1395yy(e)(3)) except that, in determining such amount, the Secretary shall—

(1) substitute the allowable costs of the facility for the cost reporting period beginning in fiscal year 1998 for those allowable costs of the cost reporting period beginning in fiscal year 1995; and

(2) exclude the update to the first cost reporting period (from fiscal year 1995 to fiscal year 1998) described in section 1888(e)(3)(B)(i) of such Act (42 U.S.C. 1395yy(e)(3)(B)(i)).

TITLE II—PROVISIONS RELATING TO PART B

Subtitle A—Hospital Outpatient Services

SEC. 201. 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)) 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.—Subject to subparagraph (D), 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 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 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.

''(D) TRANSITIONAL AUTHORITY.—In applying subparagraph (A) for covered OPD services furnished before January 1, 2002, the Secretary may—

''(i) apply such subparagraph to a bill for such services related to an outpatient encounter (rather than for a specific service or group of services) using OPD fee schedule amounts and transitional pass-through payments covered under the bill; and

''(ii) use an appropriate cost-to-charge ratio for the hospital involved (as determined by the Secretary), rather than for specific departments within the hospital.''.

(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 AND BRACHYTHERAPY.—A drug or biological that is used in cancer therapy, including (but not limited to) a chemotherapeutic agent, an antiemetic, a hematopoietic growth factor, a colony stimulating factor, a biological response modifier, a bisphosphonate, and a device of 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) CURRENT RADIOPHARMACEUTICAL DRUGS AND BIOLOGICAL PRODUCTS.—A radiopharmaceutical drug or biological product used in diagnostic, monitoring, and therapeutic nuclear medicine procedures if payment for the drug or biological as an outpatient hospital service under this part was being made on such first date.

''(iv) NEW MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—A medical device, drug, or biological not described in clause (i), (ii), or (iii) 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, biological, or device described in clause (i), (ii), or (iii) of subparagraph (A) and in the case of a device, drug, or biological described in

subparagraph (A)(iv) and 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)(iv) 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 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 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 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 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 as outlier adjustments or'' and inserting '', in a budget neutral man-

ner, 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 insignificance 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 CERTAIN IMPLANTABLE ITEMS UNDER SYSTEM.—

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

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

(B) 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 implantable items described in paragraph (3), (6), or (8) of section 1861(s); but''; and

(C) in paragraph (2)(B), by inserting after ''resources'' the following: ''and so that an implantable item is classified to the group that includes the service to which the item relates''.

(2) CONFORMING AMENDMENT.—(A) Section 1834(a)(13) (42 U.S.C. 1395m(a)(13)) is amended by striking ''1861(m)(5))'' and inserting ''1861(m)(5), but not including implantable items for which payment may be made under section 1833(t)''.

(B) Section 1834(h)(4)(B) (42 U.S.C. 1395m(h)(4)(B)) is amended by inserting before the semicolon the following: ''and does not include an

implantable item for which payment may be made under section 1833(t)''.

(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 2 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 that 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) EXTENSION OF PAYMENT PROVISIONS OF SECTION 4522 OF BBA UNTIL IMPLEMENTATION OF PPS.—Section 1861(v)(1)(S)(ii) (42 U.S.C. 1395x(v)(1)(S)(ii)) is amended in subclauses (I) and (II) by striking "and during fiscal year 2000 before January 1, 2000" and inserting "and until the first date that the prospective payment system under section 1833(t) is implemented" each place it appears.

(l) CONGRESSIONAL INTENTION REGARDING BASE AMOUNTS IN APPLYING THE HOPD PPS.—With respect

to determining the amount of copayments described in paragraph (3)(A)(ii) of section 1833(t) of the Social Security Act, as added by section 4523(a) of BBA, Congress finds that such amount should be determined without regard to such section, in a budget neutral manner with respect to aggregate payments to hospitals, and that the Secretary of Health and Human Services has the authority to determine such amount without regard to such section.

(m) 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.

(n) 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 Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate within 18 months after the date of the enactment of this Act. The Secretary shall include in the report recommendations regarding 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. 202. 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 201(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 201(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; or

''(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; or

''(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) HOLD HARMLESS PROVISIONS.—

"(i) TEMPORARY TREATMENT 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 the amount of such difference.

"(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(v), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

"(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 (8), 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 subparagraph, 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 (E), to

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

The Secretary shall determine such ratios as if the amendments made by section 4521 of the Balanced Budget Act of 1997 were in effect in 1996.

"(G) INTERIM PAYMENTS.—The Secretary shall make payments under this paragraph to hospitals on an interim basis, subject to retrospective adjustments based on settled cost reports.

"(H) 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).

"(I) 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 this section shall be effective as if included in the enactment of BBA.

SEC. 203. STUDY AND REPORT TO CONGRESS REGARDING THE SPECIAL TREATMENT OF RURAL AND CANCER HOSPITALS IN PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) STUDY.—

(1) IN GENERAL.—The Medicare Payment Advisory Commission (referred to in this section as ''MedPAC'') shall conduct a study to determine the appropriateness (and the appropriate method) of providing payments to hospitals described in paragraph (2) for covered OPD services (as defined in paragraph (1)(B) of section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t))) based on the prospective payment system established by the Secretary in accordance with such section.

(2) HOSPITALS DESCRIBED.—The hospitals described in this paragraph are the following:

(A) A medicare-dependent, small rural hospital (as defined in section 1886(d)(5)(G)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)(iv))).

(B) A sole community hospital (as defined in section 1886(d)(5)(D)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(D)(iii))).

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

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

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

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

(G) A hospital described in section 1886(d)(1)(B)(v) of such Act (42 U.S.C. 1395ww(d)(1)(B)(v)).

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, MedPAC shall submit a report to the Secretary of Health and Human Services and Congress on the study conducted under subsection (a), together with any recommendations for legislation that MedPAC determines to be appropriate as a result of such study.

(c) COMMENTS.—Not later than 60 days after the date on which MedPAC submits the report under sub-

section (b) to the Secretary of Health and Human Services, the Secretary shall submit comments on such report to Congress.

SEC. 204. 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 201(a)(1) and 202(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 (8)(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 B—Physician Services

SEC. 211. 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 expenditures 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 subsection (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 Sec-

retary'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 NEUTRALITY.—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 subsection (d)(4)(C)(ii) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), 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 subsection (d) of such section for 1999; and

(iii) the sustainable growth rate under subsection (f) of such section 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) STUDY AND REPORT REGARDING THE UTILIZATION OF PHYSICIANS' SERVICES BY MEDICARE BENEFICIARIES.—

(1) STUDY BY SECRETARY.—The Secretary of Health and Human Services, acting through the Administrator of the Agency for Health Care Policy and Research, shall conduct a study of the issues specified in paragraph (2).

(2) ISSUES TO BE STUDIED.—The issues specified in this paragraph are the following:

(A) The various methods for accurately estimating the economic impact on expenditures for physicians' services under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) resulting from—

(i) improvements in medical capabilities;

(ii) advancements in scientific technology;

(iii) demographic changes in the types of medicare beneficiaries that receive benefits under such program; and

(iv) geographic changes in locations where medicare beneficiaries receive benefits under such program.

(B) The rate of usage of physicians' services under the original medicare fee-for-service

program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) among beneficiaries between ages 65 and 74, 75 and 84, 85 and over, and disabled beneficiaries under age 65.

(C) Other factors that may be reliable predictors of beneficiary utilization of physicians' services under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(3) REPORT TO CONGRESS.—Not later than 3 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit a report to Congress setting forth the results of the study conducted pursuant to paragraph (1), together with any recommendations the Secretary determines are appropriate.

(4) MEDPAC REPORT TO CONGRESS.—Not later than 180 days after the date of submission of the report under paragraph (3), the Medicare Payment Advisory Commission shall submit a report to Congress that includes—

(A) an analysis and evaluation of the report submitted under paragraph (3); and

(B) such recommendations as it determines are appropriate.

(d) 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. 212. 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 and 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 description 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 such data are not based upon a large enough sample size to be statistically reliable.

SEC. 213. 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 medi-

care 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 title XVIII of the Social Security Act, 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 C—Other Services

SEC. 221. REVISION OF PROVISIONS RELATING TO THERAPY SERVICES.

(a) 2-YEAR MORATORIUM ON CAPS.—

(1) IN GENERAL.—Section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) is amended—

(A) in paragraphs (1) and (3), by striking ''In the case'' each place it appears and inserting ''Subject to paragraph (4), in the case''; and

(B) by adding at the end the following:

''(4) This subsection shall not apply to expenses incurred with respect to services furnished during 2000 and 2001.''.

(2) FOCUSED MEDICAL REVIEWS OF CLAIMS DURING MORATORIUM PERIOD.—During years in which paragraph (4) of section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) applies (under the amendment made by paragraph (1)(B)), the Secretary of Health and Human Services shall conduct focused medical reviews of claims for reimbursement for services described in paragraph (1) or (3) of such section, with an emphasis on such claims for services that are provided to residents of skilled nursing facilities.

(b) TECHNICAL AMENDMENT RELATING TO BEING UNDER THE CARE OF A PHYSICIAN.—

(1) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended—

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

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

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

(c) REVISION OF REPORT.—

(1) IN GENERAL.—Section 4541(d)(2) of BBA (42 U.S.C. 1395l note) is amended to read as follows:

''(2) REPORT.—Not later than January 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report that includes recommendations on—

''(A) the establishment of a mechanism for assuring appropriate utilization of outpatient physical therapy services, outpatient occupational therapy services, and speech-language pathology services that are covered under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395); and

''(B) the establishment of an alternative payment policy for such services based on classification of individuals by diagnostic category, functional status, prior use of services (in both

inpatient and outpatient settings), and such other criteria as the Secretary determines appropriate, in place of the uniform dollar limitations specified in section 1833(g) of such Act, as amended by paragraph (1).

The recommendations shall include how such a mechanism or policy might be implemented in a budget-neutral manner.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect as if included in the enactment of section 4541 of BBA.

(d) STUDY AND REPORT ON UTILIZATION.—

(1) STUDY.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study which compares—

(i) utilization patterns (including nationwide patterns, and patterns by region, types of settings, and diagnosis or condition) of outpatient physical therapy services, outpatient occupational therapy services, and speech-language pathology services that are covered under the medicare program under title XVIII of the Social

Security Act (42 U.S.C. 1395) and provided on or after January 1, 2000; with

(ii) such patterns for such services that were provided in 1998 and 1999.

(B) REVIEW OF CLAIMS.—In conducting the study under this subsection the Secretary of Health and Human Services shall review a statistically significant number of claims for reimbursement for the services described in subparagraph (A).

(2) REPORT.—Not later than June 30, 2001, the Secretary of Health and Human Services shall submit a report to Congress on the study conducted under paragraph (1), together with any recommendations for legislation that the Secretary determines to be appropriate as a result of such study.

SEC. 222. 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 during 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 payment amounts for such services furnished on December 31, 2000.''.

(b) CONFORMING AMENDMENT.—The second sentence of section 9335(a)(1) of the Omnibus Budget Reconciliation Act of 1986 (42 U.S.C. 1395rr note) is amended by inserting ''and before January 1, 2000,'' after ''on or after January 1, 1991,''.

(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. 223. IMPLEMENTATION OF THE INHERENT REASONABLENESS (IR) AUTHORITY.

(a) LIMITATION ON USE.—The Secretary of Health and Human Services may not use, or permit fiscal intermediaries or carriers to use, the inherent reasonableness authority provided under section 1842(b)(8) of the Social Security Act (42 U.S.C. 1395u(b)(8)) until after—

(1) the Comptroller General of the United States releases a report pursuant to the request for such a report made on March 1, 1999, regarding the impact of the Secretary's, fiscal intermediaries', and carriers' use of such authority; and

(2) the Secretary has published a notice of final rulemaking in the Federal Register that relates to such authority and that responds to such report and to comments received in response to the Secretary's interim final regulation relating to such authority that was published in the Federal Register on January 7, 1998.

(b) REEVALUATION OF IR CRITERIA.—In promulgating the final regulation under subsection (a)(2), the Secretary shall—

(1) reevaluate the appropriateness of the criteria included in such interim final regulation for identifying payments which are excessive or deficient; and

(2) take appropriate steps to ensure the use of valid and reliable data when exercising such authority.

(c) TECHNICAL CORRECTION.—Section 1842(b)(8)(A)(i)(I) (42 U.S.C. 1395u(b)(8)(A)(i)(I)) is amended by striking ''the application of this part'' and

inserting ''the application of this title to payment under this part''.

SEC. 224. 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 national minimum payment amount under this subsection 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 as a primary screening method for detection of cervical cancer) equal to $14.60 for tests furnished in 2000. For such tests furnished in subsequent years, such national minimum payment amount shall be adjusted annually as provided in paragraph (2).''.

(b) SENSE OF 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 and that are significantly more effective than a conventional pap smear.

SEC. 225. REFINEMENT OF AMBULANCE SERVICES DEMONSTRATION PROJECT.

Effective as if included in the enactment of BBA, section 4532 of BBA (42 U.S.C. 1395m note) is amended—

(1) in subsection (a), by adding at the end the following: ''Not later than July 1, 2000, the Secretary shall publish 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 term '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 en-

sures 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. 226. 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 section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i)), prior to incorporating data from the 1999 Medicare cost survey or a subsequent 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. 227. EXTENSION OF MEDICARE BENEFITS FOR IMMUNOSUPPRESSIVE DRUGS.

(a) IN GENERAL.—Section 1861(s)(2)(J)(v) (42 U.S.C. 1395x(s)(2)(J)(v)) is amended by inserting before the semicolon at the end the following: ''plus such additional number of months (if any) provided under section 1832(b)''.

(b) SPECIFICATION OF NUMBER OF ADDITIONAL MONTHS.—Section 1832 (42 U.S.C. 1395k) is amended—

(1) by redesignating subsection (b) as subsection (c); and

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

''(b) EXTENSION OF COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—

''(1) EXTENSION.—

''(A) IN GENERAL.—The Secretary shall specify consistent with this subsection an additional number of months (which may be portions of months) of coverage of immuno-

suppressive drugs for each cohort (as defined in subparagraph (C)) in a year during the 5-year period beginning with 2000. The number of such months for the cohort—

"(i) for 2000 shall be 8 months; and

"(ii) for 2001 shall, subject to paragraph (2)(A)(i), be 8 months.

"(B) APPLICATION OF ADDITIONAL MONTHS IN A YEAR ONLY TO COHORT IN THAT YEAR.—

"(i) IN GENERAL.—The additional months specified under this subsection for a cohort in a year in such 5-year period shall apply under section 1861(s)(2)(J)(v) only to individuals within such cohort for such year.

"(ii) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing additional months of coverage provided for a cohort for a year from extending coverage to drugs furnished in months in the succeeding year.

"(C) COHORT DEFINED.—In this subsection, the term 'cohort' means, with respect to a year, those individuals who would (but for

this subsection) exhaust benefits under section 1861(s)(2)(J)(v) for prescription drugs used in immunosuppressive therapy furnished at any time during such year.

''(2) TIMING OF SPECIFICATION.—Consistent with paragraphs (3) and (4)—

''(A) MAY 1, 2001.—Not later than May 1, 2001, the Secretary—

''(i) may increase the number of months for the cohort for 2001 above the 8 months provided under paragraph (1)(A)(ii); and

''(ii) shall compute and specify the number of additional months of benefits that will be available for the cohort for 2002.

''(B) MAY 1, 2002 AND 2003.—Not later than May 1 of 2002 and 2003, the Secretary shall compute and specify the number of additional months of benefits that will be available for the cohort for the following year under this subsection. Such number may be more or less than 8 months.

''(3) BASIS FOR SPECIFICATION.—Using appropriate actuarial methods, the Secretary shall com-

pute the number of additional months for the cohort for a year under this subsection in a manner so that the total expenditures under this part attributable to this subsection, as computed based upon the best available data at the time additional months are specified under this subsection, do not exceed $150,000,000. Subject to paragraph (4), the Secretary shall seek to compute such months in a manner that provides for a level number of months for each cohort in each year in the last 4 years of the 5-year period described in paragraph (1)(A).

''(4) ANNUAL ADJUSTMENT TO MAINTAIN AGGREGATE EXPENDITURES WITHIN LIMITS.—In computing and specifying the number of additional months under paragraph (2), the Secretary shall adjust the number of additional months under this subsection for a cohort for a year from that provided in the previous year within such 5-year period to the extent necessary to take into account, based upon the best available data, differences between actual and estimated expenditures under this part attributable to this subsection for previous years and to comply with the limitation on total expenditures under paragraph (3).''.

(c) TRANSITIONAL PASS-THROUGH OF ADDITIONAL COSTS UNDER MEDICARE+CHOICE PROGRAM FOR 2000.—The provisions of subparagraphs (A) and (B) of section 1852(a)(5) of the Social Security Act (42 U.S.C. 1395w–22(a)(5)) shall apply with respect to the coverage of additional benefits for immunosuppressive drugs under the amendments made by this section for drugs furnished in 2000 in the same manner as if such amendments constituted a national coverage determination described in the matter in such section before subparagraph (A).

(d) REPORT ON IMMUNOSUPPRESSIVE DRUG BENEFIT.—

(1) IN GENERAL.—Not later than March 1, 2003, the Secretary of Health and Human Services shall submit to Congress a report on the operation of this section and the amendments made by this section. The report shall include—

(A) an analysis of the impact of this section; and

(B) recommendations regarding an appropriate cost-effective method for providing coverage of immunosuppressive drugs under the medicare program on a permanent basis.

(2) CONSIDERATIONS.—In making recommendations under paragraph (1)(B), the Sec-

retary shall identify potential modifications to the immunosuppressive drug benefit that would best promote the objectives of—

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

(B) achieving cost savings to the medicare program (by decreasing the need for secondary transplants and other care relating to post-transplant complications); and

(C) meeting the needs of 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 modifications.

SEC. 228. TEMPORARY INCREASE IN PAYMENT RATES FOR DURABLE MEDICAL EQUIPMENT AND OXYGEN.

(a) IN GENERAL.—For purposes of payments under section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)) for covered items (as defined in paragraph (13) of that section) furnished during 2001 and 2002, the Secretary of Health and Human Services shall increase the

payment amount in effect (but for this section) for such items for—

(1) 2001 by 0.3 percent, and

(2) 2002 by 0.6 percent.

(b) LIMITING APPLICATION TO SPECIFIED YEARS.—The payment amount increase—

(1) under subsection (a)(1) shall not apply after 2001 and shall not be taken into account in calculating the payment amounts applicable for covered items furnished after such year; and

(2) under subsection (a)(2) shall not apply after 2002 and shall not be taken into account in calculating the payment amounts applicable for covered items furnished after such year.

SEC. 229. STUDIES AND REPORTS.

(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 under title XVIII of the Social Security Act 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) AHCPR STUDY ON EFFECT OF CREDENTIALING OF TECHNOLOGISTS AND SONOGRAPHERS ON QUALITY OF ULTRASOUND.—

(1) STUDY.—The Administrator for Health Care Policy and Research shall provide for a study that, with respect to the provision of ultrasound under the medicare and medicaid programs under titles XVIII and XIX of the Social Security Act, compares differences in quality between ultrasound furnished by individuals who are credentialed by private entities or organizations and ultrasound furnished by those who are not so credentialed. Such study shall examine and evaluate differences in error rates, resulting complications, 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.

(2) REPORT.—Not later than two 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 one or more reports 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 and Human Services shall pay the agency, in addition to any amount of payment made under section 1861(v)(1)(L) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)) 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 BBA (42 U.S.C. 1395fff note).

(2) PAYMENT SCHEDULE.—

(A) MIDYEAR PAYMENT.—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 to Congress a report on the 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 assessment 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 ONE YEAR AFTER IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.

(a) CONTINGENCY REDUCTION.—Section 4603 of BBA (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 subsection (e).

(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) as follows:

"(I) Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for 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.

"(II) For periods beginning after the period described in subclause (I), such amount (or amounts) shall be equal to the amount (or amounts) that would have been determined under subclause (I) 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 effect, updated under subparagraph (B).

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

(c) REPORT.—Not later than the date that is six months after the date the Secretary of Health and Human Services implements the prospective payment system for home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff), the Secretary shall submit to Congress a report analyzing the need for the 15 percent reduction under subsection (b)(3)(A)(ii) of such section, or for any reduction, in the computation of the base pay-

ment amounts under the prospective payment system for home health services established under such section.

SEC. 303. INCREASE IN PER BENEFICIARY LIMITS.

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

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

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

''(ix) Notwithstanding the per beneficiary limit under clause (viii), if the limit imposed under clause (v) (determined without regard to this clause) for a cost reporting period beginning during or after fiscal year 2000 is less than the median described in clause (vi)(I) (but determined as if any reference in clause (v) to '98 percent' were a reference to '100 percent'), the limit otherwise imposed under clause (v) for such provider and period shall be increased by 2 percent.''.

(b) INCREASE NOT INCLUDED IN PPS BASE.—The second sentence of section 1895(b)(3)(A)(i) (42 U.S.C. 1395fff(b)(3)(A)(i)), as amended by section 302(b), is further amended—

(1) in subclause (I), by inserting ''and if section 1861(v)(1)(L)(ix) had not been enacted'' before the semicolon; and

(2) in subclause (II), by inserting ''and if section 1861(v)(1)(L)(ix) had not been enacted'' after ''if the system had not been in effect''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1999.

SEC. 304. 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 of the Social Security Act is amended by inserting after section 1128E the following new section:

''COORDINATION OF MEDICARE AND MEDICAID SURETY BOND PROVISIONS

''SEC. 1128F. In the case of a home health agency that is subject to a surety bond requirement 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 (42 U.S.C. 1395x(o)(7)), 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. 305. REFINEMENT OF HOME HEALTH AGENCY CONSOLIDATED BILLING.

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

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

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

SEC. 306. 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)) is amended by striking ''fiscal year 2002 or 2003'' and inserting ''each of fiscal years 2002 and 2003''.

SEC. 307. STUDY AND REPORT TO CONGRESS REGARDING THE EXEMPTION OF RURAL AGENCIES AND POPULATIONS FROM INCLUSION IN THE HOME HEALTH PROSPECTIVE PAYMENT SYSTEM.

(a) STUDY.—The Medicare Payment Advisory Commission (referred to in this section as ''MedPAC'') shall conduct a study to determine the feasibility and advisability of exempting home health services provided by a home health agency (or by others under arrangements with such agency) located in a rural area, or to an individual residing in a rural area, from payment under the prospective payment system for such services established by the Secretary of Health and Human Services in accordance with section 1895 of the Social Security Act (42 U.S.C. 1395fff).

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, MedPAC shall submit a report to Congress on the study conducted under subsection (a), together with any recommendations for legislation that MedPAC determines to be appropriate as a result of such study.

Subtitle B—Direct Graduate Medical Education

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

(a) IN GENERAL.—Section 1886(h)(2) (42 U.S.C. 1395ww(h)(2)) is amended—

(1) in subparagraph (D)(i), by striking ''clause (ii)'' and inserting ''a subsequent clause'';

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

''(iii) FLOOR IN FISCAL YEAR 2001 AT 70 PERCENT OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—The approved FTE resident amount for a hospital for the cost reporting period beginning during fiscal year 2001 shall not be less than 70 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for the hospital and period.

''(iv) ADJUSTMENT IN RATE OF INCREASE FOR HOSPITALS WITH FTE APPROVED AMOUNT ABOVE 140 PERCENT OF

LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—

"(I) FREEZE FOR FISCAL YEARS 2001 AND 2002.—For a cost reporting period beginning during fiscal year 2001 or fiscal year 2002, if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and period, subject to subclause (III), the approved FTE resident amount for the period involved shall be the same as the approved FTE resident amount for the hospital for such preceding cost reporting period.

"(II) 2 PERCENT DECREASE IN UPDATE FOR FISCAL YEARS 2003, 2004, AND 2005.—For a cost reporting period beginning during fiscal year 2003, fiscal year 2004, or fiscal year 2005, if the approved FTE resident amount for a hospital for the pre-

ceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and preceding period, the approved FTE resident amount for the period involved shall be updated in the manner described in subparagraph (D)(i) except that, subject to subclause (III), the consumer price index applied for a 12-month period shall be reduced (but not below zero) by 2 percentage points.

''(III) NO ADJUSTMENT BELOW 140 PERCENT.—In no case shall subclause (I) or (II) reduce an approved FTE resident amount for a hospital for a cost reporting period below 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for such hospital and period.'';

(3) by redesignating subparagraph (E) as subparagraph (F); and

(4) by inserting after subparagraph (D) the following new subparagraph:

"(E) DETERMINATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—The Secretary shall determine a locality adjusted national average per resident amount with respect to a cost reporting period of a hospital beginning during a fiscal year as follows:

"(i) DETERMINING 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, as determined under paragraph (4)) 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.

"(ii) STANDARDIZING PER RESIDENT AMOUNTS.—The Secretary shall compute a standardized per resident amount for each such hospital by dividing the single per

resident amount computed under clause (i) by an average of the 3 geographic index values (weighted by the national average weight for each of the work, practice expense, and malpractice components) as applied under section 1848(e) for 1999 for the fee schedule area in which the hospital is located.

''(iii) COMPUTING OF WEIGHTED AVERAGE.—The Secretary shall compute the average of the standardized per resident amounts computed under clause (ii) for such hospitals, with the amount for each hospital weighted by the average number of full-time equivalent residents at such hospital (as determined under paragraph (4)).

''(iv) COMPUTING NATIONAL AVERAGE PER RESIDENT AMOUNT.—The Secretary shall compute the national average per resident amount, for a hospital's cost reporting period that begins during fiscal year 2001, equal to the weighted average computed under clause (iii) increased by the estimated percentage increase in the

consumer price index for all urban consumers during the period beginning with the month that represents the midpoint of the cost reporting periods described in clause (i) and ending with the midpoint of the hospital's cost reporting period that begins during fiscal year 2001.

''(v) ADJUSTING FOR LOCALITY.—The Secretary shall compute the product of—

''(I) the national average per resident amount computed under clause (iv) for the hospital, and

''(II) the geographic index value average (described and applied under clause (ii)) for the fee schedule area in which the hospital is located.

''(vi) COMPUTING LOCALITY ADJUSTED AMOUNT.—The locality adjusted national per resident amount for a hospital for—

''(I) the cost reporting period beginning during fiscal year 2001 is the product computed under clause (v); or

''(II) each subsequent cost reporting period is equal to the locality

adjusted national per resident amount for the hospital for the previous cost reporting period (as determined under this clause) updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index for all urban consumers during the 12-month period ending at that midpoint.''.

(b) CONFORMING AMENDMENTS.—Section 1886(h)(2)(D) (42 U.S.C. 1395ww(h)(2)(D)) is further amended—

(1) in clause (i)—

(A) by striking ''PERIODS.—(i)'' and inserting the following (and conforming the indentation of the succeeding matter accordingly): ''PERIODS.—

''(i) IN GENERAL.—''; and

(B) by striking ''the amount determined'' and inserting ''the approved FTE resident amount determined''; and

(2) in clause (ii)—

(A) by indenting the clause 2 ems to the right; and

(B) by inserting ''FREEZE IN UPDATE FOR FISCAL YEARS 1994 AND 1995.—'' after ''(ii)''.

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

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

(1) in the last sentence of subparagraph (F), by striking ''The initial residency period'' and inserting ''Subject to subparagraph (G)(v), the initial residency period''; and

(2) in subparagraph (G)—

(A) in clause (i) by striking ''and (iv)'' and inserting ''(iv), and (v)''; and

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

''(v) CHILD NEUROLOGY TRAINING PROGRAMS.—In the case of a resident enrolled in a child neurology residency training program, the period of board eligibility and the initial residency period shall be the period of board eligibility for pediatrics plus 2 years.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply on and after July 1, 2000, to resi-

dency 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 regarding the appropriateness of the initial residency period used 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 that require preliminary years of study in another specialty.

Subtitle C—Technical Corrections

SEC. 321. BBA TECHNICAL CORRECTIONS.

(a) SECTION 4201.—Section 1820(c)(2)(B)(i) (42 U.S.C. 1395i–4(c)(2)(B)(i)) 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)) 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 occurring 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 occurring 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)) 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)) 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)) 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)) is amended by striking ''or unit''.

(g) SECTION 4432.—(1) Section 1888(e)(8)(B) (42 U.S.C. 1395yy(e)(8)(B)) is amended by striking ''January 1, 1999,'' and inserting ''July 1, 1999''.

(2) Section 1833(h)(5)(A)(iii) (42 U.S.C. 1395l(h)(5)(A)(iii)) is amended—

(A) by striking ''or critical access hospital,'' and inserting '', critical access hospital, or skilled nursing facility,''; and

(B) by inserting ''or skilled nursing facility'' before the period.

(h) SECTION 4416.—Section 1886(b)(7)(A)(i)(II) (42 U.S.C. 1395ww(b)(7)(A)(i)(II)) is amended by inserting ''(as estimated by the Secretary)'' after ''median''.

(i) 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''.

(j) HIPAA SECTION 201.—

(1) IN GENERAL.—Section 1817(k)(2)(C)(i) (42 U.S.C. 1395i(k)(2)(C)(i)) is amended by striking

''section 982(a)(6)(B)'' and inserting ''section 24(a)''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall take effect as if included in the amendment made by section 201 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 1992).

(k) OTHER TECHNICAL AMENDMENTS.—

(1) SECTION 4611.—Section 1812(b) (42 U.S.C. 1395d(b)) is amended in the matter following paragraph (3) by inserting ''during'' after ''100 visits''.

(2) SECTION 4511.—Section 1833(a)(1)(O) (42 U.S.C. 1395l(a)(1)(O)) is amended by striking the semicolon and inserting a comma.

(3) SECTION 4551.—Section 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A)) is amended—

(A) in clause (i), by striking the comma at the end and inserting a semicolon; and

(B) in clause (v), by striking '', and'' and inserting ''; and''.

(4) SECTION 4315.— Section 1842(s)(2)(E) (42 U.S.C. 1395u(s)(2)(E)) is amended by inserting a period at the end.

(5) SECTIONS 4103, 4104, AND 4106.—

(A) SECTION 4103.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) is amended by striking ''1861(oo)(2),'' and inserting ''1861(oo)(2))''.

(B) SECTION 4104.—Such section is further amended by striking ''(B) ,'' and inserting ''(B),''.

(C) SECTION 4106.—Such section is further amended by striking ''and (15)'' and inserting '', and (15)''.

(6) SECTION 4001.—(A) Section 1851(i)(2) (42 U.S.C. 1395w–21(i)(2)) is amended by striking ''and'' after ''1857(f)(2),''.

(B) Section 1852 (42 U.S.C. 1395w–22) is amended—

(i) in subsection (a)(3)(A)—

(I) by striking the comma after ''MSA plan''; and

(II) by inserting a comma after ''the coverage)'';

(ii) in subsection (g)—

(I) in paragraph (1)(B), by inserting ''or'' after ''in whole''; and

(II) in paragraph (3)(B)(ii), by inserting a period at the end;

(iii) in subsection (h)(2), by striking the comma and inserting a semicolon; and

(iv) in subsection (k)(2)(C)(ii), by striking ''balancing'' and inserting ''balance''.

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

(i) in paragraph (2)—

(I) in subparagraph (A), in the matter preceding clause (i), by inserting ''section'' before ''1852(a)(1)(A)''; and

(II) in subparagraph (B), in the matter preceding clause (i), by inserting ''section'' after ''described in'';

(ii) in paragraph (3)—

(I) in subparagraph (A), by inserting ''section'' after ''described in''; and

(II) in subparagraph (B), by inserting ''section'' after ''described in''; and

(iii) in paragraph (4)—

(I) in the matter preceding subparagraph (A), by inserting ''section'' after ''described in'';

(II) in subparagraph (A), in the matter preceding clause (i), by inserting ''section'' after ''described in''; and

(III) in subparagraph (B), by inserting ''section'' after ''described in''.

(7) SECTION 4557.—Section 1861(s)(2)(T)(ii) (42 U.S.C. 1395x(s)(2)(T)(ii)) is amended by striking the period and inserting a semicolon.

(8) SECTION 4205.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended—

(A) in subparagraph (I), by striking the comma at the end and inserting a semicolon; and

(B) by realigning subparagraph (I) so as to align the left margin of such subparagraph with the left margin of subparagraph (H); and

(9) SECTION 4454.—Section 1861(ss)(1)(G)(i) (42 U.S.C. 1395x(ss)(1)(G)(i)) is amended—

(A) by striking ''owed'' and inserting ''owned''; and

(B) by striking ''of'' and inserting ''or''.

(10) SECTION 4103.—Section 1862(a)(7) (42 U.S.C. 1395y(a)(7)) is amended by striking ''subparagraphs'' and inserting ''subparagraph''.

(11) SECTION 4002.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(A) in subparagraph (I)(iii), by striking the semicolon and inserting a comma;

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

(C) in subparagraph (O), by striking the semicolon at the end and inserting a comma.

(12) SECTION 4321.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(A) in subparagraph (Q), by striking the semicolon at the end and inserting a comma; and

(B) in subparagraph (R), by inserting '', and'' at the end.

(13) SECTION 4003.—Section 1882(g)(1) (42 U.S.C. 1395ss(g)(1)) is amended by striking ''or'' after ''does not include''.

(14) SECTION 4031.—Section 1882(s)(2)(D) (42 U.S.C. 1395ss(s)(2)(D)), is amended in the matter preceding clause (i), by inserting ''section'' after ''as defined in''.

(15) SECTION 4421.—Section 1886(b) (42 U.S.C. 1395ww(b)) is amended—

(A) in paragraph (1), in the matter following subparagraph (C), by inserting a comma after ''paragraph (2)''; and

(B) in paragraph (3)(B)(ii)—

(i) in subclause (VI), by striking the semicolon and inserting a comma; and

(ii) in subclause (VII), by striking the semicolon and inserting a comma.

(16) SECTION 4403.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended by inserting a comma after ''1986''.

(17) SECTION 4406.—Section 1886(d)(9)(A)(ii) (42 U.S.C. 1395ww(d)(9)(A)(ii)) is amended by inserting a comma after ''1987''.

(18) SECTION 4432.—Section 1888(e)(4)(E) (42 U.S.C. 1395yy(e)(4)(E)) is amended—

(A) in clause (i), by striking ''federal'' and inserting ''Federal''; and

(B) in clause (ii), in the matter preceding subclause (I), by striking ''federal'' each place it appears and inserting ''Federal''.

(19) SECTION 4603.—Section 1895(b)(1) (42 U.S.C. 1395fff(b)(1)) is amended by striking ''the this section'' and inserting ''this section''.

(l) SECTION 1135 OF THE SOCIAL SECURITY ACT.—Effective on the date of the enactment of this Act, section 1135 (42 U.S.C. 1320b–5) is repealed.

(m) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall take effect as if included in the enactment of BBA.

TITLE IV—RURAL PROVIDER PROVISIONS

Subtitle A—Rural Hospitals

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 (in a form and manner determined by the Secretary) 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 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 most recent modification of the

Goldsmith Modification, originally 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, 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 201 and 202, 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 in a rural area 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, in the matter preceding subclause (I), 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 AN ANNUAL, AVERAGE BASIS.—

(1) IN GENERAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395i–4(c)(2)(B)(iii)) 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 HOS-

PITAL.—Section 1820(c)(2)(B)(i) (42 U.S.C. 1395i–4(c)(2)(B)(i)) 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)) 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) ELECTION OF COST-BASED PAYMENT OPTION FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

(1) IN GENERAL.—Section 1834(g) (42 U.S.C. 1395m(g)) is amended to read as follows:

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

"(1) IN GENERAL.—The amount of payment for outpatient critical access hospital services of a critical access hospital is the reasonable costs of the hospital in providing such services, unless the hospital makes the election under paragraph (2).

"(2) ELECTION OF COST-BASED HOSPITAL OUTPATIENT SERVICE PAYMENT PLUS FEE SCHEDULE FOR PROFESSIONAL SERVICES.—A critical access

hospital may elect to be paid for outpatient critical access hospital services 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) DISREGARDING CHARGES.—The payment amounts under this subsection shall be determined without regard to the amount of the customary or other charge.''.

(2) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply for cost reporting periods beginning on or after October 1, 2000.

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

(1) IN GENERAL.—Paragraphs (1)(D)(i) and (2)(D)(i) of section 1833(a) (42 U.S.C. 1395l(a)) are each 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 amendments 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. 5-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)) 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)) 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)) 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 such target amount—

''(I) with respect to discharges occurring in fiscal year 2001, 75 percent of the target amount otherwise applicable to the hospital under subparagraph (C) (referred to in this clause as the 'subparagraph

(C) target amount') and 25 percent of the rebased target amount (as defined in clause (ii));

''(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;

''(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; and

''(IV) with respect to discharges occurring after fiscal year 2003, 100 percent of the rebased target amount.

''(ii) For purposes of this subparagraph, the 'rebased target amount' has the meaning given the term 'target amount' in subparagraph (C) except that—

''(I) there shall be substituted for the base cost reporting period the 12-month cost reporting period beginning during fiscal year 1996;

''(II) any reference in subparagraph (C)(i) to the 'first cost reporting period' described in such subparagraph is deemed a reference to the first cost reporting period beginning on or after October 1, 2000; and

''(III) applicable increase percentage shall only be applied under subparagraph (C)(iv) for discharges occurring in fiscal years beginning with fiscal year 2002.''.

SEC. 406. ONE YEAR SOLE COMMUNITY HOSPITAL PAYMENT INCREASE.

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

(1) by redesignating subclause (XVII) as subclause (XVIII);

(2) by striking subclause (XVI); and

(3) by inserting after subclause (XV) the following new subclauses:

''(XVI) for fiscal year 2001, the market basket percentage increase minus 1.1 percentage points for hospitals (other than sole community hospitals) in all areas, and the market basket percentage increase for sole community hospitals,

''(XVII) for fiscal year 2002, the market basket percentage increase minus 1.1 percentage points for hospitals in all areas, and''.

SEC. 407. INCREASED FLEXIBILITY IN PROVIDING GRADUATE PHYSICIAN TRAINING IN RURAL AND OTHER AREAS.

(a) COUNTING PRIMARY CARE RESIDENTS ON CERTAIN APPROVED LEAVES OF ABSENCE IN BASE YEAR FTE COUNT.—

(1) PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION.—Section 1886(h)(4)(F) (42 U.S.C. 1395ww(h)(4)(F)) is amended—

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

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

''(ii) COUNTING PRIMARY CARE RESIDENTS ON CERTAIN APPROVED LEAVES OF ABSENCE IN BASE YEAR FTE COUNT.—

''(I) IN GENERAL.—In determining the number of such full-time equivalent residents for a hospital's most recent cost reporting period ending on or before December 31, 1996, for purposes of clause (i), the Secretary shall count an individual to the extent that the individual would have been counted as a primary care resi-

dent for such period but for the fact that the individual, as determined by the Secretary, was on maternity or disability leave or a similar approved leave of absence.

''(II) LIMITATION TO 3 FTE RESIDENTS FOR ANY HOSPITAL.—The total number of individuals counted under subclause (I) for a hospital may not exceed 3 full-time equivalent residents.''.

(2) PAYMENT FOR INDIRECT MEDICAL EDUCATION.—Section 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is amended by adding at the end the following: ''Rules similar to the rules of subsection (h)(4)(F)(ii) shall apply for purposes of this clause.''.

(3) EFFECTIVE DATE.—

(A) DGME.—The amendments made by paragraph (1) apply to cost reporting periods that begin on or after the date of the enactment of this Act.

(B) IME.—The amendment made by paragraph (2) applies to discharges occurring in

cost reporting periods that begin on or after such date of enactment.

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

(1) PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION.—Section 1886(h)(4)(F)(i) (42 U.S.C. 1395ww(h)(4)(F)(i)), as amended by subsection (a)(1), 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 MEDICAL EDUCATION.—Section 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) 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) DGME.—The amendment made by paragraph (1) applies to cost reporting periods beginning on or after April 1, 2000.

(B) IME.—The amendment made by paragraph (2) applies to discharges occurring on or after April 1, 2000.

(c) SPECIAL RULE FOR NONRURAL FACILITIES SERVING RURAL AREAS.—

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

"(iv) NONRURAL HOSPITALS OPERATING TRAINING PROGRAMS IN 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 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 rural areas in order to encourage the training of physicians in 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 April 1, 2000; 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 April 1, 2000.

(d) NOT COUNTING AGAINST NUMERICAL LIMITATION CERTAIN INTERNS AND RESIDENTS TRANSFERRED FROM A VA RESIDENCY PROGRAM THAT LOSES ACCREDITATION.—

(1) IN GENERAL.—Any applicable resident described in paragraph (2) shall not be taken into account in applying any limitation regarding the number of residents or interns for which payment may be made under section 1886 of the Social Security Act (42 U.S.C. 1395ww).

(2) APPLICABLE RESIDENT DESCRIBED.—An applicable resident described in this paragraph is a resident or intern who—

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

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

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

(3) EFFECTIVE DATE.—

(A) IN GENERAL.—Paragraph (1) applies as if included in the enactment of BBA.

(B) RETROACTIVE PAYMENTS.—If the Secretary of Health and Human Services determines that a hospital operating an approved medical residency program is owed payments as a result of enactment of this subsection, the Secretary shall make such payments not later than 60 days after the date of the enactment of this Act.

SEC. 408. 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)) for payments for covered skilled nursing facility services under the medicare program.

SEC. 409. GRANT PROGRAM FOR RURAL HOSPITAL TRANSITION TO PROSPECTIVE PAYMENT.

Section 1820(g) (42 U.S.C. 1395i–4(g)) 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, the education and training of hospital staff on computer information systems,

and to offset costs related to the implementation of prospective payment systems.

''(F) REPORTS.—

''(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) TIMING OF SUBMISSION.—

''(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. 410. 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 such reclassification results in more accurate payments for all hospitals. Such study shall examine data on the number of hospitals that are reclassified and their reclassified 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 are not reclassified;

(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).

Subtitle B—Other Rural Provisions

SEC. 411. MEDPAC STUDY OF RURAL PROVIDERS.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study of 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 the impact of such categories on beneficiary access and quality of health care services.

(b) REPORT.—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. 412. 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 note) 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 most recent Goldsmith Modification, originally 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 ALS intercept services furnished on or after such date.

SEC. 413. PROMOTING PROMPT IMPLEMENTATION OF INFORMATICS, TELEMEDICINE, AND EDUCATION DEMONSTRATION PROJECT.

Section 4207 of BBA (42 U.S.C. 1395b-1 note) 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 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'';

(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 medicare beneficiaries and providers related to participation in the project.''.

TITLE V—PROVISIONS RELATING TO PART C (MEDICARE+CHOICE PROGRAM) AND OTHER MEDICARE MANAGED CARE PROVISIONS

Subtitle A—Provisions To Accommodate and Protect Medicare Beneficiaries

SEC. 501. 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 of an impending termination of such certification; or

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

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

(A) in subparagraph (A) in the matter following clause (iii), 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 sub-

stituting, for the date of termination of enrollment, the date on which the individual was notified by the Medicare+Choice organization of the impending termination or discontinuance of the Medicare+Choice plan it offers 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.''.

(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 (as defined by the Secretary), the individual may elect under subsection (a)(1)—

"(i) to enroll in a Medicare+Choice plan; or

"(ii) to change the Medicare+Choice plan in which the individual is enrolled.".

(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 (A) and in addition to subparagraph (B), if a Medicare+Choice organization eliminates from its service area a Medicare+Choice payment area that was previously within its service area, the organization may elect to offer individuals residing in all or portions of the affected area who would other-

wise 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 DATES.—

(1) The amendments made by subsection (a) apply to notices of impending terminations or discontinuances made on or after the date of the enactment of this Act.

(2) The amendments made by subsection (c) apply to elections made on or after the date of the enactment of this Act with respect to eliminations of Medicare+Choice payment areas from a service area that occur before, on, or after the date of the enactment of this Act.

SEC. 502. CHANGE IN EFFECTIVE DATE OF ELECTIONS AND CHANGES OF ELECTIONS OF MEDICARE+CHOICE PLANS.

(a) OPEN ENROLLMENT.—Section 1851(f)(2) (42 U.S.C. 1395w–21(f)(2)) is amended—

(1) by inserting ''or change'' before ''is made''; and

(2) by inserting '', except that if such election or change is made after the 10th day of any calendar month, then the election or change shall not take effect until the first day of the second calendar month following the date on which the election or change is made'' before the period.

(b) EFFECTIVE DATE.—The amendments made by this section apply to elections and changes of coverage made on or after January 1, 2000.

SEC. 503. 2-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''.

Subtitle B—Provisions To Facilitate Implementation of the Medicare+Choice Program

SEC. 511. PHASE-IN OF NEW RISK ADJUSTMENT METHODOLOGY; STUDIES AND REPORTS ON RISK ADJUSTMENT.

(a) PHASE-IN.—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 methodology insofar as it makes adjustments to capitation rates for health status applies to—

"(I) 10 percent of 1/12 of the annual Medicare+Choice capitation rate in 2000 and 2001; and

"(II) not more than 20 percent of such capitation rate in 2002.".

(b) MEDPAC STUDY AND REPORT.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study that evaluates the methodology used by the Secretary of Health and Human Services in developing the risk factors used in adjusting the Medicare+Choice capitation rate paid to Medicare+Choice organizations under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) and includes the issues described in paragraph (2).

(2) ISSUES TO BE STUDIED.—The issues described in this paragraph are the following:

(A) The ability of the average risk adjustment factor applied to a Medicare+Choice plan to explain variations in plans' average per capita medicare costs, as reported by Medicare+Choice plans in the plans' adjusted community rate filings.

(B) The year-to-year stability of the risk factors applied to each Medicare+Choice plan and the potential for substantial changes in payment for small Medicare+Choice plans.

(C) For medicare beneficiaries newly enrolled in Medicare+Choice plans in a given year, the correspondence between the average risk factor calculated from medicare fee-for-

service data for those individuals from the period prior to their enrollment in a Medicare+Choice plan and the average risk factor calculated for such individuals during their initial year of enrollment in a Medicare+Choice plan.

(D) For medicare beneficiaries disenrolling from or switching among Medicare+Choice plans in a given year, the correspondence between the average risk factor calculated from data pertaining to the period prior to their disenrollment from a Medicare+Choice plan and the average risk factor calculated from data pertaining to the period after disenrollment.

(E) An evaluation of the exclusion of ''discretionary'' hospitalizations from consideration in the risk adjustment methodology.

(F) Suggestions for changes or improvements in the risk adjustment methodology.

(3) REPORT.—Not later than December 1, 2000, the Commission shall submit a report to Congress on the study conducted under paragraph (1), together with any recommendations for legislation

that the Commission determines to be appropriate as a result of such study.

(c) STUDY AND REPORT REGARDING REPORTING OF ENCOUNTER DATA.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study on how to reduce the costs and burdens on Medicare+Choice organizations of their complying with reporting requirements for encounter data imposed by the Secretary in establishing and implementing a risk adjustment methodology used in making payments to such organizations under section 1853 of the Social Security Act (42 U.S.C. 1395w–23). The Secretary shall consult with representatives of Medicare+Choice organizations in conducting the study. The study shall address the following issues:

(A) Limiting the number and types of sites of services (that are in addition to inpatient sites) for which encounter data must be reported.

(B) Establishing alternative risk adjustment methods that would require submission of less data.

(C) The potential for Medicare+Choice organizations to misreport, overreport, or under-

report prevalence of diagnoses in outpatient sites of care, the potential for increases in payments to Medicare+Choice organizations from changes in Medicare+Choice plan coding practices (commonly known as ''coding creep'') and proposed methods for detecting and adjusting for such variations in diagnosis coding as part of the risk adjustment methodology using encounter data from multiple sites of care.

(D) The impact of such requirements on the willingness of insurers to offer Medicare+Choice MSA plans and options for modifying encounter data reporting requirements to accommodate such plans.

(E) Differences in the ability of Medicare+Choice organizations to report encounter data, and the potential for adverse competitive impacts on group and staff model health maintenance organizations or other integrated providers of care based on data reporting capabilities.

(2) REPORT.—Not later than January 1, 2001, the Secretary shall submit a report to Congress on the study conducted under this subsection, together with any recommendations for legislation that the

Secretary determines to be appropriate as a result of such study.

SEC. 512. 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 section 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 on 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 under subsection (c) for any payment area or as applying to payment for any period not described in such paragraph and paragraph (2).

''(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 when the individual obtains benefits under the plan.''.

SEC. 513. MODIFICATION OF 5-YEAR RE-ENTRY RULE FOR CONTRACT TERMINATIONS.

(a) REDUCTION OF GENERAL EXCLUSION PERIOD TO 2 YEARS.—Section 1857(c)(4) (42 U.S.C. 1395w–27(c)(4)) is amended by striking ''5-year period'' and inserting ''2-year period''.

(b) SPECIFIC EXCEPTION WHERE CHANGE IN PAYMENT POLICY.—

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

(A) by striking ''except in circumstances'' and inserting ''except as provided in subparagraph (B) and except in such other circumstances'';

(B) by redesignating the sentence following ''(4)'' as a subparagraph (A) with an appropriate indentation and the heading ''IN GENERAL.—''; and

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

''(B) EARLIER RE-ENTRY PERMITTED WHERE CHANGE IN PAYMENT POLICY.—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 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 amounts under section 1853 for that Medicare+Choice payment area.''.

(2) CONSTRUCTION RELATING TO ADDITIONAL EXCEPTIONS.—Nothing in the amendment made by paragraph (1)(C) shall be construed to affect the authority of the Secretary of Health and Human Services to provide for exceptions in addition to the exception provided in such amendment, including exceptions provided under Operational Policy Letter #103 (OPL99.103).

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

SEC. 514. CONTINUED COMPUTATION AND PUBLICATION OF MEDICARE ORIGINAL FEE-FOR-SERVICE EXPENDITURES ON A COUNTY-SPECIFIC BASIS.

(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 beginning with 2001 at the time of publication of the annual Medicare+Choice capitation rates under paragraph (1), of the following information for the original medicare fee-for-service program under parts A and B (exclusive of individuals eligible for coverage under section 226A) for each Medicare+Choice payment area for the second calendar year ending before the date of publication:

"(A) Total expenditures per capita per month, computed separately for part A and for part B.

"(B) The expenditures described in subparagraph (A) reduced by the best estimate of the expenditures (such as graduate medical education and disproportionate share hospital payments) not related to the payment of claims.

"(C) The average risk factor for the covered population based on diagnoses reported for medicare inpatient services, using the same methodology as is expected to be applied in making payments under subsection (a).

"(D) Such average risk factor based on diagnoses for inpatient and other sites of service, using the same methodology as is expected to be applied in making payments under subsection (a).".

(b) SPECIAL RULE FOR 2001.—In providing for the publication of information under section 1853(b)(4) of the Social Security Act (42 U.S.C. 1395w–23(b)(4)), as added by subsection (a), in 2001, the Secretary of Health and Human Services shall also include the information described in such section for 1998, as well as for 1999.

SEC. 515. FLEXIBILITY TO TAILOR BENEFITS UNDER MEDICARE+CHOICE PLANS.

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

(1) in subsection (a)(1), by inserting ''(or segment of such an area if permitted under subsection (h))'' after ''service area'' in the matter preceding subparagraph (A); and

(2) by adding at the end the following:

''(h) PERMITTING USE OF SEGMENTS OF SERVICE AREAS.—The Secretary shall permit a Medicare+Choice organization to elect to apply the provisions of this section uniformly to separate segments of a service area (rather than uniformly to an entire service area) as long as such segments are composed of one or more Medicare+Choice payment areas.''.

(b) EFFECTIVE DATE.—The amendments made by this section apply to contract years beginning on or after January 1, 2001.

SEC. 516. DELAY IN DEADLINE FOR SUBMISSION OF ADJUSTED COMMUNITY RATES.

(a) DELAY IN DEADLINE FOR SUBMISSION OF ADJUSTED COMMUNITY RATES.—Section 1854(a)(1) (42 U.S.C. 1395w–24(a)(1)) is amended by striking ''May 1'' and inserting ''July 1'' in the matter preceding subparagraph (A).

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to information submitted by Medicare+Choice organizations for years beginning with 1999.

SEC. 517. REDUCTION IN ADJUSTMENT IN NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE FOR 2002.

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

SEC. 518. 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.—

''(A) IN GENERAL.—The Secretary shall provide that a Medicare+Choice organization is deemed to meet all the requirements described in any specific clause of subparagraph (B) 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 and enforces standards that meet or exceed the standards established under sec-

tion 1856 to carry out the requirements in such clause.

''(B) REQUIREMENTS DESCRIBED.—The provisions described in this subparagraph are the following:

''(i) Paragraphs (1) and (2) of this subsection (relating to quality assurance programs).

''(ii) Subsection (b) (relating to anti-discrimination).

''(iii) Subsection (d) (relating to access to services).

''(iv) Subsection (h) (relating to confidentiality and accuracy of enrollee records).

''(v) Subsection (i) (relating to information on advance directives).

''(vi) Subsection (j) (relating to provider participation rules).

''(C) TIMELY ACTION ON APPLICATIONS.—The Secretary shall determine, within 210 days after the date the Secretary receives an application by a private accrediting organization and using the criteria specified in section 1865(b)(2), whether the process of the private

accrediting organization meets the requirements with respect to any specific clause in subparagraph (B) with respect to which the application is made. The Secretary may not deny such an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, such specific clause.

''(D) CONSTRUCTION.—Nothing in this paragraph shall be construed as limiting the authority of the Secretary under section 1857, including the authority to terminate contracts with Medicare+Choice organizations under subsection (c)(2) of such section.''.

SEC. 519. TIMING OF MEDICARE+CHOICE HEALTH INFORMATION FAIRS.

(a) IN GENERAL.—Section 1851(e)(3)(C) (42 U.S.C. 1395w–21(e)(3)(C)) is amended by striking ''In the month of November'' and inserting ''During the fall season''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) first applies to campaigns conducted beginning in 2000.

SEC. 520. QUALITY ASSURANCE REQUIREMENTS FOR PREFERRED PROVIDER ORGANIZATION PLANS.

(a) IN GENERAL.—Section 1852(e)(2) (42 U.S.C. 1395w–22(e)(2)) is amended—

(1) in subparagraph (A), by striking ''or a non-network MSA plan'' and inserting '', a non-network MSA plan, or a preferred provider organization plan';

(2) in subparagraph (B)—

(A) in the heading, by striking ''AND NON-NETWORK MSA PLANS'' and inserting '', NON-NETWORK MSA PLANS, AND PREFERRED PROVIDER ORGANIZATION PLANS''; and

(B) by striking ''or a non-network MSA plan'' and inserting '', a non-network MSA plan, or a preferred provider organization plan'';

(3) by adding at the end the following:

''(D) DEFINITION OF PREFERRED PROVIDER ORGANIZATION PLAN.—In this paragraph, the term 'preferred provider organization plan' means a Medicare+Choice plan that—

''(i) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

''(ii) provides for reimbursement for all covered benefits regardless of whether

such benefits are provided within such network of providers; and

''(iii) is offered by an organization that is not licensed or organized under State law as a health maintenance organization.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to contract years beginning on or after January 1, 2000.

(c) QUALITY IMPROVEMENT STANDARDS.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the appropriate quality improvement standards that should apply to—

(A) each type of Medicare+Choice plan described in section 1851(a)(2) of the Social Security Act (42 U.S.C. 1395w–21(a)(2)), including each type of Medicare+Choice plan that is a coordinated care plan (as described in subparagraph (A) of such section); and

(B) the original medicare fee-for-service program under parts A and B title XVIII of such Act (42 U.S.C. 1395 et seq.).

(2) CONSIDERATIONS.—Such study shall specifically examine the effects, costs, and feasibility of

requiring entities, physicians, and other health care providers that provide items and services under the original medicare fee-for-service program to comply with quality standards and related reporting requirements that are comparable to the quality standards and related reporting requirements that are applicable to Medicare+Choice organizations.

(3) REPORT.—Not later than 2 years after the date of the enactment of this Act, such Commission shall submit a report to Congress on the study conducted under this subsection, together with any recommendations for legislation that it determines to be appropriate as a result of such study.

SEC. 521. CLARIFICATION OF NONAPPLICABILITY OF CERTAIN PROVISIONS OF DISCHARGE PLANNING PROCESS TO MEDICARE+CHOICE PLANS.

Section 1861(ee) (42 U.S.C. 1395x(ee)(2)(H)) is amended by adding at the end the following:

''(3) With respect to a discharge plan for an individual who is enrolled with a Medicare+Choice organization under a Medicare+Choice plan and is furnished inpatient hospital services by a hospital under a contract with the organization—

''(A) the discharge planning evaluation under paragraph (2)(D) is not required to include informa-

tion on the availability of home health services through individuals and entities which do not have a contract with the organization; and

''(B) notwithstanding subparagraph (H)(i), the plan may specify or limit the provider (or providers) of post-hospital home health services or other post-hospital services under the plan.''.

SEC. 522. USER FEE FOR MEDICARE+CHOICE ORGANIZATIONS BASED ON NUMBER OF ENROLLED BENEFICIARIES.

(a) IN GENERAL.—Section 1857(e)(2) (42 U.S.C. 1395w–27(e)(2)) is amended—

(1) in subparagraph (B), by striking ''Any amounts collected are authorized to be appropriated only for'' and inserting ''Any amounts collected shall be available without further appropriation to the Secretary for'';

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

''(C) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for the purposes described in subparagraph (B) for each fiscal year beginning with fiscal year 2001 an amount equal to $100,000,000, reduced by the amount of fees

authorized to be collected under this paragraph for the fiscal year.'';

(3) in subparagraph (D)(ii)—

(A) in subclause (II), by striking ''and'';

(B) in subclause (III), by striking '' and each subsequent fiscal year.'' and inserting ''; and''; and

(C) by adding at the end the following:

''(IV) the Medicare+Choice portion (as defined in subparagraph (E)) of $100,000,000 in fiscal year 2001 and each succeeding fiscal year.''; and

(4) by adding at the end the following:

''(E) MEDICARE+CHOICE PORTION DEFINED.—In this paragraph, the term 'Medicare+Choice portion' means, for a fiscal year, the ratio, as estimated by the Secretary, of—

''(i) the average number of individuals enrolled in Medicare+Choice plans during the fiscal year, to

''(ii) the average number of individuals entitled to benefits under part A, and enrolled under part B, during the fiscal year.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to fees charged on or after January 1, 2001. The Secretary of Health and Human Services may not increase the fees charged under section 1857(e)(2) of the Social Security Act (42 U.S.C. 1395w–27(e)(2)) for the 3-month period beginning with October 2000 above the level in effect during the previous 9-month period.

SEC. 523. CLARIFICATION REGARDING THE ABILITY OF A RELIGIOUS FRATERNAL BENEFIT SOCIETY TO OPERATE ANY MEDICARE+CHOICE PLAN.

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)''.

SEC. 524. RULES REGARDING PHYSICIAN REFERRALS FOR MEDICARE+CHOICE PROGRAM.

(a) IN GENERAL.—Section 1877(b)(3) (42 U.S.C. 1395nn(b)(3)) is amended—

(1) in subparagraph (C), by striking ''or'' at the end;

(3) by adding at the end the following:

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

''(E) that is a Medicare+Choice organization under part C that is offering a coordinated care plan described in section 1851(a)(2)(A) to an individual enrolled with the organization.''.

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

Subtitle C—Demonstration Projects and Special Medicare Populations

SEC. 531. 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) 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'';

(2) in paragraph (4), by striking ''March 31, 2001'' and inserting ''the date that is 21 months after the date on which Secretary submits to Con-

gress the report described in section 4014(c) of the Balanced Budget Act of 1997''; and

(3) 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) 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. 532. 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; 42 U.S.C. 1395mm note) 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. The Secretary of Health and Human Services shall provide for such reduction in payments under such project in the extension period provided under the previous sentence as the Secretary determines is necessary to ensure that total Federal expenditures during the extension period under the project do not exceed the total Federal expenditures that would have been made under title XVIII of the Social Security Act if such project had not been so extended.

(b) REPORT.—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. 533. MEDICARE+CHOICE COMPETITIVE BIDDING DEMONSTRATION PROJECT.

Section 4011 of BBA (42 U.S.C. 1395w–23 note) is amended—

(1) in subsection (a)—

(A) by striking ''The Secretary'' and inserting the following (and conforming the in-

dentation for the remainder of the subsection accordingly):

''(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 MEDICARE FEE-FOR-SERVICE PROGRAM INTO PROJECT.—What changes would be required in the project to feasibly incorporate the original medicare fee-for-service 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 medicare fee-for-service 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 under subsection (g), 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 medicare fee-for-service 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 the per capita bid for which is less than the standard per capita govern-

ment contribution (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. 534. 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, 2002''.

SEC. 535. MEDICARE COORDINATED CARE DEMONSTRATION PROJECT.

Section 4016(e)(1)(A)(ii) of BBA (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 In-

surance Trust Fund and the Federal Supplementary 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.''.

SEC. 536. MEDIGAP PROTECTIONS FOR PACE PROGRAM ENROLLEES.

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

(1) in clause (ii), by inserting ''or the individual is 65 years of age or older and is enrolled with a PACE provider under section 1894, and there are circumstances that would permit the discontinuance of the individual's enrollment with such provider under circumstances that are similar to the circumstances that would permit discontinuance of the individual's election under the first sentence of such section if such individual were enrolled in a Medicare+Choice plan'' before the period;

(2) in clause (v)(II), by inserting ''any PACE provider under section 1894,'' after ''demonstration project authority,''; and

(3) in clause (vi)—

(A) by inserting ''or in a PACE program under section 1894'' after ''part C''; and

(B) by striking ''such plan'' and inserting ''such plan or such program''.

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

Subtitle D—Medicare+Choice Nursing and Allied Health Professional Education Payments

SEC. 541. MEDICARE+CHOICE NURSING AND ALLIED HEALTH PROFESSIONAL EDUCATION PAYMENTS.

(a) ADDITIONAL PAYMENTS FOR NURSING AND ALLIED HEALTH EDUCATION.—Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

''(l) PAYMENT FOR NURSING AND ALLIED HEALTH EDUCATION FOR MANAGED CARE ENROLLEES.—

''(1) IN GENERAL.—For portions of cost reporting periods occurring in a year (beginning with

2000), the Secretary shall provide for an additional payment amount for any hospital that receives payments for the costs of approved educational activities for nurse and allied health professional training under section 1861(v)(1).

''(2) PAYMENT AMOUNT.—The additional payment amount under this subsection for each hospital for portions of cost reporting periods occurring in a year shall be an amount specified by the Secretary in a manner consistent with the following:

''(A) DETERMINATION OF MANAGED CARE ENROLLEE PAYMENT RATIO FOR GRADUATE MEDICAL EDUCATION PAYMENTS.—The Secretary shall estimate the ratio of payments for all hospitals for portions of cost reporting periods occurring in the year under subsection (h)(3)(D) to total direct graduate medical education payments estimated for such portions of periods under subsection (h)(3).

''(B) APPLICATION TO FEE-FOR-SERVICE NURSING AND ALLIED HEALTH EDUCATION PAYMENTS.—Such ratio shall be applied to the Secretary's estimate of total payments for nursing and allied health education determined under section 1861(v) for portions of cost re-

porting periods occurring in the year to determine a total amount of additional payments for nursing and allied health education to be distributed to hospitals under this subsection for portions of cost reporting periods occurring in the year; except that in no case shall such total amount exceed $60,000,000 in any year.

''(C) APPLICATION TO HOSPITAL.—The amount of payment under this subsection to a hospital for portions of cost reporting periods occurring in a year is equal to the total amount of payments determined under subparagraph (B) for the year multiplied by the Secretary's estimate of the ratio of the amount of payments made under section 1861(v) to the hospital for nursing and allied health education activities for the hospital's cost reporting period ending in the second preceding fiscal year to the total of such amounts for all hospitals for such cost reporting periods.''.

(b) ADJUSTMENTS IN PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION.—Section 1886(h)(3)(D) (42 U.S.C. 1395ww(h)(3)(D)) is amended—

(1) in clause (i), by inserting '', subject to clause (iii),'' after ''shall equal'';

(2) by redesignating clause (iii) as clause (iv); and

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

"(iii) PROPORTIONAL REDUCTION FOR NURSING AND ALLIED HEALTH EDUCATION.—The Secretary shall estimate a proportional adjustment in payments to all hospitals determined under clauses (i) and (ii) for portions of cost reporting periods beginning in a year (beginning with 2000) such that the proportional adjustment reduces payments in an amount for such year equal to the total additional payment amounts for nursing and allied health education determined under subsection (l) for portions of cost reporting periods occurring in that year.".

Subtitle E—Studies and Reports

SEC. 551. REPORT ON ACCOUNTING FOR VA AND DOD EXPENDITURES FOR MEDICARE BENEFICIARIES.

Not later April 1, 2001, the Secretary of Health and Human Services, jointly with the Secretaries of Defense and of Veterans Affairs, shall submit to Congress 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.

SEC. 552. MEDICARE PAYMENT ADVISORY COMMISSION STUDIES AND REPORTS.

(a) DEVELOPMENT OF SPECIAL PAYMENT RULES UNDER THE MEDICARE+CHOICE PROGRAM FOR FRAIL ELDERLY ENROLLED IN SPECIALIZED PROGRAMS.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the development of a payment methodology under the Medicare+Choice program for frail elderly Medicare+Choice beneficiaries enrolled in a Medicare+Choice plan under a specialized program for the frail elderly that—

(A) accounts for the prevalence, mix, and severity of chronic conditions among such frail elderly Medicare+Choice beneficiaries;

(B) includes medical diagnostic factors from all provider settings (including hospital and nursing facility settings); and

(C) includes functional indicators of health status and such other factors as may be necessary to achieve appropriate payments for plans serving such beneficiaries.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Commission shall submit a report to Congress on the study conducted under paragraph (1), together with any recommendations for legislation that the Commission determines to be appropriate as a result of such study.

(b) 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 Assessment Commission shall submit to Congress a report on specific legislative changes that should be made to make MSA plans (as defined in section 1859(b)(3) of the Social Security Act, 42 U.S.C. 1395w–29(b)(3)) a viable option under the Medicare+Choice program.

SEC. 553. GAO STUDIES, AUDITS, AND REPORTS.

(a) STUDY OF MEDIGAP POLICIES.—

(1) IN GENERAL.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study of the issues described in paragraph (2) regarding medicare supplemental policies described in section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(g)(1)).

(2) ISSUES TO BE STUDIED.—The issues described in this paragraph are the following:

(A) The level of coverage provided by each type of medicare supplemental policy.

(B) The current enrollment levels in each type of medicare supplemental policy.

(C) The availability of each type of medicare supplemental policy to medicare beneficiaries over age 65½.

(D) The number and type of medicare supplemental policies offered in each State.

(E) The average out-of-pocket costs (including premiums) per beneficiary under each type of medicare supplemental policy.

(2) REPORT.—Not later than July 31, 2001, the Comptroller General shall submit a report to Congress on the results of the study conducted under this subsection, together with any rec-

ommendations for legislation that the Comptroller General determines to be appropriate as a result of such study.

(b) GAO AUDIT AND REPORTS ON THE PROVISION OF MEDICARE+CHOICE HEALTH INFORMATION TO BENEFICIARIES.—

(1) IN GENERAL.—Beginning in 2000, the Comptroller General shall conduct an annual audit of the expenditures by the Secretary of Health and Human Services during the preceding year in providing information regarding the Medicare+Choice program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) to eligible medicare beneficiaries.

(3) REPORTS.—Not later than March 31 of 2001, 2004, 2007, and 2010, the Comptroller General shall submit a report to Congress on the results of the audit of the expenditures of the preceding 3 years conducted pursuant to subsection (a), together with an evaluation of the effectiveness of the means used by the Secretary of Health and Human Services in providing information regarding the Medicare+Choice program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) to eligible medicare beneficiaries.

TITLE VI—MEDICAID

SEC. 601. 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 ''0.1''.

(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. 602. REMOVAL OF FISCAL YEAR LIMITATION ON CERTAIN TRANSITIONAL ADMINISTRATIVE COSTS ASSISTANCE.

(a) IN GENERAL.—Section 1931(h) (42 U.S.C. 1396u–1(h)) is amended—

(1) in paragraph (3), by striking ''and ending with fiscal year 2000''; and

(2) by striking paragraph (4).

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 114 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2177).

SEC. 603. MODIFICATION OF THE PHASE-OUT OF PAYMENT FOR FEDERALLY-QUALIFIED HEALTH CENTER SERVICES AND RURAL HEALTH CLINIC SERVICES BASED ON REASONABLE COSTS.

(a) MODIFICATION OF PHASE-OUT.—

(1) IN GENERAL.—Section 1902(a)(13)(C)(i) (42 U.S.C. 1396a(a)(13)(C)(i)) is amended by striking ''90 percent for services furnished during fiscal year 2001, 85 percent for services furnished during fiscal year 2002, or 70 percent for services furnished during fiscal year 2003'' and inserting ''fiscal year 2001, or fiscal year 2002, 90 percent for services furnished during fiscal year 2003, or 85 percent for services furnished during fiscal year 2004''.

(2) CONFORMING AMENDMENT TO END OF TRANSITIONAL PAYMENT RULES.—Section 4712(c) of BBA (111 Stat. 509) is amended by striking ''2003'' and inserting ''2004''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect as if included in

the enactment of section 4712 of BBA (111 Stat. 508).

(b) GAO STUDY AND REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit a report to Congress that evaluates the effect on Federally-qualified health centers and rural health clinics and on the populations served by such centers and clinics of the phase-out and elimination of the reasonable cost basis for payment for Federally-qualified health center services and rural health clinic services provided under section 1902(a)(13)(C)(i) of the Social Security Act (42 U.S.C. 1396a(a)(13)(C)(i)), as amended by section 4712 of BBA (111 Stat. 508) and subsection (a) of this section. Such report shall include an analysis of the amount, method, and impact of payments made by States that have provided for payment under title XIX of such Act for such services on a basis other than payment of costs which are reasonable and related to the cost of furnishing such services, together with any recommendations for legislation, including whether a new payment system is needed, that the Comptroller General determines to be appropriate as a result of the study.

SEC. 604. PARITY IN REIMBURSEMENT FOR CERTAIN UTILIZATION AND QUALITY CONTROL SERVICES; ELIMINATION OF DUPLICATIVE REQUIREMENTS FOR EXTERNAL QUALITY REVIEW OF MEDICAID MANAGED CARE ORGANIZATIONS.

(a) PARITY IN REIMBURSEMENT FOR CERTAIN UTILIZATION AND QUALITY CONTROL SERVICES.—

(1) INTERIM AMENDMENT TO REMOVE REFERENCES TO QUALITY REVIEW.—Section 1902(d) (42 U.S.C. 1396a(d)) is amended by striking ''for the performance of the quality review functions described in subsection (a)(30)(C),''.

(2) FINAL AMENDMENTS TO REMOVE REFERENCES TO QUALITY REVIEW.—

(A) SECTION 1902.—Section 1902(d) (42 U.S.C. 1396a(d)) is amended by striking ''(including quality review functions described in subsection (a)(30)(C))''.

(B) SECTION 1903.—Section 1903(a)(3)(C)(i) (42 U.S.C. 1396b(a)(3)(C)(i)) is amended by striking ''or quality review''.

(b) ELIMINATION OF DUPLICATIVE REQUIREMENTS FOR EXTERNAL QUALITY REVIEW OF MEDICAID MANAGED CARE ORGANIZATIONS.—

(1) IN GENERAL.—Section 1902(a)(30) (42 U.S.C. 1396a(a)(30)) is amended—

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

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

(C) by striking subparagraph (C).

(2) CONFORMING AMENDMENT.—Section 1903(m)(6)(B) (42 U.S.C. 1396b(m)(6)(B)) is amended—

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

(B) in clause (iii), by striking ''; and'' and inserting a period; and

(C) by striking clause (iv).

(c) EFFECTIVE DATES.—

(1) The amendment made by subsection (a)(1) applies to expenditures made on and after the date of the enactment of this Act.

(2) The amendments made by subsections (a)(2) and (b) apply as of such date as the Secretary of Health and Human Services certifies to Congress that the Secretary is fully implementing section 1932(c)(2) of the Social Security Act (42 U.S.C. 1396u–2(c)(2)).

SEC. 605. INAPPLICABILITY OF ENHANCED MATCH UNDER THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM TO MEDICAID DSH PAYMENTS.

(a) IN GENERAL.—The last sentence of section 1905(b) (42 U.S.C. 1396d(b)) is amended by inserting ''(other than expenditures under section 1923)'' after ''with respect to expenditures''.

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

SEC. 606. OPTIONAL DEFERMENT OF THE EFFECTIVE DATE FOR OUTPATIENT DRUG AGREEMENTS.

(a) IN GENERAL.—Section 1927(a)(1) (42 U.S.C. 1396r–8(a)(1)) is amended by striking ''shall not be effective until'' and inserting ''shall become effective as of the date on which the agreement is entered into or, at State option, on any date thereafter on or before''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to agreements entered into on or after the date of enactment of this Act.

SEC. 607. MAKING MEDICAID DSH TRANSITION RULE PERMANENT.

(a) IN GENERAL.—Section 4721(e) of BBA (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 BBA.

SEC. 608. MEDICAID TECHNICAL CORRECTIONS.

(a) Section 1902(a)(64) (42 U.S.C. 1396a(a)(64)) is amended by adding ''and'' at the end.

(b) Section 1902(j) (42 U.S.C. 1396a(j)) is amended by striking ''of of'' and inserting ''of''.

(c) Section 1902(l) (42 U.S.C. 1396a(l)) is amended—

(1) in paragraph (1)(C), by striking ''children children'' and inserting ''children'';

(2) in paragraph (3), in the matter preceding subparagraph (A), by striking the first comma after ''(a)(10)(A)(i)(VII)''; and

(3) in paragraph (4)(B), by inserting a comma after ''(a)(10)(A)(i)(IV)''.

(d) Section 1902(v) (42 U.S.C. 1396a(v)) is amended by striking ''(1)''.

(e) Section 1903(b)(4) (42 U.S.C. 1396b(b)(4)) is amended, in the matter preceding subparagraph (A), by inserting ''of'' after ''for the use''.

(f) The left margins of clauses (i) and (ii) of section 1903(d)(3)(B) (42 U.S.C. 1396b(d)(3)(B)) are each re-aligned so as to align with the left margin of section 1903(d)(3)(A).

(g) Section 1903(f)(2) (42 U.S.C. 1396b(f)(2)) is amended by striking the extra period at the end.

(h) Section 1903(i)(14) (1396b(i)(14)) is amended by adding ''or'' after the semicolon.

(i) Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended—

(1) in clause (vi), by striking the semicolon the first place it appears; and

(2) by redesignating the clause (xi) added by section 4701(c)(3) of BBA (111 Stat. 493) as clause (xii).

(j) Section 1903(o) (42 U.S.C. 1396b(o)) is amended by striking ''1974))'' and inserting ''1974)''.

(k) Section 1903(w) (42 U.S.C. 1396b(w)) is amended—

(1) in paragraph (1)(B), by striking ''puroses'' and inserting ''purposes'';

(2) in paragraph (3)(B), by inserting a comma after ''(D)''; and

(3) by realigning the left margin of clause (viii) in paragraph (7)(A) so as to align with the left margin of clause (vii) of that paragraph.

(l) Section 1905(b)(1) (42 U.S.C. 1396d(b)(1)) is amended by striking ''per centum,,'' and inserting ''per centum,''.

(m) Section 1905(l)(2)(B) (42 U.S.C. 1936d(l)(2)(B)) is amended by striking ''a entity'' and inserting ''an entity''.

(n) The heading for section 1910 (42 U.S.C. 1396i) is amended by striking ''OF'' the first place it appears.

(o) Section 1915 (42 U.S.C. 1396n) is amended—

(1) in subsection (b), by striking ''1902(a)(13)(E)'' and inserting ''1902(a)(13)(C)'';

(2) in the last sentence of subsection (d)(5)(B)(iii), by striking ''75'' and inserting ''65''; and

(3) in subsection (h), by striking ''90 day'' and inserting ''90 days''.

(p) Section 1919 (42 U.S.C. 1396r) is amended—

(1) in subsection (b)(3)(C)(i)(I), by striking ''not later than'' the first place it appears; and

(2) in subsection (d)(4)(A), by striking ''1124'' and inserting ''1124)''.

(q) Section 1920(b)(2)(D)(i)(I) (42 U.S.C. 1396r–1(b)(2)(D)(i)(I)) is amended by striking ''329, 330, or 340'' and inserting ''330 or 330A''.

(r) Section 1920A(d)(1)(B) (42 U.S.C. 1396r–1a(d)(1)(B)) is amended by striking ''a entity'' and inserting ''an entity''.

(s) Section 1923(c)(3)(B) (42 U.S.C. 1396r–4(c)(3)(B)) is amended by striking ''patients.'' and inserting ''patients,''.

(t) Section 1925 (42 U.S.C. 1396r–6) is amended—

(1) in subsection (a)(3)(C), by striking ''(i)(VI) (i)(VII),,'' and inserting ''(i)(VI), (i)(VII),''; and

(2) in subsection (b)(3)(C)(i), by striking ''(i)(IV) (i)(VI) (i)(VII),,'' and inserting ''(i)(IV), (i)(VI), (i)(VII),''.

(u) Section 1927 (42 U.S.C. 1396r–8) is amended—

(1) in subsection (g)(2)(A)(ii)(II)(cc), by striking ''individuals'' and inserting ''individual's'';

(2) in subsection (i)(1), by striking ''the the'' and inserting ''the''; and

(3) in subsection (k)(7)—

(A) in subparagraph (A)(iv), by striking ''distributers'' and inserting ''distributors''; and

(B) in subparagraph (C)(i), by striking ''pharmaceuutically'' and inserting ''pharmaceutically''.

(v) Section 1929 (42 U.S.C. 1396t) is amended—

(1) in subsection (c)(2), by realigning the left margins of clauses (i) and (ii) of subparagraph (E) so as to align with the left margins of clauses (i) and (ii) of subparagraph (F) of that subsection;

(2) in subsection (k)(1)(A)(i), by striking ''settings,'' and inserting ''settings),''; and

(3) in subsection (l), by striking ''State wideness'' and inserting ''Statewideness''.

(w) Section 1932 (42 U.S.C. 1396u–2) is amended—

(1) in subsection (c)(2)(C), by inserting ''part'' before ''C of title XVIII''; and

(2) in subsection (d)—

(A) in paragraph (1)(C)(ii), by striking ''Act'' and inserting ''Regulation''; and

(B) in paragraph (2)(B), by striking ''1903(t)(3)'' and inserting ''1905(t)(3)''.

(x) Section 1933(b)(4) (42 U.S.C. 1396u–3(b)(4)) is amended by inserting ''a'' after ''for a month in''.

(y)(1) The section 1908 (42 U.S.C. 1396g–1) that relates to required laws relating to medical child support is redesignated as section 1908A.

(2) Section 1902(a)(60) (42 U.S.C. 1396b(a)(60)) is amended by striking ''1908'' and inserting ''1908A''.

(z) Effective October 1, 2004, section 1915(b) (42 U.S.C. 1396n(b)) is amended, in the matter preceding paragraph (1), by striking ''sections 1902(a)(13)(C) and'' and inserting ''section''.

(aa) Effective as if included in the enactment of BBA—

(1) section 1902(a)(10)(A)(ii)(XIV) (42 U.S.C. 1396a(a)(10)(A)(ii)(XIV)) is amended by striking ''1905(u)(2)(C)'' and inserting ''1905(u)(2)(B)'';

(2) section 1903(f)(4) (42 U.S.C. 1396b(f)(4)) is amended, in the matter preceding subparagraph

(A), by striking ''1905(p)(1), or 1905(u)'' and inserting ''1902(a)(10)(A)(ii)(XIII), 1902(a)(10)(A)(ii)(XIV), or 1905(p)(1)''; and

(3) section 1905(a)(15) (42 U.S.C. 1396d(a)(15)) is amended by striking ''1902(a)(31)(A)'' and inserting ''1902(a)(31)''.

(bb) Except as otherwise provided, the amendments made by this section shall take effect on the date of enactment of this Act.

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

SEC. 701. STABILIZING THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM 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 subparagraph (A)(iv)) so that (after the appli-

cation 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.

SEC. 703. IMPROVED DATA COLLECTION AND EVALUATIONS OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

(a) FUNDING FOR RELIABLE ANNUAL STATE-BY-STATE ESTIMATES ON THE NUMBER OF CHILDREN WHO DO NOT HAVE HEALTH INSURANCE COVERAGE.—Section 2109 (42 U.S.C. 1397ii) is amended by adding at the end the following:

"(b) ADJUSTMENT TO CURRENT POPULATION SURVEY TO INCLUDE STATE-BY-STATE DATA RELATING TO CHILDREN WITHOUT HEALTH INSURANCE COVERAGE.—

''(1) IN GENERAL.—The Secretary of Commerce shall make appropriate adjustments to the annual Current Population Survey conducted by the Bureau of the Census in order to produce statistically reliable annual State data on the number of low-income children who do not have health insurance coverage, so that real changes in the uninsurance rates of children can reasonably be detected. The Current Population Survey should produce data under this subsection that categorizes such children by family income, age, and race or ethnicity. The adjustments made to produce such data shall include, where appropriate, expanding the sample size used in the State sampling units, expanding the number of sampling units in a State, and an appropriate verification element.

''(2) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $10,000,000 for fiscal year 2000 and each fiscal year thereafter for the purpose of carrying out this subsection.''.

(b) FEDERAL EVALUATION OF STATE CHILDREN'S HEALTH INSURANCE PROGRAMS.—Section 2108 (42 U.S.C. 1397hh) is amended by adding at the end the following:

''(c) FEDERAL EVALUATION.—

''(1) IN GENERAL.—The Secretary, directly or through contracts or interagency agreements, shall conduct an independent evaluation of 10 States with approved child health plans.

''(2) SELECTION OF STATES.—In selecting States for the evaluation conducted under this subsection, the Secretary shall choose 10 States that utilize diverse approaches to providing child health assistance, represent various geographic areas (including a mix of rural and urban areas), and contain a significant portion of uncovered children.

''(3) MATTERS INCLUDED.—In addition to the elements described in subsection (b)(1), the evaluation conducted under this subsection shall include each of the following:

''(A) Surveys of the target population (enrollees, disenrollees, and individuals eligible for but not enrolled in the program under this title).

''(B) Evaluation of effective and ineffective outreach and enrollment practices with respect to children (for both the program under this title and the medicaid program under title XIX), and identification of enrollment barriers

and key elements of effective outreach and enrollment practices, including practices that have successfully enrolled hard-to-reach populations such as children who are eligible for medical assistance under title XIX but have not been enrolled previously in the medicaid program under that title.

''(C) Evaluation of the extent to which State medicaid eligibility practices and procedures under the medicaid program under title XIX are a barrier to the enrollment of children under that program, and the extent to which coordination (or lack of coordination) between that program and the program under this title affects the enrollment of children under both programs.

''(D) An assessment of the effect of cost-sharing on utilization, enrollment, and coverage retention.

''(E) Evaluation of disenrollment or other retention issues, such as switching to private coverage, failure to pay premiums, or barriers in the recertification process.

''(4) SUBMISSION TO CONGRESS.—Not later than December 31, 2001, the Secretary shall submit

to Congress the results of the evaluation conducted under this subsection.

''(5) FUNDING.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $10,000,000 for fiscal year 2000 for the purpose of conducting the evaluation authorized under this subsection. Amounts appropriated under this paragraph shall remain available for expenditure through fiscal year 2002.''.

(c) INSPECTOR GENERAL AUDIT AND GAO REPORT ON ENROLLEES ELIGIBLE FOR MEDICAID.—Section 2108 (42 U.S.C. 1397hh), as amended by subsection (b), is amended by adding at the end the following:

''(d) INSPECTOR GENERAL AUDIT AND GAO REPORT.—

''(1) AUDIT.—Beginning with fiscal year 2000, and every third fiscal year thereafter, the Secretary, through the Inspector General of the Department of Health and Human Services, shall audit a sample from among the States described in paragraph (2) in order to—

''(A) determine the number, if any, of enrollees under the plan under this title who are eligible for medical assistance under title XIX (other than as optional targeted low-in-

come children under section 1902(a)(10)(A)(ii)(XIV)); and

"(B) assess the progress made in reducing the number of uncovered low-income children, including the progress made to achieve the strategic objectives and performance goals included in the State child health plan under section 2107(a).

"(2) STATE DESCRIBED.—A State described in this paragraph is a State with an approved State child health plan under this title that does not, as part of such plan, provide health benefits coverage under the State's medicaid program under title XIX.

"(3) MONITORING AND REPORT FROM GAO.—The Comptroller General of the United States shall monitor the audits conducted under this subsection and, not later than March 1 of each fiscal year after a fiscal year in which an audit is conducted under this subsection, shall submit a report to Congress on the results of the audit conducted during the prior fiscal year.".

(d) COORDINATION OF DATA COLLECTION WITH DATA REQUIREMENTS UNDER THE MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT.—

(1) IN GENERAL.—Paragraphs (2)(D)(ii) and (3)(D)(ii)(II) of section 506(a) (42 U.S.C. 706(a)) are each amended by inserting ''or the State plan under title XXI'' after ''title XIX''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) apply to annual reports submitted under section 506 of the Social Security Act (42 U.S.C. 706) for years beginning after the date of the enactment of this Act.

(e) COORDINATION OF DATA SURVEYS AND REPORTS.—The Secretary of Health and Human Services, through the Assistant Secretary for Planning and Evaluation, shall establish a clearinghouse for the consolidation and coordination of all Federal databases and reports regarding children's health.

SEC. 704. REFERENCES TO SCHIP AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

The Secretary of Health and Human Services or any other Federal officer or employee, with respect to any reference to the program under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) in any publication or other official communication, shall use—

(1) the term ''SCHIP'' instead of the term ''CHIP''; and

(2) the term ''State children's health insurance program'' instead of the term ''children's health insurance program''.

SEC. 705. SCHIP TECHNICAL CORRECTIONS.

(a) Section 2104(b)(3)(B) (42 U.S.C. 1397dd(b)(3)(B)) is amended by striking ''States.'' and inserting ''States,''.

(b) Section 2105(d)(2)(B)(iii) (42 U.S.C. 1397ee(d)(2)(B)(iii)) is amended by inserting ''in'' after ''described''.

(c) Section 2109(a) (42 U.S.C.1397ii(a)) is amended—

(1) in paragraph (1), by striking ''title II'' and inserting ''title I''; and

(2) in paragraph (2), by inserting '')'' before the period.

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