Award from GSFC, the Exception Achievement Award, the John C. Lindsay Memorial Award, the Group Achievement Award, the Rotary National Space Achievement Award, the National Air and Space Museum Trophy, the American Institute of Aeronautics and Astronautics Space Science Award, an Honorary Doctor of Science Degree from Swarthmore College, and the Rumford Prize from the American Academy of Arts and Sciences.

In recent years, Dr. Mather has continued to publish on the topic of the COBE FIRAS Spectrum, the Far Infrared Absolute Spectrophotometer on the Cosmic Background Explorer and other topics, always maintaining his grasp of current scientific discoveries.

A native of New Jersey, Dr. Mather grew up on the Rutgers University Dairy Research Station where his father worked as a geneticist. He went on to graduate from Swarthmore College with highest honors in Physics. He received his doctorate in Physics in 1974 from the University of California at Berkeley. We in Maryland are certainly delighted that he has since decided to become a member of the Hyattsville community and a prominent member of the NASA presence in the state.

Mr. President, Dr. Mather's election to the National Academy of Sciences is a tremendous milestone in this public servant's already magnificent career. As Dr. Mather continues to be a rising star in the astrophysics community it is truly an honor to recognize this fine Marylander for his accomplishments and I wish him continued success in future endeavors.●

BALANCED BUDGET RECONCILIATION ACT OF 1997

● Mr. SPECTER. Mr. President, I wish to explain my vote against waiving the Budget Act on the point of order raised by Senator ROCKEFELLER yesterday concerning the provisions in S. 947 on balance billing in the Medicare Program.

The Balanced Budget Act of 1997 includes a new Medicare Choice Program, allowing Medicare beneficiaries for the first time to choose from a wide range of options for receiving their Medicare coverage, including traditional fee-for-service plans, private fee-for-service plans, provider sponsored organizations, medical savings accounts, health maintenance organizations, and preferred provider organizations.

Within the context of Medicare Choice, there is an issue as to whether current law Medicare balance billing requirements should apply across the board. Under the Medicare Program, balance billing refers to the arrangement in which the Federal Government pays doctors at a given rate for treating a patient and doctors can charge up to a specific percentage above that amount.

This legislation exempts from balance billing requirements the new private fee-for-service plans and medical savings accounts. If the Rockefeller point of order were sustained and the exemptions eliminated, doctors would be less likely to participate in the Medicare Choice Program's fee-for-service or medical savings account options because balance billing would cap their charges. As a result, seniors would have fewer options for medical care under this new program. I would note that under this legislation, no senior citizen would be required to choose any specific option, and each person can analyze all of the options to determine which best suits his or her individual health care needs. Further, balance billing will still remain in effect for the other options under Medicare Choice. Accordingly, in order to maximize choices for Medicare beneficiaries, I supported the motion to waive the Budget Act to overcome the Rockefeller point of order.●

SUPREME COURT STRIKES DOWN THE COMMUNICATION DECENCY ACT

● Mr. FEINGOLD. Mr. President, I rise to applaud today's U.S. Supreme Court decision striking down the Communications Decency Act as an unconstitutional restriction of free speech on the Internet, affirming the 1996 lower court decision.

In striking down the provisions of the CDA, which effectively censors the speech of adults on the Internet, the Court stated ''We agree with the District Court's conclusion that the CDA places an unacceptably heavy burden on protected speech.'' The Court concluded that the CDA ''threatens to torch a large segment of the Internet community.''

Mr. President, this decision is a victory not only for Internet users, it is a victory for all Americans who hold the first amendment right to free speech among their most cherished rights.

The Senator from Vermont [Senator LEAHY] and I spoke in opposition to the CDA when it was first brought to the Senate floor in 1995 during consideration of the Telecommunications Act. The high court decision pointed out the many flaws of the CDA that the Senator from Vermont and I raised before the legislation was approved. Among other concerns, we pointed out that indecency restrictions which have been upheld when applied to other media, were unconstitutional when applied to the Internet due to its unique nature. We urged our colleagues to study the problem and the potential solutions more carefully before they rushed headlong to pass what we knew to be unconstitutional legislation. Ultimately, the CDA passed the Senate in June 1995 with only 2 hours of debate and no Congressional hearings. The lack of congressional consideration of the CDA's problems was among the reasons cited by the Court in its finding that the act violated the first amendment. In failing to carefully examine the problem, the Congress merely tied the CDA up in Court for over a year while getting no closer to its goal of protecting children on the Internet.

Both the Supreme Court, and the lower court before it, conducted an exhaustive review of the nature of the Internet and of the technologies that exist to protect children and concluded that the CDA was an unconstitutional restriction on the free speech of adults that was not narrowly tailored to the goal of protecting kids on the Net.

Specifically, Mr. President, the Supreme Court found that:

Other laws restricting speech that have been upheld by the Supreme Court are substantially different from the CDA. Fundamentally, the Court determined that unlike other media that have been subject to some speech restrictions, the Internet receives full first amendment protection. Additionally, the Court pointed out that restrictions previously upheld by the High Court have been time, place and manner restrictions, rather than ''content-based blanket restriction on speech.'' Those differences bring into question the constitutionality of the CDA rather than confirming it.

The characteristics of other media that have some speech restrictions, such as the scarcity of broadcast spectrum and the invasive nature of broadcast media, do not apply to the Internet.

The combination of criminal penalties for violations and the vague nature of the ''indecency'' prohibition will chill speech on the Internet because speakers will not know which speech is prohibited and which is acceptable.

The breadth of the indecency standard in the CDA is unprecedented.

The CDA attempts to protect children by suppressing constitutionally protected speech of adults. This burden of speech is constitutionally unacceptable because less restrictive means of achieving the Government's goal are available.

Mr. President, the Supreme Court correctly struck down the Communications Decency Act. While this decision precludes enforcement of the act, Congress should act quickly to repeal the CDA. It is time to conduct a thorough and thoughtful review of constitutional methods to protect children on the Internet from those who would seek to harm them.

Mr. President, I urge my colleagues to read today's Supreme Court decision striking down the Communications Decency Act and work toward more effective solutions to protect our kids.●

THE BALANCED BUDGET ACT OF 1997

The text of H.R. 2015, as amended by S. 947, is as follows:

Resolved, That the bill from the House of Representatives (H.R. 2015) entitled ''An Act to provide for reconciliation pursuant to section 104(a) of the concurrent resolution on

the budget for fiscal year 1998.'', do pass with the following amendment:

Strike out all after the enacting clause and insert:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Balanced Budget Act of 1997''.

SEC. 2. TABLE OF TITLES.

The table of titles for this Act is as follows:

TITLE I—COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

SEC. 1001. HARDSHIP EXEMPTION.

Section 6(o) of the Food Stamp Act of 1977 (7 U.S.C. 2015(o)) is amended—

(1) in paragraph (2)(D), by striking ''or (5)'' and inserting ''(5), or (6)'';

(2) by redesignating paragraph (6) as paragraph (7); and

(3) by inserting after paragraph (5) the following:

''(6) 15-PERCENT HARDSHIP EXEMPTION.—

''(A) DEFINITIONS.—In this paragraph:

''(i) CASELOAD.—The term 'caseload' means the average monthly number of individuals receiving food stamps during the 12-month period ending the preceding June 30.

''(ii) COVERED INDIVIDUAL.—The term 'covered individual' means a food stamp recipient, or an individual denied eligibility for food stamp benefits solely due to paragraph (2), who—

''(I) is not eligible for an exception under paragraph (3);

''(II) does not reside in an area covered by a waiver granted under paragraph (4);

''(III) is not complying with subparagraph (A), (B), or (C) of paragraph (2);

''(IV) is not receiving food stamp benefits during the 3 months of eligibility provided under paragraph (2); and

''(V) is not receiving food stamp benefits under paragraph (5).

''(B) GENERAL RULE.—Subject to subparagraphs (C) through (F), a State agency may provide a hardship exemption from the requirements of paragraph (2) for covered individuals.

''(C) FISCAL YEAR 1998.—Subject to subparagraph (E), for fiscal year 1998, a State agency may provide a number of hardship exemptions such that the average monthly number of the exemptions in effect during the fiscal year does not exceed 15 percent of the number of covered individuals in the State in fiscal year 1998, as estimated by the Secretary, based on the survey conducted to carry out section 16(c) for fiscal year 1996 and such other factors as the Secretary considers appropriate due to the timing and limitations of the survey.

''(D) SUBSEQUENT FISCAL YEARS.—Subject to subparagraphs (E) and (F), for fiscal year 1999 and each subsequent fiscal year, a State agency may provide a number of hardship exemptions such that the average monthly number of the exemptions in effect during the fiscal year does not exceed 15 percent of the number of covered individuals in the State, as estimated by the Secretary under subparagraph (C), adjusted by the Secretary to reflect changes in the State's caseload and the Secretary's estimate of changes in the proportion of food stamp recipients covered by waivers granted under paragraph (4).

''(E) CASELOAD ADJUSTMENTS.—The Secretary shall adjust the number of individuals estimated for a State under subparagraph (C) or (D) during a fiscal year if the number of food stamp recipients in the State varies from the caseload by more than 10 percent, as determined by the Secretary.

''(F) EXEMPTION ADJUSTMENTS.—For fiscal year 1999 and each subsequent fiscal year, the Secretary shall increase or decrease the number of individuals who may be granted a hardship exemption by a State agency to the extent that the average monthly number of hardship exemptions in effect in the State for the preceding fiscal year is greater or less than the average monthly number of hardship exemptions estimated for the State agency for such preceding fiscal year.

''(G) REPORTING REQUIREMENT.—A State agency shall submit such reports to the Secretary as the Secretary determines are necessary to ensure compliance with this paragraph.''.

SEC. 1002. ADDITIONAL FUNDING FOR EMPLOYMENT AND TRAINING.

Section 16(h) of the Food Stamp Act of 1977 (7 U.S.C. 2025(h)) is amended by striking paragraphs (1) and (2) and inserting the following:

''(1) IN GENERAL.—

''(A) AMOUNTS.—To carry out employment and training programs, the Secretary shall reserve for allocation to State agencies, to remain available until expended, from funds made available for each fiscal year under section 18(a)(1) the amount of—

''(i) for fiscal year 1996, $75,000,000;

''(ii) for fiscal year 1997, $79,000,000;

''(iii) for fiscal year 1998, $221,000,000;

''(iv) for fiscal year 1999, $224,000,000;

''(v) for fiscal year 2000, $226,000,000;

''(vi) for fiscal year 2001, $228,000,000; and

''(vii) for fiscal year 2002, $170,000,000.

''(B) ALLOCATION.—The Secretary shall allocate the amounts reserved under subparagraph (A) among the State agencies using a reasonable formula (as determined by the Secretary) that reflects the proportion of food stamp recipients who are not eligible for an exception under section 6(o)(3) that reside in each State, as estimated by the Secretary based on the survey conducted to carry out subsection (c) for fiscal year 1996 and such other factors as the Secretary considers appropriate due to the timing and limitations of the survey (as adjusted by the Secretary each fiscal year to reflect changes in each State's caseload (as defined in section 6(o)(5)(A))).

''(C) REALLOCATION.—If a State agency will not expend all of the funds allocated to the State agency for a fiscal year under subparagraph (B), the Secretary shall reallocate the unexpended funds to other States (during the fiscal year or the subsequent fiscal year) as the Secretary considers appropriate and equitable.

''(D) MINIMUM ALLOCATION.—Notwithstanding subparagraph (B), the Secretary shall ensure that each State agency operating an employment and training program shall receive not less than $50,000 for each fiscal year.

''(E) PLACEMENTS.—Of the amount of funds reserved for a State agency for a fiscal year under subparagraphs (A) through (D), the State agency shall be eligible to receive for the fiscal year not more than an amount equal to the sum of—

''(i) the product obtained by multiplying—

''(I) the average monthly number of food stamp recipients who during the fiscal year—

''(aa) are not eligible for an exception under section 6(o)(3); and

''(bb) are placed in and comply with a program described in subparagraph (B) or (C) of section 6(o)(2), other than a program described in subparagraph (A) or (B) of section 6(o)(1); by

''(II) an amount determined by the Secretary to reflect the reasonable cost of efficiently and economically providing services that meet the requirements of subparagraph (B) or (C) of section 6(o)(2) to food stamp recipients described in subclause (I) for the fiscal year, as periodically adjusted by the Secretary; and

''(ii) the product obtained by multiplying—

''(I) the average monthly number of food stamp recipients in activities not described in clause (i)(I)(bb) who during the fiscal year are placed in and comply with an employment and training program; by

''(II) an amount determined by the Secretary to reflect the reasonable cost of efficiently and economically providing employment and training services to food stamp recipients described in subclause (I) for the fiscal year that is less than the amount determined under clause (i)(II), as periodically adjusted by the Secretary.

''(F) USE OF FUNDS.—Of the amount of funds a State agency receives under subparagraphs (A) through (E) for a fiscal year, not less than 75 percent shall be used by the State agency in the fiscal year to serve food stamp recipients described in subparagraph (E)(i)(I)(aa) who are placed in and comply with a program described in subparagraph (E)(i)(I)(bb).

''(G) MAINTENANCE OF EFFORT.—To receive an amount reserved under subparagraph (A), a State agency shall maintain the expenditures of the State agency for employment and training programs and workfare programs for any fiscal year under paragraph (2), and administrative expenses under section 20(g)(1), at a level that is not less than 75 percent of the level of the expenditures by the State agency to carry out the programs for fiscal year 1996.

''(2) ADDITIONAL PAYMENTS TO STATES.—If a State agency—

''(A) incurs costs to place individuals in employment and training programs, including the costs for case management and casework to facilitate the transition from economic dependency to self-sufficiency through work; and

''(B) does not use the funds provided under paragraph (1)(A) to defray the costs incurred;

the Secretary shall pay the State agency an amount equal to 50 percent of the costs incurred, subject to paragraph (3).''.

SEC. 1003. DENIAL OF FOOD STAMPS FOR PRISONERS.

(a) STATE PLANS.—

(1) IN GENERAL.—Section 11(e) of the Food Stamp Act of 1977 (7 U.S.C. 2020(e)) is amended by striking paragraph (20) and inserting the following:

''(20) that the State agency shall establish a system and take action on a periodic basis—

''(A) to verify and otherwise ensure that an individual does not receive coupons in more than 1 jurisdiction within the State; and

''(B) to verify and otherwise ensure that an individual who is placed under detention in a Federal, State, or local penal, correctional, or other detention facility for more than 30 days shall not be eligible to participate in the food stamp program as a member of any household, except that—

''(i) the Secretary may determine that extraordinary circumstances make it impracticable for the State agency to obtain information necessary to discontinue inclusion of the individual; and

''(ii) a State agency that obtains information collected under section 1611(e)(1)(I)(i)(I) of the Social Security Act (42 U.S.C. 1382(e)(1)(I)(i)(I)) through an agreement under section 1611(e)(1)(I)(ii)(II) of that Act (42 U.S.C. 1382(e)(1)(I)(ii)(II)), or under another program determined by the Secretary to be comparable to the program carried out under that section, shall be considered in compliance with this subparagraph.''.

(2) LIMITS ON DISCLOSURE AND USE OF INFORMATION.—Section 11(e)(8)(E) of the Food Stamp Act of 1977 (7 U.S.C. 2020(e)(8)(E)) is amended by striking ''paragraph (16)'' and inserting ''paragraph (16) or (20)(B)''.

(3) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this subsection shall take effect on the date that is 1 year after the date of enactment of this Act.

(B) EXTENSION.—The Secretary of Agriculture may grant a State an extension of time to comply with the amendments made by this subsection, not to exceed beyond the date that is 2 years after the date of enactment of this Act, if the chief executive officer of the State submits a request for the extension to the Secretary—

(i) stating the reasons why the State is not able to comply with the amendments made by this subsection by the date that is 1 year after the date of enactment of this Act;

(ii) providing evidence that the State is making a good faith effort to comply with the amendments made by this subsection as soon as practicable; and

(iii) detailing a plan to bring the State into compliance with the amendments made by this subsection as soon as practicable and not later than the date of the requested extension.

(b) INFORMATION SHARING.—Section 11 of the Food Stamp Act of 1977 (7 U.S.C. 2020) is amended by adding at the end the following:

''(q) DENIAL OF FOOD STAMPS FOR PRISONERS.—The Secretary shall assist States, to the maximum extent practicable, in implementing a system to conduct computer matches or other systems to prevent prisoners described in section 11(e)(20)(B) from receiving food stamp benefits.''.

SEC. 1004. NUTRITION EDUCATION.

Section 11(f) of the Food Stamp Act of 1977 (7 U.S.C. 2020(f)) is amended—

(1) by striking ''(f) To encourage'' and inserting the following:

''(f) NUTRITION EDUCATION.—

''(1) IN GENERAL.—To encourage''; and

(2) by adding at the end the following:

''(2) GRANTS.—

''(A) IN GENERAL.—The Secretary shall make available not more than $600,000 for each of fiscal years 1998 through 2001 to pay the Federal share of grants made to eligible private nonprofit organizations and State agencies to carry out subparagraph (B).

''(B) ELIGIBILITY.—A private nonprofit organization or State agency shall be eligible to receive a grant under subparagraph (A) if the organization or agency agrees—

''(i) to use the funds to direct a collaborative effort to coordinate and integrate nutrition education into health, nutrition, social service, and food distribution programs for food stamp participants and other low-income households; and

''(ii) to design the collaborative effort to reach large numbers of food stamp participants and other low-income households through a network of organizations, including schools, child care centers, farmers' markets, health clinics, and outpatient education services.

''(C) PREFERENCE.—In deciding between 2 or more private nonprofit organizations or State agencies that are eligible to receive a grant under subparagraph (B), the Secretary shall give a preference to an organization or agency that conducted a collaborative effort described in subparagraph (B) and received funding for the collaborative effort from the Secretary before the date of enactment of this paragraph.

''(D) FEDERAL SHARE.—

''(i) IN GENERAL.—Subject to subparagraph (E), the Federal share of a grant under this paragraph shall be 50 percent.

''(ii) NO IN-KIND CONTRIBUTIONS.—The non-Federal share of a grant under this paragraph shall be in cash.

''(iii) PRIVATE FUNDS.—The non-Federal share of a grant under this paragraph may include amounts from private nongovernmental sources.

''(E) LIMIT ON INDIVIDUAL GRANT.—A grant under subparagraph (A) may not exceed $200,000 for a fiscal year.''.

TITLE II—COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Subtitle A—Mortgage Assignment and Annual Adjustment Factors

SEC. 2001. TABLE OF CONTENTS.

The table of contents for this title is as follows:

SEC. 2002. EXTENSION OF FORECLOSURE AVOIDANCE AND BORROWER ASSISTANCE PROVISIONS FOR FHA SINGLE FAMILY HOUSING MORTGAGE INSURANCE PROGRAM.

Section 407 of The Balanced Budget Downpayment Act, I (12 U.S.C. 1710 note) is amended—

(1) in subsection (c)—

(A) by striking ''only''; and

(B) by inserting '', on, or after'' after ''before''; and

(2) by striking subsection (e).

SEC. 2003. ADJUSTMENT OF MAXIMUM MONTHLY RENTS FOR CERTAIN DWELLING UNITS IN NEW CONSTRUCTION AND SUBSTANTIAL OR MODERATE REHABILITATION PROJECTS ASSISTED UNDER SECTION 8 RENTAL ASSISTANCE PROGRAM.

The third sentence of section 8(c)(2)(A) of the United States Housing Act of 1937 (42 U.S.C. 1437f(c)(2)(A)) is amended by inserting before the period at the end the following: '', and during fiscal year 1999 and thereafter''.

SEC. 2004. ADJUSTMENT OF MAXIMUM MONTHLY RENTS FOR NONTURNOVER DWELLING UNITS ASSISTED UNDER SECTION 8 RENTAL ASSISTANCE PROGRAM.

The last sentence of section 8(c)(2)(A) of the United States Housing Act of 1937 (42 U.S.C. 1437f(c)(2)(A)) is amended by inserting before the period at the end the following: '', and during fiscal year 1999 and thereafter''.

Subtitle B—Multifamily Housing Reform

SEC. 2100. SHORT TITLE.

This subtitle may be cited as the ''Multifamily Assisted Housing Reform and Affordability Act of 1997''.

Part 1—FHA-Insured Multifamily Housing Mortgage and Housing Assistance Restructuring

SEC. 2101. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds that—

(1) there exists throughout the Nation a need for decent, safe, and affordable housing;

(2) as of the date of enactment of this Act, it is estimated that—

(A) the insured multifamily housing portfolio of the Federal Housing Administration consists of 14,000 rental properties, with an aggregate unpaid principal mortgage balance of $38,000,000,000; and

(B) approximately 10,000 of these properties contain housing units that are assisted with project-based rental assistance under section 8 of the United States Housing Act of 1937;

(3) FHA-insured multifamily rental properties are a major Federal investment, providing affordable rental housing to an estimated 2,000,000 low- and very low-income families;

(4) approximately 1,600,000 of these families live in dwelling units that are assisted with project-based rental assistance under section 8 of the United States Housing Act of 1937;

(5) a substantial number of housing units receiving project-based assistance have rents that are higher than the rents of comparable, unassisted rental units in the same housing rental market;

(6) many of the contracts for project-based assistance will expire during the several years following the date of enactment of this Act;

(7) it is estimated that—

(A) if no changes in the terms and conditions of the contracts for project-based assistance are made before fiscal year 2000, the cost of renewing all expiring rental assistance contracts under section 8 of the United States Housing Act of 1937 for both project-based and tenant-based rental assistance will increase from approximately $3,600,000,000 in fiscal year 1997 to over $14,300,000,000 by fiscal year 2000 and some $22,400,000,000 in fiscal year 2006;

(B) of those renewal amounts, the cost of renewing project-based assistance will increase from $1,200,000,000 in fiscal year 1997 to almost $7,400,000,000 by fiscal year 2006; and

(C) without changes in the manner in which project-based rental assistance is provided, renewals of expiring contracts for project-based rental assistance will require an increasingly larger portion of the discretionary budget authority of the Department of Housing and Urban Development in each subsequent fiscal year for the foreseeable future;

(8) absent new budget authority for the renewal of expiring rental contracts for project-based assistance, many of the FHA-insured multifamily housing projects that are assisted with

project-based assistance will likely default on their FHA-insured mortgage payments, resulting in substantial claims to the FHA General Insurance Fund and Special Risk Insurance Funds;

(9) more than 15 percent of federally assisted multifamily housing projects are physically or financially distressed, including a number which suffer from mismanagement;

(10) due to Federal budget constraints, the downsizing of the Department of Housing and Urban Development, and diminished administrative capacity, the Department lacks the ability to ensure the continued economic and physical well-being of the stock of federally insured and assisted multifamily housing projects; and

(11) the economic, physical, and management problems facing the stock of federally insured and assisted multifamily housing projects will be best served by reforms that—

(A) reduce the cost of Federal rental assistance, including project-based assistance, to these projects by reducing the debt service and operating costs of these projects while retaining the low-income affordability and availability of this housing;

(B) address physical and economic distress of this housing and the failure of some project managers and owners of projects to comply with management and ownership rules and requirements; and

(C) transfer and share many of the loan and contract administration functions and responsibilities of the Secretary with capable State, local, and other entities.

(b) PURPOSES.—The purposes of this part are—

(1) to preserve low-income rental housing affordability and availability while reducing the long-term costs of project-based assistance;

(2) to reform the design and operation of Federal rental housing assistance programs, administered by the Secretary, to promote greater multifamily housing project operating and cost efficiencies;

(3) to encourage owners of eligible multifamily housing projects to restructure their FHA-insured mortgages and project-based assistance contracts in a manner that is consistent with this part before the year in which the contract expires;

(4) to streamline and improve federally insured and assisted multifamily housing project oversight and administration;

(5) to resolve the problems affecting financially and physically troubled federally insured and assisted multifamily housing projects through cooperation with residents, owners, State and local governments, and other interested entities and individuals; and

(6) to grant additional enforcement tools to use against those who violate agreements and program requirements, in order to ensure that the public interest is safeguarded and that Federal multifamily housing programs serve their intended purposes.

SEC. 2102. DEFINITIONS.

In this part:

(1) COMPARABLE PROPERTIES.—The term ''comparable properties'' means properties that are—

(A) similar to the eligible multifamily housing project in neighborhood (including risk of crime), location, access, street appeal, age, property size, apartment mix, physical configuration, property and unit amenities, and utilities;

(B) unregulated by contractual encumbrances or local rent-control laws; and

(C) occupied predominantly by renters who receive no rent supplements or rental assistance.

(2) ELIGIBLE MULTIFAMILY HOUSING PROJECT.—The term ''eligible multifamily housing project'' means a property consisting of more than 4 dwelling units—

(A) with rents which, on an average per unit or per room basis, exceed the fair market rent or the rent of comparable properties in the same market area, as determined by the Secretary;

(B) that is covered in whole or in part by a contract for project-based assistance under—

(i) the new construction and substantial rehabilitation program under section 8(b)(2) of the United States Housing Act of 1937 (as in effect before October 1, 1983);

(ii) the property disposition program under section 8(b) of the United States Housing Act of 1937;

(iii) the moderate rehabilitation program under section 8(e)(2) of the United States Housing Act of 1937;

(iv) the loan management assistance program under section 8 of the United States Housing Act of 1937;

(v) section 23 of the United States Housing Act of 1937 (as in effect before January 1, 1975);

(vi) the rent supplement program under section 101 of the Housing and Urban Development Act of 1965; or

(vii) section 8 of the United States Housing Act of 1937, following conversion from assistance under section 101 of the Housing and Urban Development Act of 1965; and

(C) financed by a mortgage insured or held by the Secretary under the National Housing Act.

(3) EXPIRING CONTRACT.—The term ''expiring contract'' means a project-based assistance contract attached to an eligible multifamily housing project which, under the terms of the contract, will expire.

(4) EXPIRATION DATE.—The term ''expiration date'' means the date on which an expiring contract expires.

(5) FAIR MARKET RENT.—The term ''fair market rent'' means the fair market rental established under section 8(c) of the United States Housing Act of 1937.

(6) LOW-INCOME FAMILIES.—The term ''low-income families'' has the same meaning as provided under section 3(b)(2) of the United States Housing Act of 1937.

(7) PORTFOLIO RESTRUCTURING AGREEMENT.—The term ''Portfolio restructuring agreement'' means the agreement entered into between the Secretary and a participating administrative entity, as provided under section 2103.

(8) PARTICIPATING ADMINISTRATIVE ENTITY.—The term ''participating administrative entity'' means a public agency, including a State housing finance agency or local housing agency, which meets the requirements under section 2103(b).

(9) PROJECT-BASED ASSISTANCE.—The term ''project-based assistance'' means rental assistance under section 8 of the United States Housing Act of 1937 that is attached to a multifamily housing project.

(10) RENEWAL.—The term ''renewal'' means the replacement of an expiring Federal rental contract with a new contract under section 8 of the United States Housing Act of 1937, consistent with the requirements of this part.

(11) SECRETARY.—The term ''Secretary'' means the Secretary of Housing and Urban Development.

(12) STATE.—The term ''State'' has the same meaning as in section 104 of the Cranston-Gonzalez National Affordable Housing Act.

(13) TENANT-BASED ASSISTANCE.—The term ''tenant-based assistance'' has the same meaning as in section 8(f) of the United States Housing Act of 1937.

(14) UNIT OF GENERAL LOCAL GOVERNMENT.—The term ''unit of general local government'' has the same meaning as in section 104 of the Cranston-Gonzalez National Affordable Housing Act.

(15) VERY LOW-INCOME FAMILY.—The term ''very low-income family'' has the same meaning as in section 3(b) of the United States Housing Act of 1937.

(16) QUALIFIED MORTGAGEE.—The term ''qualified mortgagee'' means an entity approved by the Secretary that is capable of servicing, as well as originating, FHA-insured mortgages, and that—

(A) is not suspended or debarred by the Secretary;

(B) is not suspended or on probation imposed by the Mortgagee Review Board;

(C) is not in default under any Government National Mortgage Association obligation; and

(D) meets previous participation requirements.

SEC. 2103. AUTHORITY OF PARTICIPATING ADMINISTRATIVE ENTITIES.

(a) PARTICIPATING ADMINISTRATIVE ENTITIES.—

(1) IN GENERAL.—The Secretary shall enter into portfolio restructuring agreements with participating administrative entities for the implementation of mortgage restructuring and rental assistance sufficiency plans to restructure FHA-insured multifamily housing mortgages, in order to—

(A) reduce the costs of current and expiring contracts for assistance under section 8 of the United States Housing Act of 1937;

(B) address financially and physically troubled projects; and

(C) correct management and ownership deficiencies.

(2) PORTFOLIO RESTRUCTURING AGREEMENTS.—Each portfolio restructuring agreement entered into under this subsection shall—

(A) be a cooperative agreement to establish the obligations and requirements between the Secretary and the participating administrative entity;

(B) identify the eligible multifamily housing projects or groups of projects for which the participating administrative entity is responsible for assisting in developing and implementing approved mortgage restructuring and rental assistance sufficiency plans under section 2104;

(C) require the participating administrative entity to review and certify to the accuracy and completeness of a comprehensive needs assessment submitted by the owner of an eligible multifamily housing project, in accordance with the information and data requirements of section 403 of the Housing and Community Development Act of 1992, including such other data, information, and requirements as the Secretary may require to be included as part of the comprehensive needs assessment;

(D) identify the responsibilities of both the participating administrative entity and the Secretary in implementing a mortgage restructuring and rental assistance sufficiency plan, including any actions proposed to be taken under section 2106 or 2107;

(E) require each mortgage restructuring and rental assistance sufficiency plan to be prepared in accordance with the requirements of section 2104 for each eligible multifamily housing project;

(F) indemnify the participating administrative entity against lawsuits and penalties for actions taken pursuant to the agreement, excluding actions involving gross negligence or willful misconduct; and

(G) include compensation for all reasonable expenses incurred by the participating administrative entity necessary to perform its duties under this part, including such incentives as may be authorized under section 2108.

(b) SELECTION OF PARTICIPATING ADMINISTRATIVE ENTITY.—

(1) SELECTION CRITERIA.—The Secretary shall select a participating administrative entity based on the following criteria—

(A) is located in the State or local jurisdiction in which the eligible multifamily housing project or projects are located;

(B) has demonstrated expertise in the development or management of low-income affordable rental housing;

(C) has a history of stable, financially sound, and responsible administrative performance;

(D) has demonstrated financial strength in terms of asset quality, capital adequacy, and liquidity; and

(E) is otherwise qualified, as determined by the Secretary, to carry out the requirements of this part.

(2) SELECTION OF MORTGAGE RISK-SHARING ENTITIES AND FISCAL YEAR 1997 MULTIFAMILY DEMONSTRATION AUTHORITY.—Any State housing finance agency or local housing agency that is designated as a qualified participating entity under section 542 of the Housing and Community Development Act of 1992 or under section 212 of Public Law 104–204, shall automatically qualify as a participating administrative entity under this section.

(3) ALTERNATIVE ADMINISTRATORS.—With respect to any eligible multifamily housing project that is located in a State or local jurisdiction in which the Secretary determines that a participating administrative entity is not located, is unavailable, or does not qualify, the Secretary shall either—

(A) carry out the requirements of this part with respect to that eligible multifamily housing project; or

(B) contract with other qualified entities that meet the requirements of subsection (b), with the exception of subsection (b)(1)(A), the authority to carry out all or a portion of the requirements of this part with respect to that eligible multifamily housing project.

(4) PREFERENCE FOR PUBLIC HOUSING FINANCE AGENCIES AS PARTICIPATING ADMINISTRATIVE ENTITIES.—In selecting participating administrative entities under this subsection, the Secretary shall give preference to State housing finance agencies and local housing agencies.

(5) STATE AND LOCAL PORTFOLIO REQUIREMENTS.—

(A) IN GENERAL.—If the housing finance agency of a State is selected as the participating administrative entity, that agency shall be responsible for all eligible multifamily housing projects in that State, except that a local housing agency selected as a participating administrative entity shall be responsible for all eligible multifamily housing projects in the jurisdiction of the agency.

(B) RIGHT OF FIRST REFUSAL.—A participating State housing finance agency or local housing agency shall have the right of first refusal to assume responsibility for any properties it has financed.

(C) DELEGATION.—A participating administrative entity may delegate or transfer responsibilities and functions under this part to one or more interested and qualified public entities.

(D) WAIVER.—A State housing finance agency or local housing agency may request a waiver from the Secretary from the requirements of subparagraph (A) for good cause.

SEC. 2104. MORTGAGE RESTRUCTURING AND RENTAL ASSISTANCE SUFFICIENCY PLAN.

(a) IN GENERAL.—

(1) DEVELOPMENT OF PROCEDURES AND REQUIREMENTS.—The Secretary shall develop procedures and requirements for the submission of a mortgage restructuring and rental assistance sufficiency plan for each eligible multifamily housing project with an expiring contract.

(2) TERMS AND CONDITIONS.—Each mortgage restructuring and rental assistance sufficiency plan submitted under this subsection shall be developed at the initiative of an owner of an eligible multifamily housing project, in cooperation with the qualified mortgagee servicing the loan, with a participating administrative entity, under such terms and conditions as the Secretary shall require.

(3) CONSOLIDATION.—Mortgage restructuring and rental assistance sufficiency plans submitted under this subsection may be consolidated as part of an overall strategy for more than one property.

(b) NOTICE REQUIREMENTS.—The Secretary shall establish notice procedures and hearing requirements for tenants and owners concerning the dates for the expiration of project-based assistance contracts for any eligible multifamily housing project.

(c) EXTENSION OF CONTRACT TERM.—Subject to agreement by a project owner, the Secretary may extend the term of any expiring contract or provide a section 8 contract with rent levels set in accordance with subsection (g) for a period sufficient to facilitate the implementation of a mortgage restructuring and rental assistance sufficiency plan, as determined by the Secretary.

(d) TENANT RENT PROTECTION.—If the owner of a project with an expiring Federal rental assistance contract does not agree to extend the contract, not less than 12 months prior to terminating the contract, the project owner shall provide written notice to the Secretary and the tenants and the Secretary shall make tenant-based assistance available to tenants residing in units assisted under the expiring contract at the time of expiration.

(e) MORTGAGE RESTRUCTURING AND RENTAL ASSISTANCE SUFFICIENCY PLAN.—Each mortgage restructuring and rental assistance sufficiency plan shall—

(1) except as otherwise provided, restructure the project-based assistance rents for the eligible multifamily housing project in a manner consistent with subsection (g);

(2) allow for rent adjustments by applying an operating cost adjustment factor established under guidelines established by the Secretary;

(3) require the owner or purchaser of an eligible multifamily housing project with an expiring contract to submit to the participating administrative entity a comprehensive needs assessment, in accordance with the information and data requirements of section 403 of the Housing and Community Development Act of 1992, including such other data, information, and requirements as the Secretary may require to be included as part of the comprehensive needs assessment;

(4) require the owner or purchaser of the project to provide or contract for competent management of the project;

(5) require the owner or purchaser of the project to take such actions as may be necessary to rehabilitate, maintain adequate reserves, and to maintain the project in decent and safe condition, based on housing quality standards established by—

(A) the Secretary; or

(B) local housing codes or codes adopted by public housing agencies that—

(i) meet or exceed housing quality standards established by the Secretary; and

(ii) do not severely restrict housing choice;

(6) require the owner or purchaser of the project to maintain affordability and use restrictions for the remaining term of the existing mortgage and, if applicable, the remaining term of the second mortgage, as the participating administrative entity determines to be appropriate and consistent with the rent levels established under subsection (g), which restrictions shall be consistent with the long-term physical and financial viability character of the project as affordable housing;

(7) meet subsidy layering requirements under guidelines established by the Secretary;

(8) require the owner or purchaser of the project to meet such other requirements as the Secretary determines to be appropriate; and

(9) prohibit the owner from refusing to lease any available dwelling unit to a recipient of tenant-based assistance under section 8 of the United States Housing Act of 1937.

(f) TENANT AND COMMUNITY PARTICIPATION AND CAPACITY BUILDING.—

(1) PROCEDURES.—

(A) IN GENERAL.—The Secretary shall establish procedures to provide an opportunity for tenants of the project and other affected parties, including local government and the community in which the project is located, to participate effectively in the restructuring process established by this part.

(B) CRITERIA.—These procedures shall include—

(i) the rights to timely and adequate written notice of the proposed decisions of the owner or the Secretary or participating administrative entity;

(ii) timely access to all relevant information (except for information determined to be proprietary under standards established by the Secretary);

(iii) an adequate period to analyze this information and provide comments to the Secretary or participating administrative entity (which comments shall be taken into consideration by the participating administrative entity); and

(iv) if requested, a meeting with a representative of the participating administrative entity and other affected parties.

(2) PROCEDURES REQUIRED.—The procedures established under paragraph (1) shall permit tenant, local government, and community participation in at least the following decisions or plans specified in this part:

(A) The Portfolio Restructuring Agreement.

(B) Any proposed expiration of the section 8 contract.

(C) The project's eligibility for restructuring pursuant to section 2106 and the mortgage restructuring and rental assistance sufficiency plan pursuant to section 2104.

(D) Physical inspections.

(E) Capital needs and management assessments, whether before or after restructuring.

(F) Any proposed transfer of the project.

(3) FUNDING.—

(A) IN GENERAL.—The Secretary may provide not more than $10,000,000 annually in funding to tenant groups, nonprofit organizations, and public entities for building the capacity of tenant organizations, for technical assistance in furthering any of the purposes of this part (including transfer of developments to new owners) and for tenant services, from those amounts made available under appropriations Acts for implementing this part.

(B) ALLOCATION.—The Secretary may allocate any funds made available under subparagraph (A) through existing technical assistance programs pursuant to any other Federal law, including the Low-Income Housing Preservation and Resident Homeownership Act of 1990 and the Multifamily Property Disposition Reform Act of 1994.

(C) PROHIBITION.—None of the funds made available under subparagraph (A) may be used directly or indirectly to pay for any personal service, advertisement, telegram, telephone, letter, printed or written matter, or other device, intended or designed to influence in any manner a Member of Congress, to favor or oppose, by vote or otherwise, any legislation or appropriation by Congress, whether before or after the introduction of any bill or resolution proposing such legislation or appropriation.

(g) RENT LEVELS.—

(1) IN GENERAL.—Except as provided in paragraph (2), each mortgage restructuring and rental assistance sufficiency plan pursuant to the terms, conditions, and requirements of this part shall establish for units assisted with project-based assistance in eligible multifamily housing projects adjusted rent levels that—

(A) are equivalent to rents derived from comparable properties, if—

(i) the participating administrative entity makes the rent determination not later than 120 days after the owner submits a mortgage restructuring and rental assistance sufficiency plan; and

(ii) the market rent determination is based on not less than 2 comparable properties; or

(B) if those rents cannot be determined, are equal to 90 percent of the fair market rents for the relevant market area.

(2) EXCEPTIONS.—

(A) IN GENERAL.—A contract under this section may include rent levels that exceed the rent level described in paragraph (1) at rent levels that do not exceed 120 percent of the local fair market rent if the participating administrative entity—

(i) determines, that the housing needs of the tenants and the community cannot be adequately addressed through implementation of

the rent limitation required to be established through a mortgage restructuring and rental assistance sufficiency plan under paragraph (1); and

(ii) follows the procedures under paragraph (3).

(B) EXCEPTION RENTS.—In any fiscal year, a participating administrative entity may approve exception rents on not more than 20 percent of all units in the geographic jurisdiction of the entity with expiring contracts in that fiscal year, except that the Secretary may waive this ceiling upon a finding of special need in the geographic area served by the participating administrative entity.

(3) RENT LEVELS FOR EXCEPTION PROJECTS.—For purposes of this section, a project eligible for an exception rent shall receive a rent calculation on the actual and projected costs of operating the project, at a level that provides income sufficient to support a budget-based rent that consists of—

(A) the debt service of the project;

(B) the operating expenses of the project, as determined by the participating administrative entity, including—

(i) contributions to adequate reserves;

(ii) the costs of maintenance and necessary rehabilitation; and

(iii) other eligible costs permitted under section 8 of the United States Housing Act of 1937;

(C) an adequate allowance for potential operating losses due to vacancies and failure to collect rents, as determined by the participating administrative entity;

(D) an allowance for a reasonable rate of return to the owner or purchaser of the project, as determined by the participating administrative entity, which may be established to provide incentives for owners or purchasers to meet benchmarks of quality for management and housing quality; and

(E) other expenses determined by the participating administrative entity to be necessary for the operation of the project.

(h) EXEMPTIONS FROM RESTRUCTURING.—Subject to section 2106, the Secretary shall renew project-based assistance contracts at existing rents, or at a level that provides income sufficient to support a budget-based rent (including a budget-based rent adjustment if justified by reasonable and expected operating expenses), if—

(1) the project was financed through obligations such that the implementation of a mortgage restructuring and rental assistance sufficiency plan under this section is inconsistent with applicable law or agreements governing such financing;

(2) in the determination of the Secretary or the participating administrative entity, the restructuring would not result in significant section 8 savings to the Secretary; or

(3) the project has an expiring contract under section 8 of the United States Housing Act of 1937 but does not qualify as an eligible multifamily housing project pursuant to section 2102(2) of this part.

SEC. 2105. SECTION 8 RENEWALS AND LONG-TERM AFFORDABILITY COMMITMENT BY OWNER OF PROJECT.

(a) SECTION 8 RENEWALS OF RESTRUCTURED PROJECTS.—Subject to the availability of amounts provided in advance in appropriations Acts, the Secretary shall enter into contracts with participating administrative entities pursuant to which the participating administrative entity shall offer to renew or extend an expiring section 8 contract on an eligible multifamily housing project, and the owner of the project shall accept the offer, provided the initial renewal is in accordance with the terms and conditions specified in the mortgage restructuring and rental assistance sufficiency plan.

(b) REQUIRED COMMITMENT.—After the initial renewal of a section 8 contract pursuant to this section, the owner shall accept each offer made pursuant to subsection (a) to renew the contract, for the remaining term of the existing mortgage and, if applicable, the remaining term of an existing second mortgage, if the offer to renew is on terms and conditions specified in the mortgage restructuring and rental assistance sufficiency plan.

SEC. 2106. PROHIBITION ON RESTRUCTURING.

(a) PROHIBITION ON RESTRUCTURING.—The Secretary shall not consider any mortgage restructuring and rental assistance sufficiency plan or request for contract renewal if the participating administrative entity determines that—

(1) the owner or purchaser of the project has engaged in material adverse financial or managerial actions or omissions with regard to this project (or with regard to other similar projects if the Secretary determines that those actions or omissions constitute a pattern of mismanagement that would warrant suspension or debarment by the Secretary), including—

(A) materially violating any Federal, State, or local law or regulation with regard to this project or any other federally assisted project, after receipt of notice and an opportunity to cure;

(B) materially breaching a contract for assistance under section 8 of the United States Housing Act of 1937, after receipt of notice and an opportunity to cure;

(C) materially violating any applicable regulatory or other agreement with the Secretary or a participating administrative entity, after receipt of notice and an opportunity to cure;

(D) repeatedly and materially violating any Federal, State, or local law or regulation with regard to the project or any other federally assisted project;

(E) repeatedly and materially breaching a contract for assistance under section 8 of the United States Housing Act of 1937;

(F) repeatedly and materially violating any applicable regulatory or other agreement with the Secretary or a participating administrative entity;

(G) repeatedly failing to make mortgage payments at times when project income was sufficient to maintain and operate the property;

(H) materially failing to maintain the property according to housing quality standards after receipt of notice and a reasonable opportunity to cure; or

(I) committing any actions or omissions that would warrant suspension or debarment by the Secretary;

(2) the owner or purchaser of the property materially failed to follow the procedures and requirements of this part, after receipt of notice and an opportunity to cure; or

(3) the poor condition of the project cannot be remedied in a cost effective manner, as determined by the participating administrative entity.

(b) OPPORTUNITY TO DISPUTE FINDINGS.—

(1) IN GENERAL.—During the 30-day period beginning on the date on which the owner or purchaser of an eligible multifamily housing project receives notice of a rejection under subsection (a) or of a mortgage restructuring and rental assistance sufficiency plan under section 2104, the Secretary or participating administrative entity shall provide that owner or purchaser with an opportunity to dispute the basis for the rejection and an opportunity to cure.

(2) AFFIRMATION, MODIFICATION, OR REVERSAL.—

(A) IN GENERAL.—After providing an opportunity to dispute under paragraph (1), the Secretary or the participating administrative entity may affirm, modify, or reverse any rejection under subsection (a) or rejection of a mortgage restructuring and rental assistance sufficiency plan under section 2104.

(B) REASONS FOR DECISION.—The Secretary or the participating administrative entity, as applicable, shall identify the reasons for any final decision under this paragraph.

(C) REVIEW PROCESS.—The Secretary shall establish an administrative review process to appeal any final decision under this paragraph.

(c) FINAL DETERMINATION.—Any final determination under this section shall not be subject to judicial review.

(d) DISPLACED TENANTS.—Subject to the availability of amounts provided in advance in appropriations Acts, for any low-income tenant that is residing in a project or receiving assistance under section 8 of the United States Housing Act of 1937 at the time of rejection under this section, that tenant shall be provided with tenant-based assistance and reasonable moving expenses, as determined by the Secretary.

(e) TRANSFER OF PROPERTY.—For properties disqualified from the consideration of a mortgage restructuring and rental assistance sufficiency plan under this section because of actions by an owner or purchaser in accordance with paragraph (1) or (2) of subsection (a), the Secretary shall establish procedures to facilitate the voluntary sale or transfer of a property as part of a mortgage restructuring and rental assistance sufficiency plan, with a preference for tenant organizations and tenant-endorsed community-based nonprofit and public agency purchasers meeting such reasonable qualifications as may be established by the Secretary, which purchasers shall be eligible to receive project-based assistance under section 8 of the United States Housing Act of 1937.

SEC. 2107. RESTRUCTURING TOOLS.

(a) RESTRUCTURING TOOLS.—In this part, and to the extent these actions are consistent with this section, an approved mortgage restructuring and rental assistance sufficiency plan may include one or more of the following:

(1) FULL OR PARTIAL PAYMENT OF CLAIM.—Making a full payment of claim or partial payment of claim under section 541(b) of the National Housing Act. Any payment under this paragraph shall not require the approval of a mortgagee.

(2) REFINANCING OF DEBT.—Refinancing of all or part of the debt on a project, if the refinancing would result in significant subsidy savings under section 8 of the United States Housing Act of 1937.

(3) MORTGAGE INSURANCE.—Providing FHA multifamily mortgage insurance, reinsurance or other credit enhancement alternatives, including multifamily risk-sharing mortgage programs, as provided under section 542 of the Housing and Community Development Act of 1992. Any limitations on the number of units available for mortgage insurance under section 542 shall not apply to eligible multifamily housing projects. Any credit subsidy costs of providing mortgage insurance shall be paid from the General Insurance Fund and the Special Risk Insurance Fund.

(4) CREDIT ENHANCEMENT.—Any additional State or local mortgage credit enhancements and risk-sharing arrangements may be established with State or local housing finance agencies, the Federal Housing Finance Board, the Federal National Mortgage Association, and the Federal Home Loan Mortgage Corporation, to a modified first mortgage.

(5) COMPENSATION OF THIRD PARTIES.—Entering into agreements, incurring costs, or making payments, as may be reasonably necessary, to compensate the participation of participating administrative entities and other parties in undertaking actions authorized by this part. Upon request, participating administrative entities shall be considered to be contract administrators under section 8 of the United States Housing Act of 1937 for purposes of any contracts entered into as part of an approved mortgage restructuring and rental assistance sufficiency plan. Subject to the availability of amounts provided in advance in appropriations Acts for administrative fees under section 8 of the United States Housing Act of 1937, such fees shall be used to compensate participating administrative entities

for compliance monitoring costs incurred under section 2110.

(6) RESIDUAL RECEIPTS.—Applying any acquired residual receipts to maintain the long-term affordability and physical condition of the property or of other eligible multifamily housing projects. The participating administrative entity may expedite the acquisition of residual receipts by entering into agreements with owners of housing covered by an expiring contract to provide an owner with a share of the receipts, not to exceed 10 percent.

(7) REHABILITATION NEEDS.—Assisting in addressing the necessary rehabilitation needs of the project, except that assistance under this paragraph shall not exceed the equivalent of $5,000 per unit for those units covered with project-based assistance. Rehabilitation may be paid from the provision of grants from residual receipts or, as provided in appropriations Acts, from budget authority provided for increases in the budget authority for assistance contracts under section 8 of the United States Housing Act of 1937, the rehabilitation grant program established under section 2201 of this subtitle, or through the debt restructuring transaction. Each owner that receives rehabilitation assistance shall contribute not less than 25 percent of the amount of rehabilitation assistance received.

(8) MORTGAGE RESTRUCTURING.—Restructuring mortgages to provide a structured first mortgage to cover rents at levels that are established in section 2104(g) and a second mortgage equal to the difference between the restructured first mortgage and the mortgage balance of the eligible multifamily housing project at the time of restructuring. The second mortgage shall bear interest at a rate not to exceed the applicable Federal rate for a term not to exceed 50 years. If the first mortgage remains outstanding, payments of interest and principal on the second mortgage shall be made from a portion of the excess project income only after the payment of all reasonable and necessary operating expenses (including deposits in a reserve for replacement), debt service on the first mortgage, and such other expenditures as may be approved by the Secretary. Such portion shall be equal to not less than 75 percent of excess project income. The participating administrative entity may provide up to 25 percent of the excess project income to the project owner if the participating administrative entity determines that the project owner meets benchmarks of quality for management and housing quality. During the period in which the first mortgage remains outstanding, no payments of interest or principal shall be required on the second mortgage. The second mortgage shall be assumable by any subsequent purchaser of any multifamily housing project, pursuant to guidelines established by the Secretary. The participating administrative entity may be authorized to modify the terms or forgive all or part of the second mortgage upon acquisition by a tenant organization or tenant-endorsed community-based nonprofit or public agency, pursuant to guidelines established by the Secretary. The principal and accrued interest due under the second mortgage shall be fully payable upon disposition of the property, unless the mortgage is assumed under the preceding sentence. The owner shall begin repayment of the second mortgage upon full payment of the first mortgage in equal monthly installments in an amount equal to the monthly principal and interest payments formerly paid under the first mortgage. The principal and interest of a second mortgage shall be immediately due and payable upon a finding by the Secretary that an owner has failed to materially comply with this part or any requirements of the United States Housing Act of 1937 as those requirements apply to the applicable project, after receipt of notice of such failure and a reasonable opportunity to cure such failure. The second mortgage may be a direct obligation of the Secretary or a loan financed through a lender, other than the Secretary. If the second mortgage is a direct obligation of the Secretary, the participating administrative entity shall be authorized in the portfolio restructuring agreement to act as the agent of the Secretary in servicing such mortgage and enforcing the rights of the Secretary thereunder. Any credit subsidy costs of providing a second mortgage shall be paid from the General Insurance Fund and the Special Risk Insurance Fund.

(b) ROLE OF FNMA AND FHLMC.—Section 1335 of the Federal Housing Enterprises Financial Safety and Soundness Act of 1992 (12 U.S.C. 4565) is amended—

(1) in paragraph (3), by striking ''and'' at the end;

(2) paragraph (4), by striking the period at the end and inserting ''; and'';

(3) by striking ''To meet'' and inserting the following:

''(a) IN GENERAL.—To meet''; and

(4) by adding at the end the following:

''(5) assist in maintaining the affordability of assisted units in eligible multifamily housing projects with expiring contracts, as defined under the Multifamily Assisted Housing Reform and Affordability Act of 1997.

''(b) AFFORDABLE HOUSING GOALS.—Actions taken under subsection (a)(5) shall constitute part of the contribution of each entity in meeting their affordable housing goals under sections 1332, 1333, and 1334 for any fiscal year, as determined by the Secretary.''.

(c) PROHIBITION ON EQUITY SHARING BY THE SECRETARY.—The Secretary is prohibited from participating in any equity agreement or profit-sharing agreement in conjunction with any eligible multifamily housing project.

SEC. 2108. SHARED SAVINGS INCENTIVE.

(a) IN GENERAL.—At the time a participating administrative entity is designated, the Secretary shall negotiate an incentive agreement with the participating administrative entity, which agreement shall provide such entity with a share of any principal and interest payments on the second mortgage. The Secretary shall negotiate with participating administrative entities a savings incentive formula that provides for periodic payments over a period of not less than 5 years, which is allocated as incentives to participating administrative entities.

(b) USE OF SAVINGS.—Notwithstanding any other provision of law, the incentive agreement under subsection (a) shall require any savings provided to a participating administrative entity under that agreement to be used only for providing decent, safe, and affordable housing for very low-income families and persons with a priority for eligible multifamily housing projects.

SEC. 2109. MANAGEMENT STANDARDS.

Each participating administrative entity shall establish and implement management standards, including requirements governing conflicts of interest between owners, managers, contractors with an identity of interest, pursuant to guidelines established by the Secretary and consistent with industry standards.

SEC. 2110. MONITORING OF COMPLIANCE.

(a) COMPLIANCE AGREEMENTS.—Pursuant to regulations issued by the Secretary after public notice and comment, each participating administrative entity, through binding contractual agreements with owners and otherwise, shall ensure long-term compliance with the provisions of this part. Each agreement shall, at a minimum, provide for—

(1) enforcement of the provisions of this part; and

(2) remedies for the breach of those provisions.

(b) PERIODIC MONITORING.—

(1) IN GENERAL.—Not less than annually, each participating administrative entity shall review the status of all multifamily housing projects for which a mortgage restructuring and rental assistance sufficiency plan has been implemented.

(2) INSPECTIONS.—Each review under this subsection shall include onsite inspection to determine compliance with housing codes and other requirements as provided in this part and the portfolio restructuring agreements.

(c) AUDIT BY THE SECRETARY.—The Comptroller General of the United States, the Secretary, and the Inspector General of the Department of Housing and Urban Development may conduct an audit at any time of any multifamily housing project for which a mortgage restructuring and rental assistance sufficiency plan has been implemented.

SEC. 2111. REVIEW.

(a) ANNUAL REVIEW.—In order to ensure compliance with this part, the Secretary shall conduct an annual review and report to Congress on actions taken under this part and the status of eligible multifamily housing projects.

(b) SUBSIDY LAYERING REVIEW.—The participating administrative entity shall certify, pursuant to guidelines issued by the Secretary, that the requirements of section 102(d) of the Department of Housing and Urban Development Reform Act of 1989 are satisfied so that the combination of assistance provided in connection with a property for which a mortgage is to be restructured shall not be any greater than is necessary to provide affordable housing.

SEC. 2112. GAO AUDIT AND REVIEW.

(a) INITIAL AUDIT.—Not later than 18 months after the effective date of interim or final regulations promulgated under this part, the Comptroller General of the United States shall conduct an audit to evaluate a representative sample of all eligible multifamily housing projects and the implementation of all mortgage restructuring and rental assistance sufficiency plans.

(b) REPORT.—

(1) IN GENERAL.—Not later than 18 months after the audit conducted under subsection (a), the Comptroller General of the United States shall submit to Congress a report on the status of all eligible multifamily housing projects and the implementation of all mortgage restructuring and rental assistance sufficiency plans.

(2) CONTENTS.—The report submitted under paragraph (1) shall include—

(A) a description of the initial audit conducted under subsection (a); and

(B) recommendations for any legislative action to increase the financial savings to the Federal Government of the restructuring of eligible multifamily housing projects balanced with the continued availability of the maximum number of affordable low-income housing units.

SEC. 2113. REGULATIONS.

(a) RULEMAKING AND IMPLEMENTATION.—The Secretary shall issue interim regulations necessary to implement this part not later than the expiration of the 6-month period beginning on the date of enactment of this Act. Not later than 1 year after the date of enactment of this subtitle, in accordance with the negotiated rulemaking procedures set forth in subchapter III of chapter 5 of title 5, United States Code, the Secretary shall implement final regulations implementing this part.

(b) REPEAL OF FHA MULTIFAMILY HOUSING DEMONSTRATION AUTHORITY.—

(1) IN GENERAL.—Beginning upon the expiration of the 6-month period beginning on the date of enactment of this Act, the Secretary may not exercise any authority or take any action under section 210 of the Balanced Budget Down Payment Act, II.

(2) UNUSED BUDGET AUTHORITY.—Any unused budget authority under section 210(f) of the Balanced Budget Down Payment Act, II, shall be available for taking actions under the requirements established through regulations issued under subsection (a).

SEC. 2114. TECHNICAL AND CONFORMING AMENDMENTS.

(a) CALCULATION OF LIMIT ON PROJECT-BASED ASSISTANCE.—Section 8(d) of the United States Housing Act of 1937 (42 U.S.C. 1437f(d)) is amended by adding at the end the following:

''(5) CALCULATION OF LIMIT.—Any contract entered into under section 2104 of the Multifamily Assisted Housing Reform and Affordability

Act of 1997 shall be excluded in computing the limit on project-based assistance under this subsection.''.

(b) PARTIAL PAYMENT OF CLAIMS ON MULTIFAMILY HOUSING PROJECTS.—Section 541 of the National Housing Act (12 U.S.C. 1735f–19) is amended—

(1) in subsection (a), in the subsection heading, by striking ''AUTHORITY'' and inserting ''DEFAULTED MORTGAGES'';

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

(3) by inserting after subsection (a) the following:

''(b) EXISTING MORTGAGES.—Notwithstanding any other provision of law, the Secretary, in connection with a mortgage restructuring under section 2104 of the Multifamily Assisted Housing Reform and Affordability Act of 1997, may make a one time, nondefault partial payment of the claim under the mortgage insurance contract, which shall include a determination by the Secretary or the participating administrative entity, in accordance with the Multifamily Assisted Housing Reform and Affordability Act of 1997, of the market value of the project and a restructuring of the mortgage, under such terms and conditions as the Secretary may establish.''.

(c) REUSE AND RESCISSION OF CERTAIN RECAPTURED BUDGET AUTHORITY.—Section 8(bb) of the United States Housing Act of 1937 (42 U.S.C. 1437f(b)(b)) is amended to read as follows:

''(bb) REUSE AND RESCISSION OF CERTAIN RECAPTURED BUDGET AUTHORITY.—If a project-based assistance contract for an eligible multifamily housing project subject to actions authorized under title I is terminated or amended as part of restructuring under section 107, the Secretary shall recapture the budget authority not required for the terminated or amended contract and, without regard to section 218 of the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act of 1997, use such amounts as are necessary to provide housing assistance for the same number of families covered by such contract for the remaining term of such contract, under a contract providing for project-based or tenant-based assistance. The amount of budget authority saved as a result of the shift to project-based or tenant-based assistance shall be rescinded.''.

SEC. 2115. TERMINATION OF AUTHORITY.

(a) IN GENERAL.—Except as provided in subsection (b), this part is repealed effective October 1, 2001.

(b) EXCEPTION.—The repeal under this section does not apply with respect to projects and programs for which binding commitments have been entered into before October 1, 2001.

Part 2—Miscellaneous Provisions

SEC. 2201. REHABILITATION GRANTS FOR CERTAIN INSURED PROJECTS.

Section 236 of the National Housing Act (12 U.S.C. 1715z–1) is amended by adding at the end the following:

''(s) GRANT AUTHORITY.—

''(1) IN GENERAL.—The Secretary may make grants for the capital costs of rehabilitation to owners of projects that meet the eligibility and other criteria set forth in, and in accordance with, this subsection.

''(2) PROJECT ELIGIBILITY.—A project may be eligible for capital grant assistance under this subsection—

''(A) if—

''(i) the project was insured under section 236 or section 221(d)(3) of the National Housing Act; and

''(ii) the project was assisted by the loan management assistance program under section 8 of the United States Housing Act of 1937 on the date of enactment of the Multifamily Assisted Housing Reform and Affordability Act of 1997;

''(B) if the project owner agrees to maintain the housing quality standards that were in effect immediately prior to the extinguishment of the mortgage insurance;

''(C) if the Secretary determines that the owner or purchaser of the project has not engaged in material adverse financial or managerial actions or omissions with regard to this project (or with regard to other similar projects if the Secretary determines that those actions or omissions constitute a pattern of mismanagement that would warrant suspension or debarment by the Secretary), including—

''(i) materially violating any Federal, State, or local law or regulation with regard to this project or any other federally assisted project, after receipt of notice and an opportunity to cure;

''(ii) materially breaching a contract for assistance under section 8 of the United States Housing Act of 1937, after receipt of notice and an opportunity to cure;

''(iii) materially violating any applicable regulatory or other agreement with the Secretary or a participating administrative entity, after receipt of notice and an opportunity to cure;

''(iv) repeatedly failing to make mortgage payments at times when project income was sufficient to maintain and operate the property;

''(v) materially failing to maintain the property according to housing quality standards after receipt of notice and a reasonable opportunity to cure; or

''(vi) committing any act or omission that would warrant suspension or debarment by the Secretary; and

''(D) if the project owner demonstrates to the satisfaction of the Secretary—

''(i) using information in a comprehensive needs assessment, that capital grant assistance is needed for rehabilitation of the project; and

''(ii) that project income is not sufficient to support such rehabilitation.

''(3) ELIGIBLE PURPOSES.—The Secretary may make grants to the owners of eligible projects for the purposes of—

''(A) payment into project replacement reserves;

''(B) providing a fair return on equity investment;

''(C) debt service payments on non-Federal rehabilitation loans; and

''(D) payment of nonrecurring maintenance and capital improvements, under such terms and conditions as are determined by the Secretary.

''(4) GRANT AGREEMENT.—

''(A) IN GENERAL.—The Secretary shall provide in any grant agreement under this subsection that the grant shall be terminated if the project fails to meet housing quality standards, as applicable on the date of enactment of the Multifamily Housing Reform and Affordability Act of 1997, or any successor standards for the physical conditions of projects, as are determined by the Secretary.

''(B) AFFORDABILITY AND USE CLAUSES.—The Secretary shall include in a grant agreement under this subsection a requirement for the project owners to maintain such affordability and use restrictions as the Secretary determines to be appropriate.

''(C) OTHER TERMS.—The Secretary may include in a grant agreement under this subsection such other terms and conditions as the Secretary determines to be necessary.

''(5) DELEGATION.—

''(A) IN GENERAL.—In addition to the authorities set forth in subsection (p), the Secretary may delegate to State and local governments the responsibility for the administration of grants under this subsection. Any such government may carry out such delegated responsibilities directly or under contracts.

''(B) ADMINISTRATION COSTS.—In addition to other eligible purposes, amounts of grants under this subsection may be made available for costs of administration under subparagraph (A).

''(6) FUNDING.—

''(A) IN GENERAL.—For purposes of carrying out this subsection, the Secretary may make available amounts that are unobligated amounts for contracts for interest reduction payments—

''(i) that were previously obligated for contracts for interest reduction payments under this section until insurance under this section was extinguished;

''(ii) that become available as a result of the outstanding principal balance of a mortgage having been written down;

''(iii) that are uncommitted balances within the limitation on maximum payments that may have been, before the date of enactment of the Multifamily Assisted Housing Reform and Affordability Act of 1997, permitted in any fiscal year; or

''(iv) that become available from any other source.

''(B) LIQUIDATION AUTHORITY.—The Secretary may liquidate obligations entered into under this subsection under section 1305(10) of title 31, United States Code.

''(C) CAPITAL GRANTS.—In making capital grants under the terms of this subsection, using the amounts that the Secretary has recaptured from contracts for interest reduction payments, the Secretary shall ensure that the rates and amounts of outlays do not at any one time exceed the rates and amounts of outlays that would have been experienced if the insurance had not been extinguished or the principal amount had not been written down, and the interest reduction payments that the Secretary has recaptured had continued in accordance with the terms in effect immediately prior to such extinguishment or write-down.''.

SEC. 2202. MINIMUM RENT.

Notwithstanding section 3(a) of the United States Housing Act of 1937, the Secretary of Housing and Urban Development may provide that each family receiving project-based assistance under section 8 shall pay a minimum monthly rent in an amount not to exceed $25 per month.

SEC. 2203. REPEAL OF FEDERAL PREFERENCES.

(a) SECTION 8 EXISTING AND MODERATE REHABILITATION.—Section 8(d)(1)(A) of the United States Housing Act of 1937 (42 U.S.C. 1437f(d)(1)(A)) is amended to read as follows:

''(A) the selection of tenants shall be the function of the owner, subject to the annual contributions contract between the Secretary and the agency, except that with respect to the certificate and moderate rehabilitation programs only, for the purpose of selecting families to be assisted, the public housing agency may establish, after public notice and an opportunity for public comment, a written system of preferences for selection that are not inconsistent with the comprehensive housing affordability strategy for the jurisdiction in which the project is located, in accordance with title I of the Cranston-Gonzalez National Affordable Housing Act;''.

(b) SECTION 8 NEW CONSTRUCTION AND SUBSTANTIAL REHABILITATION.—

(1) REPEAL.—Section 545(c) of the Cranston-Gonzalez National Affordable Housing Act (42 U.S.C. 1437f note) is amended to read as follows:

''(c) [Reserved.]''.

(2) PROHIBITION.—The provisions of section 8(e)(2) of the United States Housing Act of 1937, as in existence on the day before October 1, 1983, that require tenant selection preferences shall not apply with respect to—

(A) housing constructed or substantially rehabilitated pursuant to assistance provided under section 8(b)(2) of the United States Housing Act of 1937, as in existence on the day before October 1, 1983; or

(B) projects financed under section 202 of the Housing Act of 1959, as in existence on the day before the date of enactment of the Cranston-Gonzalez National Affordable Housing Act.

(c) RENT SUPPLEMENTS.—Section 101(k) of the Housing and Urban Development Act of 1965 (12 U.S.C. 1701s(k)) is amended to read as follows:

''(k) [Reserved.]''.

(d) CONFORMING AMENDMENTS.—

(1) UNITED STATES HOUSING ACT OF 1937.—The United States Housing Act of 1937 (42 U.S.C. 1437 et seq.) is amended—

(A) in section 6(o), by striking ''preference rules specified in'' and inserting ''written selection criteria established pursuant to'';

(B) in section 8(d)(2)(A), by striking the last sentence; and

(C) in section 8(d)(2)(H), by striking ''Notwithstanding subsection (d)(1)(A)(i), an'' and inserting ''An''.

(2) CRANSTON-GONZALEZ NATIONAL AFFORDABLE HOUSING ACT.—The Cranston-Gonzalez National Affordable Housing Act (42 U.S.C. 12704 et seq.) is amended—

(A) in section 455(a)(2)(D)(iii), by striking ''would qualify for a preference under'' and inserting ''meet the written selection criteria established pursuant to''; and

(B) in section 522(f)(6)(B), by striking ''any preferences for such assistance under section 8(d)(1)(A)(i)'' and inserting ''the written selection criteria established pursuant to section 8(d)(1)(A)''.

(3) LOW-INCOME HOUSING PRESERVATION AND RESIDENT HOMEOWNERSHIP ACT OF 1990.—The second sentence of section 226(b)(6)(B) of the Low-Income Housing Preservation and Resident Homeownership Act of 1990 (12 U.S.C. 4116(b)(6)(B)) is amended by striking ''requirement for giving preferences to certain categories of eligible families under'' and inserting ''written selection criteria established pursuant to''.

(4) HOUSING AND COMMUNITY DEVELOPMENT ACT OF 1992.—Section 655 of the Housing and Community Development Act of 1992 (42 U.S.C. 13615) is amended by striking ''preferences for occupancy'' and all that follows before the period at the end and inserting ''selection criteria established by the owner to elderly families according to such written selection criteria, and to near-elderly families according to such written selection criteria, respectively''.

(5) REFERENCES IN OTHER LAW.—Any reference in any Federal law other than any provision of any law amended by paragraphs (1) through (5) of this subsection or to the preferences for assistance under section 8(d)(1)(A)(i) of the United States Housing Act of 1937, as that section existed on the day before the effective date of this part, shall be considered to refer to the written selection criteria established pursuant to section 8(d)(1)(A) of the United States Housing Act of 1937, as amended by this subsection.

Part 3—Enforcement Provisions

SEC. 2301. IMPLEMENTATION.

(a) ISSUANCE OF NECESSARY REGULATIONS.—Notwithstanding section 7(o) of the Department of Housing and Urban Development Act or part 10 of title 24, Code of Federal Regulations (as in existence on the date of enactment of this Act), the Secretary shall issue such regulations as the Secretary determines to be necessary to implement this subtitle and the amendments made by this subtitle in accordance with section 552 or 553 of title 5, United States Code, as determined by the Secretary.

(b) USE OF EXISTING REGULATIONS.—In implementing any provision of this subtitle, the Secretary may, in the discretion of the Secretary, provide for the use of existing regulations to the extent appropriate, without rulemaking.

Subpart A—FHA Single Family and Multifamily Housing

SEC. 2311. AUTHORIZATION TO IMMEDIATELY SUSPEND MORTGAGEES.

Section 202(c)(3)(C) of the National Housing Act (12 U.S.C. 1708(c)(3)(C)) is amended by inserting after the first sentence the following: ''Notwithstanding paragraph (4)(A), a suspension shall be effective upon issuance by the Board if the Board determines that there exists adequate evidence that immediate action is required to protect the financial interests of the Department or the public.''.

SEC. 2312. EXTENSION OF EQUITY SKIMMING TO OTHER SINGLE FAMILY AND MULTIFAMILY HOUSING PROGRAMS.

Section 254 of the National Housing Act (12 U.S.C. 1715z–19) is amended to read as follows:

''SEC. 254. EQUITY SKIMMING PENALTY.

''(a) IN GENERAL.—Whoever, as an owner, agent, or manager, or who is otherwise in custody, control, or possession of a multifamily project or a 1- to 4-family residence that is security for a mortgage note that is described in subsection (b), willfully uses or authorizes the use of any part of the rents, assets, proceeds, income, or other funds derived from property covered by that mortgage note for any purpose other than to meet reasonable and necessary expenses that include expenses approved by the Secretary if such approval is required, in a period during which the mortgage note is in default or the project is in a nonsurplus cash position, as defined by the regulatory agreement covering the property, or the mortgagor has failed to comply with the provisions of such other form of regulatory control imposed by the Secretary, shall be fined not more than $500,000, imprisoned not more than 5 years, or both.

''(b) MORTGAGE NOTES DESCRIBED.—For purposes of subsection (a), a mortgage note is described in this subsection if it—

''(1) is insured, acquired, or held by the Secretary pursuant to this Act;

''(2) is made pursuant to section 202 of the Housing Act of 1959 (including property still subject to section 202 program requirements that existed before the date of enactment of the Cranston-Gonzalez National Affordable Housing Act); or

''(3) is insured or held pursuant to section 542 of the Housing and Community Development Act of 1992, but is not reinsured under section 542 of the Housing and Community Development Act of 1992.''.

SEC. 2313. CIVIL MONEY PENALTIES AGAINST MORTGAGEES, LENDERS, AND OTHER PARTICIPANTS IN FHA PROGRAMS.

(a) CHANGE TO SECTION TITLE.—Section 536 of the National Housing Act (12 U.S.C. 1735f–14) is amended by striking the section heading and the section designation and inserting the following:

''SEC. 536. CIVIL MONEY PENALTIES AGAINST MORTGAGEES, LENDERS, AND OTHER PARTICIPANTS IN FHA PROGRAMS.''.

(b) EXPANSION OF PERSONS ELIGIBLE FOR PENALTY.—Section 536(a) of the National Housing Act (12 U.S.C. 1735f–14(a)) is amended—

(1) in paragraph (1), by striking the first sentence and inserting the following: ''If a mortgagee approved under the Act, a lender holding a contract of insurance under title I, or a principal, officer, or employee of such mortgagee or lender, or other person or entity participating in either an insured mortgage or title I loan transaction under this Act or providing assistance to the borrower in connection with any such loan, including sellers of the real estate involved, borrowers, closing agents, title companies, real estate agents, mortgage brokers, appraisers, loan correspondents and dealers, knowingly and materially violates any applicable provision of subsection (b), the Secretary may impose a civil money penalty on the mortgagee or lender, or such other person or entity, in accordance with this section. The penalty under this paragraph shall be in addition to any other available civil remedy or any available criminal penalty, and may be imposed whether or not the Secretary imposes other administrative sanctions.''; and

(2) in paragraph (2)—

(A) in the first sentence, by inserting ''or such other person or entity'' after ''lender''; and

(B) in the second sentence, by striking ''provision'' and inserting ''the provisions''.

(c) ADDITIONAL VIOLATIONS FOR MORTGAGEES, LENDERS, AND OTHER PARTICIPANTS IN FHA PROGRAMS.—Section 536(b) of the National Housing Act (12 U.S.C. 1735f–14(b)) is amended—

(1) by redesignating paragraph (2) as paragraph (3);

(2) by inserting after paragraph (1) the following:

''(2) The Secretary may impose a civil money penalty under subsection (a) for any knowing and material violation by a principal, officer, or employee of a mortgagee or lender, or other participants in either an insured mortgage or title I loan transaction under this Act or provision of assistance to the borrower in connection with any such loan, including sellers of the real estate involved, borrowers, closing agents, title companies, real estate agents, mortgage brokers, appraisers, loan correspondents, and dealers for—

''(A) submission to the Secretary of information that was false, in connection with any mortgage insured under this Act, or any loan that is covered by a contract of insurance under title I of this Act;

''(B) falsely certifying to the Secretary or submitting to the Secretary a false certification by another person or entity; or

''(C) failure by a loan correspondent or dealer to submit to the Secretary information which is required by regulations or directives in connection with any loan that is covered by a contract of insurance under title I.''; and

(3) in paragraph (3), as redesignated, by striking ''or paragraph (1)(F)'' and inserting ''or (F), or paragraph (2) (A), (B), or (C)''.

(d) CONFORMING AND TECHNICAL AMENDMENTS.—Section 536 of the National Housing Act (12 U.S.C. 1735f–14) is amended—

(1) in subsection (c)(1)(B), by inserting after ''lender'' the following: ''or such other person or entity'';

(2) in subsection (d)(1)—

(A) by inserting ''or such other person or entity'' after ''lender''; and

(B) by striking ''part 25'' and inserting ''parts 24 and 25''; and

(3) in subsection (e), by inserting ''or such other person or entity'' after ''lender'' each place that term appears.

Subpart B—FHA Multifamily Provisions

SEC. 2320. CIVIL MONEY PENALTIES AGAINST GENERAL PARTNERS, OFFICERS, DIRECTORS, AND CERTAIN MANAGING AGENTS OF MULTIFAMILY PROJECTS.

(a) CIVIL MONEY PENALTIES AGAINST MULTIFAMILY MORTGAGORS.—Section 537 of the National Housing Act (12 U.S.C. 1735f–15) is amended—

(1) in subsection (b)(1), by striking ''on that mortgagor'' and inserting the following: ''on that mortgagor, on a general partner of a partnership mortgagor, or on any officer or director of a corporate mortgagor'';

(2) in subsection (c)—

(A) by striking the subsection heading and inserting the following:

''(c) OTHER VIOLATIONS.—''; and

(B) in paragraph (1)—

(i) by striking ''VIOLATIONS.—The Secretary may'' and all that follows through the colon and inserting the following:

''(A) LIABLE PARTIES.—The Secretary may also impose a civil money penalty under this section on—

''(i) any mortgagor of a property that includes five or more living units and that has a mortgage insured, coinsured, or held pursuant to this Act;

''(ii) any general partner of a partnership mortgagor of such property;

''(iii) any officer or director of a corporate mortgagor;

''(iv) any agent employed to manage the property that has an identity of interest with the mortgagor, with the general partner of a partnership mortgagor, or with any officer or director of a corporate mortgagor of such property; or

''(v) any member of a limited liability company that is the mortgagor of such property or is the general partner of a limited partnership mortgagor or is a partner of a general partnership mortgagor.

''(B) VIOLATIONS.—A penalty may be imposed under this section upon any liable party under

subparagraph (A) that knowingly and materially takes any of the following actions:'';

(ii) in subparagraph (B), as designated by clause (i), by redesignating the subparagraph designations (A) through (L) as clauses (i) through (xii), respectively;

(iii) by adding after clause (xii), as redesignated by clause (ii), the following:

''(xiii) Failure to maintain the premises, accommodations, any living unit in the project, and the grounds and equipment appurtenant thereto in good repair and condition in accordance with regulations and requirements of the Secretary, except that nothing in this clause shall have the effect of altering the provisions of an existing regulatory agreement or federally insured mortgage on the property.

''(xiv) Failure, by a mortgagor, a general partner of a partnership mortgagor, or an officer or director of a corporate mortgagor, to provide management for the project that is acceptable to the Secretary pursuant to regulations and requirements of the Secretary.''; and

(iv) in the last sentence, by deleting ''of such agreement'' and inserting ''of this subsection'';

(3) in subsection (d)—

(A) in paragraph (1)(B), by inserting after ''mortgagor'' the following: '', general partner of a partnership mortgagor, officer or director of a corporate mortgagor, or identity of interest agent employed to manage the property''; and

(B) by adding at the end the following:

''(5) PAYMENT OF PENALTY.—No payment of a civil money penalty levied under this section shall be payable out of project income.'';

(4) in subsection (e)(1), by deleting ''a mortgagor'' and inserting ''an entity or person'';

(5) in subsection (f), by inserting after ''mortgagor'' each place such term appears the following: '', general partner of a partnership mortgagor, officer or director of a corporate mortgagor, or identity of interest agent employed to manage the property'';

(6) by striking the heading of subsection (f) and inserting the following: ''CIVIL MONEY PENALTIES AGAINST MULTIFAMILY MORTGAGORS, GENERAL PARTNERS OF PARTNERSHIP MORTGAGORS, OFFICERS AND DIRECTORS OF CORPORATE MORTGAGORS, AND CERTAIN MANAGING AGENTS''; and

(7) by adding at the end the following:

''(k) IDENTITY OF INTEREST MANAGING AGENT.—In this section, the terms 'agent employed to manage the property that has an identity of interest' and 'identity of interest agent' mean an entity—

''(1) that has management responsibility for a project;

''(2) in which the ownership entity, including its general partner or partners (if applicable) and its officers or directors (if applicable), has an ownership interest; and

''(3) over which the ownership entity exerts effective control.''.

(b) IMPLEMENTATION.—

(1) PUBLIC COMMENT.—The Secretary shall implement the amendments made by this section by regulation issued after notice and opportunity for public comment. The notice shall seek comments primarily as to the definitions of the terms ''ownership interest in'' and ''effective control'', as those terms are used in the definition of the terms ''agent employed to manage the property that has an identity of interest'' and ''identity of interest agent''.

(2) TIMING.—A proposed rule implementing the amendments made by this section shall be published not later than 1 year after the date of enactment of this Act.

(c) APPLICABILITY OF AMENDMENTS.—The amendments made by subsection (a) shall apply only with respect to—

(1) violations that occur on or after the effective date of the final regulations implementing the amendments made by this section; and

(2) in the case of a continuing violation (as determined by the Secretary of Housing and Urban Development), any portion of a violation that occurs on or after that date.

SEC. 2321. CIVIL MONEY PENALTIES FOR NONCOMPLIANCE WITH SECTION 8 HAP CONTRACTS.

(a) BASIC AUTHORITY.—Title I of the United States Housing Act of 1937 is amended—

(1) by designating the second section designated as section 27 (as added by section 903(b) of Public Law 104–193 (110 Stat. 2348)) as section 28; and

(2) by adding at the end the following:

''SEC. 29. CIVIL MONEY PENALTIES AGAINST SECTION 8 OWNERS.

''(a) IN GENERAL.—

''(1) EFFECT ON OTHER REMEDIES.—The penalties set forth in this section shall be in addition to any other available civil remedy or any available criminal penalty, and may be imposed regardless of whether the Secretary imposes other administrative sanctions.

''(2) FAILURE OF SECRETARY.—The Secretary may not impose penalties under this section for a violation, if a material cause of the violation is the failure of the Secretary, an agent of the Secretary, or a public housing agency to comply with an existing agreement.

''(b) VIOLATIONS OF HOUSING ASSISTANCE PAYMENT CONTRACTS FOR WHICH PENALTY MAY BE IMPOSED.—

''(1) LIABLE PARTIES.—The Secretary may impose a civil money penalty under this section on—

''(A) any owner of a property receiving project-based assistance under section 8;

''(B) any general partner of a partnership owner of that property; and

''(C) any agent employed to manage the property that has an identity of interest with the owner or the general partner of a partnership owner of the property.

''(2) VIOLATIONS.—A penalty may be imposed under this section for a knowing and material breach of a housing assistance payments contract, including the following—

''(A) failure to provide decent, safe, and sanitary housing pursuant to section 8; or

''(B) knowing or willful submission of false, fictitious, or fraudulent statements or requests for housing assistance payments to the Secretary or to any department or agency of the United States.

''(3) AMOUNT OF PENALTY.—The amount of a penalty imposed for a violation under this subsection, as determined by the Secretary, may not exceed $25,000 per violation.

''(c) AGENCY PROCEDURES.—

''(1) ESTABLISHMENT.—The Secretary shall issue regulations establishing standards and procedures governing the imposition of civil money penalties under subsection (b). These standards and procedures—

''(A) shall provide for the Secretary or other department official to make the determination to impose the penalty;

''(B) shall provide for the imposition of a penalty only after the liable party has received notice and the opportunity for a hearing on the record; and

''(C) may provide for review by the Secretary of any determination or order, or interlocutory ruling, arising from a hearing and judicial review, as provided under subsection (d).

''(2) FINAL ORDERS.—

''(A) IN GENERAL.—If a hearing is not requested before the expiration of the 15-day period beginning on the date on which the notice of opportunity for hearing is received, the imposition of a penalty under subsection (b) shall constitute a final and unappealable determination.

''(B) EFFECT OF REVIEW.—If the Secretary reviews the determination or order, the Secretary may affirm, modify, or reverse that determination or order.

''(C) FAILURE TO REVIEW.—If the Secretary does not review that determination or order before the expiration of the 90-day period beginning on the date on which the determination or order is issued, the determination or order shall be final.

''(3) FACTORS IN DETERMINING AMOUNT OF PENALTY.—In determining the amount of a penalty under subsection (b), the Secretary shall take into consideration—

''(A) the gravity of the offense;

''(B) any history of prior offenses by the violator (including offenses occurring before the enactment of this section);

''(C) the ability of the violator to pay the penalty;

''(D) any injury to tenants;

''(E) any injury to the public;

''(F) any benefits received by the violator as a result of the violation;

''(G) deterrence of future violations; and

''(H) such other factors as the Secretary may establish by regulation.

''(4) PAYMENT OF PENALTY.—No payment of a civil money penalty levied under this section shall be payable out of project income.

''(d) JUDICIAL REVIEW OF AGENCY DETERMINATION.—Judicial review of determinations made under this section shall be carried out in accordance with section 537(e) of the National Housing Act.

''(e) REMEDIES FOR NONCOMPLIANCE.—

''(1) JUDICIAL INTERVENTION.—

''(A) IN GENERAL.—If a person or entity fails to comply with the determination or order of the Secretary imposing a civil money penalty under subsection (b), after the determination or order is no longer subject to review as provided by subsections (c) and (d), the Secretary may request the Attorney General of the United States to bring an action in an appropriate United States district court to obtain a monetary judgment against that person or entity and such other relief as may be available.

''(B) FEES AND EXPENSES.—Any monetary judgment awarded in an action brought under this paragraph may, in the discretion of the court, include the attorney's fees and other expenses incurred by the United States in connection with the action.

''(2) NONREVIEWABILITY OF DETERMINATION OR ORDER.—In an action under this subsection, the validity and appropriateness of the determination or order of the Secretary imposing the penalty shall not be subject to review.

''(f) SETTLEMENT BY SECRETARY.—The Secretary may compromise, modify, or remit any civil money penalty which may be, or has been, imposed under this section.

''(g) DEPOSIT OF PENALTIES.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, if the mortgage covering the property receiving assistance under section 8 is insured or formerly insured by the Secretary, the Secretary shall apply all civil money penalties collected under this section to the appropriate insurance fund or funds established under this Act, as determined by the Secretary.

''(2) EXCEPTION.—Notwithstanding any other provision of law, if the mortgage covering the property receiving assistance under section 8 is neither insured nor formerly insured by the Secretary, the Secretary shall make all civil money penalties collected under this section available for use by the appropriate office within the Department for administrative costs related to enforcement of the requirements of the various programs administered by the Secretary.

''(h) DEFINITIONS.—In this section—

''(1) the term 'agent employed to manage the property that has an identity of interest' means an entity—

''(A) that has management responsibility for a project;

''(B) in which the ownership entity, including its general partner or partners (if applicable), has an ownership interest; and

''(C) over which such ownership entity exerts effective control; and

''(2) the term 'knowing' means having actual knowledge of or acting with deliberate ignorance of or reckless disregard for the prohibitions under this section.''.

(b) APPLICABILITY.—The amendments made by subsection (a) shall apply only with respect to—

(1) violations that occur on or after the effective date of final regulations implementing the amendments made by this section; and

(2) in the case of a continuing violation (as determined by the Secretary of Housing and Urban Development), any portion of a violation that occurs on or after such date.

(c) IMPLEMENTATION.—

(1) REGULATIONS.—

(A) IN GENERAL.—The Secretary shall implement the amendments made by this section by regulation issued after notice and opportunity for public comment.

(B) COMMENTS SOUGHT.—The notice under subparagraph (A) shall seek comments as to the definitions of the terms ''ownership interest in'' and ''effective control'', as such terms are used in the definition of the term ''agent employed to manage such property that has an identity of interest''.

(2) TIMING.—A proposed rule implementing the amendments made by this section shall be published not later than 1 year after the date of enactment of this Act.

SEC. 2322. EXTENSION OF DOUBLE DAMAGES REMEDY.

Section 421 of the Housing and Community Development Act of 1987 (12 U.S.C. 1715z–4a) is amended—

(1) in subsection (a)(1)—

(A) in the first sentence, by striking ''Act; or (B)'' and inserting the following: ''Act; (B) a regulatory agreement that applies to a multifamily project whose mortgage is insured or held by the Secretary under section 202 of the Housing Act of 1959 (including property subject to section 202 of such Act as it existed before enactment of the Cranston-Gonzalez National Affordable Housing Act of 1990); (C) a regulatory agreement or such other form of regulatory control as may be imposed by the Secretary that applies to mortgages insured or held by the Secretary under section 542 of the Housing and Community Development Act of 1992, but not reinsured under section 542 of the Housing and Community Development Act of 1992; or (D)''; and

(B) in the second sentence, by inserting after ''agreement'' the following: '', or such other form of regulatory control as may be imposed by the Secretary,'';

(2) in subsection (a)(2), by inserting after ''Act,'' the following: ''under section 202 of the Housing Act of 1959 (including section 202 of such Act as it existed before enactment of the Cranston-Gonzalez National Affordable Housing Act of 1990) and under section 542 of the Housing and Community Development Act of 1992,'';

(3) in subsection (b), by inserting after ''agreement'' the following: '', or such other form of regulatory control as may be imposed by the Secretary,'';

(4) in subsection (c)—

(A) in the first sentence, by inserting after ''agreement'' the following: '', or such other form of regulatory control as may be imposed by the Secretary,''; and

(B) in the second sentence, by inserting before the period the following: ''or under the Housing Act of 1959, as appropriate''; and

(5) in subsection (d), by inserting after ''agreement'' the following: '', or such other form of regulatory control as may be imposed by the Secretary,''.

SEC. 2323. OBSTRUCTION OF FEDERAL AUDITS.

Section 1516(a) of title 18, United States Code, is amended by inserting after ''under a contract or subcontract,'' the following: ''or relating to any property that is security for a mortgage note that is insured, guaranteed, acquired, or held by the Secretary of Housing and Urban Development pursuant to any Act administered by the Secretary,''.

TITLE III—COMMITTEE ON COMMERCE SCIENCE AND TRANSPORTATION

Subtitle A—Spectrum Auctions and License Fees

SEC. 3001. SPECTRUM AUCTIONS.

(a) EXTENSION AND EXPANSION OF AUCTION AUTHORITY.—

(1) IN GENERAL.—Section 309(j) of the Communications Act of 1934 (47 U.S.C. 309(j)) is amended—

(A) by striking paragraphs (1) and (2) and inserting in lieu thereof the following:

''(1) GENERAL AUTHORITY.—If mutually exclusive applications are accepted for any initial license or construction permit that will involve an exclusive use of the electromagnetic spectrum, then, except as provided in paragraph (2), the Commission shall grant the license or permit to a qualified applicant through a system of competitive bidding that meets the requirements of this subsection. The Commission, subject to paragraphs (2) and (7) of this subsection, also may use auctions as a means to assign spectrum when it determines that such an auction is consistent with the public interest, convenience, and necessity, and the purposes of this Act.

''(2) EXCEPTIONS.—The competitive bidding authority granted by this subsection shall not apply to a license or construction permit the Commission issues—

''(A) for public safety services, including private internal radio services used by State and local governments and non-government entities, including emergency auto service by nonprofit organizations, that—

''(i) are used to protect the safety of life, health, or property; and

''(ii) are not made commercially available to the public;

''(B) for public telecommunications services, as defined in section 397(14) of this Act, when the license application is for channels reserved for noncommercial use;

''(C) for spectrum and associated orbits used in the provision of any communications within a global satellite system;

''(D) for initial licenses or construction permits for new digital television service given to existing terrestrial broadcast licensees to replace their current television licenses;

''(E) for terrestrial radio and television broadcasting when the Commission determines that an alternative method of resolving mutually exclusive applications serves the public interest substantially better than competitive bidding; or

''(F) for spectrum allocated for unlicensed use pursuant to part 15 of the Commission's regulations (47 C.F.R. part 15), if the competitive bidding for licenses would interfere with operation of end-user products permitted under such regulations.'';

(B) by striking ''1998'' in paragraph (11) and inserting ''2007''; and

(C) by inserting after paragraph (13) the following:

''(14) OUT-OF-BAND EFFECTS.—The Commission and the National Telecommunications and Information Administration shall seek to create incentives to minimize the effects of out-of-band emissions to promote more efficient use of the electromagnetic spectrum. The Commission and the National Telecommunications and Information Administration also shall encourage licensees to minimize the effects of interference.''.

(2) CONFORMING AMENDMENT.—Subsection (i) of section 309 of the Communications Act of 1934 is repealed.

(b) AUCTION OF 45 MEGAHERTZ LOCATED AT 1,710–1,755 MEGAHERTZ.—

(1) IN GENERAL.—The Commission shall assign by competitive bidding 45 megahertz located at 1,710–1,755 megahertz no later than December 31, 2001, for commercial use.

(2) FEDERAL GOVERNMENT USERS.—Any Federal Government station that, on the date of enactment of this Act, is assigned to use electromagnetic spectrum located in the 1,710–1,755 megahertz band shall retain that use until December 31, 2003, unless exempted from relocation.

(c) COMMISSION TO MAKE ADDITIONAL SPECTRUM AVAILABLE BY AUCTION.—

(1) IN GENERAL.—The Federal Communications Commission shall complete all actions necessary to permit the assignment, by September 30, 2002, by competitive bidding pursuant to section 309(j) of the Communications Act of 1934 (47 U.S.C. 309(j)), of licenses for the use of bands of frequencies currently allocated by the Commission that—

(A) in the aggregate span not less than 55 megahertz;

(B) are located below 3 gigahertz; and

(C) as of the date of enactment of this Act, have not been—

(i) designated by Commission regulation for assignment pursuant to section 309(j);

(ii) identified by the Secretary of Commerce pursuant to section 113 of the National Telecommunications and Information Administration Organization Act (47 U.S.C. 923); or

(iii) allocated for Federal Government use pursuant to section 305 of the Communications Act of 1934 (47 U.S.C. 305).

(2) CRITERIA FOR REASSIGNMENT.—In making available bands of frequencies for competitive bidding pursuant to paragraph (1), the Commission shall—

(A) seek to promote the most efficient use of the electromagnetic spectrum;

(B) consider the cost to incumbent licensees of relocating existing uses to other bands of frequencies or other means of communication;

(C) consider the needs of public safety radio services;

(D) comply with the requirements of international agreements concerning spectrum allocations; and

(E) coordinate with the Secretary of Commerce when there is any impact on Federal Government spectrum use.

(3) NOTIFICATION TO THE SECRETARY OF COMMERCE.—The Commission shall attempt to accommodate incumbent licensees displaced under this section by relocating them to other frequencies available to the Commission. The Commission shall notify the Secretary of Commerce whenever the Commission is not able to provide for the effective relocation of an incumbent licensee to a band of frequencies available to the Commission for assignment. The notification shall include—

(A) specific information on the incumbent licensee;

(B) the bands the Commission considered for relocation of the licensee; and

(C) the reasons the incumbent cannot be accommodated in these bands.

(4) REPORT TO THE SECRETARY OF COMMERCE.—

(A) TECHNICAL REPORT.—The Commission, in consultation with the National Telecommunications and Information Administration, shall submit a detailed technical report to the Secretary of Commerce setting forth—

(i) the reasons the incumbent licensees described in paragraph (3) could not be accommodated in existing non-government spectrum; and

(ii) the Commission's recommendations for relocating those incumbents.

(B) NTIA USE OF REPORT.—The National Telecommunications and Information Administration shall review this report when assessing whether a commercial licensee can be accommodated by being reassigned to a frequency allocated for Government use.

(d) IDENTIFICATION AND REALLOCATION OF FREQUENCIES.—

(1) IN GENERAL.—Section 113 of the National Telecommunications and Information Administration Organization Act (47 U.S.C. 901 et seq.) is amended by adding at the end thereof the following:

''(f) ADDITIONAL REALLOCATION REPORT.—If the Secretary receives a report from the Commission pursuant to section 3001(c)(6) of the Balanced Budget Act of 1997, the Secretary shall

submit to the President, the Congress, and the Commission a report with the Secretary's recommendations.

''(g) REIMBURSEMENT OF FEDERAL SPECTRUM USERS FOR RELOCATION COSTS.—

''(1) IN GENERAL.—

''(A) ACCEPTANCE OF COMPENSATION AUTHORIZED.—In order to expedite the efficient use of the electromagnetic spectrum, and notwithstanding section 3302(b) of title 31, United States Code, any Federal entity that operates a Federal Government station that has been identified by NTIA for relocation may accept payment, including in-kind compensation and shall be reimbursed if required to relocate by the service applicant, provider, licensee, or representative entering the band as a result of a license assignment by the Commission or otherwise authorized by Commission rules.

''(B) DUTY TO COMPENSATE OUSTED FEDERAL ENTITY.—Any such service applicant, provider, licensee, or representative shall compensate the Federal entity in advance for relocating through monetary or in-kind payment for the cost of relocating the Federal entity's operations from one or more electromagnetic spectrum frequencies to any other frequency or frequencies, or to any other telecommunications transmission media.

''(C) COMPENSABLE COSTS.—Compensation shall include, but not be limited to, the costs of any modification, replacement, or reissuance of equipment, facilities, operating manuals, regulations, or other relocation expenses incurred by that entity.

''(D) DISPOSITION OF PAYMENTS.—Payments, other than in-kind compensation, pursuant to this section shall be deposited by electronic funds transfer in a separate agency account or accounts which shall be used to pay directly the costs of relocation, to repay or make advances to appropriations or funds which do or will initially bear all or part of such costs, or to refund excess sums when necessary, and shall remain available until expended.

''(E) APPLICATION TO CERTAIN OTHER RELOCATIONS.—The provisions of this paragraph also apply to any Federal entity that operates a Federal Government station assigned to use electromagnetic spectrum identified for reallocation under subsection (a), if before the date of enactment of the Balanced Budget Act of 1997 the Commission has not identified that spectrum for service or assigned licenses or otherwise authorized service for that spectrum.

''(2) PETITIONS FOR RELOCATION.—Any person seeking to relocate a Federal Government station that has been assigned a frequency within a band allocated for mixed Federal and non-Federal use under this Act shall submit a petition for relocation to NTIA. The NTIA shall limit or terminate the Federal Government station's operating license within 6 months after receiving the petition if the following requirements are met:

''(A) The proposed relocation is consistent with obligations undertaken by the United States in international agreements and with United States national security and public safety interests.

''(B) The person seeking relocation of the Federal Government station has guaranteed to defray entirely, through payment in advance, advance in-kind payment of costs, or a combination of payment in advance and advance in-kind payment, all relocation costs incurred by the Federal entity, including, but not limited to, all engineering, equipment, site acquisition and construction, and regulatory fee costs.

''(C) The person seeking relocation completes all activities necessary for implementing the relocation, including construction of replacement facilities (if necessary and appropriate) and identifying and obtaining on the Federal entity's behalf new frequencies for use by the relocated Federal Government station (if the station is not relocating to spectrum reserved exclusively for Federal use).

''(D) Any necessary replacement facilities, equipment modifications, or other changes have been implemented and tested by the Federal entity to ensure that the Federal Government station is able to accomplish successfully its purposes including maintaining communication system performance.

''(E) The Secretary has determined that the proposed use of any spectrum frequency band to which a Federal entity relocates its operations is suitable for the technical characteristics of the band and consistent with other uses of the band. In exercising authority under this subparagraph, the Secretary shall consult with the Secretary of Defense, the Secretary of State, and other appropriate Federal officials.

''(3) RIGHT TO RECLAIM.—If within one year after the relocation of a Federal Government station, the Federal entity affected demonstrates to the Secretary and the Commission that the new facilities or spectrum are not comparable to the facilities or spectrum from which the Federal Government station was relocated, the person who sought the relocation shall take reasonable steps to remedy any defects or pay the Federal entity for the costs of returning the Federal Government station to the electromagnetic spectrum from which the station was relocated.

''(h) FEDERAL ACTION TO EXPEDITE SPECTRUM TRANSFER.—Any Federal Government station which operates on electromagnetic spectrum that has been identified for reallocation under this Act for mixed Federal and non-Federal use in any reallocation report under subsection (a), to the maximum extent practicable through the use of subsection (g) and any other applicable law, shall take prompt action to make electromagnetic spectrum available for use in a manner that maximizes efficient use of the electromagnetic spectrum.

''(i) FEDERAL SPECTRUM ASSIGNMENT RESPONSIBILITY.—This section does not modify NTIA's authority under section 103(b)(2)(A) of this Act.

''(j) DEFINITIONS.—As used in this section—

''(1) the term 'Federal entity' means any department, agency, or instrumentality of the Federal Government that utilizes a Government station license obtained under section 305 of the 1934 Act (47 U.S.C. 305);

''(2) the term 'digital television services' means television services provided using digital technology to enhance audio quality and video resolution, as further defined in the Memorandum Opinion, Report, and Order of the Commission entitled 'Advanced Television Systems and Their Impact Upon the Existing Television Service', MM Docket No. 87–268 and any subsequent FCC proceedings dealing with digital television; and

''(3) the term 'analog television licenses' means licenses issued pursuant to 47 CFR 73.682 et seq.''.

(2) Section 114(a) of that Act (47 U.S.C. 924(a)) is amended by striking ''(a) or (d)(1)'' and inserting ''(a), (d)(1), or (f)''.

(e) IDENTIFICATION AND REALLOCATION OF AUCTIONABLE FREQUENCIES.—

(1) SECOND REPORT REQUIRED.—Section 113(a) of the National Telecommunications and Information Administration Organization Act (47 U.S.C. 923(a)) is amended by inserting ''and within 6 months after the date of enactment of the Balanced Budget Act of 1997'' after ''Act of 1993''.

(2) IN GENERAL.—Section 113(b) of the National Telecommunications and Information Administration Organization Act (47 U.S.C. 923(b)) is amended—

(A) by striking the caption of paragraph (1) and inserting ''INITIAL REALLOCATION REPORT.—'';

(B) by inserting ''in the initial report required by subsection (a)'' after ''recommend for reallocation'' in paragraph (1);

(C) by inserting ''or (3)'' after ''paragraph (1)'' each place it appears in paragraph (2); and

(D) by adding at the end thereof the following:

''(3) SECOND REALLOCATION REPORT.—The Secretary shall make available for reallocation a total of 20 megahertz in the second report required by subsection (a), for use other than by Federal Government stations under section 305 of the 1934 Act (47 U.S.C. 305), that is located below 3 gigahertz and that meets the criteria specified in paragraphs (1) through (5) of subsection (a).''.

(3) ALLOCATION AND ASSIGNMENT.—Section 115 of that Act (47 U.S.C. 925) is amended—

(A) by striking ''the report required by section 113(a)'' in subsection (b) and inserting ''the initial reallocation report required by section 113(a)''; and

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

''(c) ALLOCATION AND ASSIGNMENT OF FREQUENCIES IDENTIFIED IN THE SECOND ALLOCATION REPORT.—

''(1) PLAN.—Within 12 months after it receives a report from the Secretary under section 113(f) of this Act, the Commission shall—

''(A) submit a plan, prepared in coordination with the Secretary of Commerce, to the President and to the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committee on Commerce, for the allocation and assignment under the 1934 Act of frequencies identified in the report; and

''(B) implement the plan.

''(2) CONTENTS.—The plan prepared by the Commission under paragraph (1) shall consist of a schedule of reallocation and assignment of those frequencies in accordance with section 309(j) of the 1934 Act in time for the assignment of those licenses or permits by September 30, 2002.''.

SEC. 3002. DIGITAL TELEVISION SERVICES.

Section 309(j) of the Communications Act of 1934 (47 U.S.C. 309(j)) is amended by adding at the end thereof the following:

''(15) AUCTION OF RECAPTURED BROADCAST TELEVISION SPECTRUM AND POTENTIAL DIGITAL TELEVISION LICENSE FEES.—

''(A) LIMITATIONS ON TERMS OF TERRESTRIAL TELEVISION BROADCAST LICENSES.—

''(i) A television license that authorizes analog television services may not be renewed to authorize such services for a period that extends beyond December 31, 2006. The Commission shall extend or waive this date for any station in any television market unless 95 percent of the television households have access to digital local television signals, either by direct off-air reception or by other means.

''(ii) A commercial digital television license that is issued shall expire on September 30, 2003. A commercial digital television license shall be re-issued only subject to fulfillment of the licensee's obligations under subparagraph (C).

''(iii) No later than December 31, 2001, and every 2 years thereafter, the Commission shall report to Congress on the status of digital television conversion in each television market. In preparing this report, the Commission shall consult with other departments and agencies of the Federal Government. The report shall contain the following information:

''(I) Actual consumer purchases of analog and digital television receivers, including the price, availability, and use of conversion equipment to allow analog sets to receive a digital signal.

''(II) The percentage of television households in each market that has access to digital local television signals as defined in paragraph (a)(1), whether such access is attained by direct off-air reception or by some other means.

''(III) The cost to consumers of purchasing digital television receivers (or conversion equipment to prevent obsolescence of existing analog equipment) and other related changes in the marketplace, such as increases in the cost of cable converter boxes.

''(B) SPECTRUM REVERSION AND RESALE.—

''(i) The Commission shall—

''(I) ensure that, as analog television licenses expire pursuant to subparagraph (A)(i), each broadcaster shall return electromagnetic spectrum according to the Commission's direction; and

''(II) reclaim and organize the electromagnetic spectrum in a manner to maximize the deployment of new and existing services.

''(ii) Licensees for new services occupying electromagnetic spectrum previously used for the broadcast of analog television shall be selected by competitive bidding. The Commission shall start the competitive bidding process by July 1, 2001, with payment pursuant to the competitive bidding rules established by the Commission. The Commission shall report the total revenues from the competitive bidding by January 1, 2002.

''(C) DEFINITIONS.—As used in this paragraph—

''(i) the term 'digital television services' means television services provided using digital technology to enhance audio quality and video resolution, as further defined in the Memorandum Opinion, Report, and Order of the Commission entitled 'Advanced Television Systems and Their Impact Upon the Existing Television Service', MM Docket No. 87–268 and any subsequent Commission proceedings dealing with digital television; and

''(ii) the term 'analog television licenses' means licenses issued pursuant to 47 CFR 73.682 et seq.''.

SEC. 3003. ALLOCATION AND ASSIGNMENT OF NEW PUBLIC SAFETY AND COMMERCIAL LICENSES.

(a) IN GENERAL.—The Federal Communications Commission, not later than January 1, 1998, shall allocate from electromagnetic spectrum between 746 megahertz and 806 megahertz—

(1) 24 megahertz of that spectrum for public safety services according to terms and conditions established by the Commission, in consultation with the Secretary of Commerce and the Attorney General; and

(2) 36 megahertz of that spectrum for commercial purposes to be assigned by competitive bidding.

(b) ASSIGNMENT.—The Commission shall—

(1) commence assignment of the licenses for public safety created pursuant to subsection (a) no later than September 30, 1998; and

(2) commence competitive bidding for the commercial licenses created pursuant to subsection (a) no later than March 31, 1998.

(c) LICENSING OF UNUSED FREQUENCIES FOR PUBLIC SAFETY RADIO SERVICES.—

(1) USE OF UNUSED CHANNELS FOR PUBLIC SAFETY.—It shall be the policy of the Federal Communications Commission, notwithstanding any other provision of this Act or any other law, to waive whatever licensee eligibility and other requirements (including bidding requirements) are applicable in order to permit the use of unassigned frequencies for public safety purposes by a State or local government agency upon a showing that—

(A) no other existing satisfactory public safety channel is immediately available to satisfy the requested use;

(B) the proposed use is technically feasible without causing harmful interference to existing stations in the frequency band entitled to protection from such interference under the rules of the Commission; and

(C) use of the channel for public safety purposes is consistent with other existing public safety channel allocations in the geographic area of proposed use.

(2) APPLICABILITY.—Paragraph (1) shall apply to any application—

(A) is pending before the Commission on the date of enactment of this Act;

(B) was not finally determined under section 402 or 405 of the Communications Act of 1934 (47 U.S.C. 402 or 405) on May 15, 1997; or

(C) is filed after May 15, 1997.

(d) PROTECTION OF BROADCAST TV LICENSEES DURING DIGITAL TRANSITION.—Public safety and commercial licenses granted pursuant to this subsection—

(1) shall enjoy flexibility in use, subject to—

(A) interference limits set by the Commission at the boundaries of the electromagnetic spectrum block and service area; and

(B) any additional technical restrictions imposed by the Commission to protect full-service analog and digital television licenses during a transition to digital television;

(2) may aggregate multiple licenses to create larger spectrum blocks and service areas;

(3) may disaggregate or partition licenses to create smaller spectrum blocks or service areas; and

(4) may transfer a license to any other person qualified to be a licensee.

(e) PROTECTION OF PUBLIC SAFETY LICENSEES DURING DIGITAL TRANSITION.—The Commission shall establish rules insuring that public safety licensees using spectrum reallocated pursuant to subsection (a)(1) shall not be subject to harmful interference from television broadcast licensees.

(f) DIGITAL TELEVISION ALLOTMENT.—In assigning temporary transitional digital licenses, the Commission shall—

(1) minimize the number of allotments between 746 and 806 megahertz and maximize the amount of spectrum available for public safety and new services;

(2) minimize the number of allotments between 698 and 746 megahertz in order to facilitate the recovery of spectrum at the end of the transition;

(3) consider minimizing the number of allotments between 54 and 72 megahertz to facilitate the recovery of spectrum at the end of the transition; and

(4) develop an allotment plan designed to recover 78 megahertz of spectrum to be assigned by competitive bidding, in addition to the 60 megahertz identified in paragraph (a) of this subsection.

(g) INCUMBENT BROADCAST LICENSEES.—Any person who holds an analog television license or a digital television license between 746 and 806 megahertz—

(1) may not operate at that frequency after the date on which the digital television services transition period terminates, as determined by the Commission; and

(2) shall surrender immediately the license or permit to construct pursuant to Commission rules.

(h) DEFINITIONS.—For purposes of this section:

(1) COMMISSION.—The term ''Commission'' means the Federal Communications Commission.

(2) DIGITAL TELEVISION (DTV) SERVICE.—The term ''digital television (DTV) service'' means terrestrial broadcast services provided using digital technology to enhance audio quality and video resolution, as further defined in the Memorandum Opinion, Report, and Order of the Commission entitled ''Advanced Television Systems and Their Impact Upon the Existing Television Service'', MM Docket No. 87–268, or subsequent findings of the Commission.

(3) DIGITAL TELEVISION LICENSE.—The term ''digital television license'' means a full-service license issued pursuant to rules adopted for digital television service.

(4) ANALOG TELEVISION LICENSE.—The term ''analog television license'' means a full-service license issued pursuant to 47 CFR 73.682 et seq.

(5) PUBLIC SAFETY SERVICES.—The term ''public safety services'' means services whose sole or principal purpose is to protect the safety of life, health, or property.

(6) SERVICE AREA.—The term ''service area'' means the geographic area over which a licensee may provide service and is protected from interference.

(7) SPECTRUM BLOCK.—The term ''spectrum block'' means the range of frequencies over which the apparatus licensed by the Commission is authorized to transmit signals.

SEC. 3004. FLEXIBLE USE OF ELECTROMAGNETIC SPECTRUM.

Section 303 of the Communications Act of 1934 (47 U.S.C. 303) is amended by adding at the end thereof the following:

''(y) Shall allocate electromagnetic spectrum so as to provide flexibility of use, except—

''(1) as required by international agreements relating to global satellite systems or other telecommunication services to which the United States is a party;

''(2) as required by public safety allocations;

''(3) to the extent that the Commission finds, after notice and an opportunity for public comment, that such an allocation would not be in the public interest;

''(4) to the extent that flexible use would retard investment in communications services and systems, or technology development thereby lessening the value of the electromagnetic spectrum; or

''(5) to the extent that flexible use would result in harmful interference among users.''.

SEC. 3005. RESERVE PRICE.

In any auction conducted or supervised by the Federal Communications Commission (hereinafter the Commission) for any license, permit or right which has value, a reasonable reserve price shall be set by the Commission for each unit in the auction unless the Commission determines it not to be in the public interest. The reserve price shall establish a minimum bid for the unit to be auctioned. If no bid is received above the reserve price for a unit, the unit shall be retained. The Commission shall re-assess the reserve price for that unit and place the unit in the next scheduled or next appropriate auction.

SUBTITLE B—MERCHANT MARINE PROVISIONS

SEC. 3501. EXTENSION OF VESSEL TONNAGE DUTIES.

(a) EXTENSION OF DUTIES.—Section 36 of the Act of August 5, 1909 (36 Stat. 111; 46 U.S.C. App. 121), is amended by inserting ''1999, 2000, 2001, and 2002,'' after ''1998,'' each place it appears.

(b) CONFORMING AMENDMENT.—The Act of March 8, 1910 (36 Stat. 234; 46 U.S.C. 132), is amended by striking ''and 1998,'' and inserting ''1998, 1999, 2000, 2001, and 2002,''.

TITLE IV—COMMITTEE ON ENERGY AND NATURAL RESOURCES

SEC. 4001. LEASE OF EXCESS STRATEGIC PETROLEUM RESERVE CAPACITY.

Part B of title I of the Energy Policy and Conservation Act (42 U.S.C. 6231 et seq.) is amended by adding at the end the following new section:

''USE OF UNDERUTILIZED FACILITIES

''SEC. 168. Notwithstanding section 649(b) of the Department of Energy Organization Act (42 U.S.C. 7259(b)), the Secretary is authorized to store in underutilized Strategic Petroleum Reserve facilities, by lease or otherwise, petroleum product owned by a foreign government or its representative: Provided, That funds resulting from the leasing or other use of a Reserve facility on or after October 1, 2007, shall be available to the Secretary, without further appropriation, for the purchase of petroleum products for the Reserve: Provided further, That petroleum product stored under this section is not part of the Strategic Petroleum Reserve, is not subject to part C of this title, and notwithstanding any provision of this Act, may be exported from the United States.''.

TITLE V—COMMITTEE ON FINANCE

SEC. 5000. AMENDMENTS TO SOCIAL SECURITY ACT AND REFERENCES TO OBRA; TABLE OF CONTENTS OF TITLE.

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

(b) REFERENCES TO OBRA.—In this title, the terms ''OBRA–1986'', ''OBRA–1987'', ''OBRA–1989'', ''OBRA–1990'', and ''OBRA–1993'' refer to the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509), the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203), the Omnibus Budget Reconciliation Act of 1989

(Public Law 101–239), the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508), and the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), respectively.

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

SEC. 5000A. EXTENSION OF MORATORIUM.

Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989, as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993 is amended by striking ''December 31, 1995'' and inserting ''December 31, 2002''.

DIVISION 1—MEDICARE

Subtitle A—Medicare Choice Program

CHAPTER 1—MEDICARE CHOICE PROGRAM

Subchapter A—Medicare Choice Program

SEC. 5001. ESTABLISHMENT OF MEDICARE CHOICE PROGRAM.

Title XVIII is amended by redesignating part C as part D and by inserting after part B the following new part:

''PART C—MEDICARE CHOICE PROGRAM

''ELIGIBILITY, ELECTION, AND ENROLLMENT

''SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICARE CHOICE PLANS.—

''(1) IN GENERAL.—Subject to the provisions of this section, each Medicare Choice eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits under this title—

''(A) through the traditional medicare fee-for-service program under parts A and B, or

''(B) through enrollment in a Medicare Choice plan under this part.

''(2) TYPES OF MEDICARE CHOICE PLANS THAT MAY BE AVAILABLE.—A Medicare Choice plan may be any of the following types of plans of health insurance:

''(A) FEE-FOR-SERVICE PLANS.—A plan that reimburses hospitals, physicians, and other providers on the basis of a privately determined fee schedule or other basis.

''(B) PLANS OFFERED BY PREFERRED PROVIDER ORGANIZATIONS.—A Medicare Choice plan offered by a preferred provider organization.

''(C) POINT OF SERVICE PLANS.—A point of service plan.

''(D) PLANS OFFERED BY PROVIDER-SPONSORED ORGANIZATION.—A Medicare Choice plan offered by a provider-sponsored organization, as defined in section 1855(e).

''(E) PLANS OFFERED BY HEALTH MAINTENANCE ORGANIZATIONS.—A Medicare Choice plan offered by a health maintenance organization.

''(F) COMBINATION OF MSA PLAN AND CONTRIBUTIONS TO MEDICARE CHOICE MSA.—An MSA plan, as defined in section 1859(b)(3), and a contribution into a Medicare Choice medical savings account (MSA).

''(G) OTHER HEALTH CARE PLANS.—Any other private plan for the delivery of health care items and services that is not described in a preceding subparagraph.

''(3) MEDICARE CHOICE ELIGIBLE INDIVIDUAL.—

''(A) IN GENERAL.—In this title, subject to subparagraph (B), the term 'Medicare Choice eligible individual' means an individual who is entitled to benefits under part A and enrolled under part B.

''(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—Such term shall not include an individual medically determined to have end-stage renal disease, except that an individual who develops end-stage renal disease while enrolled in a Medicare Choice plan may continue to be enrolled in that plan.

''(b) SPECIAL RULES.—

''(1) RESIDENCE REQUIREMENT.—

''(A) IN GENERAL.—Except as the Secretary may otherwise provide, an individual is eligible to elect a Medicare Choice plan offered by a Medicare Choice organization only if the plan serves the geographic area in which the individual resides.

''(B) CONTINUATION OF ENROLLMENT PERMITTED.—Pursuant to rules specified by the Secretary, the Secretary shall provide that an individual may continue enrollment in a plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides benefits for enrollees located in the area in which the individual resides.

''(2) SPECIAL RULE FOR CERTAIN INDIVIDUALS COVERED UNDER FEHBP OR ELIGIBLE FOR VETERANS OR MILITARY HEALTH BENEFITS, VETERANS.—

''(A) FEHBP.—An individual who is enrolled in a health benefit plan under chapter 89 of title 5, United States Code, is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

''(B) VA AND DOD.—The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of title 10, United States Code, or under chapter 17 of title 38 of such Code.

''(3) LIMITATION ON ELIGIBILITY OF QUALIFIED MEDICARE BENEFICIARIES AND OTHER MEDICAID BENEFICIARIES TO ENROLL IN AN MSA PLAN.—An individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)), a qualified disabled and working individual (described in section 1905(s)), an individual described in section 1902(a)(10)(E)(iii), or otherwise entitled to medicare cost-sharing under a State plan under title XIX is not eligible to enroll in an MSA plan.

''(4) COVERAGE UNDER MSA PLANS ON A DEMONSTRATION BASIS.—

''(A) IN GENERAL.—An individual is not eligible to enroll in an MSA plan under this part—

''(i) on or after January 1, 2003, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

''(ii) as of any date if the number of such individuals so enrolled as of such date has reached 100,000.

Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

''(B) EVALUATION.—The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under this part on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds under this title.

''(C) REPORTS.—The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B). The Secretary shall submit such a report, by not later than March 1, 2002, on whether the time limitation under subparagraph (A)(i) should be extended or removed and whether to change the numerical limitation under subparagraph (A)(ii).

''(c) PROCESS FOR EXERCISING CHOICE.—

''(1) IN GENERAL.—The Secretary shall establish a process through which elections described in subsection (a) are made and changed, including the form and manner in which such elections are made and changed. Such elections shall be made or changed as provided in subsection (e) and shall become effective as provided in subsection (f).

''(2) COORDINATION THROUGH MEDICARE CHOICE ORGANIZATIONS.—

''(A) ENROLLMENT.—Such process shall permit an individual who wishes to elect a Medicare Choice plan offered by a Medicare Choice organization to make such election through the filing of an appropriate election form with the organization.

''(B) DISENROLLMENT.—Such process shall permit an individual, who has elected a Medicare Choice plan offered by a Medicare Choice organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

''(3) DEFAULT.—

''(A) INITIAL ELECTION.—

''(i) IN GENERAL.—Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the traditional medicare fee-for-service program option.

''(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary may establish procedures under which an individual who is enrolled in a health plan (other than Medicare Choice plan) offered by a Medicare Choice organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the Medicare Choice plan offered by the organization (or, if the organization offers more than one such plan, such plan or plans as the Secretary identifies under such procedures).

''(B) CONTINUING PERIODS.—An individual who has made (or is deemed to have made) an election under this section is considered to have continued to make such election until such time as—

''(i) the individual changes the election under this section, or

''(ii) the Medicare Choice plan with respect to which such election is in effect is discontinued.

''(d) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

''(1) IN GENERAL.—The Secretary shall provide for activities under this subsection to broadly disseminate information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options.

''(2) PROVISION OF NOTICE.—

''(A) OPEN SEASON NOTIFICATION.—At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each Medicare Choice eligible individual residing in an area the following:

''(i) GENERAL INFORMATION.—The general information described in paragraph (3).

''(ii) LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.—A list identifying the Medicare Choice plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative, chart-like form.

''(iii) ADDITIONAL INFORMATION.—Any other information that the Secretary determines will assist the individual in making the election under this section.

The mailing of such information shall be coordinated with the mailing of any annual notice under section 1804.

''(B) NOTIFICATION TO NEWLY MEDICARE CHOICE ELIGIBLE INDIVIDUALS.—To the extent practicable, the Secretary shall, not later than 30 days before the beginning of the initial Medicare Choice enrollment period for an individual described in subsection (e)(1)(A), mail to the individual the information described in subparagraph (A).

''(C) FORM.—The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

''(D) PERIODIC UPDATING.—The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of Medicare Choice plans and the benefits and net monthly premiums for such plans.

''(3) GENERAL INFORMATION.—General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

''(A) BENEFITS UNDER TRADITIONAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—A general description of the benefits covered under the traditional medicare fee-for-service program under parts A and B, including—

''(i) covered items and services,

''(ii) beneficiary cost sharing, such as deductibles, coinsurance, and copayment amounts, and

''(iii) any beneficiary liability for balance billing.

''(B) PART B PREMIUM.—The part B premium rates that will be charged for part B coverage.

''(C) ELECTION PROCEDURES.—Information and instructions on how to exercise election options under this section.

''(D) RIGHTS.—A general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the traditional medicare fee-for-service program and the Medicare Choice program and the right to be protected against discrimination based on health status-related factors under section 1852(b).

''(E) INFORMATION ON MEDIGAP AND MEDICARE SELECT.—A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1882 and provisions relating to medicare select policies described in section 1882(t).

''(F) POTENTIAL FOR CONTRACT TERMINATION.—The fact that a Medicare Choice organization may terminate or refuse to renew its contract under this part and the effect the termination or nonrenewal of its contract may have on individuals enrolled with the Medicare Choice plan under this part.

''(4) INFORMATION COMPARING PLAN OPTIONS.—Information under this paragraph, with respect to a Medicare Choice plan for a year, shall include the following:

''(A) BENEFITS.—The benefits covered under the plan, including—

''(i) covered items and services beyond those provided under the traditional medicare fee-for-service program,

''(ii) any beneficiary cost sharing,

''(iii) any maximum limitations on out-of-pocket expenses, and

''(iv) in the case of an MSA plan, differences in cost sharing and balance billing under such a plan compared to under other Medicare Choice plans.

''(B) PREMIUMS.—The net monthly premium, if any, for the plan.

''(C) SERVICE AREA.—The service area of the plan.

''(D) QUALITY AND PERFORMANCE.—To the extent available, plan quality and performance indicators for the benefits under the plan (and how they compare to such indicators under the traditional medicare fee-for-service program under parts A and B in the area involved), including—

''(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area),

''(ii) information on medicare enrollee satisfaction,

''(iii) information on health outcomes,

''(iv) the extent to which a medicare enrollee may select the health care provider of their choice, including health care providers within the plan's network and out-of-network health care providers (if the plan covers out-of-network items and services), and

''(v) an indication of medicare enrollee exposure to balance billing and the restrictions on coverage of items and services provided to such enrollee by an out-of-network health care provider.

''(E) SUPPLEMENTAL BENEFITS OPTIONS.—Whether the organization offering the plan offers optional supplemental benefits and the terms and conditions (including premiums) for such coverage.

''(F) PHYSICIAN COMPENSATION.—An overall summary description as to the method of compensation of participating physicians.

''(5) MAINTAINING A TOLL-FREE NUMBER AND INTERNET SITE.—The Secretary shall maintain a toll-free number for inquiries regarding Medicare Choice options and the operation of this part in all areas in which Medicare Choice plans are offered and an Internet site through which individuals may electronically obtain information on such options and Medicare Choice plans.

''(6) USE OF NON-FEDERAL ENTITIES.—The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

''(7) PROVISION OF INFORMATION.—A Medicare Choice organization shall provide the Secretary with such information on the organization and each Medicare Choice plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

''(8) COORDINATION WITH STATES.—The Secretary shall coordinate with States to the maximum extent feasible in developing and distributing information provided to beneficiaries.

''(e) COVERAGE ELECTION PERIODS.—

''(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION IF MEDICARE CHOICE PLANS AVAILABLE TO INDIVIDUAL.—If, at the time an individual first becomes entitled to benefits under part A and enrolled under part B, there is one or more Medicare Choice plans offered in the area in which the individual resides, the individual shall make the election under this section during a period specified by the Secretary such that if the individual elects a Medicare Choice plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage.

''(2) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—Subject to paragraph (5), a Medicare Choice eligible individual may change the election under subsection (a)(1) at any time, except that such individual may only enroll in a Medicare Choice plan which has an open enrollment period in effect at that time.

''(3) ANNUAL, COORDINATED ELECTION PERIOD.—

''(A) IN GENERAL.—Subject to paragraph (5), a Medicare Choice eligible individual may change an election under subsection (a)(1) during an annual, coordinated election period.

''(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term 'annual, coordinated election period' means, with respect to a calendar year (beginning with 1998), the month of November before such year.

''(C) MEDICARE CHOICE HEALTH INFORMATION FAIRS.—In the month of November of each year (beginning with 1997), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform Medicare Choice eligible individuals about Medicare Choice plans and the election process provided under this section.

''(4) SPECIAL ELECTION PERIODS.—A Medicare Choice individual may make a new election under this section if—

''(A) the organization's or plan's certification under this part has been terminated or the organization has terminated or otherwise discontinued providing the plan;

''(B) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of the individual's enrollment on the basis described in clause (i) or (ii) subsection (g)(3)(B));

''(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

''(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards); or

''(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the plan's provisions in marketing the plan to the individual; or

''(D) the individual meets such other exceptional conditions as the Secretary may provide.

''(5) SPECIAL RULES FOR MSA PLANS.—Notwithstanding the preceding provisions of this subsection, an individual—

''(A) may elect an MSA plan only during—

''(i) an initial open enrollment period described in paragraph (1), or

''(ii) an annual, coordinated election period described in paragraph (3)(B), and

''(B) may not discontinue an election of an MSA plan except during the periods described in subparagraph (A) and under paragraph (4).

''(6) OPEN ENROLLMENT PERIODS.—A Medicare Choice organization—

''(A) shall accept elections or changes to elections described in paragraphs (1), (3), and (4) during the periods prescribed in such paragraphs, and

''(B) may accept other changes to elections at such other times as the organization provides.

''(f) EFFECTIVENESS OF ELECTIONS AND CHANGES OF ELECTIONS.—

''(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1)(A) shall take effect upon the date the individual becomes entitled to benefits under part A and enrolled under part B, except as the Secretary may provide (consistent with section 1838) in order to prevent retroactive coverage.

''(2) DURING CONTINUOUS OPEN ENROLLMENT PERIODS.—An election or change of coverage made under subsection (e)(2) shall take effect with the first day of the first calendar month following the date on which the election is made.

''(3) ANNUAL, COORDINATED ELECTION PERIOD.—An election or change of coverage made during an annual, coordinated election period (as defined in subsection (e)(3)(B)) in a year shall take effect as of the first day of the following year unless the individual elects to have it take effect on December 1 of the election year.

''(4) OTHER PERIODS.—An election or change of coverage made during any other period under subsection (e)(4) shall take effect in such manner as the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

''(g) GUARANTEED ISSUE AND RENEWAL.—

''(1) IN GENERAL.—Except as provided in this subsection, a Medicare Choice organization shall provide that at any time during which elections are accepted under this section with respect to a Medicare Choice plan offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

''(2) PRIORITY.—If the Secretary determines that a Medicare Choice organization, in relation to a Medicare Choice plan it offers, has a capacity limit and the number of Medicare Choice eligible individuals who elect the plan under this section exceeds the capacity limit, the organization may limit the election of individuals of the plan under this section but only if priority in election is provided—

''(A) first to such individuals as have elected the plan at the time of the determination, and

''(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1852(b), among the individuals (who seek to elect the plan).

The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

''(3) LIMITATION ON TERMINATION OF ELECTION.—

''(A) IN GENERAL.—Subject to subparagraph (B), a Medicare Choice organization may not for any reason terminate the election of any individual under this section for a Medicare Choice plan it offers.

''(B) BASIS FOR TERMINATION OF ELECTION.—A Medicare Choice organization may terminate an individual's election under this section with respect to a Medicare Choice plan it offers if—

''(i) any net monthly premiums required with respect to such plan are not paid on a timely basis (consistent with standards under section 1856 that provide for a grace period for late payment of net monthly premiums),

''(ii) the individual has engaged in disruptive behavior (as specified in such standards), or

''(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

''(C) CONSEQUENCE OF TERMINATION.—

''(i) TERMINATIONS FOR CAUSE.—Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected the traditional medicare fee-for-service program option described in subsection (a)(1)(A).

''(ii) TERMINATION BASED ON PLAN TERMINATION OR SERVICE AREA REDUCTION.—Any individual whose election is terminated under subparagraph (B)(iii) shall have a special election period under subsection (e)(4)(A) in which to change coverage to coverage under another Medicare Choice plan. Such an individual who fails to make an election during such period is deemed to have chosen to change coverage to the traditional medicare fee-for-service program option described in subsection (a)(1)(A).

''(D) ORGANIZATION OBLIGATION WITH RESPECT TO ELECTION FORMS.—Pursuant to a contract under section 1857, each Medicare Choice organization receiving an election form under subsection (c)(3) shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

''(h) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—

''(1) SUBMISSION.—No marketing material or application form may be distributed by a Medicare Choice organization to (or for the use of) Medicare Choice eligible individuals unless—

''(A) at least 45 days before the date of distribution the organization has submitted the material or form to the Secretary for review, and

''(B) the Secretary has not disapproved the distribution of such material or form.

''(2) REVIEW.—The standards established under section 1856 shall include guidelines for the review of any material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

''(3) DEEMED APPROVAL (1-STOP SHOPPING).—In the case of material or form that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing material or form under paragraph (1)(B) with respect to a Medicare Choice plan in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the plan and organization except to the extent that such material or form is specific only to an area involved.

''(4) PROHIBITION OF CERTAIN MARKETING PRACTICES.—Each Medicare Choice organization shall conform to fair marketing standards, in relation to Medicare Choice plans offered under this part, included in the standards established under section 1856.

''(i) EFFECT OF ELECTION OF MEDICARE CHOICE PLAN OPTION.—Subject to sections 1852(a)(5) and 1857(f)(2)—

''(1) payments under a contract with a Medicare Choice organization under section 1853(a) with respect to an individual electing a Medicare Choice plan offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A and B for items and services furnished to the individual, and

''(2) subject to subsections (e) and (g) of section 1853, only the Medicare Choice organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

''BENEFITS AND BENEFICIARY PROTECTIONS

''SEC. 1852. (a) BASIC BENEFITS.—

''(1) IN GENERAL.—Except as provided in section 1859(b)(3) for MSA plans, each Medicare Choice plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

''(A) those items and services for which benefits are available under parts A and B to individuals residing in the area served by the plan, and

''(B) additional benefits required under section 1854(f)(1)(A).

''(2) SUPPLEMENTAL BENEFITS.—

''(A) BENEFITS INCLUDED SUBJECT TO SECRETARY'S APPROVAL.—Each Medicare Choice organization may provide to individuals enrolled under this part (without affording those individuals an option to decline the coverage) supplemental health care benefits that the Secretary may approve. The Secretary shall approve any such supplemental benefits unless the Secretary determines that including such supplemental benefits would substantially discourage enrollment by Medicare Choice eligible individuals with the organization.

''(B) AT ENROLLEES' OPTION.—A Medicare Choice organization may provide to individuals enrolled under this part (other than under an MSA plan) supplemental health care benefits that the individuals may elect, at their option, to have covered.

''(3) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a Medicare Choice organization may (in the case of the provision of items and services to an individual under a Medicare Choice plan under circumstances in which payment under this title is made secondary pursuant to section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section—

''(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

''(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

''(4) NATIONAL COVERAGE DETERMINATIONS.—If there is a national coverage determination made in the period beginning on the date of an announcement under section 1853(b) and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a Medicare Choice organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the annual Medicare Choice capitation rate under section 1853 included in the announcement made at the beginning of such period, then, unless otherwise required by law—

''(A) such determination shall not apply to contracts under this part until the first contract year that begins after the end of such period, and

''(B) if such coverage determination provides for coverage of additional benefits or coverage under additional circumstances, section 1851(i) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period.

''(5) SATISFACTION OF REQUIREMENT.—

''(A) IN GENERAL.—A MedicarePlus plan offered by a MedicarePlus organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider that has a contract with the organization offering the plan, if the plan provides (in addition to any cost sharing provided for under the plan) for at least the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

''(B) EXCEPTION FOR MSA PLANS AND UNRESTRICTED FEE-FOR-SERVICE PLANS.—Subparagraph (A) shall not apply to an MSA plan or an unrestricted fee-for-service plan.

''(b) ANTIDISCRIMINATION.—

''(1) BENEFICIARIES.—

''(A) IN GENERAL.—A Medicare Choice organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(B) CONSTRUCTION.—Subparagraph (A) shall not be construed as requiring a Medicare Choice organization to enroll individuals who are determined to have end-stage renal disease, except as provided under section 1851(a)(3)(B).

''(2) PROVIDERS.—A Medicare Choice organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

''(c) DISCLOSURE REQUIREMENTS.—

''(1) DETAILED DESCRIPTION OF PLAN PROVISIONS.—A Medicare Choice organization shall disclose, in clear, accurate, and standardized form to each enrollee with a Medicare Choice plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

''(A) SERVICE AREA.—The plan's service area.

''(B) BENEFITS.—Benefits offered under the plan, including information described in section 1851(d)(3)(A) and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other Medicare Choice plans.

''(C) ACCESS.—The number, mix, and distribution of plan providers.

''(D) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan.

''(E) EMERGENCY COVERAGE.—Coverage of emergency services and urgently needed care, including—

''(i) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

''(ii) the process and procedures of the plan for obtaining emergency services; and

''(iii) the locations of (I) emergency departments, and (II) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

''(F) SUPPLEMENTAL BENEFITS.—Supplemental benefits available from the organization offering the plan, including—

''(i) whether the supplemental benefits are optional,

''(ii) the supplemental benefits covered, and

''(iii) the premium price for the supplemental benefits.

''(G) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in nonpayment.

''(H) PLAN GRIEVANCE AND APPEALS PROCEDURES.—All plan appeal or grievance rights and procedures.

''(I) QUALITY ASSURANCE PROGRAM.—A description of the organization's quality assurance program under subsection (e).

''(J) OUT-OF-NETWORK COVERAGE.—The out-of-network coverage (if any) provided by the plan.

''(2) DISCLOSURE UPON REQUEST.—Upon request of a Medicare Choice eligible individual, a Medicare Choice organization must provide the following information to such individual:

''(A) The information described in paragraphs (3) and (4) of section 1851(d).

''(B) Information on utilization review procedures.

''(d) ACCESS TO SERVICES.—

''(1) IN GENERAL.—A Medicare Choice organization offering a Medicare Choice plan, other than an unrestricted fee-for-service plan, may select the providers from whom the benefits under the plan are provided so long as—

''(A) the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

''(B) when medically necessary the organization makes such benefits available and accessible 24 hours a day and 7 days a week;

''(C) the plan provides for reimbursement with respect to services which are covered under subparagraphs (A) and (B) and which are provided to such an individual other than through the organization, if—

''(i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and it was not reasonable given the circumstances to obtain the services through the organization, or

''(ii) the services were renal dialysis services and were provided other than through the organization because the individual was temporarily out of the plan's service area;

''(D) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services;

''(E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency

care provider's contractual relationship with the organization; and

''(F) except as provided by the Secretary on a case-by-case basis, the organization provides primary care services within 30 minutes or 30 miles from an enrollee's place of residence if the enrollee resides in a rural area.

''(2) GUIDELINES RESPECTING COORDINATION OF POST-STABILIZATION CARE.—

''(A) IN GENERAL.—A Medicare Choice plan shall comply with such guidelines as the Secretary shall prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867.

''(B) CONTENT OF GUIDELINES.—The guidelines prescribed under subparagraph (A) shall provide that—

''(i) a provider of emergency services shall make a documented good faith effort to contact the plan in a timely fashion from the point at which the individual is stabilized to request approval for medically necessary post-stabilization care,

''(ii) the plan shall respond in a timely fashion to the initial contact with the plan with a decision as to whether the services for which approval is requested will be authorized, and

''(iii) if a denial of a request is communicated, the plan shall, upon request from the treating physician, arrange for a physician who is authorized by the plan to review the denial to communicate directly with the treating physician in a timely fashion.

''(3) DEFINITION OF EMERGENCY SERVICES.—In this subsection—

''(A) IN GENERAL.—The term 'emergency services' means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

''(i) are furnished by a provider that is qualified to furnish such services under this title, and

''(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

''(B) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

''(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

''(ii) serious impairment to bodily functions, or

''(iii) serious dysfunction of any bodily organ or part.

''(e) QUALITY ASSURANCE PROGRAM.—

''(1) IN GENERAL.—Each Medicare Choice organization must have arrangements, consistent with any regulation, for an ongoing quality assurance program for health care services it provides to individuals enrolled with Medicare Choice plans of the organization.

''(2) ELEMENTS OF PROGRAM.—The quality assurance program shall—

''(A) stress health outcomes and provide for the collection, analysis, and reporting of data (in accordance with a quality measurement system that the Secretary recognizes) that will permit measurement of outcomes and other indices of the quality of Medicare Choice plans and organizations;

''(B) provide for the establishment of written protocols for utilization review, based on current standards of medical practice;

''(C) provide review by physicians and other health care professionals of the process followed in the provision of such health care services;

''(D) monitor and evaluate high volume and high risk services and the care of acute and chronic conditions;

''(E) evaluate the continuity and coordination of care that enrollees receive;

''(F) have mechanisms to detect both underutilization and overutilization of services;

''(G) after identifying areas for improvement, establish or alter practice parameters;

''(H) take action to improve quality and assesses the effectiveness of such action through systematic followup;

''(I) make available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options (in such form and on such quality and outcomes measures as the Secretary determines to be appropriate);

''(J) be evaluated on an ongoing basis as to its effectiveness;

''(K) include measures of consumer satisfaction; and

''(L) provide the Secretary with such access to information collected as may be appropriate to monitor and ensure the quality of care provided under this part.

''(3) EXTERNAL REVIEW.—Each Medicare Choice organization shall, for each Medicare Choice plan it operates, have an agreement with an independent quality review and improvement organization approved by the Secretary to perform functions of the type described in sections 1154(a)(4)(B) and 1154(a)(14) with respect to services furnished by Medicare Choice plans for which payment is made under this title.

''(4) EXCEPTION FOR MEDICARE CHOICE UNRESTRICTED FEE-FOR-SERVICE PLANS.—Paragraphs (1) through (3) of this subsection and subsection (h)(2) (relating to maintaining medical records) shall not apply in the case of a Medicare Choice organization in relation to a Medicare Choice unrestricted fee-for-service plan.

''(5) TREATMENT OF ACCREDITATION.—The Secretary shall provide that a Medicare Choice organization is deemed to meet requirements of paragraphs (1) and (2) of this subsection and subsection (h) (relating to confidentiality and accuracy of enrollee records) if the organization is accredited (and periodically reaccredited) by a private organization under a process that the Secretary has determined assures that the organization, as a condition of accreditation, applies and enforces standards with respect to the requirements involved that are no less stringent than the standards established under section 1856 to carry out the respective requirements.

''(6) ANNUAL REPORT ON NON-HEALTH EXPENDITURES.—Each Medicare Choice organization shall, at the request of the enrollee, annually provide to enrollees a statement disclosing the proportion of the premiums and other revenues received by the organization that are expended for non-health care items and services.

''(f) COVERAGE DETERMINATIONS.—

''(1) DECISIONS ON NONEMERGENCY CARE.—A Medicare Choice organization shall make determinations regarding authorization requests for nonemergency care on a timely basis, depending on the urgency of the situation.

''(2) RECONSIDERATIONS.—

''(A) IN GENERAL.—Subject to subsection (g)(4), a reconsideration of a determination of an organization denying coverage shall be made within 30 days of the date of receipt of medical information, but not later than 60 days after the date of the determination.

''(B) PHYSICIAN DECISION ON CERTAIN RECONSIDERATIONS.—A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician other than a physician involved in the initial determination.

''(g) GRIEVANCES AND APPEALS.—

''(1) GRIEVANCE MECHANISM.—Each Medicare Choice organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees with Medicare Choice plans of the organization under this part.

''(2) APPEALS.—An enrollee with a Medicare Choice plan of a Medicare Choice organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is $1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the organization shall be entitled to be parties to that judicial review. In applying subsections (b) and (g) of section 205 as provided in this paragraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

''(3) INDEPENDENT REVIEW OF CERTAIN COVERAGE DENIALS.—The Secretary shall contract with an independent, outside entity to review and resolve reconsiderations that affirm denial of coverage.

''(4) EXPEDITED DETERMINATIONS AND RECONSIDERATIONS.—

''(A) RECEIPT OF REQUESTS.—An enrollee in a Medicare Choice plan may request, either in writing or orally, an expedited determination or reconsideration by the Medicare Choice organization regarding a matter described in paragraph (2). The organization shall also permit the acceptance of such requests by physicians.

''(B) ORGANIZATION PROCEDURES.—

''(i) IN GENERAL.—The Medicare Choice organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of normal time frames for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

''(ii) TIMELY RESPONSE.—In an urgent case described in clause (i), the organization shall notify the enrollee (and the physician involved, as appropriate) of the determination (or determination on the reconsideration) as expeditiously as the enrollee's health condition requires, but not later than 72 hours (or 24 hours in the case of a reconsideration) of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

''(h) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Each Medicare Choice organization shall establish procedures—

''(1) to safeguard the privacy of individually identifiable enrollee information,

''(2) to maintain accurate and timely medical records and other health information for enrollees, and

''(3) to assure timely access of enrollees to their medical information.

''(i) INFORMATION ON ADVANCE DIRECTIVES.—Each Medicare Choice organization shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

''(j) RULES REGARDING PHYSICIAN PARTICIPATION.—

''(1) PROCEDURES.—Each Medicare Choice organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under Medicare Choice plans offered by the organization under this part. Such procedures shall include—

''(A) providing notice of the rules regarding participation,

''(B) providing written notice of participation decisions that are adverse to physicians, and

''(C) providing a process within the organization for appealing such adverse decisions, including the presentation of information and views of the physician regarding such decision.

''(2) CONSULTATION IN MEDICAL POLICIES.—A Medicare Choice organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality, and medical management procedures.

''(3) LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.—

''(A) IN GENERAL.—No Medicare Choice organization may operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

''(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

''(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

''(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or group, and

''(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

''(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

''(B) PHYSICIAN INCENTIVE PLAN DEFINED.—In this paragraph, the term 'physician incentive plan' means any compensation arrangement between a Medicare Choice organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

''(4) LIMITATION ON PROVIDER INDEMNIFICATION.—A Medicare Choice organization may not provide (directly or indirectly) for a provider (or group of providers) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a Medicare Choice plan of the organization under this part by the organization's denial of medically necessary care.

''(k) TREATMENT OF SERVICES FURNISHED BY CERTAIN PROVIDERS.—

''(1) IN GENERAL.—A physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a MedicarePlus organization shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a MedicarePlus organization under this part) also applies with respect to an individual so enrolled.

''(2) EXCEPTION FOR MSA PLANS AND UNRESTRICTED FEE-FOR-SERVICE PLANS.—Paragraph (1) shall not apply to an MSA plan or an unrestricted fee-for-service plan.

''PAYMENTS TO MEDICARE CHOICE ORGANIZATIONS

''SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

''(1) MONTHLY PAYMENTS.—

''(A) IN GENERAL.—Under a contract under section 1857 and subject to subsections (e) and (f), the Secretary shall make monthly payments under this section in advance to each Medicare Choice organization, with respect to coverage of an individual under this part in a Medicare Choice payment area for a month, in an amount equal to 1/12 of the annual Medicare Choice capitation rate (as calculated under subsection (c)) with respect to that individual for that area, adjusted for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such factors, if such changes will improve the determination of actuarial equivalence.

''(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment to a Medicare Choice organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a Medicare Choice plan of the organization. Such rates of payment shall be actuarially equivalent to rates paid to other enrollees in the Medicare Choice payment area (or such other area as specified by the Secretary). In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1881(b)(7) to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence.

''(2) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—

''(A) IN GENERAL.—The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

''(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a Medicare Choice organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

''(ii) EXCEPTION.—No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1852(c) at the time the individual enrolled with the organization.

''(3) ESTABLISHMENT OF RISK ADJUSTMENT FACTORS.—

''(A) IN GENERAL.—The Secretary shall develop and implement a method of risk adjustment of payment rates under this section that accounts for variations in per capita costs based on health status. Such method shall not be implemented before the Secretary receives an evaluation by an outside, independent actuary of the actuarial soundness of such method.

''(B) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require Medicare Choice organizations (and eligible organizations with risk-sharing contracts under section 1876) to submit, for periods beginning on or after January 1, 1998, data regarding inpatient hospital services and other services and other information the Secretary deems necessary.

''(4) INTERIM RISK ADJUSTMENT.—

''(A) IN GENERAL.—In the case of an applicable enrollee in a Medicare Choice plan, the payment to the Medicare Choice organization under this section shall be reduced by an amount equal to the applicable percentage of the amount of such payment (determined without regard to this paragraph).

''(B) APPLICABLE ENROLLEE.—For purposes of this paragraph—

''(i) IN GENERAL.—The term 'applicable enrollee' means, with respect to any month, a medicare eligible individual who—

''(I) is enrolled in a Medicare Choice plan, and

''(II) has not been enrolled in Medicare Choice plans and plans operated by eligible organizations with risk-sharing contracts under section 1876 for an aggregate number of months greater than 60 (including the month for which the determination is being made).

''(ii) EXCEPTION FOR BENEFICIARIES MAINTAINING ENROLLMENT IN CERTAIN PLANS.—The term 'applicable enrollee' shall not include any individual enrolled in a Medicare Choice plan offered by a Medicare Choice organization if such individual was enrolled in a health plan (other than a Medicare Choice plan) offered by such organization at the time of the individual's initial election period under section 1851(e)(1) and has been continuously enrolled in such Medicare Choice plan (or another Medicare Choice plan offered by such organization) since such election period.

''(C) APPLICABLE PERCENTAGE.—For purposes of this paragraph, the applicable percentage shall be determined in accordance with the following table:

''Months enrolled in HMOs:	Applicable percentage:
1–12	5
13–24	4
25–36	3
37–48	2
49–60	1.

''(D) EXCEPTION FOR NEW PLANS.—This paragraph shall not apply to applicable enrollees in a Medicare Choice plan for any month if—

''(i) such month occurs during the first 12 months during which the plan enrolls Medicare Choice eligible individuals in the Medicare Choice payment area, and

''(ii) the annual Medicare Choice capitation rate for such area for the calendar year preceding the calendar year in which such 12-month period begins is less than the annual national Medicare Choice capitation rate (as determined under subsection (c)(4)) for such preceding calendar year.

In the case of 1998, clause (ii) shall be applied by using the adjusted average per capita cost under section 1876 for 1997 rather than such capitation rate.

''(E) TERMINATION.—This paragraph shall not apply to any month beginning on or after the first day of the first month to which the method for risk adjustment described in paragraph (3) applies.

''(b) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—

''(1) ANNUAL ANNOUNCEMENT.—The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than August 1 before the calendar year concerned—

''(A) the annual Medicare Choice capitation rate for each Medicare Choice payment area for the year, and

''(B) the risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) for payments for months in that year.

''(2) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (1) for a year, the Secretary shall provide for notice to Medicare Choice organizations of proposed changes

to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

''(3) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that Medicare Choice organizations can compute monthly adjusted Medicare Choice capitation rates for individuals in each Medicare Choice payment area which is in whole or in part within the service area of such an organization.

''(c) CALCULATION OF ANNUAL MEDICARE CHOICE CAPITATION RATES.—

''(1) IN GENERAL.—For purposes of this part, each annual Medicare Choice capitation rate, for a Medicare Choice payment area for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraph (A), (B), or (C):

''(A) BLENDED CAPITATION RATE.—The sum of—

''(i) the area-specific percentage for the year (as specified under paragraph (2) for the year) of the annual area-specific Medicare Choice capitation rate for the year for the Medicare Choice payment area, as determined under paragraph (3), and

''(ii) the national percentage (as specified under paragraph (2) for the year) of the annual national Medicare Choice capitation rate for the year, as determined under paragraph (4),

multiplied by the payment adjustment factors described in subparagraphs (A) and (B) of paragraph (5).

''(B) MINIMUM AMOUNT.—Subject to paragraph (8)—

''(i) For 1998, $4,200 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area).

''(ii) For each subsequent year, 101 percent of the amount in effect under this subparagraph for the previous year.

''(C) MINIMUM PERCENTAGE INCREASE.—Subject to paragraph (8)—

''(i) For 1998, 101 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the Medicare Choice payment area.

''(ii) For each subsequent year, 101 percent of the annual Medicare Choice capitation rate under this paragraph for the area for the previous year.

''(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

''(A) for 1998, the 'area-specific percentage' is 90 percent and the 'national percentage' is 10 percent,

''(B) for 1999, the 'area-specific percentage' is 80 percent and the 'national percentage' is 20 percent,

''(C) for 2000, the 'area-specific percentage' is 70 percent and the 'national percentage' is 30 percent,

''(D) for 2001, the 'area-specific percentage' is 60 percent and the 'national percentage' is 40 percent, and

''(E) for a year after 2001, the 'area-specific percentage' is 50 percent and the 'national percentage' is 50 percent.

''(3) ANNUAL AREA-SPECIFIC MEDICARE CHOICE CAPITATION RATE.—

''(A) IN GENERAL.—For purposes of paragraph (1)(A), the annual area-specific Medicare Choice capitation rate for a Medicare Choice payment area—

''(i) for 1998 is the modified annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area, increased by the national average per capita growth percentage for 1998 (as defined in paragraph (6)); or

''(ii) for a subsequent year is the annual area-specific Medicare Choice capitation rate for the previous year determined under this paragraph for the area, increased by the national average per capita growth percentage for such subsequent year.

''(B) MODIFIED ANNUAL PER CAPITA RATE OF PAYMENT.—For purposes of subparagraph (A), the modified annual per capita rate of payment for a Medicare Choice payment area for 1997 shall be equal to the annual per capita rate of payment for such area for such year which would have been determined under section 1876(a)(1)(C) if 25 percent of any payments attributable to sections 1886(d)(5)(B), 1886(h), and 1886(d)(5)(F) (relating to IME, GME, and DSH payments) were not taken into account.

''(C) SPECIAL RULES FOR 1999, 2000, AND 2001.—In applying subparagraph (A)(ii) for 1999, 2000, and 2001, the annual area-specific Medicare Choice capitation rate for the preceding calendar year shall be the amount which would have been determined if subparagraph (B) had been applied by substituting the following percentages for '25 percent':

''(i) In 1999, 50 percent.

''(ii) In 2000, 75 percent.

''(iii) In 2001, 100 percent.

''(4) ANNUAL NATIONAL MEDICARE CHOICE CAPITATION RATE.—For purposes of paragraph (1)(A), the annual national Medicare Choice capitation rate for a Medicare Choice payment area for a year is equal to—

''(A) the sum (for all Medicare Choice payment areas) of the product of—

''(i) the annual area-specific Medicare Choice capitation rate for that year for the area under paragraph (3), and

''(ii) the average number of medicare beneficiaries residing in that area in the year; divided by

''(B) the sum of the amounts described in subparagraph (A)(ii) for all Medicare Choice payment areas for that year.

''(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTORS.—For purposes of paragraph (1)(A)—

''(A) BLENDED RATE PAYMENT ADJUSTMENT FACTOR.—For each year, the Secretary shall compute a blended rate payment adjustment factor such that, not taking into account subparagraphs (B) and (C) of paragraph (1) and the application of the payment adjustment factor described in subparagraph (B) but taking into account paragraph (7), the aggregate of the payments that would be made under this part is equal to the aggregate payments that would have been made under this part (not taking into account such subparagraphs and such other adjustment factor) if the area-specific percentage under paragraph (1) for the year had been 100 percent and the national percentage had been 0 percent.

''(B) FLOOR-AND-MINIMUM-UPDATE PAYMENT ADJUSTMENT FACTOR.—For each year, the Secretary shall compute a floor-and-minimum-update payment adjustment factor so that, taking into account the application of the blended rate payment adjustment factor under subparagraph (A) and subparagraphs (B) and (C) of paragraph (1) and the application of the adjustment factor under this subparagraph, the aggregate of the payments under this part shall not exceed the aggregate payments that would have been made under this part if subparagraphs (B) and (C) of paragraph (1) did not apply and if the floor-and-minimum-update payment adjustment factor under this subparagraph was 1.

''(6) NATIONAL AVERAGE PER CAPITA GROWTH PERCENTAGE DEFINED.—In this part, the 'national average per capita growth percentage' for any year (beginning with 1998) is equal to the sum of—

''(A) the percentage increase in the gross domestic product per capita for the 12-month period ending on June 30 of the preceding year, plus

''(B) 0.5 percentage points.

''(7) TREATMENT OF AREAS WITH HIGHLY VARIABLE PAYMENT RATES.—In the case of a Medicare Choice payment area for which the annual per capita rate of payment determined under section 1876(a)(1)(C) for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for 1997 a rate that is more representative of the costs of the enrollees in the area.

''(8) ADJUSTMENTS TO MINIMUM AMOUNTS AND MINIMUM PERCENTAGE INCREASES.—After computing all amounts under this subsection (without regard to this paragraph) for any year, the Secretary shall—

''(A) redetermine the amount under paragraph (1)(C) for such year by substituting '100 percent' for '101 percent' each place it appears, and

''(B) increase the minimum amount under paragraph (1)(B) to an amount equal to the lesser of—

''(i) the amount the Secretary estimates will result in increased payments under such paragraph equal to the decrease in payments by reason of the redetermination under subparagraph (A), or

''(ii) an amount equal to 85 percent of the annual national Medicare Choice capitation rate determined under paragraph (4).

''(9) STUDY OF LOCAL PRICE INDICATORS.—The Secretary and the Medicare Payment Advisory Commission shall each conduct a study with respect to appropriate measures for adjusting the annual Medicare Choice capitation rates determined under this section to reflect local price indicators, including the medicare hospital wage index and the case-mix of a geographic region. The Secretary and the Advisory Commission shall report the results of such study to the appropriate committees of Congress, including recommendations (if any) for legislation.

''(d) MEDICARE CHOICE PAYMENT AREA DEFINED.—

''(1) IN GENERAL.—In this part, except as provided in paragraph (3), the term 'Medicare Choice payment area' means a county, or equivalent area specified by the Secretary.

''(2) RULE FOR ESRD BENEFICIARIES.—In the case of individuals who are determined to have end stage renal disease, the Medicare Choice payment area shall be a State or such other payment area as the Secretary specifies.

''(3) GEOGRAPHIC ADJUSTMENT.—

''(A) IN GENERAL.—Upon written request of the chief executive officer of a State for a contract year (beginning after 1998) made at least 7 months before the beginning of the year, the Secretary shall make a geographic adjustment to a Medicare Choice payment area in the State otherwise determined under paragraph (1)—

''(i) to a single statewide Medicare Choice payment area,

''(ii) to the metropolitan based system described in subparagraph (C), or

''(iii) to consolidating into a single Medicare Choice payment area noncontiguous counties (or equivalent areas described in paragraph (1)) within a State.

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

''(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the Secretary shall adjust the payment rates otherwise established under this section for Medicare Choice payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for Medicare Choice payment areas in the State in the absence of the adjustment under this paragraph.

''(C) METROPOLITAN BASED SYSTEM.—The metropolitan based system described in this subparagraph is one in which—

''(i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area, all of the

portions of each primary metropolitan statistical area within the consolidated area within the State, are treated as a single Medicare Choice payment area, and

''(ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single Medicare Choice payment area.

''(D) AREAS.—In subparagraph (C), the terms 'metropolitan statistical area', 'consolidated metropolitan statistical area', and 'primary metropolitan statistical area' mean any area designated as such by the Secretary of Commerce.

''(e) SPECIAL RULES FOR INDIVIDUALS ELECTING MSA PLANS.—

''(1) IN GENERAL.—If the amount of the monthly premium for an MSA plan for a Medicare Choice payment area for a year is less than 1/12 of the annual Medicare Choice capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a Medicare Choice MSA established (and, if applicable, designated) by the individual under paragraph (2).

''(2) ESTABLISHMENT AND DESIGNATION OF MEDICARE CHOICE MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) on behalf of an individual for a month unless the individual—

''(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a Medicare Choice MSA (as defined in section 138(b)(2) of the Internal Revenue Code of 1986), and

''(B) if the individual has established more than one such Medicare Choice MSA, has designated one of such accounts as the individual's Medicare Choice MSA for purposes of this part. Under rules under this section, such an individual may change the designation of such account under subparagraph (B) for purposes of this part.

''(3) LUMP-SUM DEPOSIT OF MEDICAL SAVINGS ACCOUNT CONTRIBUTION.—In the case of an individual electing an MSA plan effective beginning with a month in a year, the amount of the contribution to the Medicare Choice MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

''(4) SPECIAL RULE FOR APPLICABLE ENROLLEE.—In the case of an enrollee in a MSA plan for any month who is an applicable enrollee for such month under section 1853(a)(4)(B), the amount of the deposit under paragraph (1) for such month shall be reduced by the applicable percentage (as defined in section 1853(a)(4)(C)) of the amount of such deposit (determined without regard to this paragraph).

''(f) PAYMENTS FROM TRUST FUND.—The payment to a Medicare Choice organization under this section for individuals enrolled under this part with the organization and payments to a Medicare Choice MSA under subsection (e)(1)(B) shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this title. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001. Monthly payments otherwise payable under this section for October 2006 shall be paid on the first business day of October 2006.

''(g) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

''(1) election under this part of a Medicare Choice plan offered by a Medicare Choice organization—

''(A) payment for such services until the date of the individual's discharge shall be made under this title through the Medicare Choice plan or the traditional medicare fee-for-service program option described in section 1851(a)(1)(A) (as the case may be) elected before the election with such organization,

''(B) the elected organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

''(C) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

''(2) termination of election with respect to a Medicare Choice organization under this part—

''(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

''(B) payment for such services during the stay shall not be made under section 1886(d) or by any succeeding Medicare Choice organization, and

''(C) the terminated organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

''PREMIUMS

''SEC. 1854. (a) SUBMISSION AND CHARGING OF PREMIUMS.—

''(1) IN GENERAL.—Subject to paragraph (3), each Medicare Choice organization shall file with the Secretary each year, in a form and manner and at a time specified by the Secretary—

''(A) the amount of the monthly premium for coverage for services under section 1852(a) under each Medicare Choice plan it offers under this part in each Medicare Choice payment area (as defined in section 1853(d)) in which the plan is being offered; and

''(B) the enrollment capacity in relation to the plan in each such area.

''(2) TERMINOLOGY.—In this part—

''(A) the term 'monthly premium' means, with respect to a Medicare Choice plan offered by a Medicare Choice organization, the monthly premium filed under paragraph (1), not taking into account the amount of any payment made toward the premium under section 1853; and

''(B) the term 'net monthly premium' means, with respect to such a plan and an individual enrolled with the plan, the premium (as defined in subparagraph (A)) for the plan reduced by the amount of payment made toward such premium under section 1853.

''(b) MONTHLY PREMIUM CHARGED.—The monthly amount of the premium charged by a Medicare Choice organization for a Medicare Choice plan offered in a Medicare Choice payment area to an individual under this part shall be equal to the net monthly premium plus any monthly premium charged in accordance with subsection (e)(2) for supplemental benefits.

''(c) UNIFORM PREMIUM.—The monthly premium and monthly amount charged under subsection (b) of a Medicare Choice organization under this part may not vary among individuals who reside in the same Medicare Choice payment area.

''(d) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each Medicare Choice organization shall permit the payment of net monthly premiums on a monthly basis and may terminate election of individuals for a Medicare Choice plan for failure to make premium payments only in accordance with section 1851(g)(3)(B)(i). A Medicare Choice organization is not authorized to provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

''(e) LIMITATION ON ENROLLEE COST-SHARING.—

''(1) FOR BASIC AND ADDITIONAL BENEFITS.—Except as provided in paragraph (2), in no event may—

''(A) the net monthly premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with a Medicare Choice plan of an organization with respect to required benefits described in section 1852(a)(1) and additional benefits (if any) required under subsection (f)(1) for a year, exceed

''(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a Medicare Choice organization for the year.

''(2) FOR SUPPLEMENTAL BENEFITS.—If the Medicare Choice organization provides to its members enrolled under this part supplemental benefits described in section 1852(a)(3), the sum of the monthly premium rate (multiplied by 12) charged for such supplemental benefits and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits may not exceed the adjusted community rate for such benefits (as defined in subsection (f)(4)).

''(3) EXCEPTION FOR MSA PLANS AND UNRESTRICTED FEE-FOR-SERVICE PLANS.—Paragraphs (1) and (2) do not apply to an MSA plan or an unrestricted fee-for-service plan.

''(4) DETERMINATION ON OTHER BASIS.—If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A) or (2), the Secretary may determine such amount with respect to all individuals in the Medicare Choice payment area, the State, or in the United States, eligible to enroll in the Medicare Choice plan involved under this part or on the basis of other appropriate data.

''(f) REQUIREMENT FOR ADDITIONAL BENEFITS.—

''(1) REQUIREMENT.—

''(A) IN GENERAL.—Each Medicare Choice organization (in relation to a Medicare Choice plan it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits (as the organization may specify) in a value which is at least equal to the adjusted excess amount (as defined in subparagraph (C)).

''(B) EXCESS AMOUNT.—For purposes of this paragraph, the 'excess amount', for an organization for a plan, is the amount (if any) by which—

''(i) the average of the capitation payments made to the organization under section 1853 for the plan at the beginning of contract year, exceeds

''(ii) the actuarial value of the required benefits described in section 1852(a)(1) under the plan for individuals under this part, as determined based upon an adjusted community rate described in paragraph (4) (as reduced for the actuarial value of the coinsurance and deductibles under parts A and B).

''(C) ADJUSTED EXCESS AMOUNT.—For purposes of this paragraph, the 'adjusted excess amount', for an organization for a plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (3).

''(D) NO APPLICATION TO MSA PLANS.—Subparagraph (A) shall not apply to an MSA plan.

''(E) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a plan in a Medicare Choice payment area.

''(F) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a Medicare Choice organization from providing health care benefits that are in addition to the benefits otherwise required to be provided under this paragraph and from imposing a premium for such additional benefits.

''(2) STABILIZATION FUND.—A Medicare Choice organization may provide that a part of the

value of an excess amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the Medicare Choice plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

''(3) DETERMINATION BASED ON INSUFFICIENT DATA.—For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience to determine an average of the capitation payments to be made under this part at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part.

''(4) ADJUSTED COMMUNITY RATE.—

''(A) IN GENERAL.—For purposes of this subsection, subject to subparagraph (B), the term 'adjusted community rate' for a service or services means, at the election of a Medicare Choice organization, either—

''(i) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a Medicare Choice plan under this part if the rate of payment were determined under a 'community rating system' (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)), or

''(ii) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to such an individual, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the plan (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals selecting other Medicare Choice coverage, or Medicare Choice eligible individuals in the area, in the State, or in the United States, eligible to elect Medicare Choice coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

''(B) SPECIAL RULE FOR PROVIDER-SPONSORED ORGANIZATIONS.—In the case of a Medicare Choice organization that is a provider-sponsored organization, the adjusted community rate under subparagraph (A) for a Medicare Choice plan of the organization may be computed (in a manner specified by the Secretary) using data in the general commercial marketplace or (during a transition period) based on the costs incurred by the organization in providing such a plan.

''(g) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of the financial records (including data relating to medicare utilization, costs, and computation of the adjusted community rate) of at least one-third of the Medicare Choice organizations offering Medicare Choice plans under this part. The Comptroller General shall monitor auditing activities conducted under this subsection.

''(h) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to payments on Medicare Choice plans or the offering of such plans.

''ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR MEDICARE CHOICE ORGANIZATIONS; PROVIDER-SPONSORED ORGANIZATIONS

''SEC. 1855. (a) ORGANIZED AND LICENSED UNDER STATE LAW.—

''(1) IN GENERAL.—Subject to paragraphs (2) and (3), a Medicare Choice organization shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a Medicare Choice plan.

''(2) SPECIAL EXCEPTION BEFORE 2001 FOR PROVIDER-SPONSORED ORGANIZATIONS.—

''(A) IN GENERAL.—In the case of a provider-sponsored organization that seeks to offer a Medicare Choice plan in a State, the Secretary shall waive the requirement of paragraph (1) that the organization be licensed in that State for any year before 2001 if—

''(i) the organization files an application for such waiver with the Secretary, and

''(ii) the contract with the organization under section 1857 requires the organization to meet all requirements of State law which relate to the licensing of the organization (other than solvency requirements or a prohibition on licensure for such organization).

''(B) TREATMENT OF WAIVER.—

''(i) IN GENERAL.—In the case of a waiver granted under this paragraph for a provider-sponsored organization—

''(I) the waiver shall be effective for the years specified in the waiver, except it may be renewed based on a subsequent application, and

''(II) subject to subparagraph (A)(ii), any provisions of State law which would otherwise prohibit the organization from providing coverage pursuant to a contract under this part shall be superseded.

''(ii) TERMINATION.—A waiver granted under this paragraph shall in no event extend beyond the earlier of—

''(I) December 31, 2000; or

''(II) the date on which the Secretary determines that the State has in effect solvency standards identical to the standards established under section 1856(a).

''(C) PROMPT ACTION ON APPLICATION.—The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete application has been filed.

''(D) ENFORCEMENT OF STATE STANDARDS.—

''(i) IN GENERAL.—The Secretary shall enter into agreements with States subject to a waiver under this paragraph to ensure the adequate enforcement of standards incorporated into the contract under subparagraph (A)(ii). Such agreements shall provide methods by which States may notify the Secretary of any failure by an organization to comply with such standards.

''(ii) ENFORCEMENT.—If the Secretary determines that an organization is not in compliance with the standards described in clause (i), the Secretary shall take appropriate actions under subsections (g) and (h) with respect to civil penalties and termination of the contract. The Secretary shall allow an organization 60 days to comply with the standards after notification of failure.

''(E) REPORT.—The Secretary shall, not later than December 31, 1998, report to Congress on the waiver procedure in effect under this paragraph. Such report shall include an analysis of State efforts to adopt regulatory standards that take into account health plan sponsors that provide services directly to enrollees through affiliated providers.

''(3) EXCEPTION IF REQUIRED TO OFFER MORE THAN MEDICARE CHOICE PLANS.—Paragraph (1) shall not apply to a Medicare Choice organization in a State if the State requires the organization, as a condition of licensure, to offer any product or plan other than a Medicare Choice plan.

''(4) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an organization is licensed in accordance with paragraph (1) does not deem the organization to meet other requirements imposed under this part.

''(b) PREPAID PAYMENT.—A Medicare Choice organization shall be compensated (except for premiums, deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members under the contract under this part by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

''(c) ASSUMPTION OF FULL FINANCIAL RISK.—The Medicare Choice organization shall assume full financial risk on a prospective basis for the provision of the health care services (except, at the election of the organization, hospice care) for which benefits are required to be provided under section 1852(a)(1), except that the organization—

''(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which for any year exceeds the applicable amount determined under the last sentence of this subsection for the year,

''(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization,

''(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

''(4) may make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

For purposes of paragraph (1), the applicable amount for 1998 is the amount established by the Secretary, and for 1999 and any succeeding year is the amount in effect for the previous year increased by the percentage change in the Consumer Price Index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

''(d) CERTIFICATION OF PROVISION AGAINST RISK OF INSOLVENCY FOR PSOS.—

''(1) IN GENERAL.—Each Medicare Choice organization that is a provider-sponsored organization with a waiver in effect under subsection (a)(2) shall meet the standards established under section 1856(a) with respect to the financial solvency and capital adequacy of the organization.

''(2) CERTIFICATION PROCESS FOR SOLVENCY STANDARDS FOR PSOS.—The Secretary shall establish a process for the receipt and approval of applications of a provider-sponsored organization for certification (and periodic recertification) of the organization as meeting such solvency standards. Under such process, the Secretary shall act upon such an application not later than 60 days after the date the application has been received.

''(e) PROVIDER-SPONSORED ORGANIZATION DEFINED.—

''(1) IN GENERAL.—In this part, the term 'provider-sponsored organization' means a public or private entity—

''(A) that is established or organized and operated by a local health care provider, or local group of affiliated health care providers,

''(B) that provides a substantial proportion (as defined by the Secretary in accordance with paragraph (2)) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers, and

''(C) with respect to which those affiliated providers that share, directly or indirectly, substantial financial risk with respect to the provision of such items and services have at least a majority financial interest in the entity.

''(2) SUBSTANTIAL PROPORTION.—In defining what is a 'substantial proportion' for purposes of paragraph (1)(B), the Secretary—

''(A) shall take into account the need for such an organization to assume responsibility for providing—

''(i) significantly more than the majority of the items and services under the contract under this section through its own affiliated providers; and

''(ii) most of the remainder of the items and services under the contract through providers with which the organization has an agreement to provide such items and services,

in order to assure financial stability and to address the practical considerations involved in integrating the delivery of a wide range of service providers;

''(B) shall take into account the need for such an organization to provide a limited proportion of the items and services under the contract through providers that are neither affiliated with nor have an agreement with the organization; and

''(C) may allow for variation in the definition of substantial proportion among such organizations based on relevant differences among the organizations, such as their location in an urban or rural area.

''(3) AFFILIATION.—For purposes of this subsection, a provider is 'affiliated' with another provider if, through contract, ownership, or otherwise—

''(A) one provider, directly or indirectly, controls, is controlled by, or is under common control with the other,

''(B) both providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986,

''(C) each provider is a participant in a lawful combination under which each provider shares substantial financial risk in connection with the organization's operations, or

''(D) both providers are part of an affiliated service group under section 414 of such Code.

''(4) CONTROL.—For purposes of paragraph (3), control is presumed to exist if one party, directly or indirectly, owns, controls, or holds the power to vote, or proxies for, not less than 51 percent of the voting rights or governance rights of another.

''(5) HEALTH CARE PROVIDER DEFINED.—In this subsection, the term 'health care provider' means—

''(A) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, and

''(B) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

''(6) REGULATIONS.—The Secretary shall issue regulations to carry out this subsection.

''ESTABLISHMENT OF STANDARDS

''SEC. 1856. (a) ESTABLISHMENT OF SOLVENCY STANDARDS FOR PROVIDER-SPONSORED ORGANIZATIONS.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code, standards described in section 1855(d)(1) (relating to the financial solvency and capital adequacy of the organization) that entities must meet to qualify as provider-sponsored organizations under this part.

''(B) FACTORS TO CONSIDER FOR SOLVENCY STANDARDS.—In establishing solvency standards under subparagraph (A) for provider-sponsored organizations, the Secretary shall consult with interested parties and shall take into account—

''(i) the delivery system assets of such an organization and ability of such an organization to provide services directly to enrollees through affiliated providers,

''(ii) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care, and

''(iii) any standards developed by the National Association of Insurance Commissioners specifically for risk-based health care delivery organizations.

''(C) ENROLLEE PROTECTION AGAINST INSOLVENCY.—Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the Medicare Choice organization's debts in the event of the organization's insolvency.

''(2) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this subsection, the Secretary, after consultation with the National Association of Insurance Commissioners, the American Academy of Actuaries, organizations representative of medicare beneficiaries, and other interested parties, shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this section.

''(3) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under paragraph (2), and for purposes of this subsection, the 'target date for publication' (referred to in section 564(a)(5) of such title) shall be April 1, 1998.

''(4) ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.—In applying section 564(c) of such title under this subsection, '15 days' shall be substituted for '30 days'.

''(5) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

''(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

''(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

''(6) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than January 1, 1998, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before 1 month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

''(7) FINAL COMMITTEE REPORT.—If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than 1 month before the target date of publication.

''(8) INTERIM, FINAL EFFECT.—The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target date of publication. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

''(9) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target date of publication.

''(b) ESTABLISHMENT OF OTHER STANDARDS.—

''(1) IN GENERAL.—The Secretary shall establish by regulation other standards (not described in subsection (a)) for Medicare Choice organizations and plans consistent with, and to carry out, this part.

''(2) USE OF CURRENT STANDARDS.—Consistent with the requirements of this part, standards established under this subsection shall be based on standards established under section 1876 to carry out analogous provisions of such section.

''(3) USE OF INTERIM STANDARDS.—For the period in which this part is in effect and standards are being developed and established under the preceding provisions of this subsection, the Secretary shall provide by not later than June 1, 1998, for the application of such interim standards (without regard to any requirements for notice and public comment) as may be appropriate to provide for the expedited implementation of this part. Such interim standards shall not apply after the date standards are established under the preceding provisions of this subsection.

''(4) APPLICATION OF NEW STANDARDS TO ENTITIES WITH A CONTRACT.—In the case of a Medicare Choice organization with a contract in effect under this part at the time standards applicable to the organization under this section are changed, the organization may elect not to have such changes apply to the organization until the end of the current contract year (or, if there is less than 6 months remaining in the contract year, until 1 year after the end of the current contract year).

''(5) RELATION TO STATE LAWS.—The standards established under this subsection shall supersede any State law or regulation with respect to Medicare Choice plans which are offered by Medicare Choice organizations under this part to the extent such law or regulation is inconsistent with such standards.

''CONTRACTS WITH MEDICARE CHOICE ORGANIZATIONS

''SEC. 1857. (a) IN GENERAL.—The Secretary shall not permit the election under section 1851 of a Medicare Choice plan offered by a Medicare Choice organization under this part, and no payment shall be made under section 1853 to an organization, unless the Secretary has entered into a contract under this section with the organization with respect to the offering of such plan. Such a contract with an organization may cover more than 1 Medicare Choice plan. Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

''(b) MINIMUM ENROLLMENT REQUIREMENTS.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary may not enter into a contract under this section with a Medicare Choice organization unless the organization has at least 1,500 individuals who are receiving health benefits through the organization (500 such individuals if the organization primarily serves individuals residing outside of urbanized areas).

''(2) ALLOWING TRANSITION.—The Secretary may waive the requirement of paragraph (1) during the first 2 contract years with respect to an organization.

''(3) SPECIAL RULE FOR PSO.—In the case of a Medicare Choice organization which is a provider-sponsored organization, paragraph (1) shall be applied by taking into account individuals for whom the organization has assumed substantial financial risk.

''(c) CONTRACT PERIOD AND EFFECTIVENESS.—

''(1) PERIOD.—Each contract under this section shall be for a term of at least 1 year, as determined by the Secretary, and may be made

automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

''(2) TERMINATION AUTHORITY.—In accordance with procedures established under subsection (h), the Secretary may at any time terminate any such contract, or may impose the intermediate sanctions described in an applicable paragraph of subsection (g)(3) on the Medicare Choice organization, if the Secretary determines that the organization—

''(A) has failed substantially to carry out the contract;

''(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part; or

''(C) no longer substantially meets the applicable conditions of this part.

''(3) EFFECTIVE DATE OF CONTRACTS.—The effective date of any contract executed pursuant to this section shall be specified in the contract, except that in no case shall a contract under this section which provides for coverage under an MSA plan be effective before January 1999 with respect to such coverage.

''(4) PREVIOUS TERMINATIONS.—The Secretary may not enter into a contract with a Medicare Choice organization if a previous contract with that organization under this section was terminated at the request of the organization within the preceding 5-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

''(5) NO CONTRACTING AUTHORITY.—The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

''(d) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—

''(1) INSPECTION AND AUDIT.—Each contract under this section shall provide that the Secretary, or any person or organization designated by the Secretary—

''(A) shall have the right to inspect or otherwise evaluate (i) the quality, appropriateness, and timeliness of services performed under the contract and (ii) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

''(B) shall have the right to audit and inspect any books and records of the Medicare Choice organization that pertain (i) to the ability of the organization to bear the risk of potential financial losses, or (ii) to services performed or determinations of amounts payable under the contract.

''(2) ENROLLEE NOTICE AT TIME OF TERMINATION.—Each contract under this section shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled with the organization under this part.

''(3) DISCLOSURE.—

''(A) IN GENERAL.—Each Medicare Choice organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

''(i) Such information as the Secretary may require demonstrating that the organization has a fiscally sound operation.

''(ii) A copy of the report, if any, filed with the Health Care Financing Administration containing the information required to be reported under section 1124 by disclosing entities.

''(iii) A description of transactions, as specified by the Secretary, between the organization and a party in interest. Such transactions shall include—

''(I) any sale or exchange, or leasing of any property between the organization and a party in interest;

''(II) any furnishing for consideration of goods, services (including management services), or facilities between the organization and a party in interest, but not including salaries paid to employees for services provided in the normal course of their employment and health services provided to members by hospitals and other providers and by staff, medical group (or groups), individual practice association (or associations), or any combination thereof; and

''(III) any lending of money or other extension of credit between an organization and a party in interest.

The Secretary may require that information reported respecting an organization which controls, is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

''(B) PARTY IN INTEREST DEFINED.—For the purposes of this paragraph, the term 'party in interest' means—

''(i) any director, officer, partner, or employee responsible for management or administration of a Medicare Choice organization, any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 percent of the organization, and, in the case of a Medicare Choice organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

''(ii) any entity in which a person described in clause (i)—

''(I) is an officer or director;

''(II) is a partner (if such entity is organized as a partnership);

''(III) has directly or indirectly a beneficial interest of more than 5 percent of the equity; or

''(IV) has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of such entity;

''(iii) any person directly or indirectly controlling, controlled by, or under common control with an organization; and

''(iv) any spouse, child, or parent of an individual described in clause (i).

''(C) ACCESS TO INFORMATION.—Each Medicare Choice organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

''(4) LOAN INFORMATION.—The contract shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties.

''(e) ADDITIONAL CONTRACT TERMS.—

''(1) IN GENERAL.—The contract shall contain such other terms and conditions not inconsistent with this part (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

''(2) COST-SHARING IN ENROLLMENT-RELATED COSTS.—The contract with a Medicare Choice organization shall require the payment to the Secretary for the organization's pro rata share (as determined by the Secretary) of the estimated costs to be incurred by the Secretary in carrying out section 1851 (relating to enrollment and dissemination of information). Such payments are appropriated to defray the costs described in the preceding sentence, to remain available until expended.

''(3) NOTICE TO ENROLLEES IN CASE OF DECERTIFICATION.—If a contract with a Medicare Choice organization is terminated under this section, the organization shall notify each enrollee with the organization under this part of such termination.

''(f) PROMPT PAYMENT BY MEDICARE CHOICE ORGANIZATION.—

''(1) REQUIREMENT.—A contract under this part shall require a Medicare Choice organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to individuals pursuant to the contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

''(2) SECRETARY'S OPTION TO BYPASS NONCOMPLYING ORGANIZATION.—In the case of a Medicare Choice eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with paragraph (1), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for covered services and supplies furnished to individuals enrolled under this part under the contract. If the Secretary provides for the direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this part to reflect the amount of the Secretary's payments (and the Secretary's costs in making the payments).

''(g) INTERMEDIATE SANCTIONS.—

''(1) IN GENERAL.—If the Secretary determines that a Medicare Choice organization with a contract under this section—

''(A) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

''(B) imposes net monthly premiums on individuals enrolled under this part in excess of the net monthly premiums permitted;

''(C) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this part;

''(D) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this part) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

''(E) misrepresents or falsifies information that is furnished—

''(i) to the Secretary under this part, or

''(ii) to an individual or to any other entity under this part;

''(F) fails to comply with the requirements of section 1852(j)(3); or

''(G) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services;

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2).

''(2) REMEDIES.—The remedies described in this paragraph are—

''(A) civil money penalties of not more than $25,000 for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than $100,000 for each such determination, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), $15,000 for each individual not enrolled as a result of the practice involved,

''(B) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

''(C) suspension of payment to the organization under this part for individuals enrolled after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

''(3) OTHER INTERMEDIATE SANCTIONS.—In the case of a Medicare Choice organization for which the Secretary makes a determination under subsection (c)(2) the basis of which is not described in paragraph (1), the Secretary may apply the following intermediate sanctions:

''(A) Civil money penalties of not more than $25,000 for each determination under subsection (c)(2) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

''(B) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under subsection (g) during which the deficiency that is the basis of a determination under subsection (c)(2) exists.

''(C) Suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under subsection (c)(2) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

''(4) CIVIL MONEY PENALTIES.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subsection (f) or under paragraph (2) or (3) of this subsection in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

''(h) PROCEDURES FOR TERMINATION.—

''(1) IN GENERAL.—The Secretary may terminate a contract with a Medicare Choice organization under this section in accordance with formal investigation and compliance procedures established by the Secretary under which—

''(A) the Secretary provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under subsection (c)(2);

''(B) the Secretary shall impose more severe sanctions on an organization that has a history of deficiencies or that has not taken steps to correct deficiencies the Secretary has brought to the organization's attention;

''(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

''(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

''(2) EXCEPTION FOR IMMINENT AND SERIOUS RISK TO HEALTH.—Paragraph (1) shall not apply if the Secretary determines that a delay in termination, resulting from compliance with the procedures specified in such paragraph prior to termination, would pose an imminent and serious risk to the health of individuals enrolled under this part with the organization.

''DEFINITIONS; MISCELLANEOUS PROVISIONS

''SEC. 1859. (a) DEFINITIONS RELATING TO MEDICARE CHOICE ORGANIZATIONS.—In this part—

''(1) MEDICARE CHOICE ORGANIZATION.—The term 'Medicare Choice organization' means a public or private entity that is certified under section 1856 as meeting the requirements and standards of this part for such an organization.

''(2) PROVIDER-SPONSORED ORGANIZATION.—The term 'provider-sponsored organization' is defined in section 1855(e)(1).

''(b) DEFINITIONS RELATING TO MEDICARE CHOICE PLANS.—

''(1) MEDICARE CHOICE PLAN.—The term 'Medicare Choice plan' means health benefits coverage offered under a policy, contract, or plan by a Medicare Choice organization pursuant to and in accordance with a contract under section 1857.

''(2) MEDICARE CHOICE UNRESTRICTED FEE-FOR-SERVICE PLAN.—The term 'Medicare Choice unrestricted fee-for-service plan' means a Medicare Choice plan that provides for coverage of benefits without restrictions relating to utilization and without regard to whether the provider has a contract or other arrangement with the organization offering the plan for the provision of such benefits.

''(3) MSA PLAN.—

''(A) IN GENERAL.—The term 'MSA plan' means a Medicare Choice plan that—

''(i) provides reimbursement for at least the items and services described in section 1852(a)(1) in a year but only after the enrollee incurs countable expenses (as specified under the plan) equal to the amount of an annual deductible (described in subparagraph (B));

''(ii) counts as such expenses (for purposes of such deductible) at least all amounts that would have been payable under parts A and B, and that would have been payable by the enrollee as deductibles, coinsurance, or copayments, if the enrollee had elected to receive benefits through the provisions of such parts;

''(iii) subject to clause (iv), provides, after such deductible is met for a year and for all subsequent expenses for items and services referred to in clause (i) in the year, for a level of reimbursement that is not less than—

''(I) 100 percent of such expenses, or

''(II) 100 percent of the amounts that would have been paid (without regard to any deductibles or coinsurance) under parts A and B with respect to such expenses,

whichever is less; and

''(iv) provides that the annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed the amount in effect under section 220(c)(2)(A)(iii)(I) of the Internal Revenue Code of 1986 for the year.

''(B) DEDUCTIBLE.—The amount of annual deductible under an MSA plan shall not be less than or more than the amounts in excess under section 220(c)(2)(A)(i) of the Internal Revenue Code of 1986 for the year.

''(c) OTHER REFERENCES TO OTHER TERMS.—

''(1) MEDICARE CHOICE ELIGIBLE INDIVIDUAL.—The term 'Medicare Choice eligible individual' is defined in section 1851(a)(3).

''(2) MEDICARE CHOICE PAYMENT AREA.—The term 'Medicare Choice payment area' is defined in section 1853(d).

''(3) NATIONAL AVERAGE PER CAPITA GROWTH PERCENTAGE.—The 'national average per capita growth percentage' is defined in section 1853(c)(6).

''(4) MONTHLY PREMIUM; NET MONTHLY PREMIUM.—The terms 'monthly premium' and 'net monthly premium' are defined in section 1854(a)(2).

''(d) COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER A MEDICARE CHOICE PLAN.—Nothing in this part shall be construed as preventing a State from coordinating benefits under a medicaid plan under title XIX with those provided under a Medicare Choice plan in a manner that assures continuity of a full-range of acute care and long-term care services to poor elderly or disabled individuals eligible for benefits under this title and under such plan.

''(e) RESTRICTION ON ENROLLMENT FOR CERTAIN MEDICARE CHOICE PLANS.—

''(1) IN GENERAL.—In the case of a Medicare Choice religious fraternal benefit society plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the society offering the plan may restrict the enrollment of individuals under this part to individuals who are members of the church, convention, or group described in paragraph (3)(B) with which the society is affiliated.

''(2) MEDICARE CHOICE RELIGIOUS FRATERNAL BENEFIT SOCIETY PLAN DESCRIBED.—For purposes of this subsection, a Medicare Choice religious fraternal benefit society plan described in this paragraph is a Medicare Choice plan described in section 1851(a)(2)(A) that—

''(A) is offered by a religious fraternal benefit society described in paragraph (3) only to members of the church, convention, or group described in paragraph (3)(B); and

''(B) permits all such members to enroll under the plan without regard to health status-related factors.

Nothing in this subsection shall be construed as waiving any plan requirements relating to financial solvency. In developing solvency standards under section 1856, the Secretary shall take into account open contract and assessment features characteristic of fraternal insurance certificates.

''(3) RELIGIOUS FRATERNAL BENEFIT SOCIETY DEFINED.—For purposes of paragraph (2)(A), a 'religious fraternal benefit society' described in this section is an organization that—

''(A) is exempt from Federal income taxation under section 501(c)(8) of the Internal Revenue Code of 1986;

''(B) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches;

''(C) offers, in addition to a Medicare Choice religious fraternal benefit society plan, at least the same level of health coverage to individuals not entitled to benefits under this title who are members of such church, convention, or group; and

''(D) does not impose any limitation on membership in the society based on any health status-related factor.

''(4) PAYMENT ADJUSTMENT.—Under regulations of the Secretary, in the case of individuals enrolled under this part under a Medicare Choice religious fraternal benefit society plan described in paragraph (2), the Secretary shall provide for such adjustment to the payment amounts otherwise established under section 1854 as may be appropriate to assure an appropriate payment level, taking into account the actuarial characteristics and experience of such individuals.''.

SEC. 5002. TRANSITIONAL RULES FOR CURRENT MEDICARE HMO PROGRAM.

(a) AUTHORIZING TRANSITIONAL WAIVER OF 50:50 RULE.—Section 1876(f) (42 U.S.C. 1395mm(f)) is amended—

(1) in paragraph (1)—

(A) by striking ''Each'' and inserting ''For contract periods beginning before January 1, 1999, each''; and

(B) by striking ''or under a State plan approved under title XIX'';

(2) in paragraph (2), by striking ''The Secretary'' and inserting ''Subject to paragraph (4), the Secretary'', and

(3) by adding at the end the following:

''(4) The Secretary may waive the requirement imposed by paragraph (1) if the Secretary determines that the plan meets all other beneficiary protections and quality standards under this section.''.

(b) TRANSITION.—Section 1876 (42 U.S.C. 1395mm) is amended by adding at the end the following new subsection:

''(k)(1) Except as provided in paragraph (2) or (3), the Secretary shall not enter into, renew, or continue any risk-sharing contract under this section with an eligible organization for any contract year beginning on or after—

''(A) the date standards for Medicare Choice organizations and plans are first established under section 1856 with respect to Medicare Choice organizations that are insurers or health maintenance organizations, or

''(B) in the case of such an organization with such a contract in effect as of the date such standards were first established, 1 year after such date.

''(2) The Secretary shall not enter into, renew, or continue any risk-sharing contract under this section with an eligible organization for any contract year beginning on or after January 1, 2000.

''(3) An individual who is enrolled in part B only and is enrolled in an eligible organization with a risk-sharing contract under this section on December 31, 1998, may continue enrollment in such organization in accordance with regulations issued by not later than July 1, 1998.

''(4) Notwithstanding subsection (a), the Secretary shall provide that payment amounts under risk-sharing contracts under this section for months in a year (beginning with January 1998) shall be computed—

''(A) with respect to individuals entitled to benefits under both parts A and B, by substituting payment rates under section 1853(a) for the payment rates otherwise established under section 1876(a), and

''(B) with respect to individuals only entitled to benefits under part B, by substituting an appropriate proportion of such rates (reflecting the relative proportion of payments under this title attributable to such part) for the payment rates otherwise established under subsection (a).

For purposes of carrying out this paragraph for payments for months in 1998, the Secretary shall compute, announce, and apply the payment rates under section 1853(a) (notwithstanding any deadlines specified in such section) in as timely a manner as possible and may (to the extent necessary) provide for retroactive adjustment in payments made under this section not in accordance with such rates.''.

(c) ENROLLMENT TRANSITION RULE.—An individual who is enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm) shall be considered to be enrolled with that organization on January 1, 1999, under part C of title XVIII of such Act if that organization has a contract under that part for providing services on January 1, 1999 (unless the individual has disenrolled effective on that date).

(d) ADVANCE DIRECTIVES.—Section 1866(f) (42 U.S.C. 1395cc(f)) is amended—

(1) in paragraph (1)—

(A) by inserting ''1855(i),'' after ''1833(s),'', and

(B) by inserting '', Medicare Choice organization,'' after ''provider of services''; and

(2) in paragraph (2)(E), by inserting ''or a Medicare Choice organization'' after ''section 1833(a)(1)(A)''.

(e) EXTENSION OF PROVIDER REQUIREMENT.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended—

(1) by striking ''in the case of hospitals and skilled nursing facilities,'';

(2) by striking ''inpatient hospital and extended care'';

(3) by inserting ''with a Medicare Choice organization under part C or'' after ''any individual enrolled''; and

(4) by striking ''(in the case of hospitals) or limits (in the case of skilled nursing facilities)''.

(f) ADDITIONAL CONFORMING CHANGES.—

(1) CONFORMING REFERENCES TO PREVIOUS PART C.—Any reference in law (in effect before the date of the enactment of this Act) to part C of title XVIII of the Social Security Act is deemed a reference to part D of such title (as in effect after such date).

(2) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this chapter.

(g) IMMEDIATE EFFECTIVE DATE FOR CERTAIN REQUIREMENTS FOR DEMONSTRATIONS.—Section 1857(e)(2) of the Social Security Act (requiring contribution to certain costs related to the enrollment process comparative materials) applies to demonstrations with respect to which enrollment is effected or coordinated under section 1851 of such Act.

(h) USE OF INTERIM, FINAL REGULATIONS.—In order to carry out the amendments made by this chapter in a timely manner, the Secretary of Health and Human Services may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

(i) TRANSITION RULE FOR PSO ENROLLMENT.—In applying subsection (g)(1) of section 1876 of the Social Security Act (42 U.S.C. 1395mm) to a risk-sharing contract entered into with an eligible organization that is a provider-sponsored organization (as defined in section 1855(e)(1) of such Act, as inserted by section 5001) for a contract year beginning on or after January 1, 1998, there shall be substituted for the minimum number of enrollees provided under such section the minimum number of enrollees permitted under section 1857(b)(1) of such Act (as so inserted).

SEC. 5003. CONFORMING CHANGES IN MEDIGAP PROGRAM.

(a) CONFORMING AMENDMENTS TO MEDICARE CHOICE CHANGES.—

(1) IN GENERAL.—Section 1882(d)(3)(A)(i) (42 U.S.C. 1395ss(d)(3)(A)(i)) is amended—

(A) in the matter before subclause (I), by inserting ''(including an individual electing a Medicare Choice plan under section 1851)'' after ''of this title''; and

(B) in subclause (II)—

(i) by inserting ''in the case of an individual not electing a Medicare Choice plan'' after ''(II)'', and

(ii) by inserting before the comma at the end the following: ''or in the case of an individual electing a Medicare Choice plan, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under the Medicare Choice plan or under another medicare supplemental policy''.

(2) CONFORMING AMENDMENTS.—Section 1882(d)(3)(B)(i)(I) (42 U.S.C. 1395ss(d)(3)(B)(i)(I)) is amended by inserting ''(including any Medicare Choice plan)'' after ''health insurance policies''.

(3) MEDICARE CHOICE PLANS NOT TREATED AS MEDICARE SUPPLEMENTARY POLICIES.—Section 1882(g)(1) (42 U.S.C. 1395ss(g)(1)) is amended by inserting ''or a Medicare Choice plan or'' after ''does not include''.

(b) ADDITIONAL RULES RELATING TO INDIVIDUALS ENROLLED IN MSA PLANS.—Section 1882 (42 U.S.C. 1395ss) is further amended by adding at the end the following new subsection:

''(u)(1) It is unlawful for a person to sell or issue a policy described in paragraph (2) to an individual with knowledge that the individual has in effect under section 1851 an election of an MSA plan.

''(2) A policy described in this subparagraph is a health insurance policy that provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the MSA plan.''.

Subchapter B—Special Rules for Medicare Choice Medical Savings Accounts

SEC. 5006. MEDICARE CHOICE MSA.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to amounts specifically excluded from gross income) is amended by redesignating section 138 as section 139 and by inserting after section 137 the following new section:

''SEC. 138. MEDICARE CHOICE MSA.

''(a) EXCLUSION.—Gross income shall not include any payment to the Medicare Choice MSA of an individual by the Secretary of Health and Human Services under part C of title XVIII of the Social Security Act.

''(b) MEDICARE CHOICE MSA.—For purposes of this section, the term 'Medicare Choice MSA' means a medical savings account (as defined in section 220(d))—

''(1) which is designated as a Medicare Choice MSA,

''(2) with respect to which no contribution may be made other than—

''(A) a contribution made by the Secretary of Health and Human Services pursuant to part C of title XVIII of the Social Security Act, or

''(B) a trustee-to-trustee transfer described in subsection (c)(4),

''(3) the governing instrument of which provides that trustee-to-trustee transfers described in subsection (c)(4) may be made to and from such account, and

''(4) which is established in connection with an MSA plan described in section 1859(b)(3) of the Social Security Act.

''(c) SPECIAL RULES FOR DISTRIBUTIONS.—

''(1) DISTRIBUTIONS FOR QUALIFIED MEDICAL EXPENSES.—In applying section 220 to a Medicare Choice MSA—

''(A) qualified medical expenses shall not include amounts paid for medical care for any individual other than the account holder, and

''(B) section 220(d)(2)(C) shall not apply.

''(2) PENALTY FOR DISTRIBUTIONS FROM MEDICARE CHOICE MSA NOT USED FOR QUALIFIED MEDICAL EXPENSES IF MINIMUM BALANCE NOT MAINTAINED.—

''(A) IN GENERAL.—The tax imposed by this chapter for any taxable year in which there is a payment or distribution from a Medicare Choice MSA which is not used exclusively to pay the qualified medical expenses of the account holder shall be increased by 50 percent of the excess (if any) of—

''(i) the amount of such payment or distribution, over

''(ii) the excess (if any) of—

''(I) the fair market value of the assets in such MSA as of the close of the calendar year preceding the calendar year in which the taxable year begins, over

''(II) an amount equal to 60 percent of the deductible under the Medicare Choice MSA plan covering the account holder as of January 1 of the calendar year in which the taxable year begins.

Section 220(f)(2) shall not apply to any payment or distribution from a Medicare Choice MSA.

''(B) EXCEPTIONS.—Subparagraph (A) shall not apply if the payment or distribution is made on or after the date the account holder—

''(i) becomes disabled within the meaning of section 72(m)(7), or

''(ii) dies.

''(C) SPECIAL RULES.—For purposes of subparagraph (A)—

''(i) all Medicare Choice MSAs of the account holder shall be treated as 1 account,

''(ii) all payments and distributions not used exclusively to pay the qualified medical expenses of the account holder during any taxable year shall be treated as 1 distribution, and

''(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

''(3) WITHDRAWAL OF ERRONEOUS CONTRIBUTIONS.—Section 220(f)(2) and paragraph (2) of this subsection shall not apply to any payment or distribution from a Medicare Choice MSA to the Secretary of Health and Human Services of an erroneous contribution to such MSA and of the net income attributable to such contribution.

''(4) TRUSTEE-TO-TRUSTEE TRANSFERS.—Section 220(f)(2) and paragraph (2) of this subsection shall not apply to any trustee-to-trustee transfer from a Medicare Choice MSA of an account holder to another Medicare Choice MSA of such account holder.

''(d) SPECIAL RULES FOR TREATMENT OF ACCOUNT AFTER DEATH OF ACCOUNT HOLDER.—In applying section 220(f)(8)(A) to an account which was a Medicare Choice MSA of a decedent, the rules of section 220(f) shall apply in lieu of the rules of subsection (c) of this section with respect to the spouse as the account holder of such Medicare Choice MSA.

''(e) REPORTS.—In the case of a Medicare Choice MSA, the report under section 220(h)—

''(1) shall include the fair market value of the assets in such Medicare Choice MSA as of the close of each calendar year, and

''(2) shall be furnished to the account holder—

''(A) not later than January 31 of the calendar year following the calendar year to which such reports relate, and

''(B) in such manner as the Secretary prescribes in such regulations.

''(f) COORDINATION WITH LIMITATION ON NUMBER OF TAXPAYERS HAVING MEDICAL SAVINGS ACCOUNTS.—Subsection (i) of section 220 shall not apply to an individual with respect to a Medicare Choice MSA, and Medicare Choice MSA's shall not be taken into account in determining whether the numerical limitations under section 220(j) are exceeded.''.

(b) TECHNICAL AMENDMENTS.—

(1) The last sentence of section 4973(d) of such Code is amended by inserting ''or section 138(c)(3)'' after ''section 220(f)(3)''.

(2) Subsection (b) of section 220 of such Code is amended by adding at the end the following new paragraph:

''(7) MEDICARE ELIGIBLE INDIVIDUALS.—The limitation under this subsection for any month with respect to an individual shall be zero for the first month such individual is entitled to benefits under title XVIII of the Social Security Act and for each month thereafter.''.

(3) The table of sections for part III of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

''Sec. 138. Medicare Choice MSA.

''Sec. 139. Cross references to other Acts.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1998.

CHAPTER 2—INTEGRATED LONG-TERM CARE PROGRAMS

Subchapter A—Programs of All-Inclusive Care for the Elderly (PACE)

SEC. 5011. COVERAGE OF PACE UNDER THE MEDICARE PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''PAYMENTS TO, AND COVERAGE OF BENEFITS UNDER, PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

''SEC. 1894. (a) RECEIPT OF BENEFITS THROUGH ENROLLMENT IN PACE PROGRAM; DEFINITIONS FOR PACE PROGRAM RELATED TERMS.—

''(1) BENEFITS THROUGH ENROLLMENT IN A PACE PROGRAM.—In accordance with this section, in the case of an individual who is entitled to benefits under part A or enrolled under part B and who is a PACE program eligible individual (as defined in paragraph (5)) with respect to a PACE program offered by a PACE provider under a PACE program agreement—

''(A) the individual may enroll in the program under this section; and

''(B) so long as the individual is so enrolled and in accordance with regulations—

''(i) the individual shall receive benefits under this title solely through such program; and

''(ii) the PACE provider is entitled to payment under and in accordance with this section and such agreement for provision of such benefits.

''(2) PACE PROGRAM DEFINED.—For purposes of this section and section 1932, the term 'PACE program' means a program of all-inclusive care for the elderly that meets the following requirements:

''(A) OPERATION.—The entity operating the program is a PACE provider (as defined in paragraph (3)).

''(B) COMPREHENSIVE BENEFITS.—The program provides comprehensive health care services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

''(C) TRANSITION.—In the case of an individual who is enrolled under the program under this section and whose enrollment ceases for any reason (including that the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or otherwise), the program provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.

''(3) PACE PROVIDER DEFINED.—

''(A) IN GENERAL.—For purposes of this section, the term 'PACE provider' means an entity that—

''(i) subject to subparagraph (B), is (or is a distinct part of) a public entity or a private, nonprofit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986; and

''(ii) has entered into a PACE program agreement with respect to its operation of a PACE program.

''(B) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.—Clause (i) of subparagraph (A) shall not apply—

''(i) to entities subject to a demonstration project waiver under subsection (h); and

''(ii) after the date the report under section 5013(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C), or (D) of paragraph (2) of such section are true.

''(4) PACE PROGRAM AGREEMENT DEFINED.—For purposes of this section, the term 'PACE program agreement' means, with respect to a PACE provider, an agreement, consistent with this section, section 1932 (if applicable), and regulations promulgated to carry out such sections, between the PACE provider and the Secretary, or an agreement between the PACE provider and a State administering agency for the operation of a PACE program by the provider under such sections.

''(5) PACE PROGRAM ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term 'PACE program eligible individual' means, with respect to a PACE program, an individual who—

''(A) is 55 years of age or older;

''(B) subject to subsection (c)(4), is determined under subsection (c) to require the level of care required under the State medicaid plan for coverage of nursing facility services;

''(C) resides in the service area of the PACE program; and

''(D) meets such other eligibility conditions as may be imposed under the PACE program agreement for the program under subsection (e)(2)(A)(ii).

''(6) PACE PROTOCOL.—For purposes of this section, the term 'PACE protocol' means the Protocol for the Program of All-inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995, or any successor protocol that may be agreed upon between the Secretary and On Lok, Inc.

''(7) PACE DEMONSTRATION WAIVER PROGRAM DEFINED.—For purposes of this section, the term 'PACE demonstration waiver program' means a demonstration program under either of the following sections (as in effect before the date of their repeal):

''(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21), as extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

''(B) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

''(8) STATE ADMINISTERING AGENCY DEFINED.—For purposes of this section, the term 'State administering agency' means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under title XIX in the State) responsible for administering PACE program agreements under this section and section 1932 in the State.

''(9) TRIAL PERIOD DEFINED.—

''(A) IN GENERAL.—For purposes of this section, the term 'trial period' means, with respect to a PACE program operated by a PACE provider under a PACE program agreement, the first 3 contract years under such agreement with respect to such program.

''(B) TREATMENT OF ENTITIES PREVIOUSLY OPERATING PACE DEMONSTRATION WAIVER PROGRAMS.—Each contract year (including a year occurring before the effective date of this section) during which an entity has operated a PACE demonstration waiver program shall be counted under subparagraph (A) as a contract year during which the entity operated a PACE program as a PACE provider under a PACE program agreement.

''(10) REGULATIONS.—For purposes of this section, the term 'regulations' refers to interim final or final regulations promulgated under subsection (f) to carry out this section and section 1932.

''(b) SCOPE OF BENEFITS; BENEFICIARY SAFEGUARDS.—

''(1) IN GENERAL.—Under a PACE program agreement, a PACE provider shall—

''(A) provide to PACE program eligible individuals, regardless of source of payment and directly or under contracts with other entities, at a minimum—

''(i) all items and services covered under this title (for individuals enrolled under this section) and all items and services covered under title XIX, but without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost-sharing that would otherwise apply under this title or such title, respectively; and

''(ii) all additional items and services specified in regulations, based upon those required under the PACE protocol;

''(B) provide such enrollees access to necessary covered items and services 24 hours per day, every day of the year;

''(C) provide services to such enrollees through a comprehensive, multidisciplinary health and social services delivery system which integrates acute and long-term care services pursuant to regulations; and

''(D) specify the covered items and services that will not be provided directly by the entity, and to arrange for delivery of those items and services through contracts meeting the requirements of regulations.

''(2) QUALITY ASSURANCE; PATIENT SAFEGUARDS.—The PACE program agreement shall require the PACE provider to have in effect at a minimum—

''(A) a written plan of quality assurance and improvement, and procedures implementing such plan, in accordance with regulations; and

''(B) written safeguards of the rights of enrolled participants (including a patient bill of rights and procedures for grievances and appeals) in accordance with regulations and with other requirements of this title and Federal and State law that are designed for the protection of patients.

''(c) ELIGIBILITY DETERMINATIONS.—

''(1) IN GENERAL.—The determination of whether an individual is a PACE program eligible individual—

''(A) shall be made under and in accordance with the PACE program agreement; and

''(B) who is entitled to medical assistance under title XIX, shall be made (or who is not so entitled, may be made) by the State administering agency.

''(2) CONDITION.—An individual is not a PACE program eligible individual (with respect to payment under this section) unless the individual's health status has been determined by the Secretary or the State administering agency, in accordance with regulations, to be comparable to the health status of individuals who

have participated in the PACE demonstration waiver programs. Such determination shall be based upon information on health status and related indicators (such as medical diagnoses and measures of activities of daily living, instrumental activities of daily living, and cognitive impairment) that are part of a uniform minimum data set collected by PACE providers on potential eligible individuals.

''(3) ANNUAL ELIGIBILITY RECERTIFICATIONS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the determination described in subsection (a)(5)(B) for an individual shall be reevaluated at least annually.

''(B) EXCEPTION.—The requirement of annual reevaluation under subparagraph (A) may be waived during a period in accordance with regulations in those cases where the State administering agency determines that there is no reasonable expectation of improvement or significant change in an individual's condition during the period because of the advanced age, severity of the advanced age, severity of chronic condition, or degree of impairment of functional capacity of the individual involved.

''(4) CONTINUATION OF ELIGIBILITY.—An individual who is a PACE program eligible individual may be deemed to continue to be such an individual notwithstanding a determination that the individual no longer meets the requirement of subsection (a)(5)(B) if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6-month period.

''(5) ENROLLMENT; DISENROLLMENT.—The enrollment and disenrollment of PACE program eligible individuals in a PACE program shall be pursuant to regulations and the PACE program agreement and shall permit enrollees to voluntarily disenroll without cause at any time. Such regulations and agreement shall provide that the PACE program may not disenroll a PACE program eligible individual on the ground that the individual has engaged in noncompliant behavior if such behavior is related to a mental or physical condition of the individual. For purposes of the preceding sentence, the term 'noncompliant behavior' includes repeated noncompliance with medical advice and repeated failure to appear for appointments.

''(d) PAYMENTS TO PACE PROVIDERS ON A CAPITATED BASIS.—

''(1) IN GENERAL.—In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the Secretary shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section in the same manner and from the same sources as payments are made to an eligible organization under a risk-sharing contract under section 1876. Such payments shall be subject to adjustment in the manner described in section 1876(a)(1)(E).

''(2) CAPITATION AMOUNT.—The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be based upon payment rates established under section 1876 for risk-sharing contracts and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. Such amount under such an agreement shall be computed in a manner so that the total payment level for all PACE program eligible individuals enrolled under a program is less than the projected payment under this title for a comparable population not enrolled under a PACE program.

''(e) PACE PROGRAM AGREEMENT.—

''(1) REQUIREMENT.—

''(A) IN GENERAL.—The Secretary, in close cooperation with the State administering agency, shall establish procedures for entering into, extending, and terminating PACE program agreements for the operation of PACE programs by entities that meet the requirements for a PACE provider under this section, section 1932, and regulations.

''(B) NUMERICAL LIMITATION.—

''(i) IN GENERAL.—The Secretary shall not permit the number of PACE providers with which agreements are in effect under this section or under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 to exceed—

''(I) 40 as of the date of the enactment of this section; or

''(II) as of each succeeding anniversary of such date, the numerical limitation under this subparagraph for the preceding year plus 20.

Subclause (II) shall apply without regard to the actual number of agreements in effect as of a previous anniversary date.

''(ii) TREATMENT OF CERTAIN PRIVATE, FOR-PROFIT PROVIDERS.—The numerical limitation in clause (i) shall not apply to a PACE provider that—

''(I) is operating under a demonstration project waiver under subsection (h); or

''(II) was operating under such a waiver and subsequently qualifies for PACE provider status pursuant to subsection (a)(3)(B)(ii).

''(2) SERVICE AREA AND ELIGIBILITY.—

''(A) IN GENERAL.—A PACE program agreement for a PACE program—

''(i) shall designate the service area of the program;

''(ii) may provide additional requirements for individuals to qualify as PACE program eligible individuals with respect to the program;

''(iii) shall be effective for a contract year, but may be extended for additional contract years in the absence of a notice by a party to terminate and is subject to termination by the Secretary and the State administering agency at any time for cause (as provided under the agreement);

''(iv) shall require a PACE provider to meet all applicable State and local laws and requirements; and

''(v) shall have such additional terms and conditions as the parties may agree to, provided that such terms and conditions are consistent with this section and regulations.

''(B) SERVICE AREA OVERLAP.—In designating a service area under a PACE program agreement under subparagraph (A)(i), the Secretary (in consultation with the State administering agency) may exclude from designation an area that is already covered under another PACE program agreement, in order to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program.

''(3) DATA COLLECTION; DEVELOPMENT OF OUTCOME MEASURES.—

''(A) DATA COLLECTION.—

''(i) IN GENERAL.—Under a PACE program agreement, the PACE provider shall—

''(I) collect data;

''(II) maintain, and afford the Secretary and the State administering agency access to, the records relating to the program, including pertinent financial, medical, and personnel records; and

''(III) make to the Secretary and the State administering agency reports that the Secretary finds (in consultation with State administering agencies) necessary to monitor the operation, cost, and effectiveness of the PACE program under this Act.

''(ii) REQUIREMENTS DURING TRIAL PERIOD.—During the first 3 years of operation of a PACE program (either under this section or under a PACE demonstration waiver program), the PACE provider shall provide such additional data as the Secretary specifies in regulations in order to perform the oversight required under paragraph (4)(A).

''(B) DEVELOPMENT OF OUTCOME MEASURES.—Under a PACE program agreement, the PACE provider, the Secretary, and the State administering agency shall jointly cooperate in the development and implementation of health status and quality of life outcome measures with respect to PACE program eligible individuals.

''(4) OVERSIGHT.—

''(A) ANNUAL, CLOSE OVERSIGHT DURING TRIAL PERIOD.—During the trial period (as defined in subsection (a)(9)) with respect to a PACE program operated by a PACE provider, the Secretary (in cooperation with the State administering agency) shall conduct a comprehensive annual review of the operation of the PACE program by the provider in order to assure compliance with the requirements of this section and regulations. Such a review shall include—

''(i) an on-site visit to the program site;

''(ii) comprehensive assessment of a provider's fiscal soundness;

''(iii) comprehensive assessment of the provider's capacity to provide all PACE services to all enrolled participants;

''(iv) detailed analysis of the entity's substantial compliance with all significant requirements of this section and regulations; and

''(v) any other elements the Secretary or State agency considers necessary or appropriate.

''(B) CONTINUING OVERSIGHT.—After the trial period, the Secretary (in cooperation with the State administering agency) shall continue to conduct such review of the operation of PACE providers and PACE programs as may be appropriate, taking into account the performance level of a provider and compliance of a provider with all significant requirements of this section and regulations.

''(C) DISCLOSURE.—The results of reviews under this paragraph shall be reported promptly to the PACE provider, along with any recommendations for changes to the provider's program, and shall be made available to the public upon request.

''(5) TERMINATION OF PACE PROVIDER AGREEMENTS.—

''(A) IN GENERAL.—Under regulations—

''(i) the Secretary or a State administering agency may terminate a PACE program agreement for cause; and

''(ii) a PACE provider may terminate an agreement after appropriate notice to the Secretary, the State agency, and enrollees.

''(B) CAUSES FOR TERMINATION.—In accordance with regulations establishing procedures for termination of PACE program agreements, the Secretary or a State administering agency may terminate a PACE program agreement with a PACE provider for, among other reasons, the fact that—

''(i) the Secretary or State administering agency determines that—

''(I) there are significant deficiencies in the quality of care provided to enrolled participants; or

''(II) the provider has failed to comply substantially with conditions for a program or provider under this section or section 1932; and

''(ii) the entity has failed to develop and successfully initiate, within 30 days of the receipt of written notice of such a determination, a plan to correct the deficiencies, or has failed to continue implementation of such a plan.

''(C) TERMINATION AND TRANSITION PROCEDURES.—An entity whose PACE provider agreement is terminated under this paragraph shall implement the transition procedures required under subsection (a)(2)(C).

''(6) SECRETARY'S OVERSIGHT; ENFORCEMENT AUTHORITY.—

''(A) IN GENERAL.—Under regulations, if the Secretary determines (after consultation with the State administering agency) that a PACE provider is failing substantially to comply with the requirements of this section and regulations, the Secretary (and the State administering agency) may take any or all of the following actions:

''(i) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

''(ii) Withhold some or all further payments under the PACE program agreement under this

section or section 1932 with respect to PACE program services furnished by such provider until the deficiencies have been corrected.

''(iii) Terminate such agreement.

''(B) APPLICATION OF INTERMEDIATE SANCTIONS.—Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in section 1876(i)(6)(B) or 1903(m)(5)(B) in the case of violations by the provider of the type described in section 1876(i)(6)(A) or 1903(m)(5)(A), respectively (in relation to agreements, enrollees, and requirements under this section or section 1932, respectively).

''(7) PROCEDURES FOR TERMINATION OR IMPOSITION OF SANCTIONS.—Under regulations, the provisions of section 1876(i)(9) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and an eligible organization under section 1876.

''(8) TIMELY CONSIDERATION OF APPLICATIONS FOR PACE PROGRAM PROVIDER STATUS.—In considering an application for PACE provider program status, the application shall be deemed approved unless the Secretary, within 90 days after the date of the submission of the application to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information that is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

''(f) REGULATIONS.—

''(1) IN GENERAL.—The Secretary shall issue interim final or final regulations to carry out this section and section 1932.

''(2) USE OF PACE PROTOCOL.—

''(A) IN GENERAL.—In issuing such regulations, the Secretary shall, to the extent consistent with the provisions of this section, incorporate the requirements applied to PACE demonstration waiver programs under the PACE protocol.

''(B) FLEXIBILITY.—In order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use nonstaff physicians according to State licensing law requirements) under this section and section 1932, the Secretary (in close consultation with State administering agencies) may modify or waive provisions of the PACE protocol so long as any such modification or waiver is not inconsistent with and would not impair the essential elements, objectives, and requirements of this section, but may not modify or waive any of the following provisions:

''(i) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

''(ii) The delivery of comprehensive, integrated acute and long-term care services.

''(iii) The interdisciplinary team approach to care management and service delivery.

''(iv) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

''(v) The assumption by the provider of full financial risk.

''(3) APPLICATION OF CERTAIN ADDITIONAL BENEFICIARY AND PROGRAM PROTECTIONS.—

''(A) IN GENERAL.—In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of sections 1876 and 1903(m) relating to protection of beneficiaries and program integrity as would apply to eligible organizations under risk-sharing contracts under section 1876 and to health maintenance organizations under prepaid capitation agreements under section 1903(m).

''(B) CONSIDERATIONS.—In issuing such regulations, the Secretary shall—

''(i) take into account the differences between populations served and benefits provided under this section and under sections 1876 and 1903(m);

''(ii) not include any requirement that conflicts with carrying out PACE programs under this section; and

''(iii) not include any requirement restricting the proportion of enrollees who are eligible for benefits under this title or title XIX.

''(g) WAIVERS OF REQUIREMENTS.—With respect to carrying out a PACE program under this section, the following requirements of this title (and regulations relating to such requirements) are waived and shall not apply:

''(1) Section 1812, insofar as it limits coverage of institutional services.

''(2) Sections 1813, 1814, 1833, and 1886, insofar as such sections relate to rules for payment for benefits.

''(3) Sections 1814(a)(2)(B), 1814(a)(2)(C), and 1835(a)(2)(A), insofar as they limit coverage of extended care services or home health services.

''(4) Section 1861(i), insofar as it imposes a 3-day prior hospitalization requirement for coverage of extended care services.

''(5) Paragraphs (1) and (9) of section 1862(a), insofar as they may prevent payment for PACE program services to individuals enrolled under PACE programs.

''(h) DEMONSTRATION PROJECT FOR FOR-PROFIT ENTITIES.—

''(1) IN GENERAL.—In order to demonstrate the operation of a PACE program by a private, for-profit entity, the Secretary (in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) that a PACE provider may not be a for-profit, private entity.

''(2) SIMILAR TERMS AND CONDITIONS.—

''(A) IN GENERAL.—Except as provided under subparagraph (B), and paragraph (1), the terms and conditions for operation of a PACE program by a provider under this subsection shall be the same as those for PACE providers that are nonprofit, private organizations.

''(B) NUMERICAL LIMITATION.—The number of programs for which waivers are granted under this subsection shall not exceed 10. Programs with waivers granted under this subsection shall not be counted against the numerical limitation specified in subsection (e)(1)(B).

''(i) MISCELLANEOUS PROVISIONS.—Nothing in this section or section 1932 shall be construed as preventing a PACE provider from entering into contracts with other governmental or nongovernmental payers for the care of PACE program eligible individuals who are not eligible for benefits under part A, or enrolled under part B, or eligible for medical assistance under title XIX.''.

SEC. 5012. EFFECTIVE DATE; TRANSITION.

(a) TIMELY ISSUANCE OF REGULATIONS; EFFECTIVE DATE.—The Secretary of Health and Human Services shall promulgate regulations to carry out this subtitle in a timely manner. Such regulations shall be designed so that entities may establish and operate PACE programs under sections 1894 and 1932 of the Social Security Act (as added by sections 5011 and 5751 of this Act) for periods beginning not later than 1 year after the date of the enactment of this Act.

(b) EXPANSION AND TRANSITION FOR PACE DEMONSTRATION PROJECT WAIVERS.—

(1) EXPANSION IN CURRENT NUMBER OF DEMONSTRATION PROJECTS.—Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 4118(g) of the Omnibus Budget Reconciliation Act of 1987, is amended—

(A) in paragraph (1), by inserting before the period at the end the following: '', except that the Secretary shall grant waivers of such requirements up to the applicable numerical limitation specified in section 1894(e)(1)(B) of the Social Security Act''; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking '', including permitting the organization to assume progressively (over the initial 3-year period of the waiver) the full financial risk''; and

(ii) in subparagraph (C), by adding at the end the following: ''In granting further extensions, an organization shall not be required to provide for reporting of information which is only required because of the demonstration nature of the project.''.

(2) ELIMINATION OF REPLICATION REQUIREMENT.—Subparagraph (B) of paragraph (2) of such section shall not apply to waivers granted under such section after the date of the enactment of this Act.

(3) TIMELY CONSIDERATION OF APPLICATIONS.—In considering an application for waivers under such section before the effective date of repeals made under subsection (d), subject to the numerical limitation under the amendment made by paragraph (1), the application shall be deemed approved unless the Secretary of Health and Human Services, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information which is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

(c) PRIORITY AND SPECIAL CONSIDERATION IN APPLICATION.—During the 3-year period beginning on the date of enactment of this Act:

(1) PROVIDER STATUS.—The Secretary of Health and Human Services shall give priority, in processing applications of entities to qualify as PACE programs under section 1894 or 1932 of the Social Security Act—

(A) first, to entities that are operating a PACE demonstration waiver program (as defined in section 1894(a)(7) of such Act); and

(B) then entities that have applied to operate such a program as of May 1, 1997.

(2) NEW WAIVERS.—The Secretary shall give priority, in the awarding of additional waivers under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986—

(A) to any entities that have applied for such waivers under such section as of May 1, 1997; and

(B) to any entity that, as of May 1, 1997, has formally contracted with a State to provide services for which payment is made on a capitated basis with an understanding that the entity was seeking to become a PACE provider.

(3) SPECIAL CONSIDERATION.—The Secretary shall give special consideration, in the processing of applications described in paragraph (1) and the awarding of waivers described in paragraph (2), to an entity which as of May 1, 1997 through formal activities (such as entering into contracts for feasibility studies) has indicated a specific intent to become a PACE provider.

(d) REPEAL OF CURRENT PACE DEMONSTRATION PROJECT WAIVER AUTHORITY.—

(1) IN GENERAL.—Subject to paragraph (2), the following provisions of law are repealed:

(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21).

(B) Section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

(C) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

(2) DELAY IN APPLICATION.—

(A) IN GENERAL.—Subject to subparagraph (B), the repeals made by paragraph (1) shall not apply to waivers granted before the initial effective date of regulations described in subsection (a).

(B) APPLICATION TO APPROVED WAIVERS.—Such repeals shall apply to waivers granted before such date only after allowing such organizations a transition period (of up to 24 months) in order to permit sufficient time for an orderly

transition from demonstration project authority to general authority provided under the amendments made by this subtitle.

SEC. 5013. STUDY AND REPORTS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in close consultation with State administering agencies, as defined in section 1894(a)(8) of the Social Security Act) shall conduct a study of the quality and cost of providing PACE program services under the medicare and medicaid programs under the amendments made by this subtitle.

(2) STUDY OF PRIVATE, FOR-PROFIT PROVIDERS.—Such study shall specifically compare the costs, quality, and access to services by entities that are private, for-profit entities operating under demonstration projects waivers granted under section 1894(h) of the Social Security Act with the costs, quality, and access to services of other PACE providers.

(b) REPORT.—

(1) IN GENERAL.—Not later than 4 years after the date of enactment of this Act, the Secretary shall provide for a report to Congress on the impact of such amendments on quality and cost of services. The Secretary shall include in such report such recommendations for changes in the operation of such amendments as the Secretary deems appropriate.

(2) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.—The report shall include specific findings on whether any of the following findings is true:

(A) The number of covered lives enrolled with entities operating under demonstration project waivers under section 1894(h) of the Social Security Act is fewer than 800 (or such lesser number as the Secretary may find statistically sufficient to make determinations respecting findings described in the succeeding subparagraphs).

(B) The population enrolled with such entities is less frail than the population enrolled with other PACE providers.

(C) Access to or quality of care for individuals enrolled with such entities is lower than such access or quality for individuals enrolled with other PACE providers.

(D) The application of such section has resulted in an increase in expenditures under the medicare or medicaid programs above the expenditures that would have been made if such section did not apply.

(c) INFORMATION INCLUDED IN ANNUAL RECOMMENDATIONS.—The Physician Payment Review Commission shall include in its annual recommendations under section 1845(b) of the Social Security Act (42 U.S.C. 1395w–1), and the Prospective Payment Review Commission shall include in its annual recommendations reported under section 1886(e)(3)(A) of such Act (42 U.S.C. 1395ww(e)(3)(A)), recommendations on the methodology and level of payments made to PACE providers under section 1894(d) of such Act and on the treatment of private, for-profit entities as PACE providers. References in the preceding sentence to the Physician Payment Review Commission and the Prospective Payment Review Commission shall be deemed to be references to the Medicare Payment Advisory Commission (MedPAC) established under section 5022(a) after the termination of the Physician Payment Review Commission and the Prospective Payment Review Commission provided for in section 5022(c)(2).

Subchapter B—Social Health Maintenance Organizations

SEC. 5015. SOCIAL HEALTH MAINTENANCE ORGANIZATIONS (SHMOS).

(a) EXTENSION OF DEMONSTRATION PROJECT AUTHORITIES.—Section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 is amended—

(1) in paragraph (1), by striking ''1997'' and inserting ''2000'', and

(2) in paragraph (4), by striking ''1998'' and inserting ''2001''.

(b) EXPANSION OF CAP.—Section 13567(c) of the Omnibus Budget Reconciliation Act of 1993 is amended by striking ''12,000'' and inserting ''36,000''.

(c) REPORT ON INTEGRATION AND TRANSITION.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall submit to Congress, by not later than January 1, 1999, a plan for the integration of health plans offered by social health maintenance organizations (including SHMO I and SHMO II sites developed under section 2355 of the Deficit Reduction Act of 1984 and under the amendment made by section 4207(b)(3)(B)(i) of OBRA–1990, respectively) and similar plans as an option under the Medicare Choice program under part C of title XVIII of the Social Security Act.

(2) PROVISION FOR TRANSITION.—Such plan shall include a transition for social health maintenance organizations operating under demonstration project authority under such section.

(3) PAYMENT POLICY.—The report shall also include recommendations on appropriate payment levels for plans offered by such organizations, including an analysis of the application of risk adjustment factors appropriate to the population served by such organizations.

Subchapter C—Other Programs

SEC. 5018. EXTENSION OF CERTAIN MEDICARE COMMUNITY NURSING ORGANIZATION DEMONSTRATION PROJECTS.

Notwithstanding any other provision of law, demonstration projects conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987 may be conducted for an additional period of 2 years, and the deadline for any report required relating to the results of such projects shall be not later than 6 months before the end of such additional period.

CHAPTER 3—COMMISSIONS

SEC. 5021. NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE.

(a) ESTABLISHMENT.—There is established a commission to be known as the National Bipartisan Commission on the Future of Medicare (in this section referred to as the ''Commission'').

(b) FINDINGS.—Congress finds that—

(1) the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) provides essential health care coverage to this Nation's senior citizens and to individuals with disabilities;

(2) the Federal Hospital Insurance Trust Fund established under that Act has been spending more than it receives since 1995, and will be bankrupt in the year 2001;

(3) the Federal Hospital Insurance Trust Fund faces even greater solvency problems in the long run with the aging of the baby boom generation and the continuing decline in the number of workers paying into the medicare program for each medicare beneficiary;

(4) the trustees of the trust funds of the medicare program have reported that growth in spending within the Federal Supplementary Medical Insurance Trust Fund established under that Act is unsustainable; and

(5) expeditious action is needed in order to restore the financial integrity of the medicare program and to maintain this Nation's commitment to senior citizens and to individuals with disabilities.

(c) DUTIES OF THE COMMISSION.—The Commission shall—

(1) review and analyze the long-term financial condition of the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.);

(2) identify problems that threaten the financial integrity of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under that title (42 U.S.C. 1395i, 1395t), including the extent to which current medicare update indexes do not accurately reflect inflation;

(3) analyze potential solutions to the problems identified under paragraph (2) that will ensure both the financial integrity of the medicare program and the provision of appropriate benefits under such program;

(4) make recommendations to restore the solvency of the Federal Hospital Insurance Trust Fund and the financial integrity of the Federal Supplementary Medical Insurance Trust Fund through the year 2030, when the last of the baby boomers reaches age 65;

(5) make recommendations for establishing the appropriate financial structure of the medicare program as a whole;

(6) make recommendations for establishing the appropriate balance of benefits covered and beneficiary contributions to the medicare program;

(7) make recommendations for the time periods during which the recommendations described in paragraphs (4), (5), and (6) should be implemented;

(8) make recommendations regarding the financing of graduate medical education (GME), including consideration of alternative broad-based sources of funding for such education and funding for institutions not currently eligible for such GME support under the medicare program that conduct approved graduate medical residency programs, such as children's hospitals;

(9) make recommendations on the feasibility of allowing individuals between the age of 62 and the medicare eligibility age to buy into the medicare program;

(10) make recommendations on the impact of chronic disease and disability trends on future costs and quality of services under the current benefit, financing, and delivery system structure of the medicare program; and

(11) review and analyze such other matters as the Commission deems appropriate.

(d) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members, of whom—

(A) three shall be appointed by the President;

(B) six shall be appointed by the Majority Leader of the Senate, in consultation with the Minority Leader of the Senate, of whom not more than 4 shall be of the same political party; and

(C) six shall be appointed by the Speaker of the House of Representatives, in consultation with the Minority Leader of the House of Representatives, of whom not more than 4 shall be of the same political party.

(2) COMPTROLLER GENERAL.—The Comptroller General of the United States shall advise the Commission on the methodology to be used in identifying problems and analyzing potential solutions in accordance with the duties of the Commission described in subsection (c).

(3) TERMS OF APPOINTMENT.—The members shall serve on the Commission for the life of the Commission.

(4) MEETINGS.—The Commission shall locate its headquarters in the District of Columbia, and shall meet at the call of the Chairperson.

(5) QUORUM.—Ten members of the Commission shall constitute a quorum, but a lesser number may hold hearings.

(6) CHAIRPERSON.—The Speaker of the House of Representatives, in consultation with the Majority Leader of the Senate, shall designate 1 of the members appointed under paragraph (1) as Chairperson of the Commission.

(7) VACANCIES.—A vacancy on the Commission shall be filled in the same manner in which the original appointment was made not later than 30 days after the Commission is given notice of the vacancy.

(8) COMPENSATION.—Members of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission.

(9) EXPENSES.—Each member of the Commission shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(e) STAFF AND SUPPORT SERVICES.—

(1) EXECUTIVE DIRECTOR.—

(A) APPOINTMENT.—The Chairperson shall appoint an executive director of the Commission.

(B) COMPENSATION.—The executive director shall be paid the rate of basic pay for level V of the Executive Schedule.

(2) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director considers appropriate.

(3) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

(4) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(5) STAFF OF FEDERAL AGENCIES.—Upon the request of the Commission, the head of any Federal agency may detail any of the personnel of such agency to the Commission to assist in carrying out the duties of the Commission.

(6) OTHER RESOURCES.—The Commission shall have reasonable access to materials, resources, statistical data, and other information from the Library of Congress and agencies and elected representatives of the executive and legislative branches of the Federal Government. The Chairperson of the Commission shall make requests for such access in writing when necessary.

(7) PHYSICAL FACILITIES.—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

(f) POWERS OF COMMISSION.—

(1) HEARINGS.—The Commission may conduct public hearings or forums at the discretion of the Commission, at any time and place the Commission is able to secure facilities and witnesses, for the purpose of carrying out the duties of the Commission.

(2) GIFTS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(3) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as other Federal agencies.

(g) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Commission shall submit a report to the President and Congress which shall contain a detailed statement of the recommendations, findings, and conclusions of the Commission.

(h) TERMINATION.—The Commission shall terminate on the date which is 30 days after the date the Commission submits its report to the President and to Congress under subsection (g).

(i) FUNDING.—There is authorized to be appropriated to the Commission such sums as are necessary to carry out the purposes of this section. Sums appropriated under this subsection shall be paid equally from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t).

SEC. 5022. MEDICARE PAYMENT ADVISORY COMMISSION.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1804 the following new section:

''MEDICARE PAYMENT ADVISORY COMMISSION

''SEC. 1805. (a) ESTABLISHMENT.—There is hereby established the Medicare Payment Advisory Commission (in this section referred to as the 'Commission').

''(b) DUTIES.—

''(1) REVIEW OF PAYMENT POLICIES AND ANNUAL REPORTS.—The Commission shall—

''(A) review payment policies under this title, including the topics described in paragraph (2);

''(B) make recommendations to Congress concerning such payment policies;

''(C) by not later than March 1 of each year (beginning with 1998), submit a report to Congress containing the results of such reviews and its recommendations concerning such policies; and

''(D) by not later than June 1 of each year (beginning with 1998), submit a report to Congress containing an examination of issues affecting the medicare program, including the implications of changes in health care delivery in the United States and in the market for health care services on the medicare program.

''(2) SPECIFIC TOPICS TO BE REVIEWED.—

''(A) MEDICARE CHOICE PROGRAM.—Specifically, the Commission shall review, with respect to the Medicare Choice program under part C, the following:

''(i) The methodology for making payment to plans under such program, including the making of differential payments and the distribution of differential updates among different payment areas.

''(ii) The mechanisms used to adjust payments for risk and the need to adjust such mechanisms to take into account health status of beneficiaries.

''(iii) The implications of risk selection both among Medicare Choice organizations and between the Medicare Choice option and the traditional medicare fee-for-service option.

''(iv) The development and implementation of mechanisms to assure the quality of care for those enrolled with Medicare Choice organizations.

''(v) The impact of the Medicare Choice program on access to care for medicare beneficiaries.

''(vi) Other major issues in implementation and further development of the Medicare Choice program.

''(B) TRADITIONAL MEDICARE FEE-FOR-SERVICE SYSTEM.—Specifically, the Commission shall review payment policies under parts A and B, including—

''(i) the factors affecting expenditures for services in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees,

''(ii) payment methodologies, and

''(iii) their relationship to access and quality of care for medicare beneficiaries.

''(C) INTERACTION OF MEDICARE PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—Specifically, the Commission shall review the effect of payment policies under this title on the delivery of health care services other than under this title and assess the implications of changes in health care delivery in the United States and in the general market for health care services on the medicare program.

''(3) COMMENTS ON CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to payment policies under this title, the Secretary shall transmit a copy of the report to the Commission. The Commission shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Commission deems appropriate.

''(4) AGENDA AND ADDITIONAL REVIEWS.—The Commission shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding the Commission's agenda and progress towards achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title as may be requested by such chairmen and members and as the Commission deems appropriate.

''(5) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

''(6) APPROPRIATE COMMITTEES OF CONGRESS.—For purposes of this section, the term 'appropriate committees of Congress' means the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate.

''(c) MEMBERSHIP.—

''(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members appointed by the Comptroller General.

''(2) QUALIFICATIONS.—

''(A) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(B) INCLUSION.—The membership of the Commission shall include (but not be limited to) physicians and other health professionals, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

''(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under this title shall not constitute a majority of the membership of the Commission.

''(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

''(3) TERMS.—

''(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

''(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

''(4) COMPENSATION.—While serving on the business of the Commission (including traveltime), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

''(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment.

''(6) MEETINGS.—The Commission shall meet at the call of the Chairman.

''(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General deems necessary to assure the efficient administration of the Commission, the Commission may—

''(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(4) make advance, progress, and other payments which relate to the work of the Commission;

''(5) provide transportation and subsistence for persons serving without compensation; and

''(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

''(e) POWERS.—

''(1) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

''(2) DATA COLLECTION.—In order to carry out its functions, the Commission shall—

''(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

''(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and

''(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

''(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data of the Commission, immediately upon request.

''(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General.

''(f) AUTHORIZATION OF APPROPRIATIONS.—

''(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

''(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Sixty percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.''.

(b) ABOLITION OF PROPAC AND PPRC.—

(1) PROPAC.—

(A) IN GENERAL.—Section 1886(e) (42 U.S.C. 1395ww(e)) is amended—

(i) by striking paragraphs (2) and (6); and

(ii) in paragraph (3), by striking ''(A) The Commission'' and all that follows through ''(B)''.

(B) CONFORMING AMENDMENT.—Section 1862 (42 U.S.C. 1395y) is amended by striking ''Prospective Payment Assessment Commission'' each place it appears in subsection (a)(1)(D) and subsection (i) and inserting ''Medicare Payment Advisory Commission''.

(2) PPRC.—

(A) IN GENERAL.—Title XVIII is amended by striking section 1845 (42 U.S.C. 1395w–1).

(B) ELIMINATION OF CERTAIN REPORTS.—Section 1848 (42 U.S.C. 1395w–4) is amended—

(i) by striking subparagraph (F) of subsection (d)(2),

(ii) by striking subparagraph (B) of subsection (f)(1), and

(iii) in subsection (f)(3), by striking ''Physician Payment Review Commission,''.

(C) CONFORMING AMENDMENTS.—Section 1848 (42 U.S.C. 1395w–4) is amended by striking ''Physician Payment Review Commission'' and inserting ''Medicare Payment Advisory Commission'' each place it appears in subsections (c)(2)(B)(iii), (g)(6)(C), and (g)(7)(C).

(c) EFFECTIVE DATE; TRANSITION.—

(1) IN GENERAL.—The Comptroller General shall first provide for appointment of members to the Medicare Payment Advisory Commission (in this subsection referred to as ''MedPAC'') by not later than September 30, 1997.

(2) TRANSITION.—As quickly as possible after the date a majority of members of MedPAC are first appointed, the Comptroller General, in consultation with the Prospective Payment Assessment Commission (in this subsection referred to as ''ProPAC'') and the Physician Payment Review Commission (in this subsection referred to as ''PPRC''), shall provide for the termination of the ProPAC and the PPRC. As of the date of termination of the respective Commissions, the amendments made by paragraphs (1) and (2), respectively, of subsection (b) become effective. The Comptroller General, to the extent feasible, shall provide for the transfer to the MedPAC of assets and staff of the ProPAC and the PPRC, without any loss of benefits or seniority by virtue of such transfers. Fund balances available to the ProPAC or the PPRC for any period shall be available to the MedPAC for such period for like purposes.

(3) CONTINUING RESPONSIBILITY FOR REPORTS.—The MedPAC shall be responsible for the preparation and submission of reports required by law to be submitted (and which have not been submitted by the date of establishment of the MedPAC) by the ProPAC and the PPRC, and, for this purpose, any reference in law to either such Commission is deemed, after the appointment of the MedPAC, to refer to the MedPAC.

CHAPTER 4—MEDIGAP PROTECTIONS

SEC. 5031. MEDIGAP PROTECTIONS.

(a) GUARANTEEING ISSUE WITHOUT PREEXISTING CONDITIONS FOR CONTINUOUSLY COVERED INDIVIDUALS.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(1) in paragraph (3), by striking ''paragraphs (1) and (2)'' and inserting ''this subsection'',

(2) by redesignating paragraph (3) as paragraph (4), and

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

''(3)(A) The issuer of a medicare supplemental policy—

''(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (C) that is offered and is available for issuance to new enrollees by such issuer;

''(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

''(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such subparagraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

''(B) An individual described in this subparagraph is an individual described in any of the following clauses:

''(i) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under this title and the plan terminates or ceases to provide all such supplemental health benefits to the individual.

''(ii) The individual is enrolled with a Medicare Choice organization under a Medicare Choice plan under part C, and there are circumstances permitting discontinuance of the individual's election of the plan under section 1851(e)(4).

''(iii) The individual is enrolled with an eligible organization under a contract under section 1876, a similar organization operating under demonstration project authority, with an organization under an agreement under section 1833(a)(1)(A), or with an organization under a policy described in subsection (t), and such enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under section 1851(c)(4) and, in the case of a policy described in subsection (t), there is no provision under applicable State law for the continuation of coverage under such policy.

''(iv) The individual is enrolled under a medicare supplemental policy under this section and such enrollment ceases because—

''(I) of the bankruptcy or insolvency of the issuer or because of other involuntary termination of coverage or enrollment under such policy and there is no provision under applicable State law for the continuation of such coverage;

''(II) the issuer of the policy substantially violated a material provision of the policy; or

''(III) the issuer (or an agent or other entity acting on the issuer's behalf) materially misrepresented the policy's provisions in marketing the policy to the individual.

''(v) The individual—

''(I) was enrolled under a medicare supplemental policy under this section,

''(II) subsequently terminates such enrollment and enrolls, for the first time, with any Medicare Choice organization under a Medicare Choice plan under part C, any eligible organization under a contract under section 1876, any similar organization operating under demonstration project authority, any organization under an agreement under section 1833(a)(1)(A), or any policy described in subsection (t), and

''(III) the subsequent enrollment under subclause (II) is terminated by the enrollee during the first 12 months of such enrollment.

''(vi) The individual, upon first becoming eligible for medicare at age 65, enrolls in a Medicare Choice plan and within 12 months of such enrollment, disenrolls from such plan.

''(C)(i) Subject to clauses (ii), a medicare supplemental policy described in this subparagraph is a policy the benefits under which are comparable or lessor in relation to the benefits under the plan, policy, or contract described in the applicable clause of subparagraph (B).

''(ii) Only for purposes of an individual described in subparagraph (B)(vi), a medicare supplemental policy described in this subparagraph shall include any medicare supplemental policy.

''(D) At the time of an event described in subparagraph (B) because of which an individual ceases enrollment or loses coverage or benefits under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, the insurer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the rights of the individual, and obligations of issuers of medicare supplemental policies, under subparagraph (A).''.

(b) LIMITATION ON IMPOSITION OF PRE-EXISTING CONDITION EXCLUSION DURING INITIAL OPEN ENROLLMENT PERIOD.—Section 1882(s)(2)(42 U.S.C. 1395ss(s)(2)) is amended—

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

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

''(D) In the case of a policy issued during the 6-month period described in subparagraph (A) to an individual who is 65 years of age or older as of the date of issuance and who as of the date of the application for enrollment has a continuous period of creditable coverage (as defined in section 2701(c) of the Public Health Service Act) of—

''(i) at least 6 months, the policy may not exclude benefits based on a pre-existing condition; or

''(ii) less than 6 months, if the policy excludes benefits based on a preexisting condition, the policy shall reduce the period of any preexisting condition exclusion by the aggregate of the periods of creditable coverage (if any, as so defined) applicable to the individual as of the enrollment date.

The Secretary shall specify the manner of the reduction under clause (ii), based upon the rules used by the Secretary in carrying out section 2701(a)(3) of such Act.''.

(c) EXTENDING 6-MONTH INITIAL ENROLLMENT PERIOD TO NON-ELDERLY MEDICARE BENEFICIARIES.—Section 1882(s)(2)(A)(ii) of (42 U.S.C. 1395ss(s)(2)(A)) is amended by striking ''is submitted'' and all that follows and inserting the following: ''is submitted—

''(I) before the end of the 6-month period beginning with the first month as of the first day on which the individual is 65 years of age or older and is enrolled for benefits under part B; and

''(II) at the time the individual first becomes eligible for benefits under part A pursuant to section 226(b) and is enrolled for benefits under part B, before the end of the 6-month period beginning with the first month as of the first day on which the individual is so eligible and so enrolled.''.

(d) EFFECTIVE DATES.—

(1) GUARANTEED ISSUE.—The amendment made by subsection (a) shall take effect on July 1, 1998.

(2) LIMIT ON PREEXISTING CONDITION EXCLUSIONS.—The amendment made by subsection (b) shall apply to policies issued on or after July 1, 1998.

(3) NONELDERLY MEDICARE BENEFICIARIES.—

(A) IN GENERAL.—The amendment made by subsection (c) shall apply to policies issued on and after July 1, 1998.

(B) TRANSITION RULE.—In the case of an individual who first became eligible for benefits under part A of title XVIII of the Social Security Act pursuant to section 226(b) of such Act and enrolled for benefits under part B of such title before July 1, 1998, the 6-month period described in section 1882(s)(2)(A) of such Act shall begin on July 1, 1998. Before July 1, 1998, the Secretary of Health and Human Services shall notify any individual described in the previous sentence of their rights in connection with medicare supplemental policies under section 1882 of such Act, by reason of the amendment made by subsection (c).

(e) TRANSITION PROVISIONS.—

(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section, the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act due solely to failure to make such change until the date specified in paragraph (4).

(2) NAIC STANDARDS.—If, within 9 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (in this subsection referred to as the ''NAIC'') modifies its NAIC Model regulation relating to section 1882 of the Social Security Act (referred to in such section as the 1991 NAIC Model Regulation, as modified pursuant to section 171(m)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432) and as modified pursuant to section 1882(d)(3)(A)(vi)(IV) of the Social Security Act, as added by section 271(a) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191) to conform to the amendments made by this section, such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate Regulation for the purposes of such section.

(4) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or

(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section, but

(ii) having a legislature which is not scheduled to meet in 1999 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after July 1, 1999. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 5032. ADDITION OF HIGH DEDUCTIBLE MEDIGAP POLICY.

(a) IN GENERAL.—Section 1882(p) (42 U.S.C. 1395ss(p)) is amended by adding at the end the following:

''(11)(A) On and after the date specified in subparagraph (C)—

''(i) each State with an approved regulatory program, and

''(ii) in the case of a State without an approved regulatory program, the Secretary,

shall, in addition to the 10 policies allowed under paragraph (2)(C), allow at least 1 other policy described in subparagraph (B).

''(B)(i) A policy is described in this subparagraph if it consists of—

''(I) one of the 10 benefit packages described in paragraph (2)(C), and

''(II) a high deductible feature.

''(ii) For purposes of clause (i), a high deductible feature is one which requires the beneficiary of the policy to pay annual out-of-pocket expenses (other than premiums) of $1,500 before the policy begins payment of benefits.

''(C)(i) Subject to clause (ii), the date described in this subparagraph is one year after the date of the enactment of this paragraph.

''(ii) In the case of a State which the Secretary identifies as—

''(I) requiring State legislation (other than legislation appropriating funds) in order to meet the requirements of this paragraph, but

''(II) having a legislature which is not scheduled to meet in 1997 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1998. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.''.

(b) CONFORMING AMENDMENT.—Section 1882(p)(2)(C) (42 U.S.C. 1395ss(p)(2)(C)) is amended by inserting ''or (11)'' after ''paragraph (4)(B)''.

CHAPTER 5—DEMONSTRATIONS

Subchapter A—Medicare Choice Competitive Pricing Demonstration Project

PART I—IN GENERAL

SEC. 5041. MEDICARE CHOICE COMPETITIVE PRICING DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services (in this subchapter referred to as the ''Secretary'') shall, beginning January 1, 1999, conduct demonstration projects in applicable areas (in this section referred to as the ''project'') for the purpose of—

(1) applying a pricing methodology for payments to Medicare Choice organizations under part C of title XVIII of the Social Security Act (as amended by section 5001 of this Act) that uses the competitive market approach described in section 5042;

(2) applying a benefit structure and beneficiary premium structure described in section 5043;

(3) applying the information and quality programs under part II; and

(4) evaluating the effects of the methodology and structures described in the preceding paragraphs on medicare fee-for-service spending under parts A and B of the Social Security Act in the project area.

(b) APPLICABLE AREA DEFINED.—

(1) IN GENERAL.—In subsection (a), the term ''applicable area'' means, as determined by the Secretary—

(A) 10 urban areas with respect to which less than 25 percent of medicare beneficiaries are enrolled with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm); and

(B) 3 rural areas not described in paragraph (1).

(2) TREATMENT AS MEDICARE CHOICE PAYMENT AREA.—For purposes of this subchapter and part C of title XVIII of the Social Security Act, any applicable area shall be treated as a Medicare Choice payment area (hereinafter referred to as the ''applicable Medicare Choice payment area'').

(c) TECHNICAL ADVISORY GROUP.—Upon the selection of an area for inclusion in the project, the Secretary shall appoint a technical advisory group, composed of representatives of Medicare Choice organizations, medicare beneficiaries, employers, and other persons in the area affected by the project who have technical expertise relative to the design and implementation of the project to advise the Secretary concerning how the project will be implemented in the area.

(d) EVALUATION.—

(1) IN GENERAL.—Not later than December 31, 2001, the Secretary shall submit to the President a report regarding the demonstration projects conducted under this section.

(2) CONTENTS OF REPORT.—The report described in paragraph (1) shall include the following:

(A) A description of the demonstration projects conducted under this section.

(B) An evaluation of the effectiveness of the demonstration projects conducted under this section and any legislative recommendations determined appropriate by the Secretary.

(C) Any other information regarding the demonstration projects conducted under this section that the Secretary determines to be appropriate.

(D) An evaluation as to whether the method of payment under section 5042 which was used in the demonstration projects for payment to Medicare Choice plans should be extended to the entire medicare population and if such evaluation determines that such method should not be extended, legislative recommendations to modify such method so that it may be applied to the entire medicare population.

(3) SUBMISSION TO CONGRESS.—The President shall submit the report under paragraph (2) to the Congress and if the President determines appropriate, any legislative recommendations for extending the project to the entire medicare population.

(e) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of titles XI, XVIII, and XIX of the Social Security Act (42 U.S.C. 1301 et seq., 1395 et seq., 1396 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

SEC. 5042. DETERMINATION OF ANNUAL MEDICARE CHOICE CAPITATION RATES.

(a) IN GENERAL.—In the case of an applicable Medicare Choice payment area within which a project is being conducted under section 5041, the annual Medicare Choice capitation rate under part C of title XVIII of the Social Security Act for Medicare Choice plans within such area shall be the standardized payment amount determined under this section rather than the amount determined under section 1853 of such Act.

(b) DETERMINATION OF STANDARDIZED PAYMENT AMOUNT.—

(1) SUBMISSION AND CHARGING OF PREMIUMS.—

(A) IN GENERAL.—Not later than June 1 of each calendar year, each Medicare Choice organization offering one or more Medicare Choice plans in an applicable Medicare Choice payment area shall file with the Secretary, in a form and manner and at a time specified by the Secretary, a bid which contains the amount of the monthly premium for coverage under each such Medicare Choice plan.

(B) UNIFORM PREMIUM.—The premiums charged by a Medicare Choice plan sponsor under this part may not vary among individuals who reside in the same applicable Medicare Choice payment area.

(C) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each Medicare Choice organization shall permit the payment of premiums on a monthly basis.

(2) ANNOUNCEMENT OF STANDARDIZED PAYMENT AMOUNT.—

(A) AUTHORITY TO NEGOTIATE.—After bids are submitted under paragraph (1), the Secretary may negotiate with Medicare Choice organizations in order to modify such bids if the Secretary determined that the bids do not provide enough revenues to ensure the plan's actuarial soundness, are too high relative to the applicable Medicare Choice payment area, foster adverse selection, or otherwise require renegotiation under this paragraph.

(B) IN GENERAL.—Not later than July 31 of each calendar year (beginning with 1998), the Secretary shall determine, and announce in a manner intended to provide notice to interested parties, a standardized payment amount determined in accordance with this paragraph for the following calendar year for each applicable Medicare Choice payment area.

(3) CALCULATION OF PAYMENT AMOUNTS.—

(A) IN GENERAL.—The standardized payment amount for a calendar year after 1998 for any applicable Medicare Choice payment area shall be equal to the maximum premium determined for such area under subparagraph (B).

(B) MAXIMUM PREMIUM.—The maximum premium for any applicable Medicare Choice payment area shall be equal to the amount determined under subparagraph (C) for the payment area, but in no case shall such amount be greater than the sum of—

(i) the average per capita amount, as determined by the Secretary as appropriate for the population eligible to enroll in Medicare Choice plans in such payment area, for such calendar year that the Secretary would have expended for an individual in such payment area enrolled under the medicare fee-for-service program under parts A and B, plus

(ii) the amount equal to the actuarial value of deductibles, coinsurance, and copayments charged an individual for services provided under the medicare fee-for-service program (as determined by the Secretary).

(C) DETERMINATION OF AMOUNT.—

(i) IN GENERAL.—The Secretary shall determine for each applicable Medicare Choice payment area for each calendar year an amount equal to the average of the bids (weighted based on capacity) submitted to the Secretary under paragraph (1)(A) for that payment area.

(ii) DISREGARD CERTAIN PLANS.—In determining the amount under clause (i), the Secretary may disregard any plan that the Secretary determines would unreasonably distort the amount determined under such subparagraph.

(4) ADJUSTMENTS FOR PAYMENTS TO PLAN SPONSORS.—

(A) IN GENERAL.—For purposes of determining the amount of payment under part C of title XVIII of the Social Security Act to a Medicare Choice organization with respect to any Medicare Choice eligible individual enrolled in a Medicare Choice plan of the sponsor, the standardized payment amount for the applicable Medicare Choice payment area and the premium charged by the plan sponsor shall be adjusted with respect to such individual for such risk factors as age, disability status, gender, institutional status, health status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

(B) RECOMMENDATIONS.—

(i) IN GENERAL.—In addition to any other duties required by law, the Physician Payment Review Commission and the Prospective Payment Assessment Commission (or their successors) shall each develop recommendations on—

(I) the risk factors that the Secretary should use in adjusting the standardized payment amount and premium under subparagraph (A), and

(II) the methodology that the Secretary should use in determining the risk factors to be used in adjusting the standardized payment amount and premium under subparagraph (A).

(ii) TIME.—The recommendations described in clause (i) shall be developed not later than January 1, 1999.

(iii) ANNUAL REPORT.—The Physician Payment Review Commission and the Prospective Payment Assessment Commission (or their successors) shall include the recommendations described in clause (i) in their respective annual reports to Congress.

(c) PAYMENTS TO PLAN SPONSORS.—

(1) MONTHLY PAYMENTS.—

(A) IN GENERAL.—Subject to paragraph (4), for each individual enrolled with a plan under this subchapter, the Secretary shall make monthly payments in advance to the Medicare Choice organization of the Medicare Choice plan with which the individual is enrolled in an amount equal to 1/12 of the amount determined under paragraph (2).

(B) RETROACTIVE ADJUSTMENTS.—The amount of payment under this paragraph may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

(2) AMOUNT OF PAYMENT TO MEDICARE CHOICE PLANS.—The amount determined under this paragraph with respect to any individual shall be equal to the sum of—

(A) the lesser of—

(i) the standardized payment amount for the applicable Medicare Choice payment area, as adjusted for such individual under subsection (a)(4), or

(ii) the premium charged by the plan for such individual, as adjusted for such individual under section (a)(4), minus

(B) the amount such individual paid to the plan pursuant to section 5043 (relating to 10 percent of the premium).

(3) PAYMENTS FROM TRUST FUNDS.—The payment to a Medicare Choice organization or to a Medicare Choice account under this section for a medicare-eligible individual shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under parts A and B are representative of the actuarial value of the total benefits under this part.

(4) LIMITATION ON AMOUNTS AN OUT-OF-PLAN PHYSICIAN OR OTHER ENTITY MAY COLLECT.—A physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this subchapter with a Medicare Choice organization shall accept as payment in full for services that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a Medicare Choice organization under this part) also applies with respect to an individual so enrolled.

(d) OFFICE OF COMPETITION.—

(1) ESTABLISHMENT.—There is established within the Department of Health and Human Services an office to be known as the 'Office of Competition'.

(2) DIRECTOR.—The Secretary shall appoint the Director of the Office of Competition.

(3) DUTIES.—

(A) IN GENERAL.—The Director shall administer this subchapter and so much of part C of title XVIII of the Social Security Act as relates to this subchapter.

(B) TRANSFER AUTHORITY.—The Secretary shall transfer such personnel, administrative support systems, assets, records, funds, and other resources in the Health Care Financing Administration to the Office of Competition as are used in the administration of section 1876 and as may be required to implement the provisions of this part promptly and efficiently.

(4) USE OF NON-FEDERAL ENTITIES.—The Secretary shall, to the maximum extent feasible, enter into contracts with appropriate non-Federal entities to carry out activities under this subchapter.

SEC. 5043. BENEFITS AND BENEFICIARY PREMIUMS.

(a) BENEFITS PROVIDED TO INDIVIDUALS.—

(1) BASIC BENEFIT PLAN.—Each Medicare Choice plan in an applicable Medicare Choice payment area shall provide to members enrolled under this subchapter, through providers and other persons that meet the applicable requirements of title XVIII of the Social Security Act and part A of title XI of such Act—

(A) those items and services covered under parts A and B of title XVIII of such Act which are available to individuals residing in such area, subject to nominal copayments as determined by the Secretary,

(B) prescription drugs, subject to such limits as established by the Secretary, and

(C) additional health services as the Secretary may approve.

(2) SUPPLEMENTAL BENEFITS.—

(A) IN GENERAL.—Each Medicare Choice plan may offer any of the optional supplemental benefit plans described in subparagraph (B) to an individual enrolled in the basic benefit plan offered by such organization under this subchapter for an additional premium amount. If

the supplemental benefits are offered only to individuals enrolled in the sponsor's plan under this subchapter, the additional premium amount shall be the same for all enrolled individuals in the applicable Medicare Choice payment area. Such benefits may be marketed and sold by the Medicare Choice organization outside of the enrollment process described in part C of title XVIII of the Social Security Act.

(B) OPTIONAL SUPPLEMENTAL BENEFIT PLANS DESCRIBED.—The Secretary shall provide for 2 optional supplemental benefit plans. Such plans shall include such standardized items and services that the Secretary determines must be provided to enrollees of such plans described in order to offer the plans to Medicare Choice eligible individuals.

(C) LIMITATION.—A Medicare Choice organization may not offer an optional benefit plan to a Medicare Choice eligible individual unless such individual is enrolled in a basic benefit plan offered by such organization.

(D) LIMITATION ON PREMIUM.—If a Medicare Choice organization provides to individuals enrolled in a Medicare Choice plan supplemental benefits described in subparagraph (A), the sum of—

(i) the annual premiums for such benefits, plus

(ii) the actuarial value of any deductibles, coinsurance, and copayments charged with respect to such benefits for the year,

shall not exceed the amount that would have been charged for a plan in the applicable Medicare Choice payment area which is not a Medicare Choice plan (adjusted in such manner as the Secretary may prescribe to reflect that only medicare beneficiaries are enrolled in such plan). The Secretary shall negotiate the limitation under this subparagraph with each plan to which this paragraph applies.

(3) OTHER RULES.—Rules similar to rules of paragraphs (3) and (4) of section 1852 of the Social Security Act (relating to national coverage determinations and secondary payor provisions) shall apply for purposes of this subchapter.

(b) PREMIUM REQUIREMENTS FOR BENEFICIARIES.—

(1) PREMIUM DIFFERENTIALS.—If a Medicare Choice eligible individual enrolls in a Medicare Choice plan under this subchapter, the individual shall be required to pay—

(A) 10 percent of the plan's premium;

(B) if the premium of the plan is higher than the standardized payment amount (as determined under section 5042), 100 percent of such difference; and

(C) an amount equal to cost-sharing under the medicare fee-for-service program, except that such amount shall not exceed the actuarial value of the deductibles and coinsurance under such program less the actual value of nominal copayments for benefits under such plan for basic benefits described in subsection (a)(1).

(2) PART B PREMIUM.—An individual enrolled in a Medicare Choice plan under this subchapter shall not be required to pay the premium amount (determined under section 1839 of the Social Security Act) under part B of title XVIII of such Act for so long as such individual is so enrolled.

PART II—INFORMATION AND QUALITY STANDARDS

Subpart A—Information

SEC. 5044. INFORMATION REQUIREMENTS.

(a) IN GENERAL.—The Secretary shall provide that in the case of a demonstration plan conducted under part I, the information and comparative reports described in this section shall be used in lieu of that provided under part C of title XVIII of the Social Security Act.

(b) SECRETARY'S MATERIALS; CONTENTS.—The notice and informational materials mailed by the Secretary under this part shall be written and formatted in the most easily understandable manner possible, and shall include, at a minimum, the following:

(1) GENERAL INFORMATION.—General information with respect to coverage under this part during the next calendar year, including—

(A) the part B premium rates that will be charged for part B coverage, and a statement of the fact that enrollees in demonstration plans are not required to pay such premium,

(B) the deductible, copayment, and coinsurance amounts for coverage under the traditional medicare program,

(C) a description of the coverage under the traditional medicare program and any changes in coverage under the program from the prior year,

(D) a description of the individual's medicare payment area, and the standardized medicare payment amount available with respect to such individual,

(E) information and instructions on how to enroll in a demonstration plan,

(F) the right of each demonstration plan sponsor by law to terminate or refuse to renew its contract and the effect the termination or nonrenewal of its contract may have on individuals enrolled with the demonstration plan under this part,

(G) appeal rights of enrollees, including the right to address grievances to the Secretary or the applicable external review entity, and

(H) the benefits offered by plans in basic benefit plans under section 1895H(a), and how those benefits differ from the benefits offered under parts A and B.

(2) COMPARATIVE REPORT.—A copy of the most recent comparative report (as established by the Secretary under subsection (c)) for the demonstration plans in the individual's medicare payment area.

(c) COMPARATIVE REPORT.—

(1) IN GENERAL.—The Secretary shall develop an understandable standardized comparative report on the demonstration plans offered by demonstration plan sponsors, that will assist demonstration eligible individuals in their decisionmaking regarding medical care and treatment by allowing such individuals to compare the demonstration plans that such individuals are eligible to enroll with. In developing such report the Secretary shall consult with outside organizations, including groups representing the elderly, demonstration plan sponsors, providers of services, and physicians and other health care professionals, in order to assist the Secretary in developing the report.

(2) REPORT.—The report described in paragraph (1) shall include a comparison for each demonstration plan of—

(A) the plan's medicare service area;

(B) coverage by the plan of emergency services and urgently needed care;

(C) the amount of any deductibles, coinsurance, or any monetary limits on benefits;

(D) the number of individuals who disenrolled from the plan within 3 months of enrollment during the previous fiscal year (excluding individuals whose disenrollment was due to death or moving outside of the plan's service area) stated as percentages of the total number of individuals in the plan;

(E) process, outcome, and enrollee satisfaction measures, as recommended by the Quality Advisory Institute as established under section 5044B;

(F) information on access and quality of services obtained from the analysis described in section 5044B;

(G) the procedures used by the plan to control utilization of services and expenditures, including any financial incentives;

(H) the number of applications during the previous fiscal year requesting that the plan cover or pay for certain medical services that were denied by the plan (and the number of such denials that were subsequently reversed by the plan), stated as a percentage of the total number of applications during such period requesting that the plan cover such services;

(I) the number of times during the previous fiscal year (after an appeal was filed with the Secretary) that the Secretary upheld or reversed a denial of a request that the plan cover certain medical services;

(J) the restrictions (if any) on payment for services provided outside the plan's health care provider network;

(K) the process by which services may be obtained through the plan's health care provider network;

(L) coverage for out-of-area services;

(M) any exclusions in the types of health care providers participating in the plan's health care provider network;

(N) whether the plan is, or has within the past two years been, out-of-compliance with any requirements of this part (as determined by the Secretary);

(O) the plan's premium price for the basic benefit plan submitted under part C of title XVIII of the Social Security Act, an indication of the difference between such premium price and the standardized medicare payment amount, and the portion of the premium an individual must pay out of pocket;

(P) whether the plan offers any of the optional supplemental benefit plans, and if so, the plan's premium price for such benefits; and

(Q) any additional information that the Secretary determines would be helpful for demonstration eligible individuals to compare the demonstration plans that such individuals are eligible to enroll with.

(3) ADDITIONAL INFORMATION.—The comparative report shall also include—

(A) a comparison of each demonstration plan to the fee-for-service program under parts A and B of title XVIII of the Social Security Act;

(B) an explanation of medicare supplemental policies under section 1882 of such Act and how to obtain specific information regarding such policies; and

(C) a phone number for each demonstration plan that will enable demonstration eligible individuals to call to receive a printed listing of all health care providers participating in the plan's health care provider network.

(4) UPDATE.—The Secretary shall, not less than annually, update each comparative report.

(5) DEFINITIONS.—In this subsection—

(A) HEALTH CARE PROVIDER.—The term ''health care provider'' means anyone licensed under State law to provide health care services under part A or B.

(B) NETWORK.—The term ''network'' means, with respect to a demonstration plan sponsor, the health care providers who have entered into a contract or agreement with the plan sponsor under which such providers are obligated to provide items, treatment, and services under this section to individuals enrolled with the plan sponsor under this part.

(C) OUT-OF-NETWORK.—The term ''out-of-network'' means services provided by health care providers who have not entered into a contract agreement with the demonstration plan sponsor under which such providers are obligated to provide items, treatment, and services under this section to individuals enrolled with the plan sponsor under this part.

(6) COST SHARING.—Each demonstration plan sponsor shall pay to the Secretary its pro rata share of the estimated costs incurred by the Secretary in carrying out the requirements of this section and section 4360 of the Omnibus Reconciliation Act of 1990. There are hereby appropriated to the Secretary the amount of the payments under this paragraph for purposes of defraying the cost described in the preceding sentence. Such amounts shall remain available until expended.

Subpart B—Quality in Demonstration Plans

SEC. 5044A. DEFINITIONS.

In this subpart:

(1) COMPARATIVE REPORT.—The term ''comparative report'' means the comparative report developed under section 5044.

(2) DIRECTOR.—The term ''Director'' means the Director of the Office of Competition within

the Department of Health and Human Services as established under part I.

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

(4) DEMONSTRATION PLAN.—The term ''demonstration plan'' means a plan established under part I.

(5) DEMONSTRATION PLAN SPONSOR.—The term ''demonstration plan sponsor'' means a sponsor of a demonstration plan.

SEC. 5044B. QUALITY ADVISORY INSTITUTE.

(a) ESTABLISHMENT.—There is established an Institute to be known as the ''Quality Advisory Institute'' (in this subpart referred to as the ''Institute'') to make recommendations to the Director concerning licensing and certification criteria and comparative measurement methods under this subpart.

(b) MEMBERSHIP.—

(1) COMPOSITION.—The Institute shall be composed of 5 members to be appointed by the Director from among individuals who have demonstrable expertise in—

(A) health care quality measurement;

(B) health plan certification criteria setting;

(C) the analysis of information that is useful to consumers in making choices regarding health coverage options, health plans, health care providers, and decisions regarding health treatments; and

(D) the analysis of health plan operations.

(2) TERMS AND VACANCIES.—The members of the Institute shall be appointed for 5-year terms with the terms of the initial members staggered as determined appropriate by the Director. Vacancies shall be filled in a manner provided for by the Director.

(c) DUTIES.—The Institute shall—

(1) not later than 1 year after the date on which all members of the Institute are appointed under subsection (b)(2), provide advice to the Director concerning the initial set of criteria for the certification of demonstration plans;

(2) analyze the use of the criteria for the certification of demonstration plans implemented by the Director under this subpart and recommend modifications in such criteria as needed;

(3) analyze the use of the comparative measurements implemented by the Director in developing comparative reports and recommend modifications in such measurements as needed;

(4) perform, or enter into contracts with other entities for the performance of, an analysis of access to services and clinical outcomes based on patient encounter data;

(5) enter into contracts with other entities for the development of such criteria and measurements and to otherwise carry out its duties under this section; and

(6) carry out any other activities determined appropriate by the Institute to carry out its duties under this section.

The analysis described in paragraph (4) should focus on conditions and procedures of significance to beneficiaries under the medicare program, as determined by the Institute, and should be designed, and the results summarized, in a manner that facilitates comparisons across health plans.

SEC. 5044C. DUTIES OF DIRECTOR.

(a) IN GENERAL.—The Director shall—

(1) adopt, adapt, or develop criteria in accordance with sections 5044F through 5044I to be used in the licensing of certifying entities and in the certification of demonstration plans, including any minimum criteria needed for the operation of demonstration plans during the transition period described in section 5044F(c);

(2) issue licenses to certifying entities that meet the criteria developed under paragraph (1) for the purpose of enabling such entities to certify demonstration plans in accordance with this subpart;

(3) develop comparative health care measures in addition to those implemented by the Director in developing comparative reports in order to guide consumer choice under the medicare program and to improve the delivery of quality health care under such program;

(4) develop procedures, consistent with section 5044A, for the dissemination of certification and comparative quality information provided to the Director;

(5) contract with an independent entity for the conduct of audits concerning certification and quality measurement and require that as part of the certification process performed by licensed certification entities that there include an onsite evaluation, using performance-based standards, of the providers of items and services under a demonstration plan;

(6) at least quarterly, meet jointly with the Agency for Health Care Policy and Research to review innovative health outcomes measures, new measurement processes, and other matters determined appropriate by the Director;

(7) at least annually, meet with the Institute concerning certification criteria;

(8) not later than January 1, 1999, and each January 1 thereafter, prepare and submit to demonstration plan sponsors and to Congress, a report concerning the activities of the Director for the previous year;

(9) advise the President and Congress concerning health insurance and health care provided under demonstration plans and make recommendations concerning measures that may be implemented to protect the health of all enrollees in demonstration plans; and

(10) carry out other activities determined appropriate by the Director.

(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit the authority of the Director or the Secretary of Health and Human Services with respect to requirements other than those applied under this subpart with respect to demonstration plans.

SEC. 5044D. COMPLIANCE.

(a) IN GENERAL.—Not later than January 1, 1999, the Director shall ensure that a demonstration plan may not be offered unless it has been certified in accordance with this subpart.

(b) CONTRACTS OR REIMBURSEMENTS.—In carrying out subsection (a), the Director—

(1) may not enter into a contract with a demonstration plan sponsor for the provision of a demonstration plan unless the demonstration plan is certified in accordance with this subpart;

(2) may not reimburse a demonstration plan sponsor for items and services provided under a demonstration plan unless the demonstration plan is certified in accordance with this subpart; and

(3) shall, after providing notice to the demonstration plan sponsor operating a demonstration plan and an opportunity for such demonstration plan to be certified, and in accordance with any applicable grievance and appeals procedures under section 5044I, terminate any contract with a demonstration plan sponsor for the operation of a demonstration plan if such demonstration plan is not certified in accordance with this subpart.

SEC. 5044E. PAYMENTS FOR VALUE.

(a) ESTABLISHMENT OF PROGRAM.—The Director shall establish a program under which payments are made to various demonstration plans to reward such plans for meeting or exceeding quality targets.

(b) PERFORMANCE MEASURES.—In carrying out the program under subsection (a), the Director shall establish broad categories of quality targets and performance measures. Such targets and measures shall be designed to permit the Director to determine whether a demonstration plan is being operated in a manner consistent with this subpart.

(c) USE OF FUNDS.—

(1) IN GENERAL.—The Secretary shall withhold 0.50 percent from any payment that a demonstration plan sponsor receives with respect to an individual enrolled with such plan under part I.

(2) PAYMENTS.—The Director shall use amounts collected under paragraph (1) to make annual payments to those demonstration plans that have been determined by the Director to meet or exceed the quality targets and performance measures established under subsection (b). Any amounts collected under such paragraph for a fiscal year and remaining available after payments are made under subsection (d), shall be used for deficit reduction.

(d) AMOUNT OF PAYMENT.—

(1) FORMULA.—The amount of any payment made to a demonstration plan under this section shall be determined in accordance with a formula to be developed by the Director. The formula shall ensure that a payment made to a demonstration plan under this section be in an amount equal to—

(A) with respect to a demonstration plan that is determined to be in the first quintile, 1 percent of the amount allocated to the plan under this subpart;

(B) with respect to a demonstration plan that is determined to be in the second quintile, 0.75 percent of the amount allocated to the plan under this subpart;

(C) with respect to a demonstration plan that is determined to be in the third quintile, 0.50 percent of the amount allocated by the plan under this subpart; and

(D) with respect to a demonstration plan that is determined to be in the fourth quintile, 0.25 percent of the amount allocated by the plan under this subpart.

(2) NO PAYMENT.—A demonstration plan that is determined by the Director to be in the fifth quintile shall not be eligible to receive a payment under this section.

(3) DETERMINATION OF QUINTILES.—Not later than April 30 of each calendar year, the Director shall rank each demonstration plan based on the performance of the plan during the preceding year as determined using the quality targets and performance measures established under subsection (b). Such rankings shall be divided into quintiles with the first quintile containing the highest ranking plans and the fifth quintile containing the lowest ranking plans. Each such quintile shall contain plans that in the aggregate cover an equal number of beneficiaries as compared to another quintile.

SEC. 5044F. CERTIFICATION REQUIREMENT.

(a) IN GENERAL.—To be eligible to enter into a contract with the Director to enroll individuals in a demonstration plan, a demonstration plan sponsor shall participate in the certification process and have the demonstration plans offered by such plan sponsor certified in accordance with this subpart.

(b) EFFECT OF MERGERS OR PURCHASE.—

(1) CERTIFIED PLANS.—Where 2 or more demonstration plan sponsors offering certified demonstration plans are merged or where 1 such plan sponsor is purchased by another plan sponsor, the resulting plan sponsor may continue to operate and enroll individuals for coverage under the demonstration plan as if the demonstration plan involved were certified. The certification of any resulting demonstration plan shall be reviewed by the applicable certifying entity to ensure the continued compliance of the contract with the certification criteria.

(2) NONCERTIFIED PLANS.—The certification of a demonstration plan shall be terminated upon the merger of the demonstration plan sponsor involved or the purchase of the plan sponsor by another entity that does not offer any certified demonstration plans. Any demonstration plans offered through the resulting plan sponsor may reapply for certification after the completion of the merger or purchase.

(c) TRANSITION FOR NEW PLANS.—

(1) IN GENERAL.—A demonstration plan that has not provided health insurance coverage to individuals prior to the effective date of this Act

shall be permitted to contract with the Director and operate and enroll individuals under a demonstration plan without being certified for the 2-year period beginning on the date on which such demonstration plan sponsor enrolls the first individual in the demonstration plan. Such demonstration plan must be certified in order to continue to provide coverage under the contract after such period.

(2) LIMITATION.—A new demonstration plan described in paragraph (1) shall, during the period referred to in paragraph (1) prior to certification, comply with the minimum criteria developed by the Director under section 5044F(a)(1).

SEC. 5044G. LICENSING OF CERTIFICATION ENTITIES.

(a) IN GENERAL.—The Director shall develop procedures for the licensing of entities to certify demonstration plans under this subpart.

(b) REQUIREMENTS.—The procedures developed under subsection (a) shall ensure that—

(1) to be licensed under this section a certification entity shall apply the requirements of this subpart to demonstration plans seeking certification;

(2) a certification entity has procedures in place to suspend or revoke the certification of a demonstration plan that is failing to comply with the certification requirements; and

(3) the Director will give priority to licensing entities that are accrediting health plans that contract with the Director on the date of enactment of this Act.

SEC. 5044H. CERTIFICATION CRITERIA.

(a) ESTABLISHMENT.—The Director shall establish minimum criteria under this section to be used by licensed certifying entities in the certification of demonstration plans under this subpart.

(b) REQUIREMENTS.—Criteria established by the Director under subsection (a) shall require that, in order to be certified, a demonstration plan shall comply at a minimum with the following:

(1) QUALITY IMPROVEMENT PLAN.—The demonstration plan shall implement a total quality improvement plan that is designed to improve the clinical and administrative processes of the demonstration plan on an ongoing basis and demonstrate that improvements in the quality of items and services provided under the demonstration plan have occurred as a result of such improvement plan.

(2) PROVIDER CREDENTIALS.—The demonstration plan shall compile and annually provide to the licensed certifying entity documentation concerning the credentials of the hospitals, physicians, and other health care professionals reimbursed under the demonstration plan.

(3) COMPARATIVE INFORMATION.—The demonstration plan shall compile and provide, as requested by the Secretary of Health and Human Services, to the such Secretary the information necessary to develop a comparative report.

(4) ENCOUNTER DATA.—The demonstration plan shall maintain patient encounter data in accordance with standards established by the Institute, and shall provide these data, as requested by the Institute, to the Institute in support of conducting the analysis described in section 5044B(c)(4).

(5) OTHER REQUIREMENTS.—The demonstration plan shall comply with other requirements authorized under this subpart and implemented by the Director.

SEC. 5044I. GRIEVANCE AND APPEALS.

The Director shall develop grievance and appeals procedures under which a demonstration plan that is denied certification under this subpart may appeal such denial to the Director.

Subchapter B—Other Projects

SEC. 5045. MEDICARE ENROLLMENT DEMONSTRATION PROJECT.

(a) DEMONSTRATION PROJECT.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall implement a demonstration project (in this section referred to as the ''project'') for the purpose of evaluating the use of a third-party contractor to conduct the Medicare Choice plan enrollment and disenrollment functions, as described in part C of the Social Security Act (as added by section 5001 of this Act), in an area.

(2) CONSULTATION.—Before implementing the project under this section, the Secretary shall consult with affected parties on—

(A) the design of the project;

(B) the selection criteria for the third-party contractor; and

(C) the establishment of performance standards, as described in paragraph (3).

(3) PERFORMANCE STANDARDS.—

(A) IN GENERAL.—The Secretary shall establish performance standards for the accuracy and timeliness of the Medicare Choice plan enrollment and disenrollment functions performed by the third-party contractor.

(B) NONCOMPLIANCE.—If the Secretary determines that a third-party contractor is out of compliance with the performance standards established under subparagraph (A), such enrollment and disenrollment functions shall be performed by the Medicare Choice plan until the Secretary appoints a new third-party contractor.

(C) DISPUTE.—In the event that there is a dispute between the Secretary and a Medicare Choice plan regarding whether or not the third-party contractor is in compliance with the performance standards, such enrollment and disenrollment functions shall be performed by the Medicare Choice plan.

(b) REPORT TO CONGRESS.—The Secretary shall periodically report to Congress on the progress of the project conducted pursuant to this section.

(c) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of part C of the Social Security Act (as amended by section 5001 of this Act) to such extent and for such period as the Secretary determines is necessary to conduct the project.

(d) DURATION.—A demonstration project under this section shall be conducted for a 3-year period.

(e) SEPARATE FROM OTHER DEMONSTRATION PROJECTS.—A project implemented by the Secretary under this section shall not be conducted in conjunction with any other demonstration project.

SEC. 5046. MEDICARE COORDINATED CARE DEMONSTRATION PROJECT.

(a) DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct demonstration projects for the purpose of evaluating methods, such as case management and other models of coordinated care, that—

(A) improve the quality of items and services provided to target individuals; and

(B) reduce expenditures under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for items and services provided to target individuals.

(2) TARGET INDIVIDUAL DEFINED.—In this section, the term ''target individual'' means an individual that has a chronic illness, as defined and identified by the Secretary, and is enrolled under the fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.).

(b) PROGRAM DESIGN.—

(1) INITIAL DESIGN.—The Secretary shall evaluate best practices in the private sector of methods of coordinated care for a period of 1 year and design the demonstration project based on such evaluation.

(2) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of enactment of this Act, the Secretary shall implement at least 9 demonstration projects, including—

(A) 6 projects in urban areas; and

(B) 3 projects in rural areas.

(3) EXPANSION OF PROJECTS; IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—

(A) EXPANSION OF PROJECTS.—If the initial report under subsection (c) contains an evaluation that demonstration projects—

(i) reduce expenditures under the medicare program; or

(ii) do not increase expenditures under the medicare program and increase the quality of health care services provided to target individuals and satisfaction of beneficiaries and health care providers;

the Secretary shall continue the existing demonstration projects and may expand the number of demonstration projects.

(B) IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—If a report under subsection (c) contains an evaluation as described in subparagraph (A), the Secretary may issue regulations to implement, on a permanent basis, the components of the demonstration project that are beneficial to the medicare program.

(c) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 2 years after the Secretary implements the initial demonstration projects under this section, and biannually thereafter, the Secretary shall submit to Congress a report regarding the demonstration projects conducted under this section.

(2) CONTENTS OF REPORT.—The report in paragraph (1) shall include the following:

(A) A description of the demonstration projects conducted under this section.

(B) An evaluation of—

(i) the cost-effectiveness of the demonstration projects;

(ii) the quality of the health care services provided to target individuals under the demonstration projects; and

(iii) beneficiary and health care provider satisfaction under the demonstration project.

(C) Any other information regarding the demonstration projects conducted under this section that the Secretary determines to be appropriate.

(d) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of titles XI, XVIII, and XIX of the Social Security Act (42 U.S.C. 1301 et seq., 1395 et seq., 1396 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(e) FUNDING.—

(1) DEMONSTRATION PROJECTS.—

(A) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance 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 for the costs of carrying out the demonstration projects under this section.

(B) LIMITATION.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration projects under this section were not implemented.

(2) EVALUATION AND REPORT.—There are authorized to be appropriated such sums as are necessary for the purpose of developing and submitting the report to Congress under subsection (c).

SEC. 5047. ESTABLISHMENT OF MEDICARE REIMBURSEMENT DEMONSTRATION PROJECTS.

Title XVIII (42 U.S.C. 1395 et seq.) (as amended by section 5343) is amended by adding at the end the following:

''MEDICARE SUBVENTION DEMONSTRATION PROJECT FOR VETERANS

''SEC. 1896. (a) DEFINITIONS.—In this section:

''(1) ADMINISTERING SECRETARIES.—The term 'administering Secretaries' means the Secretary and the Secretary of Veterans Affairs acting jointly.

''(2) DEMONSTRATION PROJECT; PROJECT.—The terms 'demonstration project' and 'project' mean the demonstration project carried out under this section.

''(3) MILITARY RETIREE.—The term 'military retiree' means a member or former member of the Armed Forces who is entitled to retired pay.

''(4) TARGETED MEDICARE-ELIGIBLE VETERAN.—The term 'targeted medicare-eligible veteran' means an individual who—

''(A) is a veteran (as defined in section 101(2) of title 38, United States Code) and is described in section 1710(a)(3) of title 38, United States Code; and

''(B) is entitled to benefits under part A of this title and is enrolled under part B of this title.

''(5) TRUST FUNDS.—The term 'trust funds' means the Federal Hospital Insurance Trust Fund established in section 1817 and the Federal Supplementary Medical Insurance Trust Fund established in section 1841.

''(b) DEMONSTRATION PROJECT.—

''(1) IN GENERAL.—

''(A) ESTABLISHMENT.—The administering Secretaries are authorized to establish a demonstration project (under an agreement entered into by the administering Secretaries) under which the Secretary shall reimburse the Secretary of Veterans Affairs, from the trust funds, for medicare health care services furnished to certain targeted medicare-eligible veterans.

''(B) AGREEMENT.—The agreement entered into under subparagraph (A) shall include at a minimum—

''(i) a description of the benefits to be provided to the participants of the demonstration project established under this section;

''(ii) a description of the eligibility rules for participation in the demonstration project, including any criteria established under subsection (c) and any cost sharing under subsection (d);

''(iii) a description of how the demonstration project will satisfy the requirements under this title;

''(iv) a description of the sites selected under paragraph (2);

''(v) a description of how reimbursement and maintenance of effort requirements under subsection (l) will be implemented in the demonstration project; and

''(vi) a statement that the Secretary shall have access to all data of the Department of Veterans Affairs that the Secretary determines is necessary to conduct independent estimates and audits of the maintenance of effort requirement, the annual reconciliation, and related matters required under the demonstration project.

''(2) NUMBER OF SITES.—The administering Secretaries shall establish a plan for the selection of up to 12 medical centers under the jurisdiction of the Secretary of Veterans Affairs and located in geographically dispersed locations to participate in the project.

''(3) GENERAL CRITERIA.—The selection plan shall favor selection of those medical centers that are suited to serve targeted medicare-eligible individuals because—

''(A) there is a high potential demand by targeted medicare-eligible veterans for their services;

''(B) they have sufficient capability in billing and accounting to participate;

''(C) they have favorable indicators of quality of care, including patient satisfaction;

''(D) they deliver a range of services required by targeted medicare-eligible veterans; and

''(E) they meet other relevant factors identified in the plan.

''(4) MEDICAL CENTER NEAR CLOSED BASE.—The administering Secretaries shall endeavor to include at least 1 medical center that is in the same catchment area as a military medical facility which was closed pursuant to either of the following laws:

''(A) The Defense Base Closure and Realignment Act of 1990.

''(B) Title II of the Defense Authorization Amendments and Base Closure and Realignment Act.

''(5) RESTRICTION.—No new facilities will be built or expanded with funds from the demonstration project.

''(6) DURATION.—The administering Secretaries shall conduct the demonstration project during the 3-year period beginning on January 1, 1998.

''(c) VOLUNTARY PARTICIPATION.—Participation of targeted medicare-eligible veterans in the demonstration project shall be voluntary, subject to the capacity of participating medical centers and the funding limitations specified in subsection (l), and shall be subject to such terms and conditions as the administering Secretaries may establish. In the case of a demonstration project at a medical center described in subsection (b)(3), targeted medicare-eligible veterans who are military retirees shall be given preference in participating in the project.

''(d) COST SHARING.—The Secretary of Veterans Affairs may establish cost-sharing requirements for veterans participating in the demonstration project. If such cost sharing requirements are established, those requirements shall be the same as the requirements that apply to targeted medicare-eligible patients at nongovernmental facilities.

''(e) CREDITING OF PAYMENTS.—A payment received by the Secretary of Veterans Affairs under the demonstration project shall be credited to the applicable Department of Veterans Affairs medical appropriation and (within that appropriation) to funds that have been allotted to the medical center that furnished the services for which the payment is made. Any such payment received during a fiscal year for services provided during a prior fiscal year may be obligated by the Secretary of Veterans Affairs during the fiscal year during which the payment is received.

''(f) AUTHORITY TO WAIVE CERTAIN MEDICARE REQUIREMENTS.—The Secretary may, to the extent necessary to carry out the demonstration project, waive any requirement under this title. If the Secretary waives any such requirement, the Secretary shall include a description of such waiver in the agreement described in subsection (b)(1)(B).

''(g) INSPECTOR GENERAL.—Nothing in the agreement entered into under subsection (b) shall limit the Inspector General of the Department of Health and Human Services from investigating any matters regarding the expenditure of funds under this title for the demonstration project, including compliance with the provisions of this title and all other relevant laws.

''(h) REPORT.—At least 30 days prior to the commencement of the demonstration project, the administering Secretaries shall submit a copy of the agreement entered into under subsection (b) to the committees of jurisdiction in Congress.

''(i) MANAGED HEALTH CARE PLANS.—(1) In carrying out the demonstration project, the Secretary of Veterans Affairs may establish and operate managed health care plans.

''(2) Any such plan shall be operated by or through a Department of Veterans Affairs medical center or group of medical centers and may include the provision of health care services through other facilities under the jurisdiction of the Secretary of Veterans Affairs as well as public and private entities under arrangements made between the Department and the other public or private entity concerned. Any such managed health care plan shall be established and operated in conformance with standards prescribed by the administering Secretaries.

''(3) The administering Secretaries shall prescribe the minimum health care benefits to be provided under such a plan to veterans enrolled in the plan. Those benefits shall include at least all health care services covered under the medicare program under this title.

''(4) The establishment of a managed health care plan under this section shall be counted as the selection of a medical center for purposes of applying the numerical limitation under subsection (b)(1).

''(j) MEDICAL CENTER REQUIREMENTS.—The Secretary of Veterans Affairs may establish a managed health care plan using 1 or more medical centers and other facilities only after the Secretary of Veterans Affairs submits to Congress a report setting forth a plan for the use of such centers and facilities. The plan may not be implemented until the Secretary of Veterans Affairs has received from the Inspector General of the Department of Veterans Affairs, and has forwarded to Congress, certification of each of the following:

''(1) The cost accounting system of the Veterans Health Administration (known as the Decision Support System) is operational and is providing reliable cost information on care delivered on an inpatient and outpatient basis at such centers and facilities.

''(2) The centers and facilities have operated in conformity with the eligibility reform amendments made by title I of the Veterans Health Care Act of 1996 for not less than 3 months.

''(3) The centers and facilities have developed a credible plan (on the basis of market surveys, data from the Decision Support System, actuarial analysis, and other appropriate methods and taking into account the level of payment under subsection (l) and the costs of providing covered services at the centers and facilities) to minimize, to the extent feasible, the risk that appropriated funds allocated to the centers and facilities will be required to meet the centers' and facilities' obligation to targeted medicare-eligible veterans under the demonstration project.

''(4) The centers and facilities collectively have available capacity to provide the contracted benefits package to a sufficient number of targeted medicare-eligible veterans.

''(5) The entity administering the health plan has sufficient systems and safeguards in place to minimize any risk that instituting the managed care model will result in reducing the quality of care delivered to enrollees in the demonstration project or to other veterans receiving care under paragraphs subsection (1) or (2) of section 1710(a) of title 38, United States Code.

''(k) RESERVES.—The Secretary of Veterans Affairs shall maintain such reserves as may be necessary to ensure against the risk that appropriated funds, allocated to medical centers and facilities participating in the demonstration project through a managed health care plan under this section, will be required to meet the obligations of those medical centers and facilities to targeted medicare-eligible veterans.

''(l) PAYMENTS BASED ON REGULAR MEDICARE PAYMENT RATES.—

''(1) PAYMENTS.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall reimburse the Secretary of Veterans Affairs for services provided under the demonstration project at the following rates:

''(i) NONCAPITATION.—Except as provided in clause (ii) and subject to subparagraphs (B)(i) and (D), at a rate equal to 95 percent of the amounts that otherwise would be payable under this title on a noncapitated basis for such services if the medical center were not a Federal medical center, were participating in the program, and imposed charges for such services.

''(ii) CAPITATION.—Subject to subparagraphs (B)(ii) and (D), in the case of services provided to an enrollee under a managed health care plan established under subsection (i), at a rate equal to 95 percent of the amount paid to a Medicare Choice organization under part C with respect to such an enrollee.

In cases in which a payment amount may not otherwise be readily computed, the Secretaries shall establish rules for computing equivalent or comparable payment amounts.

''(B) EXCLUSION OF CERTAIN AMOUNTS.—

''(i) NONCAPITATION.—In computing the amount of payment under subparagraph (A)(i), the following shall be excluded:

(i) DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT.—Any amount attributable to an adjustment under subsection (d)(5)(F) of section 1886 of the Social Security Act (42 U.S.C. 1395ww).

(ii) DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.—Any amount attributable to a payment under subsection (h) of such section.

(iii) PERCENTAGE OF INDIRECT MEDICAL EDUCATION ADJUSTMENT.—40 percent of any amount attributable to the adjustment under subsection (d)(5)(B) of such section.

(iv) PERCENTAGE OF CAPITAL PAYMENTS.—67 percent of any amounts attributable to payments for capital-related costs under subsection (g) of such section.

''(ii) CAPITATION.—In the case of years before 2001, in computing the amount of payment under subparagraph (A)(ii), the payment rate shall be computed as though the amounts excluded under clause (i) had been excluded in the determination of the amount paid to a Medicare Choice organization under part C with respect to an enrollee.

''(C) PERIODIC PAYMENTS FROM MEDICARE TRUST FUNDS.—Payments under this subsection shall be made—

''(i) on a periodic basis consistent with the periodicity of payments under this title; and

''(ii) in appropriate part, as determined by the Secretary, from the trust funds.

''(D) ANNUAL LIMIT ON MEDICARE PAYMENTS.—The amount paid to the Department of Veterans Affairs under this subsection for any year for the demonstration project may not exceed $50,000,000.

''(2) REDUCTION IN PAYMENT FOR VA FAILURE TO MAINTAIN EFFORT.—

''(A) IN GENERAL.—In order to avoid shifting onto the medicare program under this title costs previously assumed by the Department of Veterans Affairs for the provision of medicare-covered services to targeted medicare-eligible veterans, the payment amount under this subsection for the project for a fiscal year shall be reduced by the amount (if any) by which—

''(i) the amount of the VA effort level for targeted veterans (as defined in subparagraph (B)) for the fiscal year ending in such year, is less than

''(ii) the amount of the VA effort level for targeted veterans for fiscal year 1997.

''(B) VA EFFORT LEVEL FOR TARGETED VETERANS DEFINED.—For purposes of subparagraph (A), the term 'VA effort level for targeted veterans' means, for a fiscal year, the amount, as estimated by the administering Secretaries, that would have been expended under the medicare program under this title for VA-provided medicare-covered services for targeted veterans (as defined in subparagraph (C)) for that fiscal year if benefits were available under the medicare program for those services. Such amount does not include expenditures attributable to services for which reimbursement is made under the demonstration project.

''(C) VA-PROVIDED MEDICARE-COVERED SERVICES FOR TARGETED VETERANS.—For purposes of subparagraph (B), the term 'VA-provided medicare-covered services for targeted veterans' means, for a fiscal year, items and services—

''(i) that are provided during the fiscal year by the Department of Veterans Affairs to targeted medicare-eligible veterans;

''(ii) that constitute hospital care and medical services under chapter 17 of title 38, United States Code; and

''(iii) for which benefits would be available under the medicare program under this title if they were provided other than by a Federal provider of services that does not charge for those services.

''(3) ASSURING NO INCREASE IN COST TO MEDICARE PROGRAM.—

''(A) MONITORING EFFECT OF DEMONSTRATION PROGRAM ON COSTS TO MEDICARE PROGRAM.—

''(i) IN GENERAL.—The Secretaries, in consultation with the Comptroller General, shall closely monitor the expenditures made under the medicare program for targeted medicare-eligible veterans during the period of the demonstration project compared to the expenditures that would have been made for such veterans during that period if the demonstration project had not been conducted.

''(ii) ANNUAL REPORT BY THE COMPTROLLER GENERAL.—Not later than December 31 of each year during which the demonstration project is conducted, the Comptroller General shall submit to the Secretaries and the appropriate committees of Congress a report on the extent, if any, to which the costs of the Secretary under the medicare program under this title increased during the preceding fiscal year as a result of the demonstration project.

''(B) REQUIRED RESPONSE IN CASE OF INCREASE IN COSTS.—

''(i) IN GENERAL.—If the administering Secretaries find, based on subparagraph (A), that the expenditures under the medicare program under this title increased (or are expected to increase) during a fiscal year because of the demonstration project, the administering Secretaries shall take such steps as may be needed—

''(I) to recoup for the medicare program the amount of such increase in expenditures; and

''(II) to prevent any such increase in the future.

''(ii) STEPS.—Such steps—

''(I) under clause (i)(I) shall include payment of the amount of such increased expenditures by the Secretary of Veterans Affairs from the current medical care appropriation of the Department of Veterans Affairs to the trust funds; and

''(II) under clause (i)(II) shall include suspending or terminating the demonstration project (in whole or in part) or lowering the amount of payment under paragraph (1)(A).

''(m) EVALUATION AND REPORTS.—

''(1) INDEPENDENT EVALUATION.—The administering Secretaries shall arrange for an independent entity with expertise in the evaluation of health services to conduct an evaluation of the demonstration project. The entity shall submit annual reports on the demonstration project to the administering Secretaries and to the committees of jurisdiction in the Congress. The first report shall be submitted not later than 12 months after the date on which the demonstration project begins operation, and the final report not later than 3½ years after that date. The evaluation and reports shall include an assessment, based on the agreement entered into under subsection (b), of the following:

''(A) The cost to the Department of Veterans Affairs of providing care to veterans under the project.

''(B) Compliance of participating medical centers with applicable measures of quality of care, compared to such compliance for other medicare-participating medical centers.

''(C) A comparison of the costs of medical centers' participation in the program with the reimbursements provided for services of such medical centers.

''(D) Any savings or costs to the medicare program under this title from the project.

''(E) Any change in access to care or quality of care for targeted medicare-eligible veterans participating in the project.

''(F) Any effect of the project on the access to care and quality of care for targeted medicare-eligible veterans not participating in the project and other veterans not participating in the project.

''(G) The provision of services under managed health care plans under subsection (l), including the circumstances (if any) under which the Secretary of Veterans Affairs uses reserves described in subsection (k) and the Secretary of Veterans Affairs' response to such circumstances (including the termination of managed health care plans requiring the use of such reserves).

''(H) Any effect that the demonstration project has on the enrollment in Medicare Choice organizations under part C of this title in the established site areas.

''(2) REPORT ON EXTENSION AND EXPANSION OF DEMONSTRATION PROJECT.—Not later than six months after the date of the submission of the penultimate report under paragraph (1), the administering Secretaries shall submit to Congress a report containing their recommendation as to—

''(A) whether to extend the demonstration project or make the project permanent;

''(B) whether to expand the project to cover additional sites and areas and to increase the maximum amount of reimbursement (or the maximum amount of reimbursement permitted for managed health care plans under this section) under the project in any year; and

''(C) whether the terms and conditions of the project should be continued (or modified) if the project is extended or expanded.

''MEDICARE SUBVENTION DEMONSTRATION PROJECT FOR MILITARY RETIREES

''SEC. 1897. (a) DEFINITIONS.—In this section:

''(1) ADMINISTERING SECRETARIES.—The term 'administering Secretaries' means the Secretary and the Secretary of Defense acting jointly.

''(2) DEMONSTRATION PROJECT; PROJECT.—The terms 'demonstration project' and 'project' mean the demonstration project carried out under this section.

''(3) DESIGNATED PROVIDER.—The term 'designated provider' has the meaning given that term in section 721(5) of the National Defense Authorization Act For Fiscal Year 1997 (Public Law 104–201; 110 Stat. 2593; 10 U.S.C. 1073 note).

''(4) MEDICARE-ELIGIBLE MILITARY RETIREE OR DEPENDENT.—The term 'medicare-eligible military retiree or dependent' means an individual described in section 1074(b) or 1076(b) of title 10, United States Code, who—

''(A) would be eligible for health benefits under section 1086 of such title by reason of subsection (c)(1) of such section 1086 but for the operation of subsection (d) of such section 1086;

''(B)(i) is entitled to benefits under part A of this title; and

''(ii) if the individual was entitled to such benefits before July 1, 1996, received health care items or services from a health care facility of the uniformed services before that date, but after becoming entitled to benefits under part A of this title;

''(C) is enrolled for benefits under part B of this title; and

''(D) has attained age 65.

''(5) MEDICARE HEALTH CARE SERVICES.—The term 'medicare health care services' means items or services covered under part A or B of this title.

''(6) MILITARY TREATMENT FACILITY.—The term 'military treatment facility' means a facility referred to in section 1074(a) of title 10, United States Code.

''(7) TRICARE.—The term 'TRICARE' has the same meaning as the term 'TRICARE program' under section 711 of the National Defense Authorization Act for Fiscal Year 1996 (10 U.S.C. 1073 note).

''(5) TRUST FUNDS.—The term 'trust funds' means the Federal Hospital Insurance Trust Fund established in section 1817 and the Federal Supplementary Medical Insurance Trust Fund established in section 1841.

''(b) DEMONSTRATION PROJECT.—

''(1) IN GENERAL.—

''(A) ESTABLISHMENT.—The administering Secretaries are authorized to establish a demonstration project (under an agreement entered into by the administering Secretaries) under which the Secretary shall reimburse the Secretary of Defense, from the trust funds, for medicare health care services furnished to certain medicare-eligible military retirees or dependents.

''(B) AGREEMENT.—The agreement entered into under subparagraph (A) shall include at a minimum—

''(i) a description of the benefits to be provided to the participants of the demonstration project established under this section;

''(ii) a description of the eligibility rules for participation in the demonstration project, including any cost sharing requirements established under subsection (h);

''(iii) a description of how the demonstration project will satisfy the requirements under this title;

''(iv) a description of the sites selected under paragraph (2);

''(v) a description of how reimbursement and maintenance of effort requirements under subsection (j) will be implemented in the demonstration project; and

''(vi) a statement that the Secretary shall have access to all data of the Department of Defense that the Secretary determines is necessary to conduct independent estimates and audits of the maintenance of effort requirement, the annual reconciliation, and related matters required under the demonstration project.

''(2) IN GENERAL.—The project established under this section shall be conducted in no more than 6 sites, designated jointly by the administering Secretaries after review of all TRICARE regions.

''(3) RESTRICTION.—No new military treatment facilities will be built or expanded with funds from the demonstration project.

''(4) DURATION.—The administering Secretaries shall conduct the demonstration project during the 3-year period beginning on January 1, 1998.

''(c) CREDITING OF PAYMENTS.—A payment received by the Secretary of Defense under the demonstration project shall be credited to the applicable Department of Defense medical appropriation and (within that appropriation). Any such payment received during a fiscal year for services provided during a prior fiscal year may be obligated by the Secretary of Defense during the fiscal year during which the payment is received.

''(d) AUTHORITY TO WAIVE CERTAIN MEDICARE REQUIREMENTS.—The Secretary may, to the extent necessary to carry out the demonstration project, waive any requirement under this title. If the Secretary waives any such requirement, the Secretary shall include a description of such waiver in the agreement described in subsection (b).

''(e) INSPECTOR GENERAL.—Nothing in the agreement entered into under subsection (b) shall limit the Inspector General of the Department of Health and Human Services from investigating any matters regarding the expenditure of funds under this title for the demonstration project, including compliance with the provisions of this title and all other relevant laws.

''(f) REPORT.—At least 30 days prior to the commencement of the demonstration project, the administering Secretaries shall submit a copy of the agreement entered into under subsection (b) to the committees of jurisdiction in Congress.

''(g) VOLUNTARY PARTICIPATION.—Participation of medicare-eligible military retirees or dependents in the demonstration project shall be voluntary, subject to the capacity of participating military treatment facilities and designated providers and the funding limitations specified in subsection (j), and shall be subject to such terms and conditions as the administering Secretaries may establish.

''(h) COST-SHARING BY DEMONSTRATION ENROLLEES.—The Secretary of Defense may establish cost-sharing requirements for medicare-eligible military retirees and dependents who enroll in the demonstration project consistent with part C of this title.

''(i) TRICARE HEALTH CARE PLANS.—

''(1) TRICARE PROGRAM ENROLLMENT FEE WAIVER.—The Secretary of Defense shall waive the enrollment fee applicable to any medicare-eligible military retiree or dependent enrolled in the managed care option of the TRICARE program for any period for which reimbursement is made under this section with respect to such retiree or dependent.

''(2) MODIFICATION OF TRICARE CONTRACTS.—In carrying out the demonstration project, the Secretary of Defense is authorized to amend existing TRICARE contracts in order to provide the medicare health care services to the medicare-eligible military retirees and dependents enrolled in the demonstration project.

''(3) HEALTH CARE BENEFITS.—The administering Secretaries shall prescribe the minimum health care benefits to be provided under such a plan to medicare-eligible military retirees or dependents enrolled in the plan. Those benefits shall include at least all medicare health care services covered under this title.

''(j) PAYMENTS BASED ON REGULAR MEDICARE PAYMENT RATES.—

''(1) PAYMENTS.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall reimburse the Secretary of Defense for services provided under the demonstration project at the following rates:

''(i) NONCAPITATION.—Except as provided in clause (ii) and subject to subparagraphs (B)(i) and (D), at a rate equal to 95 percent of the amounts that otherwise would be payable under this title on a noncapitated basis for such services if the military treatment facility or designated provider were not a Federal medical center, were participating in the program, and imposed charges for such services.

''(ii) CAPITATION.—Subject to subparagraphs (B)(ii) and (D), in the case of services provided to an enrollee under a managed health care plan established under subsection (i), at a rate equal to 95 percent of the amount paid to a Medicare Choice organization under part C with respect to such an enrollee.

In cases in which a payment amount may not otherwise be readily computed, the Secretaries shall establish rules for computing equivalent or comparable payment amounts.

''(B) EXCLUSION OF CERTAIN AMOUNTS.—

''(i) NONCAPITATION.—In computing the amount of payment under subparagraph (A)(i), the following shall be excluded:

''(I) SPECIAL PAYMENTS.—Any amount attributable to an adjustment under subparagraphs (B) and (F) of section 1886(d)(5) and subsection (h) of such section.

''(II) PERCENTAGE OF CAPITAL PAYMENTS.—An amount determined by the administering Secretaries for amounts attributable to payments for capital-related costs under subsection (g) of such section.

''(ii) CAPITATION.—In the case of years before 2001, in computing the amount of payment under subparagraph (A)(ii), the payment rate shall be computed as though the amounts excluded under clause (i) had been excluded in the determination of the amount paid to a Medicare Choice organization under part C with respect to an enrollee.

''(C) PERIODIC PAYMENTS FROM MEDICARE TRUST FUNDS.—Payments under this subsection shall be made—

''(i) on a periodic basis consistent with the periodicity of payments under this title; and

''(ii) in appropriate part, as determined by the Secretary, from the trust funds.

''(D) CAP ON AMOUNT.—The aggregate amount to be reimbursed under this paragraph pursuant to the agreement entered into between the administering Secretaries under subsection (b) shall not exceed a total of—

''(i) $55,000,000 for calendar year 1998;

''(ii) $65,000,000 for calendar year 1999; and

''(iii) $75,000,000 for calendar year 2000.

''(2) ASSURING NO INCREASE IN COST TO MEDICARE PROGRAM.—

''(A) MONITORING EFFECT OF DEMONSTRATION PROGRAM ON COSTS TO MEDICARE PROGRAM.—

''(i) IN GENERAL.—The Secretaries, in consultation with the Comptroller General, shall closely monitor the expenditures made under the medicare program for medicare-eligible military retirees or dependents during the period of the demonstration project compared to the expenditures that would have been made for such medicare-eligible military retirees or dependents during that period if the demonstration project had not been conducted. The agreement entered into by the administering Secretaries under subsection (b) shall require any participating military treatment facility to maintain the level of effort for space available care to medicare-eligible military retirees or dependents.

''(ii) ANNUAL REPORT BY THE COMPTROLLER GENERAL.—Not later than December 31 of each year during which the demonstration project is conducted, the Comptroller General shall submit to the Secretaries and the appropriate committees of Congress a report on the extent, if any, to which the costs of the Secretary under the medicare program under this title increased during the preceding fiscal year as a result of the demonstration project.

''(B) REQUIRED RESPONSE IN CASE OF INCREASE IN COSTS.—

''(i) IN GENERAL.—If the administering Secretaries find, based on subparagraph (A), that the expenditures under the medicare program under this title increased (or are expected to increase) during a fiscal year because of the demonstration project, the administering Secretaries shall take such steps as may be needed—

''(I) to recoup for the medicare program the amount of such increase in expenditures; and

''(II) to prevent any such increase in the future.

''(ii) STEPS.—Such steps—

''(I) under clause (i)(I) shall include payment of the amount of such increased expenditures by the Secretary of Defense from the current medical care appropriation of the Department of Defense to the trust funds; and

''(II) under clause (i)(II) shall include suspending or terminating the demonstration project (in whole or in part) or lowering the amount of payment under paragraph (1)(A).

''(k) EVALUATION AND REPORTS.—

''(1) INDEPENDENT EVALUATION.—The administering Secretaries shall arrange for an independent entity with expertise in the evaluation of health services to conduct an evaluation of the demonstration project. The entity shall submit annual reports on the demonstration project to the administering Secretaries and to the committees of jurisdiction in the Congress. The first report shall be submitted not later than 12 months after the date on which the demonstration project begins operation, and the final report not later than 3½ years after that date. The evaluation and reports shall include an assessment, based on the agreement entered into under subsection (b), of the following:

''(A) The number of medicare-eligible military retirees and dependents opting to participate in the demonstration project instead of receiving health benefits through another health insurance plan (including benefits under this title).

''(B) Compliance by the Department of Defense with the requirements under this title.

''(C) The cost to the Department of Defense of providing care to medicare-eligible military retirees and dependents under the demonstration project.

''(D) Compliance by the Department of Defense with the standards of quality required of entities that furnish medicare health care services.

''(E) An analysis of whether, and in what manner, easier access to the uniformed services treatment system affects the number of medicare-eligible military retirees and dependents receiving medicare health care services.

''(F) Any savings or costs to the medicare program under this title resulting from the demonstration project.

''(G) An assessment of the access to care and quality of care for medicare-eligible military retirees and dependents under the demonstration project.

''(H) Any impact of the demonstration project on the access to care for medicare-eligible military retirees and dependents who did not enroll in the demonstration project and for other individuals entitled to benefits under this title.

''(I) Any impact of the demonstration project on private health care providers.

''(J) Any impact of the demonstration project on access to care for active duty military personnel and their dependents.

''(K) A list of the health insurance plans and programs that were the primary payers for medicare-eligible military retirees and dependents during the year prior to their participation in the demonstration project and the distribution of their previous enrollment in such plans and programs.

''(L) An identification of cost-shifting (if any) between the medicare program under this title and the Defense health program as a result of the demonstration project and a description of the nature of any such cost-shifting.

''(M) An analysis of how the demonstration project affects the overall accessibility of the uniformed services treatment system and the amount of space available for point-of-service care, and a description of the unintended effects (if any) upon the normal treatment priority system.

''(N) A description of the difficulties (if any) experienced by the Department of Defense in managing the demonstration project.

''(O) A description of the effects of the demonstration project on military treatment facility readiness and training and the probable effects of the project on overall Department of Defense medical readiness and training.

''(P) A description of the effects that the demonstration project, if permanent, would be expected to have on the overall budget of the Defense health program, the budgets of individual military treatment facilities and designated providers, and on the budget of the medicare program under this title.

''(Q) An analysis of whether the demonstration project affects the cost to the Department of Defense of prescription drugs or the accessibility, availability, and cost of such drugs to demonstration program beneficiaries.

''(R) Any additional elements specified in the agreement entered into under subsection (b).

''(2) REPORT ON EXTENSION AND EXPANSION OF DEMONSTRATION PROJECT.—Not later than six months after the date of the submission of the penultimate report under paragraph (1), the administering Secretaries shall submit to Congress a report containing their recommendation as to—

''(A) whether to extend the demonstration project or make the project permanent;

''(B) whether to expand the project to cover additional sites and areas and to increase the maximum amount of reimbursement (or the maximum amount of reimbursement permitted for managed health care plans under this section) under the project in any year; and

''(C) whether the terms and conditions of the project should be continued (or modified) if the project is extended or expanded.''.

CHAPTER 6—TAX TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS

SEC. 5049. TAX TREATMENT OF HOSPITALS WHICH PARTICIPATE IN PROVIDER-SPONSORED ORGANIZATIONS.

(a) IN GENERAL.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

''(o) TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS.—An organization shall not fail to be treated as organized and operated exclusively for a charitable purpose for purposes of subsection (c)(3) solely because a hospital which is owned and operated by such organization participates in a provider-sponsored organization (as defined in section 1853(e) of the Social Security Act), whether or not the provider-sponsored organization is exempt from tax. For purposes of subsection (c)(3), any person with a material financial interest in such a provider-sponsored organization shall be treated as a private shareholder or individual with respect to the hospital.''.

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

Subtitle B—Prevention Initiatives

SEC. 5101. ANNUAL SCREENING MAMMOGRAPHY FOR WOMEN OVER AGE 39.

(a) IN GENERAL.—Section 1834(c)(2)(A) (42 U.S.C. 1395m(c)(2)(A)) is amended by striking clauses (iii), (iv), and (v) and inserting the following:

''(iii) in the case of a woman over 39 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.''.

(b) WAIVER OF COINSURANCE.—

(1) IN GENERAL.—Section 1834(c)(1)(C) (42 U.S.C. 1395m(c)(1)(C)) is amended by striking ''80 percent of''.

(2) WAIVER OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—The third sentence of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting after ''1861(s)(10)(A)'' the following: '', with respect to screening mammography (as defined in section 1861(jj),''.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) apply to items and services furnished on or after January 1, 1998.

SEC. 5102. COVERAGE OF COLORECTAL SCREENING.

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

(1) in subsection (s)(2)—

(A) by striking ''and'' at the end of subparagraphs (N) and (O); and

(B) by inserting after subparagraph (O) the following:

''(P) colorectal cancer screening tests (as defined in subsection (oo)); and''; and

(2) by adding at the end the following:

''Colorectal Cancer Screening Test

''(oo)(1)(A) The term 'colorectal cancer screening test' means a procedure furnished to an individual that the Secretary prescribes in regulations as appropriate for the purpose of early detection of colorectal cancer, taking into account availability, effectiveness, costs, changes in technology and standards of medical practice, and such other factors as the Secretary considers appropriate.

''(B) The Secretary shall consult with appropriate organizations in prescribing regulations under subparagraph (A).''.

(b) FREQUENCY AND PAYMENT LIMITS.—Section 1834 (42 U.S.C. 1395m) is amended by inserting after subsection (c) the following new subsection:

''(d) FREQUENCY AND PAYMENT LIMITS FOR COLORECTAL CANCER SCREENING TESTS.—

''(1) IN GENERAL.—The Secretary shall prescribe regulations that—

''(A) establish frequency limits for colorectal cancer screening tests that take into account the risk status of an individual and that are consistent with frequency limits for similar or related services; and

''(B) establish payment limits (including limits on charges of nonparticipating physicians) for colorectal cancer screening tests that are consistent with payment limits for similar or related services.

''(2) REVISIONS.—The Secretary shall periodically review and, to the extent the Secretary considers appropriate, revise the frequency and payment limits established under paragraph (1).

''(3) FACTORS TO DETERMINE INDIVIDUALS AT RISK.—In establishing criteria for determining whether an individual is at risk for purposes of this subsection, the Secretary shall take into consideration family history, prior experience of cancer, a history of chronic digestive disease condition, and the presence of any appropriate recognized gene markers for colorectal cancer.

''(4) CONSULTATION.—In establishing and revising frequency and payment limits under this subsection, the Secretary shall consult with appropriate organizations.''.

(c) CONFORMING AMENDMENTS.—(1) Paragraphs (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended by inserting ''or section 1834(d)'' after ''subsection (h)(1)''.

(2) Section 1833(h)(1)(A) (42 U.S.C. 1395l(h)(1)(A)) is amended by striking ''The Secretary'' and inserting ''Subject to section 1834(d), the Secretary''.

(3) Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

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

(ii) in subparagraph (F), by striking the semicolon at the end and inserting '', and'', and

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

''(G) in the case of colorectal cancer screening tests, which are performed more frequently than is covered under section 1834(d);''; and

(B) in paragraph (7), by striking ''paragraph (1)(B) or under paragraph (1)(F)'' and inserting ''subparagraph (B), (F), or (G) of paragraph (1)''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

(2) REGULATIONS.—The Secretary of Health and Human Services shall issue final regulations described in sections 1861(oo) and 1834(d) of the Social Security Act (as added by this section) within 3 months after the date of enactment of this Act.

SEC. 5103. DIABETES SCREENING TESTS.

(a) DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES.—

(1) IN GENERAL.—Section 1861(s) (42 U.S.C. 1395x(s)), as amended by section 5102, is amended—

(A) in subsection (s)(2)—

(i) by striking ''and'' at the end of subparagraph (P);

(ii) by inserting ''and'' at the end of subparagraph (Q); and

(iii) by adding at the end the following:

''(R) diabetes outpatient self-management training services (as defined in subsection (pp));'', and

(B) by adding at the end the following:

''Diabetes Outpatient Self-Management Training Services

''(pp)(1) The term 'diabetes outpatient self-management training services' means educational and training services furnished to an individual with diabetes by a certified provider (as described in paragraph (2)(A)) in an outpatient setting by an individual or entity that meets the quality standards described in paragraph (2)(B), but only if the physician who is managing the individual's diabetic condition certifies that the services are needed under a comprehensive plan of care related to the individual's diabetic condition to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual's condition.

''(2) In paragraph (1)—

''(A) a 'certified provider' is a physician, or other individual or entity designated by the Secretary, that, in addition to providing diabetes outpatient self-management training services, provides other items or services for which payment may be made under this title; and

''(B) a physician, or other such individual or entity, meets the quality standards described in this subparagraph if the physician, or individual or entity, meets quality standards established by the Secretary, except that the physician, or other individual or entity, shall be deemed to have met such standards if the physician or other individual or entity—

''(i) meets applicable standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards by such Board, or

''(ii) is recognized by an organization that represents individuals (including individuals under this title) with diabetes as meeting standards for furnishing the services.''.

(2) CONSULTATION WITH ORGANIZATIONS IN ESTABLISHING PAYMENT AMOUNTS FOR SERVICES PROVIDED BY PHYSICIANS.—In establishing payment amounts under section 1848 of the Social Security Act for physicians' services consisting of diabetes outpatient self-management training services, the Secretary of Health and Human Services shall consult with appropriate organizations, including such organizations representing individuals or medicare beneficiaries with diabetes, in determining the relative value for such services under section 1848(c)(2) of such Act.

(b) BLOOD-TESTING STRIPS FOR INDIVIDUALS WITH DIABETES.—

(1) INCLUDING STRIPS AND MONITORS AS DURABLE MEDICAL EQUIPMENT.—The first sentence of section 1861(n) (42 U.S.C. 1395x(n)) is amended by inserting before the semicolon the following: '', and includes blood-testing strips and blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individual's use of insulin (as determined under standards established by the Secretary in consultation with the appropriate organizations)''.

(2) 10 PERCENT REDUCTION IN PAYMENTS FOR TESTING STRIPS.—Section 1834(a)(2)(B)(iv) (42 U.S.C. 1395m(a)(2)(B)(iv)) is amended by adding before the period the following: ''(reduced by 10 percent, in the case of a blood glucose testing strip furnished after 1997 for an individual with diabetes)''.

(c) ESTABLISHMENT OF OUTCOME MEASURES FOR BENEFICIARIES WITH DIABETES.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with appropriate organizations, shall establish outcome measures, including glysolated hemoglobin (past 90-day average blood sugar levels), for purposes of evaluating the improvement of the health status of medicare beneficiaries with diabetes mellitus.

(2) RECOMMENDATIONS FOR MODIFICATIONS TO SCREENING BENEFITS.—Taking into account information on the health status of medicare beneficiaries with diabetes mellitus as measured under the outcome measures established under subparagraph (A), the Secretary shall from time to time submit recommendations to Congress regarding modifications to the coverage of services for such beneficiaries under the medicare program.

(d) EFFECTIVE DATE.—The amendments made by this section apply to items and services furnished on or after January 1, 1998.

SEC. 5104. COVERAGE OF BONE MASS MEASUREMENTS.

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

(1) in subsection (s)—

(A) in paragraph (12)(C), by striking ''and'' at the end;

(B) by striking the period at the end of paragraph (14) and inserting ''; and'';

(C) by redesignating paragraphs (15) and (16) as paragraphs (16) and (17), respectively; and

(D) by inserting after paragraph (14) the following:

''(15) bone mass measurement (as defined in subsection (oo)).''; and

(2) by inserting after subsection (pp), as added by section 5103, the following:

''Bone Mass Measurement

''(gg)(1) The term 'bone mass measurement' means a radiologic or radioscopic procedure or other Food and Drug Administration approved technology performed on a qualified individual (as defined in paragraph (2)) for the purpose of identifying bone mass, detecting bone loss, or determining bone quality, and includes a physician's interpretation of the results of the procedure.

''(2) For purposes of paragraph (1), the term 'qualified individual' means an individual who is (in accordance with regulations prescribed by the Secretary)—

''(A) an estrogen-deficient woman at clinical risk for osteoporosis and who is considering treatment;

''(B) an individual with vertebral abnormalities;

''(C) an individual receiving long-term glucocorticoid steroid therapy;

''(D) an individual with primary hyperparathyroidism; or

''(E) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.''.

(b) CONFORMING AMENDMENTS.—Sections 1864(a), 1865(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) (42 U.S.C. 1395aa(a), 1395bb(a), 1396a(a)(9)(C), and 1396n(a)(1)(B)(ii)(I)) are amended by striking ''paragraphs (15) and (16)'' each place such term appears and inserting ''paragraphs (16) and (17)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to bone mass measurements performed on or after January 1, 1998.

SEC. 5105. STUDY ON MEDICAL NUTRITION THERAPY SERVICES.

(a) STUDY.—The Secretary of Health and Human Services shall request the National Academy of Sciences, in conjunction with the United States Preventive Services Task Force, to analyze the expansion or modification of the preventive benefits provided to medicare beneficiaries under title XVIII of the Social Security Act to include medical nutrition therapy services by a registered dietitian.

(b) REPORT.—

(1) INITIAL REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report on the findings of the analysis conducted under subsection (a) to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate.

(2) CONTENTS.—Such report shall include specific findings with respect to the expansion or modification of coverage of medical nutrition therapy services by a registered dietitian for medicare beneficiaries regarding—

(A) cost to the medicare system;

(B) savings to the medicare system;

(C) clinical outcomes; and

(D) short and long term benefits to the medicare system.

(3) FUNDING.—From funds appropriated to the Department of Health and Human Services for fiscal years 1998 and 1999, the Secretary shall provide for such funding as may be necessary for the conduct of the analysis by the National Academy of Sciences under this section.

Subtitle C—Rural Initiatives

SEC. 5151. SOLE COMMUNITY HOSPITALS.

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

(1) in clause (i), by redesignating subclauses (I) and (II) as items (aa) and (bb), respectively;

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

(3) by striking ''(C) In'' and inserting ''(C)(i) Subject to clause (ii), in''; and

(4) by striking the last sentence and inserting the following:

''(ii)(I) There shall be substituted for the base cost reporting period described in clause (i)(I) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

''(II) Beginning with discharges occurring in fiscal year 1998, there shall be substituted for the base cost reporting period described in clause (i)(I) either—

''(aa) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital's cost reporting period (if any) beginning during fiscal year 1994 increased (in a compounded manner) by the applicable percentage increases applied to the hospital under this paragraph for discharges occurring in fiscal years 1995, 1996, 1997, and 1998, or

''(bb) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital's cost reporting period (if any) beginning during fiscal year 1995 increased (in a compounded manner) by the applicable percentage increase applied to the hospital under this paragraph for discharges occurring in fiscal years 1995, 1996, 1997, and 1998,

if such substitution results in an increase in the target amount for the hospital.''.

SEC. 5152. MEDICARE-DEPENDENT, SMALL RURAL HOSPITAL PAYMENT EXTENSION.

(a) SPECIAL TREATMENT EXTENDED.—

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

(A) in clause (i), by striking ''October 1, 1994,'' and inserting ''October 1, 1994, or beginning on or after October 1, 1997, and before October 1, 2001,''; and

(B) in clause (ii)(II), by striking ''October 1, 1994,'' and inserting ''October 1, 1994, or beginning on or after October 1, 1997, and before October 1, 2001,''.

(2) 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 ''September 30, 1994,'' and inserting ''September 30, 1994, and for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2001,'';

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

(C) in clause (iii), by striking the period at the end and inserting '', and''; and

(D) by adding after clause (iii) the following new clause:

''(iv) with respect to discharges occurring during fiscal year 1998 through fiscal year 2000, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).''.

(3) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of OBRA–93 (42 U.S.C. 1395ww note) is amended by striking ''or fiscal year 1994'' and inserting '', fiscal year 1994, fiscal year 1998, fiscal year 1999, or fiscal year 2000''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to discharges occurring on or after October 1, 1997.

SEC. 5153. MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.

(a) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.—Section 1820 (42 U.S.C. 1395i–4) is amended to read as follows:

''MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

''SEC. 1820. (a) ESTABLISHMENT.—Any State that submits an application in accordance with subsection (b) may establish a medicare rural hospital flexibility program described in subsection (c).

''(b) APPLICATION.—A State may establish a medicare rural hospital flexibility program described in subsection (c) if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing—

''(1) assurances that the State—

''(A) has developed, or is in the process of developing, a State rural health care plan that—

''(i) provides for the creation of 1 or more rural health networks (as defined in subsection (d)) in the State;

''(ii) promotes regionalization of rural health services in the State; and

''(iii) improves access to hospital and other health services for rural residents of the State; and

''(B) has developed the rural health care plan described in subparagraph (A) in consultation with the hospital association of the State, rural hospitals located in the State, and the State Office of Rural Health (or, in the case of a State in the process of developing such plan, that assures the Secretary that the State will consult with its State hospital association, rural hospitals located in the State, and the State Office of Rural Health in developing such plan);

''(2) assurances that the State has designated (consistent with the rural health care plan described in paragraph (1)(A)), or is in the process of so designating, rural nonprofit or public hospitals or facilities located in the State as critical access hospitals; and

''(3) such other information and assurances as the Secretary may require.

''(c) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM DESCRIBED.—

''(1) IN GENERAL.—A State that has submitted an application in accordance with subsection (b), may establish a medicare rural hospital flexibility program that provides that—

''(A) the State shall develop at least 1 rural health network (as defined in subsection (d)) in the State; and

''(B) at least 1 facility in the State shall be designated as a critical access hospital in accordance with paragraph (2).

''(2) STATE DESIGNATION OF FACILITIES.—

''(A) IN GENERAL.—A State may designate 1 or more facilities as a critical access hospital in accordance with subparagraph (B).

''(B) CRITERIA FOR DESIGNATION AS CRITICAL ACCESS HOSPITAL.—A State may designate a facility as a critical access hospital if the facility—

''(i) is a nonprofit or public hospital 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—

''(I) is located more than a 35-mile drive from a hospital, or another facility described in this subsection; or

''(II) is certified by the State as being a necessary provider of health care services to residents in the area;

''(ii) makes available 24-hour emergency care services that a State determines are necessary for ensuring access to emergency care services in each area served by a critical access hospital;

''(iii) provides not more than 15 acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period not to exceed 96 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions), except that a peer review organization or equivalent entity may, on request, waive the 96-hour restriction on a case-by-case basis;

''(iv) meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

''(I) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open and fully staffed, except insofar as the facility is required to make available emergency care services as determined under clause (ii) and must have nursing services available on a 24-hour basis, but need not otherwise staff the facility except when an inpatient is present;

''(II) the facility may provide any services otherwise required to be provided by a full-time, on site dietitian, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, off site basis under arrangements as defined in section 1861(w)(1); and

''(III) the inpatient care described in clause (iii) may be provided by a physician's assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who need not be present in the facility; and

''(v) meets the requirements of section 1861(aa)(2)(I).

''(d) DEFINITION OF RURAL HEALTH NETWORK.—

''(1) IN GENERAL.—In this section, the term 'rural health network' means, with respect to a State, an organization consisting of—

''(A) at least 1 facility that the State has designated or plans to designate as a critical access hospital; and

''(B) at least 1 hospital that furnishes acute care services.

''(2) AGREEMENTS.—

''(A) IN GENERAL.—Each critical access hospital that is a member of a rural health network shall have an agreement with respect to each item described in subparagraph (B) with at least 1 hospital that is a member of the network.

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

''(i) Patient referral and transfer.

''(ii) The development and use of communications systems including (where feasible)—

''(I) telemetry systems; and

''(II) systems for electronic sharing of patient data.

''(iii) The provision of emergency and nonemergency transportation among the facility and the hospital.

''(C) CREDENTIALING AND QUALITY ASSURANCE.—Each critical access hospital that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least—

''(i) 1 hospital that is a member of the network;

''(ii) 1 peer review organization or equivalent entity; or

''(iii) 1 other appropriate and qualified entity identified in the State rural health care plan.

''(e) CERTIFICATION BY THE SECRETARY.—The Secretary shall certify a facility as a critical access hospital if the facility—

''(1) is located in a State that has established a medicare rural hospital flexibility program in accordance with subsection (c);

''(2) is designated as a critical access hospital by the State in which it is located; and

''(3) meets such other criteria as the Secretary may require.

''(f) PERMITTING MAINTENANCE OF SWING BEDS.—Nothing in this section shall be construed to prohibit a critical access hospital from entering into an agreement with the Secretary under section 1883 under which the facility's inpatient hospital facilities are used for the furnishing of extended care services.

''(g) GRANTS.—

''(1) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.—The Secretary may award grants to States that have submitted applications in accordance with subsection (b) for—

''(A) engaging in activities relating to planning and implementing a rural health care plan;

''(B) engaging in activities relating to planning and implementing rural health networks; and

''(C) designating facilities as critical access hospitals.

''(2) RURAL EMERGENCY MEDICAL SERVICES.—

''(A) IN GENERAL.—The Secretary may award grants to States that have submitted applications in accordance with subparagraph (B) for the establishment or expansion of a program for the provision of rural emergency medical services.

''(B) APPLICATION.—An application is in accordance with this subparagraph if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing the assurances described in subparagraphs (A)(ii), (A)(iii), and (B) of subsection (b)(1) and paragraph (3) of that subsection.

''(h) GRANDFATHERING OF CERTAIN FACILITIES.—

''(1) IN GENERAL.—Any medical assistance facility operating in Montana and any rural primary care hospital designated by the Secretary under this section prior to the date of the enactment of the Balanced Budget Act of 1997 shall be deemed to have been certified by the Secretary under subsection (e) as a critical access hospital if such facility or hospital is otherwise eligible to be designated by the State as a critical access hospital under subsection (c).

''(2) CONTINUATION OF MEDICAL ASSISTANCE FACILITY AND RURAL PRIMARY CARE HOSPITAL TERMS.—Notwithstanding any other provision of this title, with respect to any medical assistance facility or rural primary care hospital described in paragraph (1), any reference in this title to a 'critical access hospital' shall be deemed to be a reference to a 'medical assistance facility' or 'rural primary care hospital'.

''(i) WAIVER OF CONFLICTING PART A PROVISIONS.—The Secretary is authorized to waive such provisions of this part and part D as are necessary to conduct the program established under this section.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for making grants to all States under subsection (g), $25,000,000 in each of the fiscal years 1998 through 2002.''.

(b) REPORT ON ALTERNATIVE TO 96-HOUR RULE.—Not later than January 1, 1998, the Administrator of the Health Care Financing Administration shall submit to Congress a report on the feasibility of, and administrative requirements necessary to establish an alternative for certain medical diagnoses (as determined by the Administrator) to the 96-hour limitation for inpatient care in critical access hospitals required by section 1820(c)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395i–4), as added by subsection (a) of this section.

(c) CONFORMING AMENDMENTS RELATING TO RURAL PRIMARY CARE HOSPITALS AND CRITICAL ACCESS HOSPITALS.—

(1) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) and title XVIII of that Act (42 U.S.C. 1395 et seq.) are each amended by striking ''rural primary care'' each place it appears and inserting ''critical access''.

(2) DEFINITIONS.—Section 1861(mm) of the Social Security Act (42 U.S.C. 1395x(mm)) is amended to read as follows:

''CRITICAL ACCESS HOSPITAL; CRITICAL ACCESS HOSPITAL SERVICES

''(mm)(1) The term 'critical access hospital' means a facility certified by the Secretary as a critical access hospital under section 1820(e).

''(2) The term 'inpatient critical access hospital services' means items and services, furnished to an inpatient of a critical access hospital by such facility, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.

''(3) The term 'outpatient critical access hospital services' means medical and other health services furnished by a critical access hospital on an outpatient basis.''.

(3) PART A PAYMENT.—Section 1814 of the Social Security Act (42 U.S.C. 1395f) is amended—

(A) in subsection (a)(8), by striking ''72'' and inserting ''96''; and

(B) by amending subsection (l) to read as follows:

''Payment for Inpatient Critical Access Hospital Services

''(l) The amount of payment under this part for inpatient critical access hospital services is the reasonable costs of the critical access hospital in providing such services.''.

(4) PAYMENT CONTINUED TO DESIGNATED EACHS.—Section 1886(d)(5)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(D)) is amended—

(A) in clause (iii)(III), by inserting ''as in effect on September 30, 1997'' before the period at the end; and

(B) in clause (v)—

(i) by inserting ''as in effect on September 30, 1997'' after ''1820(i)(1)''; and

(ii) by striking ''1820(g)'' and inserting ''1820(d)''.

(5) PART B PAYMENT.—Section 1834(g) of the Social Security Act (42 U.S.C. 1395m(g)) is amended to read as follows:

''(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—The amount of payment under this part for outpatient critical access hospital services is the reasonable costs of the critical access hospital in providing such services.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 1997.

SEC. 5154. PROHIBITING DENIAL OF REQUEST BY RURAL REFERRAL CENTERS FOR RECLASSIFICATION ON BASIS OF COMPARABILITY OF WAGES.

(a) IN GENERAL.—Section 1886(d)(10)(D) (42 U.S.C. 1395ww(d)(10)(D)) is amended—

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

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

''(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which has ever been classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.''.

(b) CONTINUING TREATMENT OF PREVIOUSLY DESIGNATED CENTERS.—

(1) IN GENERAL.—Any hospital classified as a rural referral center by the Secretary of Health and Human Services under section 1886(d)(5)(C) of the Social Security Act for fiscal year 1991 shall be classified as such a rural referral center for fiscal year 1998 and each subsequent fiscal year.

(2) BUDGET NEUTRALITY.—The provisions of section 1886(d)(8)(D) of the Social Security Act shall apply to reclassifications made pursuant to paragraph (1) in the same manner as such provisions apply to a reclassification under section 1886(d)(10) of such Act.

SEC. 5155. RURAL HEALTH CLINIC SERVICES.

(a) PER-VISIT PAYMENT LIMITS FOR PROVIDER-BASED CLINICS.—

(1) EXTENSION OF LIMIT.—

(A) IN GENERAL.—The matter in section 1833(f) (42 U.S.C. 1395l(f)) preceding paragraph (1) is amended by striking ''independent rural health clinics'' and inserting ''rural health clinics (other than such clinics in rural hospitals with less than 50 beds)''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) applies to services furnished after 1997.

(2) TECHNICAL CLARIFICATION.—Section 1833(f)(1) (42 U.S.C. 1395l(f)(1)) is amended by inserting ''per visit'' after ''$46''.

(b) ASSURANCE OF QUALITY SERVICES.—

(1) IN GENERAL.—Subparagraph (I) of the first sentence of section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended to read as follows:

''(I) has a quality assessment and performance improvement program, and appropriate procedures for review of utilization of clinic services, as the Secretary may specify,''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 1998.

(c) WAIVER OF CERTAIN STAFFING REQUIREMENTS LIMITED TO CLINICS IN PROGRAM.—

(1) IN GENERAL.—Section 1861(aa)(7)(B)) (42 U.S.C. 1395x(aa)(7)(B)) is amended by inserting before the period '', or if the facility has not yet been determined to meet the requirements (including subparagraph (J) of the first sentence of paragraph (2)) of a rural health clinic.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) applies to waiver requests made after 1997.

(d) REFINEMENT OF SHORTAGE AREA REQUIREMENTS.—

(1) DESIGNATION REVIEWED TRIENNIALLY.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended in the second sentence, in the matter in clause (i) preceding subclause (I)—

(A) by striking ''and that is designated'' and inserting ''and that, within the previous 3-year period, has been designated''; and

(B) by striking ''or that is designated'' and inserting ''or designated''.

(2) AREA MUST HAVE SHORTAGE OF HEALTH CARE PRACTITIONERS.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)), as amended by paragraph (1), is further amended in the second sentence, in the matter in clause (i) preceding subclause (I)—

(A) by striking the comma after ''personal health services''; and

(B) by inserting ''and in which there are insufficient numbers of needed health care practitioners (as determined by the Secretary),'' after ''Bureau of the Census)''.

(3) PREVIOUSLY QUALIFYING CLINICS GRANDFATHERED ONLY TO PREVENT SHORTAGE.—

(A) IN GENERAL.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended in the third sentence by inserting before the period ''if it is determined, in accordance with criteria established by the Secretary in regulations, to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic''.

(B) PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT SERVICES.—

(i) IN GENERAL.—With respect to any regulations issued to implement section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) (as amended by subparagraph (A)), the Secretary of Health and Human Services shall include in such regulations provisions providing for the direct payment to the physician assistant for any physician assistant services as described in clause (ii).

(ii) SERVICES DESCRIBED.—Services described in this clause are physician assistant services provided at a rural health clinic that is principally owned, as determined by the Secretary, by a physician assistant—

(I) as of the date of enactment of this Act; and

(II) continuously from such date through the date on which such services are provided.

(iii) SUNSET.—The provisions of this subparagraph shall not apply after January 1, 2003.

(4) EFFECTIVE DATES; IMPLEMENTING REGULATIONS.—

(A) IN GENERAL.—Except as otherwise provided, the amendments made by the preceding paragraphs take effect on January 1 of the first calendar year beginning at least 1 month after enactment of this Act.

(B) CURRENT RURAL HEALTH CLINICS.—The amendments made by the preceding paragraphs take effect, with respect to entities that are rural health clinics under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) on the date of enactment of this Act, on January 1 of the second calendar year following the calendar year specified in subparagraph (A).

(C) GRANDFATHERED CLINICS.—

(i) IN GENERAL.—The amendment made by paragraph (3) shall take effect on the effective date of regulations issued by the Secretary under clause (ii).

(ii) REGULATIONS.—The Secretary shall issue final regulations implementing paragraph (3) that shall take effect no later than January 1 of the third calendar year beginning at least 1 month after the date of enactment of this Act.

SEC. 5156. MEDICARE REIMBURSEMENT FOR TELEHEALTH SERVICES.

(a) IN GENERAL.—Not later than July 1, 1998, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall make payments from the Federal Supplementary Medical Insurance Trust Fund under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) in accordance with the methodology described in subsection (b) for professional consultation via telecommunications systems with a health care provider furnishing a service for which payment may be made under such part to a beneficiary under the medicare program residing in a county in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) that is designated as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) or a rural county that is not adjacent to a Metropolitan Statistical Area, notwithstanding that the individual health care provider providing the professional consultation is not at the same location as the health care provider furnishing the service to that beneficiary.

(b) METHODOLOGY FOR DETERMINING AMOUNT OF PAYMENTS.—Taking into account the findings of the report required under section 192 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 1988), the findings of the report required under paragraph (c), and any other findings related to the clinical efficacy and cost-effectiveness of telehealth applications, the Secretary shall establish a methodology for determining the amount of payments made under subsection (a) within the following parameters:

(1) The payment shall include a bundled payment to be shared between the referring health care provider and the consulting health care provider. The amount of such bundled payment shall not be greater than the current fee schedule of the consulting health care provider for the health care services provided.

(2) The payment shall not include any reimbursement for any line charges or any facility fees.

(c) SUPPLEMENTAL REPORT.—Not later than January 1, 1998, the Secretary shall submit a report to Congress which shall contain a detailed analysis of—

(1) how telemedicine and telehealth systems are expanding access to health care services;

(2) the clinical efficacy and cost-effectiveness of telemedicine and telehealth applications;

(3) the quality of telemedicine and telehealth services delivered; and

(4) the reasonable cost of telecommunications charges incurred in practicing telemedicine and telehealth in rural, frontier, and underserved areas.

(d) EXPANSION OF TELEHEALTH SERVICES FOR CERTAIN MEDICARE BENEFICIARIES.—

(1) IN GENERAL.—Not later than January 1, 1999, the Secretary shall submit a report to Congress that examines the possibility of making payments from the Federal Supplementary Medical Insurance Trust Fund under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) for professional consultation via telecommunications systems with a health care provider furnishing a service for which payment may be made under such part to a beneficiary described in paragraph (2), notwithstanding that the individual health care provider providing the professional consultation is not at the same location as the health care provider furnishing the service to that beneficiary.

(2) BENEFICIARY DESCRIBED.—A beneficiary described in this paragraph is a beneficiary under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) who does not reside in a rural area (as so defined) that is designated as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)), who is homebound or nursing homebound, and for whom being transferred for health care services imposes a serious hardship.

(3) REPORT.—The report described in paragraph (1) shall contain a detailed statement of the potential costs to the medicare program of

making the payments described in that paragraph using various reimbursement schemes.

SEC. 5157. TELEMEDICINE, INFORMATICS, AND EDUCATION DEMONSTRATION PROJECT.

(a) PURPOSE AND AUTHORIZATION.—

(1) IN GENERAL.—Not later than 9 months after the date of enactment of this section, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a demonstration project described in paragraph (2).

(2) DESCRIPTION OF PROJECT.—The demonstration project described in this paragraph is a single demonstration project to study the use of eligible health care provider telemedicine networks to implement high-capacity computing and advanced networks to improve primary care (and prevent health care complications), improve access to specialty care, and provide educational and training support to rural practitioners.

(3) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of titles XI, XVIII, and XIX of the Social Security Act (42 U.S.C. 1301 et seq., 1395 et seq., 1396 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct the demonstration project.

(4) DURATION OF PROJECT.—The project shall be conducted for a 5-year period.

(b) OBJECTIVES OF PROJECT.—The objectives of the demonstration project conducted under this section shall include the following:

(1) The improvement of patient access to primary and specialty care and the reduction of inappropriate hospital visits in order to improve patient quality-of-life and reduce overall health care costs.

(2) The development of a curriculum to train and development of standards for required credentials and licensure of health professionals (particularly primary care health professionals) in the use of medical informatics and telecommunications.

(3) The demonstration of the application of advanced technologies such as video-conferencing from a patient's home and remote monitoring of a patient's medical condition.

(4) The development of standards in the application of telemedicine and medical informatics.

(5) The development of a model for cost-effective delivery of primary and related care in both a managed care environment and in a fee-for-service environment.

(c) ELIGIBLE HEALTH CARE PROVIDER TELEMEDICINE NETWORK DEFINED.—In this section, the term ''eligible health care provider telemedicine network'' means a consortium that—

(1) includes—

(A) at least 1 tertiary care hospital with an existing telemedicine network with an existing relationship with a medical school; and

(B) not more than 6 facilities, including at least 3 rural referral centers, in rural areas; and

(2) meets the following requirements:

(A) The consortium is located in a region that is predominantly rural.

(B) The consortium submits to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the use the consortium would make of any amounts received under the demonstration project and the source and amount of non-Federal funds used in the project.

(C) The consortium guarantees that it will be responsible for payment for all costs of the project that are not paid under this section and that the maximum amount of payment that may be made to the consortium under this section shall not exceed the amount specified in subsection (d)(3).

(d) COVERAGE AS MEDICARE PART B SERVICES.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, services for medicare beneficiaries furnished under the demonstration project shall be considered to be services covered under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j).

(2) PAYMENTS.—

(A) IN GENERAL.—Subject to paragraph (3), payment for services provided under this section shall be made at a rate of 50 percent of the costs that are reasonable and related to the provision of such services. In computing such costs, the Secretary shall include costs described in subparagraph (B), but may not include costs described in subparagraph (C).

(B) COSTS THAT MAY BE INCLUDED.—The costs described in this subparagraph are the permissible costs (as recognized by the Secretary) for the following:

(i) The acquisition of telemedicine equipment for use in patients' homes (but only in the case of patients located in medically underserved areas).

(ii) Curriculum development and training of health professionals in medical informatics and telemedicine.

(iii) Payment of telecommunications costs including salaries, maintenance of equipment, and costs of telecommunications between patients' homes and the eligible network and between the network and other entities under the arrangements described in subsection (c).

(iv) Payments to practitioners and providers under the medicare programs.

(C) OTHER COSTS.—The costs described in this subparagraph include the following:

(i) The purchase or installation of transmission equipment (other than such equipment used by health professionals to deliver medical informatics services under the project).

(ii) The establishment or operation of a telecommunications common carrier network.

(iii) Construction that is limited to minor renovations related to the installation of equipment.

(3) LIMITATION AND FUNDS.—The Secretary shall make the payments under the demonstration project conducted under this section from the Federal Supplementary Medical Insurance Trust Fund, established under section 1841 of the Social Security Act (42 U.S.C. 1395t), except that the total amount of the payments that may be made by the Secretary under this section shall not exceed $27,000,000.

Subtitle D—Anti-Fraud and Abuse Provisions and Improvements in Protecting Program Integrity

CHAPTER 1—REVISIONS TO SANCTIONS FOR FRAUD AND ABUSE

SEC. 5201. AUTHORITY TO REFUSE TO ENTER INTO MEDICARE AGREEMENTS WITH INDIVIDUALS OR ENTITIES CONVICTED OF FELONIES.

(a) MEDICARE PART A.—Section 1866(b)(2) (42 U.S.C. 1395cc(b)(2)) is amended—

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

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

(3) by adding at the end the following:

''(D) has ascertained that the provider has been convicted of a felony under Federal or State law for an offense that the Secretary determines is inconsistent with the best interests of program beneficiaries.''.

(b) MEDICARE PART B.—Section 1842 (42 U.S.C. 1395u) is amended by adding at the end the following:

''(s) The Secretary may refuse to enter into an agreement with a physician or supplier under subsection (h), or may terminate or refuse to renew such agreement, in the event that such physician or supplier has been convicted of a felony under Federal or State law for an offense which the Secretary determines is inconsistent with the best interests of program beneficiaries.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and apply to the entry and renewal of contracts on or after such date.

SEC. 5202. EXCLUSION OF ENTITY CONTROLLED BY FAMILY MEMBER OF A SANCTIONED INDIVIDUAL.

(a) IN GENERAL.—Section 1128 (42 U.S.C. 1320a–7) is amended—

(1) in subsection (b)(8)(A)—

(A) in clause (i), by striking ''or'' at the end;

(B) in clause (ii), by striking the dash at the end and inserting ''; or''; and

(C) by inserting after clause (ii) the following:

''(iii) who was described in clause (i) but is no longer so described because of a transfer of ownership or control interest, in anticipation of (or following) a conviction, assessment, or exclusion described in subparagraph (B) against the person, to an immediate family member (as defined in subsection (j)(1)) or a member of the household of the person (as defined in subsection (j)(2)) who continues to maintain an interest described in such clause—''; and

(2) by adding at the end the following:

''(j) DEFINITION OF IMMEDIATE FAMILY MEMBER AND MEMBER OF HOUSEHOLD.—For purposes of subsection (b)(8)(A)(iii):

''(1) The term 'immediate family member' means, with respect to a person—

''(A) the husband or wife of the person;

''(B) the natural or adoptive parent, child, or sibling of the person;

''(C) the stepparent, stepchild, stepbrother, or stepsister of the person;

''(D) the father-, mother-, daughter-, son-, brother-, or sister-in-law of the person;

''(E) the grandparent or grandchild of the person; and

''(F) the spouse of a grandparent or grandchild of the person.

''(2) The term 'member of the household' means, with respect to any person, any individual sharing a common abode as part of a single family unit with the person, including domestic employees and others who live together as a family unit, but not including a roomer or boarder.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date that is 45 days after the date of the enactment of this Act.

SEC. 5203. IMPOSITION OF CIVIL MONEY PENALTIES.

(a) CIVIL MONEY PENALTIES FOR PERSONS THAT CONTRACT WITH EXCLUDED INDIVIDUALS.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(1) in paragraph (4), by striking ''or'' at the end;

(2) in paragraph (5), by adding ''or'' at the end; and

(3) by inserting after paragraph (5) the following:

''(6) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in section 1128B(f)), for the provision of items or services for which payment may be made under such a program;''.

(b) CIVIL MONEY PENALTIES FOR SERVICES ORDERED OR PRESCRIBED BY AN EXCLUDED INDIVIDUAL OR ENTITY.—Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1)) is amended—

(1) in subparagraph (D)—

(A) by inserting '', ordered, or prescribed by such person'' after ''other item or service furnished'';

(B) by inserting ''(pursuant to this title or title XVIII)'' after ''period in which the person was excluded'';

(C) by striking ''pursuant to a determination by the Secretary'' and all that follows through ''the provisions of section 1842(j)(2)''; and

(D) by striking ''or'' at the end;

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

(3) by inserting after subparagraph (D) the following:

''(E) is for a medical or other item or service ordered or prescribed by a person excluded pursuant to this title or title XVIII from the program under which the claim was made, and the

person furnishing such item or service knows or should know of such exclusion, or''.

(c) CIVIL MONEY PENALTIES FOR KICKBACKS.—

(1) PERMITTING SECRETARY TO IMPOSE CIVIL MONEY PENALTY.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by subsection (a), is amended—

(A) in paragraph (5), by striking ''or'' at the end;

(B) in paragraph (6), by adding ''or'' at the end; and

(C) by adding after paragraph (6) the following:

''(7) commits an act described in paragraph (1) or (2) of section 1128B(b);''.

(2) DESCRIPTION OF CIVIL MONEY PENALTY APPLICABLE.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by paragraph (1), is amended in the matter following paragraph (7)—

(A) by striking ''occurs).'' and inserting ''occurs; or in cases under paragraph (7), $50,000 for each such act).''; and

(B) by inserting after ''of such claim'' the following: ''(or, in cases under paragraph (7), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose)''.

(d) EFFECTIVE DATES.—

(1) CONTRACTS WITH EXCLUDED PERSONS.—The amendments made by subsection (a) shall apply to arrangements and contracts entered into after the date of the enactment of this Act.

(2) SERVICES ORDERED OR PRESCRIBED.—The amendments made by subsection (b) shall apply to items and services furnished, ordered, or prescribed after the date of the enactment of this Act.

(3) KICKBACKS.—The amendments made by subsection (c) shall apply to acts taken after the date of the enactment of this Act.

CHAPTER 2—IMPROVEMENTS IN PROTECTING PROGRAM INTEGRITY

SEC. 5211. DISCLOSURE OF INFORMATION, SURETY BONDS, AND ACCREDITATION.

(a) DISCLOSURE OF INFORMATION, SURETY BOND, AND ACCREDITATION REQUIREMENT FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by inserting after paragraph (15) the following:

''(16) DISCLOSURE OF INFORMATION, SURETY BOND, AND ACCREDITATION.—The Secretary shall not provide for the issuance (or renewal) of a provider number for a supplier of durable medical equipment, for purposes of payment under this part for durable medical equipment furnished by the supplier, unless the supplier provides the Secretary on a continuing basis—

''(A) with—

''(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1124(a)(3)) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest; and

''(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1124(a)(2)) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity;

''(B) with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000; and

''(C) at the discretion of the Secretary, with evidence of compliance with the applicable conditions or requirements of this title through an accreditation survey conducted by a national accreditation body under section 1865(b).

The Secretary may waive the requirement of a bond under subparagraph (B) in the case of a supplier that provides a comparable surety bond under State law.''.

(b) SURETY BOND REQUIREMENT FOR HOME HEALTH AGENCIES.—

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

(A) in paragraph (7), by inserting ''and including providing the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000'' after ''financial security of the program''; and

(B) by adding at the end the following: ''The Secretary may waive the requirement of a surety bond under paragraph (7) in the case of an agency or organization that provides a comparable surety bond under State law.''.

(2) CONFORMING AMENDMENTS.—Section 1861(v)(1)(H) (42 U.S.C. 1395x(v)(1)(H)) is amended—

(A) in clause (i), by striking ''the financial security requirement'' and inserting ''the financial security and surety bond requirements''; and

(B) in clause (ii), by striking ''the financial security requirement described in subsection (o)(7) applies'' and inserting ''the financial security and surety bond requirements described in subsection (o)(7) apply''.

(3) REFERENCE TO CURRENT DISCLOSURE REQUIREMENT.—For additional provisions requiring home health agencies to disclose information on ownership and control interests, see section 1124 of the Social Security Act (42 U.S.C. 1320a–3).

(c) AUTHORIZING APPLICATION OF DISCLOSURE AND SURETY BOND REQUIREMENTS TO AMBULANCE SERVICES AND CERTAIN CLINICS.—Section 1834(a)(16) (42 U.S.C. 1395m(a)(16)), as added by subsection (a), is amended by adding at the end the following flush sentence:

The Secretary, in the Secretary's discretion, may impose the requirements of the previous sentence with respect to some or all classes of suppliers of ambulance services described in section 1861(s)(7) and clinics that furnish medical and other health services (other than physicians' services) under this part.''.

(d) APPLICATION TO COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORFS).—Section 1861(cc)(2) (42 U.S.C. 1395x(cc)(2)) is amended—

(1) in subparagraph (I), by inserting before the period at the end the following: ''and providing the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000''; and

(2) by adding at the end the following flush sentence:

''The Secretary may waive the requirement of a bond under subparagraph (I) in the case of a facility that provides a comparable surety bond under State law.''.

(e) APPLICATION TO REHABILITATION AGENCIES.—Section 1861(p) (42 U.S.C. 1395x(p)) is amended—

(1) in paragraph (4)(A)(v), by inserting after ''as the Secretary may find necessary,'' the following: ''and provides the Secretary, to the extent required by the Secretary, on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000,'', and

(2) by adding at the end the following: ''The Secretary may waive the requirement of a bond under paragraph (4)(A)(v) in the case of a clinic or agency that provides a comparable surety bond under State law.''.

(f) EFFECTIVE DATES.—

(1) SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.—The amendment made by subsection (a) shall apply to suppliers of durable medical equipment with respect to such equipment furnished on or after January 1, 1998.

(2) HOME HEALTH AGENCIES.—The amendments made by subsection (b) shall apply to home health agencies with respect to services furnished on or after January 1, 1998. The Secretary of Health and Human Services shall modify participation agreements under section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) with respect to home health agencies to provide for implementation of such amendments on a timely basis.

(3) OTHER AMENDMENTS.—The amendments made by subsections (c) through (e) shall take effect on the date of the enactment of this Act and may be applied with respect to items and services furnished on or after the date specified in paragraph (1).

SEC. 5212. PROVISION OF CERTAIN IDENTIFICATION NUMBERS.

(a) REQUIREMENTS TO DISCLOSE EMPLOYER IDENTIFICATION NUMBERS (EINS) AND SOCIAL SECURITY ACCOUNT NUMBERS (SSNS).—Section 1124(a)(1) (42 U.S.C. 1320a–3(a)(1)) is amended by inserting before the period at the end the following: ''and supply the Secretary with the both the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing entity, each person with an ownership or control interest (as defined in subsection (a)(3)), and any subcontractor in which the entity directly or indirectly has a 5 percent or more ownership interest''.

(b) OTHER MEDICARE PROVIDERS.—Section 1124A (42 U.S.C. 1320a–3a) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking ''and'' at the end;

(B) in paragraph (2), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(3) including the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing part B provider and any person, managing employee, or other entity identified or described under paragraph (1) or (2).''; and

(2) in subsection (c)(1), by inserting ''(or, for purposes of subsection (a)(3), any entity receiving payment)'' after ''on an assignment-related basis''.

(c) VERIFICATION BY SOCIAL SECURITY ADMINISTRATION (SSA).—Section 1124A (42 U.S.C. 1320a–3a), as amended by subsection (b), is amended—

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

(2) by inserting after subsection (b) the following:

''(c) VERIFICATION.—

''(1) TRANSMITTAL BY HHS.—The Secretary shall transmit—

''(A) to the Commissioner of Social Security information concerning each social security account number (assigned under section 205(c)(2)(B)), and

''(B) to the Secretary of the Treasury information concerning each employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986),

supplied to the Secretary pursuant to subsection (a)(3) or section 1124(c) to the extent necessary for verification of such information in accordance with paragraph (2).

''(2) VERIFICATION.—The Commissioner of Social Security and the Secretary of the Treasury shall verify the accuracy of, or correct, the information supplied by the Secretary to such official pursuant to paragraph (1), and shall report such verifications or corrections to the Secretary.

''(3) FEES FOR VERIFICATION.—The Secretary shall reimburse the Commissioner and Secretary of the Treasury, at a rate negotiated between the Secretary and such official, for the costs incurred by such official in performing the verification and correction services described in this subsection.''.

(d) REPORT.—The Secretary of Health and Human Services shall submit to Congress a report on steps the Secretary has taken to assure the confidentiality of social security account numbers that will be provided to the Secretary under the amendments made by this section.

(e) EFFECTIVE DATES.—

(1) DISCLOSURE REQUIREMENTS.—The amendment made by subsection (a) shall apply to the application of conditions of participation, and entering into and renewal of contracts and agreements, occurring more than 90 days after the date of submission of the report under subsection (d).

(2) OTHER PROVIDERS.—The amendments made by subsection (b) shall apply to payment for items and services furnished more than 90 days after the date of submission of such report.

SEC. 5213. APPLICATION OF CERTAIN PROVISIONS OF THE BANKRUPTCY CODE.

(a) RESTRICTED APPLICABILITY OF BANKRUPTCY STAY, DISCHARGE, AND PREFERENTIAL TRANSFER PROVISIONS TO MEDICARE AND MEDICAID DEBTS.—Part A of title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1143 the following:

''APPLICATION OF CERTAIN PROVISIONS OF THE BANKRUPTCY CODE

''SEC. 1144. (a) MEDICARE AND MEDICAID-RELATED ACTIONS NOT STAYED BY BANKRUPTCY PROCEEDINGS.—The commencement or continuation of any action against a debtor under this title or title XVIII or XIX (other than an action with respect to health care services for the debtor under title XVIII), including any action or proceeding to exclude or suspend the debtor from program participation, assess civil money penalties, recoup or set off overpayments, or deny or suspend payment of claims shall not be subject to the provisions of section 362(a) of title 11, United States Code.

''(b) CERTAIN MEDICARE- AND MEDICAID-RELATED DEBT NOT DISCHARGEABLE IN BANKRUPTCY.—A debt owed to the United States or to a State for an overpayment under title XVIII or XIX (other than an overpayment for health care services for the debtor under title XVIII) resulting from the fraudulent actions of the debtor, or for a penalty, fine, or assessment under this title or title XVIII or XIX, shall not be dischargeable under any provision of title 11, United States Code.

''(c) REPAYMENT OF CERTAIN DEBTS CONSIDERED FINAL.—Payments made to repay a debt to the United States or to a State with respect to items or services provided, or claims for payment made, under title XVIII or XIX (including repayment of an overpayment (other than an overpayment for health care services for the debtor under title XVIII) resulting from the fraudulent actions of the debtor), or to pay a penalty, fine, or assessment under this title or title XVIII or XIX, shall be considered final and not preferential transfers under section 547 of title 11, United States Code.''.

(b) MEDICARE RULES APPLICABLE TO BANKRUPTCY PROCEEDINGS.—Title XVIII (42 U.S.C. 1395 et seq.) is amended by adding at the end the following:

''APPLICATION OF PROVISIONS OF THE BANKRUPTCY CODE

''SEC. 1894. (a) USE OF MEDICARE STANDARDS AND PROCEDURES.—Notwithstanding any provision of title 11, United States Code, or any other provision of law, in the case of claims by a debtor in bankruptcy for payment under this title, the determination of whether the claim is allowable and of the amount payable, shall be made in accordance with the provisions of this title and title XI and implementing regulations.

''(b) NOTICE TO CREDITOR OF BANKRUPTCY PETITIONER.—In the case of a debt owed to the United States with respect to items or services provided, or claims for payment made, under this title (including a debt arising from an overpayment or a penalty, fine, or assessment under title XI or this title), the notices to the creditor of bankruptcy petitions, proceedings, and relief required under title 11, United States Code (including under section 342 of that title and section 2002(j) of the Federal Rules of Bankruptcy Procedure), shall be given to the Secretary. Provision of such notice to a fiscal agent of the Secretary shall not be considered to satisfy this requirement.

''(c) TURNOVER OF PROPERTY TO THE BANKRUPTCY ESTATE.—For purposes of section 542(b) of title 11, United States Code, a claim for payment under this title shall not be considered to be a matured debt payable to the estate of a debtor until such claim has been allowed by the Secretary in accordance with procedures under this title.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to bankruptcy petitions filed after the date of the enactment of this Act.

SEC. 5214. REPLACEMENT OF REASONABLE CHARGE METHODOLOGY BY FEE SCHEDULES.

(a) IN GENERAL.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended in the matter preceding subparagraph (A) by striking ''the reasonable charges for the services'' and inserting ''the lesser of the actual charges for the services and the amounts determined by the applicable fee schedules developed by the Secretary for the particular services''.

(b) CONFORMING AMENDMENTS.—

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

(A) in subparagraph (A), by striking ''reasonable charges for'' and inserting ''payment bases otherwise applicable to'';

(B) in subparagraph (B), by striking ''reasonable charges'' and inserting ''fee schedule amounts''; and

(C) by inserting after subparagraph (F) the following: ''(G) with respect to services described in clause (i) or (ii) of section 1861(s)(2)(K) (relating to physician assistants and nurse practitioners), the amounts paid shall be 80 percent of the lesser of the actual charge for the services and the applicable amount determined under subclause (I) or (II) of section 1842(b)(12)(A)(ii),''.

(2) Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended—

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

(B) by striking subparagraph (C).

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

(A) in paragraph (3)—

(i) by striking subparagraph (B); and

(ii) by striking ''(3)(A)'' and inserting ''(3)''; and

(B) by striking paragraph (6).

(4) Section 1834(a)(10)(B) (42 U.S.C. 1395m(a)(10)(B)) is amended by striking ''paragraphs (8) and (9)'' and all that follows through ''section 1848(i)(3).'' and inserting ''section 1842(b)(8) to covered items and suppliers of such items and payments under this subsection as such provisions would otherwise apply to physicians' services and physicians.''.

(5) Section 1834(g)(1)(A)(ii) (42 U.S.C. 1395m(g)(1)(A)(ii)) is amended in the heading by striking ''REASONABLE CHARGES FOR PROFESSIONAL'' and inserting ''PROFESSIONAL''.

(6) Section 1842(a) (42 U.S.C. 1395u(a)) is amended—

(A) in the matter preceding paragraph (1), by striking ''reasonable charge'' and inserting ''fee schedule''; and

(B) in paragraph (1)(A), by striking ''reasonable charge'' and inserting ''other''.

(7) Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(A) in subparagraph (B)—

(i) in the matter preceding clause (i), by striking ''where payment'' and all that follows through ''made—'' and inserting ''where payment under this part for a service is on a basis other than a cost basis, such payment will (except as otherwise provided in section 1870(f)) be made—''; and

(ii) by striking clause (ii)(I) and inserting the following: ''(I) the amount determined by the applicable payment basis under this part is the full charge for the service,''; and

(B) by striking the second, third, fourth, fifth, sixth, eighth, and ninth sentences.

(8) Section 1842(b)(4) (42 U.S.C. 1395u(b)(4)) is amended to read as follows:

''(4) In the case of an enteral or parenteral pump that is furnished on a rental basis during a period of medical need—

''(A) monthly rental payments shall not be made under this part for more than 15 months during that period, and

''(B) after monthly rental payments have been made for 15 months during that period, payment under this part shall be made for maintenance and servicing of the pump in amounts that the Secretary determines to be reasonable and necessary to ensure the proper operation of the pump.''.

(9) Section 6112(b) (42 U.S.C. 1395m note; Public Law 101–239) of OBRA—1989 is repealed.

(10) Section 1842(b)(7) (42 U.S.C. 1395u(b)(7)) is amended—

(A) in subparagraph (D)(i), in the matter preceding subclause (I), by striking '', to the extent that such payment is otherwise allowed under this paragraph,'';

(B) in subparagraph (D)(ii), by striking ''subparagraph'' and inserting ''paragraph'';

(C) by striking ''(7)(A) In the case of'' and all that follows through subparagraph (C);

(D) by striking ''(D)(i)'' and inserting ''(7)(A)'';

(E) by redesignating clauses (ii) and (iii) as subparagraphs (B) and (C), respectively; and

(F) by redesignating subclauses (I), (II), and (III) of subparagraph (A) (as redesignated by subparagraph (D) of this paragraph) as clauses (i), (ii), and (iii), respectively.

(11) Section 1842(b)(9) (42 U.S.C. 1395u(b)(9)) is repealed.

(12) Section 1842(b)(10) (42 U.S.C. 1395u(b)(10)) is repealed.

(13) Section 1842(b)(11) (42 U.S.C. 1395u(b)(11)) is amended—

(A) by striking subparagraphs (B) through (D);

(B) by striking ''(11)(A)'' and inserting ''(11)''; and

(C) by redesignating clauses (i) and (ii) as subparagraphs (A) and (B), respectively.

(14) Section 1842(b)(12)(A)(ii) (42 U.S.C. 1395u(b)(12)(A)(ii)) is amended—

(A) in the matter preceding subclause (I), by striking ''prevailing charges determined under paragraph (3)'' and inserting ''the amounts determined under section 1833(a)(1)(G)''; and

(B) in subclause (II), by striking ''prevailing charge rate'' and all that follows up to the period and inserting ''fee schedule amount specified in section 1848 for such services performed by physicians''.

(15) Paragraphs (14) through (17) of section 1842(b) (42 U.S.C. 1395u(b)) are repealed.

(16) Section 1842(b) (42 U.S.C. 1395u(b)) is amended—

(A) in paragraph (18)(A), by striking ''reasonable charge or''; and

(B) by redesignating paragraph (18) as paragraph (14).

(17) Section 1842(j)(1) (42 U.S.C. 1395u(j)) is amended to read as follows:

''(j)(1) See subsections (k), (l), (m), (n), and (p) as to the cases in which sanctions may be applied under paragraph (2).''.

(18) Section 1842(j)(4) (42 U.S.C. 1395u(j)(4)) is amended by striking ''under paragraph (1)''.

(19) Section 1842(n)(1)(A) (42 U.S.C. 1395u(n)(1)(A)) is amended by striking ''reasonable charge (or other applicable limit)'' and inserting ''other applicable limit''.

(20) Section 1842(q) (42 U.S.C. 1395u(q)) is amended—

(A) by striking paragraph (1)(B); and

(B) by striking ''(q)(1)(A)'' and inserting ''(q)(1)''.

(21) Section 1845(b)(1) (42 U.S.C. 1395w–1(b)(1)) is amended by striking ''adjustments to the reasonable charge levels for physicians' services recognized under section 1842(b) and''.

(22) Section 1848(i)(3) (42 U.S.C. 1395w–4(i)(3)) is repealed.

(23) Section 1866(a)(2)(A)(ii) (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by striking ''reasonable charges'' and all that follows through ''provider)'' and inserting ''amount customarily charged for the items and services by the provider''.

(24) Section 1881(b)(3)(A) (42 U.S.C. 1395rr(b)(3)(A)) is amended by striking ''a reasonable charge'' and all that follows through ''section 1848)'' and inserting ''the basis described in section 1848''.

(25) Section 9340 of OBRA—1986 (42 U.S.C. 1395u note; Public Law 99-509) is repealed.

(c) EFFECTIVE DATES.—The amendments made by this section to the extent such amendments substitute fee schedules for reasonable charges, shall apply to particular services as of the date specified by the Secretary of Health and Human Services.

(d) INITIAL BUDGET NEUTRALITY.—The Secretary, in developing a fee schedule for particular services (under the amendments made by this section), shall set amounts for the first year period to which the fee schedule applies at a level so that the total payments under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for those services for that year period shall be approximately equal to the estimated total payments if those amendments had not been made.

SEC. 5215. APPLICATION OF INHERENT REASONABLENESS TO ALL PART B SERVICES OTHER THAN PHYSICIANS' SERVICES.

(a) IN GENERAL.—Section 1842(b)(8) (42 U.S.C. 1395u(b)(8)) is amended to read as follows:

''(8) The Secretary shall describe by regulation the factors to be used in determining the cases (of particular items or services) in which the application of this part (other than to physicians' services paid under section 1848) results in the determination of an amount that, because of its being grossly excessive or grossly deficient, is not inherently reasonable, and provide in those cases for the factors to be considered in establishing an amount that is realistic and equitable.''.

(b) CONFORMING AMENDMENT.—Section 1834(a)(10) (42 U.S.C. 1395m(a)(10)(B)) is amended—

(1) by striking subparagraph (B); and

(2) by redesignating subparagraph (C) as subparagraph (B).

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

SEC. 5216. REQUIREMENT TO FURNISH DIAGNOSTIC INFORMATION.

(a) INCLUSION OF NON-PHYSICIAN PRACTITIONERS IN REQUIREMENT TO PROVIDE DIAGNOSTIC CODES FOR PHYSICIAN SERVICES.—Paragraphs (1) and (2) of section 1842(p) (42 U.S.C. 1395u(p)) are each amended by inserting ''or practitioner specified in subsection (b)(18)(C)'' after ''by a physician''.

(b) REQUIREMENT TO PROVIDE DIAGNOSTIC INFORMATION WHEN ORDERING CERTAIN ITEMS OR SERVICES FURNISHED BY ANOTHER ENTITY.—Section 1842(p) (42 U.S.C. 1395u(p)), is amended by adding at the end the following:

''(4) In the case of an item or service defined in paragraph (3), (6), (8), or (9) of subsection 1861(s) ordered by a physician or a practitioner specified in subsection (b)(18)(C), but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 5217. REPORT BY GAO ON OPERATION OF FRAUD AND ABUSE CONTROL PROGRAM.

Section 1817(k)(6) (42 U.S.C. 1395i(k)(6)) is amended by inserting ''June 1, 1998, and'' after ''Not later than''.

SEC. 5218. COMPETITIVE BIDDING.

(a) GENERAL RULE.—Part B of title XVIII (42 U.S.C. 1395j et seq.) is amended by inserting after section 1846 the following:

''SEC. 1847. COMPETITIVE ACQUISITION OF ITEMS AND SERVICES.

''(a) ESTABLISHMENT OF BIDDING AREAS.—

''(1) IN GENERAL.—The Secretary shall establish competitive acquisition areas for contract award purposes for the furnishing under this part after 1997 of the items and services described in subsection (c). The Secretary may establish different competitive acquisition areas under this subsection for different classes of items and services.

''(2) CRITERIA FOR ESTABLISHMENT.—The competitive acquisition areas established under paragraph (1) shall be chosen based on the availability and accessibility of entities able to furnish items and services, and the probable savings to be realized by the use of competitive bidding in the furnishing of items and services in the area.

''(b) AWARDING OF CONTRACTS IN AREAS.—

''(1) IN GENERAL.—The Secretary shall conduct a competition among individuals and entities supplying items and services described in subsection (c) for each competitive acquisition area established under subsection (a) for each class of items and services.

''(2) CONDITIONS FOR AWARDING CONTRACT.—The Secretary may not award a contract to any entity under the competition conducted pursuant to paragraph (1) to furnish an item or service unless the Secretary finds that the entity meets quality standards specified by the Secretary, and subject to paragraph (3), that the total amounts to be paid under the contract are expected to be less than the total amounts that would otherwise be paid.

''(3) LIMIT ON AMOUNT OF PAYMENT.—The Secretary may not under a contract awarded under this section provide for payment for an item or service in an amount in excess of the applicable fee schedule under this part for similar or related items or services. The preceding sentence shall not apply if the Secretary determines that an amount in excess of such amount is warranted by reason of technological innovation, quality improvement, or similar reasons, except that the total amount paid under the contract shall not exceed the limit under paragraph (2).

''(4) CONTENTS OF CONTRACT.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

''(5) LIMIT ON NUMBER OF CONTRACTORS.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts.

''(c) SERVICES DESCRIBED.—The items and services to which this section applies are all items and services covered under this part (except for physician services as defined by 1861(r)) that the Secretary may specify.''.

(b) ITEMS AND SERVICES TO BE FURNISHED ONLY THROUGH COMPETITIVE ACQUISITION.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) by striking ''or'' at the end of paragraph (14),

(2) by striking the period at the end of paragraph (15) and inserting ''; or'', and

(3) by inserting after paragraph (15) the following:

''(16) where the expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1847(a)) by an entity other than an entity with which the Secretary has entered into a contract under section 1847(b) for the furnishing of such an item or service in that area, unless the Secretary finds that the expenses were incurred in a case of urgent need, or in other circumstances specified by the Secretary.''.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) apply to items and services furnished after December 31, 1997.

SEC. 5219. IMPROVING INFORMATION TO MEDICARE BENEFICIARIES.

(a) CLARIFICATION OF REQUIREMENT TO PROVIDE EXPLANATION OF MEDICARE BENEFITS.—Section 1804 of the Social Security Act (42 U.S.C. 1395b–2) is amended by adding at the end the following new subsection:

''(c)(1) The Secretary shall provide a statement which explains the benefits provided under this title with respect to each item or service for which payment may be made under this title which is furnished to an individual, without regard to whether or not a deductible or coinsurance may be imposed against the individual with respect to such item or service.

''(2) Each explanation of benefits provided under paragraph (1) shall include—

''(A) a statement which indicates that because errors do occur and because medicare fraud, waste and abuse is a significant problem, beneficiaries should carefully check the statement for accuracy and report any errors or questionable charges by calling the toll-free phone number described in subparagraph (C);

''(B) a statement of the beneficiary's right to request an itemized bill (as provided in section 1128A(n)); and

''(C) a toll-free telephone number for reporting errors, questionable charges or other acts that would constitute medicare fraud, waste, or abuse, which may be the same number as described in subsection (b).''.

(b) REQUEST FOR ITEMIZED BILL FOR MEDICARE ITEMS AND SERVICES.—

(1) IN GENERAL.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended by adding at the end the following new subsection:

''(m) WRITTEN REQUEST FOR ITEMIZED BILL.—

''(1) IN GENERAL.—A beneficiary may submit a written request for an itemized bill for medical or other items or services provided to such beneficiary by any person (including an organization, agency, or other entity) that receives payment under title XVIII for providing such items or services to such beneficiary.

''(2) 30-DAY PERIOD TO RECEIVE BILL.—

''(A) IN GENERAL.—Not later than 30 days after the date on which a request under paragraph (1) has been received, a person described in such paragraph shall furnish an itemized bill describing each medical or other item or service provided to the beneficiary requesting the itemized bill.

''(B) PENALTY.—Whoever knowingly fails to furnish an itemized bill in accordance with subparagraph (A) shall be subject to a civil fine of not more than $100 for each such failure.

''(3) REVIEW OF ITEMIZED BILL.—

''(A) IN GENERAL.—Not later than 90 days after the receipt of an itemized bill furnished under paragraph (1), a beneficiary may submit a written request for a review of the itemized bill to the appropriate fiscal intermediary or carrier with a contract under section 1816 or 1842.

''(B) SPECIFIC ALLEGATIONS.—A request for a review of the itemized bill shall identify—

''(i) specific medical or other items or services that the beneficiary believes were not provided as claimed, or

''(ii) any other billing irregularity (including duplicate billing).

''(4) FINDINGS OF FISCAL INTERMEDIARY OR CARRIER.—Each fiscal intermediary or carrier with a contract under section 1816 or 1842 shall, with respect to each written request submitted to the fiscal intermediary or carrier under paragraph (3), determine whether the itemized bill identifies specific medical or other items or services that were not provided as claimed or any other billing irregularity (including duplicate

billing) that has resulted in unnecessary payments under the title XVIII.

''(5) RECOVERY OF AMOUNTS.—The Secretary shall require fiscal intermediaries and carriers to take all appropriate measures to recover amounts unnecessarily paid under title XVIII with respect to a bill described in paragraph (4).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to medical or other items or services provided on or after January 1, 1998.

SEC. 5220. PROHIBITING UNNECESSARY AND WASTEFUL MEDICARE PAYMENTS FOR CERTAIN ITEMS.

Section 1861(v) of the Social Security Act is amended by adding at the end the following new paragraph:

''(8) ITEMS UNRELATED TO PATIENT CARE.—Reasonable costs do not include costs for the following—

''(i) entertainment;

''(ii) gifts or donations;

''(iii) costs for fines and penalties resulting from violations of Federal, State, or local laws; and

''(iv) education expenses for spouses or other dependents of providers of services, their employees or contractors.''.

SEC. 5221. REDUCING EXCESSIVE BILLINGS AND UTILIZATION FOR CERTAIN ITEMS.

Section 1834(a)(15) of the Social Security Act (42 U.S.C. 1395m(a)(15)) is amended by striking ''Secretary may'' both places it appears and inserting ''Secretary shall''.

SEC. 5222. IMPROVING INFORMATION TO MEDICARE BENEFICIARIES.

(a) CLARIFICATION OF REQUIREMENT TO PROVIDE EXPLANATION OF MEDICARE BENEFITS.—Section 1804 of the Social Security Act (42 U.S.C. 1395b–2) is amended by adding at the end the following new subsection:

''(c)(1) The Secretary shall provide a statement which explains the benefits provided under this title with respect to each item or service for which payment may be made under this title which is furnished to an individual, without regard to whether or not a deductible or coinsurance may be imposed against the individual with respect to such item or service.

''(2) Each explanation of benefits provided under paragraph (1) shall include—

''(A) a statement which indicates that because errors do occur and because medicare fraud, waste and abuse is a significant problem, beneficiaries should carefully check the statement for accuracy and report any errors or questionable charges by calling the toll-free phone number described in subparagraph (C);

''(B) a statement of the beneficiary's right to request an itemized bill (as provided in section 1128A(n)); and

''(C) a toll-free telephone number for reporting errors, questionable charges or other acts that would constitute medicare fraud, waste, or abuse, which may be the same number as described in subsection (b).''.

(b) REQUEST FOR ITEMIZED BILL FOR MEDICARE ITEMS AND SERVICES.—

(1) IN GENERAL.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended by adding at the end the following new subsection:

''(m) WRITTEN REQUEST FOR ITEMIZED BILL.—

''(1) IN GENERAL.—A beneficiary may submit a written request for an itemized bill for medical or other items or services provided to such beneficiary by any person (including an organization, agency, or other entity) that receives payment under title XVIII for providing such items or services to such beneficiary.

''(2) 30-DAY PERIOD TO RECEIVE BILL.—

''(A) IN GENERAL.—Not later than 30 days after the date on which a request under paragraph (1) has been received, a person described in such paragraph shall furnish an itemized bill describing each medical or other item or service provided to the beneficiary requesting the itemized bill.

''(B) PENALTY.—Whoever knowingly fails to furnish an itemized bill in accordance with subparagraph (A) shall be subject to a civil fine of not more than $100 for each such failure.

''(3) REVIEW OF ITEMIZED BILL.—

''(A) IN GENERAL.—Not later than 90 days after the receipt of an itemized bill furnished under paragraph (1), a beneficiary may submit a written request for a review of the itemized bill to the appropriate fiscal intermediary or carrier with a contract under section 1816 or 1842.

''(B) SPECIFIC ALLEGATIONS.—A request for a review of the itemized bill shall identify—

''(i) specific medical or other items or services that the beneficiary believes were not provided as claimed, or

''(ii) any other billing irregularity (including duplicate billing).

''(4) FINDINGS OF FISCAL INTERMEDIARY OR CARRIER.—Each fiscal intermediary or carrier with a contract under section 1816 or 1842 shall, with respect to each written request submitted to the fiscal intermediary or carrier under paragraph (3), determine whether the itemized bill identifies specific medical or other items or services that were not provided as claimed or any other billing irregularity (including duplicate billing) that has resulted in unnecessary payments under the title XVIII.

''(5) RECOVERY OF AMOUNTS.—The Secretary shall require fiscal intermediaries and carriers to take all appropriate measures to recover amounts unnecessarily paid under title XVIII with respect to a bill described in paragraph (4).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to medical or other items or services provided on or after January 1, 1998.

SEC. 5223. PROHIBITING UNNECESSARY AND WASTEFUL MEDICARE PAYMENTS FOR CERTAIN ITEMS.

Notwithstanding any other provision of law, including any regulation or payment policy, the following categories of charges shall not be reimbursable under title XVIII of the Social Security Act:

(1) Entertainment costs, including the costs of tickets to sporting and other entertainment events.

(2) Gifts or donations.

(3) Personal use of motor vehicles.

(4) Costs for fines and penalties resulting from violations of Federal, State, or local laws.

(5) Tuition or other education fees for spouses or dependents of providers of services, their employees, or contractors.

SEC. 5224. REDUCING EXCESSIVE BILLINGS AND UTILIZATION FOR CERTAIN ITEMS.

Section 1834(a)(15) of the Social Security Act (42 U.S.C. 1395m(a)(15)) is amended by striking ''Secretary may'' both places it appears and inserting ''Secretary shall''.

SEC. 5225. IMPROVED CARRIER AUTHORITY TO REDUCE EXCESSIVE MEDICARE PAYMENTS.

Section 1834(i) of the Social Security Act (42 U.S.C. 1395m(i)) is amended by adding at the end the following new paragraph:

''(3) GROSSLEY EXCESSIVE PAYMENT AMOUNTS.—Notwithstanding paragraph (1), the Secretary may apply the provisions of section 1842(b)(8) to payments under this subsection.''.

SEC. 5226. ITEMIZATION OF SURGICAL DRESSING BILLS SUBMITTED BY HOME HEALTH AGENCIES.

Section 1834(i)(2) (42 U.S.C. 1395m(i)(2)) is amended to read as follows:

''(2) EXCEPTION.—Paragraph (1) shall not apply to surgical dressings that are furnished as an incident to a physician's professional service.''.

CHAPTER 3—CLARIFICATIONS AND TECHNICAL CHANGES

SEC. 5231. OTHER FRAUD AND ABUSE RELATED PROVISIONS.

(a) REFERENCE CORRECTION.—(1) Section 1128D(b)(2)(D) (42 U.S.C. 1320a–7d(b)(2)(D)), as added by section 205 of the Health Insurance Portability and Accountability Act of 1996, is amended by striking ''1128B(b)'' and inserting ''1128A(b)''.

(2) Section 1128E(g)(3)(C) (42 U.S.C. 1320a–7e(g)(3)(C)) is amended by striking ''Veterans' Administration'' and inserting ''Department of Veterans Affairs''.

(b) LANGUAGE IN DEFINITION OF CONVICTION.—Section 1128E(g)(5) (42 U.S.C. 1320a–7e(g)(5)), as inserted by section 221(a) of the Health Insurance Portability and Accountability Act of 1996, is amended by striking ''paragraph (4)'' and inserting ''paragraphs (1) through (4)''.

(c) IMPLEMENTATION OF EXCLUSIONS.—Section 1128 (42 U.S.C. 1320a–7) is amended—

(1) in subsection (a), by striking ''any program under title XVIII and shall direct that the following individuals and entities be excluded from participation in any State health care program (as defined in subsection (h))'' and inserting ''any Federal health care program (as defined in section 1128B(f))''; and

(2) in subsection (b), by striking ''any program under title XVIII and may direct that the following individuals and entities be excluded from participation in any State health care program'' and inserting ''any Federal health care program (as defined in section 1128B(f))''.

(d) SANCTIONS FOR FAILURE TO REPORT.—Section 1128E(b) (42 U.S.C. 1320a–7e(b)), as inserted by section 221(a) of the Health Insurance Portability and Accountability Act of 1996, is amended by adding at the end the following:

''(6) SANCTIONS FOR FAILURE TO REPORT.—

''(A) HEALTH PLANS.—Any health plan that fails to report information on an adverse action required to be reported under this subsection shall be subject to a civil money penalty of not more than $25,000 for each such adverse action not reported. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) GOVERNMENTAL AGENCIES.—The Secretary shall provide for a publication of a public report that identifies those Government agencies that have failed to report information on adverse actions as required to be reported under this subsection.''.

(e) CLARIFICATION OF TREATMENT OF CERTAIN WAIVERS AND PAYMENTS OF PREMIUMS.—

(1) Section 1128A(i)(6) (42 U.S.C. 1320a–7a(i)(6)) is amended—

(A) in subparagraph (A)(iii)—

(i) in subclause (I), by adding ''or'' at the end;

(ii) in subclause (II), by striking ''or'' at the end; and

(iii) by striking subclause (III);

(B) by redesignating subparagraphs (B) and (C) as subparagraphs (C) and (D); and

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

''(B) any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;''.

(2) Section 1128A(i)(6) (42 U.S.C. 1320a–7a(i)(6)), is amended—

(A) in subparagraph (C), as redesignated by paragraph (1), by striking ''or'' at the end;

(B) in subparagraph (D), as so redesignated, by striking the period at the end and inserting ''; or''; and

(C) by adding at the end the following:

''(D) the waiver of deductible and coinsurance amounts pursuant to medicare supplemental policies under section 1882(t).''.

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in this subsection, the amendments made by this section shall be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996.

(2) FEDERAL HEALTH PROGRAM.—The amendments made by subsection (c) shall take effect on the date of the enactment of this Act.

(3) SANCTION FOR FAILURE TO REPORT.—The amendment made by subsection (d) shall apply to failures occurring on or after the date of the enactment of this Act.

(4) CLARIFICATION.—The amendments made by subsection (e)(2) shall take effect on the date of the enactment of this Act.

Subtitle E—Prospective Payment Systems

CHAPTER 1—PROVISIONS RELATING TO PART A

SEC. 5301. PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION HOSPITAL SERVICES.

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

''(j) PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION SERVICES.—

''(1) PAYMENT DURING TRANSITION PERIOD.—

''(A) IN GENERAL.—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation hospital or a rehabilitation unit (in this subsection referred to as a 'rehabilitation facility'), in a cost reporting period beginning on or after October 1, 2000, and before October 1, 2003, is equal to the sum of—

''(i) the TEFRA percentage (as defined in subparagraph (C)) of the amount that would have been paid under part A of this title with respect to such costs if this subsection did not apply, and

''(ii) the prospective payment percentage (as defined in subparagraph (C)) of the product of (I) the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs, and (II) the number of such payment units occurring in the cost reporting period.

''(B) FULLY IMPLEMENTED SYSTEM.—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation facility for a payment unit in a cost reporting period beginning on or after October 1, 2003, is equal to the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs.

''(C) TEFRA AND PROSPECTIVE PAYMENT PERCENTAGES SPECIFIED.—For purposes of subparagraph (A), for a cost reporting period beginning—

''(i) on or after October 1, 2000, and before October 1, 2001, the 'TEFRA percentage' is 75 percent and the 'prospective payment percentage' is 25 percent;

''(ii) on or after October 1, 2001, and before October 1, 2002, the 'TEFRA percentage' is 50 percent and the 'prospective payment percentage' is 50 percent; and

''(iii) on or after October 1, 2002, and before October 1, 2003, the 'TEFRA percentage' is 25 percent and the 'prospective payment percentage' is 75 percent.

''(D) PAYMENT UNIT.—For purposes of this subsection, the term 'payment unit' means a discharge, day of inpatient hospital services, or other unit of payment defined by the Secretary.

''(2) PATIENT CASE MIX GROUPS.—

''(A) ESTABLISHMENT.—The Secretary shall establish—

''(i) classes of patients of rehabilitation facilities (each in this subsection referred to as a 'case mix group'), based on such factors as the Secretary deems appropriate, which may include impairment, age, related prior hospitalization, comorbidities, and functional capability of the patient; and

''(ii) a method of classifying specific patients in rehabilitation facilities within these groups.

''(B) WEIGHTING FACTORS.—For each case mix group the Secretary shall assign an appropriate weighting which reflects the relative facility resources used with respect to patients classified within that group compared to patients classified within other groups.

''(C) ADJUSTMENTS FOR CASE MIX.—

''(i) IN GENERAL.—The Secretary shall from time to time adjust the classifications and weighting factors established under this paragraph as appropriate to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment is made under this title, and other factors which may affect the relative use of resources. Such adjustments shall be made in a manner so that changes in aggregate payments under the classification system are a result of real changes and are not a result of changes in coding that are unrelated to real changes in case mix.

''(ii) ADJUSTMENT.—Insofar as the Secretary determines that such adjustments for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under the classification system during the fiscal year that are a result of changes in the coding or classification of patients that do not reflect real changes in case mix, the Secretary shall adjust the per payment unit payment rate for subsequent years so as to discount the effect of such coding or classification changes.

''(D) DATA COLLECTION.—The Secretary is authorized to require rehabilitation facilities that provide inpatient hospital services to submit such data as the Secretary deems necessary to establish and administer the prospective payment system under this subsection.

''(3) PAYMENT RATE.—

''(A) IN GENERAL.—The Secretary shall determine a prospective payment rate for each payment unit for which such rehabilitation facility is entitled to receive payment under this title. Subject to subparagraph (B), such rate for payment units occurring during a fiscal year shall be based on the average payment per payment unit under this title for inpatient operating and capital costs of rehabilitation facilities using the most recent data available (as estimated by the Secretary as of the date of establishment of the system) adjusted—

''(i) by updating such per-payment-unit amount to the fiscal year involved by the weighted average of the applicable percentage increases provided under subsection (b)(3)(B)(ii) (for cost reporting periods beginning during the fiscal year) covering the period from the midpoint of the period for such data through the midpoint of fiscal year 2000 and by an increase factor (described in subparagraph (C)) specified by the Secretary for subsequent fiscal years up to the fiscal year involved;

''(ii) by reducing such rates by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on prospective payment amounts which are additional payments described in paragraph (4) (relating to outlier and related payments) or paragraph (7);

''(iii) for variations among rehabilitation facilities by area under paragraph (6);

''(iv) by the weighting factors established under paragraph (2)(B); and

''(v) by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

''(B) BUDGET NEUTRAL RATES.—The Secretary shall establish the prospective payment amounts under this subsection for payment units during fiscal years 2001 through 2004 at levels such that, in the Secretary's estimation, the amount of total payments under this subsection for such fiscal years (including any payment adjustments pursuant to paragraph (7)) shall be equal to 99 percent of the amount of payments that would have been made under this title during the fiscal years for operating and capital costs of rehabilitation facilities had this subsection not been enacted. In establishing such payment amounts, the Secretary shall consider the effects of the prospective payment system established under this subsection on the total number of payment units from rehabilitation facilities and other factors described in subparagraph (A).

''(C) INCREASE FACTOR.—For purposes of this subsection for payment units in each fiscal year (beginning with fiscal year 2001), the Secretary shall establish an increase factor. Such factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under this subsection, which may be the market basket percentage increase described in subsection (b)(3)(B)(iii).

''(4) OUTLIER AND SPECIAL PAYMENTS.—

''(A) OUTLIERS.—

''(i) IN GENERAL.—The Secretary may provide for an additional payment to a rehabilitation facility for patients in a case mix group, based upon the patient being classified as an outlier based on an unusual length of stay, costs, or other factors specified by the Secretary.

''(ii) PAYMENT BASED ON MARGINAL COST OF CARE.—The amount of such additional payment under clause (i) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable under clause (i).

''(iii) TOTAL PAYMENTS.—The total amount of the additional payments made under this subparagraph for payment units in a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on prospective payment rates for payment units in that year.

''(B) ADJUSTMENT.—The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of rehabilitation facilities located in Alaska and Hawaii.

''(5) PUBLICATION.—The Secretary shall provide for publication in the Federal Register, on or before September 1 before each fiscal year (beginning with fiscal year 2001, of the classification and weighting factors for case mix groups under paragraph (2) for such fiscal year and a description of the methodology and data used in computing the prospective payment rates under this subsection for that fiscal year.

''(6) AREA WAGE ADJUSTMENT.—The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under paragraph (3) for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. Not later than October 1, 2001 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under this paragraph for a fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.

''(7) ADDITIONAL ADJUSTMENTS.—The Secretary may provide by regulation for—

''(A) an additional payment to take into account indirect costs of medical education and the special circumstances of hospitals that serve a significantly disproportionate number of low-income patients in a manner similar to that provided under subparagraphs (B) and (F), respectively, of subsection (d)(5); and

''(B) such other exceptions and adjustments to payment amounts under this subsection in a manner similar to that provided under subsection (d)(5)(I) in relation to payments under subsection (d).

''(8) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the establishment of—

''(A) case mix groups, of the methodology for the classification of patients within such groups, and of the appropriate weighting factors thereof under paragraph (2),

''(B) the prospective payment rates under paragraph (3),

''(C) outlier and special payments under paragraph (4),

''(D) area wage adjustments under paragraph (6), and

''(E) additional adjustments under paragraph (7).''.

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

(1) in paragraph (1), by inserting ''and other than a rehabilitation facility described in subsection (j)(1)'' after ''subsection (d)(1)(B)'', and

(2) in paragraph (3)(B)(i), by inserting ''and subsection (j)'' after ''For purposes of subsection (d)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 2000, except that the Secretary of Health and Human Services may require the submission of data under section 1886(j)(2)(D) of the Social Security Act (as added by subsection (a)) on and after the date of the enactment of this section.

SEC. 5302. STUDY AND REPORT ON PAYMENTS FOR LONG-TERM CARE HOSPITALS.

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

(1) collect data to develop, establish, administer and evaluate a case-mix adjusted prospective payment system for hospitals described in section 1886(d)(1)(B)(iv) (42 U.S.C. 1395ww(d)(1)(B)(iv)); and

(2) develop a legislative proposal for establishing and administering such a payment system that includes an adequate patient classification system that reflects the differences in patient resource use and costs among such hospitals.

(b) REPORT.—Not later than October 1, 1999, the Secretary of Health and Human Services shall submit the proposal described in subsection (a)(2) to the appropriate committees of Congress.

CHAPTER 2—PROVISIONS RELATING TO PART B

Subchapter A—Payment for Hospital Outpatient Department Services

SEC. 5311. ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS (FDO) FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.

(a) ELIMINATION OF FDO FOR AMBULATORY SURGICAL CENTER PROCEDURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C. 1395l(i)(3)(B)(i)(II)) is amended—

(1) by striking ''of 80 percent''; and

(2) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(b) ELIMINATION OF FDO FOR RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i) (42 U.S.C. 1395l(n)(1)(B)(i)) is amended—

(1) by striking ''of 80 percent'', and

(2) by inserting before the period at the end the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished during portions of cost reporting periods occurring on or after October 1, 1997.

SEC. 5312. EXTENSION OF REDUCTIONS IN PAYMENTS FOR COSTS OF HOSPITAL OUTPATIENT SERVICES.

(a) REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS.—Section 1861(v)(1)(S)(ii)(I) (42 U.S.C. 1395x(v)(1)(S)(ii)(I)) is amended by striking ''through 1998'' and inserting ''through 1999 and during fiscal year 2000 before January 1, 2000''.

(b) REDUCTION IN PAYMENTS FOR OTHER COSTS.—Section 1861(v)(1)(S)(ii)(II) (42 U.S.C. 1395x(v)(1)(S)(ii)(II)) is amended by striking ''through 1998'' and inserting ''through 1999 and during fiscal year 2000 before January 1, 2000''.

SEC. 5313. PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l) is amended by adding at the end the following:

''(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

''(1) IN GENERAL.—With respect to hospital outpatient services designated by the Secretary (in this section referred to as 'covered OPD services') and furnished during a year beginning with 1999, the amount of payment under this part shall be determined under a prospective payment system established by the Secretary in accordance with this subsection.

''(2) SYSTEM REQUIREMENTS.—Under the payment system—

''(A) the Secretary shall develop a classification system for covered OPD services;

''(B) the Secretary may establish groups of covered OPD services, within the classification system described in subparagraph (A), so that services classified within each group are comparable clinically and with respect to the use of resources;

''(C) the Secretary shall, using data on claims from 1997 and using data from the most recent available cost reports, establish relative payment weights for covered OPD services (and any groups of such services described in subparagraph (B)) based on median hospital costs and shall determine projections of the frequency of utilization of each such service (or group of services) in 1999;

''(D) the Secretary shall determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner;

''(E) the Secretary shall establish other adjustments as determined to be necessary to ensure equitable payments, such as outlier adjustments or adjustments for certain classes of hospitals; and

''(F) the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services.

''(3) CALCULATION OF BASE AMOUNTS.—

''(A) AGGREGATE AMOUNTS THAT WOULD BE PAYABLE IF DEDUCTIBLES WERE DISREGARDED.—The Secretary shall estimate the total amounts that would be payable from the Trust Fund under this part for covered OPD services in 1999, determined without regard to this subsection, as though the deductible under section 1833(b) did not apply, and as though the coinsurance described in section 1866(a)(2)(A)(ii) (as in effect before the date of the enactment of this subsection) continued to apply.

''(B) UNADJUSTED COPAYMENT AMOUNT.—

''(i) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the 'unadjusted copayment amount' applicable to a covered OPD service (or group of such services) is 20 percent of the national median of the charges for the service (or services within the group) furnished during 1997, updated to 1999 using the Secretary's estimate of charge growth during the period.

''(ii) ADJUSTMENTS WHEN FULLY PHASED IN.—If the pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year would be equal to or exceed 80 percent, then the unadjusted copayment amount shall be 25 percent of amount determined under subparagraph (D)(i).

''(iii) RULES FOR NEW SERVICES.—The Secretary shall establish rules for establishment of an unadjusted copayment amount for a covered OPD service not furnished during 1997, based upon its classification within a group of such services.

''(C) CALCULATION OF CONVERSION FACTORS.—

''(i) FOR 1999.—

''(I) IN GENERAL.—The Secretary shall establish a 1999 conversion factor for determining the medicare pre-deductible OPD fee payment amounts for each covered OPD service (or group of such services) furnished in 1999. Such conversion factor shall be established—

''(aa) on the basis of the weights and frequencies described in paragraph (2)(C), and

''(bb) in such manner that the sum of the products determined under subclause (II) for each service or group equals the total project amount described in subparagraph (A).

''(II) PRODUCT.—The Secretary shall determine for each service or group the product of the medicare pre-deductible OPD fee payment amount (taking into account appropriate adjustments described in paragraphs (2)(D) and (2)(E)) and the frequencies for such service or group.

''(ii) SUBSEQUENT YEARS.—Subject to paragraph (8)(B), the Secretary shall establish a conversion factor for covered OPD services furnished in subsequent years in an amount equal to the conversion factor established under this subparagraph and applicable to such services furnished in the previous year increased by the OPD payment increase factor specified under clause (iii) for the year involved.

''(iii) OPD PAYMENT INCREASE FACTOR.—For purposes of this subparagraph, the 'OPD payment increase factor' for services furnished in a year is equal to the sum of—

''(I) the market basket percentage increase applicable under section 1886(b)(3)(B)(iii) to hospital discharges occurring during the fiscal year ending in such year, plus

''(II) in the case of a covered OPD service (or group of such services) furnished in a year in which the pre-deductible payment percentage would not exceed 80 percent, 3.5 percentage points.

In applying the previous sentence for years beginning with 2000, the Secretary may substitute for the market basket percentage increase under subclause (I) an annual percentage increase that is computed and applied with respect to covered OPD services furnished in a year in the same manner as the market basket percentage increase is determined and applied to inpatient hospital services for discharges occurring in a fiscal year.

''(D) PRE-DEDUCTIBLE PAYMENT PERCENTAGE.—The pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year is equal to the ratio of—

''(i) the conversion factor established under subparagraph (C) for the year, multiplied by the weighting factor established under paragraph (2)(C) for the service (or group), to

''(ii) the sum of the amount determined under clause (i) and the unadjusted copayment amount determined under subparagraph (B) for such service or group.

''(E) CALCULATION OF MEDICARE OPD FEE SCHEDULE AMOUNTS.—The Secretary shall compute a medicare OPD fee schedule amount for each covered OPD service (or group of such services) furnished in a year, in an amount equal to the product of—

''(i) the conversion factor computed under subparagraph (C) for the year, and

''(ii) the relative payment weight (determined under paragraph (2)(C)) for the service or group.

''(4) MEDICARE PAYMENT AMOUNT.—The amount of payment made from the Trust Fund under this part for a covered OPD service (and such services classified within a group) furnished in a year is determined as follows:

''(A) FEE SCHEDULE AND COPAYMENT AMOUNT.—Add (i) the medicare OPD fee schedule amount (computed under paragraph (3)(E)) for the service or group and year, and (ii) the

unadjusted copayment amount (determined under paragraph (3)(B)) for the service or group.

''(B) SUBTRACT APPLICABLE DEDUCTIBLE.—Reduce the sum under subparagraph (A) by the amount of the deductible under section 1833(b), to the extent applicable.

''(C) APPLY PAYMENT PROPORTION TO REMAINDER.—Multiply the amount determined under subparagraph (B) by the pre-deductible payment percentage (as determined under paragraph (3)(D)) for the service or group and year involved.

''(D) LABOR-RELATED ADJUSTMENT.—The amount of payment is the product determined under subparagraph (C) with the labor-related portion of such product adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraph (2)(D).

''(5) COPAYMENT AMOUNT.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the copayment amount under this subsection is determined as follows:

''(i) UNADJUSTED COPAYMENT.—Compute the amount by which the amount described in paragraph (4)(B) exceeds the amount of payment determined under paragraph (4)(C).

''(ii) LABOR ADJUSTMENT.—The copayment amount is the difference determined under clause (i) with the labor-related portion of such difference adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraphs (2)(D). The adjustment under this clause shall be made in a manner that does not result in any change in the aggregate copayments made in any year if the adjustment had not been made.

''(B) ELECTION TO OFFER REDUCED COPAYMENT AMOUNT.—The Secretary shall establish a procedure under which a hospital, before the beginning of a year (beginning with 1999), may elect to reduce the copayment amount otherwise established under subparagraph (A) for some or all covered OPD services to an amount that is not less than 25 percent of the medicare OPD fee schedule amount (computed under paragraph (3)(E)) for the service involved, adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under subparagraphs (D) and (E) of paragraph (2). Under such procedures, such reduced copayment amount may not be further reduced or increased during the year involved and the hospital may disseminate information on the reduction of copayment amount effected under this subparagraph.

''(C) NO IMPACT ON DEDUCTIBLES.—Nothing in this paragraph shall be construed as affecting a hospital's authority to waive the charging of a deductible under section 1833(b).

''(6) PERIODIC REVIEW AND ADJUSTMENTS COMPONENTS OF PROSPECTIVE PAYMENT SYSTEM.—

''(A) PERIODIC REVIEW.—The Secretary may periodically review and revise the groups, the relative payment weights, and the wage and other adjustments described in paragraph (2) to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

''(B) BUDGET NEUTRALITY ADJUSTMENT.—If the Secretary makes adjustments under subparagraph (A), then the adjustments for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expenditures under this part that would have been made if the adjustments had not been made.

''(C) UPDATE FACTOR.—If the Secretary determines under methodologies described in subparagraph (2)(F) that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary may appropriately adjust the update to the conversion factor otherwise applicable in a subsequent year.

''(7) SPECIAL RULE FOR AMBULANCE SERVICES.—The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in the matter in subsection (a)(1) preceding subparagraph (A).

''(8) SPECIAL RULES FOR CERTAIN HOSPITALS.—In the case of hospitals described in section 1886(d)(1)(B)(v)—

''(A) the system under this subsection shall not apply to covered OPD services furnished before January 1, 2000; and

''(B) the Secretary may establish a separate conversion factor for such services in a manner that specifically takes into account the unique costs incurred by such hospitals by virtue of their patient population and service intensity.

''(9) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

''(A) the development of the classification system under paragraph (2), including the establishment of groups and relative payment weights for covered OPD services, of wage adjustment factors, other adjustments, and methods described in paragraph (2)(F);

''(B) the calculation of base amounts under paragraph (3);

''(C) periodic adjustments made under paragraph (6); and

''(D) the establishment of a separate conversion factor under paragraph (8)(B).''.

(b) COINSURANCE.—Section 1866(a)(2)(A)(ii) (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by adding at the end the following: ''In the case of items and services for which payment is made under part B under the prospective payment system established under section 1833(t), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1833(t)(5).''.

(c) TREATMENT OF REDUCTION IN COPAYMENT AMOUNT.—Section 1128A(i)(6) (42 U.S.C. 1320a–7a(i)(6)) is amended—

(1) by striking ''or'' at the end of subparagraph (B),

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

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

''(D) a reduction in the copayment amount for covered OPD services under section 1833(t)(5)(B).''.

(d) CONFORMING AMENDMENTS.—

(1) APPROVED ASC PROCEDURES PERFORMED IN HOSPITAL OUTPATIENT DEPARTMENTS.—

(A)(i) Section 1833(i)(3)(A) (42 U.S.C. 1395l(i)(3)(A)) is amended—

(I) by inserting ''before January 1, 1999'' after ''furnished'', and

(II) by striking ''in a cost reporting period''.

(ii) The amendment made by clause (i) shall apply to services furnished on or after January 1, 1999.

(B) Section 1833(a)(4) (42 U.S.C. 1395l(a)(4)) is amended by inserting ''or subsection (t)'' before the semicolon.

(2) RADIOLOGY AND OTHER DIAGNOSTIC PROCEDURES.—

(A) Section 1833(n)(1)(A) (42 U.S.C. 1395l(n)(1)(A)) is amended by inserting ''and before January 1, 1999'' after ''October 1, 1988,'' and after ''October 1, 1989,''.

(B) Section 1833(a)(2)(E) (42 U.S.C. 1395l(a)(2)(E)) is amended by inserting ''or , for services or procedures performed on or after January 1, 1999, subsection (t)'' before the semicolon.

(3) OTHER HOSPITAL OUTPATIENT SERVICES.—Section 1833(a)(2)(B) (42 U.S.C. 1395l(a)(2)(B)) is amended—

(A) in clause (i), by inserting ''furnished before January 1, 1999,'' after ''(i)'',

(B) in clause (ii), by inserting ''before January 1, 1999,'' after ''furnished'',

(C) by redesignating clause (iii) as clause (iv), and

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

''(iii) if such services are furnished on or after January 1, 1999, the amount determined under subsection (t), or''.

Subchapter B—Ambulance Services

SEC. 5321. PAYMENTS FOR AMBULANCE SERVICES.

(a) INTERIM REDUCTIONS.—

(1) PAYMENTS DETERMINED ON REASONABLE COST BASIS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

''(V) In determining the reasonable cost of ambulance services (as described in subsection (s)(7)) provided during a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2002), the Secretary shall not recognize any costs in excess of costs recognized as reasonable for ambulance services provided during the previous fiscal year (after application of this subparagraph), increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the fiscal year involved reduced in the case of fiscal year 1998 by 1.0 percentage point.''.

(2) PAYMENTS DETERMINED ON REASONABLE CHARGE BASIS.—Section 1842(b) (42 U.S.C. 1395u(b)) is amended by adding at the end the following new paragraph:

''(19) For purposes of section 1833(a)(1), the reasonable charge for ambulance services (as described in section 1861(s)(7)) provided during a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2002) may not exceed the reasonable charge for such services provided during the previous fiscal year (after application of this paragraph), increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved reduced in the case of fiscal year 1998 by 1.0 percentage point.''.

(b) ESTABLISHMENT OF PROSPECTIVE FEE SCHEDULE.—

(1) PAYMENT IN ACCORDANCE WITH FEE SCHEDULE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking ''and (P)'' and inserting ''(P)''; and

(B) by striking the semicolon at the end and inserting the following: '', and (Q) with respect to ambulance service, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary under section 1834(k);''.

(2) ESTABLISHMENT OF SCHEDULE.—Section 1834 (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(k) ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.—

''(1) IN GENERAL.—The Secretary shall establish a fee schedule for payment for ambulance services under this part through a negotiated rulemaking process described in title 5, United States Code, and in accordance with the requirements of this subsection.

''(2) CONSIDERATIONS.—In establishing such fee schedule, the Secretary shall—

''(A) establish mechanisms to control increases in expenditures for ambulance services under this part;

''(B) establish definitions for ambulance services which link payments to the type of services provided;

''(C) consider appropriate regional and operational differences;

''(D) consider adjustments to payment rates to account for inflation and other relevant factors; and

''(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner.

''(3) SAVINGS.—In establishing such fee schedule, the Secretary shall—

''(A) ensure that the aggregate amount of payments made for ambulance services under this part during 1999 does not exceed the aggregate amount of payments which would have

been made for such services under this part during such year if the amendments made by section 5321 of the Balanced Budget Act of 1997 had not been made; and

''(B) set the payment amounts provided under the fee schedule for services furnished in 2000 and each subsequent year at amounts equal to the payment amounts under the fee schedule for service furnished during the previous year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced (but not below zero) by 1.0 percentage points.

''(4) CONSULTATION.—In establishing the fee schedule for ambulance services under this subsection, the Secretary shall consult with various national organizations representing individuals and entities who furnish and regulate ambulance services and share with such organizations relevant data in establishing such schedule.

''(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of the amounts established under the fee schedule for ambulance services under this subsection, including matters described in paragraph (2).

''(6) RESTRAINT ON BILLING.—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to ambulance services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).''.

(3) EFFECTIVE DATE.—The amendments made by this section apply to ambulance services furnished on or after January 1, 1999.

(c) AUTHORIZING PAYMENT FOR PARAMEDIC INTERCEPT SERVICE PROVIDERS IN RURAL COMMUNITIES.—In promulgating regulations to carry out section 1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7)) with respect to the coverage of ambulance service, the Secretary of Health and Human Services may include coverage of advanced life support services (in this subsection referred to as ''ALS intercept services'') provided by a paramedic intercept service provider in a rural area if the following conditions are met:

(1) The ALS intercept services are provided under a contract with one or more volunteer ambulance services and are medically necessary based on the health condition of the individual being transported.

(2) The volunteer ambulance service involved—

(A) is certified as qualified to provide ambulance service for purposes of such section,

(B) provides only basic life support services at the time of the intercept, and

(C) is prohibited by State law from billing for any services.

(3) The entity supplying the ALS intercept services—

(A) is certified as qualified to provide such services under the medicare program under title XVIII of the Social Security Act, and

(B) bills all recipients who receive ALS intercept services from the entity, regardless of whether or not such recipients are medicare beneficiaries.

CHAPTER 3—PROVISIONS RELATING TO PARTS A AND B

Subchapter A—Payments to Skilled Nursing Facilities

SEC. 5331. EXTENSION OF COST LIMITS.

The last sentence of section 1888(a) (42 U.S.C. 1395yy(a)) is amended by striking ''subsection'' the last place it appears and all that follows and inserting ''subsection, except that the limits effective for cost reporting periods beginning on or after October 1, 1997, shall be based on the limits effective for cost reporting periods beginning on or after October 1, 1996.''.

SEC. 5332. PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITY SERVICES.

(a) IN GENERAL.—Section 1888 (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

''(e) PROSPECTIVE PAYMENT.—

''(1) PAYMENT PROVISION.—Notwithstanding any other provision of this title, subject to paragraph (7), the amount of the payment for all costs (as defined in paragraph (2)(B)) of covered skilled nursing facility services (as defined in paragraph (2)(A)) for each day of such services furnished—

''(A) in a cost reporting period during the transition period (as defined in paragraph (2)(E)), is equal to the sum of—

''(i) the non-Federal percentage of the facility-specific per diem rate (computed under paragraph (3)), and

''(ii) the Federal percentage of the adjusted Federal per diem rate (determined under paragraph (4)) applicable to the facility; and

''(B) after the transition period is equal to the adjusted Federal per diem rate applicable to the facility.

''(2) DEFINITIONS.—For purposes of this subsection:

''(A) COVERED SKILLED NURSING FACILITY SERVICES.—

''(i) IN GENERAL.—The term 'covered skilled nursing facility services'—

''(I) means post-hospital extended care services as defined in section 1861(i) for which benefits are provided under part A; and

''(II) includes all items and services (other than services described in clause (ii)) for which payment may be made under part B and which are furnished to an individual who is a resident of a skilled nursing facility during the period in which the individual is provided covered post-hospital extended care services.

''(ii) SERVICES EXCLUDED.—Services described in this clause are physicians' services, services described by clauses (i) through (iii) of section 1861(s)(2)(K), certified nurse-midwife services, qualified psychologist services, services of a certified registered nurse anesthetist, items and services described in subparagraphs in (F) and (O) of section 1861(s)(2), and, only with respect to services furnished during 1998, the transportation costs of electrocardiogram equipment for electrocardiogram tests services (HCPCS Code R0076). Services described in this clause do not include any physical, occupational, or speech-language therapy services regardless of whether or not the services are furnished by, or under the supervision of, a physician or other health care professional.

''(B) ALL COSTS.—The term 'all costs' means routine service costs, ancillary costs, and capital-related costs of covered skilled nursing facility services, but does not include costs associated with approved educational activities.

''(C) NON-FEDERAL PERCENTAGE; FEDERAL PERCENTAGE.—For—

''(i) the first cost reporting period (as defined in subparagraph (D)) of a facility, the 'non-Federal percentage' is 75 percent and the 'Federal percentage' is 25 percent;

''(ii) the next cost reporting period of such facility, the 'non-Federal percentage' is 50 percent and the 'Federal percentage' is 50 percent; and

''(iii) the subsequent cost reporting period of such facility, the 'non-Federal percentage' is 25 percent and the 'Federal percentage' is 75 percent.

''(D) FIRST COST REPORTING PERIOD.—The term 'first cost reporting period' means, with respect to a skilled nursing facility, the first cost reporting period of the facility beginning on or after July 1, 1998.

''(E) TRANSITION PERIOD.—

''(i) IN GENERAL.—The term 'transition period' means, with respect to a skilled nursing facility, the 3 cost reporting periods of the facility beginning with the first cost reporting period.

''(ii) TREATMENT OF NEW SKILLED NURSING FACILITIES.—In the case of a skilled nursing facility that does not have a settled cost report for a cost reporting period before July 1, 1998, payment for such services shall be made under this subsection as if all services were furnished after the transition period.

''(3) DETERMINATION OF FACILITY SPECIFIC PER DIEM RATES.—The Secretary shall determine a facility-specific per diem rate for each skilled nursing facility for a cost reporting period as follows:

''(A) DETERMINING BASE PAYMENTS.—The Secretary shall determine, on a per diem basis, the total of—

''(i) the allowable costs of extended care services for the facility for cost reporting periods beginning in 1995 with appropriate adjustments (as determined by the Secretary) to non-settled cost reports, and

''(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during such period to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

''(B) UPDATE TO COST REPORTING PERIODS THROUGH 1998.—The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the 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.

''(C) UPDATING TO APPLICABLE COST REPORTING PERIOD.—The Secretary shall further update such amount for each cost reporting period beginning with the first cost reporting period and up to and including the cost reporting period involved by a factor equal to the skilled nursing facility market basket percentage increase.

''(D) CERTAIN DEMONSTRATION PROJECTS.—In the case of a facility participating in the Nursing Home Case-Mix and Quality Demonstration (RUGS–III), the Secretary shall determine the facility specific per diem rate for any year after 1997 by computing the base period payments by using the RUGS–III rate received by the facility for 1997, increased by a factor equal to the skilled nursing facility market basket percentage increase.

''(4) FEDERAL PER DIEM RATE.—

''(A) DETERMINATION OF HISTORICAL PER DIEM FOR FACILITIES.—For each skilled nursing facility that received payments for post-hospital extended care services during a cost reporting period beginning in fiscal year 1995 and that was subject to (and not exempted from) the per diem limits referred to in paragraph (1) or (2) of subsection (a) (and facilities described in subsection (d)), the Secretary shall estimate, on a per diem basis for such cost reporting period, the total of—

''(i) subject to subparagraph (I), the allowable costs of extended care services for the facility for cost reporting periods beginning in 1995 with appropriate adjustments (as determined by the Secretary) to non-settled cost reports, and

''(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during such period to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

''(B) UPDATE TO COST REPORTING PERIODS THROUGH 1998.—The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the 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 reduced (on an annualized basis) by 1 percentage point.

''(C) COMPUTATION OF STANDARDIZED PER DIEM RATE.—The Secretary shall standardize

the amount updated under subparagraph (B) for each facility by—

''(i) adjusting for variations among facility by area in the average facility wage level per diem, and

''(ii) adjusting for variations in case mix per diem among facilities.

''(D) COMPUTATION OF WEIGHTED AVERAGE PER DIEM RATE.—The Secretary shall compute a weighted average per diem rate by computing an average of the standardized amounts computed under subparagraph (C), weighted for each facility by the number of days of extended care services furnished during the cost reporting period referred to in subparagraph (A). The Secretary may compute and apply such average separately for facilities located in urban and rural areas (as defined in section 1886(d)(2)(D)).

''(E) UPDATING.—

''(i) FISCAL YEAR 1999.—For fiscal year 1999, the Secretary shall compute for each skilled nursing facility an unadjusted Federal per diem rate equal to the weighted average per diem rate computed under subparagraph (D) and applicable to the facility increased by skilled nursing facility market basket percentage change for the fiscal year involved.

''(ii) SUBSEQUENT FISCAL YEARS.—For each subsequent fiscal year the Secretary shall compute for each skilled nursing facility an unadjusted Federal per diem rate equal to the Federal per diem rate computed under this subparagraph for the previous fiscal year and applicable to the facility increased by the skilled nursing facility market basket percentage change for the fiscal year involved.

''(F) ADJUSTMENT FOR CASE MIX CREEP.—Insofar as the Secretary determines that such adjustments under subparagraph (G)(i) for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in the coding or classification of residents that do not reflect real changes in case mix, the Secretary may adjust unadjusted Federal per diem rates for subsequent years so as to discount the effect of such coding or classification changes.

''(G) APPLICATION TO SPECIFIC FACILITIES.—The Secretary shall compute for each skilled nursing facility for each fiscal year (beginning with fiscal year 1998) an adjusted Federal per diem rate equal to the unadjusted Federal per diem rate determined under subparagraph (E), as adjusted under subparagraph (F), and as further adjusted as follows:

''(i) ADJUSTMENT FOR CASE MIX.—The Secretary shall provide for an appropriate adjustment to account for case mix. Such adjustment shall be based on a resident classification system, established by the Secretary, that accounts for the relative resource utilization of different patient types. The case mix adjustment shall be based on resident assessment data and other data that the Secretary considers appropriate.

''(ii) ADJUSTMENT FOR GEOGRAPHIC VARIATIONS IN LABOR COSTS.—The Secretary shall adjust the portion of such per diem rate attributable to wages and wage-related costs for the area in which the facility is located compared to the national average of such costs using an appropriate wage index as determined by the Secretary. Such adjustment shall be done in a manner that does not result in aggregate payments under this subsection that are greater or less than those that would otherwise be made if such adjustment had not been made.

''(H) PUBLICATION OF INFORMATION ON PER DIEM RATES.—The Secretary shall provide for publication in the Federal Register, before the July 1 preceding each fiscal year (beginning with fiscal year 1999), of—

''(i) the unadjusted Federal per diem rates to be applied to days of covered skilled nursing facility services furnished during the fiscal year,

''(ii) the case mix classification system to be applied under subparagraph (G)(i) with respect to such services during the fiscal year, and

''(iii) the factors to be applied in making the area wage adjustment under subparagraph (G)(ii) with respect to such services.

''(I) EXCLUSION OF EXCEPTION PAYMENTS FROM DETERMINATION OF HISTORICAL PER DIEM.—In determining allowable costs under subparagraph (A)(i), the Secretary shall not take into account any payments described in subsection (c).

''(5) SKILLED NURSING FACILITY MARKET BASKET INDEX AND PERCENTAGE.—For purposes of this subsection:

''(A) SKILLED NURSING FACILITY MARKET BASKET INDEX.—The Secretary shall establish a skilled nursing facility market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered skilled nursing facility services.

''(B) SKILLED NURSING FACILITY MARKET BASKET PERCENTAGE.—The term 'skilled nursing facility market basket percentage' means, for a fiscal year or other annual period and as calculated by the Secretary, the percentage change in the skilled nursing facility market basket index (established under subparagraph (A)) from the midpoint of the prior fiscal year (or period) to the midpoint of the fiscal year (or other period) involved.

''(6) SUBMISSION OF RESIDENT ASSESSMENT DATA.—A skilled nursing facility shall provide the Secretary, in a manner and within the timeframes prescribed by the Secretary, the resident assessment data necessary to develop and implement the rates under this subsection. For purposes of meeting such requirement, a skilled nursing facility may submit the resident assessment data required under section 1819(b)(3), using the standard instrument designated by the State under section 1819(e)(5).

''(7) TRANSITION FOR MEDICARE SWING BED HOSPITALS.—

''(A) IN GENERAL.—The Secretary shall determine an appropriate manner in which to apply this subsection to the facilities described in subparagraph (B), taking into account the purposes of this subsection, and shall provide that at the end of the transition period (as defined in paragraph (2)(E)) such facilities shall be paid only under this subsection. Payment shall not be made under this subsection to such facilities for cost reporting periods beginning before such date (not earlier than July 1, 1999) as the Secretary specifies.

''(B) FACILITIES DESCRIBED.—The facilities described in this subparagraph are facilities that have in effect an agreement described in section 1883, for which payment is made for the furnishing of extended care services on a reasonable cost basis under section 1814(l) (as in effect on and after such date).

''(8) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

''(A) the establishment of Federal per diem rates under paragraph (4), including the computation of the standardized per diem rates under paragraph (4)(C), adjustments and corrections for case mix under paragraphs (4)(F) and (4)(G)(i), and adjustments for variations in labor-related costs under paragraph (4)(G)(ii); and

''(B) the establishment of transitional amounts under paragraph (7).''.

(b) CONSOLIDATED BILLING.—

(1) FOR SNF SERVICES.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) by striking ''or'' at the end of paragraph (15),

(B) by striking the period at the end of paragraph (16) and inserting ''; or'', and

(C) by inserting after paragraph (16) the following new paragraph:

''(17) which are covered skilled nursing facility services described in section 1888(e)(2)(A)(i)(II) and which are furnished to an individual who is a resident of a skilled nursing facility by an entity other than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the skilled nursing facility, or such services are furnished by a physician described in section 1861(r)(1).''.

(2) REQUIRING PAYMENT FOR ALL PART B ITEMS AND SERVICES TO BE MADE TO FACILITY.—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended—

(A) by striking ''and (D)'' and inserting ''(D)''; and

(B) by striking the period at the end and inserting the following: '', and (E) in the case of an item or service (other than services described in section 1888(e)(2)(A)(ii)) furnished to an individual who (at the time the item or service is furnished) is a resident of a skilled nursing facility, payment shall be made to the facility (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).''.

(3) PAYMENT RULES.—Section 1888(e) (42 U.S.C. 1395yy(e)), as added by subsection (a), is amended by adding at the end the following:

''(9) PAYMENT FOR CERTAIN SERVICES.—

''(A) IN GENERAL.—In the case of an item or service furnished by a skilled nursing facility (or by others under arrangement with them made by a skilled nursing facility or under any other contracting or consulting arrangement or otherwise) for which payment would otherwise (but for this paragraph) be made under part B in an amount determined in accordance with section 1833(a)(2)(B), the amount of the payment under such part shall be based on the part B methodology applicable to the item or service, except that for items and services that would be included in a facility's cost report if not for this section, the facility may continue to use a cost report for reimbursement purposes until the prospective payment system established under this section is implemented.

''(B) THERAPY AND PATHOLOGY SERVICES.—Payment for physical therapy, occupational therapy, respiratory therapy, and speech language pathology services shall reflect new salary equivalency guidelines calculated pursuant to section 1861(v)(5) when finalized through the regulatory process.

''(10) REQUIRED CODING.—No payment may be made under part B for items and services (other than services described in paragraph (2)(A)(ii)) furnished to an individual who is a resident of a skilled nursing facility unless the claim for such payment includes a code (or codes) under a uniform coding system specified by the Secretary that identifies the items or services delivered.''.

(4) CONFORMING AMENDMENTS.—

(A) Section 1819(b)(3)(C)(i) (42 U.S.C. 1395i–3(b)(3)(C)(i)) is amended by striking ''Such'' and inserting ''Subject to the timeframes prescribed by the Secretary under section 1888(t)(6), such''.

(B) Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)) is amended by striking ''(2);'' and inserting ''(2) and section 1842(b)(6)(E);''.

(C) Section 1833(a)(2)(B) (42 U.S.C. 1395l(a)(2)(B)) is amended by inserting ''or section 1888(e)(9)'' after ''section 1886''.

(D) Section 1861(h) (42 U.S.C 1395x(h)) is amended—

(i) in the opening paragraph, by striking ''paragraphs (3) and (6)'' and inserting ''paragraphs (3), (6), and (7)'', and

(ii) in paragraph (7), after ''skilled nursing facilities'', by inserting '', or by others under arrangements with them made by the facility''.

(E) Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)) is amended—

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

(ii) by inserting ''(i)'' after ''(H)'', and

(iii) by adding after clause (i), as so redesignated, the following new clause:

''(ii) in the case of skilled nursing facilities which provide covered skilled nursing facility services—

''(I) that are furnished to an individual who is a resident of the skilled nursing facility, and

''(II) for which the individual is entitled to have payment made under this title,

to have items and services (other than services described in section 1888(e)(2)(A)(ii)) furnished by the skilled nursing facility or otherwise under arrangements (as defined in section 1861(w)(1)) made by the skilled nursing facility,''.

(c) MEDICAL REVIEW PROCESS.—In order to ensure that medicare beneficiaries are furnished appropriate services in skilled nursing facilities, the Secretary of Health and Human Services shall establish and implement a thorough medical review process to examine the effects of the amendments made by this section on the quality of covered skilled nursing facility services furnished to medicare beneficiaries. In developing such a medical review process, the Secretary shall place a particular emphasis on the quality of non-routine covered services and physicians' services for which payment is made under title XVIII of the Social Security Act for which payment is made under section 1848 of such Act.

(d) EFFECTIVE DATE.—The amendments made by this section are effective for cost reporting periods beginning on or after July 1, 1998; except that the amendments made by subsection (b) shall apply to items and services furnished on or after July 1, 1998.

Subchapter B—Home Health Services and Benefits

PART I—PAYMENTS FOR HOME HEALTH SERVICES

SEC. 5341. RECAPTURING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES FOR HOME HEALTH SERVICES.

(a) BASING UPDATES TO PER VISIT COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the end the following:

''(iv) In establishing limits under this subparagraph for cost reporting periods beginning after September 30, 1997, the Secretary shall not take into account any changes in the home health market basket, as determined by the Secretary, with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.''.

(b) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by subsection (a) in making any exemptions and exceptions pursuant to section 1861(v)(1)(L)(ii) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(ii)).

SEC. 5342. INTERIM PAYMENTS FOR HOME HEALTH SERVICES.

(a) REDUCTIONS IN COST LIMITS.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) by moving the indentation of subclauses (I) through (III) 2-ems to the left;

(2) in subclause (I), by inserting ''of the mean of the labor-related and nonlabor per visit costs for freestanding home health agencies'' before the comma at the end;

(3) in subclause (II), by striking '', or'' and inserting ''of such mean,'';

(4) in subclause (III)—

(A) by inserting ''and before October 1, 1997,'' after ''July 1, 1987'', and

(B) by striking the period at the end and inserting ''of such mean, or''; and

(5) by striking the matter following subclause (III) and inserting the following:

''(IV) October 1, 1997, 105 percent of the median of the labor-related and nonlabor per visit costs for freestanding home health agencies.''.

(b) DELAY IN UPDATES.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by inserting '', or on or after July 1, 1997, and before October 1, 1997'' after ''July 1, 1996''.

(c) ADDITIONS TO COST LIMITS.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)), as amended by section 5341(a), is amended by adding at the end the following:

''(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the Secretary shall provide for an interim system of limits. Payment shall be the lower of—

''(I) costs determined under the preceding provisions of this subparagraph, or

''(II) an agency-specific per beneficiary annual limitation calculated from the agency's 12-month cost reporting period ending on or after January 1, 1994, and on or before December 31, 1994, based on reasonable costs (including non-routine medical supplies), updated by the home health market basket index.

The per beneficiary limitation in subclause (II) shall be multiplied by the agency's unduplicated census count of patients (entitled to benefits under this title) for the cost reporting period subject to the limitation to determine the aggregate agency-specific per beneficiary limitation.

''(vi) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the following rules apply:

''(I) For new providers and those providers without a 12-month cost reporting period ending in calendar year 1994, the per beneficiary limitation shall be equal to the median of these limits (or the Secretary's best estimates thereof) applied to other home health agencies as determined by the Secretary. A home health agency that has altered its corporate structure or name shall not be considered a new provider for this purpose.

''(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitations shall be prorated among the agencies.''.

(d) DEVELOPMENT OF CASE MIX SYSTEM.—The Secretary of Health and Human Services shall expand research on a prospective payment system for home health agencies under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) that ties prospective payments to a unit of service, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of the variances in costs.

(e) SUBMISSION OF DATA FOR CASE MIX SYSTEM.—Effective for cost reporting periods beginning on or after October 1, 1997, the Secretary of Health and Human Services may require all home health agencies to submit additional information that the Secretary considers necessary for the development of a reliable case mix system.

SEC. 5343. PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 5011, is amended by adding at the end the following new section:

''PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

''SEC. 1895. (a) IN GENERAL.—Notwithstanding section 1861(v), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 1999, for payments for home health services in accordance with a prospective payment system established by the Secretary under this section.

''(b) SYSTEM OF PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary shall establish under this subsection a prospective payment system for payment for all costs of home health services. Under the system under this subsection all services covered and paid on a reasonable cost basis under the medicare home health benefit as of the date of the enactment of the this section, including medical supplies, shall be paid for on the basis of a prospective payment amount determined under this subsection and applicable to the services involved. In implementing the system, the Secretary may provide for a transition (of not longer than 4 years) during which a portion of such payment is based on agency-specific costs, but only if such transition does not result in aggregate payments under this title that exceed the aggregate payments that would be made if such a transition did not occur.

''(2) UNIT OF PAYMENT.—In defining a prospective payment amount under the system under this subsection, the Secretary shall consider an appropriate unit of service and the number, type, and duration of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

''(3) PAYMENT BASIS.—

''(A) INITIAL BASIS.—

''(i) IN GENERAL.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts). Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for fiscal year 2000 shall be equal to the total amount that would have been made if the system had not been in effect but if the reduction in limits described in clause (ii) had been in effect. Such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

''(ii) REDUCTION.—The reduction described in this clause is a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L), as those limits are in effect on September 30, 1999.

''(B) ANNUAL UPDATE.—

''(i) IN GENERAL.—The standard prospective payment amount (or amounts) shall be adjusted for each fiscal year (beginning with fiscal year 2001) in a prospective manner specified by the Secretary by the home health market basket percentage increase applicable to the fiscal year involved.

''(ii) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE.—For purposes of this subsection, the term 'home health market basket percentage increase' means, with respect to a fiscal year, a percentage (estimated by the Secretary before the beginning of the fiscal year) determined and applied with respect to the mix of goods and services included in home health services in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to the mix of goods and services comprising inpatient hospital services for the fiscal year.

''(C) ADJUSTMENT FOR OUTLIERS.—The Secretary shall reduce the standard prospective payment amount (or amounts) under this paragraph applicable to home health services furnished during a period by such proportion as will result in an aggregate reduction in payments for the period equal to the aggregate increase in payments resulting from the application of paragraph (5) (relating to outliers).

''(4) PAYMENT COMPUTATION.—

''(A) IN GENERAL.—The payment amount for a unit of home health services shall be the applicable standard prospective payment amount adjusted as follows:

''(i) CASE MIX ADJUSTMENT.—The amount shall be adjusted by an appropriate case mix adjustment factor (established under subparagraph (B)).

''(ii) AREA WAGE ADJUSTMENT.—The portion of such amount that the Secretary estimates to be attributable to wages and wage-related costs shall be adjusted for geographic differences in such costs by an area wage adjustment factor

(established under subparagraph (C)) for the area in which the services are furnished or such other area as the Secretary may specify.

''(B) ESTABLISHMENT OF CASE MIX ADJUSTMENT FACTORS.—The Secretary shall establish appropriate case mix adjustment factors for home health services in a manner that explains a significant amount of the variation in cost among different units of services.

''(C) ESTABLISHMENT OF AREA WAGE ADJUSTMENT FACTORS.—The Secretary shall establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services in a geographic area compared to the national average applicable level. Such factors may be the factors used by the Secretary for purposes of section 1886(d)(3)(E).

''(5) OUTLIERS.—The Secretary may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year.

''(6) PRORATION OF PROSPECTIVE PAYMENT AMOUNTS.—If a beneficiary elects to transfer to, or receive services from, another home health agency within the period covered by the prospective payment amount, the payment shall be prorated between the home health agencies involved.

''(c) REQUIREMENTS FOR PAYMENT INFORMATION.—With respect to home health services furnished on or after October 1, 1998, no claim for such a service may be paid under this title unless—

''(1) the claim has the unique identifier for the physician who prescribed the services or made the certification described in section 1814(a)(2) or 1835(a)(2)(A); and

''(2) in the case of a service visit described in paragraph (1), (2), (3), or (4) of section 1861(m), the claim has information (coded in an appropriate manner) on the length of time of the service visit, as measured in 15 minute increments.

''(d) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

''(1) the establishment of a transition period under subsection (b)(1);

''(2) the definition and application of payment units under subsection (b)(2);

''(3) the computation of initial standard prospective payment amounts under subsection (b)(3)(A) (including the reduction described in clause (ii) of such subsection);

''(4) the adjustment for outliers under subsection (b)(3)(C);

''(5) case mix and area wage adjustments under subsection (b)(4);

''(6) any adjustments for outliers under subsection (b)(5); and

''(7) the amounts or types of exceptions or adjustments under subsection (b)(7).''.

(b) ELIMINATION OF PERIODIC INTERIM PAYMENTS FOR HOME HEALTH AGENCIES.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(1) by inserting ''and'' at the end of subparagraph (C),

(2) by striking subparagraph (D), and

(3) by redesignating subparagraph (E) as subparagraph (D).

(c) CONFORMING AMENDMENTS.—

(1) PAYMENTS UNDER PART A.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended in the matter preceding paragraph (1) by striking ''and 1886'' and inserting ''1886, and 1895''.

(2) TREATMENT OF ITEMS AND SERVICES PAID UNDER PART B.—

(A) PAYMENTS UNDER PART B.—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended—

(i) by amending subparagraph (A) to read as follows:

''(A) with respect to home health services (other than a covered osteoporosis drug) (as defined in section 1861(kk)), the amount determined under the prospective payment system under section 1895;'';

(ii) by striking ''and'' at the end of subparagraph (E);

(iii) by adding ''and'' at the end of subparagraph (F); and

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

''(G) with respect to items and services described in section 1861(s)(10)(A), the lesser of—

''(i) the reasonable cost of such services, as determined under section 1861(v), or

''(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);''.

(B) REQUIRING PAYMENT FOR ALL ITEMS AND SERVICES TO BE MADE TO AGENCY.—

(i) IN GENERAL.—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) (as amended by section 5332(b)(2)) is amended—

(I) by striking ''and (E)'' and inserting ''(E)''; and

(II) by striking the period at the end and inserting the following: '', and (F) in the case of home health services furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or when any other contracting or consulting arrangement, or otherwise).''.

(ii) CONFORMING AMENDMENT.—Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)) (as amended by section 5332(b)(4)(B)) is amended by striking ''section 1842(b)(6)(E);'' and inserting ''subparagraphs (E) and (F) of section 1842(b)(6);''.

(C) EXCLUSIONS FROM COVERAGE.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 5332(b)(1), is amended—

(i) by striking ''or'' at the end of paragraph (16);

(ii) by striking the period at the end of paragraph (17) and inserting ''or''; and

(iii) by inserting after paragraph (17) the following:

''(18) where such expenses are for home health services furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency.''.

(d) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 1999.

(e) CONTINGENCY.—If the Secretary of Health and Human Services for any reason does not establish and implement the prospective payment system for home health services described in section 1895(b) of the Social Security Act (as added by subsection (a)) for cost reporting periods described in subsection (d), for such cost reporting periods the Secretary shall provide for a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L) of such Act, as those limits would otherwise be in effect on September 30, 1999.

SEC. 5344. PAYMENT BASED ON LOCATION WHERE HOME HEALTH SERVICE IS FURNISHED.

(a) CONDITIONS OF PARTICIPATION.—Section 1891 (42 U.S.C. 1395bbb) is amended by adding at the end the following:

''(g) PAYMENT ON BASIS OF LOCATION OF SERVICE.—A home health agency shall submit claims for payment for home health services under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.''.

(b) WAGE ADJUSTMENT.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking ''agency is located'' and inserting ''service is furnished''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to cost reporting periods beginning on or after October 1, 1997.

PART II—HOME HEALTH BENEFITS

SEC. 5361. MODIFICATION OF PART A HOME HEALTH BENEFIT FOR INDIVIDUALS ENROLLED UNDER PART B.

(a) IN GENERAL.—Section 1812 (42 U.S.C. 1395d) is amended—

(1) in subsection (a)(3), by striking ''home health services'' and inserting ''for individuals not enrolled in part B, home health services, and for individuals so enrolled, part A home health services (as defined in subsection (g))'';

(2) by redesignating subsection (g) as subsection (h); and

(3) by inserting after subsection (f) the following new subsection:

''(g)(1) For purposes of this section, the term 'part A home health services' means—

''(A) for services furnished during each year beginning with 1998 and ending with 2003, home health services subject to the transition reduction applied under paragraph (2)(C) for services furnished during the year, and

''(B) for services furnished on or after January 1, 2004, post-institutional home health services for up to 100 visits during a home health spell of illness.

''(2) For purposes of paragraph (1)(A), the Secretary shall specify, before the beginning of each year beginning with 1998 and ending with 2003, a transition reduction in the home health services benefit under this part as follows:

''(A) The Secretary first shall estimate the amount of payments that would have been made under this part for home health services furnished during the year if—

''(i) part A home health services were all home health services, and

''(ii) part A home health services were limited to services described in paragraph (1)(B).

''(B)(i) The Secretary next shall compute a transfer reduction amount equal to the appropriate proportion (specified under clause (ii)) of the amount by which the amount estimated under subparagraph (A)(i) for the year exceeds the amount estimated under subparagraph (A)(ii) for the year.

''(ii) For purposes of clause (i), the 'appropriate proportion' is equal to—

''(I) 1/7 for 1998,

''(II) 2/7 for 1999,

''(III) 3/7 for 2000,

''(IV) 4/7 for 2001,

''(V) 5/7 for 2002, and

''(VI) 6/7 for 2003.

''(C) The Secretary shall establish a transition reduction by specifying such a visit limit (during a home health spell of illness) or such a post-institutional limitation on home health services furnished under this part during the year as the Secretary estimates will result in a reduction in the amount of payments that would otherwise be made under this part for home health services furnished during the year equal to the transfer amount computed under subparagraph (B)(i) for the year.

''(3) Payment under this part for home health services furnished an individual enrolled under part B—

''(A) during a year beginning with 1998 and ending with 2003, may not be made for services that are not within the visit limit or other limitation specified by the Secretary under the transition reduction under paragraph (3)(C) for services furnished during the year; or

''(B) on or after January 1, 2004, may not be made for home health services that are not post-institutional home health services or for post-institutional furnished to the individual after

such services have been furnished to the individual for a total of 100 visits during a home health spell of illness.''.

(b) POST-INSTITUTIONAL HOME HEALTH SERVICES DEFINED.—Section 1861 (42 U.S.C. 1395x), as amended by sections 5102(a) and 5103(a), is amended by adding at the end the following:

''Post-Institutional Home Health Services; Home Health Spell of Illness

''(qq)(1) The term 'post-institutional home health services' means home health services furnished to an individual—

''(A) after discharge from a hospital or rural primary care hospital in which the individual was an inpatient for not less than 3 consecutive days before such discharge if such home health services were initiated within 14 days after the date of such discharge; or

''(B) after discharge from a skilled nursing facility in which the individual was provided post-hospital extended care services if such home health services were initiated within 14 days after the date of such discharge.

''(2) The term 'home health spell of illness' with respect to any individual means a period of consecutive days—

''(A) beginning with the first day (not included in a previous home health spell of illness) (i) on which such individual is furnished post-institutional home health services, and (ii) which occurs in a month for which the individual is entitled to benefits under part A, and

''(B) ending with the close of the first period of 60 consecutive days thereafter on each of which the individual is neither an inpatient of a hospital or rural primary care hospital nor an inpatient of a facility described in section 1819(a)(1) or subsection (y)(1) nor provided home health services.''.

(c) MAINTAINING APPEAL RIGHTS FOR HOME HEALTH SERVICES.—Section 1869(b)(2)(B) (42 U.S.C. 1395ff(b)(2)(B)) is amended by inserting ''(or $100 in the case of home health services)'' after ''$500''.

(d) MAINTAINING SEAMLESS ADMINISTRATION THROUGH FISCAL INTERMEDIARIES.—Section 1842(b)(2) (42 U.S.C. 1395u(b)(2)) is amended by adding at the end the following:

''(E) With respect to the payment of claims for home health services under this part that, but for the amendments made by section 5361, would be payable under part A instead of under this part, the Secretary shall continue administration of such claims through fiscal intermediaries under section 1816.''.

(e) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after January 1, 1998. For the purpose of applying such amendments, any home health spell of illness that began, but did not end, before such date shall be considered to have begun as of such date.

SEC. 5362. IMPOSITION OF $5 COPAYMENT FOR PART B HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1833(a)(2)(A) (42 U.S.C. 1395l(a)(2)(A)) (as amended by section 5343(c)(2)) is amended by striking ''1895'' and inserting ''1895, less a copayment amount equal to $5 per visit, not to exceed a total annual copayment amount equal to the inpatient hospital deductible determined under section 1813 for the calendar year in which such service is furnished''.

(b) PROVIDER CHARGES.—Section 1866(a)(2)(A)(i) (42 U.S.C. 1395cc(a)(2)(A)(i)) is amended—

(1) by striking ''deduction or coinsurance'' and inserting ''deduction, coinsurance, or copayment''; and

(2) by striking ''section 1833(b)'' and inserting ''subsection (a)(2)(A) or (b) of section 1833''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 1997.

SEC. 5363. CLARIFICATION OF PART-TIME OR INTERMITTENT NURSING CARE.

(a) IN GENERAL.—Section 1861(m) (42 U.S.C. 1395x(m)) is amended by adding at the end the following: ''For purposes of paragraphs (1) and (4), the term 'part-time or intermittent services' means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of sections 1814(a)(2)(C) and 1835(a)(2)(A), 'intermittent' means skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to services furnished on or after October 1, 1997.

SEC. 5364. STUDY ON DEFINITION OF HOMEBOUND.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the criteria that should be applied, and the method of applying such criteria, in the determination of whether an individual is homebound for purposes of qualifying for receipt of benefits for home health services under the medicare program. Such criteria shall include the extent and circumstances under which a person may be absent from the home but nonetheless qualify.

(b) REPORT.—Not later than October 1, 1998, the Secretary shall submit a report to the Congress on the study conducted under subsection (a). The report shall include specific recommendations on such criteria and methods.

SEC. 5365. NORMATIVE STANDARDS FOR HOME HEALTH CLAIMS DENIALS.

(a) IN GENERAL.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by section 5102(c), is amended—

(1) by striking ''and'' at the end of subparagraph (F),

(2) by striking the semicolon at the end of subparagraph (G) and inserting '', and'', and

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

''(H) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation;''.

(b) NOTIFICATION.—The Secretary of Health and Human Services may establish a process for notifying a physician in cases in which the number of home health service visits furnished under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) pursuant to a prescription or certification of the physician significantly exceeds such threshold (or thresholds) as the Secretary specifies. The Secretary may adjust such threshold to reflect demonstrated differences in the need for home health services among different beneficiaries.

(c) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after October 1, 1997.

SEC. 5366. INCLUSION OF COST OF SERVICE IN EXPLANATION OF MEDICARE BENEFITS.

(a) IN GENERAL.—Section 1842(h)(7) of the Social Security Act (42 U.S.C. 1395u(h)(7)) is amended—

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

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

(3) by adding at the end the following:

''(E) in the case of home health services furnished to an individual enrolled under this part, the total amount that the home health agency or other provider of such services billed for such services.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to explanation of benefits provided on and after October 1, 1997.

Subtitle F—Provisions Relating to Part A

CHAPTER 1—PAYMENT OF PPS HOSPITALS

SEC. 5401. PPS HOSPITAL PAYMENT UPDATE.

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

(1) in subclause (XII)—

(A) by inserting ''and the period beginning on October 1, 1997, and ending on December 31, 1997,'' after ''fiscal year 1997,''; and

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

(2) by striking subclause (XIII) and inserting the following:

''(XIII) for calendar year 1998 for hospitals in all areas, the market basket percentage increase minus 2.5 percentage points,

''(XIV) for calendar year 1999 for hospitals in all areas, the market basket percentage increase minus 1.3 percentage points,

''(XV) for calendar years 2000 through 2002 for hospitals in all areas, the market basket percentage increase minus 1.0 percentage points, and

''(XVI) for calendar year 2003 and each subsequent calendar year for hospitals in all areas, the market basket percentage increase.''.

(b) RULE OF CONSTRUCTION.—Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

''(j) PPS CALENDAR YEAR PAYMENTS.—Notwithstanding any other provision of this title, any updates or payment amounts determined under this section shall on and after December 31, 1998, take effect and be applied on a calendar year basis. With respect to any cost reporting periods that relate to any such updates or payment amounts, the Secretary shall revise such cost reporting periods to ensure that on and after December 31, 1998, such cost reporting periods relate to updates and payment amounts made under this section on a calendar year basis in the same manner as such cost reporting periods applied to updates and payment amounts under this section on the day before the date of enactment of this subsection.''.

SEC. 5402. CAPITAL PAYMENTS FOR PPS HOSPITALS.

(a) MAINTAINING SAVINGS FROM TEMPORARY REDUCTION IN PPS CAPITAL RATES.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following: ''In addition to the reduction described in the preceding sentence, for discharges occurring on or after October 1, 1997, the Secretary shall apply the budget neutrality adjustment factor used to determine the Federal capital payment rate in effect on September 30, 1995 (as described in section 412.352 of title 42 of the Code of Federal Regulations), to (i) the unadjusted standard Federal capital payment rate (as described in section 412.308(c) of that title, as in effect on September 30, 1997), and (ii) the unadjusted hospital-specific rate (as described in section 412.328(e)(1) of that title, as in effect on September 30, 1997).''.

(b) SYSTEM EXCEPTION PAYMENTS FOR TRANSITIONAL CAPITAL.—

(1) IN GENERAL.—Section 1886(g)(l) (42 U.S.C. 1395ww(g)(1)) is amended—

(A) by redesignating subparagraph (C) as subparagraph (F), and

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

''(C) The exceptions under the system provided by the Secretary under subparagraph (B)(iii) shall include the provision of exception payments under the special exceptions process provided under section 412.348(g) of title 42, Code of Federal Regulations (as in effect on September 1, 1995), except that the Secretary shall revise such process, effective for discharges occurring after September 30, 1997, as follows:

''(i) Eligible hospital requirements, as described in section 412.348(g)(1) of title 42, Code of Federal Regulations, shall apply except that subparagraph (ii) shall be revised to require that hospitals located in an urban area with at least 300 beds shall be eligible under such process and

that such a hospital shall be eligible without regard to its disproportionate patient percentage under subsection (d)(5)(F) or whether it qualifies for additional payment amounts under such subsection.

''(ii) Project size requirements, as described in section 412.348(g)(5) of title 42, Code of Federal Regulations, shall apply except that subparagraph (ii) shall be revised to require that the project costs of a hospital are at least 150 percent of its operating cost during the first 12 month cost reporting period beginning on or after October 1, 1991.

''(iii) The minimum payment level for qualifying hospitals shall be 85 percent.

''(iv) A hospital shall be considered to meet the requirement that it complete the project involved no later than the end of the last cost reporting period of the hospital beginning before October l, 2001, if—

''(I) the hospital has obtained a certificate of need for the project approved by the State or a local planning authority by September 1, 1995; and

''(II) by September 1, 1995, the hospital has expended on the project at least $750,000 or 10 percent of the estimated cost of the project.

''(v) Offsetting amounts, as described in section 412.348(g)(8)(ii) of title 42, Code of Federal Regulations, shall apply except that subparagraph (B) of such section shall be revised to require that the additional payment that would otherwise be payable for the cost reporting period shall be reduced by the amount (if any) by which the hospital's current year medicare capital payments (excluding, if applicable, 75 percent of the hospital's capital-related disproportionate share payments) exceeds its medicare capital costs for such year.

''(D)(i) The Secretary shall reduce the Federal capital and hospital rates up to $50,000,000 for a calendar year to ensure that the application of subparagraph (C) does not result in an increase in the total amount that would have been paid under this subsection in the fiscal year if such subparagraph did not apply.

''(ii) Payments made pursuant to the application of subparagraph (C) shall not be considered for purposes of calculating total estimated payments under section 412.348(h), title 42, Code of Federal Regulations.

''(E) The Secretary shall provide for publication in the Federal Register each year (beginning with 1999) of a description of the distributional impact of the application of subparagraph (C) on hospitals which receive, and do not receive, an exception payment under such subparagraph.''.

(2) CONFORMING AMENDMENT.—Section 1886(g)(1)(B)(iii) (42 U.S.C. 1395ww(g)(1)(B)(iii)) is amended by striking ''may provide'' and inserting ''shall provide (in accordance with subparagraph (C))''.

CHAPTER 2—PAYMENT OF PPS EXEMPT HOSPITALS

SEC. 5421. PAYMENT UPDATE.

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

(1) by striking ''and'' at the end of subclause (V);

(2) by redesignating subclause (VI) as subclause (VIII); and

(3) by inserting after subclause (V), the following subclauses:

''(VI) for fiscal years 1998 through 2001, is 0 percent;

''(VII) for fiscal year 2002, is the market basket percentage increase minus 3.0 percentage points, and''.

(b) NO EFFECT OF PAYMENT REDUCTION ON EXCEPTIONS AND ADJUSTMENTS.—Section 1886(b)(4)(A)(ii) (42 U.S.C. 1395ww(b)(4)(A)(ii)) is amended by adding at the end the following new sentence: ''In making such reductions, the Secretary shall treat the applicable update factor described in paragraph (3)(B)(vi) for a fiscal year as being equal to the market basket percentage for that year.''.

SEC. 5422. REDUCTIONS TO CAPITAL PAYMENTS FOR CERTAIN PPS-EXEMPT HOSPITALS AND UNITS.

Section 1886(g) (42 U.S.C. 1395ww(g)) is amended by adding at the end the following new paragraph:

''(4) In determining the amount of the payments that are attributable to portions of cost reporting periods occurring during fiscal years 1998 through 2002 and that may be made under this title with respect to capital-related costs of inpatient hospital services of a hospital which is described in clause (i), (ii), or (iv) of subsection (d)(1)(B) or a unit described in the matter after clause (v) of such subsection, the Secretary shall reduce the amounts of such payments otherwise determined under this title by 15 percent.''.

SEC. 5423. CAP ON TEFRA LIMITS.

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

(1) in subparagraph (A) by striking ''subparagraphs (C), (D), and (E)'' and inserting ''subparagraph (C) and succeeding subparagraphs'', and

(2) by adding at the end the following:

''(F)(i) Except as provided in clause (ii), in the case of a hospital or unit that is within a class of hospital described in clause (iii), for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002, such target amount may not be greater than the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods beginning during that fiscal year (determined without regard to clause (ii)).

''(ii) In the case of a hospital or unit—

''(I) that is within a class of hospital described in clause (iii); and

''(II) whose operating costs of inpatient hospital services recognized under this title for the most recent cost reporting period for which information is available are less than the target amount for the hospital or unit under clause (i) (determined without regard to this clause) for its cost reporting period beginning on or after October 1, 1997, and before October 1, 1998,

clause (i) shall be applied for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002, by substituting for the dollar limit on the target amounts established under such clause for such period a dollar limit that is equal to the greater of 90 percent of such dollar limit or the operating costs of the hospital or unit determined under subclause (II).

''(iii) For purposes of this subparagraph, 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 (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

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

SEC. 5424. CHANGE IN BONUS AND RELIEF PAYMENTS.

(a) CHANGE IN BONUS PAYMENT.—Section 1886(b)(1)(A) (42 U.S.C. 1395ww(b)(1)(A)) is amended by striking all that follows ''plus—'' and inserting the following:

''(i) in the case of a hospital with a target amount that is less than 135 percent of the median of the target amounts for hospitals in the same class of hospital, the lesser of 40 percent of the amount by which the target amount exceeds the amount of the operating costs or 4 percent of the target amount;

''(ii) in the case of a hospital with a target amount that equals or exceeds 135 of such median but is less than 150 percent of such median, the lesser of 30 percent of the amount by which the target amount exceeds the amount of the operating costs or 3 percent of the target amount; and

''(iii) in the case of a hospital with a target amount that equals or exceeds 150 of such median, the lesser of 20 percent of the amount by which the target amount exceeds the amount of the operating costs or 2 percent of the target amount; or''.

(b) CHANGE IN RELIEF PAYMENTS.—Section 1886(b)(1) (42 U.S.C. 1395ww(b)(1)) is amended—

(1) in subparagraph (B)—

(A) by striking ''greater than the target amount'' and inserting ''greater than 110 percent of the target amount'',

(B) by striking ''exceed the target amount'' and inserting ''exceed 110 percent of the target amount'',

(C) by striking ''10 percent'' and inserting ''20 percent'', and

(D) by redesignating such subparagraph as subparagraph (C); and

(2) by inserting after subparagraph (A) the following new subparagraph:

''(B) are greater than the target amount but do not exceed 110 percent of the target amount, the amount of the payment with respect to those operating costs payable under part A on a per discharge basis shall equal the target amount; or''.

SEC. 5425. TARGET AMOUNTS FOR REHABILITATION HOSPITALS, LONG-TERM CARE HOSPITALS, AND PSYCHIATRIC HOSPITALS.

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

(1) in subparagraph (A), in the matter preceding clause (i), by striking ''and (E)'' and inserting ''(E), (F), and (G)''; and

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

''(F) In the case of a rehabilitation hospital (or unit thereof) (as described in clause (ii) of subsection (d)(1)(B)), for cost reporting periods beginning on or after October 1, 1997—

''(i) in the case of a hospital which first receives payments under this section before October 1, 1997, the target amount determined under subparagraph (A) for such hospital or unit for a cost reporting period beginning during a fiscal year shall not be less than 50 percent of the national mean of the target amounts determined under such subparagraph for all such hospitals for cost reporting periods beginning during such fiscal year (determined without regard to this subparagraph); and

''(ii) in the case of a hospital which first receives payments under this section on or after October 1, 1997, such target amount may not be greater than 110 percent of the national mean of the target amounts for such hospitals (and units thereof) for cost reporting periods beginning during fiscal year 1991.

''(G) In the case of a hospital which has an average inpatient length of stay of greater than 25 days (as described in clause (iv) of subsection (d)(1)(B)), for cost reporting periods beginning on or after October 1, 1997—

''(i) in the case of a hospital which first receives payments under this section as a hospital that is not a subsection (d) hospital or a subsection (d) Puerto Rico hospital before October 1, 1997, the target amount determined under subparagraph (A) for such hospital for a cost reporting period beginning during a fiscal year shall not be less than 50 percent of the national mean of the target amounts determined under such subparagraph for all such hospitals for cost reporting periods beginning during such fiscal year (determined without regard to this subparagraph); and

''(ii) in the case of any other hospital which first receives payment under this section on or after October 1, 1997, such target amount may not be greater than 110 percent of such national mean of the target amounts for such hospitals for cost reporting periods beginning during fiscal year 1991.

''(H) In the case of a psychiatric hospital (as defined in section 1861(f)), for cost reporting periods beginning on or after October 1, 1997—

''(i) in the case of a hospital which first receives payments under this section before October 1, 1997, the target amount determined under

subparagraph (A) for such hospital for a cost reporting period beginning during a fiscal year shall not be less than 50 percent of the national mean of the target amounts determined under such subparagraph for all such hospitals for cost reporting periods beginning during such fiscal year (determined without regard to this subparagraph); and

''(ii) in the case of any other hospital which first receives payment under this section on or after October 1, 1997, such target amount may not be greater than 110 percent of such national mean of the target amounts for such hospitals for cost reporting periods beginning during fiscal year 1991.''.

SEC. 5426. TREATMENT OF CERTAIN LONG-TERM CARE HOSPITALS LOCATED WITHIN OTHER HOSPITALS.

(a) IN GENERAL.—Section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended by adding at the end the following new sentence: ''A hospital that was classified by the Secretary on or before September 30, 1995, as a hospital described in clause (iv) shall continue to be so classified notwithstanding that it is located in the same building as, or on the same campus as, another hospital.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to discharges occurring on or after October 1, 1995.

SEC. 5426A. REBASING.

Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)), as amended by section 5423, is amended by adding at the end the following:

''(G)(i) In the case of a hospital (or unit described in the matter following clause (v) of subsection (d)(1)(B)) that received payment under this subsection for inpatient hospital services furnished before January 1, 1990, that is within a class of hospital described in clause (iii), and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospital's 12-month cost reporting period beginning during fiscal year 1998 is equal to the average described in clause (ii).

''(ii) The average described in this clause for a hospital or unit shall be determined by the Secretary as follows:

''(I) The Secretary shall determine the allowable operating costs for inpatient hospital services for the hospital or unit for each of the 5 cost reporting periods for which the Secretary has the most recent settled cost reports as of the date of the enactment of this subparagraph.

''(II) The Secretary shall increase the amount determined under subclause (I) for each cost reporting period by the applicable percentage increase under subparagraph (B)(ii) for each subsequent cost reporting period up to the cost reporting period described in clause (i).

''(III) The Secretary shall identify among such 5 cost reporting periods the cost reporting periods for which the amount determined under subclause (II) is the highest, and the lowest.

''(IV) The Secretary shall compute the averages of the amounts determined under subclause (II) for the 3 cost reporting periods not identified under subclause (III).

''(iii) For purposes of this subparagraph, 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 (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

''(III) Hospitals described in clause (iii) of such subsection.

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

''(V) Hospitals described in clause (v) of such subsection.''.

SEC. 5427. ELIMINATION OF EXEMPTIONS; REPORT ON EXCEPTIONS AND ADJUSTMENTS.

(a) ELIMINATION OF EXEMPTIONS.—

(1) IN GENERAL.—Section 1886(b)(4)(A)(i) (42 U.S.C. 1395ww(b)(4)(A)(i)) is amended by striking ''exemption from, or an exception and adjustment to,'' and inserting ''an exception and adjustment to'' each place it appears.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to hospitals that first qualify as a hospital described in clause (i), (ii), or (iv) of section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) on or after October 1, 1997.

(b) REPORT.—The Secretary of Health and Human Services shall publish annually in the Federal Register a report describing the total amount of payments made to hospitals by reason of section 1886(b)(4) of the Social Security Act (42 U.S.C. 1395ww(b)(4)), as amended by subsection (a), for cost reporting periods ending during the previous fiscal year.

SEC. 5428. TECHNICAL CORRECTION RELATING TO SUBSECTION (d) HOSPITALS.

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

(1) in subparagraph (B)(v)—

(A) by inserting ''(I)'' after ''(v)''; and

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

(C) by adding at the end the following:

''(II) a hospital that—

''(aa) was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, or is able to demonstrate, for any six-month period, that at least 50 percent of its total discharges have a principal diagnosis that reflects a finding of neoplastic disease, as defined in subparagraph (E);

''(bb) applied on or before December 31, 1990, for classification as a hospital involved extensively in treatment for or research on cancer under this clause (as in effect on the day before the date of the enactment of this subclause), but was not approved for such classification; and

''(cc) is located in a State which, as of December 19, 1989, was not operating a demonstration project under section 1814(b);''; and

(2) by adding at the end the following:

''(E) For purposes of subparagraph (B)(v)(II)(aa), the term 'principal diagnosis that reflects a finding of neoplastic disease' means the condition established after study to be chiefly responsible for occasioning the admission of a patient to a hospital, except that only discharges with ICD–9–CM principal diagnosis codes of 140 through 239, V58.0, V58.1, V66.1, V66.2, or 990 will be considered to reflect such a principal diagnosis.''.

(b) PAYMENTS.—Any classification by reason of section 1886(d)(1)(B)(v)(II) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(v)(II)) (as added by subsection (a)) shall apply to all cost reporting periods beginning on or after January 1, 1991. Any payments owed to a hospital as a result of such section (as so amended) shall be made expeditiously, but in no event later than 1 year after the date of enactment of this Act.

SEC. 5429. CERTAIN CANCER HOSPITALS.

(a) IN GENERAL.—Section 1886(d)(1) (42 U.S.C. 1395ww(d)(1)), as amended by section 5428, is amended—

(1) in subparagraph (B)(v), by striking the semicolon at the end of subclause (II)(cc) and inserting the following: '', or'', and by adding at the end the following:

''(III) a hospital—

''(aa) that was classified under subsection (iv) beginning on or before December 31, 1990, and through December 31, 1995; and

''(bb) throughout the period described in item (aa) and currently has greater than 49 percent of its total patient discharges with a principal diagnosis that reflects a finding of neoplastic disease;''; and

(2) by adding at the end the following:

''(F) In the case of a hospital that is classified under subparagraph (B)(v)(III), no rebasing is permitted by such hospital and such hospital shall use the base period in effect at the time of such hospital's December 31, 1995, cost report.''.

CHAPTER 3—GRADUATE MEDICAL EDUCATION PAYMENTS

Subchapter A—Direct Medical Education

SEC. 5441. LIMITATION ON NUMBER OF RESIDENTS AND ROLLING AVERAGE FTE COUNT.

Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended by adding after subparagraph (E) the following:

''(F) LIMITATION ON NUMBER OF RESIDENTS IN ALLOPATHIC AND OSTEOPATHIC MEDICINE.—Except as provided in subparagraph (H), such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number of full-time equivalent residents with respect to such programs for the hospital's most recent cost reporting period ending on or before December 31, 1996.

''(G) COUNTING INTERNS AND RESIDENTS FOR 1998 AND SUBSEQUENT YEARS.—

''(i) IN GENERAL.—For cost reporting periods beginning on or after October 1, 1997, subject to the limit described in subparagraph (F) and except as provided in subparagraph (H), the total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.

''(ii) ADJUSTMENT FOR SHORT PERIODS.—If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent resident counts pursuant to clause (ii) are based on the equivalent of full twelve-month cost reporting periods.

''(iii) TRANSITION RULE FOR 1998.—In the case of a hospital's first cost reporting period beginning on or after October 1, 1997, clause (i) shall be applied by using the average for such period and the preceding cost reporting period.

''(H) SPECIAL RULES FOR NEW FACILITIES.—

''(i) IN GENERAL.—If a hospital is an applicable facility under clause (iii) for any year with respect to any approved medical residency training program described in subsection (h)—

''(I) subject to the applicable annual limit under clause (ii), the Secretary may provide an additional amount of full-time equivalent residents which may be taken into account with respect to such program under subparagraph (F) for cost reporting periods beginning during such year, and

''(II) the averaging rules under subparagraph (G) shall not apply for such year.

''(ii) APPLICABLE ANNUAL LIMIT.—The total of additional full-time equivalent residents which the Secretary may authorize under clause (i) for all applicable facilities for any year shall not exceed the amount which would result in the number of full-time equivalent residents with respect to approved medical residency training programs in the fields of allopathic and osteopathic medicine for all hospitals exceeding such number for the preceding year. In allocating such additional residents, the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

''(iii) APPLICABLE FACILITY.—For purposes of this subparagraph, a hospital shall be treated as an applicable facility with respect to an approved medical residency training program only during the first 5 years during which such program is in existence. A hospital shall not be

treated as such a facility if the 5-year period described in the preceding sentence ended on or before December 31, 1996.

''(iv) COORDINATION WITH LIMIT.—For purposes of applying subparagraph (F), the number of full-time equivalent residents of an applicable facility with respect to any approved medical residency training program in the fields of allopathic and osteopathic medicine for the facility's most recent cost reporting period ending on or before December 31, 1996, shall be increased by the number of such residents allocated to such facility under clause (i).''.

SEC. 5442. PERMITTING PAYMENT TO NONHOSPITAL PROVIDERS.

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

''(j) PAYMENT TO NONHOSPITAL PROVIDERS.—

''(1) IN GENERAL.—For cost reporting periods beginning on or after October 1, 1997, the Secretary may establish rules for payment to qualified nonhospital providers for their direct costs of medical education, if those costs are incurred in the operation of an approved medical residency training program described in subsection (h). Such rules shall specify the amounts, form, and manner in which payments will be made and the portion of such payments that will be made from each of the trust funds under this title.

''(2) QUALIFIED NONHOSPITAL PROVIDERS.—For purposes of this subsection, the term 'qualified nonhospital providers' means—

''(A) a federally qualified health center, as defined in section 1861(aa)(4);

''(B) a rural health clinic, as defined in section 1861(aa)(2); and

''(C) such other providers (other than hospitals) as the Secretary determines to be appropriate.''.

(b) PROHIBITION ON DOUBLE PAYMENTS.—Section 1886(h)(3)(B) (42 U.S.C. 1395ww(h)(3)(B)) is amended by adding at the end the following:

''The Secretary shall reduce the aggregate approved amount to the extent payment is made under subsection (j) for residents included in the hospital's count of full-time equivalent residents.''.

SEC. 5443. MEDICARE SPECIAL REIMBURSEMENT RULE FOR PRIMARY CARE COMBINED RESIDENCY PROGRAMS.

(a) IN GENERAL.—Section 1886(h)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(G)) is amended—

(1) in clause (i), by striking ''and (iii)'' and inserting '', (iii), and (iv)''; and

(2) by adding at the end the following:

''(iv) SPECIAL RULE FOR PRIMARY CARE COMBINED RESIDENCY PROGRAMS.—(I) In the case of a resident enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training a primary care resident (as defined in subparagraph (H)), the period of board eligibility shall be the minimum number of years of formal training required to satisfy the requirements for initial board eligibility in the longest of the individual programs plus one additional year.

''(II) A resident enrolled in a combined medical residency training program that includes an obstetrics and gynecology program qualifies for the period of board eligibility under subclause (I) if the other programs such resident combines with such obstetrics and gynecology program are for training a primary care resident.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to combined medical residency training programs in effect on or after January 1, 1998.

Subchapter B—Indirect Medical Education

SEC. 5446. INDIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.

(a) MULTIYEAR TRANSITION REGARDING PERCENTAGES.—

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

''(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to c (((1+r) to the nth power) − 1), where 'r' is the ratio of the hospital's full-time equivalent interns and residents to beds and 'n' equals .405. For discharges occurring—

''(I) on or after May 1, 1986, and before October 1, 1997, 'c' is equal to 1.89;

''(II) during fiscal year 1998, 'c' is equal to 1.72;

''(III) during fiscal year 1999, 'c' is equal to 1.6;

''(IV) during fiscal year 2000, 'c' is equal to 1.47; and

''(V) on or after October 1, 2000, 'c' is equal to 1.35.''.

(2) NO RESTANDARDIZATION OF PAYMENT AMOUNTS REQUIRED.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by adding at the end the following: ''except that the Secretary shall not take into account any reduction in the amount of additional payments under paragraph (5)(B)(ii) resulting from the amendment made by section 5446(a)(1) of the Balanced Budget Act of 1997,''.

(b) LIMITATION.—

(1) IN GENERAL.—Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding after clause (iv) the following:

''(v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full-time equivalent interns and residents in either a hospital or nonhospital setting may not exceed the number of such full-time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996.

''(vi) For purposes of clause (ii)—

''(I) 'r' may not exceed the ratio of the number of interns and residents as determined under clause (v) with respect to the hospital for its most recent cost reporting period ending on or before December 31, 1996, to the hospital's available beds (as defined by the Secretary) during that cost reporting period, and

''(II) for the hospital's cost reporting periods beginning on or after October 1, 1997, subject to the limits described in clauses (iv) and (v), the total number of full-time equivalent residents for payment purposes shall equal the average of the actual full-time equivalent resident count for the cost reporting period and the preceding two cost reporting periods.

In the case of the first cost reporting period beginning on or after October 1, 1997, subclause (II) shall be applied by using the average for such period and the preceding cost reporting period.

''(vii)(I) If a hospital is an applicable facility under subclause (III) for any year with respect to any approved medical residency training program described in subsection (h)—

''(aa) subject to the applicable annual limit under subclause (II), the Secretary may provide an additional amount of full-time equivalent interns and residents which may be taken into account with respect to such program under clauses (v) and (vi) for cost reporting periods beginning during such year, and

''(bb) the averaging rules under clause (vi)(II) shall not apply for such year.

''(II) The total of additional full-time equivalent interns and residents which the Secretary may authorize under subclause (I) for all applicable facilities for any year shall not exceed the amount which would result in the number of full-time equivalent interns or residents for all hospitals exceeding such number for the preceding year. In allocating such additional residents, the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

''(III) For purposes of this clause, a hospital shall be treated as an applicable facility with respect to an approved medical residency training program only during the first 5 years during which such program is in existence. A hospital shall not be treated as such a facility if the 5-year period described in the preceding sentence ended on or before December 31, 1996.

''(IV) For purposes of applying clause (v), the number of full-time equivalent residents of an applicable facility with respect to any approved medical residency training program for the facility's most recent cost reporting period ending on or before December 31, 1996, shall be increased by the number of such residents allocated to such facility under subclause (I).

''(viii) If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent residency count pursuant to subclause (II) of clause (vi) is based on the equivalent of full twelve-month cost reporting periods.''.

(2) PAYMENT FOR INTERNS AND RESIDENTS PROVIDING OFF-SITE SERVICES.—Section 1886(d)(5)(B)(iv) (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended to read as follows:

''(iv) Effective for discharges occurring on or after October 1, 1997, all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.''.

Subchapter C—Graduate Medical Education Payments for Managed Care Enrollees

SEC. 5451. DIRECT AND INDIRECT MEDICAL EDUCATION PAYMENTS TO HOSPITALS FOR MANAGED CARE ENROLLEES.

(a) PAYMENTS TO HOSPITALS FOR DIRECT COSTS OF GRADUATE MEDICAL EDUCATION.—Section 1886(h)(3) (42 U.S.C. 1395ww(h)(3)) is amended by adding after subparagraph (C) the following:

''(D) PAYMENT FOR MEDICARE CHOICE ENROLLEES.—

''(i) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount under this subsection for services furnished to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 and who are entitled to part A or with a Medicare Choice organization under part C. The amount of such a payment shall equal the applicable percentage of the product of—

''(I) the aggregate approved amount (as defined in subparagraph (B)) for that period; and

''(II) the fraction of the total number of inpatient-bed days (as established by the Secretary) during the period which are attributable to such enrolled individuals.

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

''(I) 25 percent in 1998,

''(II) 50 percent in 1999,

''(III) 75 percent in 2000, and

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

''(iii) SPECIAL RULE FOR HOSPITALS UNDER REIMBURSEMENT SYSTEM.—The Secretary shall establish rules for the application of this subparagraph to a hospital reimbursed under a reimbursement system authorized under section 1814(b)(3) in the same manner as it would apply to the hospital if it were not reimbursed under such section.''.

(b) PAYMENT TO HOSPITALS OF INDIRECT MEDICAL EDUCATION COSTS.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following:

''(11) ADDITIONAL PAYMENTS FOR MANAGED CARE SAVINGS.—

''(A) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital (or any

hospital reimbursed under a reimbursement system authorized under section 1814(b)(3)) that has an approved medical residency training program.

''(B) APPLICABLE DISCHARGE.—For purposes of this paragraph, the term 'applicable discharge' means the discharge of any individual who is enrolled under a risk-sharing contract with an eligible organization under section 1876 and who is entitled to benefits under part A or any individual who is enrolled with a Medicare Choice organization under part C.

''(C) DETERMINATION OF AMOUNT.—The amount of the payment under this paragraph with respect to any applicable discharge shall be equal to the applicable percentage (as defined in subsection (h)(3)(D)(ii)) of the estimated average per discharge amount that would otherwise have been paid under paragraph (1)(A) if the individuals had not been enrolled as described in subparagraph (B).''.

SEC. 5452. DEMONSTRATION PROJECT ON USE OF CONSORTIA.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a demonstration project under which, instead of making payments to teaching hospitals pursuant to section 1886(h) of the Social Security Act, the Secretary shall make payments under this section to each consortium that meets the requirements of subsection (b).

(b) QUALIFYING CONSORTIA.—For purposes of subsection (a), a consortium meets the requirements of this subsection if the consortium is in compliance with the following:

(1) The consortium consists of an approved medical residency training program in a teaching hospital and one or more of the following entities:

(A) A school of allopathic medicine or osteopathic medicine.

(B) Another teaching hospital, which may be a children's hospital.

(C) Another approved medical residency training program.

(D) A federally qualified health center.

(E) A medical group practice.

(F) A managed care entity.

(G) An entity furnishing outpatient services.

(I) Such other entity as the Secretary determines to be appropriate.

(2) The members of the consortium have agreed to participate in the programs of graduate medical education that are operated by the entities in the consortium.

(3) With respect to the receipt by the consortium of payments made pursuant to this section, the members of the consortium have agreed on a method for allocating the payments among the members.

(4) The consortium meets such additional requirements as the Secretary may establish.

(c) AMOUNT AND SOURCE OF PAYMENT.—The total of payments to a qualifying consortium for a fiscal year pursuant to subsection (a) shall not exceed the amount that would have been paid under section 1886(h) of the Social Security Act for the teaching hospital (or hospitals) in the consortium. Such payments shall be made in such proportion from each of the trust funds established under title XVIII of such Act as the Secretary specifies.

CHAPTER 4—OTHER HOSPITAL PAYMENTS

SEC. 5461. DISPROPORTIONATE SHARE PAYMENTS TO HOSPITALS FOR MANAGED CARE AND MEDICARE CHOICE ENROLLEES.

Section 1886(d) (42 U.S.C. 1395ww(d)) (as amended by section 5451) is amended by adding at the end the following:

''(12) ADDITIONAL PAYMENTS FOR MANAGED CARE AND MEDICARE CHOICE SAVINGS.—

''(A) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each applicable discharge of—

(i) any subsection (d) hospital that is a disproportionate share hospital (as described in paragraph (5)(F)(i)); or

(ii) any hospital reimbursed under a reimbursement system authorized under section 1814(b)(3)) if such hospital would qualify as a disproportionate share hospital were it not so reimbursed.

''(B) APPLICABLE DISCHARGE.—For purposes of this paragraph, the term 'applicable discharge' means the discharge of any individual who is enrolled under a risk-sharing contract with an eligible organization under section 1876 and who is entitled to benefits under part A or any individual who is enrolled with a Medicare Choice organization under part C.

''(C) DETERMINATION OF AMOUNT.—The amount of the payment under this paragraph with respect to any applicable discharge shall be equal to the applicable percentage (as defined in subsection (h)(3)(D)(ii)) of the estimated average per discharge amount that would otherwise have been paid under paragraph (1)(A) if the individuals had not been enrolled as described in subparagraph (B).''.

SEC. 5462. REFORM OF DISPROPORTIONATE SHARE PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS.

(a) IN GENERAL.—Section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (i), by inserting ''and before December 31, 1998,'' after ''May, 1, 1986,'';

(2) in clause (ii), by striking ''The amount'' and inserting ''Subject to clauses (ix) and (x), the amount''; and

(3) by adding at the end the following:

''(ix) In the case of discharges occurring on or after October 1, 1997, and before December 31, 1998, the additional payment amount otherwise determined under clause (ii) shall be reduced by 4 percent.

''(x)(I) In the case of discharges occurring during calendar years 1999 and succeeding calendar years, the additional payment amount shall be determined in accordance with the formula established under subclause (II).

''(II) Not later than January 1, 1999, the Secretary shall establish a formula for determining additional payment amounts under this subparagraph. In determining such formula the Secretary shall—

''(aa) establish a single threshold for costs incurred by hospitals in serving low-income patients,

''(bb) consider the costs described in subclause (III), and

''(cc) ensure that such formula complies with the requirement described in subclause (IV).

''(III) The costs described in this subclause are as follows:

''(aa) The costs incurred by the hospital during a period (as determined by the Secretary) of furnishing inpatient and outpatient hospital services to individuals who are entitled to benefits under part A of this title and are entitled to supplemental security income benefits under title XVI (excluding any supplementation of those benefits by a State under section 1616).

''(bb) The costs incurred by the hospital during a period (as so determined) of furnishing inpatient and outpatient hospital services to individuals who are eligible for medical assistance under the State plan under title XIX and are not entitled to benefits under part A of this title (including individuals enrolled in a health maintenance organization (as defined in section 1903(m)(1)(A)) or any other managed care plan under such title, individuals who are eligible for medical assistance under such title pursuant to a waiver approved by the Secretary under section 1115, and individuals who are eligible for medical assistance under the State plan under title XIX (regardless of whether the State has provided reimbursement for any such assistance provided under such title)).

''(cc) The costs incurred by the hospital during a period (as so determined) of furnishing inpatient and outpatient hospital services to individuals who are not described in item (aa) or (bb) and who do not have health insurance coverage (or any other source of third party payment for such services) and for which the hospital did not receive compensation.

''(IV)(aa) The requirement described in this subclause is that for each calendar year for which the formula established under this clause applies, the additional payment amount determined for such calendar year under such formula shall not exceed an amount equal to the additional payment amount that, in the absence of such formula, would have been determined under this subparagraph, reduced by the applicable percentage for such calendar year.

''(bb) For purposes of subclause (aa), the applicable percentage for—

''(AA) calendar year 1999 is 8 percent;

''(BB) calendar year 2000 is 12 percent;

''(CC) calendar year 2001 is 16 percent;

''(DD) calendar year 2002 is 20 percent;

''(EE) calendar year 2003 and subsequent calendar years, is 0 percent''.

(b) DATA COLLECTION.—

(1) IN GENERAL.—In developing the formula under section 1886(g)(5)(F)(x) of the Social Security Act (42 U.S.C. 1395ww(g)(5)(F)(x)), as added by subsection (a), and in implementing the provisions of and amendments made by this section, the Secretary of Health and Human Services may 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))) receiving additional payments by reason of section 1886(d)(5)(F) of that Act (42 U.S.C. 1395ww(d)(5)(F)) (as amended by subsection (a) of this section) to submit to the Secretary any information that the Secretary determines is necessary to implement the provisions of and amendments made by this section.

(2) FAILURE TO COMPLY.—Any subsection (d) hospital (as so defined) that fails to submit to the Secretary of Health and Human Services any information requested under paragraph (1), shall be deemed ineligible for an additional payment amount under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) (as amended by subsection (a) of this section).

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to discharges occurring on and after October 1, 1997.

SEC. 5463. MEDICARE CAPITAL ASSET SALES PRICE EQUAL TO BOOK VALUE.

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

(1) in clause (i)—

(A) by striking ''and (if applicable) a return on equity capital'';

(B) by striking ''hospital or skilled nursing facility'' and inserting ''provider of services'';

(C) by striking ''clause (iv)'' and inserting ''clause (iii)''; and

(D) by striking ''the lesser of the allowable acquisition cost'' and all that follows and inserting ''the historical cost of the asset, as recognized under this title, less depreciation allowed, to the owner of record as of the date of enactment of the Balanced Budget Act of 1997 (or, in the case of an asset not in existence as of that date, the first owner of record of the asset after that date).'';

(2) by striking clause (ii); and

(3) by redesignating clauses (iii) and (iv) as clauses (ii) and (iii), respectively.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to changes of ownership that occur after the third month beginning after the date of enactment of this section.

SEC. 5464. ELIMINATION OF IME AND DSH PAYMENTS ATTRIBUTABLE TO OUTLIER PAYMENTS.

(a) INDIRECT MEDICAL EDUCATION.—Section 1886(d)(5)(B)(i)(I) (42 U.S.C. 1395ww(d)(5)(B)(i)(I)) is amended by inserting '', for cases qualifying for additional payment under subparagraph (A)(i),'' before ''the amount paid to the hospital under subparagraph (A)''.

(b) DISPROPORTIONATE SHARE ADJUSTMENTS.—Section 1886(d)(5)(F)(ii)(I) (42 U.S.C. 1395ww(d)(5)(F)(ii)(I)) is amended by inserting '', for cases qualifying for additional payment under subparagraph (A)(i),'' before ''the amount paid to the hospital under subparagraph (A)''.

(c) COST OUTLIER PAYMENTS.—Section 1886(d)(5)(A)(ii) (42 U.S.C. 1395ww(d)(5)(A)(ii)) is amended by striking ''exceed the applicable DRG prospective payment rate'' and inserting ''exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under subparagraphs (B) and (F) of subsection (d)(5)''.

(d) EFFECTIVE DATE.—The amendments made by this section apply to discharges occurring after September 30, 1997.

SEC. 5465. TREATMENT OF TRANSFER CASES.

(a) TRANSFERS TO PPS EXEMPT HOSPITALS AND SKILLED NURSING FACILITIES.—Section 1886(d)(5)(I) (42 U.S.C. 1395ww(d)(5)(I)) is amended by adding at the end the following new clause:

''(iii) In carrying out this subparagraph, the Secretary shall treat the term 'transfer case' as including the case of an individual who, immediately upon discharge from, and pursuant to the discharge planning process (as defined in section 1861(ee)) of, a subsection (d) hospital—

''(I) is admitted as an inpatient to a hospital or hospital unit that is not a subsection (d) hospital for the receipt of inpatient hospital services; or

''(II) is admitted to a skilled nursing facility or facility described in section 1861(y)(1) for the receipt of extended care services.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to discharges occurring on or after October 1, 1997.

SEC. 5466. REDUCTIONS IN PAYMENTS FOR ENROLLEE BAD DEBT.

Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

''(T) In determining such reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs which are attributable to the deductibles and coinsurance amounts under this title shall be reduced—

''(i) for cost reporting periods beginning on or after October 1, 1997 and on or before December 31, 1998, by 25 percent of such amount otherwise allowable,

''(ii) for cost reporting periods beginning during calendar year 1999, by 40 percent of such amount otherwise allowable, and

''(iii) for cost reporting periods beginning during a subsequent calendar year, by 50 percent of such amount otherwise allowable.''.

SEC. 5467. FLOOR ON AREA WAGE INDEX.

(a) IN GENERAL.—For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)) may not be less than the average of the area wage indices applicable under such section to hospitals located in rural areas in the State in which the hospital is located.

(b) IMPLEMENTATION.—The Secretary of Health and Human Services shall adjust the area wage indices referred to in subsection (a) for hospitals not described in such subsection in a manner which assures that the aggregate payments made under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) in a fiscal year for the operating costs of inpatient hospital services are not greater or less than those which would have been made in the year if this section did not apply.

(c) EXCLUSION OF CERTAIN WAGES.—In the case of a hospital that is owned by a municipality and that was reclassified as an urban hospital under section 1886(d)(10) of the Social Security Act for fiscal year 1996, in calculating the hospital's average hourly wage for purposes of geographic reclassification under such section for fiscal year 1998, the Secretary of Health and Human Services shall exclude the general service wages and hours of personnel associated with a skilled nursing facility that is owned by the hospital of the same municipality and that is physically separated from the hospital to the extent that such wages and hours of such personnel are not shared with the hospital and are separately documented. A hospital that applied for and was denied reclassification as an urban hospital for fiscal year 1998, but that would have received reclassification had the exclusion required by this section been applied to it, shall be reclassified as an urban hospital for fiscal year 1998.

SEC. 5468. INCREASE BASE PAYMENT RATE TO PUERTO RICO HOSPITALS.

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

(1) in the matter preceding clause (i), by striking ''in a fiscal year beginning on or after October 1, 1987,'',

(2) in clause (i), by striking ''75 percent'' and inserting ''for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)'', and

(3) in clause (ii), by striking ''25 percent'' and inserting ''for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987 and September 30, 1997, 25 percent)''.

SEC. 5469. PERMANENT EXTENSION OF HEMOPHILIA PASS-THROUGH.

Effective October 1, 1997, section 6011(d) of OBRA–1989 (as amended by section 13505 of OBRA–1993) is amended by striking ''and shall expire September 30, 1994''.

SEC. 5470. COVERAGE OF SERVICES IN RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONS UNDER THE MEDICARE AND MEDICAID PROGRAMS.

(a) MEDICARE COVERAGE.—

(1) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) (as amended by section 5361) is amended—

(1) in the sixth sentence of subsection (e)—

(A) by striking ''includes'' and all that follows up to ''but only'' and inserting ''includes a religious nonmedical health care institution (as defined in subsection (rr)(1)),'', and

(B) by inserting ''consistent with section 1821'' before the period;

(2) in subsection (y)—

(A) by amending the heading to read as follows:

''Extended Care in Religious Nonmedical Health Care Institutions'',

(B) in paragraph (1), by striking ''includes'' and all that follows up to ''but only'' and inserting ''includes a religious nonmedical health care institution (as defined in subsection (rr)(1)),'', and

(C) by inserting ''consistent with section 1821'' before the period; and

(3) by adding at the end the following:

''Religious Nonmedical Health Care Institution

''(rr)(1) The term 'religious nonmedical health care institution' means an institution that—

''(A) is described in subsection (c)(3) of section 501 of the Internal Revenue Code of 1986 and is exempt from taxes under subsection (a) of such section;

''(B) is lawfully operated under all applicable Federal, State, and local laws and regulations;

''(C) provides only nonmedical nursing items and services exclusively to patients who choose to rely solely upon a religious method of healing and for whom the acceptance of medical health services would be inconsistent with their religious beliefs;

''(D) provides such nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of such patients;

''(E) provides such nonmedical items and services to inpatients on a 24-hour basis;

''(F) on the basis of its religious beliefs, does not provide through its personnel or otherwise medical items and services (including any medical screening, examination, diagnosis, prognosis, treatment, or the administration of drugs) for its patients;

''(G) is not a part of, or owned by, or under common ownership with, or affiliated through ownership with, a health care facility that provides medical services;

''(H) has in effect a utilization review plan which—

''(i) provides for the review of admissions to the institution, of the duration of stays therein, of cases of continuous extended duration, and of the items and services furnished by the institution,

''(ii) requires that such reviews be made by an appropriate committee of the institution that includes the individuals responsible for overall administration and for supervision of nursing personnel at the institution,

''(iii) provides that records be maintained of the meetings, decisions, and actions of such committee, and

''(iv) meets such other requirements as the Secretary finds necessary to establish an effective utilization review plan;

''(I) provides the Secretary with such information as the Secretary may require to implement section 1821, to monitor quality of care, and to provide for coverage determinations; and

''(J) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

''(2) If the Secretary finds that the accreditation of an institution by a State, regional, or national agency or association provides reasonable assurances that any or all of the requirements of paragraph (1) are met or exceeded, the Secretary shall, to the extent the Secretary deems it appropriate, treat such institution as meeting the condition or conditions with respect to which the Secretary made such finding.

''(3)(A)(i) In administering this subsection and section 1821, the Secretary shall not require any patient of a religious nonmedical health care institution to undergo any medical screening, examination, diagnosis, prognosis, or treatment or to accept any other medical health care service, if such patient (or legal representative of the patient) objects thereto on religious grounds.

''(ii) Clause (i) shall not be construed as preventing the Secretary from requiring under section 1821(a)(2) the provision of sufficient information regarding an individual's condition as a condition for receipt of benefits under part A for services provided in such an institution.

''(B)(i) In administering this subsection and section 1821, the Secretary shall not subject a religious nonmedical health care institution to any medical supervision, regulation, or control, insofar as such supervision, regulation, or control would be contrary to the religious beliefs observed by the institution.

''(ii) Clause (i) shall not be construed as preventing the Secretary from reviewing items and services billed by the institution to the extent the Secretary determines such review to be necessary to determine whether such items and services were not covered under part A, are excessive, or are fraudulent.''.

(2) CONDITIONS OF COVERAGE.—Part A of title XVIII of the Social Security Act is amended by adding at the end the following new section:

''CONDITIONS FOR COVERAGE OF RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONAL SERVICES

''SEC. 1821. (a) IN GENERAL.—Subject to subsections (c) and (d), payment under this part may be made for inpatient hospital services or post-hospital extended care services furnished an individual in a religious nonmedical health care institution only if—

''(1) the individual has an election in effect for such benefits under subsection (b); and

''(2) the individual has a condition such that the individual would qualify for benefits under this part for inpatient hospital services or extended care services, respectively, if the individual were an inpatient or resident in a hospital or skilled nursing facility that was not such an institution.

''(b) ELECTION.—

''(1) IN GENERAL.—An individual may make an election under this subsection in a form and manner specified by the Secretary consistent with this subsection. Unless otherwise provided, such an election shall take effect immediately upon its execution. Such an election, once made, shall continue in effect until revoked.

''(2) FORM.—The election form under this subsection shall include the following:

''(A) A statement, signed by the individual (or such individual's legal representative), that—

''(i) the individual is conscientiously opposed to acceptance of nonexcepted medical treatment; and

''(ii) the individual's acceptance of nonexcepted medical treatment would be inconsistent with the individual's sincere religious beliefs.

''(B) A statement that the receipt of non-excepted medical services shall constitute a revocation of the election and may limit further receipt of services described in subsection (a).

''(3) REVOCATION.—An election under this subsection by an individual may be revoked in a form and manner specified by the Secretary and shall be deemed to be revoked if the individual receives medicare reimbursable non-excepted medical treatment, regardless of whether or not benefits for such treatment are provided under this title.

''(4) LIMITATION ON SUBSEQUENT ELECTIONS.—Once an individual's election under this subsection has been made and revoked twice—

''(A) the next election may not become effective until the date that is 1 year after the date of most recent previous revocation, and

''(B) any succeeding election may not become effective until the date that is 5 years after the date of the most recent previous revocation.

''(5) EXCEPTED MEDICAL TREATMENT.—For purposes of this subsection:

''(A) EXCEPTED MEDICAL TREATMENT.—The term 'excepted medical treatment' means medical care or treatment (including medical and other health services)—

''(i) for the setting of fractured bones,

''(ii) received involuntarily, or

''(iii) required under Federal or State law or law of a political subdivision of a State.

''(B) NON-EXCEPTED MEDICAL TREATMENT.—The term 'nonexcepted medical treatment' means medical care or treatment (including medical and other health services) other than excepted medical treatment.

''(c) MONITORING AND SAFEGUARD AGAINST EXCESSIVE EXPENDITURES.—

''(1) ESTIMATE OF EXPENDITURES.—Before the beginning of each fiscal year (beginning with fiscal year 2000), the Secretary shall estimate the level of expenditures under this part for services described in subsection (a)for that fiscal year.

''(2) ADJUSTMENT IN PAYMENTS.—

''(A) PROPORTIONAL ADJUSTMENT.—If the Secretary determines that the level estimated under paragraph (1) for a fiscal year will exceed the trigger level (as defined in subparagraph (C)) for that fiscal year, the Secretary shall, subject to subparagraph (B), provide for such a proportional reduction in payment amounts under this part for services described in subsection (a) for the fiscal year involved as will assure that such level (taking into account any adjustment under subparagraph (B)) does not exceed the trigger level for that fiscal year.

''(B) ALTERNATIVE ADJUSTMENTS.—The Secretary may, instead of making some or all of the reduction described in subparagraph (A), impose such other conditions or limitations with respect to the coverage of covered services (including limitations on new elections of coverage and new facilities) as may be appropriate to reduce the level of expenditures described in paragraph (1) to the trigger level.

''(C) TRIGGER LEVEL.—For purposes of this subsection, subject to adjustment under paragraph (3)(B), the 'trigger level' for—

''(i) fiscal year 1998, is $20,000,000, or

''(ii) a succeeding fiscal year is the amount specified under this subparagraph for the previous fiscal year increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with July preceding the beginning of the fiscal year.

''(D) PROHIBITION OF ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the estimation of expenditures under subparagraph (A) or the application of reduction amounts under subparagraph (B).

''(E) EFFECT ON BILLING.—Notwithstanding any other provision of this title, in the case of a reduction in payment provided under this subsection for services of a religious nonmedical health care institution provided to an individual, the amount that the institution is otherwise permitted to charge the individual for such services is increased by the amount of such reduction.

''(3) MONITORING EXPENDITURE LEVEL.—

''(A) IN GENERAL.—The Secretary shall monitor the expenditure level described in paragraph (2)(A) for each fiscal year (beginning with fiscal year 1999).

''(B) ADJUSTMENT IN TRIGGER LEVEL.—If the Secretary determines that such level for a fiscal year exceeded, or was less than, the trigger level for that fiscal year, then the trigger level for the succeeding fiscal year shall be reduced, or increased, respectively, by the amount of such excess or deficit.

''(d) SUNSET.—If the Secretary determines that the level of expenditures described in subsection (c)(1) for 3 consecutive fiscal years (with the first such year being not earlier than fiscal year 2002) exceeds the trigger level for such expenditures for such years (as determined under subsection (c)(2)), benefits shall be paid under this part for services described in subsection (a) and furnished on or after the first January 1 that occurs after such 3 consecutive years only with respect to an individual who has an election in effect under subsection (b) as of such January 1 and only during the duration of such election.

''(e) ANNUAL REPORT.—At the beginning of each fiscal year (beginning with fiscal year 1999), the Secretary shall submit to the Committees on Ways and Means of the House of Representatives and the Committee on Finance of the Senate an annual report on coverage and expenditures for services described in subsection (a) under this part and under State plans under title XIX. Such report shall include—

''(1) level of expenditures described in subsection (c)(1) for the previous fiscal year and estimated for the fiscal year involved;

''(2) trends in such level; and

''(3) facts and circumstances of any significant change in such level from the level in previous fiscal years.''.

(b) MEDICAID.—

(1) The third sentence of section 1902(a) of such Act (42 U.S.C. 1396a(a)) is amended by striking all that follows ''shall not apply'' and inserting ''to a religious nonmedical health care institution (as defined in section 1861(rr)(1)).''.

(2) Section 1908(e)(1) of such Act (42 U.S.C. 1396g–1(e)(1)) is amended by striking all that follows ''does not include'' and inserting ''a religious nonmedical health care institution (as defined in section 1861(rr)(1)).''.

(c) CONFORMING AMENDMENTS.—

(1) Section 1122(h) of such Act (42 U.S.C. 1320a–1(h)) is amended by striking all that follows ''shall not apply to'' and inserting ''a religious nonmedical health care institution (as defined in section 1861(rr)(1)).''.

(2) Section 1162 of such Act (42 U.S.C. 1320c–11) is amended—

(A) by amending the heading to read as follows:

''EXEMPTIONS FOR RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONS''; and

(B) by striking all that follows ''shall not apply with respect to a'' and inserting ''religious nonmedical health care institution (as defined in section 1861(rr)(1)).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date. By not later than July 1, 1998, the Secretary of Health and Human Services shall first issue regulations to carry out such amendments. Such regulations may be issued so they are effective on an interim basis pending notice and opportunity for public comment. For periods before the effective date of such regulations, such regulations shall recognize elections entered into in good faith in order to comply with the requirements of section 1821(b) of the Social Security Act.

CHAPTER 5—PAYMENTS FOR HOSPICE SERVICES

SEC. 5481. PAYMENT FOR HOME HOSPICE CARE BASED ON LOCATION WHERE CARE IS FURNISHED.

(a) IN GENERAL.—Section 1814(i)(2) (42 U.S.C. 1395f(i)(2)) is amended by adding at the end the following:

''(D) A hospice program shall submit claims for payment for hospice care furnished in an individual's home under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to cost reporting periods beginning on or after October 1, 1997.

SEC. 5482. HOSPICE CARE BENEFITS PERIODS.

(a) RESTRUCTURING OF BENEFIT PERIOD.—Section 1812 (42 U.S.C. 1395d) is amended in subsections (a)(4) and (d)(1), by striking '', a subsequent period of 30 days, and a subsequent extension period'' and inserting ''and an unlimited number of subsequent periods of 60 days each''.

(b) CONFORMING AMENDMENTS.—(1) Section 1812 (42 U.S.C. 1395d) is amended in subsection (d)(2)(B) by striking ''90- or 30-day period or a subsequent extension period'' and inserting ''90-day period or a subsequent 60-day period''.

(2) Section 1814(a)(7)(A) (42 U.S.C. 1395f(a)(7)(A)) is amended—

(A) in clause (i), by inserting ''and'' at the end;

(B) in clause (ii)—

(i) by striking ''30-day'' and inserting ''60-day''; and

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

(C) by striking clause (iii).

SEC. 5483. OTHER ITEMS AND SERVICES INCLUDED IN HOSPICE CARE.

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

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

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

(3) by inserting after subparagraph (H) the following:

''(I) any other item or service which is specified in the plan and for which payment may otherwise be made under this title.''.

SEC. 5484. CONTRACTING WITH INDEPENDENT PHYSICIANS OR PHYSICIAN GROUPS FOR HOSPICE CARE SERVICES PERMITTED.

Section 1861(dd)(2) (42 U.S.C. 1395x(dd)(2)) is amended—

(1) in subparagraph (A)(ii)(I), by striking ''(F),''; and

(2) in subparagraph (B)(i), by inserting ''or, in the case of a physician described in subclause (I), under contract with'' after ''employed by''.

SEC. 5485. WAIVER OF CERTAIN STAFFING REQUIREMENTS FOR HOSPICE CARE PROGRAMS IN NON-URBANIZED AREAS.

Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended—

(1) in subparagraph (B), by inserting ''or (C)'' after ''subparagraph (A)'' each place it appears; and

(2) by adding at the end the following:

''(C) The Secretary may waive the requirements of paragraph clauses (i) and (ii) of paragraph (2)(A) for an agency or organization with respect to the services described in paragraph (1)(B) and, with respect to dietary counseling, paragraph (1)(H), if such agency or organization—

''(i) is located in an area which is not an urbanized area (as defined by the Bureau of the Census), and

''(ii) demonstrates to the satisfaction of the Secretary that the agency or organization has been unable, despite diligent efforts, to recruit appropriate personnel.''.

SEC. 5486. LIMITATION ON LIABILITY OF BENEFICIARIES FOR CERTAIN HOSPICE COVERAGE DENIALS.

Section 1879 (42 U.S.C. 1395pp) is amended—

(1) in subsection (a), in the matter following paragraph (2), by inserting ''and except as provided in subsection (i),'' after ''to the extent permitted by this title,'';

(2) in subsection (g)—

(A) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and indenting such subparagraphs appropriately;

(B) by striking ''is,'' and inserting ''is—'';

(C) by making the remaining text of subsection (g) (as amended) that follows ''is—'' a new paragraph (1) and indenting that paragraph appropriately;

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

(E) by adding at the end the following:

''(2) with respect to the provision of hospice care to an individual, a determination that the individual is not terminally ill.''; and

(3) by adding at the end the following:

''(i) In any case involving a coverage denial with respect to hospice care described in subsection (g)(2), only the individual that received such care shall, notwithstanding such determination, be indemnified for any payments that the individual made to a provider or other person for such care that would, but for such denial, otherwise be paid to the individual under part A or B of this title.''.

SEC. 5487. EXTENDING THE PERIOD FOR PHYSICIAN CERTIFICATION OF AN INDIVIDUAL'S TERMINAL ILLNESS.

Section 1814(a)(7)(A)(i) (42 U.S.C. 1395f(a)(7)(A)(i)) is amended, in the matter following subclause (II), by striking '', not later than 2 days after hospice care is initiated (or, if each certify verbally not later than 2 days after hospice care is initiated, not later than 8 days after such care is initiated)'' and inserting ''at the beginning of the period''.

SEC. 5488. EFFECTIVE DATE.

Except as otherwise provided in this chapter, the amendments made by this chapter apply to benefits provided on or after the date of the enactment of this chapter, regardless of whether or not an individual has made an election under section 1812(d) of the Social Security Act (42 U.S.C. 1395d(d)) before such date.

Subtitle G—Provisions Relating to Part B Only

CHAPTER 1—PAYMENTS FOR PHYSICIANS AND OTHER HEALTH CARE PROVIDERS

SEC. 5501. ESTABLISHMENT OF SINGLE CONVERSION FACTOR FOR 1998.

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

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—The conversion factor for each year shall be the conversion factor established under this subsection for the previous year, adjusted by the update established under paragraph (3) for the year involved.

''(B) SPECIAL RULE FOR 1998.—The single conversion factor for 1998 shall be the conversion factor for primary care services for 1997, increased by the Secretary's estimate of the weighted average of the 3 separate updates that would otherwise occur but for the enactment of chapter 1 of subtitle G of title V of the Balanced Budget Act of 1997.

''(C) PUBLICATION.—The Secretary shall, during the last 15 days of October of each year, publish the conversion factor which will apply to physicians' services for the following year and the update determined under paragraph (3) for such year.''.

(b) CONFORMING AMENDMENT.—Section 1848(i)(1)(C) (42 U.S.C. 1395w–4(i)(1)(C)) is amended by striking ''conversion factors'' and inserting ''the conversion factor''.

SEC. 5502. ESTABLISHING UPDATE TO CONVERSION FACTOR TO MATCH SPENDING UNDER SUSTAINABLE GROWTH RATE.

(a) UPDATE.—

(1) IN GENERAL.—Section 1848(d)(3) (42 U.S.C. 1395w–4(d)(3)) is amended to read as follows:

''(3) UPDATE.—

''(A) IN GENERAL.—Unless otherwise provided by law, subject to subparagraph (D) and the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii), the update to the single conversion factor established in paragraph (1)(B) for a year beginning with 1999 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 for the year (divided by 100),

minus 1 and multiplied by 100.

''(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), the 'update adjustment factor' for a year is equal to the quotient (as estimated by the Secretary) of—

''(i) the difference between (I) the sum of the allowed expenditures for physicians' services (as determined under subparagraph (C)) for the period beginning July 1, 1997, and ending on June 30 of the year involved, and (II) the amount of actual expenditures for physicians' services furnished during the period beginning July 1, 1997, and ending on June 30 of the preceding year; divided by

''(ii) the actual expenditures for physicians' services for the 12-month period ending on June 30 of the preceding year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

''(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph, the allowed expenditures for physicians' services for the 12-month period ending with June 30 of—

''(i) 1997 is equal to the actual expenditures for physicians' services furnished during such 12-month period, as estimated by the Secretary; or

''(ii) a subsequent year is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

''(D) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

''(i) greater than 100 times the following amount: (1.03 + (MEI percentage/100)) −1; or

''(ii) less than 100 times the following amount: (0.93 + (MEI percentage/100)) −1,

where 'MEI percentage' means the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.''.

(b) ELIMINATION OF REPORT.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended by striking paragraph (2).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to the update for years beginning with 1999.

SEC. 5503. REPLACEMENT OF VOLUME PERFORMANCE STANDARD WITH SUSTAINABLE GROWTH RATE.

(a) IN GENERAL.—Section 1848(f) (42 U.S.C. 1395w–4(f)) is amended by striking paragraphs (2) through (5) and inserting the following:

''(2) SPECIFICATION OF GROWTH RATE.—The sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998) shall be equal to the product of—

''(A) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services in the fiscal year involved,

''(B) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than Medicare Choice plan enrollees) from the previous fiscal year to the fiscal year involved,

''(C) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous fiscal year to the fiscal year involved, and

''(D) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the fiscal year (compared with the previous fiscal year) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services resulting from changes in the update to the conversion factor under subsection (d)(3),

minus 1 and multiplied by 100.

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

''(A) SERVICES INCLUDED IN PHYSICIANS' SERVICES.—The term 'physicians' services' includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare Choice plan enrollee.

''(B) MEDICARE CHOICE PLAN ENROLLEE.—The term 'Medicare Choice plan enrollee' means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a Medicare Choice plan offered under part C, and also includes an individual who is receiving benefits under this part through enrollment with an eligible organization with a risk-sharing contract under section 1876.''.

(b) CONFORMING AMENDMENTS.—So much of section 1848(f) (42 U.S.C. 1395w–4(f)) as precedes paragraph (2) is amended to read as follows:

''(f) SUSTAINABLE GROWTH RATE.—

''(1) PUBLICATION.—The Secretary shall cause to have published in the Federal Register the sustainable growth rate for each fiscal year beginning with fiscal year 1998. Such publication shall occur in the last 15 days of October of the year in which the fiscal year begins, except that such rate for fiscal year 1998 shall be published not later than January 1, 1998.''.

SEC. 5504. PAYMENT RULES FOR ANESTHESIA SERVICES.

(a) IN GENERAL.—Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)), as amended by section 5501, is amended—

(A) in subparagraph (B), striking ''The single'' and inserting ''Except as provided in subparagraph (C), the single'';

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

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

''(C) SPECIAL RULES FOR ANESTHESIA SERVICES.—The separate conversion factor for anesthesia services for a year shall be equal to 46 percent of the single conversion factor established for other physicians' services, except as adjusted for changes in work, practice expense, or malpractice relative value units.''.

(b) CLASSIFICATION OF ANESTHESIA SERVICES.—The first sentence of section 1848(j)(1) (42 U.S.C. 1395w–4(j)(1)) is amended—

(1) by striking ''and including anesthesia services''; and

(2) by inserting before the period the following: ''(including anesthesia services)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1998.

SEC. 5505. IMPLEMENTATION OF RESOURCE-BASED METHODOLOGIES.

(a) ADJUSTMENTS TO RELATIVE VALUE UNITS FOR 1998.—Section 1848(c)(2) (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraph:

''(G) ADJUSTMENTS IN RELATIVE VALUE UNITS FOR 1998.—

''(i) IN GENERAL.—The Secretary shall—

''(I) reduce the practice expense relative value units applied to any services described in clause (ii) furnished in 1998 to a number equal to 110 percent of the number of work relative value units, and

''(II) increase the practice expense relative value units for office visit procedure codes during 1998 by a uniform percentage which the Secretary estimates will result in an aggregate increase in payments for such services equal to the aggregate decrease in payments by reason of subclause (I).

''(ii) SERVICES COVERED.—For purposes of clause (i), the services described in this clause are physicians' services that are not described in clause (iii) and for which—

''(I) there are work relative value units, and

''(II) the number of practice expense relative value units (determined for 1998) exceeds 110 percent of the number of work relative value units (determined for such year).

''(iii) EXCLUDED SERVICES.—For purposes of clause (ii), the services described in this clause are services which the Secretary determines at least 75 percent of which are provided under this title in an office setting.''.

(b) DELAY OF IMPLEMENTATION TO 1999; PHASEIN OF IMPLEMENTATION.—Section 1848(c)(2) (42 U.S.C. 1395w–4(c)(2)), as amended by subsection (a), is amended—

(1) in subparagraph (C)(ii)—

(A) by striking ''1998'' each place it appears and inserting ''1999'', and

(B) by inserting '', to the extent provided under subparagraph (H),'' after ''based'' in the matter following subclause (II), and

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

''(H) 3-YEAR ADDITIONAL PHASEIN OF RESOURCE-BASED PRACTICE EXPENSE UNITS.—Notwithstanding subparagraph (C)(ii), the Secretary shall implement the resource-based practice expense unit methodology described in such subparagraph ratably over the 3-year period beginning with 1999 such that such methodology is fully implemented for 2001 and succeeding years.''.

(c) REVIEW BY COMPTROLLER GENERAL.—The Comptroller General of the United States shall review and evaluate the proposed rule on resource-based methodology for practice expenses issued by the Health Care Financing Administration. The Comptroller General shall, within 6 months of the date of the enactment of this Act, report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate the results of its evaluation, including an analysis of—

(1) the adequacy of the data used in preparing the rule,

(2) categories of allowable costs,

(3) methods for allocating direct and indirect expenses,

(4) the potential impact of the rule on beneficiary access to services, and

(5) any other matters related to the appropriateness of resource-based methodology for practice expenses.

The Comptroller General shall consult with representatives of physicians' organizations with respect to matters of both data and methodology.

(d) CONSULTATION.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall assemble a group of physicians with expertise in both surgical and nonsurgical areas (including primary care physicians and academics), accounting experts, and the chair of the Prospective Payment Review Commission (or its successor) to solicit their individual views on whether sufficient data exist to allow the Health Care Financing Administration to proceed with implementation of the rule described in subsection (c). After hearing the views of individual members of the group, the Secretary shall determine whether sufficient data exists to proceed with practice expense relative value determination and shall report on such views of the individual members to the committees described in subsection (c), including any recommendations for modifying such rule.

(2) ACTION.—If the Secretary determines under paragraph (1) that insufficient data exists or that the rule described in subsection (c) needs to be revised, the Secretary shall provide for additional data collection and such other actions to correct any deficiencies.

(e) APPLICATION OF RESOURCE-BASED METHODOLOGY TO MALPRACTICE RELATIVE VALUE UNITS.—Section 1848(c)(2)(C)(iii) (42 U.S.C. 1395w–4(c)(2)(C)(iii)) is amended—

(1) by inserting ''for years before 1999'' before ''equal'', and

(2) by striking the period at the end and inserting a comma and by adding at the end the following flush matter:

''and for years beginning with 1999 based on the malpractice expense resources involved in furnishing the service''.

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply to years beginning on and after January 1, 1998.

(2) MALPRACTICE.—The amendments made by subsection (e) shall apply to years beginning on and after January 1, 1999.

SEC. 5506. INCREASED MEDICARE REIMBURSEMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.

(a) REMOVAL OF RESTRICTIONS ON SETTINGS.—

(1) IN GENERAL.—Clause (ii) of section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended to read as follows:

''(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services;''.

(2) CONFORMING AMENDMENTS.—(A) Section 1861(s)(2)(K) of such Act (42 U.S.C. 1395x(s)(2)(K)) is further amended—

(i) in clause (i), by inserting ''and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service; and'' after ''are performed,''; and

(ii) by striking clauses (iii) and (iv).

(B) Section 1861(b)(4) (42 U.S.C. 1395x(b)(4)) is amended by striking ''clauses (i) or (iii) of subsection (s)(2)(K)'' and inserting ''subsection (s)(2)(K)''.

(C) Section 1862(a)(14) (42 U.S.C. 1395y(a)(14)) is amended by striking ''section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)'' and inserting ''section 1861(s)(2)(K)''.

(D) Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)) is amended by striking ''section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)'' and inserting ''section 1861(s)(2)(K)''.

(E) Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)), as added by section 5301(a), is amended by striking ''through (iii)'' and inserting ''and (ii)''.

(b) INCREASED PAYMENT.—

(1) FEE SCHEDULE AMOUNT.—Clause (O) of section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended to read as follows: ''(O) with respect to services described in section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848, or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery; and''.

(2) CONFORMING AMENDMENTS.—(A) Section 1833(r) (42 U.S.C. 1395l(r)) is amended—

(i) in paragraph (1), by striking ''section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area)'' and inserting ''section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services)'';

(ii) by striking paragraph (2);

(iii) in paragraph (3), by striking ''section 1861(s)(2)(K)(iii)'' and inserting ''section 1861(s)(2)(K)(ii)''; and

(iv) by redesignating paragraph (3) as paragraph (2).

(B) Section 1842(b)(12)(A) (42 U.S.C. 1395u(b)(12)(A)) is amended, in the matter preceding clause (i), by striking ''clauses (i), (ii), or (iv) of section 1861(s)(2)(K) (relating to a physician assistants and nurse practitioners)'' and inserting ''section 1861(s)(2)(K)(i) (relating to physician assistants)''.

(c) DIRECT PAYMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.—

(1) IN GENERAL.—Section 1832(a)(2)(B)(iv) (42 U.S.C. 1395k(a)(2)(B)(iv)) is amended by striking ''provided in a rural area (as defined in section 1886(d)(2)(D))'' and inserting ''but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services''.

(2) CONFORMING AMENDMENT.—Section 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is amended—

(A) by striking ''clauses (i), (ii), or (iv)'' and inserting ''clause (i)''; and

(B) by striking ''or nurse practitioner''.

(d) DEFINITION OF CLINICAL NURSE SPECIALIST CLARIFIED.—Section 1861(aa)(5) (42 U.S.C. 1395x(aa)(5)) is amended—

(1) by inserting ''(A)'' after ''(5)'';

(2) by striking ''The term 'physician assistant'' and all that follows through ''who performs'' and inserting ''The term 'physician assistant' and the term 'nurse practitioner' mean, for purposes of this title, a physician assistant or nurse practitioner who performs''; and

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

''(B) The term 'clinical nurse specialist' means, for purposes of this title, an individual who—

''(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

''(ii) holds a master's degree in a defined clinical area of nursing from an accredited educational institution.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after January 1, 1998.

SEC. 5507. INCREASED MEDICARE REIMBURSEMENT FOR PHYSICIAN ASSISTANTS.

(a) REMOVAL OF RESTRICTION ON SETTINGS.—Section 1861(s)(2)(K)(i) (42 U.S.C. 1395x(s)(2)(K)(i)), as amended by the section 5506, is amended—

(1) by striking ''(I) in a hospital'' and all that follows through ''shortage area,'', and

(2) by adding at the end the following: ''but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services,''.

(b) INCREASED PAYMENT.—Paragraph (12) of section 1842(b) (42 U.S.C. 1395u(b)), as amended by section 5506(b)(2)(B), is amended to read as follows:

''(12) With respect to services described in section 1861(s)(2)(K)(i)—

''(A) payment under this part may only be made on an assignment-related basis; and

''(B) the amounts paid under this part shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848 for the same service provided by a physician who is not a specialist; or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery.''.

(c) REMOVAL OF RESTRICTION ON EMPLOYMENT RELATIONSHIP.—Section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by adding at the end the following new sentence: ''For purposes of clause (C) of the first sentence of this paragraph, an employment relationship may include any independent contractor arrangement, and employer status shall be determined in accordance with the law of the State in which the services described in such clause are performed.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after January 1, 1998.

CHAPTER 2—OTHER PAYMENT PROVISIONS

SEC. 5521. REDUCTION IN UPDATES TO PAYMENT AMOUNTS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS; STUDY ON LABORATORY SERVICES.

(a) CHANGE IN UPDATE.—Section 1833(h)(2)(A)(ii) (42 U.S.C. 1395l(h)(2)(A)(ii)) is amended by striking ''and'' at the end of subclause (III), by striking the period at the end of subclause (IV) and inserting '', and'', and by adding at the end the following:

''(V) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1998 through 2002 shall be reduced (but not below zero) by 2.0 percentage points.''.

(b) LOWERING CAP ON PAYMENT AMOUNTS.—Section 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)) is amended—

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

(2) in clause (vii)—

(A) by inserting ''and before January 1, 1998,'' after ''1995,'', and

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

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

''(viii) after December 31, 1997, is equal to 74 percent of such median.''.

(c) STUDY AND REPORT ON CLINICAL LABORATORY SERVICES.—

(1) IN GENERAL.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to conduct a study of payments under part B of title XVIII of the Social Security Act for clinical laboratory services. The study shall include a review of the adequacy of the current methodology and recommendations regarding alternative payment systems. The study shall also analyze and discuss the relationship between such payment systems and access to high quality laboratory services for medicare beneficiaries, including availability and access to new testing methodologies.

(2) REPORT TO CONGRESS.—The Secretary shall, not later than 2 years after the date of enactment of this section, report to the appropriate committees of Congress the results of the study described in paragraph (1), including any recommendations for legislation.

SEC. 5522. IMPROVEMENTS IN ADMINISTRATION OF LABORATORY SERVICES BENEFIT.

(a) SELECTION OF REGIONAL CARRIERS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall—

(A) divide the United States into no more than 5 regions, and

(B) designate a single carrier for each such region,

for the purpose of payment of claims under part B of title XVIII of the Social Security Act with respect to clinical diagnostic laboratory services furnished on or after such date (not later than January 1, 1999) as the Secretary specifies.

(2) DESIGNATION.—In designating such carriers, the Secretary shall consider, among other criteria—

(A) a carrier's timeliness, quality, and experience in claims processing, and

(B) a carrier's capacity to conduct electronic data interchange with laboratories and data matches with other carriers.

(3) SINGLE DATA RESOURCE.—The Secretary shall select one of the designated carriers to serve as a central statistical resource for all claims information relating to such clinical diagnostic laboratory services handled by all the designated carriers under such part.

(4) ALLOCATION OF CLAIMS.—The allocation of claims for clinical diagnostic laboratory services to particular designated carriers shall be based on whether a carrier serves the geographic area where the laboratory specimen was collected or other method specified by the Secretary.

(5) TEMPORARY EXCEPTION.—Paragraph (1) shall not apply with respect to clinical diagnostic laboratory services furnished by independent physician offices until such time as the Secretary determines that such offices would not be unduly burdened by the application of billing responsibilities with respect to more than one carrier.

(b) ADOPTION OF UNIFORM POLICIES FOR CLINICAL LABORATORY BENEFITS.—

(1) IN GENERAL.—Not later than July 1, 1998, the Secretary shall first adopt, consistent with paragraph (2), uniform coverage, administration, and payment policies for clinical diagnostic laboratory tests under part B of title XVIII of the Social Security Act, using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code.

(2) CONSIDERATIONS IN DESIGN OF UNIFORM POLICIES.—The policies under paragraph (1) shall be designed to promote program integrity and uniformity and simplify administrative requirements with respect to clinical diagnostic laboratory tests payable under such part in connection with the following:

(A) Beneficiary information required to be submitted with each claim or order for laboratory services.

(B) Physicians' obligations regarding documentation requirements and recordkeeping.

(C) Procedures for filing claims and for providing remittances by electronic media.

(D) The documentation of medical necessity.

(E) Limitation on frequency of coverage for the same tests performed on the same individual.

(3) CHANGES IN LABORATORY POLICIES PENDING ADOPTION OF UNIFORM POLICY.—During the period that begins on the date of the enactment of this Act and ends on the date the Secretary first implements uniform policies pursuant to regulations promulgated under this subsection, a carrier under such part may implement changes relating to requirements for the submission of a claim for clinical diagnostic laboratory tests.

(4) USE OF INTERIM POLICIES.—After the date the Secretary first implements such uniform policies, the Secretary shall permit any carrier to develop and implement interim policies of the type described in paragraph (1), in accordance with guidelines established by the Secretary, in cases in which a uniform national policy has not been established under this subsection and there is a demonstrated need for a policy to respond to aberrant utilization or provision of unnecessary services. Except as the Secretary specifically permits, no policy shall be implemented under this paragraph for a period of longer than 2 years.

(5) INTERIM NATIONAL GUIDELINES.—After the date the Secretary first designates regional carriers under subsection (a), the Secretary shall establish a process under which designated carriers can collectively develop and implement interim national guidelines of the type described in paragraph (1). No such policy shall be implemented under this paragraph for a period of longer than 2 years.

(6) BIENNIAL REVIEW PROCESS.—Not less often than once every 2 years, the Secretary shall solicit and review comments regarding changes in the uniform policies established under this subsection. As part of such biennial review process, the Secretary shall specifically review and consider whether to incorporate or supersede interim, regional, or national policies developed under paragraph (4) or (5). Based upon such review, the Secretary may provide for appropriate changes in the uniform policies previously adopted under this subsection.

(7) REQUIREMENT AND NOTICE.—The Secretary shall ensure that any guidelines adopted under paragraph (3), (4), or (5) shall apply to all laboratory claims payable under part B of title XVIII of the Social Security Act, and shall provide for advance notice to interested parties and a 45-day period in which such parties may submit comments on the proposed change.

(c) INCLUSION OF LABORATORY REPRESENTATIVE ON CARRIER ADVISORY COMMITTEES.—The Secretary shall direct that any advisory committee established by such a carrier, to advise with respect to coverage, administration or payment policies under part B of title XVIII of the Social Security Act, shall include an individual to represent the interest and views of independent clinical laboratories and such other laboratories as the Secretary deems appropriate. Such individual shall be selected by such committee from among nominations submitted by national and local organizations that represent independent clinical laboratories.

SEC. 5523. PAYMENTS FOR DURABLE MEDICAL EQUIPMENT.

(a) REDUCTION IN PAYMENT AMOUNTS FOR ITEMS OF DURABLE MEDICAL EQUIPMENT.—

(1) FREEZE IN UPDATE FOR COVERED ITEMS.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended to read as follows:

''(14) COVERED ITEM UPDATE.—In this subsection—

''(A) IN GENERAL.—The term 'covered item update' means, with respect to any year, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

''(B) REDUCTION FOR CERTAIN YEARS.—In the case of each of the years 1998 through 2002, the covered item update under subparagraph (A) shall be reduced (but not below zero) by 2.0 percentage points.''.

(2) UPDATE FOR ORTHOTICS AND PROSTHETICS.—Section 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A)) is amended to read as follows:

''(A) the term 'applicable percentage increase' means, with respect to any year, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year, except that in each of the years 1998 through 2000, such increase shall be reduced (but not below zero) by 2.0 percentage points;''.

(3) EFFECTIVE DATE.—The amendments made by this subsection applies to items furnished on and after January 1, 1998.

(b) REDUCTION IN INCREASE FOR PARENTERAL AND ENTERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT.—The reasonable charge under part B of title XVIII of the Social Security Act for parenteral and enteral nutrients, supplies, and equipment furnished during each of the years 1998 through 2002, shall not exceed the reasonable charge for such items furnished during the previous year (after application of this subsection), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year reduced (but not below zero) by 2.0 percentage points.

SEC. 5524. OXYGEN AND OXYGEN EQUIPMENT.

(a) IN GENERAL.—Section 1834(a)(9)(B) (42 U.S.C. 1395m(a)(9)(B)) is amended—

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

(2) in clause (iv)—

(A) by striking ''a subsequent year'' and inserting ''1995, 1996, and 1997'', and

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

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

''(v) in 1998, 75 percent of the amount determined under this subparagraph for 1997;

''(vi) in 1999, 62.5 percent of the amount determined under this subparagraph for 1997; and

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

(b) UPGRADED DURABLE MEDICAL EQUIPMENT.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by inserting after paragraph (15) the following new paragraph:

''(16) CERTAIN UPGRADED ITEMS.—

''(A) INDIVIDUAL'S RIGHT TO CHOOSE UPGRADED ITEM.—Notwithstanding any other provision of law, effective on the date on which the Secretary issues regulations under subparagraph (C), an individual may purchase or rent from a supplier an item of upgraded durable medical equipment for which payment would be made under this subsection if the item were a standard item.

''(B) PAYMENTS TO SUPPLIER.—In the case of the purchase or rental of an upgraded item under subparagraph (A)—

''(i) the supplier shall receive payment under this subsection with respect to such item as if such item were a standard item; and

''(ii) the individual purchasing or renting the item shall pay the supplier an amount equal to the difference between the supplier's charge and the amount under clause (i).

In no event may the supplier's charge for an upgraded item exceed the applicable fee schedule amount (if any) for such item.

''(C) CONSUMER PROTECTION SAFEGUARDS.—The Secretary shall issue regulations providing for consumer protection standards with respect to the furnishing of upgraded equipment under subparagraph (A). Such regulations shall provide for—

''(i) determination of fair market prices with respect to an upgraded item;

''(ii) full disclosure of the availability and price of standard items and proof of receipt of such disclosure information by the beneficiary before the furnishing of the upgraded item;

''(iii) conditions of participation for suppliers in the simplified billing arrangement;

''(iv) sanctions of suppliers who are determined to engage in coercive or abusive practices, including exclusion; and

''(v) such other safeguards as the Secretary determines are necessary.''.

(c) ESTABLISHMENT OF CLASSES FOR PAYMENT.—Section 1848(a)(9) (42 U.S.C. 1395m(a)(9)) is amended by adding at the end the following:

''(D) AUTHORITY TO CREATE CLASSES.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary may establish separate classes for any item of oxygen and oxygen equipment and separate national limited monthly payment rates for each of such classes.

''(ii) BUDGET NEUTRALITY.—The Secretary may take actions under clause (i) only to the extent such actions do not result in expenditures for any year to be more or less than the expenditures which would have been made if such actions had not been taken.''.

(d) STANDARDS AND ACCREDITATION.—The Secretary shall as soon as practicable establish service standards and accreditation requirements for persons seeking payment under part B of title XVIII of the Social Security Act for the providing of oxygen and oxygen equipment to beneficiaries within their homes.

(e) ACCESS TO HOME OXYGEN EQUIPMENT.—

(1) STUDY.—The Comptroller General of the United States shall study issues relating to access to home oxygen equipment and shall, within 6 months after the date of the enactment of this Act, report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate the results of the study, including recommendations (if any) for legislation.

(2) PEER REVIEW EVALUATION.—The Secretary of Health and Human Services shall arrange for peer review organizations established under section 1154 of the Social Security Act to evaluate access to, and quality of, home oxygen equipment.

(f) DEMONSTRATION PROJECT.—Not later than 6 months after the date of enactment of this Act, the Secretary shall, in consultation with appropriate organizations, initiate a demonstration project in which the Secretary utilizes a competitive bidding process for the furnishing of home oxygen equipment to medicare beneficiaries under title XVIII of the Social Security Act.

(g) EFFECTIVE DATE.—

(1) OXYGEN.—The amendments made by subsection (a) shall apply to items furnished on and after January 1, 1998.

(2) OTHER PROVISIONS.—The amendments made by this section other than subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 5525. UPDATES FOR AMBULATORY SURGICAL SERVICES.

Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is amended by inserting at the end the following: ''In each of the fiscal years 1998 through 2002, the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points.''.

SEC. 5526. REIMBURSEMENT FOR DRUGS AND BIOLOGICALS.

(a) IN GENERAL.—Section 1842 (42 U.S.C. 1395u) is amended by inserting after subsection (n) the following new subsection:

''(o)(1) If a physician's, supplier's, or any other person's bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the amount payable for the drug or biological is equal to 95 percent of the average wholesale price, as specified by the Secretary.

''(2)(A) In the case of a drug or biological for which payment was under this part on May 1, 1997, the amount determined under paragraph (1) for any drug or biological shall not exceed—

''(i) in the case of 1998, the amount of the payment under this part on May 1, 1997, and

''(ii) in the case of 1999 and each succeeding year, the amount determined under this subparagraph for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

''(B) In the case of a drug or biological not described in subparagraph (A), the amount determined under paragraph (1) for any year following the first year for which payment is made under this part for such drug or biological shall not exceed the amount payable under this part (after application of this subparagraph) for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

''(3) If payment for a drug or biological is made to a licensed pharmacy approved to dispense drugs or biologicals under this part, the Secretary shall pay a dispensing fee (less the applicable deductible and insurance amounts) to the pharmacy, as the Secretary determines appropriate.

''(4) The Secretary shall conduct such studies or surveys as are necessary to determine the average wholesale price (and such other price as the Secretary determines appropriate) of any drug or biological for purposes of paragraph (1). The Secretary shall, not later than 6 months after the date of the enactment of this subsection, report to the appropriate committees of Congress the results of the studies and surveys conducted under this paragraph.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to drugs and biologicals furnished on or after January 1, 1998.

CHAPTER 3—PART B PREMIUM AND RELATED PROVISIONS

SEC. 5541. PART B PREMIUM.

(a) IN GENERAL.—Section 1839(a)(3) (42 U.S.C. 1395r(a)(3)) is amended by striking the first 3 sentences and inserting the following: ''The Secretary, during September of each year, shall determine and promulgate a monthly premium rate for the succeeding calendar year that is equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1), for that succeeding calendar year.''.

(b) CONFORMING AND TECHNICAL AMENDMENTS.—

(1) SECTION 1839.—Section 1839 (42 U.S.C. 1395r) is amended—

(A) in subsection (a)(2), by striking ''(b) and (e)'' and inserting ''(b), (c), and (f)'',

(B) in the last sentence of subsection (a)(3)—

(i) by inserting ''rate'' after ''premium'', and

(ii) by striking ''and the derivation of the dollar amounts specified in this paragraph'',

(C) by striking subsection (e), and

(D) by redesignating subsection (g) as subsection (e) and inserting that subsection after subsection (d).

(2) SECTION 1844.—Subparagraphs (A)(i) and (B)(i) of section 1844(a)(1) (42 U.S.C. 1395w(a)(1)) are each amended by striking ''or 1839(e), as the case may be''.

SEC. 5542. INCOME-RELATED REDUCTION IN MEDICARE SUBSIDY.

(a) IN GENERAL.—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following:

''(h)(1) Notwithstanding the previous subsections of this section, in the case of an individual whose modified adjusted gross income for a taxable year ending with or within a calendar year (as initially determined by the Secretary in accordance with paragraph (3)) exceeds the threshold amount described in paragraph (5)(B), the Secretary shall increase the amount of the monthly premium for months in the calendar year by an amount equal to the difference between—

''(A) 200 percent of the monthly actuarial rate for enrollees age 65 and over as determined under subsection (a)(1) for that calendar year; and

''(B) the total of the monthly premiums paid by the individual under this section (determined without regard to subsection (b)) during such calendar year.

''(2) In the case of an individual described in paragraph (1) whose modified adjusted gross income exceeds the threshold amount by less than

$50,000, the amount of the increase in the monthly premium applicable under paragraph (1) shall be an amount which bears the same ratio to the amount of the increase described in paragraph (1) (determined without regard to this paragraph) as such excess bears to $50,000.

''(3) The Secretary shall make an initial determination of the amount of an individual's modified adjusted gross income for a taxable year ending with or within a calendar year for purposes of this subsection as follows:

''(A) Not later than September 1 of the year preceding the year, the Secretary shall provide notice to each individual whom the Secretary finds (on the basis of the individual's actual modified adjusted gross income for the most recent taxable year for which such information is available or other information provided to the Secretary by the Secretary of the Treasury) will be subject to an increase under this subsection that the individual will be subject to such an increase, and shall include in such notice the Secretary's estimate of the individual's modified adjusted gross income for the year.

''(B) If, during the 30-day period beginning on the date notice is provided to an individual under subparagraph (A), the individual provides the Secretary with information on the individual's anticipated modified adjusted gross income for the year, the amount initially determined by the Secretary under this paragraph with respect to the individual shall be based on the information provided by the individual.

''(C) If an individual does not provide the Secretary with information under subparagraph (B), the amount initially determined by the Secretary under this paragraph with respect to the individual shall be the amount included in the notice provided to the individual under subparagraph (A).

''(4)(A) If the Secretary determines (on the basis of final information provided by the Secretary of the Treasury) that the amount of an individual's actual modified adjusted gross income for a taxable year ending with or within a calendar year is less than or greater than the amount initially determined by the Secretary under paragraph (3), the Secretary shall increase or decrease the amount of the individual's monthly premium under this section (as the case may be) for months during the following calendar year by an amount equal to 1/12 of the difference between—

''(i) the total amount of all monthly premiums paid by the individual under this section during the previous calendar year; and

''(ii) the total amount of all such premiums which would have been paid by the individual during the previous calendar year if the amount of the individual's modified adjusted gross income initially determined under paragraph (3) were equal to the actual amount of the individual's modified adjusted gross income determined under this paragraph.

''(B)(i) In the case of an individual for whom the amount initially determined by the Secretary under paragraph (3) is based on information provided by the individual under subparagraph (B) of such paragraph, if the Secretary determines under subparagraph (A) that the amount of the individual's actual modified adjusted gross income for a taxable year is greater than the amount initially determined under paragraph (3), the Secretary shall increase the amount otherwise determined for the year under subparagraph (A) by interest in an amount equal to the sum of the amounts determined under clause (ii) for each of the months described in clause (ii).

''(ii) Interest shall be computed for any month in an amount determined by applying the underpayment rate established under section 6621 of the Internal Revenue Code of 1986 (compounded daily) to any portion of the difference between the amount initially determined under paragraph (3) and the amount determined under subparagraph (A) for the period beginning on the first day of the month beginning after the individual provided information to the Secretary under subparagraph (B) of paragraph (3) and ending 30 days before the first month for which the individual's monthly premium is increased under this paragraph.

''(iii) Interest shall not be imposed under this subparagraph if the amount of the individual's modified adjusted gross income provided by the individual under subparagraph (B) of paragraph (3) was not less than the individual's modified adjusted gross income determined on the basis of information shown on the return of tax imposed by chapter 1 of the Internal Revenue Code of 1986 for the taxable year involved.

''(C) In the case of an individual who is not enrolled under this part for any calendar year for which the individual's monthly premium under this section for months during the year would be increased pursuant to subparagraph (A) if the individual were enrolled under this part for the year, the Secretary may take such steps as the Secretary considers appropriate to recover from the individual the total amount by which the individual's monthly premium for months during the year would have been increased under subparagraph (A) if the individual were enrolled under this part for the year.

''(D) In the case of a deceased individual for whom the amount of the monthly premium under this section for months in a year would have been decreased pursuant to subparagraph (A) if the individual were not deceased, the Secretary shall make a payment to the individual's surviving spouse (or, in the case of an individual who does not have a surviving spouse, to the individual's estate) in an amount equal to the difference between—

''(i) the total amount by which the individual's premium would have been decreased for all months during the year pursuant to subparagraph (A); and

''(ii) the amount (if any) by which the individual's premium was decreased for months during the year pursuant to subparagraph (A).

''(5) In this subsection, the following definitions apply:

''(A) The term 'modified adjusted gross income' means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

''(i) determined without regard to sections 135, 911, 931, and 933 of such Code, and

''(ii) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax under such Code.

''(B) The term 'threshold amount' means—

''(i) except as otherwise provided in this paragraph, $50,000,

''(ii) $75,000, in the case of a joint return (as defined in section 7701(a)(38) of such Code), and

''(iii) zero in the case of a taxpayer who—

''(I) is married at the close of the taxable year but does not file a joint return (as so defined) for such year, and

''(II) does not live apart from his spouse at all times during the taxable year.

''(6)(A) The Secretary shall transfer amounts received pursuant to this subsection to the Federal Hospital Insurance Trust Fund.

''(B) In applying section 1844(a), amounts attributable to clause (i) shall not be counted in determining the dollar amount of the premium per enrollee under paragraph (1)(A) or (1)(B).''.

(b) CONFORMING AMENDMENTS.—(1) Section 1839 (42 U.S.C. 1395r) is amended—

(A) in subsection (a)(2), by inserting ''or section subsection (h)'' after ''subsections (b) and (e)'';

(B) in subsection (a)(3) of section 1839(a), by inserting ''or subsection (h)'' after ''subsection (e)'';

(C) in subsection (b), inserting ''(and as increased under subsection (h))'' after ''subsection (a) or (e)''; and

(D) in subsection (f), by striking ''if an individual'' and inserting the following: ''if an individual (other than an individual subject to an increase in the monthly premium under this section pursuant to subsection (h))''.

(2) Section 1840(c) (42 U.S.C. 1395r(c)) is amended by inserting ''or an individual determines that the estimate of modified adjusted gross income used in determining whether the individual is subject to an increase in the monthly premium under section 1839 pursuant to subsection (h) of such section (or in determining the amount of such increase) is too low and results in a portion of the premium not being deducted,'' before ''he may''.

(c) REPORTING REQUIREMENTS FOR SECRETARY OF THE TREASURY.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to confidentiality and disclosure of returns and return information) is amended by adding at the end the following new paragraph:

''(16) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT INCOME-RELATED REDUCTION IN MEDICARE PART B PREMIUM.—

''(A) IN GENERAL.—The Secretary may, upon written request from the Secretary of Health and Human Services, disclose to officers and employees of the Health Care Financing Administration return information with respect to a taxpayer who is required to pay a monthly premium under section 1839 of the Social Security Act. Such return information shall be limited to—

''(i) taxpayer identity information with respect to such taxpayer,

''(ii) the filing status of such taxpayer,

''(iii) the adjusted gross income of such taxpayer,

''(iv) the amounts excluded from such taxpayer's gross income under sections 135 and 911,

''(v) the interest received or accrued during the taxable year which is exempt from the tax imposed by chapter 1 to the extent such information is available, and

''(vi) the amounts excluded from such taxpayer's gross income by sections 931 and 933 to the extent such information is available.

''(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Health Care Financing Administration only for the purposes of, and to the extent necessary in, establishing the appropriate monthly premium under section 1839 of the Social Security Act.''.

(2) CONFORMING AMENDMENT.—Paragraphs (3)(A) and (4) of section 6103(p) of such Code are each amended by striking ''or (15)'' each place it appears and inserting ''(15), or (16)''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsections (a) and (b) shall apply to the monthly premium under section 1839 of the Social Security Act for months beginning with January 1998.

(2) INFORMATION FOR PRIOR YEARS.—The Secretary of Health and Human Services may request information under section 6013(l)(16) of the Social Security Act (as added by subsection (c)) for taxable years beginning after December 31, 1994.

SEC. 5543. DEMONSTRATION PROJECT ON INCOME-RELATED PART B DEDUCTIBLE.

(a) ESTABLISHMENT OF PROJECT.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a demonstration project (in this section referred to as the ''project'') in which individuals otherwise responsible for an income-related premium by reason of section 1839(h) of the Social Security Act (42 U.S.C. 1395r(h)) (as added by section 5542 of this Act) would instead be responsible for an income-related deductible using the same income limits and administrative procedures provided for in such section 1839(h).

(2) SITES.—The Secretary shall conduct the project in a representative number of sites and

shall include a sufficient number of individuals in the project to ensure that the project produces statistically satisfactory findings.

(3) PARTICIPATION.—

(A) IN GENERAL.—Participation in the project shall be on a voluntary basis.

(B) MEDIGAP.—No individual shall be eligible to participate in the project if such individual is covered under a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395ss).

(4) CONSULTATION.—In conducting the project, the Secretary shall consult with appropriate organizations and experts.

(5) DURATION.—The project shall be conducted for a period not to exceed 5 years.

(b) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of titles XI, XVIII, and XIX of the Social Security Act (42 U.S.C. 1301 et seq., 1395 et seq., 1396 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct the project.

(c) REPORTS TO CONGRESS.—

(1) IN GENERAL.—Not later than 2 and 5 years after the date of enactment of this Act, and biannually thereafter, the Secretary shall submit to Congress a report regarding the project.

(2) CONTENTS OF REPORT.—The reports in paragraph (1) shall include the following:

(A) A description of the demonstration projects conducted under this section.

(B) A description of the utilization and health care status of individuals participating in the project.

(C) Any other information regarding the project that the Secretary determines to be appropriate.

SEC. 5544. LOW-INCOME MEDICARE BENEFICIARY BLOCK GRANT PROGRAM.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 5047, is amended by adding at the end the following:

''LOW-INCOME MEDICARE BENEFICIARY BLOCK GRANT PROGRAM

''SEC. 1898. (a) ESTABLISHMENT.—The Secretary shall establish a program to award block grants to States for the payment of medicare cost sharing described in section 1905(p)(3)(A)(ii) on behalf of eligible low-income medicare beneficiaries.

''(b) APPLICATION.—To be eligible to receive a block grant under this section, a State shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) PAYMENTS.—

''(1) AMOUNT OF GRANT.—From amounts appropriated under subsection (d) for a fiscal year, the Secretary shall award a grant to each State with an application approved under subsection (b), in an amount that bears the same ratio to such amounts as the total number of eligible low-income medicare beneficiaries in the State bears to the total number of eligible low-income medicare beneficiaries in all States.

''(2) 100 PERCENT FMAP.—Notwithstanding section 1905(b), the Federal medical assistance percentage for any State that receives a grant under this section shall be 100 percent.

''(d) APPROPRIATIONS.—

''(1) IN GENERAL.—The Secretary is authorized to transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841 for the purpose of carrying out this section, an amount equal to $200,000,000 in fiscal year 1998, $250,000,000 in fiscal year 1999, $300,000,000 in fiscal year 2000, $350,000,000 in fiscal year 2001, and $400,000,000 in fiscal year 2002, to remain available without fiscal year limitation.

''(2) STATE ENTITLEMENT.—This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided in accordance with the provisions of this section.

''(e) DEFINITIONS.—In this section:

''(1) ELIGIBLE LOW-INCOME MEDICARE BENEFICIARY.—The term 'eligible low-income medicare beneficiary' means an individual who is described in section 1902(a)(10)(E)(iii) but whose family income is greater than or equal to 120 percent of the poverty line and does not exceed 150 percent of the poverty line for a family of the size involved.

''(2) STATE.—The term 'State' means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands.''.

Subtitle H—Provisions Relating to Parts A and B

CHAPTER 1—SECONDARY PAYOR PROVISIONS

SEC. 5601. EXTENSION AND EXPANSION OF EXISTING REQUIREMENTS.

(a) DATA MATCH.—

(1) ELIMINATION OF MEDICARE SUNSET.—Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) ELIMINATION OF INTERNAL REVENUE CODE SUNSET.—Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) APPLICATION TO DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

(1) IN GENERAL.—Section 1862(b)(1)(B) (42 U.S.C. 1395y(b)(1)(B)) is amended—

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

(B) by striking clause (iii); and

(C) by redesignating clause (iv) as clause (iii).

(2) CONFORMING AMENDMENTS.—Paragraphs (1) through (3) of section 1837(i) (42 U.S.C. 1395p(i)) and the second sentence of section 1839(b) (42 U.S.C. 1395r(b)) are each amended by striking ''1862(b)(1)(B)(iv)'' each place it appears and inserting ''1862(b)(1)(B)(iii)''.

(c) INDIVIDUALS WITH END STAGE RENAL DISEASE.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the last sentence by striking ''October 1, 1998'' and inserting ''the date of enactment of the Balanced Budget Act of 1997''; and

(2) by adding at the end the following: ''Effective for items and services furnished on or after the date of enactment of the Balanced Budget Act of 1997, (with respect to periods beginning on or after the date that is 18 months prior to such date), clauses (i) and (ii) shall be applied by substituting '30-month' for '12-month' each place it appears.''.

SEC. 5602. IMPROVEMENTS IN RECOVERY OF PAYMENTS.

(a) PERMITTING RECOVERY AGAINST THIRD PARTY ADMINISTRATORS OF PRIMARY PLANS.—Section 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is amended—

(1) by striking ''under this subsection to pay'' and inserting ''(directly, as a third-party administrator, or otherwise) to make payment''; and

(2) by adding at the end the following: ''The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.''.

(b) EXTENSION OF CLAIMS FILING PERIOD.—Section 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amended by adding at the end the following:

''(v) CLAIMS-FILING PERIOD.—Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to items and services furnished on or after the date of enactment of this Act.

CHAPTER 2—OTHER PROVISIONS

SEC. 5611. CONFORMING AGE FOR ELIGIBILITY UNDER MEDICARE TO RETIREMENT AGE FOR SOCIAL SECURITY BENEFITS.

(a) ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS.—Section 226 (42 U.S.C. 426) is amended by striking ''age 65'' each place such term appears and inserting ''retirement age''.

(b) HOSPITAL INSURANCE BENEFITS FOR THE AGED.—Section 1811 (42 U.S.C. 1395c) is amended by striking ''age 65'' each place such term appears and inserting ''retirement age (as such term is defined in section 216(l)(1))''.

(c) HOSPITAL INSURANCE BENEFITS FOR UNINSURED ELDERLY INDIVIDUALS NOT OTHERWISE ELIGIBLE.—Section 1818 (42 U.S.C. 1395i–2) is amended—

(1) in subsection (a)(1), by striking ''age of 65'' and inserting ''retirement age (as such term is defined in section 216(l)(1))'';

(2) in subsection (d)(1), by striking ''age 65'' and inserting ''retirement age (as such term is defined in section 216(l)(1))''; and

(3) in subsection (d)(3), by striking ''65'' and inserting ''retirement age (as such term is defined in section 216(l)(1))''.

(d) HOSPITAL INSURANCE BENEFITS FOR DISABLED INDIVIDUALS WHO HAVE EXHAUSTED OTHER ENTITLEMENT.—Section 1818A(a)(1) (42 U.S.C. 1395i–2a(a)(1)) is amended by striking ''the age of 65'' and inserting ''retirement age (as such term is defined in section 216(l)(1))''.

(e) ELIGIBILITY FOR PART B BENEFITS.—

(1) IN GENERAL.—Section 1836 (42 U.S.C. 1395o) is amended by striking ''age 65'' each place such term appears and inserting ''retirement age (as such term is defined in section 216(l)(1))''.

(2) ENROLLMENT PERIODS.—Section 1837 (42 U.S.C. 1395p) is amended by striking ''age 65'' and ''the age of 65'' each place such terms appear and inserting ''retirement age (as such term is defined in section 216(l)(1))''.

(3) COVERAGE PERIOD.—Section 1838(c) (42 U.S.C. 1395q(c)) is amended by striking ''the age of 65'' and inserting ''retirement age (as such term is defined in section 216(l)(1))''.

(4) AMOUNTS OF PREMIUMS.—Section 1839 (42 U.S.C. 1395r) is amended by striking ''age 65'' and ''the age of 65'' each place such terms appear and inserting ''retirement age (as such term is defined in section 216(l)(1))''.

(f) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS AND CONTINGENCY RESERVE.—Section 1844(a)(1) (42 U.S.C. 1395w) is amended by striking ''age 65'' each place such term appears and inserting ''retirement age''.

(g) MEDICARE SECONDARY PAYER.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended by striking ''age 65'' each place such term appears and inserting ''retirement age (as such term is defined in section 216(l)(1))''.

(h) MEDICARE SUPPLEMENTAL POLICIES.—Section 1882(s)(2)(A) (42 U.S.C. 1395ss(s)(2)(A)) is amended by striking ''65 years of age'' and inserting ''retirement age (as such term is defined in section 216(l)(1))''.

SEC. 5612. INCREASED CERTIFICATION PERIOD FOR CERTAIN ORGAN PROCUREMENT ORGANIZATIONS.

Section 1138(b)(1)(A)(ii) (42 U.S.C. 1320b–8(b)(1)(A)(ii)) is amended by striking ''two years'' and inserting ''2 years (3 years if the Secretary determines appropriate for an organization on the basis of its past practices)''.

SEC. 5613. FACILITATING THE USE OF PRIVATE CONTRACTS UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1804 of such Act (42 U.S.C. 1395b–2) the following:

''CLARIFICATION OF PRIVATE CONTRACTS FOR HEALTH SERVICES

''SEC. 1805. (a) IN GENERAL.—Nothing in this title shall prohibit a physician or another health care professional who does not provide items or services under the program under this title from entering into a private contract with a medicare beneficiary for health services for which no claim for payment is to be submitted under this title.

''(b) LIMITATION ON ACTUAL CHARGE NOT APPLICABLE.—Section 1848(g) shall not apply with respect to a health service provided to a medicare beneficiary under a contract described in subsection (a).

''(c) DEFINITION OF MEDICARE BENEFICIARY.—In this section, the term 'medicare beneficiary' means an individual who is entitled to benefits under part A or enrolled under part B.

''(d) REPORT.—Not later than October 1, 2001, the Administrator of the Health Care Financing Administration shall submit a report to Congress on the effect on the program under this title of private contracts entered into under this section. Such report shall include—

''(1) analyses regarding—

''(A) the fiscal impact of such contracts on total Federal expenditures under this title and on out-of-pocket expenditures by medicare beneficiaries for health services under this title; and

''(B) the quality of the health services provided under such contracts; and

''(2) recommendations as to whether medicare beneficiaries should continue to be able to enter private contracts under this section and if so, what legislative changes, if any should be made to improve such contracts.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to contracts entered into on and after October 1, 1997.

Subtitle I—Miscellaneous Provisions

SEC. 5651. INCLUSION OF STANLY COUNTY, N.C. IN A LARGE URBAN AREA UNDER MEDICARE PROGRAM.

(a) IN GENERAL.—For purposes of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), the large urban area of Charlotte-Gastonia-Rock Hill-North Carolina-South Carolina may be deemed to include Stanly County, North Carolina.

(b) EFFECTIVE DATE.—This section shall apply with respect to discharges occurring on or after October 1, 1997.

SEC. 5652. MEDICARE ANTI-DUPLICATION PROVISION.

(a) In section 1395ss(d)(3)(A)(v) of title 42, United States Code, insert ''(a)'' before ''For'', and after the first sentence insert:

''(b) For purposes of this subparagraph, a health insurance policy (which may be a contract with a health maintenance organization) is not considered to 'duplicate' health benefits under this title or title XIX or under another health insurance policy if it—

''(1) provides comprehensive health care benefits that replace the benefits provided by another health insurance policy,

''(2) is being provided to an individual entitled to benefits under part A or enrolled under part B on the basis of section 226(b), and

''(3) coordinates against items and services available or paid for under this title or title XIX, provided that payments under this title or title XIX shall not be treated as payments under such policy in determining annual or lifetime benefit limits.''.

(b) In section 1395ss(d)(3)(A)(v) of title 42, United States Code, insert ''(c)'' before ''For purposes of this clause''.

DIVISION 2—MEDICAID AND CHILDREN'S HEALTH INSURANCE INITIATIVES

Subtitle I—Medicaid

CHAPTER 1—MEDICAID SAVINGS

Subchapter A—Managed Care Reforms

SEC. 5701. STATE OPTION FOR MANDATORY MANAGED CARE.

(a) IN GENERAL.—Title XIX is amended—

(1) by inserting after the title heading the following:

''PART A—GENERAL PROVISIONS''; and

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

''PART B—PROVISIONS RELATING TO MANAGED CARE

''SEC. 1941. BENEFICIARY CHOICE; ENROLLMENT.

''(a) STATE OPTIONS FOR ENROLLMENT OF BENEFICIARIES IN MANAGED CARE ARRANGEMENTS.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this part and notwithstanding paragraphs (1), (10)(B), and (23)(A) of section 1902(a), a State may require an individual who is eligible for medical assistance under the State plan under this title and who is not a special needs individual (as defined in subsection (e)) to enroll with a managed care entity (as defined in section 1950(a)(1)) as a condition of receiving such assistance (and, with respect to assistance furnished by or under arrangements with such entity, to receive such assistance through the entity), if the following provisions are met:

''(A) ENTITY MEETS REQUIREMENTS.—The entity meets the applicable requirements of this part.

''(B) CONTRACT WITH STATE.—The entity enters into a contract with the State to provide services for the benefit of individuals eligible for benefits under this title under which prepaid payments to such entity are made on an actuarially sound basis. Such contract shall specify benefits the provision (or arrangement) for which the entity is responsible.

''(C) CHOICE OF COVERAGE.—

''(i) IN GENERAL.—The State permits an individual to choose a managed care entity from managed care organizations and primary care case managers who meet the requirements of this part but not less than from—

''(I) 2 medicaid managed care organizations,

''(II) a medicaid managed care organization and a primary care case manager, or

''(III) a primary care case manager as long as an individual may choose between 2 primary care case managers.

''(ii) STATE OPTION.—At the option of the State, a State shall be considered to meet the requirements of clause (i) in the case of an individual residing in a rural area, if the State—

''(I) requires the individual to enroll with a medicaid managed care organization or a primary care case manager if such organization or entity permits the individual to receive such assistance through not less than 2 physicians or case managers (to the extent that at least 2 physicians or case managers are available to provide such assistance in the area), and

''(II) permits the individual to obtain such assistance from any other provider in appropriate circumstances (as established by the State under regulations of the Secretary).

''(iii) RELIGIOUS CHOICE.—The State, in permitting an individual to choose a managed care entity under clause (i) shall permit the individual to have access to appropriate religiously-affiliated long-term care facilities that are not pervasively sectarian and that provide comparable non-sectarian medical care. With respect to such access, the State shall permit an individual to select a facility that is not a part of the network of the managed care entity if such network does not provide access to appropriate faith-based facilities. Such facility that provides care under this clause shall accept the terms and conditions offered by the managed care entity to other providers in the network. No facility may be compelled to admit an individual if the medical director of that facility believes that the facility cannot provide the specific nursing care and services an enrollee requires.

''(D) CHANGES IN ENROLLMENT.—The State—

''(i) provides the individual with the opportunity to change enrollment among managed care entities once annually and notifies the individual of such opportunity not later than 60 days prior to the first date on which the individual may change enrollment, and

''(ii) permits individuals to terminate their enrollment as provided under paragraph (2).

''(E) ENROLLMENT PRIORITIES.—The State establishes a method for establishing enrollment priorities in the case of a managed care entity that does not have sufficient capacity to enroll all such individuals seeking enrollment under which individuals already enrolled with the entity are given priority in continuing enrollment with the entity.

''(F) DEFAULT ENROLLMENT PROCESS.—The State establishes a default enrollment process which meets the requirements described in paragraph (3) and under which any such individual who does not enroll with a managed care entity during the enrollment period specified by the State shall be enrolled by the State with such an entity in accordance with such process.

''(G) SANCTIONS.—The State establishes the sanctions provided for in section 1949.

''(H) INDIAN ENROLLMENT.—No individual who is an Indian (as defined in section 4 of the Indian Health Care Improvement Act of 1976) is required to enroll in any entity that is not one of the following (and only if such entity is participating under the plan):

''(i) The Indian Health Service.

''(ii) An Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.).

''(iii) An urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(2) TERMINATION OF ENROLLMENT.—

''(A) IN GENERAL.—The State, enrollment broker, and managed care entity (if any) shall permit an individual eligible for medical assistance under the State plan under this title who is enrolled with the entity to terminate such enrollment for cause at any time, and without cause during the 90-day period beginning on the date the individual receives notice of enrollment and at least every 12 months thereafter, and shall notify each such individual of the opportunity to terminate enrollment under these conditions.

''(B) FRAUDULENT INDUCEMENT OR COERCION AS GROUNDS FOR CAUSE.—For purposes of subparagraph (A), an individual terminating enrollment with a managed care entity on the grounds that the enrollment was based on fraudulent inducement or was obtained through coercion or pursuant to the imposition against the managed care entity of the sanction described in section 1949(b)(3) shall be considered to terminate such enrollment for cause.

''(C) NOTICE OF TERMINATION.—

''(i) NOTICE TO STATE.—

''(I) BY INDIVIDUALS.—Each individual terminating enrollment with a managed care entity under subparagraph (A) shall do so by providing notice of the termination to an office of the State agency administering the State plan under this title, the State or local welfare agency, or an office of a managed care entity.

''(II) BY ORGANIZATIONS.—Any managed care entity which receives notice of an individual's termination of enrollment with such entity through receipt of such notice at an office of a managed care entity shall provide timely notice of the termination to the State agency administering the State plan under this title.

''(ii) NOTICE TO PLAN.—The State agency administering the State plan under this title or the State or local welfare agency which receives notice of an individual's termination of enrollment with a managed care entity under clause (i) shall provide timely notice of the termination to such entity.

''(3) DEFAULT ENROLLMENT PROCESS REQUIREMENTS.—The requirements of a default enrollment process established by a State under paragraph (1)(F) are as follows:

''(A) The process shall provide that the State may not enroll individuals with a managed care entity which is not in compliance with the applicable requirements of this part.

''(B) The process shall provide (consistent with subparagraph (A)) for enrollment of such an individual with a medicaid managed care organization—

''(i) that maintains existing provider-individual relationships or that has entered into contracts with providers (such as Federally qualified health centers, rural health clinics, hospitals that qualify for disproportionate share hospital payments under section 1886(d)(5)(F), and hospitals described in section 1886(d)(1)(B)(iii)) that have traditionally served beneficiaries under this title, and

''(ii) if there is no provider described in clause (i), in a manner that provides for an equitable distribution of individuals among all qualified managed care entities available to enroll individuals through such default enrollment process, consistent with the enrollment capacities of such entities.

''(C) The process shall permit and assist an individual enrolled with an entity under such process to change such enrollment to another managed care entity during a period (of at least 90 days) after the effective date of the enrollment.

''(D) The process may provide for consideration of factors such as quality, geographic proximity, continuity of providers, and capacity of the plan when conducting such process.

''(b) REENROLLMENT OF INDIVIDUALS WHO REGAIN ELIGIBILITY.—

''(1) IN GENERAL.—If an individual eligible for medical assistance under a State plan under this title and enrolled with a managed care entity with a contract under subsection (a)(1)(B) ceases to be eligible for such assistance for a period of not greater than 2 months, the State may provide for the automatic reenrollment of the individual with the entity as of the first day of the month in which the individual is again eligible for such assistance, and may consider factors such as quality, geographic proximity, continuity of providers, and capacity of the plan when conducting such reenrollment.

''(2) CONDITIONS.—Paragraph (1) shall only apply if—

''(A) the month for which the individual is to be reenrolled occurs during the enrollment period covered by the individual's original enrollment with the managed care entity,

''(B) the managed care entity continues to have a contract with the State agency under subsection (a)(1)(B) as of the first day of such month, and

''(C) the managed care entity complies with the applicable requirements of this part.

''(3) NOTICE OF REENROLLMENT.—The State shall provide timely notice to a managed care entity of any reenrollment of an individual under this subsection.

''(c) STATE OPTION OF MINIMUM ENROLLMENT PERIOD.—

''(1) IN GENERAL.—In the case of an individual who is enrolled with a managed care entity under this part and who would (but for this subsection) lose eligibility for benefits under this title before the end of the minimum enrollment period (defined in paragraph (2)), the State plan under this title may provide, notwithstanding any other provision of this title, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but, except for benefits furnished under section 1902(a)(23)(B), only with respect to such benefits provided to the individual as an enrollee of such entity.

''(2) MINIMUM ENROLLMENT PERIOD DEFINED.—For purposes of paragraph (1), the term 'minimum enrollment period' means, with respect to an individual's enrollment with an entity under a State plan, a period, established by the State, of not more than 6 months beginning on the date the individual's enrollment with the entity becomes effective, except that a State may extend such period for up to a total of 12 months in the case of an individual's enrollment with a managed care entity (as defined in section 1950(a)(1)) so long as such extension is done uniformly for all individuals enrolled with all such entities.

''(d) OTHER ENROLLMENT-RELATED PROVISIONS.—

''(1) NONDISCRIMINATION.—A managed care entity may not discriminate on the basis of health status or anticipated need for services in the enrollment, reenrollment, or disenrollment of individuals eligible to receive medical assistance under a State plan under this title or by discouraging enrollment (except as permitted by this section) by eligible individuals.

''(2) PROVISION OF INFORMATION.—

''(A) IN GENERAL.—Each State, enrollment broker, or managed care organization shall provide all enrollment notices and informational and instructional materials in a manner and form which may be easily understood by enrollees of the entity who are eligible for medical assistance under the State plan under this title, including enrollees and potential enrollees who are blind, deaf, disabled, or cannot read or understand the English language.

''(B) INFORMATION TO HEALTH CARE PROVIDERS, ENROLLEES, AND POTENTIAL ENROLLEES.—Each medicaid managed care organization shall—

''(i) upon request, make the information described in section 1945(c)(1) available to enrollees and potential enrollees in the organization's service area, and

''(ii) provide to enrollees and potential enrollees information regarding all items and services that are available to enrollees under the contract between the State and the organization that are covered either directly or through a method of referral and prior authorization.

''(3) PROVISION OF COMPARATIVE INFORMATION.—

''(A) BY STATE.—A State that requires individuals to enroll with managed care entities under this part shall annually provide to all enrollees and potential enrollees a list identifying the managed care entities that are (or will be) available and information described in subparagraph (C) concerning such entities. Such information shall be presented in a comparative, chart-like form.

''(B) BY ENTITY.—Upon the enrollment, or renewal of enrollment, of an individual with a managed care entity under this part, the entity shall provide such individual with the information described in subparagraph (C) concerning such entity and other entities available in the area, presented in a comparative, chart-like form.

''(C) REQUIRED INFORMATION.—Information under this subparagraph, with respect to a managed care entity for a year, shall include the following:

''(i) BENEFITS.—The benefits covered by the entity, including—

''(I) covered items and services beyond those provided under a traditional fee-for-service program;

''(II) any beneficiary cost sharing; and

''(III) any maximum limitations on out-of-pocket expenses.

''(ii) PREMIUMS.—The net monthly premium, if any, under the entity.

''(iii) SERVICE AREA.—The service area of the entity.

''(iv) QUALITY AND PERFORMANCE.—To the extent available, quality and performance indicators for the benefits under the entity (and how they compare to such indicators under the traditional fee-for-service programs in the area involved), including—

''(I) disenrollment rates for enrollees electing to receive benefits through the entity for the previous 2 years (excluding disenrollment due to death or moving outside the service area of the entity);

''(II) information on enrollee satisfaction;

''(III) information on health process and outcomes;

''(IV) grievance procedures;

''(V) the extent to which an enrollee may select the health care provider of their choice, including health care providers within the network of the entity and out-of-network health care providers (if the entity covers out-of-network items and services); and

''(VI) an indication of enrollee exposure to balance billing and the restrictions on coverage of items and services provided to such enrollee by an out-of-network health care provider.

''(v) SUPPLEMENTAL BENEFITS OPTIONS.—Whether the entity offers optional supplemental benefits and the terms and conditions (including premiums) for such coverage.

''(vi) PHYSICIAN COMPENSATION.—An overall summary description as to the method of compensation of participating physicians.

''(e) SPECIAL NEEDS INDIVIDUALS DESCRIBED.—In this part, the term 'special needs individual' means any of the following individuals:

''(1) SPECIAL NEEDS CHILD.—An individual who is under 19 years of age who—

''(A) is eligible for supplemental security income under title XVI;

''(B) is described under section 501(a)(1)(D);

''(C) is a child described in section 1902(e)(3); or

''(D) is not described in any preceding subparagraph but is in foster care or otherwise in an out-of-home placement.

''(2) MEDICARE BENEFICIARIES.—A qualified medicare beneficiary (as defined in section 1905(p)(1)) or an individual otherwise eligible for benefits under title XVIII.

''(f) RULE OF CONSTRUCTION.—Nothing in this part shall be construed as allowing a managed care entity that has entered into a contract with the State under this part to restrict the choice of an individual in receiving services described in section 1905(a)(4)(C).

''SEC. 1942. BENEFICIARY ACCESS TO SERVICES GENERALLY.

''(a) ACCESS TO SERVICES.—

''(1) IN GENERAL.—Each managed care entity shall provide or arrange for the provision of all medically necessary medical assistance under this title which is specified in the contract entered into between such entity and the State under section 1941(a)(1)(B) for enrollees who are eligible for medical assistance under the State plan under this title.

''(2) PRIMARY-CARE-PROVIDER-TO-ENROLLEE RATIO AND MAXIMUM TRAVEL TIME.—Each such entity shall assure adequate access to primary care services by meeting standards, established by the Secretary, relating to the maximum ratio of enrollees under this title to full-time-equivalent primary care providers available to serve such enrollees and to maximum travel time for such enrollees to access such providers. The Secretary may permit such a maximum ratio to vary depending on the area and population served. Such standards shall be based on standards commonly applied in the commercial market, commonly used in accreditation of managed care organizations, and standards used in the approval of waiver applications under section 1115, and shall be consistent with the requirements of section 1876(c)(4)(A) and part C of title XVIII.

''(b) REFERRAL TO SPECIALTY CARE FOR ENROLLEES REQUIRING TREATMENT BY SPECIALISTS.—

''(1) IN GENERAL.—In the case of an enrollee under a managed care entity and who has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist, the entity shall make or provide for a referral to a specialist who is available and accessible to provide the treatment for such condition or disease.

''(2) SPECIALIST DEFINED.—For purposes of this subsection, the term 'specialist' means, with respect to a condition, a health care practitioner, facility, or center (such as a center of excellence) that has adequate expertise through appropriate training and experience (including, in the case of a child, an appropriate pediatric specialist) to provide high quality care in treating the condition.

''(3) CARE UNDER REFERRAL.—Care provided pursuant to such referral under paragraph (1) shall be—

''(A) pursuant to a treatment plan (if any) developed by the specialist and approved by the entity, in consultation with the designated primary care provider or specialist and the enrollee (or the enrollee's designee), and

''(B) in accordance with applicable quality assurance and utilization review standards of the entity.

Nothing in this subsection shall be construed as preventing such a treatment plan for an enrollee from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

''(4) REFERRALS TO PARTICIPATING PROVIDERS.—An entity is not required under paragraph (1) to provide for a referral to a specialist that—

''(A) is not a participating provider, unless the entity does not have an appropriate specialist that is available and accessible to treat the enrollee's condition, and

''(B) is a participating provider with respect to such treatment.

''(5) TREATMENT OF NONPARTICIPATING PROVIDERS.—If an entity refers an enrollee to a nonparticipating specialist, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received by such a specialist that is a participating provider.

''(c) TIMELY DELIVERY OF SERVICES.—Each managed care entity shall respond to requests from enrollees for the delivery of medical assistance in a manner which—

''(1) makes such assistance—

''(A) available and accessible to each such individual, within the area served by the entity, with reasonable promptness and in a manner which assures continuity; and

''(B) when medically necessary, available and accessible 24 hours a day and 7 days a week, and

''(2) with respect to assistance provided to such an individual other than through the entity, or without prior authorization, in the case of a primary care case manager, provides for reimbursement to the individual (if applicable under the contract between the State and the entity) if—

''(A) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition and meet the requirements for access to emergency care under section 1943; and

''(B) it was not reasonable given the circumstances to obtain the services through the entity, or, in the case of a primary care case manager, with prior authorization.

''(d) INTERNAL GRIEVANCE PROCEDURE.—Each medicaid managed care organization shall establish an internal grievance procedure under which an enrollee who is eligible for medical assistance under the State plan under this title, or a provider on behalf of such an enrollee, may challenge the denial of coverage of or payment for such assistance.

''(e) INFORMATION ON BENEFIT CARVE OUTS.—Each managed care entity shall inform each enrollee, in a written and prominent manner, of any benefits to which the enrollee may be entitled to medical assistance under this title but which are not made available to the enrollee through the entity. Such information shall include information on where and how such enrollees may access benefits not made available to the enrollee through the entity.

''(f) DEMONSTRATION OF ADEQUATE CAPACITY AND SERVICES.—Each medicaid managed care organization shall provide the State and the Secretary with adequate assurances (as determined by the Secretary) that the organization, with respect to a service area—

''(1) has the capacity to serve the expected enrollment in such service area,

''(2) offers an appropriate range of services for the population expected to be enrolled in such service area, including transportation services and translation services consisting of the principal languages spoken in the service area,

''(3) maintains a sufficient number, mix, and geographic distribution of providers of services included in the contract with the State to ensure that services are available to individuals receiving medical assistance and enrolled in the organization to the same extent that such services are available to individuals enrolled in the organization who are not recipients of medical assistance under the State plan under this title,

''(4) maintains extended hours of operation with respect to primary care services that are beyond those maintained during a normal business day,

''(5) provides preventive and primary care services in locations that are readily accessible to members of the community,

''(6) provides information concerning educational, social, health, and nutritional services offered by other programs for which enrollees may be eligible, and

''(7) complies with such other requirements relating to access to care as the Secretary or the State may impose.

''(g) COMPLIANCE WITH CERTAIN MATERNITY AND MENTAL HEALTH REQUIREMENTS.—Each medicaid managed care organization shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

''(h) TREATMENT OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS.—

''(1) IN GENERAL.—In the case of an enrollee of a managed care entity who is a child described in section 1941(e)(1)—

''(A) if any medical assistance specified in the contract with the State is identified in a treatment plan prepared for the enrollee, the managed care entity shall provide (or arrange to be provided) such assistance in accordance with the treatment plan either—

''(i) by referring the enrollee to a pediatric health care provider who is trained and experienced in the provision of such assistance and who has a contract with the managed care entity to provide such assistance; or

''(ii) if appropriate services are not available through the managed care entity, permitting such enrollee to seek appropriate specialty services from pediatric health care providers outside of or apart from the managed care entity, and

''(B) the managed care entity shall require each health care provider with whom the managed care entity has entered into an agreement to provide medical assistance to enrollees to furnish the medical assistance specified in such enrollee's treatment plan to the extent the health care provider is able to carry out such treatment plan.

''(2) PRIOR AUTHORIZATION.—An enrollee referred for treatment under paragraph (1)(A)(i), or permitted to seek treatment outside of or apart from the managed care entity under paragraph (1)(A)(ii) shall be deemed to have obtained any prior authorization required by the entity.

''SEC. 1943. REQUIREMENTS FOR ACCESS TO EMERGENCY CARE.

''(a) IN GENERAL.—A managed care entity shall—

''(1) provide coverage for emergency services (as defined in subsection (c)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization; and

''(2) comply with such guidelines as the Secretary shall prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable in accordance with section 1867.

''(b) CONTENT OF GUIDELINES.—The guidelines prescribed under subsection (a) shall provide that—

''(1) a provider of emergency services shall make a documented good faith effort to contact the managed care entity in a timely fashion from the point at which the individual is stabilized to request approval for medically necessary post-stabilization care,

''(2) the entity shall respond in a timely fashion to the initial contact with the entity with a decision as to whether the services for which approval is requested will be authorized, and

''(3) if a denial of a request is communicated, the entity shall, upon request from the treating physician, arrange for a physician who is authorized by the entity to review the denial to communicate directly with the treating physician in a timely fashion.

''(c) DEFINITION OF EMERGENCY SERVICES.—In this section—

''(1) IN GENERAL.—The term 'emergency services' means, with respect to an individual enrolled with a managed care entity, covered inpatient and outpatient services that—

''(A) are furnished by a provider that is qualified to furnish such services under this title, and

''(B) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

''(2) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

''(A) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

''(B) serious impairment to bodily functions, or

''(C) serious dysfunction of any bodily organ or part.

''SEC. 1944. OTHER BENEFICIARY PROTECTIONS.

''(a) PROTECTING ENROLLEES AGAINST THE INSOLVENCY OF MANAGED CARE ENTITIES AND AGAINST THE FAILURE OF THE STATE TO PAY SUCH ENTITIES.—Each managed care entity shall provide that an individual eligible for medical assistance under the State plan under this title who is enrolled with the entity may not be held liable—

''(1) for the debts of the managed care entity, in the event of the entity's insolvency,

''(2) for services provided to the individual—

''(A) in the event of the entity failing to receive payment from the State for such services; or

''(B) in the event of a health care provider with a contractual or other arrangement with the entity failing to receive payment from the State or the managed care entity for such services, or

''(3) for the debts of any health care provider with a contractual or other arrangement with the entity to provide services to the individual, in the event of the insolvency of the health care provider.

''(b) PROTECTION OF BENEFICIARIES AGAINST BALANCE BILLING THROUGH SUBCONTRACTORS.—

''(1) IN GENERAL.—Any contract between a managed care entity that has an agreement with a State under this title and another entity under which the other entity (or any other entity pursuant to the contract) provides directly or indirectly for the provision of services to beneficiaries under the agreement with the State

shall include such provisions as the Secretary may require in order to assure that the other entity complies with balance billing limitations and other requirements of this title (such as limitation on withholding of services) as they would apply to the managed care entity if such entity provided such services directly and not through a contract with another entity.

''(2) APPLICATION OF SANCTIONS FOR VIOLATIONS.—The provisions of section 1128A(b)(2)(B) and 1128B(d)(1) shall apply with respect to entities contracting directly or indirectly with a managed care entity (with a contract with a State under this title) for the provision of services to beneficiaries under such a contract in the same manner as such provisions would apply to the managed care entity if it provided such services directly and not through a contract with another entity.

''SEC. 1945. ASSURING QUALITY CARE.

''(a) EXTERNAL INDEPENDENT REVIEW OF MANAGED CARE ENTITY ACTIVITIES.—

''(1) REVIEW OF MEDICAID MANAGED CARE ORGANIZATION CONTRACT.—

''(A) IN GENERAL.—Except as provided in paragraph (2), each medicaid managed care organization shall be subject to an annual external independent review of the quality outcomes and timeliness of, and access to, the items and services specified in such organization's contract with the State under section 1941(a)(1)(B). Such review shall specifically evaluate the extent to which the medicaid managed care organization provides such services in a timely manner.

''(B) CONTENTS OF REVIEW.—An external independent review conducted under this subsection shall include—

''(i) a review of the entity's medical care, through sampling of medical records or other appropriate methods, for indications of quality of care and inappropriate utilization (including overutilization) and treatment,

''(ii) a review of enrollee inpatient and ambulatory data, through sampling of medical records or other appropriate methods, to determine trends in quality and appropriateness of care,

''(iii) notification of the entity and the State when the review under this paragraph indicates inappropriate care, treatment, or utilization of services (including overutilization), and

''(iv) other activities as prescribed by the Secretary or the State.

''(C) USE OF PROTOCOLS.—An external independent review conducted under this subsection on and after January 1, 1999, shall use protocols that have been developed, tested, and validated by the Secretary and that are at least as rigorous as those used by the National Committee on Quality Assurance as of the date of the enactment of this section.

''(D) AVAILABILITY OF RESULTS.—The results of each external independent review conducted under this paragraph shall be available to participating health care providers, enrollees, and potential enrollees of the medicaid managed care organization, except that the results may not be made available in a manner that discloses the identity of any individual patient.

''(2) DEEMED COMPLIANCE.—

''(A) MEDICARE ORGANIZATIONS.—The requirements of paragraph (1) shall not apply with respect to a medicaid managed care organization if the organization is an eligible organization with a contract in effect under section 1876 or under part C of title XVIII.

''(B) PRIVATE ACCREDITATION.—

''(i) IN GENERAL.—The requirements of paragraph (1) shall not apply with respect to a medicaid managed care organization if—

''(I) the organization is accredited by an organization meeting the requirements described in subparagraph (C)), and

''(II) the standards and process under which the organization is accredited meet such requirements as are established under clause (ii), without regard to whether or not the time requirement of such clause is satisfied.

''(ii) STANDARDS AND PROCESS.—Not later than 180 days after the date of the enactment of this section, the Secretary shall specify requirements for the standards and process under which a medicaid managed care organization is accredited by an organization meeting the requirements of subparagraph (B).

''(C) ACCREDITING ORGANIZATION.—An accrediting organization meets the requirements of this subparagraph if the organization—

''(i) is a private, nonprofit organization,

''(ii) exists for the primary purpose of accrediting managed care organizations or health care providers, and

''(iii) is independent of health care providers or associations of health care providers.

''(3) REVIEW OF PRIMARY CARE CASE MANAGER CONTRACT.—Each primary care case manager shall be subject to an annual external independent review of the quality and timeliness of, and access to, the items and services specified in the contract entered into between the State and the primary care case manager under section 1941(a)(1)(B).

''(4) USE OF VALIDATION SURVEYS.—The Secretary shall conduct surveys each year to validate external reviews of the number of managed care entities in the year. In conducting such surveys the Secretary shall use the same protocols as were used in preparing the external reviews. If an external review finds that an individual managed care entity meets applicable requirements, but the Secretary determines that the entity does not meet such requirements, the Secretary's determination as to the entity's noncompliance with such requirements is binding and supersedes that of the previous survey.

''(b) FEDERAL MONITORING RESPONSIBILITIES.—The Secretary shall review the external independent reviews conducted pursuant to subsection (a) and shall monitor the effectiveness of the State's monitoring of managed care entities and any followup activities required under this part. If the Secretary determines that a State's monitoring and followup activities are not adequate to ensure that the requirements of such section are met, the Secretary shall undertake appropriate followup activities to ensure that the State improves its monitoring and followup activities.

''(c) PROVIDING INFORMATION ON SERVICES.—

''(1) REQUIREMENTS FOR MEDICAID MANAGED CARE ORGANIZATIONS.—Each medicaid managed care organization shall provide to the State complete and timely information concerning the following:

''(A) The services that the organization provides to (or arranges to be provided to) individuals eligible for medical assistance under the State plan under this title.

''(B) The identity, locations, qualifications, and availability of participating health care providers.

''(C) The rights and responsibilities of enrollees.

''(D) The services provided by the organization which are subject to prior authorization by the organization as a condition of coverage (in accordance with subsection (d)).

''(E) The procedures available to an enrollee and a health care provider to appeal the failure of the organization to cover a service.

''(F) The performance of the organization in serving individuals eligible for medical assistance under the State plan under this title.

Such information shall be provided in a form consistent with the reporting of similar information by eligible organizations under section 1876 or under part C of title XVIII.

''(2) REQUIREMENTS FOR PRIMARY CARE CASE MANAGERS.—Each primary care case manager shall—

''(A) provide to the State (at least at such frequency as the Secretary may require), complete and timely information concerning the services that the primary care case manager provides to (or arranges to be provided to) individuals eligible for medical assistance under the State plan under this title,

''(B) make available to enrollees and potential enrollees information concerning services available to the enrollee for which prior authorization by the primary care case manager is required,

''(C) provide enrollees and potential enrollees information regarding all items and services that are available to enrollees under the contract between the State and the primary care case manager that are covered either directly or through a method of referral and prior authorization, and

''(D) provide assurances that such entities and their professional personnel are licensed as required by State law and qualified to provide case management services, through methods such as ongoing monitoring of compliance with applicable requirements and providing information and technical assistance.

''(3) REQUIREMENTS FOR BOTH MEDICAID MANAGED CARE ORGANIZATIONS AND PRIMARY CARE CASE MANAGERS.—Each managed care entity shall provide the State with aggregate encounter data for all items and services, including early and periodic screening, diagnostic, and treatment services under section 1905(r) furnished to individuals under 21 years of age. Any such data provided may be audited by the State.

''(d) CONDITIONS FOR PRIOR AUTHORIZATION.—Subject to section 1943, a managed care entity may require the approval of medical assistance for nonemergency services before the assistance is furnished to an enrollee only if the system providing for such approval provides that such decisions are made in a timely manner, depending upon the urgency of the situation.

''(e) PATIENT ENCOUNTER DATA.—Each medicaid managed care organization shall maintain sufficient patient encounter data to identify the health care provider who delivers services to patients and to otherwise enable the State plan to meet the requirements of section 1902(a)(27) and shall submit such data to the State or the Secretary upon request. The medicaid managed care organization shall incorporate such information in the maintenance of patient encounter data with respect to such health care provider.

''(f) INCENTIVES FOR HIGH QUALITY MANAGED CARE ENTITIES.—The Secretary and the State may establish a program to reward, through public recognition, incentive payments, or enrollment of additional individuals (or combinations of such rewards), managed care entities that provide the highest quality care to individuals eligible for medical assistance under the State plan under this title who are enrolled with such entities. For purposes of section 1903(a)(7), proper expenses incurred by a State in carrying out such a program shall be considered to be expenses necessary for the proper and efficient administration of the State plan under this title.

''(g) QUALITY ASSURANCE STANDARDS.—Any contract between a State and a managed care entity shall provide—

''(1) that the State agency will develop and implement a State specific quality assessment and improvement strategy, consistent with standards that the Secretary, in consultation with the States, shall establish and monitor (but that shall not preempt any State standards that are more stringent than the standards established under this paragraph), and that includes—

''(A) standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity; and

''(B) procedures for monitoring and evaluating the quality and appropriateness of care and services to beneficiaries that reflect the full spectrum of populations enrolled in the plan and that include—

''(i) requirements for provision of quality assurance data to the State using the data and information set that the Secretary, in consultation with the States, shall specify with respect to entities contracting under section 1876 or under part C of title XVIII or alternative data requirements approved by the Secretary;

''(ii) if necessary, an annual examination of the scope and content of the quality improvement strategy; and

''(iii) other aspects of care and service directly related to the improvement of quality of care (including grievance procedures and marketing and information standards),

''(2) that entities entering into such agreements under which payment is made on a prepaid capitated or other risk basis shall be required—

''(A) to submit to the State agency information that demonstrates significant improvement in the care delivered to members;

''(B) to maintain an internal quality assurance program consistent with paragraph (1), and meeting standards that the Secretary, in consultation with the States, shall establish in regulations; and

''(C) to provide effective procedures for hearing and resolving grievances between the entity and members enrolled with the entity under this section, and

''(3) that provision is made, consistent with State law or with regulations under State law, with respect to the solvency of those entities, financial reporting by those entities, and avoidance of waste, fraud, and abuse.

''(h) ANNUAL REPORT ON NON-HEALTH EXPENDITURES.—Each medicaid managed care organization shall annually provide to enrollees a statement disclosing the proportion of the premiums and other revenues received by the organization that are expended for non-health care items and services.

''SEC. 1946. PROTECTIONS FOR PROVIDERS.

''(a) TIMELINESS OF PAYMENT.—A medicaid managed care organization shall make payment to health care providers for items and services which are subject to the contract under section 1941(a)(1)(B) and which are furnished to individuals eligible for medical assistance under the State plan under this title who are enrolled with the entity on a timely basis consistent with section 1943 and under the claims payment procedures described in section 1902(a)(37)(A), unless the health care provider and the managed care entity agree to an alternate payment schedule.

''(b) PHYSICIAN INCENTIVE PLANS.—Each medicaid managed care organization shall require that any physician incentive plan covering physicians who are participating in the medicaid managed care organization shall meet the requirements of section 1876(i)(8) and comparable requirements under part C of title XVIII.

''(c) WRITTEN PROVIDER PARTICIPATION AGREEMENTS FOR CERTAIN PROVIDERS.—

''(1) IN GENERAL.—Each medicaid managed care organization that enters into a written provider participation agreement with a provider described in paragraph (2) shall—

''(A) include terms and conditions that are no more restrictive than the terms and conditions that the medicaid managed care organization includes in its agreements with other participating providers with respect to—

''(i) the scope of covered services for which payment is made to the provider;

''(ii) the assignment of enrollees by the organization to the provider;

''(iii) the limitation on financial risk or availability of financial incentives to the provider;

''(iv) accessibility of care;

''(v) professional credentialing and recredentialing;

''(vi) licensure;

''(vii) quality and utilization management;

''(viii) confidentiality of patient records;

''(ix) grievance procedures; and

''(x) indemnification arrangements between the organizations and providers; and

''(B) provide for payment to the provider on a basis that is comparable to the basis on which other providers are paid.

''(2) PROVIDERS DESCRIBED.—The providers described in this paragraph are the following:

''(A) Rural health clinics, as defined in section 1905(l)(1).

''(B) Federally-qualified health centers, as defined in section 1905(l)(2)(B).

''(C) Clinics which are eligible to receive payment for services provided under title X of the Public Health Service Act.

''(d) PAYMENTS TO RURAL HEALTH CLINICS AND FEDERALLY-QUALIFIED HEALTH CENTERS.—Each medicaid managed care organization that has a contract under this title with respect to the provision of services of a rural health clinic or a Federally-qualified health center shall provide, at the election of such clinic or center, that the organization shall provide payments to such a clinic or center for services described in 1905(a)(2)(C) at the rates of payment specified in section 1902(a)(13)(E).

''(e) ANTIDISCRIMINATION.—A managed care entity shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This subsection shall not be construed to prohibit a managed care entity from including providers only to the extent necessary to meet the needs of the entity's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the entity.

''SEC. 1947. ASSURING ADEQUACY OF PAYMENTS TO MEDICAID MANAGED CARE ORGANIZATIONS AND ENTITIES.

A State shall find, determine, and make assurances satisfactory to the Secretary that the rates it pays a managed care entity for individuals eligible under the State plan have been determined by an independent actuary that meets the standards for qualification and practice established by the Actuarial Standards Board, to be sufficient and not excessive with respect to the estimated costs of the services provided.

''SEC. 1948. FRAUD AND ABUSE.

''(a) PROVISIONS APPLICABLE TO MANAGED CARE ENTITIES.—

''(1) PROHIBITING AFFILIATIONS WITH INDIVIDUALS DEBARRED BY FEDERAL AGENCIES.—

''(A) IN GENERAL.—A managed care entity may not knowingly—

''(i) have a person described in subparagraph (C) as a director, officer, partner, or person with beneficial ownership of more than 5 percent of the entity's equity, or

''(ii) have an employment, consulting, or other agreement with a person described in such subparagraph for the provision of items and services that are significant and material to the entity's obligations under its contract with the State.

''(B) EFFECT OF NONCOMPLIANCE.—If a State finds that a managed care entity is not in compliance with clause (i) or (ii) of subparagraph (A), the State—

''(i) shall notify the Secretary of such noncompliance,

''(ii) may continue an existing agreement with the entity unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) directs otherwise, and

''(iii) may not renew or otherwise extend the duration of an existing agreement with the entity unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) provides to the State and to the Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

''(C) PERSONS DESCRIBED.—A person is described in this subparagraph if such person—

''(i) is debarred, suspended, or otherwise excluded from participating in procurement activities under any Federal procurement or nonprocurement program or activity, as provided for in the Federal Acquisition Streamlining Act of 1994 (Public Law 103–355; 108 Stat. 3243), or

''(ii) is an affiliate (as defined in such Act) of a person described in clause (i).

''(2) RESTRICTIONS ON MARKETING.—

''(A) DISTRIBUTION OF MATERIALS.—

''(i) IN GENERAL.—A managed care entity may not distribute directly or through any agent or independent contractor marketing materials within any State—

''(I) without the prior approval of the State, and

''(II) that contain false or materially misleading information.

''(ii) CONSULTATION IN REVIEW OF MARKET MATERIALS.—In the process of reviewing and approving such materials, the State shall provide for consultation with a medical care advisory committee.

''(iii) PROHIBITION.—The State may not enter into or renew a contract with a managed care entity for the provision of services to individuals enrolled under the State plan under this title if the State determines that the entity distributed directly or through any agent or independent contractor marketing materials in violation of clause (i).

''(B) SERVICE MARKET.—A managed care entity shall distribute marketing materials to the entire service area of such entity.

''(C) PROHIBITION OF TIE-INS.—A managed care entity, or any agency of such entity, may not seek to influence an individual's enrollment with the entity in conjunction with the sale of any other insurance.

''(D) PROHIBITING MARKETING FRAUD.—Each managed care entity shall comply with such procedures and conditions as the Secretary prescribes in order to ensure that, before an individual is enrolled with the entity, the individual is provided accurate oral and written and sufficient information to make an informed decision whether or not to enroll.

''(E) PROHIBITION OF COLD CALL MARKETING.—Each managed care entity shall not, directly or indirectly, conduct door-to-door, telephonic, or other 'cold call' marketing of enrollment under this title.

''(b) PROVISIONS APPLICABLE ONLY TO MEDICAID MANAGED CARE ORGANIZATIONS.—

''(1) STATE CONFLICT-OF-INTEREST SAFEGUARDS IN MEDICAID RISK CONTRACTING.—A medicaid managed care organization may not enter into a contract with any State under section 1941(a)(1)(B) unless the State has in effect conflict-of-interest safeguards with respect to officers and employees of the State with responsibilities relating to contracts with such organizations or to the default enrollment process described in section 1941(a)(1)(F) that are at least as effective as the Federal safeguards provided under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423), against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.

''(2) REQUIRING DISCLOSURE OF FINANCIAL INFORMATION.—In addition to any requirements applicable under paragraph (27) or (35) of section 1902(a), a medicaid managed care organization shall—

''(A) report to the State such financial information as the State may require to demonstrate that—

''(i) the organization has the ability to bear the risk of potential financial losses and otherwise has a fiscally sound operation;

''(ii) the organization uses the funds paid to it by the State for activities consistent with the requirements of this title and the contract between the State and organization; and

''(iii) the organization does not place an individual physician, physician group, or other health care provider at substantial risk for services not provided by such physician, group, or health care provider, by providing adequate protection to limit the liability of such physician,

group, or health care provider, through measures such as stop loss insurance or appropriate risk corridors,

''(B) agree that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the organization (and of any subcontractor) relating to the information reported pursuant to subparagraph (A) and any information required to be furnished under section paragraphs (27) or (35) of section 1902(a),

''(C) make available to the Secretary and the State a description of each transaction described in subparagraphs (A) through (C) of section 1318(a)(3) of the Public Health Service Act between the organization and a party in interest (as defined in section 1318(b) of such Act),

''(D) agree to make available to its enrollees upon reasonable request—

''(i) the information reported pursuant to subparagraph (A); and

''(ii) the information required to be disclosed under sections 1124 and 1126,

''(E) comply with subsections (a) and (c) of section 1318 of the Public Health Service Act (relating to disclosure of certain financial information) and with the requirement of section 1301(c)(8) of such Act (relating to liability arrangements to protect members), and

''(F) notify the State of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties.

Each State is required to conduct audits on the books and records of at least 1 percent of the number of medicaid managed care organizations operating in the State.

''(3) ADEQUATE PROVISION AGAINST RISK OF INSOLVENCY.—

''(A) ESTABLISHMENT OF STANDARDS.—The Secretary shall establish standards, including appropriate equity standards, under which each medicaid managed care organization shall make adequate provision against the risk of insolvency.

''(B) CONSIDERATION OF OTHER STANDARDS.—In establishing the standards described in subparagraph (A), the Secretary shall consider solvency standards applicable to eligible organizations with a risk-sharing contract under section 1876 or under part C of title XVIII.

''(C) MODEL CONTRACT ON SOLVENCY.—At the earliest practicable time after the date of the enactment of this section, the Secretary shall issue guidelines concerning solvency standards for risk contracting entities and subcontractors of such risk contracting entities. Such guidelines shall take into account characteristics that may differ among risk contracting entities, including whether such an entity is at risk for inpatient hospital services.

''(4) REQUIRING REPORT ON NET EARNINGS AND ADDITIONAL BENEFITS.—Each medicaid managed care organization shall submit a report to the State not later than 12 months after the close of a contract year containing the most recent audited financial statement of the organization's net earnings and consistent with generally accepted accounting principles.

''(c) DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION.—Each medicaid managed care organization shall provide for disclosure of information in accordance with section 1124.

''(d) DISCLOSURE OF TRANSACTION INFORMATION.—

''(1) IN GENERAL.—Each medicaid managed care organization which is not a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) shall report to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General, a description of transactions between the organization and a party in interest (as defined in section 1318(b) of such Act), including the following transactions:

''(A) Any sale or exchange, or leasing of any property between the organization and such a party.

''(B) Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

''(C) Any lending of money or other extension of credit between the organization and such a party.

The State or Secretary may require that information reported respecting an organization which controls, or is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

''(2) DISCLOSURE TO ENROLLEES.—Each such organization shall make the information reported pursuant to paragraph (1) available to its enrollees upon reasonable request.

''(e) CONTRACT OVERSIGHT.—

''(1) IN GENERAL.—The Secretary must provide prior review and approval for contracts under this part with a medicaid managed care organization providing for expenditures under this title in excess of $1,000,000.

''(2) INSPECTOR GENERAL REVIEW.—As part of such approval process, the Inspector General in the Department of Health and Human Services, effective October 1, 1997, shall make a determination (to the extent practicable) as to whether persons with an ownership interest (as defined in section 1124(a)(3)) or an officer, director, agent, or managing employee (as defined in section 1126(b)) of the organization are or have been described in subsection (a)(1)(C) based on a ground relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct or obstruction of an investigation.

''(f) LIMITATION ON AVAILABILITY OF FFP FOR USE OF ENROLLMENT BROKERS.—Amounts expended by a State for the use of an enrollment broker in marketing managed care entities to eligible individuals under this title shall be considered, for purposes of section 1903(a)(7), to be necessary for the proper and efficient administration of the State plan but only if the following conditions are met with respect to the broker:

''(1) The broker is independent of any such entity and of any health care providers (whether or not any such provider participates in the State plan under this title) that provide coverage of services in the same State in which the broker is conducting enrollment activities.

''(2) No person who is an owner, employee, consultant, or has a contract with the broker either has any direct or indirect financial interest with such an entity or health care provider or has been excluded from participation in the program under this title or title XVIII or debarred by any Federal agency, or subject to a civil money penalty under this Act.

''(g) USE OF UNIQUE PHYSICIAN IDENTIFIER FOR PARTICIPATING PHYSICIANS.—Each medicaid managed care organization shall require each physician providing services to enrollees eligible for medical assistance under the State plan under this title to have a unique identifier in accordance with the system established under section 1173(b).

''(h) SECRETARIAL RECOVERY OF FFP FOR CAPITATION PAYMENTS FOR INSOLVENT MANAGED CARE ENTITIES.—The Secretary shall provide for the recovery and offset against any amount owed a State under section 1903(a)(1) in an amount equal to the amounts paid to the State for medical assistance provided under such section, for expenditures for capitation payments to a managed care entity that becomes insolvent or for services contracted for with, but not provided by, such organization.

''SEC. 1949. SANCTIONS FOR NONCOMPLIANCE BY MANAGED CARE ENTITIES.

''(a) USE OF INTERMEDIATE SANCTIONS BY THE STATE TO ENFORCE REQUIREMENTS.—

''(1) IN GENERAL.—Each State shall establish intermediate sanctions, which may include any of the types described in subsection (b) other than the termination of a contract with a managed care entity, which the State may impose against a managed care entity with a contract under section 1941(a)(1)(B) if the entity—

''(A) fails substantially to provide medically necessary items and services that are required (under law or under such entity's contract with the State) to be provided to an enrollee covered under the contract,

''(B) imposes premiums or charges on enrollees in excess of the premiums or charges permitted under this title,

''(C) acts to discriminate among enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to reenroll an individual, except as permitted by this part, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the entity by eligible individuals whose medical condition or history indicates a need for substantial future medical services,

''(D) misrepresents or falsifies information that is furnished—

''(i) to the Secretary or the State under this part; or

''(ii) to an enrollee, potential enrollee, or a health care provider under such sections, or

''(E) fails to comply with the requirements of section 1876(i)(8) (or comparable requirements under part C of title XVIII) or this part.

''(2) RULE OF CONSTRUCTION.—For purposes of paragraph (1)(A), the term 'medically necessary' shall not be construed as requiring an abortion be performed for any individual, except if necessary to save the life of the mother or if a pregnancy is the result of an act of rape or incest.

''(b) INTERMEDIATE SANCTIONS.—The sanctions described in this subsection are as follows:

''(1) Civil money penalties as follows:

''(A) Except as provided in subparagraph (B), (C), or (D), not more than $25,000 for each determination under subsection (a).

''(B) With respect to a determination under paragraph (3) or (4)(A) of subsection (a), not more than $100,000 for each such determination.

''(C) With respect to a determination under subsection (a)(2), double the excess amount charged in violation of such subsection (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned).

''(D) Subject to subparagraph (B), with respect to a determination under subsection (a)(3), $15,000 for each individual not enrolled as a result of a practice described in such subsection.

''(2) The appointment of temporary management—

''(A) to oversee the operation of the medicaid-only managed care entity upon a finding by the State that there is continued egregious behavior by the plan, or

''(B) to assure the health of the entity's enrollees, if there is a need for temporary management while—

''(i) there is an orderly termination or reorganization of the managed care entity; or

''(ii) improvements are made to remedy the violations found under subsection (a),

except that temporary management under this paragraph may not be terminated until the State has determined that the managed care entity has the capability to ensure that the violations shall not recur.

''(3) Permitting individuals enrolled with the managed care entity to terminate enrollment without cause, and notifying such individuals of such right to terminate enrollment.

''(4) Suspension or default of all enrollment of individuals under this title after the date the Secretary or the State notifies the entity of a determination of a violation of any requirement of this part.

''(5) Suspension of payment to the entity under this title for individuals enrolled after the

date the Secretary or State notifies the entity of such a determination and until the Secretary or State is satisfied that the basis for such determination has been corrected and is not likely to recur.

''(c) TREATMENT OF CHRONIC SUBSTANDARD ENTITIES.—In the case of a managed care entity which has repeatedly failed to meet the requirements of sections 1942 through 1946, the State shall (regardless of what other sanctions are provided) impose the sanctions described in paragraphs (2) and (3) of subsection (b).

''(d) AUTHORITY TO TERMINATE CONTRACT.—In the case of a managed care entity which has failed to meet the requirements of this part, the State shall have the authority to terminate its contract with such entity under section 1941(a)(1)(B) and to enroll such entity's enrollees with other managed care entities (or to permit such enrollees to receive medical assistance under the State plan under this title other than through a managed care entity).

''(e) AVAILABILITY OF SANCTIONS TO THE SECRETARY.—

''(1) INTERMEDIATE SANCTIONS.—In addition to the sanctions described in paragraph (2) and any other sanctions available under law, the Secretary may provide for any of the sanctions described in subsection (b) if the Secretary determines that a managed care entity with a contract under section 1941(a)(1)(B) fails to meet any of the requirements of this part.

''(2) DENIAL OF PAYMENTS TO THE STATE.—The Secretary may deny payments to the State for medical assistance furnished under the contract under section 1941(a)(1)(B) for individuals enrolled after the date the Secretary notifies a managed care entity of a determination under subsection (a) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

''(f) DUE PROCESS FOR MANAGED CARE ENTITIES.—

''(1) AVAILABILITY OF HEARING PRIOR TO TERMINATION OF CONTRACT.—A State may not terminate a contract with a managed care entity under section 1941(a)(1)(B) unless the entity is provided with a hearing prior to the termination.

''(2) NOTICE TO ENROLLEES OF TERMINATION HEARING.—A State shall notify all individuals enrolled with a managed care entity which is the subject of a hearing to terminate the entity's contract with the State of the hearing and that the enrollees may immediately disenroll with the entity without cause.

''(3) OTHER PROTECTIONS FOR MANAGED CARE ENTITIES AGAINST SANCTIONS IMPOSED BY STATE.—Before imposing any sanction against a managed care entity other than termination of the entity's contract, the State shall provide the entity with notice and such other due process protections as the State may provide, except that a State may not provide a managed care entity with a pre-termination hearing before imposing the sanction described in subsection (b)(2).

''(4) IMPOSITION OF CIVIL MONETARY PENALTIES BY SECRETARY.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply with respect to a civil money penalty imposed by the Secretary under subsection (b)(1) in the same manner as such provisions apply to a penalty or proceeding under section 1128A.

''SEC. 1950. DEFINITIONS; MISCELLANEOUS PROVISIONS.

''(a) DEFINITIONS.—For purposes of this title:

''(1) MANAGED CARE ENTITY.—The term 'managed care entity' means—

''(A) a medicaid managed care organization; or

''(B) a primary care case manager.

''(2) MEDICAID MANAGED CARE ORGANIZATION.—The term 'medicaid managed care organization' means a health maintenance organization, an eligible organization with a contract under section 1876 or under part C of title XVIII, a provider sponsored network, or any other organization which is organized under the laws of a State, has made adequate provision (as determined under standards established for purposes of eligible organizations under section 1876 or under part C of title XVIII, and through its capitalization or otherwise) against the risk of insolvency, and provides or arranges for the provision of one or more items and services to individuals eligible for medical assistance under the State plan under this title in accordance with a contract with the State under section 1941(a)(1)(B).

''(3) PRIMARY CARE CASE MANAGER.—

''(A) IN GENERAL.—The term 'primary care case manager' has the meaning given such term in section 1905(t)(2).''.

(b) STUDIES AND REPORTS.—

(1) REPORT ON PUBLIC HEALTH SERVICES.—

(A) IN GENERAL.—Not later than January 1, 1998, the Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall report to the Committee on Finance of the Senate and the Committee on Commerce of the House of Representatives on the effect of managed care entities (as defined in section 1950(a)(1) of the Social Security Act) on the delivery of and payment for the services traditionally provided through providers described in section 1941(a)(2)(B)(i) of such Act.

(B) CONTENTS OF REPORT.—The report referred to in subparagraph (A) shall include—

(i) information on the extent to which enrollees with eligible managed care entities seek services at local health departments, public hospitals, and other facilities that provide care without regard to a patient's ability to pay;

(ii) information on the extent to which the facilities described in clause (i) provide services to enrollees with eligible managed care entities without receiving payment;

(iii) information on the effectiveness of systems implemented by facilities described in clause (i) for educating such enrollees on services that are available through eligible managed care entities with which such enrollees are enrolled;

(iv) to the extent possible, identification of the types of services most frequently sought by such enrollees at such facilities; and

(v) recommendations about how to ensure the timely delivery of the services traditionally provided through providers described in section 1941(a)(2)(B)(i) of the Social Security Act to enrollees of managed care entities and how to ensure that local health departments, public hospitals, and other facilities are adequately compensated for the provision of such services to such enrollees.

(2) REPORT ON PAYMENTS TO HOSPITALS.—

(A) IN GENERAL.—Not later than October 1 of each year, beginning with October 1, 1998, the Secretary and the Comptroller General shall analyze and submit a report to the Committee on Finance of the Senate and the Committee on Commerce of the House of Representatives on rates paid for hospital services under managed care entities under contracts under section 1941(a)(1)(B) of the Social Security Act.

(B) CONTENTS OF REPORT.—The information in the report described in subparagraph (A) shall—

(i) be organized by State, type of hospital, type of service; and

(ii) include a comparison of rates paid for hospital services under managed care entities with rates paid for hospital services furnished to individuals who are entitled to benefits under a State plan under title XIX of the Social Security Act and are not enrolled with such entities.

(3) REPORTS BY STATES.—Each State shall transmit to the Secretary, at such time and in such manner as the Secretary determines appropriate, the information on hospital rates submitted to such State under section 1947(b)(2) of the Social Security Act.

(4) INDEPENDENT STUDY AND REPORT ON QUALITY ASSURANCE AND ACCREDITATION STANDARDS.—The Institute of Medicine of the National Academy of Sciences shall conduct a study and analysis of the quality assurance programs and accreditation standards applicable to managed care entities operating in the private sector or to such entities that operate under contracts under the medicare program under title XVIII of the Social Security Act to determine if such programs and standards include consideration of the accessibility and quality of the health care items and services delivered under such contracts to low-income individuals.

(c) CONFORMING AMENDMENTS.—

(1) REPEAL OF CURRENT REQUIREMENTS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), section 1903(m) (42 U.S.C. 1396b(m)) is repealed on the date of the enactment of this Act.

(B) EXISTING CONTRACTS.—In the case of any contract under section 1903(m) of such Act which is in effect on the day before the date of the enactment of this Act, the provisions of such section shall apply to such contract until the earlier of—

(i) the day after the date of the expiration of the contract; or

(ii) the date which is 1 year after the date of the enactment of this Act.

(2) FEDERAL FINANCIAL PARTICIPATION.—

(A) CLARIFICATION OF APPLICATION OF FFP DENIAL RULES TO PAYMENTS MADE PURSUANT TO MANAGED CARE ENTITIES.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended by adding at the end the following new sentence: ''Paragraphs (1)(A), (1)(B), (2), (5), and (12) shall apply with respect to items or services furnished and amounts expended by or through a managed care entity (as defined in section 1950(a)(1)) in the same manner as such paragraphs apply to items or services furnished and amounts expended directly by the State.''.

(B) FFP FOR EXTERNAL QUALITY REVIEW ORGANIZATIONS.—Section 1903(a)(3)(C) (42 U.S.C. 1396b(a)(3)(C)) is amended—

(i) by inserting ''(i)'' after ''(C)'', and

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

''(ii) 75 percent of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of independent external reviews of managed care entities (as defined in section 1950(a)(1)) by external quality review organizations, but only if such organizations conduct such reviews under protocols approved by the Secretary and only in the case of such organizations that meet standards established by the Secretary relating to the independence of such organizations from agencies responsible for the administration of this title or eligible managed care entities; and''.

(3) EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN PROGRAM.—Section 1128(b)(6)(C) (42 U.S.C. 1320a–7(b)(6)(C)) is amended—

(A) in clause (i), by striking ''a health maintenance organization (as defined in section 1903(m))'' and inserting ''a managed care entity, as defined in section 1950(a)(1),''; and

(B) in clause (ii), by inserting ''section 1115 or'' after ''approved under''.

(4) STATE PLAN REQUIREMENTS.—Section 1902 (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(30)(C), by striking ''section 1903(m)'' and inserting ''section 1941(a)(1)(B)''; and

(B) in subsection (a)(57), by striking ''health maintenance organization (as defined in section 1903(m)(1)(A))'' and inserting ''managed care entity, as defined in section 1950(a)(1)'';

(C) in subsection (e)(2)(A), by striking ''or with an entity described in paragraph (2)(B)(iii), (2)(E), (2)(G), or (6) of section 1903(m) under a contract described in section 1903(m)(2)(A)'' and inserting ''or with a managed care entity, as defined in section 1950(a)(1);

(D) in subsection (p)(2)—

(i) by striking ''a health maintenance organization (as defined in section 1903(m))'' and inserting ''a managed care entity, as defined in section 1950(a)(1),'';

(ii) by striking ''an organization'' and inserting ''an entity''; and

(iii) by striking ''any organization'' and inserting ''any entity''; and

(E) in subsection (w)(1), by striking ''sections 1903(m)(1)(A) and'' and inserting ''section''.

(5) PAYMENT TO STATES.—Section 1903(w)(7)(A)(viii) (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended to read as follows:

''(viii) Services of a managed care entity with a contract under section 1941(a)(1)(B).''.

(6) USE OF ENROLLMENT FEES AND OTHER CHARGES.—Section 1916 (42 U.S.C. 1396o) is amended in subsections (a)(2)(D) and (b)(2)(D) by striking ''a health maintenance organization (as defined in section 1903(m))'' and inserting ''a managed care entity, as defined in section 1950(a)(1),'' each place it appears.

(7) EXTENSION OF ELIGIBILITY FOR MEDICAL ASSISTANCE.—Section 1925(b)(4)(D)(iv) (42 U.S.C. 1396r–6(b)(4)(D)(iv)) is amended to read as follows:

''(iv) ENROLLMENT WITH MANAGED CARE ENTITY.—Enrollment of the caretaker relative and dependent children with a managed care entity, as defined in section 1950(a)(1), less than 50 percent of the membership (enrolled on a prepaid basis) of which consists of individuals who are eligible to receive benefits under this title (other than because of the option offered under this clause). The option of enrollment under this clause is in addition to, and not in lieu of, any enrollment option that the State might offer under subparagraph (A)(i) with respect to receiving services through a managed care entity in accordance with part B.''.

(8) PAYMENT FOR COVERED OUTPATIENT DRUGS.—Section 1927(j)(1) (42 U.S.C. 1396r–8(j)(1)) is amended by striking ''***Health Maintenance Organizations, including those organizations that contract under section 1903(m),'' and inserting ''health maintenance organizations and medicaid managed care organizations, as defined in section 1950(a)(2),''.

(9) APPLICATION OF SANCTIONS FOR BALANCED BILLING THROUGH SUBCONTRACTORS.—(A) Section 1128A(b)(2)(B) (42 U.S.C. 1320a–7a(b)) is amended by inserting '', including section 1944(b)'' after ''title XIX''.

(B) Section 1128B(d)(1) (42 U.S.C. 1320a–7b(d)(1)) is amended by inserting ''or, in the case of an individual enrolled with a managed care entity under part B of title XIX, the applicable rates established by the entity under the agreement with the State agency under such part'' after ''established by the State''.

(10) REPEAL OF CERTAIN RESTRICTIONS ON OBSTETRICAL AND PEDIATRIC PROVIDERS.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended by striking paragraph (12).

(11) DEMONSTRATION PROJECTS TO STUDY EFFECT OF ALLOWING STATES TO EXTEND MEDICAID COVERAGE FOR CERTAIN FAMILIES.—Section 4745(a)(5)(A) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1396a note) is amended by striking ''(except section 1903(m)'' and inserting ''(except part B)''.

(12) CONFORMING AMENDMENT FOR DISCLOSURE REQUIREMENTS FOR MANAGED CARE ENTITIES.—Section 1124(a)(2)(A) (42 U.S.C. 1320a–3(a)(2)(A)) is amended by inserting ''managed care entity under title XIX,'' after ''renal dialysis facility,''.

(13) ELIMINATION OF REGULATORY PAYMENT CAP.—The Secretary of Health and Human Services may not, under the authority of section 1902(a)(30)(A) of the Social Security Act or any other provision of title XIX of such Act, impose a limit by regulation on the amount of the capitation payments that a State may make to qualified entities under such title, and section 447.361 of title 42, Code of Federal Regulations (relating to upper limits of payment: risk contracts), is hereby nullified.

(14) CONTINUATION OF ELIGIBILITY.—Section 1902(e)(2) (42 U.S.C. 1396a(e)(2)) is amended to read as follows:

''(2) For provision providing for extended liability in the case of certain beneficiaries enrolled with managed care entities, see section 1941(c).''.

(15) CONFORMING AMENDMENTS TO FREEDOM-OF-CHOICE PROVISIONS.—Section 1902(a)(23) (42 U.S.C. 1396a(a)(23)) is amended—

(A) in the matter preceding subparagraph (A), by striking ''subsection (g) and in section 1915'' and inserting ''subsection (g), section 1915, and section 1941,''; and

(B) in subparagraph (B), by striking ''a health maintenance organization, or a'' and inserting ''or with a managed care entity, as defined in section 1950(a)(1), or''.

(d) EFFECTIVE DATE; STATUS OF WAIVERS.—

(1) EFFECTIVE DATE.—Except as provided in paragraph (2), the amendments made by this section shall apply to medical assistance furnished—

(A) during quarters beginning on or after October 1, 1997; or

(B) in the case of assistance furnished under a contract described in subsection (c)(1)(B), during quarters beginning after the earlier of—

(i) the date of the expiration of the contract; or

(ii) the expiration of the 1-year period which begins on the date of the enactment of this Act.

(2) APPLICATION TO WAIVERS.—If any waiver granted to a State under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n), or otherwise, which relates to the provision of medical assistance under a State plan under title XIX of the such Act (42 U.S.C. 1396 et seq.), is in effect or approved by the Secretary of Health and Human Services as of the applicable effective date described in paragraph (1), the amendments made by this section shall not apply with respect to the State before the expiration (determined without regard to any extensions) of the waiver to the extent such amendments are inconsistent with the terms of the waiver.

SEC. 5702. PRIMARY CARE CASE MANAGEMENT SERVICES AS STATE OPTION WITHOUT NEED FOR WAIVER.

(a) OPTIONAL COVERAGE AS PART OF MEDICAL ASSISTANCE.—

(1) IN GENERAL.—Section 1905(a) (42 U.S.C. 1396d(a)) is amended—

(A) by striking ''and'' at the end of paragraph (24);

(B) by redesignating paragraph (25) as paragraph (26); and

(C) by inserting after paragraph (24) the following new paragraph:

''(25) primary care case management services (as defined in subsection (t)); and''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(10)(C)(iv) (42 U.S.C. 1396a(a)(10)(C)(iv)) is amended by striking ''through (24)'' and inserting ''through (25)''.

(B) Section 1902(j) (42 U.S.C. 1396a(j)) is amended by striking ''through (25)'' and inserting ''through (26)''.

(b) PRIMARY CARE CASE MANAGEMENT SERVICES DEFINED.—Section 1905 (42 U.S.C. 1396d)) is amended by adding at the end the following new subsection:

''(t)(1) The term 'primary care case management services' means case-management related services (including coordination and monitoring of health care services) provided by a primary care case manager under a primary care case management contract.

''(2)(A) The term 'primary care case manager' means, with respect to a primary care case management contract, a provider described in subparagraph (B).

''(B) A provider described in this subparagraph is—

''(i) a physician, a physician group practice, or an entity employing or having other arrangements with physicians who provide case management services; or

''(ii) at State option—

''(I) a nurse practitioner (as described in section 1905(a)(21));

''(II) a certified nurse-midwife (as defined in section 1861(gg)(2)); or

''(III) a physician assistant (as defined in section 1861(aa)(5)).

''(3) The term 'primary care case management contract' means a contract with a State agency under which a primary care case manager undertakes to locate, coordinate, and monitor covered primary care, covered primary care (and such other covered services as may be specified under the contract) to all individuals enrolled with the primary care case manager, and that provides for—

''(A) reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment with respect to medical emergencies;

''(B) restriction of enrollment to individuals residing sufficiently near a service delivery site of the entity to be able to reach that site within a reasonable time using available and affordable modes of transportation;

''(C) employment of, or contracts or other arrangements with, sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

''(D) a prohibition on discrimination on the basis of health status or requirements for health services in the enrollment or disenrollment of individuals eligible for medical assistance under this title; and

''(E) a right for an enrollee to terminate enrollment without cause during the first month of each enrollment period, which period shall not exceed 6 months in duration, and to terminate enrollment at any time for cause.

''(4) For purposes of this subsection, the term 'primary care' includes all health care services customarily provided in accordance with State licensure and certification laws and regulations, and all laboratory services customarily provided by or through, a general practitioner, family medicine physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.''.

(c) CONFORMING AMENDMENT.—Section 1915(b)(1) (42 U.S.C. 1396n(b)(1)) is repealed.

(d) EFFECTIVE DATE.—The amendments made by this section apply to primary care case management services furnished on or after October 1, 1997.

SEC. 5703. ADDITIONAL REFORMS TO EXPAND AND SIMPLIFY MANAGED CARE.

(a) ELIMINATION OF 75:25 RESTRICTION ON RISK CONTRACTS.—

(1) 75 PERCENT LIMIT ON MEDICARE AND MEDICAID ENROLLMENT.—

(A) IN GENERAL.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended by striking clause (ii).

(B) CONFORMING AMENDMENTS.—

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

(I) by striking subparagraphs (C), (D), and (E); and

(II) in subparagraph (G), by striking ''clauses (i) and (ii)'' and inserting ''clause (i)''.

(ii) Section 1902(e)(2)(A) (42 U.S.C. 1396a(e)(2)(A)) is amended by striking ''(2)(E),''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply on and after June 20, 1997.

(b) ELIMINATION OF PROHIBITION ON COPAYMENTS FOR SERVICES FURNISHED BY HEALTH MAINTENANCE ORGANIZATIONS.—Section 1916 (42 U.S.C. 1396o) is amended—

(1) in subsection (a)(2)(D), by striking ''or services furnished'' and all that follows through ''enrolled,''; and

(2) in subsection (b)(2)(D), by striking ''or (at the option'' and all that follows through ''enrolled,''.

Subchapter B—Management Flexibility Reforms

SEC. 5711. ELIMINATION OF BOREN AMENDMENT REQUIREMENTS FOR PROVIDER PAYMENT RATES.

(a) PLAN AMENDMENTS.—Section 1902(a)(13) is amended—

(1) by striking all that precedes subparagraph (D) and inserting the following:

''(13) provide—

''(A) for a public process for determination of rates of payment under the plan for hospital services (and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), nursing facility services, services provided in intermediate care facilities for the mentally retarded, and home and community-based services, under which—

''(i) proposed rates, the methodologies underlying the establishment of such rates, and a description of how such methodologies will affect access to services, quality of services, and safety of beneficiaries are published, and providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on such proposed rates, methodologies, and description; and

''(ii) final rates, the methodologies underlying the establishment of such rates, and justifications for such rates (that may take into account public comments received by the State (if any) are published in 1 or more daily newspapers of general circulation in the State or in any publication used by the State to publish State statutes or rules); and'';

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

(3) in subparagraph (B), as so redesignated, by adding ''and'' at the end; and

(4) by striking subparagraph (F).

(b) STUDY AND REPORT.—

(1) STUDY.—The Secretary of Health and Human Services shall study the effect on access to services, the quality of services, and the safety of services provided to beneficiaries of the rate-setting methods used by States pursuant to section 1902(a)(13) of the Social Security Act (42 U.S.C. 1396a(a)(13), as amended by subsection (a).

(2) REPORT.—Not later than 4 years after the date of enactment of this Act, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the conclusions of the study conducted under paragraph (1), together with any recommendations for legislation as a result of such conclusions.

(c) CONFORMING AMENDMENTS.—

(1) Section 1903(m)(2)(A)(ix) (42 U.S.C. 1396b(m)(2)(A)(ix)) is amended by striking ''1902(a)(13)(E)'' each place it appears and inserting ''1902(a)(13)(C)''.

(2) Section 1905(o)(3) (42 U.S.C. 1396d(o)(3)) is amended by striking ''amount described in section 1902(a)(13)(D)'' and inserting ''amount determined in section 1902(a)(13)(B)''.

(3) Section 1913(b)(3) (42 U.S.C. 1396l(b)(3)) is amended by striking ''1902(a)(13)(A)'' and inserting ''1902(a)(13)''.

(4) Section 1923 (42 U.S.C. 1396r–4) is amended in subsections (a)(1) and (e)(1), by striking ''1902(a)(13)(A)'' each place it appears and inserting ''1902(a)(13)''.

SEC. 5712. MEDICAID PAYMENT RATES FOR QUALIFIED MEDICARE BENEFICIARIES.

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

(1) by inserting ''(1)'' after ''(n)'', and

(2) by adding at the end the following:

''(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for a coinsurance or copayment for medicare cost-sharing if the amount of the payment under title XVIII for the service exceeds the payment amount that otherwise would be made under the State plan under this title for such service.

''(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (1) or (2) of this subsection—

''(A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service,

''(B) the beneficiary shall not have any legal liability to make payment to a provider or managed care entity (as defined in section 1950(a)(1)) for the service, and

''(C) any lawful sanction that may be imposed upon a provider or managed care entity (as defined in section 1950(a)(1)) for excess charges under this title or title XVIII shall apply to the imposition of any charge on the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.''.

(b) LIMITATION IN MEDICARE PROVIDER AGREEMENTS.—Section 1866(a)(1)(A) (42 U.S.C. 1395cc(a)(1)(A)) is amended—

(1) by inserting ''(i)'' after ''(A)'', and

(2) by inserting before the comma at the end the following: '', and (ii) not to impose any charge that may not be charged under section 1902(n)(3)''.

(c) LIMITATION ON NONPARTICIPATING PROVIDERS.—Section 1848(g)(3)(A) (42 U.S.C. 1395w–4(g)(3)(A)) is amended by inserting before the period at the end the following: ''and the provisions of section 1902(n)(3)(A) apply to further limit permissible charges under this section''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to payment for items and services furnished on or after the later of—

(1) October 1, 1997; or

(2) the termination date of a provider agreement under the medicare program under title XVIII or under a State plan under title XIX that is in effect on the date of the enactment of this Act.

Subchapter C—Reduction of Disproportionate Share Hospital (DSH) Payments

SEC. 5721. DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

(a) REDUCTION OF PAYMENTS.—Section 1923(f) (42 U.S.C. 1396r–4(f)) is amended to read as follows:

''(f) LIMITATION ON FEDERAL FINANCIAL PARTICIPATION.—

''(1) IN GENERAL.—Beginning with fiscal year 1998, payment under section 1903(a) shall not be made to a State with respect to any payment adjustment made under this section for hospitals in a State for quarters in a fiscal year in excess of the disproportionate share hospital (in this subsection referred to as 'DSH') allotment for the State for the fiscal year, as specified in paragraphs (2), (3), (4), and (5).

''(2) DETERMINATION OF STATE DSH ALLOTMENTS FOR FISCAL YEAR 1998.—

''(A) IN GENERAL.—Except as provided in subparagraph (B) and paragraph (4), the DSH allotment for a State for fiscal year 1998 is equal to the State 1995 DSH spending amount.

''(B) HIGH DSH STATES.—In the case of any State that is a high DSH State, the DSH allotment for that State for fiscal year 1998 is equal to the sum of—

''(i) the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for inpatient hospital services provided (based on reporting data specified by the State on HCFA Form 64 as inpatient DSH, and as approved by the Secretary); and

''(ii) 70 percent of the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

''(3) DETERMINATION OF STATE DSH ALLOTMENTS FOR FISCAL YEARS 1999 THROUGH 2002.—

''(A) NON HIGH DSH STATES.—

''(i) IN GENERAL.—Except as provided in subparagraph (B) and paragraph (4), the DSH allotment for a State for each of fiscal years 1999 through 2002 is equal to the applicable percentage of the State 1995 DSH spending amount.

''(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the applicable percentage with respect to a State described in that clause is—

''(I) for fiscal year 1999, 98 percent;

''(II) for fiscal year 2000, 95 percent;

''(III) for fiscal year 2001, 90 percent; and

''(IV) for fiscal year 2002, 85 percent.

''(B) HIGH DSH STATES.—

''(i) IN GENERAL.—In the case of any State that is a high DSH State, the DSH allotment for that State for each of fiscal years 1999 through 2002 is equal to the applicable reduction percentage of the high DSH State modified 1995 spending amount for that fiscal year.

''(ii) HIGH DSH STATE MODIFIED 1995 SPENDING AMOUNT.—

''(I) IN GENERAL.—For purposes of clause (i), the high DSH State modified 1995 spending amount means, with respect to a State and a fiscal year, the sum of—

''(aa) the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for inpatient hospital services provided (based on reporting data specified by the State on HCFA Form 64 as inpatient DSH, and as approved by the Secretary); and

''(bb) the applicable mental health percentage for such fiscal year of the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

''(II) APPLICABLE MENTAL HEALTH PERCENTAGE.—For purposes of subclause (I)(bb), the applicable mental health percentage for such fiscal year is—

''(aa) for fiscal year 1999, 50 percent;

''(bb) for fiscal year 2000, 20 percent; and

''(cc) for fiscal years 2001 and 2002, 0 percent.

''(iii) APPLICABLE REDUCTION PERCENTAGE.—For purposes of clause (i), the applicable reduction percentage described in that clause is—

''(I) for fiscal year 1999, 92 percent;

''(II) for fiscal year 2000, 85 percent; and

''(III) for fiscal years 2001 and 2002, 80 percent.

''(4) EXCEPTIONS.—

''(A) CERTAIN STATES WITHOUT 1995 MENTAL HEALTH DSH SPENDING.—In the case of any State with a State 1995 DSH spending amount that exceeds 12 percent of the Federal medical assistance percentage of expenditures made under the State plan under this title for medical assistance during fiscal year 1995 and that, during such fiscal year, did not make any payment adjustments to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary), the DSH allotment for that State for each of fiscal years 1998 through 2002 is equal to the average of the State 1995 DSH spending amount and the State 1996 DSH spending amount.

''(B) STATES WITH LOW STATE 1995 DSH SPENDING AMOUNTS.—In the case of any State with a

State 1995 DSH spending amount that is less than 3 percent of the Federal medical assistance percentage of expenditures made under the State plan under this title for medical assistance during fiscal year 1995, the DSH allotment for that State for each of fiscal years 1998 through 2002 is equal to the State 1995 DSH spending amount.

''(C) STATES WITH STATE 1995 DSH SPENDING AMOUNTS ABOVE 3 PERCENT.—In the case of any State with a State 1995 DSH spending amount that is more than 3 percent of the Federal medical assistance percentage of expenditures made under the State plan under this title for medical assistance during fiscal year 1995, the DSH allotment for that State for each of fiscal years 1999 through 2002 is equal to the greater of—

''(i) the amount otherwise determined for such State under paragraph (3); or

''(ii) 50 percent of the State 1995 DSH spending amount.

''(5) DETERMINATION OF STATE DSH ALLOTMENTS FOR FISCAL YEAR 2003 AND THEREAFTER.—The DSH allotment for any State for fiscal year 2003 and each fiscal year thereafter is equal to the DSH allotment for the State for the preceding fiscal year, increased by the estimated percentage change in the consumer price index for medical services (as determined by the Bureau of Labor Statistics).

''(6) DEFINITIONS.—

''(A) HIGH DSH STATE.—The term 'high DSH State' means a State that, with respect to fiscal year 1997, had a State base allotment under this section that exceeded 12 percent of the Federal medical assistance percentage of expenditures made under the State plan under this title for medical assistance during such fiscal year, as determined using the preliminary State DSH allotment for the State for fiscal year 1997, as published in the Federal Register on January 31, 1997.

''(B) STATE.—In this subsection, the term 'State' means the 50 States and the District of Columbia.''.

''(C) STATE 1995 DSH SPENDING AMOUNT.—The term 'State 1995 DSH spending amount' means, with respect to a State, the Federal medical assistance percentage of payment adjustments made under subsection (c) under the State plan that are attributable to the fiscal year 1995 DSH allotment, as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary.

''(D) STATE 1996 DSH SPENDING AMOUNT.—The term 'State 1996 DSH spending amount' means, with respect to a State, the Federal share of payment adjustments made under subsection (c) under the State plan during fiscal year 1996 as reported by the State not later than December 31, 1997, on HCFA Form 64, and as approved by the Secretary.''.

(b) LIMITATION ON PAYMENTS TO INSTITUTIONS FOR MENTAL DISEASES.—Section 1923 of the Social Security Act (42 U.S.C. 1396r–4) is amended by adding at the end the following:

''(h) LIMITATION ON CERTAIN STATE DSH EXPENDITURES.—

''(1) IN GENERAL.—Notwithstanding any other provision of this section, payment under section 1903(a) shall not be made to a State with respect to any payment adjustments made under this section for quarters in a fiscal year to institutions for mental diseases or other mental health facilities, in excess of—

''(A) the total State DSH expenditures that are attributable to fiscal year 1995 for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary); or

''(B) the amount of such payment adjustment which is equal to the applicable percentage of the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

''(2) APPLICABLE PERCENTAGE.—

''(A) IN GENERAL.—For purposes of paragraph (1), the applicable percentage with respect to a fiscal year is the lesser of the percentage determined under subparagraph (B) or—

''(i) for fiscal year 2001, 50 percent;

''(ii) for fiscal year 2002, 40 percent; and

''(iii) for fiscal year 2003 and thereafter, 33 percent.

''(B) 1995 PERCENTAGE.—The percentage determined under this subparagraph is the ratio (determined as a percentage) of the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for payments to institutions for mental diseases and other mental health facilities, to the State 1995 DSH spending amount, as defined under subsection (f)(6)(C).''.

(c) TARGETING PAYMENTS.—Section 1923(a)(2) (42 U.S.C. 1396r–4(a)(2)) is amended by adding at the end the following:

''(D) A State plan under this title shall not be considered to meet the requirements of section 1902(a)(13)(A) (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs), as of October 1, 1998, unless the State has provided assurances to the Secretary that the State has developed a methodology for prioritizing payments to disproportionate share hospitals, including children's hospitals, on the basis of the proportion of low-income and medicaid patients served by such hospitals. In making such assurances, the State plan shall provide a definition of high-volume disproportionate share hospitals and a detailed description of the specific methodology to be used to provide disproportionate share payments to such hospitals. The State shall provide an annual report to the Secretary describing the disproportionate share payments to such high-volume disproportionate share hospitals.''.

(d) EFFECTIVE DATE.—The amendments made by this section apply on and after October 1, 1997.

CHAPTER 2—EXPANSION OF MEDICAID ELIGIBILITY

SEC. 5731. STATE OPTION TO PERMIT WORKERS WITH DISABILITIES TO BUY INTO MEDICAID.

Section 1902(a)(10)(A)(ii) (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

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

(2) in subclause (XII), by adding ''or'' at the end; and

(3) by adding at the end the following:

''(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1619(b), would be considered to be receiving supplemental security income (subject, notwithstanding section 1916, to payment of premiums or other charges (set on a sliding scale based on income) that the State may determine);''.

SEC. 5732. 12-MONTH CONTINUOUS ELIGIBILITY FOR CHILDREN.

(a) IN GENERAL.—Section 1902(e) (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

''(12) At the option of the State, the State plan may provide that an individual who is under an age specified by the State (not to exceed 19 years of age) and who is determined to be eligible for benefits under a State plan approved under this title under subsection (a)(10)(A) shall remain eligible for those benefits until the earlier of—

''(A) the end of the 12-month period following the determination; or

''(B) the date that the individual exceeds that age.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to medical assistance for items and services furnished on or after October 1, 1997.

CHAPTER 3—PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

SEC. 5741. ESTABLISHMENT OF PACE PROGRAM AS MEDICAID STATE OPTION.

(a) IN GENERAL.—Title XIX is amended—

(1) in section 1905(a) (42 U.S.C. 1396d(a)), as amended by section 5702(a)(1)—

(A) by striking ''and'' at the end of paragraph (25);

(B) by redesignating paragraph (26) as paragraph (27); and

(C) by inserting after paragraph (25) the following new paragraph:

''(26) services furnished under a PACE program under section 1932 to PACE program eligible individuals enrolled under the program under such section; and'';

(2) by redesignating section 1932 as section 1933; and

(3) by inserting after section 1931 the following new section:

''PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

''SEC. 1932. (a) STATE OPTION.—

''(1) IN GENERAL.—A State may elect to provide medical assistance under this section with respect to PACE program services to PACE program eligible individuals who are eligible for medical assistance under the State plan and who are enrolled in a PACE program under a PACE program agreement. Such individuals need not be eligible for benefits under part A, or enrolled under part B, of title XVIII to be eligible to enroll under this section. In the case of an individual enrolled with a PACE program pursuant to such an election—

''(A) the individual shall receive benefits under the plan solely through such program, and

''(B) the PACE provider shall receive payment in accordance with the PACE program agreement for provision of such benefits.

''(2) PACE PROGRAM DEFINED.—For purposes of this section and section 1894, the term 'PACE program' means a program of all-inclusive care for the elderly that meets the following requirements:

''(A) OPERATION.—The entity operating the program is a PACE provider (as defined in paragraph (3)).

''(B) COMPREHENSIVE BENEFITS.—The program provides comprehensive health care services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

''(C) TRANSITION.—In the case of an individual who is enrolled under the program under this section and whose enrollment ceases for any reason (including that the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or otherwise), the program provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.

''(3) PACE PROVIDER DEFINED.—

''(A) IN GENERAL.—For purposes of this section, the term 'PACE provider' means an entity that—

''(i) subject to subparagraph (B), is (or is a distinct part of) a public entity or a private, nonprofit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986, and

''(ii) has entered into a PACE program agreement with respect to its operation of a PACE program.

''(B) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.—Clause (i) of subparagraph (A) shall not apply—

''(i) to entities subject to a demonstration project waiver under subsection (h); and

''(ii) after the date the report under section 5743(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C), or (D) of paragraph (2) of such section are true.

''(4) PACE PROGRAM AGREEMENT DEFINED.—For purposes of this section, the term 'PACE program agreement' means, with respect to a PACE provider, an agreement, consistent with this section, section 1894 (if applicable), and regulations promulgated to carry out such sections, among the PACE provider, the Secretary, and a State administering agency for the operation of a PACE program by the provider under such sections.

''(5) PACE PROGRAM ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term 'PACE program eligible individual' means, with respect to a PACE program, an individual who—

''(A) is 55 years of age or older;

''(B) subject to subsection (c)(4), is determined under subsection (c) to require the level of care required under the State medicaid plan for coverage of nursing facility services;

''(C) resides in the service area of the PACE program; and

''(D) meets such other eligibility conditions as may be imposed under the PACE program agreement for the program under subsection (e)(2)(A)(ii).

''(6) PACE PROTOCOL.—For purposes of this section, the term 'PACE protocol' means the Protocol for the Program of All-inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995, or any successor protocol that may be agreed upon between the Secretary and On Lok, Inc.

''(7) PACE DEMONSTRATION WAIVER PROGRAM DEFINED.—For purposes of this section, the term 'PACE demonstration waiver program' means a demonstration program under either of the following sections (as in effect before the date of their repeal):

''(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21), as extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

''(B) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

''(8) STATE ADMINISTERING AGENCY DEFINED.—For purposes of this section, the term 'State administering agency' means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under this title in the State) responsible for administering PACE program agreements under this section and section 1894 in the State.

''(9) TRIAL PERIOD DEFINED.—

''(A) IN GENERAL.—For purposes of this section, the term 'trial period' means, with respect to a PACE program operated by a PACE provider under a PACE program agreement, the first 3 contract years under such agreement with respect to such program.

''(B) TREATMENT OF ENTITIES PREVIOUSLY OPERATING PACE DEMONSTRATION WAIVER PROGRAMS.—Each contract year (including a year occurring before the effective date of this section) during which an entity has operated a PACE demonstration waiver program shall be counted under subparagraph (A) as a contract year during which the entity operated a PACE program as a PACE provider under a PACE program agreement.

''(10) REGULATIONS.—For purposes of this section, the term 'regulations' refers to interim final or final regulations promulgated under subsection (f) to carry out this section and section 1894.

''(b) SCOPE OF BENEFITS; BENEFICIARY SAFEGUARDS.—

''(1) IN GENERAL.—Under a PACE program agreement, a PACE provider shall—

''(A) provide to PACE program eligible individuals, regardless of source of payment and directly or under contracts with other entities, at a minimum—

''(i) all items and services covered under title XVIII (for individuals enrolled under section 1894) and all items and services covered under this title, but without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost-sharing that would otherwise apply under such title or this title, respectively; and

''(ii) all additional items and services specified in regulations, based upon those required under the PACE protocol;

''(B) provide such enrollees access to necessary covered items and services 24 hours per day, every day of the year;

''(C) provide services to such enrollees through a comprehensive, multidisciplinary health and social services delivery system which integrates acute and long-term care services pursuant to regulations; and

''(D) specify the covered items and services that will not be provided directly by the entity, and to arrange for delivery of those items and services through contracts meeting the requirements of regulations.

''(2) QUALITY ASSURANCE; PATIENT SAFEGUARDS.—The PACE program agreement shall require the PACE provider to have in effect at a minimum—

''(A) a written plan of quality assurance and improvement, and procedures implementing such plan, in accordance with regulations, and

''(B) written safeguards of the rights of enrolled participants (including a patient bill of rights and procedures for grievances and appeals) in accordance with regulations and with other requirements of this title and Federal and State law designed for the protection of patients.

''(c) ELIGIBILITY DETERMINATIONS.—

''(1) IN GENERAL.—The determination of—

''(A) whether an individual is a PACE program eligible individual shall be made under and in accordance with the PACE program agreement, and

''(B) who is entitled to medical assistance under this title shall be made (or who is not so entitled, may be made) by the State administering agency.

''(2) CONDITION.—An individual is not a PACE program eligible individual (with respect to payment under this section) unless the individual's health status has been determined by the Secretary or the State administering agency, in accordance with regulations, to be comparable to the health status of individuals who have participated in the PACE demonstration waiver programs. Such determination shall be based upon information on health status and related indicators (such as medical diagnoses and measures of activities of daily living, instrumental activities of daily living, and cognitive impairment) that are part of a uniform minimum data set collected by PACE providers on potential eligible individuals.

''(3) ANNUAL ELIGIBILITY RECERTIFICATIONS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the determination described in subsection (a)(5)(B) for an individual shall be reevaluated at least annually.

''(B) EXCEPTION.—The requirement of annual reevaluation under subparagraph (A) may be waived during a period in accordance with regulations in those cases in which the State administering agency determines that there is no reasonable expectation of improvement or significant change in an individual's condition during the period because of the advanced age, severity of the advanced age, severity of chronic condition, or degree of impairment of functional capacity of the individual involved.

''(4) CONTINUATION OF ELIGIBILITY.—An individual who is a PACE program eligible individual may be deemed to continue to be such an individual notwithstanding a determination that the individual no longer meets the requirement of subsection (a)(5)(B) if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6-month period.

''(5) ENROLLMENT; DISENROLLMENT.—The enrollment and disenrollment of PACE program eligible individuals in a PACE program shall be pursuant to regulations and the PACE program agreement and shall permit enrollees to voluntarily disenroll without cause at any time. Such regulations and agreement shall provide that the PACE program may not disenroll a PACE program eligible individual on the ground that the individual has engaged in noncompliant behavior if such behavior is related to a mental or physical condition of the individual. For purposes of the preceding sentence, the term 'noncompliant behavior' includes repeated noncompliance with medical advice and repeated failure to appear for appointments.

''(d) PAYMENTS TO PACE PROVIDERS ON A CAPITATED BASIS.—

''(1) IN GENERAL.—In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the State shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section.

''(2) CAPITATION AMOUNT.—The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be an amount, specified under the PACE agreement, which is less than the amount that would otherwise have been made under the State plan if the individuals were not so enrolled and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. The payment under this section shall be in addition to any payment made under section 1894 for individuals who are enrolled in a PACE program under such section.

''(e) PACE PROGRAM AGREEMENT.—

''(1) REQUIREMENT.—

''(A) IN GENERAL.—The Secretary, in close cooperation with the State administering agency, shall establish procedures for entering into, extending, and terminating PACE program agreements for the operation of PACE programs by entities that meet the requirements for a PACE provider under this section, section 1894, and regulations.

''(B) NUMERICAL LIMITATION.—

''(i) IN GENERAL.—The Secretary shall not permit the number of PACE providers with which agreements are in effect under this section or under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 to exceed—

''(I) 40 as of the date of the enactment of this section, or

''(II) as of each succeeding anniversary of such date, the numerical limitation under this subparagraph for the preceding year plus 20.

Subclause (II) shall apply without regard to the actual number of agreements in effect as of a previous anniversary date.

''(ii) TREATMENT OF CERTAIN PRIVATE, FOR-PROFIT PROVIDERS.—The numerical limitation in clause (i) shall not apply to a PACE provider that—

''(I) is operating under a demonstration project waiver under subsection (h), or

''(II) was operating under such a waiver and subsequently qualifies for PACE provider status pursuant to subsection (a)(3)(B)(ii).

''(2) SERVICE AREA AND ELIGIBILITY.—

''(A) IN GENERAL.—A PACE program agreement for a PACE program—

''(i) shall designate the service area of the program;

''(ii) may provide additional requirements for individuals to qualify as PACE program eligible individuals with respect to the program;

''(iii) shall be effective for a contract year, but may be extended for additional contract years in the absence of a notice by a party to terminate, and is subject to termination by the Secretary and the State administering agency at any time for cause (as provided under the agreement);

''(iv) shall require a PACE provider to meet all applicable State and local laws and requirements; and

''(v) shall have such additional terms and conditions as the parties may agree to, provided that such terms and conditions are consistent with this section and regulations.

''(B) SERVICE AREA OVERLAP.—In designating a service area under a PACE program agreement under subparagraph (A)(i), the Secretary (in consultation with the State administering agency) may exclude from designation an area that is already covered under another PACE program agreement, in order to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program.

''(3) DATA COLLECTION; DEVELOPMENT OF OUTCOME MEASURES.—

''(A) DATA COLLECTION.—

''(i) IN GENERAL.—Under a PACE program agreement, the PACE provider shall—

''(I) collect data;

''(II) maintain, and afford the Secretary and the State administering agency access to, the records relating to the program, including pertinent financial, medical, and personnel records; and

''(III) submit to the Secretary and the State administering agency such reports as the Secretary finds (in consultation with State administering agencies) necessary to monitor the operation, cost, and effectiveness of the PACE program.

''(ii) REQUIREMENTS DURING TRIAL PERIOD.—During the first 3 years of operation of a PACE program (either under this section or under a PACE demonstration waiver program), the PACE provider shall provide such additional data as the Secretary specifies in regulations in order to perform the oversight required under paragraph (4)(A).

''(B) DEVELOPMENT OF OUTCOME MEASURES.—Under a PACE program agreement, the PACE provider, the Secretary, and the State administering agency shall jointly cooperate in the development and implementation of health status and quality of life outcome measures with respect to PACE program eligible individuals.

''(4) OVERSIGHT.—

''(A) ANNUAL, CLOSE OVERSIGHT DURING TRIAL PERIOD.—During the trial period (as defined in subsection (a)(9)) with respect to a PACE program operated by a PACE provider, the Secretary (in cooperation with the State administering agency) shall conduct a comprehensive annual review of the operation of the PACE program by the provider in order to assure compliance with the requirements of this section and regulations. Such a review shall include—

''(i) an onsite visit to the program site;

''(ii) comprehensive assessment of a provider's fiscal soundness;

''(iii) comprehensive assessment of the provider's capacity to provide all PACE services to all enrolled participants;

''(iv) detailed analysis of the entity's substantial compliance with all significant requirements of this section and regulations; and

''(v) any other elements the Secretary or the State administering agency considers necessary or appropriate.

''(B) CONTINUING OVERSIGHT.—After the trial period, the Secretary (in cooperation with the State administering agency) shall continue to conduct such review of the operation of PACE providers and PACE programs as may be appropriate, taking into account the performance level of a provider and compliance of a provider with all significant requirements of this section and regulations.

''(C) DISCLOSURE.—The results of reviews under this paragraph shall be reported promptly to the PACE provider, along with any recommendations for changes to the provider's program, and shall be made available to the public upon request.

''(5) TERMINATION OF PACE PROVIDER AGREEMENTS.—

''(A) IN GENERAL.—Under regulations—

''(i) the Secretary or a State administering agency may terminate a PACE program agreement for cause, and

''(ii) a PACE provider may terminate such an agreement after appropriate notice to the Secretary, the State administering agency, and enrollees.

''(B) CAUSES FOR TERMINATION.—In accordance with regulations establishing procedures for termination of PACE program agreements, the Secretary or a State administering agency may terminate a PACE program agreement with a PACE provider for, among other reasons, the fact that—

''(i) the Secretary or State administering agency determines that—

''(I) there are significant deficiencies in the quality of care provided to enrolled participants; or

''(II) the provider has failed to comply substantially with conditions for a program or provider under this section or section 1894; and

''(ii) the entity has failed to develop and successfully initiate, within 30 days of the date of the receipt of written notice of such a determination, a plan to correct the deficiencies, or has failed to continue implementation of such a plan.

''(C) TERMINATION AND TRANSITION PROCEDURES.—An entity whose PACE provider agreement is terminated under this paragraph shall implement the transition procedures required under subsection (a)(2)(C).

''(6) SECRETARY'S OVERSIGHT; ENFORCEMENT AUTHORITY.—

''(A) IN GENERAL.—Under regulations, if the Secretary determines (after consultation with the State administering agency) that a PACE provider is failing substantially to comply with the requirements of this section and regulations, the Secretary (and the State administering agency) may take any or all of the following actions:

''(i) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

''(ii) Withhold some or all further payments under the PACE program agreement under this section or section 1894 with respect to PACE program services furnished by such provider until the deficiencies have been corrected.

''(iii) Terminate such agreement.

''(B) APPLICATION OF INTERMEDIATE SANCTIONS.—Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in section 1857(f)(2) (or, for periods before January 1, 1999, section 1876(i)(6)(B)) or 1903(m)(5)(B) in the case of violations by the provider of the type described in section 1857(f)(1) (or 1876(i)(6)(A) for such periods) or 1903(m)(5)(A), respectively (in relation to agreements, enrollees, and requirements under section 1894 or this section, respectively).

''(7) PROCEDURES FOR TERMINATION OR IMPOSITION OF SANCTIONS.—Under regulations, the provisions of section 1857(g) (or for periods before January 1, 1999, section 1876(i)(9)) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and a Medicare Choice organization under part C of title XVIII (or for such periods an eligible organization under section 1876).

''(8) TIMELY CONSIDERATION OF APPLICATIONS FOR PACE PROGRAM PROVIDER STATUS.—In considering an application for PACE provider program status, the application shall be deemed approved unless the Secretary, within 90 days after the date of the submission of the application to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information that is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

''(f) REGULATIONS.—

''(1) IN GENERAL.—The Secretary shall issue interim final or final regulations to carry out this section and section 1894.

''(2) USE OF PACE PROTOCOL.—

''(A) IN GENERAL.—In issuing such regulations, the Secretary shall, to the extent consistent with the provisions of this section, incorporate the requirements applied to PACE demonstration waiver programs under the PACE protocol.

''(B) FLEXIBILITY.—In order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use nonstaff physicians according to State licensing law requirements) under this section and section 1894, the Secretary (in close consultation with State administering agencies) may modify or waive provisions of the PACE protocol so long as any such modification or waiver is not inconsistent with and would not impair the essential elements, objectives, and requirements of this section, but may not modify or waive any of the following provisions:

''(i) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

''(ii) The delivery of comprehensive, integrated acute and long-term care services.

''(iii) The interdisciplinary team approach to care management and service delivery.

''(iv) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

''(v) The assumption by the provider of full financial risk.

''(3) APPLICATION OF CERTAIN ADDITIONAL BENEFICIARY AND PROGRAM PROTECTIONS.—

''(A) IN GENERAL.—In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of part C of title XVIII (or, for periods before January 1, 1999, section 1876) and section 1903(m) relating to protection of beneficiaries and program integrity as would apply to Medicare Choice organizations under such part C (or for such periods eligible organizations under risk-sharing contracts under section 1876) and to health maintenance organizations under prepaid capitation agreements under section 1903(m).

''(B) CONSIDERATIONS.—In issuing such regulations, the Secretary shall—

''(i) take into account the differences between populations served and benefits provided under this section and under part C of title XVIII (or, for periods before January 1, 1999, section 1876) and section 1903(m);

''(ii) not include any requirement that conflicts with carrying out PACE programs under this section; and

''(iii) not include any requirement restricting the proportion of enrollees who are eligible for benefits under this title or title XVIII.

''(g) WAIVERS OF REQUIREMENTS.—With respect to carrying out a PACE program under this section, the following requirements of this title (and regulations relating to such requirements) shall not apply:

''(1) Section 1902(a)(1), relating to any requirement that PACE programs or PACE program services be provided in all areas of a State.

''(2) Section 1902(a)(10), insofar as such section relates to comparability of services among different population groups.

''(3) Sections 1902(a)(23) and 1915(b)(4), relating to freedom of choice of providers under a PACE program.

''(4) Section 1903(m)(2)(A), insofar as it restricts a PACE provider from receiving prepaid capitation payments.

''(h) DEMONSTRATION PROJECT FOR FOR-PROFIT ENTITIES.—

''(1) IN GENERAL.—In order to demonstrate the operation of a PACE program by a private, for-profit entity, the Secretary (in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) that a PACE provider may not be a for-profit, private entity.

''(2) SIMILAR TERMS AND CONDITIONS.—

''(A) IN GENERAL.—Except as provided under subparagraph (B), and paragraph (1), the terms and conditions for operation of a PACE program by a provider under this subsection shall be the same as those for PACE providers that are nonprofit, private organizations.

''(B) NUMERICAL LIMITATION.—The number of programs for which waivers are granted under this subsection shall not exceed 10. Programs with waivers granted under this subsection shall not be counted against the numerical limitation specified in subsection (e)(1)(B).

''(i) POST-ELIGIBILITY TREATMENT OF INCOME.—A State may provide for post-eligibility treatment of income for individuals enrolled in PACE programs under this section in the same manner as a State treats post-eligibility income for individuals receiving services under a waiver under section 1915(c).

''(j) MISCELLANEOUS PROVISIONS.—Nothing in this section or 1894 shall be construed as preventing a PACE provider from entering into contracts with other governmental or nongovernmental payers for the care of PACE program eligible individuals who are not eligible for benefits under part A, or enrolled under part B, of title XVIII or eligible for medical assistance under this title.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1902(j) (42 U.S.C. 1396a(j)), as amended by section 5702(a)(2)(B), is amended by striking ''(26)'' and inserting ''(27)''.

(2) Section 1924(a)(5) (42 U.S.C. 1396r–5(a)(5)) is amended—

(A) in the heading, by striking ''FROM ORGANIZATIONS RECEIVING CERTAIN WAIVERS'' and inserting ''UNDER PACE PROGRAMS''; and

(B) by striking ''from any organization'' and all that follows and inserting ''under a PACE demonstration waiver program (as defined in section 1932(a)(7)) or under a PACE program under section 1932 or 1894.''.

(3) Section 1903(f)(4)(C) (42 U.S.C. 1396b(f)(4)(C)) is amended by inserting ''or who is a PACE program eligible individual enrolled in a PACE program under section 1932,'' after ''section 1902(a)(10)(A),''.

SEC. 5742. EFFECTIVE DATE; TRANSITION.

(a) TIMELY ISSUANCE OF REGULATIONS; EFFECTIVE DATE.—The Secretary of Health and Human Services shall promulgate regulations to carry out this chapter in a timely manner. Such regulations shall be designed so that entities may establish and operate PACE programs under sections 1894 and 1932 of the Social Security Act (as added by sections 5011 and 5741 of this Act) for periods beginning not later than 1 year after the date of the enactment of this Act.

(b) EXPANSION AND TRANSITION FOR PACE DEMONSTRATION PROJECT WAIVERS.—

(1) EXPANSION IN CURRENT NUMBER AND EXTENSION OF DEMONSTRATION PROJECTS.—Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 4118(g) of the Omnibus Budget Reconciliation Act of 1987, is amended—

(A) in paragraph (1), by inserting before the period at the end the following: '', except that the Secretary shall grant waivers of such requirements to up to the applicable numerical limitation specified in section 1933(e)(1)(B) of the Social Security Act''; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking '', including permitting the organization to assume progressively (over the initial 3-year period of the waiver) the full financial risk''; and

(ii) in subparagraph (C), by adding at the end the following: ''In granting further extensions, an organization shall not be required to provide for reporting of information which is only required because of the demonstration nature of the project.''.

(2) ELIMINATION OF REPLICATION REQUIREMENT.—Section 9412(b)(2)(B) of such Act, as so amended, shall not apply to waivers granted under such section after the date of the enactment of this Act.

(3) TIMELY CONSIDERATION OF APPLICATIONS.—In considering an application for waivers under such section before the effective date of the repeals under subsection (d), subject to the numerical limitation under the amendment made by paragraph (1), the application shall be deemed approved unless the Secretary of Health and Human Services, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information which is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

(c) PRIORITY AND SPECIAL CONSIDERATION IN APPLICATION.—During the 3-year period beginning on the date of the enactment of this Act:

(1) PROVIDER STATUS.—The Secretary of Health and Human Services shall give priority in processing applications of entities to qualify as PACE programs under section 1894 or 1932 of the Social Security Act—

(A) first, to entities that are operating a PACE demonstration waiver program (as defined in section 1932(a)(7) of such Act), and

(B) then to entities that have applied to operate such a program as of May 1, 1997.

(2) NEW WAIVERS.—The Secretary shall give priority, in the awarding of additional waivers under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986—

(A) to any entities that have applied for such waivers under such section as of May 1, 1997; and

(B) to any entity that, as of May 1, 1997, has formally contracted with a State to provide services for which payment is made on a capitated basis with an understanding that the entity was seeking to become a PACE provider.

(3) SPECIAL CONSIDERATION.—The Secretary shall give special consideration, in the processing of applications described in paragraph (1) and the awarding of waivers described in paragraph (2), to an entity which as of May 1, 1997, through formal activities (such as entering into contracts for feasibility studies) has indicated a specific intent to become a PACE provider.

(d) REPEAL OF CURRENT PACE DEMONSTRATION PROJECT WAIVER AUTHORITY.—

(1) IN GENERAL.—Subject to paragraph (2), the following provisions of law are repealed:

(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21).

(B) Section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

(C) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

(2) DELAY IN APPLICATION.—

(A) IN GENERAL.—Subject to subparagraph (B), the repeals made by paragraph (1) shall not apply to waivers granted before the initial effective date of regulations described in subsection (a).

(B) APPLICATION TO APPROVED WAIVERS.—Such repeals shall apply to waivers granted before such date only after allowing such organizations a transition period (of up to 24 months) in order to permit sufficient time for an orderly transition from demonstration project authority to general authority provided under the amendments made by this chapter.

SEC. 5743. STUDY AND REPORTS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in close consultation with State administering agencies, as defined in section 1932(a)(8) of the Social Security Act) shall conduct a study of the quality and cost of providing PACE program services under the medicare and medicaid programs under the amendments made by this chapter.

(2) STUDY OF PRIVATE, FOR-PROFIT PROVIDERS.—Such study shall specifically compare the costs, quality, and access to services by entities that are private, for-profit entities operating under demonstration projects waivers granted under section 1932(h) of the Social Security Act with the costs, quality, and access to services of other PACE providers.

(b) REPORT.—

(1) IN GENERAL.—Not later than 4 years after the date of the enactment of this Act, the Secretary shall provide for a report to Congress on the impact of such amendments on quality and cost of services. The Secretary shall include in such report such recommendations for changes in the operation of such amendments as the Secretary deems appropriate.

(2) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.—The report shall include specific findings on whether any of the following findings is true:

(A) The number of covered lives enrolled with entities operating under demonstration project waivers under section 1932(h) of the Social Security Act is fewer than 800 (or such lesser number as the Secretary may find statistically sufficient to make determinations respecting findings described in the succeeding subparagraphs).

(B) The population enrolled with such entities is less frail than the population enrolled with other PACE providers.

(C) Access to or quality of care for individuals enrolled with such entities is lower than such access or quality for individuals enrolled with other PACE providers.

(D) The application of such section has resulted in an increase in expenditures under the medicare or medicaid programs above the expenditures that would have been made if such section did not apply.

(c) INFORMATION INCLUDED IN ANNUAL RECOMMENDATIONS.—The Physician Payment Review Commission shall include in its annual recommendations under section 1845(b) of the Social Security Act (42 U.S.C. 1395w–1), and the Prospective Payment Review Commission shall include in its annual recommendations reported under section 1886(e)(3)(A) of such Act (42 U.S.C. 1395ww(e)(3)(A)), recommendations on the methodology and level of payments made to PACE providers under section 1894(d) of such Act and on the treatment of private, for-profit entities as PACE providers. References in the preceding sentence to the Physician Payment Review Commission and the Prospective Payment Review Commission shall be deemed to be references to the Medicare Payment Advisory Commission (MedPAC) established under section 5022(a) after the termination of the Physician Payment Review Commission and the Prospective Payment Review Commission provided for in section 5022(c)(2).

CHAPTER 4—MEDICAID MANAGEMENT AND PROGRAM REFORMS

SEC. 5751. ELIMINATION OF REQUIREMENT TO PAY FOR PRIVATE INSURANCE.

(a) REPEAL OF STATE PLAN PROVISION.—Section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) is amended—

(1) by striking subparagraph (G); and

(2) by redesignating subparagraphs (H) and (I) as subparagraphs (G) and (H), respectively.

(b) REPEAL OF ENROLLMENT REQUIREMENTS.—Section 1906 (42 U.S.C. 1396e) is repealed.

(c) REINSTATEMENT OF STATE OPTION.—Section 1905(a) (42 U.S.C. 1396a(a)) is amended, in the matter preceding clause (i), by inserting ''(including, at State option, through purchase or payment of enrollee costs of health insurance)'' after ''The term 'medical assistance' means payment''.

SEC. 5752. ELIMINATION OF OBSTETRICAL AND PEDIATRIC PAYMENT RATE REQUIREMENTS.

(a) IN GENERAL.—Section 1926 (42 U.S.C. 1396r–7) is repealed.

(b) EFFECTIVE DATE.—The repeal made by subsection (a) shall apply to services furnished on or after October 1, 1997.

SEC. 5753. PHYSICIAN QUALIFICATION REQUIREMENTS.

(a) IN GENERAL.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended by striking paragraph (12).

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

SEC. 5754. EXPANDED COST-SHARING REQUIREMENTS.

Section 1916 (42 U.S.C. 1396o) is amended by adding at the end the following:

''(g)(1) Notwithstanding any other provision of this title, the State plan may impose cost-sharing with respect to any medical assistance provided to an individual who is not described in section 1902(a)(10)(A)(i) in accordance with the provisions of this subsection, except that no cost-sharing may be imposed with respect to medical assistance provided to an individual who has not attained age 18 if such individual's family income does not exceed 150 percent of the poverty line applicable to a family of the size involved, and if, as of the date of enactment of the Balanced Budget Act of 1997, cost-sharing could not be imposed with respect to medical assistance provided to such individual.

''(2) Any cost-sharing imposed under this subsection shall be pursuant to a public schedule and shall reflect such economic factors, employment status, and family size with respect to each such individual as the State determines appropriate.

''(3) In the case of any family whose income is less than 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved, the total annual amount of cost-sharing that may be imposed for such family shall not exceed 3 percent of the family's average gross monthly earnings (less the average monthly costs for such child care as is necessary for the employment of the caretaker relative) for such period.

''(4) In the case of any family whose income exceeds 150 percent, but does not exceed 200 percent of, such poverty line, paragraph (3) shall be applied by substituting '5 percent' for '3 percent'.

''(5) Nothing in this subsection shall be construed as preventing a State from imposing cost-sharing with respect to individuals eligible for medical assistance under the State plan, or with respect to items or services provided as medical assistance under such plan, if the provisions of this title otherwise allow the State to do so or if the State has received a waiver that authorizes such cost-sharing.

''(6) Any cost-sharing imposed under this subsection may not be included in determining the amount of the State percentage required for reimbursement of expenditures under a State plan under this title.

''(7) In this subsection, the term 'cost-sharing' includes copayments, deductibles, coinsurance, enrollment fees, premiums, and other charges for the provision of health care services.''.

SEC. 5755. PENALTY FOR FRAUDULENT ELIGIBILITY.

Section 1128B(a) (42 U.S.C. 1320a–7b(a)), as amended by section 217 of the Health Insurance Portability and Accountability Act of 1996, is amended—

(1) by amending paragraph (6) to read as follows:

''(6) for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c),''; and

(2) in clause (ii) of the matter following such paragraph, by striking ''failure, or conversion by any other person'' and inserting ''failure, conversion, or provision of counsel or assistance by any other person''.

SEC. 5756. ELIMINATION OF WASTE, FRAUD, AND ABUSE.

(a) BAN ON SPENDING FOR NONHEALTH RELATED ITEMS.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(1) in paragraphs (2) and (15), by striking the period at the end and inserting ''; or'';

(2) in paragraphs (10)(B), (11), and (13), by adding ''or'' at the end; and

(3) by inserting after paragraph (15), the following:

''(16) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under a State plan under this title.''.

(b) DISCLOSURE OF INFORMATION AND SURETY BOND REQUIREMENT FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.—

(1) REQUIREMENT.—Section 1902(a) (42 U.S.C. 1396a(a)), is amended—

(A) by striking ''and'' at the end of paragraph (62);

(B) by striking the period at the end of paragraph (63) and inserting ''; and''; and

(C) by inserting after paragraph (63) the following:

''(64) provide that the State shall not issue or renew a provider number for a supplier of medical assistance consisting of durable medical equipment, as defined in section 1861(n), for purposes of payment under this part for such assistance that is furnished by the supplier, unless the supplier provides the State agency on a continuing basis with—

''(A)(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1124(a)(3)) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest; and

(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1124(a)(2)) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity; and

''(B) a surety bond in a form specified by the State and in an amount that is not less than $50,000.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to suppliers of medical assistance consisting of durable medical equipment furnished on or after January 1, 1998.

(c) SURETY BOND REQUIREMENT FOR HOME HEALTH AGENCIES.—

(1) IN GENERAL.—Section 1905(a)(7) (42 U.S.C. 1396d(a)(7) is amended by inserting '', provided that the agency or organization providing such services provides the State agency on a continuing basis with a surety bond in a form specified by the State and in an amount that is not less than $50,000'' after ''services''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to home health agencies with respect to services furnished on or after January 1, 1998.

(d) CONFLICT OF INTEREST SAFEGUARDS.—Section 1902(a)(4) (42 U.S.C. 1396a(a)(4)) is amended to read as follows:

''(4) provide—

''(A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

''(B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency; and

''(C) that each State or local officer or employee, or independent contractor—

''(i) who is responsible for the expenditure of substantial amounts of funds under the State plan, or who is responsible for administering the State plan under this title, each individual who formerly was such an officer, employee, or independent contractor, and each partner of such an officer, employee, or independent contractor shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of title 18, United States Code; and

''(ii) who is responsible for selecting, awarding, or otherwise obtaining items and services under the State plan shall be subject to safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) to persons described in subsection (a)(2) of such section of that Act;''.

(e) AUTHORITY TO REFUSE TO ENTER INTO MEDICAID AGREEMENTS WITH INDIVIDUALS OR ENTITIES CONVICTED OF FELONIES.—Section 1902(a)(23) (42 U.S.C. 1396a(a)(23)) is amended to read as follows:

''(23) provide that—

''(A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services; and

''(B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1915(b)(1)), a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1905(a)(4)(C), except as provided in subsection (g) and in section 1915, except in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for items or services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interest of beneficiaries under the State plan;''.

(f) MONITORING PAYMENTS FOR DUAL ELIGIBLES.—The Administrator of the Health Care Financing Administration shall—

(1) develop mechanisms to better monitor and prevent inappropriate payments under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) in the case of individuals who are dually eligible for benefits under such program and under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.);

(2) study the use of case management or care coordination in order to improve the appropriateness of care, quality of care, and cost effectiveness of care for individuals who are dually eligible for benefits under such programs; and

(3) work with the States to ensure better care coordination for dual eligibles and make recommendations to Congress as to any statutory changes that would not compromise beneficiary protections and that would improve or facilitate such care.

(g) BENEFICIARY AND PROGRAM PROTECTION AGAINST WASTE, FRAUD, AND ABUSE.—Section 1902(a) (42 U.S.C. 1396a(a)), as amended by subsection (b)(1), is amended—

(1) by striking ''and'' at the end of paragraph (63);

(2) by striking the period at the end of paragraph (64) and inserting ''; and''; and

(3) by inserting after paragraph (64) the following:

''(65) provide programs—

''(A) to ensure program integrity, protect and advocate on behalf of individuals, and to report to the State data concerning beneficiary concerns and complaints and instances of beneficiary abuse or program waste or fraud by managed care plans operating in the State under contact with the State agency;

''(B) to provide assistance to beneficiaries, with particular emphasis on the families of special needs children and persons with disabilities to—

''(i) explain the differences between managed care and fee-for-service plans;

''(ii) clarify the coverage for such beneficiaries under any managed care plan offered under the State plan under this title;

''(iii) explain the implications of the choices between competing plans;

''(iv) assist such beneficiaries in understanding their rights under any managed care plan offered under the State plan, including their right to—

''(I) access and benefits;

''(II) nondiscrimination;

''(III) grievance and appeal mechanisms; and

''(IV) change plans, as designated in the State plan; and

''(v) exercise the rights described in clause (iv); and

''(C) to collect and report to the State data on the number of complaints or instances identified under subparagraph (A) and to report to the State annually on any systematic problems in the implementation of managed care entities contracting with the State under the State plan under this title.''.

SEC. 5757. STUDY ON EPSDT BENEFITS.

(a) STUDY.—The Secretary of Health and Human Services, in consultation with Governors, directors of State medicaid and State maternal and child programs, the Institute of Medicine, the American Academy of Pediatrics, and representatives of beneficiaries under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) shall conduct a study of the early and periodic screening, diagnostic, and treatment services provided under State plans under title XIX of the Social Security Act in accordance with section 1905(r) of such Act (42 U.S.C. 1396d(r)).

(b) REPORT.—Not later than 12 months after the date of enactment of this Act, the Secretary of Health and Human Services shall submit a report to Congress on the results of the conducted study under subsection (a).

SEC. 5758. STUDY AND GUIDELINES REGARDING MANAGED CARE ORGANIZATIONS AND INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS.

(a) STUDY AND RECOMMENDATIONS.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), in consultation with States, managed care organizations, the National Academy of State Health Policy, representatives of beneficiaries with special health care needs, experts in specialized health care, and others, shall conduct a study and develop the guidelines described in subsection (b). Not later than 2 years after the date of enactment of this Act, the Secretary shall report such guidelines to Congress and make recommendations for implementing legislation.

(b) GUIDELINES DESCRIBED.—The guidelines to be developed by the Secretary shall relate to issues such as risk adjustment, solvency, medical necessity definitions, case management, quality controls, adequacy of provider networks, access to specialists (including pediatric specialists and the use of specialists as primary care providers), marketing, compliance with the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), speedy grievance and appeals procedures, data collection, and such other matters as the Secretary may determine, as these issues affect care provided to individuals with special health care needs and chronic conditions in capitated managed care or primary care case management plans. The Secretary shall distinguish which guidelines should apply to primary care case management arrangements, to capitated risk sharing arrangements, or to both. Such guidelines should be designed to be used in reviewing State proposals under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (by waiver request or State plan amendment) to implement mandatory capitated managed care or primary care case management arrangements that enroll beneficiaries with chronic conditions or special health care needs.

CHAPTER 5—MISCELLANEOUS

SEC. 5761. INCREASED FMAPS.

Section 1905(b) (42 U.S.C. 1396d(b)(1)) is amended—

(1) by striking ''and (2)'' and inserting ''(2)''; and

(2) by striking the period and inserting '', and (3) during the period beginning on October 1, 1997, and ending on September 30, 2000, the Federal medical assistance percentage for the District of Columbia shall be 60 per centum, and the Federal medical assistance percentage for Alaska shall be 59.8 per centum (but only, in the case of such States, with respect to expenditures under a State plan under this title).''.

SEC. 5762. INCREASE IN PAYMENT CAPS FOR TERRITORIES.

Section 1108 (42 U.S.C. 1308) is amended—

(1) in subsection (f), by striking ''The'' and inserting ''Subject to subsection (g), the''; and

(2) by adding at the end the following:

''(g) MEDICAID PAYMENTS TO TERRITORIES FOR FISCAL YEAR 1998 AND THEREAFTER.—

''(1) FISCAL YEAR 1998.—With respect to fiscal year 1998, the amounts otherwise determined for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa under subsection (f) for such fiscal year shall be increased in the following manner:

''(A) For Puerto Rico, $30,000,000.

''(B) For the Virgin Islands, $750,000.

''(C) For Guam, $750,000.

''(D) For the Northern Mariana Islands, $500,000.

''(E) For American Samoa, $500,000.

''(2) FISCAL YEAR 1999 AND THEREAFTER.—Notwithstanding subsection (f), with respect to fiscal year 1999 and any fiscal year thereafter, the total amount certified by the Secretary under title XIX for payment to—

''(A) Puerto Rico shall not exceed the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase in the medical care component of the consumer price index for all urban consumers (as published by the Bureau of Labor Statistics) for the twelve-month period ending in March preceding the beginning of the fiscal year, rounded to the nearest $100,000;

''(B) the Virgin Islands shall not exceed the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase referred to in subparagraph (A), rounded to the nearest $10,000;

''(C) Guam shall not exceed the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase referred to in subparagraph (A), rounded to the nearest $10,000;

''(D) Northern Mariana Islands shall not exceed the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase referred to in subparagraph (A), rounded to the nearest $10,000; and

''(E) American Samoa shall not exceed the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase referred to in subparagraph (A), rounded to the nearest $10,000.''.

SEC. 5763. COMMUNITY-BASED MENTAL HEALTH SERVICES.

(a) IN GENERAL.—Section 1905(a) (42 U.S.C. 1396d(a)), as amended by section 5741(a)(1), is amended—

(1) by striking ''and'' at the end of paragraph (26);

(2) by redesignating paragraph (27) as paragraph (28); and

(3) by inserting after paragraph (26) the following new paragraph:

''(27) outpatient and intensive community-based mental health services, including psychiatric rehabilitation, day treatment, intensive in-home services for children, assertive community treatment, therapeutic out-of-home placements (excluding room and board), clinic services, partial hospitalization, and targeted case management; and''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1902(a)(10)(C)(iv) (42 U.S.C. 1396a(a)(10)(C)(iv)), as amended by section 5702(a)(2)(A), is amended by inserting ''or (27)'' after ''(25)''.

(2) Section 1902(j) (42 U.S.C. 1396a(j)), as amended by section 5741(b)(1), is amended by striking ''(27)'' and inserting ''(28)''.

SEC. 5764. OPTIONAL MEDICAID COVERAGE OF CERTAIN CDC-SCREENED BREAST CANCER PATIENTS.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—Section 1902(a)(10)(A)(ii) (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

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

(2) in subclause (XII), by adding ''or'' at the end; and

(3) by adding at the end the following:

''(XIII) who are described in subsection (aa)(1)(relating to certain CDC-screened breast cancer patients);''.

(b) GROUP AND BENEFIT DESCRIBED.—Section 1902 (42 U.S.C. 1396a) is amended by adding at the end the following:

''(aa)(1) Individuals described in this paragraph are individuals not described in subsection (a)(10)(A)(i) who—

''(A) have not attained age 65;

''(B) have been diagnosed with breast cancer through participation in the program to screen women for breast and cervical cancer conducted by the Director of the Centers for Disease Control and Prevention under title 15 of the Public Health Service Act (42 U.S.C. 300k et seq.);

''(C) satisfy the income and resource eligibility criteria established by such Director for participation in such program; and

''(D) are not otherwise eligible for medical assistance under the State plan under this title.

''(2) For purposes of subsection (a)(10), the term ''breast cancer-related services'' means

each of the following services relating to treatment of breast cancer:

''(A) Prescribed drugs.

''(B) Physicians' services and services described in section 1905(a)(2).

''(C) Laboratory and X-ray services (including services to confirm the presence of breast cancer).

''(D) Rural health clinic services and Federally-qualified health center services.

''(E) Case management services (as defined in section 1915(g)(2)).

''(F) Services (other than room and board) designed to encourage completion of regimens of prescribed drugs by outpatients, including services to observe directly the intake of prescribed drugs.''.

(c) LIMITATION ON BENEFITS.—Section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (F)—

(1) by striking '', and (XIII)''; and

(2) by inserting before the semicolon at the end the following: '', and (XIV) the medical assistance made available to an individual described in subsection (aa)(1) who is eligible for medical assistance only because of subparagraph (A)(ii)(XIII) shall be limited to medical assistance for breast cancer-related services (described in subsection (aa)(2))''.

(d) CONFORMING AMENDMENTS.—

(1) Section 1905(a) (42 U.S.C. 1396d(a)) is amended—

(A) in clause (x), by striking ''or'' at the end;

(B) in clause (xi), by adding ''or'' at the end;

(C) by inserting after clause (xi) the following:

''(xii) individuals described in section 1902(aa)(1),''; and

(D) by striking paragraph (19) and inserting the following:

''(19) case management services (as defined in section 1915(g)(2)), TB-related services described in section 1902(z)(2)(F), and breast cancer-related services described in section 1902)(2)(F);''.

(2) Section 1915(g)(1) (42 U.S.C. 1396n(g)(1)) is amended by inserting ''or section 1902(aa)(1)'' after ''section 1902(z)(1)(A)''.

(e) EFFECTIVE DATE.—The amendments made by this section apply to medical assistance furnished on or after October 1, 1997, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 5765. TREATMENT OF STATE TAXES IMPOSED ON CERTAIN HOSPITALS THAT PROVIDE FREE CARE.

(a) EXCEPTION FROM TAX DOES NOT DISQUALIFY AS BROAD-BASED TAX.—Section 1903(w)(3) (42 U.S.C. 1396b(w)(3)) is amended—

(1) in subparagraph (B), by striking ''and (E)'' and inserting ''(E), and (F)''; and

(2) by adding at the end the following:

''(F) In no case shall a tax not qualify as a broad-based health care related tax under this paragraph because it does not apply to a hospital that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code and that does not accept payment under the State plan under this title or under title XVIII.''.

(b) REDUCTION IN FEDERAL FINANCIAL PARTICIPATION IN CASE OF IMPOSITION OF TAX.—Section 1903(b) (42 U.S.C. 1396b(b)) is amended by adding at the end the following:

''(4) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State shall be decreased in a quarter by the amount of any health care related taxes (described in section 1902(w)(3)(A)) that are imposed on a hospital described in subsection (w)(3)(F) in that quarter.''.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to taxes imposed before, on, or after the date of the enactment of this Act and the amendment made by subsection (b) shall apply to taxes imposed on or after such date.

SEC. 5766. TREATMENT OF VETERANS PENSIONS UNDER MEDICAID.

(a) POST-ELIGIBILITY.—Section 1902(r)(1) of the Social Security Act (42 U.S.C. 1396a(r)(1)) is amended to read as follows:

''(r)(1) For purposes of sections 1902(a)(17) and 1924(d)(1)(D) and for purposes of a waiver under section 1915, with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver—

''(A) there shall be disregarded reparation payments made by the Federal Republic of Germany;

''(B) there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

''(i) medicare and other health insurance premiums, deductibles, or coinsurance, and

''(ii) necessary medical or remedial care recognized under State law but not covered under the State plan under this title, subject to reasonable limits the State may establish on the amount of these expenses; and

''(C) in the case of a resident in a State veterans home, there shall be taken into account, as income, any and all payments received under a Department of Veterans Affairs pension or compensation program, including payments attributable to the recipient's medical expenses or to the recipient's need for aid and attendance, but excluding that part of any augmented benefit attributable to a dependent.

For purposes of subparagraph (C), any Department of Veterans Affairs pension benefit that has been limited to $90 per month pursuant to section 5503(f) of title 38, United States Code, may be applied to meet the monthly personal needs allowance provided by the State plan under this title, but shall not otherwise be used to reduce the amount paid to a facility under the State plan.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall be effective with respect to periods beginning on and after July 1, 1994.

SEC. 5767. REMOVAL OF NAME FROM NURSE AIDE REGISTRY.

(a) MEDICARE.—Section 1819(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i-3(g)(1)(C)) is amended—

(1) in the first sentence by striking ''The State'' and inserting ''(i) The State''; and

(2) by adding at the end the following:

''(ii)(I) In the case of a finding of neglect, the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that—

''(aa) the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect; and

''(bb) the neglect involved in the original finding was a singular occurrence.

''(II) In no case shall a determination on a petition submitted under clause (I) be made prior to the expiration of the 1-year period beginning on the date on which the name of the petitioner was added to the registry under this subparagraph.''.

(b) MEDICAID.—Section 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1396r(g)(1)(C)) is amended—

(1) in the first sentence by striking ''The State'' and inserting ''(i) The State''; and

(2) by adding at the end the following:

''(ii)(I) In the case of a finding of neglect, the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that—

''(aa) the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect; and

''(bb) the neglect involved in the original finding was a singular occurrence.

''(II) In no case shall a determination on a petition submitted under clause (I) be made prior to the expiration of the 1-year period beginning on the date on which the name of the petitioner was added to the registry under this subparagraph.''.

(c) RETROACTIVE REVIEW.—The procedures developed by a State under the amendments made by subsection (a) and (b) shall permit an individual to petition for a review of any finding made by a State under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i-3(g)(1)(C) or 1396r(g)(1)(C)) after January 1, 1995.

(d) STUDY AND REPORT.—

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

(A) the use of nurse aide registries by States, including the number of nurse aides placed on the registries on a yearly basis and the circumstances that warranted their placement on the registries;

(B) the extent to which institutional environmental factors (such as a lack of adequate training or short staffing) contribute to cases of abuse and neglect at nursing facilities; and

(C) whether alternatives (such as a probational period accompanied by additional training or mentoring or sanctions on facilities that create an environment that encourages abuse or neglect) to the sanctions that are currently applied under the Social Security Act for abuse and neglect at nursing facilities might be more effective in minimizing future cases of abuse and neglect.

(2) REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress, a report concerning the results of the study conducted under paragraph (1) and the recommendation of the Secretary for legislation based on such study.

SEC. 5768. WAIVER OF CERTAIN PROVIDER TAX PROVISIONS.

Notwithstanding any other provision of law, taxes, fees, or assessments, as defined in section 1903(w)(3)(A) of the Social Security Act (42 U.S.C. 1396b(w)(3)(A)), that were collected by the State of New York from a health care provider before June 1, 1997, and for which a waiver of the provisions of subparagraph (B) or (C) of section 1903(w)(3) of such Act has been applied for, or that would, but for this paragraph require that such a waiver be applied for, in accordance with subparagraph (E) of such section, and, (if so applied for) upon which action by the Secretary of Health and Human Services (including any judicial review of any such proceeding) has not been completed as of the date of enactment of this Act, are deemed to be permissible health care related taxes and in compliance with the requirements of subparagraphs (B) and (C) of sections 1903(w)(3) of such Act.

SEC. 5769. CONTINUATION OF STATE-WIDE SECTION 1115 MEDICAID WAIVERS.

(a) IN GENERAL.—Section 1115 of the Social Security Act (42 U.S.C. 1315) is amended by adding at the end the following:

''(d)(1) The provisions of this subsection shall apply to the extension of statewide comprehensive research and demonstration projects (in this subsection referred to as 'waiver project') for which waivers of compliance with the requirements of title XIX are granted under subsection (a). With respect to a waiver project that, but for the enactment of this subsection, would expire, the State at its option may not later than 1 year before the waiver under subsection (a) would expire (acting through the chief executive officer of the State who is operating the project), submit to the Secretary a written request for an extension of such waiver project for up to 2 years.

''(2) The requirements of this paragraph are that the waiver project—

''(A) has been successfully operated for 5 or more years; and

''(B) has been shown, through independent evaluations sponsored by the Health Care Financing Administration, to successfully contain costs and provide access to health care.

''(3)(A) In the case of waiver projects described in paragraph (1)(A), if the Secretary fails to respond to the request within 6 months after the date on which the request was submitted, the request is deemed to have been granted.

''(B) If the request is granted or deemed to have been granted, the deadline for submittal of a final report shall be 1 year after the date on which the waiver project would have expired but for the enactment of this subsection.

''(C) The Secretary shall release an evaluation of each such project not later than 1 year after the date of receipt of the final report.

''(D) Phase-down provisions which were applicable to waiver projects before an extension was provided under this subsection shall not apply.

''(4) The extension of a waiver project under this subsection shall be on the same terms and conditions (including applicable terms and conditions related to quality and access of services, budget neutrality as adjusted for inflation, data and reporting requirements and special population protections), except for any phase down provisions, and subject to the same set of waivers that applied to the project or were granted before the extension of the project under this subsection. The permanent continuation of a waiver project shall be on the same terms and conditions, including financing, and subject to the same set of waivers. No test of budget neutrality shall be applied in the case of projects described in paragraph (2) after that date on which the permanent extension was granted.

''(5) In the case of a waiver project described in paragraph (2), the Secretary, acting through the Health Care Financing Administration shall, deem any State's request to expand medicaid coverage in whole or in part to individuals who have an income at or below the Federal poverty level as budget neutral if independent evaluations sponsored by the Health Care Financing Administration have shown that the State's medicaid managed care program under such original waiver is more cost effective and efficient than the traditional fee-for-service medicaid program that, in the absence of any managed care waivers under this section, would have been provided in the State.''.

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

SEC. 5770. EFFECTIVE DATE.

(a) IN GENERAL.—Except as otherwise specifically provided, the provisions of and amendments made by this subtitle shall apply with respect to State programs under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) on and after October 1, 1997.

(b) EXTENSION FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this subtitle, the State plan shall not be regarded as failing to comply with the requirements of this subtitle solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

Subtitle J—Children's Health Insurance Initiatives

SEC. 5801. ESTABLISHMENT OF CHILDREN'S HEALTH INSURANCE INITIATIVES.

(a) IN GENERAL.—The Social Security Act is amended by adding at the end the following:

''TITLE XXI—CHILD HEALTH INSURANCE INITIATIVES

''SEC. 2101. PURPOSE.

''The purpose of this title is to provide funds to States to enable such States to expand the provision of health insurance coverage for low-income children. Funds provided under this title shall be used to achieve this purpose through outreach activities described in section 2106(a) and, at the option of the State through—

''(1) a grant program conducted in accordance with section 2107 and the other requirements of this title; or

''(2) expansion of coverage of such children under the State medicaid program who are not required to be provided medical assistance under section 1902(l) (taking into account the process of individuals aging into eligibility under subsection (l)(1)(D)).

''SEC. 2102. DEFINITIONS.

''In this title:

''(1) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—The term 'base-year covered low-income child population' means the total number of low-income children with respect to whom, as of fiscal year 1996, an eligible State provides or pays the cost of health benefits either through a State funded program or through expanded eligibility under the State plan under title XIX (including under a waiver of such plan), as determined by the Secretary. Such term does not include any low-income child described in paragraph (3)(A) that a State must cover in order to be considered an eligible State under this title.

''(2) CHILD.—The term 'child' means an individual under 19 years of age.

''(3) ELIGIBLE STATE.—The term 'eligible State' means, with respect to a fiscal year, a State that—

''(A) provides, under section 1902(l)(1)(D) or under a waiver, for eligibility for medical assistance under a State plan under title XIX of individuals under 17 years of age in fiscal year 1998, and under 19 years of age in fiscal year 2000, regardless of date of birth;

''(B) has submitted to the Secretary under section 2104 a program outline that—

''(i) sets forth how the State intends to use the funds provided under this title to provide health insurance coverage for low-income children consistent with the provisions of this title; and

''(ii) is approved under section 2104; and

''(iii) otherwise satisfies the requirements of this title; and

''(C) satisfies the maintenance of effort requirement described in section 2105(c)(5).

''(4) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' means, with respect to a State, the meaning given that term under section 1905(b). Any cost-sharing imposed under this title may not be included in determining Federal medical assistance percentage for reimbursement of expenditures under a State program funded under this title.

''(5) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The term 'FEHBP-equivalent children's health insurance coverage' means, with respect to a State, any plan or arrangement that provides, or pays the cost of, health benefits that the Secretary has certified are equivalent to or better than the services covered for a child, including hearing and vision services, under the standard Blue Cross/Blue Shield preferred provider option service benefit plan offered under chapter 89 of title 5, United States Code.

''(6) INDIANS.—The term 'Indians' has the meaning given that term in section 4(c) of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(7) LOW-INCOME CHILD.—The term 'low-income child' means a child in a family whose income is below 200 percent of the poverty line for a family of the size involved.

''(8) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

''(9) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(10) STATE.—The term 'State' means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands.

''(11) STATE CHILDREN'S HEALTH EXPENDITURES.—The term 'State children's health expenditures' means the State share of expenditures by the State for providing children with health care items and services under—

''(A) the State plan for medical assistance under title XIX;

''(B) the maternal and child health services block grant program under title V;

''(C) the preventive health services block grant program under part A of title XIX of the Public Health Services Act (42 U.S.C. 300w et seq.);

''(D) State-funded programs that are designed to provide health care items and services to children;

''(E) school-based health services programs;

''(F) State programs that provide uncompensated or indigent health care;

''(G) county-indigent care programs for which the State requires a matching share by a county government or for which there are intergovernmental transfers from a county to State government; and

''(H) any other program under which the Secretary determines the State incurs uncompensated expenditures for providing children with health care items and services.

''(12) STATE MEDICAID PROGRAM.—The term 'State medicaid program' means the program of medical assistance provided under title XIX.

''SEC. 2103. APPROPRIATION.

''(a) APPROPRIATION.—

''(1) IN GENERAL.—Subject to subsection (b), out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated for the purpose of carrying out this title—

''(A) for fiscal year 1998, $2,500,000,000;

''(B) for each of fiscal years 1999 and 2000, $3,200,000,000;

''(C) for fiscal year 2001, $3,600,000,000;

''(D) for fiscal year 2002, $3,500,000,000;

''(E) for each of fiscal years 2003 through 2007, $4,580,000,000.

''(2) AVAILABILITY.—Funds appropriated under this section shall remain available without fiscal year limitation, as provided under section 2105(b)(4).

''(b) REDUCTION FOR INCREASED MEDICAID EXPENDITURES.—With respect to each of the fiscal years described in subsection (a)(1), the amount appropriated under subsection (a)(1) for each such fiscal year shall be reduced by an amount equal to the amount of the total Federal outlays under the medicaid program under title XIX resulting from—

''(1) the amendment made by section 5732 of the Balanced Budget Act of 1997 (regarding the State option to provide 12-month continuous eligibility for children);

''(2) increased enrollment under State plans approved under such program as a result of outreach activities under section 2106(a); and

''(3) the requirement under section 2102(3)A) to provide eligibility for medical assistance under the State plan under title XIX for all children under 19 years of age who have families with income that is at or below the poverty line.

''(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided in accordance with the provisions of this title.

''(d) EFFECTIVE DATE.—No State is eligible for payments under section 2105 for any calendar quarter beginning before October 1, 1997.

"SEC. 2104. PROGRAM OUTLINE.

"(a) GENERAL DESCRIPTION.—A State shall submit to the Secretary for approval a program outline, consistent with the requirements of this title, that—

"(1) identifies, on or after the date of enactment of the Balanced Budget Act of 1997, which of the 2 options described in section 2101 the State intends to use to provide low-income children in the State with health insurance coverage;

"(2) describes the manner in which such coverage shall be provided; and

"(3) provides such other information as the Secretary may require.

"(b) OTHER REQUIREMENTS.—The program outline submitted under this section shall include the following:

"(1) ELIGIBILITY STANDARDS AND METHODOLOGIES.—A summary of the standards and methodologies used to determine the eligibility of low-income children for health insurance coverage under a State program funded under this title.

"(2) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE.—A description of the procedures to be used to ensure—

"(A) through both intake and followup screening, that only low-income children are furnished health insurance coverage through funds provided under this title; and

"(B) that any health insurance coverage provided for children through funds under this title does not reduce the number of children who are provided such coverage through any other publicly or privately funded health plan.

"(3) INDIANS.—A description of how the State will ensure that Indians are served through a State program funded under this title.

"(c) DEADLINE FOR SUBMISSION.—A State program outline shall be submitted to the Secretary by not later than March 31 of any fiscal year (October 1, 1997, in the case of fiscal year 1998).

"SEC. 2105. DISTRIBUTION OF FUNDS.

"(a) ESTABLISHMENT OF FUNDING POOLS.—

"(1) IN GENERAL.—From the amount appropriated under section 2103(a)(1) for each fiscal year, determined after the reduction required under section 2103(b), the Secretary shall, for purposes of fiscal year 1998, reserve 85 percent of such amount for distribution to eligible States through the basic allotment pool under subsection (b) and 15 percent of such amount for distribution through the new coverage incentive pool under subsection (c)(2)(B)(ii).

"(2) ANNUAL ADJUSTMENT OF RESERVE PERCENTAGES.—The Secretary shall annually adjust the amount of the percentages described in paragraph (1) in order to provide sufficient basic allotments and sufficient new coverage incentives to achieve the purpose of this title.

"(b) DISTRIBUTION OF FUNDS UNDER THE BASIC ALLOTMENT POOL.—

"(1) STATES.—

"(A) IN GENERAL.—From the total amount reserved under subsection (a) for a fiscal year for distribution through the basic allotment pool, the Secretary shall first set aside 0.25 percent for distribution under paragraph (2) and shall allot from the amount remaining to each eligible State not described in such paragraph the State's allotment percentage for such fiscal year.

"(B) STATE'S ALLOTMENT PERCENTAGE.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the allotment percentage for a fiscal year for each State is the percentage equal to the ratio of the number of low-income children in the base period in the State to the total number of low-income children in the base period in all States not described in paragraph (2).

"(ii) NUMBER OF LOW-INCOME CHILDREN IN THE BASE PERIOD.—In clause (i), the number of low-income children in the base period for a fiscal year in a State is equal to the average of the number of low-income children in the State for the period beginning on October 1, 1992, and ending on September 30, 1995, as reported in the March 1994, March 1995, and March 1996 supplements to the Current Population Survey of the Bureau of the Census.

"(2) OTHER STATES.—

"(A) IN GENERAL.—From the amount set aside under paragraph (1)(A) for each fiscal year, the Secretary shall make allotments for such fiscal year in accordance with the percentages specified in subparagraph (B) to Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands, if such States are eligible States for such fiscal year.

"(B) PERCENTAGES SPECIFIED.—The percentages specified in this subparagraph are in the case of—

"(i) Puerto Rico, 91.6 percent;

"(ii) Guam, 3.5 percent;

"(iii) the Virgin Islands, 2.6 percent;

"(iv) American Samoa, 1.2 percent; and

"(v) the Northern Mariana Islands, 1.1 percent.

"(3) THREE-YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

"(4) PROCEDURE FOR DISTRIBUTION OF UNUSED FUNDS.—The Secretary shall determine an appropriate procedure for distribution of funds to eligible States that remain unused under this subsection after the expiration of the availability of funds required under paragraph (3). Such procedure shall be developed and administered in a manner that is consistent with the purpose of this title.

"(c) PAYMENTS.—

"(1) IN GENERAL.—The Secretary shall—

"(A) before October 1 of any fiscal year, pay an eligible State an amount equal to 1 percent of the amount allotted to the State under subsection (b) for conducting the outreach activities required under section 2106(a); and

"(B) make quarterly fiscal year payments to an eligible State from the amount remaining of such allotment for such fiscal year in an amount equal to the Federal medical assistance percentage for the State (as defined under section 2102(4) and determined without regard to the amount of Federal funds received by the State under title XIX before the date of enactment of this title) of the Federal and State incurred cost of providing health insurance coverage for a low-income child in the State plus the applicable bonus amount.

"(2) APPLICABLE BONUS.—

"(A) IN GENERAL.—For purposes of paragraph (1), the applicable bonus amount is—

"(i) 5 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the base-year covered low-income child population (measured in full year equivalency) (including such children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title, but excluding any low-income child described in section 2102(3)(A) that a State must cover in order to be considered an eligible State under this title); and

"(ii) 10 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the number (as so measured) of low-income children that are in excess of such population.

"(B) SOURCE OF BONUSES.—

"(i) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—A bonus described in subparagraph (A)(i) shall be paid out of an eligible State's allotment for a fiscal year.

"(ii) FOR OTHER LOW-INCOME CHILD POPULATIONS.—A bonus described in subparagraph (A)(ii) shall be paid out of the new coverage incentive pool reserved under subsection (a)(1).

"(3) DEFINITION OF COST OF PROVIDING HEALTH INSURANCE COVERAGE.—For purposes of this subsection the cost of providing health insurance coverage for a low-income child in the State means—

"(A) in the case of an eligible State that opts to use funds provided under this title through the medicaid program, the cost of providing such child with medical assistance under the State plan under title XIX; and

"(B) in the case of an eligible State that opts to use funds provided under this title under section 2107, the cost of providing such child with health insurance coverage under such section.

"(4) LIMITATION ON TOTAL PAYMENTS.—With respect to a fiscal year, the total amount paid to an eligible State under this title (including any bonus payments) shall not exceed 85 percent of the total cost of a State program conducted under this title for such fiscal year.

"(5) MAINTENANCE OF EFFORT.—

"(A) DEEMED COMPLIANCE.—A State shall be deemed to be in compliance with this provision if—

"(i) it does not adopt income and resource standards and methodologies that are more restrictive than those applied as of June 1, 1997, for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX; and

"(ii) in the case of fiscal year 1998 and each fiscal year thereafter, the State children's health expenditures defined in section 2102(11) are not less than the amount of such expenditures for fiscal year 1996.

"(B) FAILURE TO MAINTAIN MEDICAID STANDARDS AND METHODOLOGIES.—A State that fails to meet the conditions described in subparagraph (A) shall not receive—

"(i) funds under this title for any child that would be determined eligible for medical assistance under the State plan under title XIX using the income and resource standards and methodologies applied under such plan as of June 1, 1997; and

"(ii) any bonus amounts described in paragraph (2)(A)(ii).

"(C) FAILURE TO MAINTAIN SPENDING ON CHILD HEALTH PROGRAMS.—A State that fails to meet the condition described in subparagraph (A)(ii) shall not receive funding under this title.

"(6) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this subsection for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and shall reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

"SEC. 2106. USE OF FUNDS.

"(a) SET-ASIDE FOR OUTREACH ACTIVITIES.—

"(1) IN GENERAL.—From the amount allotted to a State under section 2105(b) for a fiscal year, each State shall conduct outreach activities described in paragraph (2).

"(2) OUTREACH ACTIVITIES DESCRIBED.—The outreach activities described in this paragraph include activities to—

"(A) identify and enroll children who are eligible for medical assistance under the State plan under title XIX; and

"(B) conduct public awareness campaigns to encourage employers to provide health insurance coverage for children.

"(b) STATE OPTIONS FOR REMAINDER.—A State may use the amount remaining of the allotment to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), in accordance with section 2107 or the State medicaid program (but not both). Nothing in the preceding sentence shall be construed as limiting a State's eligibility for receiving the 5 percent bonus described in section 2105(c)(2)(A)(i) for children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title.

"(c) PROHIBITION ON USE OF FUNDS.—No funds provided under this title may be used to provide health insurance coverage for—

''(1) families of State public employees; or

''(2) children who are committed to a penal institution.

''(d) USE LIMITED TO STATE PROGRAM EXPENDITURES.—Funds provided to an eligible State under this title shall only be used to carry out the purpose of this title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

''(e) ADMINISTRATIVE EXPENDITURES.—

''(1) IN GENERAL.—Not more than the applicable percentage of the amount allotted to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), shall be used for administrative expenditures for the program funded under this title.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage with respect to a fiscal year is—

''(A) for the first 2 years of a State program funded under this title, 10 percent;

''(B) for the third year of a State program funded under this title, 7.5 percent; and

''(C) for the fourth year of a State program funded under this title and each year thereafter, 5 percent.

''(f) NONAPPLICATION OF FIVE-YEAR LIMITED ELIGIBILITY FOR MEANS-TESTED PUBLIC BENEFITS.—The provisions of section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613) shall not apply with respect to a State program funded under this title.

''(g) AUDITS.—The provisions of section 506(b) shall apply to funds expended under this title to the same extent as they apply to title V.

''(h) REQUIREMENT TO FOLLOW STATE PROGRAM OUTLINE.—The State shall conduct the program in accordance with the program outline approved by the Secretary under section 2104.

''SEC. 2107. STATE OPTION FOR THE PURCHASE OR PROVISION OF CHILDREN'S HEALTH INSURANCE.

''(a) STATE OPTION.—

''(1) IN GENERAL.—An eligible State that opts to use funds provided under this title under this section shall use such funds to provide FEHBP-equivalent children's health insurance coverage for low-income children who reside in the State.

''(2) PRIORITY FOR LOW-INCOME CHILDREN.—A State that uses funds provided under this title under this section shall not cover low-income children with higher family income without covering such children with a lower family income.

''(3) DETERMINATION OF ELIGIBILITY AND FORM OF ASSISTANCE.—An eligible State may establish any additional eligibility criteria for the provision of health insurance coverage for a low-income child through funds provided under this title, so long as such criteria and assistance are consistent with the purpose and provisions of this title.

''(4) AFFORDABILITY.—An eligible State may impose any family premium obligations or cost-sharing requirements otherwise permitted under this title on low-income children with family incomes that exceed 150 percent of the poverty line. In the case of a low-income child whose family income is at or below 150 percent of the poverty line, limits on beneficiary costs generally applicable under title XIX apply to coverage provided such children under this section.

''(b) NONENTITLEMENT.—Nothing in this section shall be construed as providing an entitlement for an individual or person to any health insurance coverage, assistance, or service provided through a State program funded under this title. If, with respect to a fiscal year, an eligible State determines that the funds provided under this title are not sufficient to provide health insurance coverage for all the low-income children that the State proposes to cover in the State program outline submitted under section 2104 for such fiscal year, the State may adjust the applicable eligibility criteria for such children appropriately or adjust the State program in another manner specified by the Secretary, so long as any such adjustments are consistent with the purpose of this title.

''SEC. 2108. PROGRAM INTEGRITY.

''The following provisions of the Social Security Act shall apply to eligible States under this title in the same manner as such provisions apply to a State under title XIX:

''(1) Section 1116 (relating to administrative and judicial review).

''(2) Section 1124 (relating to disclosure of ownership and related information).

''(3) Section 1126 (relating to disclosure of information about certain convicted individuals).

''(4) Section 1128 (relating to exclusion from individuals and entities from participation in State health care plans).

''(5) Section 1128A (relating to civil monetary penalties).

''(6) Section 1128B (relating to criminal penalties).

''(7) Section 1132 (relating to periods within which claims must be filed).

''(8) Section 1902(a)(4)(C) (relating to conflict of interest standards).

''(9) Section 1903(i) (relating to limitations on payment).

''(10) Section 1903(m)(5) (as in effect on the day before the date of enactment of the Balanced Budget Act of 1997).

''(11) Section 1903(w) (relating to limitations on provider taxes and donations).

''(12) Section 1905(a)(B) (relating to the exclusion of care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases from the definition of medical assistance).

''(13) Section 1921 (relating to state licensure authorities).

''(14) Sections 1902(a)(25), 1912(a)(1)(A), and 1903(o) (insofar as such sections relate to third party liability).

''(15) Sections 1948 and 1949 (as added by section 5701(a)(2) of the Balanced Budget Act of 1997).

''SEC. 2109. ANNUAL REPORTS.

''(a) ANNUAL STATE ASSESSMENT OF PROGRESS.—An eligible State shall—

''(1) assess the operation of the State program funded under this title in each fiscal year, including the progress made in providing health insurance coverage for low-income children; and

''(2) report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

''(b) REPORT OF THE SECRETARY.—The Secretary shall submit to the appropriate committees of Congress an annual report and evaluation of the State programs funded under this title based on the State assessments and reports submitted under subsection (a). Such report shall include any conclusions and recommendations that the Secretary considers appropriate.''.

(b) CONFORMING AMENDMENT.—Section 1128(h) (42 U.S.C. 1320a–7(h)) is amended by—

(1) in paragraph (2), by striking ''or'' at the end;

(2) in paragraph (3), by striking the period and inserting '', or''; and

(3) by adding at the end the following:

''(4) a program funded under title XXI.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply on and after October 1, 1997.

DIVISION 3—INCOME SECURITY AND OTHER PROVISIONS

Subtitle K—Income Security, Welfare-to-Work Grant Program, and Other Provisions

CHAPTER 1—INCOME SECURITY

SEC. 5811. SSI ELIGIBILITY FOR ALIENS RECEIVING SSI ON AUGUST 22, 1996.

(a) IN GENERAL.—Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding after subparagraph (D) the following new subparagraph:

''(E) ALIENS RECEIVING SSI ON AUGUST 22, 1996.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to an alien who is lawfully residing in any State and who was receiving such benefits on August 22, 1996.''.

(b) STATUS OF CUBAN AND HAITIAN ENTRANTS.—For purposes of section 402(a)(2)(E) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(E)), an alien who is a Cuban and Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980, shall be considered a qualified alien.

(c) CONFORMING AMENDMENTS.—Section 402(a)(2)(D) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(D)) is amended—

(1) by striking clause (i);

(2) in the subparagraph heading by striking ''BENEFITS'' and inserting ''FOOD STAMPS'';

(3) by striking ''(ii) FOOD STAMPS''; and

(4) by redesignating subclauses (I), (II), and (III) as clauses (i), (ii), and (iii).

SEC. 5812. EXTENSION OF ELIGIBILITY PERIOD FOR REFUGEES AND CERTAIN OTHER QUALIFIED ALIENS FROM 5 TO 7 YEARS FOR SSI AND MEDICAID.

(a) SSI.—Section 402(a)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A)) is amended to read as follows:

''(A) TIME-LIMITED EXCEPTION FOR REFUGEES AND ASYLEES.—

''(i) SSI.—With respect to the specified Federal program described in paragraph (3)(A) paragraph 1 shall not apply to an alien until 7 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act; or

''(III) an alien's deportation is withheld under section 243(h) of such Act.

''(ii) FOOD STAMPS.—With respect to the specified Federal program described in paragraph (3)(B), paragraph 1 shall not apply to an alien until 5 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act; or

''(III) an alien's deportation is withheld under section 243(h) of such Act.''.

(b) MEDICAID.—Section 402(b)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)(A)) is amended to read as follows:

''(A) TIME-LIMITED EXCEPTION FOR REFUGEES AND ASYLEES.—

''(i) MEDICAID.—With respect to the designated Federal program described in paragraph (3)(C), paragraph 1 shall not apply to an alien until 7 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act; or

''(III) an alien's deportation is withheld under section 243(h) of such Act.

''(ii) OTHER DESIGNATED FEDERAL PROGRAMS.—With respect to the designated Federal programs under paragraph (3) (other than subparagraph (C)), paragraph 1 shall not apply to an alien until 5 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act; or

''(III) an alien's deportation is withheld under section 243(h) of such Act.''.

(c) STATUS OF CUBAN AND HAITIAN ENTRANTS.—For purposes of sections 402(a)(2)(A) and 402(b)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A), (b)(2)(A)), an alien who is a Cuban and Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980, shall be considered a refugee.

SEC. 5813. EXCEPTIONS FOR CERTAIN INDIANS FROM LIMITATION ON ELIGIBILITY FOR SUPPLEMENTAL SECURITY INCOME AND MEDICAID BENEFITS.

(a) EXCEPTION FROM LIMITATION ON SSI ELIGIBILITY.—Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended—

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

(2) by inserting after subparagraph (C) the following:

''(D) SSI EXCEPTION FOR CERTAIN INDIANS.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to any individual—

''(i) who is an American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (8 U.S.C. 1358) apply; or

''(ii) who is a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)).''.

(b) EXCEPTION FROM LIMITATION ON MEDICAID ELIGIBILITY.—Section 402(b)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended—

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

(2) by inserting after subparagraph (C) the following:

''(D) MEDICAID EXCEPTION FOR CERTAIN INDIANS.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the medicaid program), paragraph (1) shall not apply to any individual described in subsection (a)(2)(D).''.

(c) SSI AND MEDICAID EXCEPTIONS FROM LIMITATION ON ELIGIBILITY OF NEW ENTRANTS.—Section 403(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613(b)) is amended by adding at the end the following:

''(3) SSI AND MEDICAID EXCEPTION FOR CERTAIN INDIANS.—An individual described in section 402(a)(2)(D), but only with respect to the programs specified in subsections (a)(3)(A) and (b)(3)(C) of section 402.''.

(d) EFFECTIVE DATE.—

(1) SECTION 402.—The amendments made by subsections (a) and (b) shall take effect as though they had been included in the enactment of section 402 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(2) SECTION 403.—The amendment made by subsection (c) shall take effect as though they had been included in the enactment of section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

SEC. 5814. SSI ELIGIBILITY FOR DISABLED LEGAL ALIENS IN THE UNITED STATES ON AUGUST 22, 1996.

Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) (as amended by section 5813) is amended by adding at the end the following:

''(G) DISABLED ALIENS LAWFULLY RESIDING IN THE UNITED STATES ON AUGUST 22, 1996.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to an alien who—

''(i) is lawfully residing in any State on August 22, 1996; and

''(ii) is disabled, as defined in section 1614(a)(3) of the Social Security Act (42 U.S.C. 1382c(a)(3)).''.

SEC. 5815. EXEMPTION FROM RESTRICTION ON SUPPLEMENTAL SECURITY INCOME PROGRAM PARTICIPATION BY CERTAIN RECIPIENTS ELIGIBLE ON THE BASIS OF VERY OLD APPLICATIONS.

Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) (as amended by section 5814) is amended by adding at the end the following:

''(H) SSI EXCEPTION FOR CERTAIN RECIPIENTS ON THE BASIS OF VERY OLD APPLICATIONS.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to any individual—

''(i) who is receiving benefits under such program for months after July 1996 on the basis of an application filed before January 1, 1979; and

''(ii) with respect to whom the Commissioner of Social Security lacks clear and convincing evidence that such individual is an alien ineligible for such benefits as a result of the application of this section.''.

SEC. 5816. REINSTATEMENT OF ELIGIBILITY FOR BENEFITS.

(a) FOOD STAMPS.—The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended by adding after section 435 the following new section:

''SEC. 436. DERIVATIVE ELIGIBILITY FOR BENEFITS.

Notwithstanding any other provision of law, an alien who under the provisions of this title is ineligible for benefits under the food stamp program (as defined in section 402(a)(3)(A)) shall not be eligible for such benefits because the alien receives benefits under the supplemental security income program (as defined in section 402(a)(3)(B)).''.

(b) MEDICAID.—Section 402(b)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended by adding at the end the following:

''(E) MEDICAID EXCEPTION FOR ALIENS RECEIVING SSI.—An alien who is receiving benefits under the program defined in subsection (a)(3)(A) (relating to the supplemental security income program) shall be eligible for medical assistance under a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) under the same terms and conditions that apply to other recipients of benefits under the program defined in such subsection.''.

(c) CLERICAL AMENDMENT.—Section 2 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended by adding after the item related to section 435 the following:

''Sec. 436. Derivative eligibility for benefits.''.

SEC. 5817. EXEMPTION FOR CHILDREN WHO ARE LEGAL ALIENS FROM 5-YEAR BAN ON MEDICAID ELIGIBILITY.

Section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613)) is amended by adding at the end the following:

''(e) MEDICAID ELIGIBILITY EXEMPTION FOR CHILDREN.—The limitation under subsection (a) shall not apply to any alien who has not attained age 19 and is lawfully residing in any State, but only with respect to such alien's eligibility for medical assistance under a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).''.

SEC. 5818. TREATMENT OF CERTAIN AMERASIAN IMMIGRANTS AS REFUGEES.

(a) AMENDMENTS TO EXCEPTIONS FOR REFUGEES/ASYLEES.—

(1) FOR PURPOSES OF SSI AND FOOD STAMPS.—Section 402(a)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A)) is amended—

(A) by striking ''; or'' at the end of clause (ii);

(B) by striking the period at the end of clause (iii) and inserting ''; or''; and

(C) by adding at the end the following:

''(iv) an alien who is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in section 101(e) of Public Law 100–202 and amended by the 9th proviso under MIGRATION AND REFUGEE ASSISTANCE in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1989, Public Law 100–461, as amended).''.

(2) FOR PURPOSES OF TANF, SSBG, AND MEDICAID.—Section 402(b)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A)) is amended—

(A) by striking ''; or'' at the end of clause (ii);

(B) by striking the period at the end of clause (iii) and inserting ''; or''; and

(C) by adding at the end the following:

''(iv) an alien described in subsection (a)(2)(A)(iv) until 5 years after the date of such alien's entry into the United States.''.

(3) FOR PURPOSES OF EXCEPTION FROM 5-YEAR LIMITED ELIGIBILITY OF QUALIFIED ALIENS.—Section 403(b)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613(b)(1)) is amended by adding at the end the following:

''(D) An alien described in section 402(a)(2)(A)(iv).''.

(4) FOR PURPOSES OF CERTAIN STATE PROGRAMS.—Section 412(b)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1622(b)(1)) is amended by adding at the end the following new subparagraph:

''(D) An alien described in section 402(a)(2)(A)(iv).''.

(b) FUNDING.—

(1) LEVY OF FEE.—The Attorney General through the Immigration and Naturalization Service shall levy a $100 processing fee upon each alien that the Service determines—

(A) is unlawfully residing in the United States;

(B) has been arrested by a Federal law enforcement officer for the commission of a felony; and

(C) merits deportation after having been determined by a court of law to have committed a felony while residing illegally in the United States.

(2) COLLECTION AND USE.—In addition to any other penalty provided by law, a court shall impose the fee described in paragraph (1) upon an alien described in such paragraph upon the entry of a judgment of deportation by such court. Funds collected pursuant to this subsection shall be credited by the Secretary of the Treasury as offsetting increased Federal outlays resulting from the amendments made by section 5817A of the Balanced Budget Act of 1997.

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective with respect to the period beginning on or after October 1, 1997.

SEC. 5819. SSI ELIGIBILITY FOR SEVERELY DISABLED ALIENS.

Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)), as amended by section 5815, is amended by adding at the end the following:

''(I) SSI EXCEPTION FOR SEVERELY DISABLED ALIENS.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1), and the September 30, 1997 application deadline under subparagraph (G), shall not apply to any alien who is lawfully present in the United States and who has been denied approval of an application for naturalization by the Attorney General solely on the ground that the alien is so severely disabled that the alien is otherwise unable to satisfy the requirements for naturalization.''.

SEC. 5820. EFFECTIVE DATE.

The amendments made by this chapter shall take effect as if they were included in the enactment of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2260).

CHAPTER 2—WELFARE-TO-WORK GRANT PROGRAM

SEC. 5821. WELFARE-TO-WORK GRANTS.

(a) GRANTS TO STATES.—

(1) IN GENERAL.—Section 403(a) (42 U.S.C. 603(a)) is amended by adding at the end the following:

''(5) WELFARE-TO-WORK GRANTS.—

''(A) NONCOMPETITIVE GRANTS.—

''(i) ENTITLEMENT.—A State shall be entitled to receive from the Secretary a grant for each fiscal year specified in subparagraph (H) of this paragraph for which the State is a welfare-to-work State, in an amount that does not exceed the greater of—

''(I) the allotment of the State under clause (iii) of this subparagraph for the fiscal year; or

''(II) 0.5 percent of the amount specified in subparagraph (H) for each fiscal year minus the total of the amounts reserved pursuant to subparagraphs (E), (F), and (G) for the fiscal year. The Secretary shall make pro rata reductions in the amounts otherwise payable to States under this paragraph as necessary so that grants under this paragraph do not exceed the available amount, as defined in clause (iv).

''(ii) WELFARE-TO-WORK STATE.—A State shall be considered a welfare-to-work State for a fiscal year for purposes of this subparagraph if the Secretary determines that the State meets the following requirements:

''(I) The State has submitted to the Secretary (in the form of an addendum to the State plan submitted under section 402) a plan which—

''(aa) describes how, consistent with this subparagraph, the State will use any funds provided under this subparagraph during the fiscal year;

''(bb) specifies the formula to be used pursuant to clause (vi) to distribute funds in the State, and describes the process by which the formula was developed;

''(cc) contains evidence that the plan was developed in consultation and coordination with sub-State areas; and

''(dd) is approved by the agency administering the State program funded under this part.

''(II) The State certifies to the Secretary that the State intends to expend during the fiscal year (excluding expenditures described in section 409(a)(7)(B)(iv)) for activities described in clauses (i) and (ii) of subparagraph (C) of this paragraph an amount equal to not less than 33 percent of the Federal funds provided under this paragraph.

''(III) The State has agreed to negotiate in good faith with the Secretary with respect to the substance of any evaluation under section 413(j), and to cooperate with the conduct of any such evaluation.

''(IV) The State is an eligible State for the fiscal year.

''(V) Qualified State expenditures (within the meaning of section 409(a)(7)) are the applicable percentage for the immediately preceding fiscal year, as defined by section 409(a)(7)(B)(ii).

''(iii) ALLOTMENTS TO WELFARE-TO-WORK STATES.—The allotment of a welfare-to-work State for a fiscal year shall be the available amount for the fiscal year multiplied by the State percentage for the fiscal year.

''(iv) AVAILABLE AMOUNT.—As used in this subparagraph, the term 'available amount' means, for a fiscal year, the sum of—

''(I) 75 percent of the sum of—

''(aa) the amount specified in subparagraph (H) for the fiscal year, minus the total of the amounts reserved pursuant to subparagraphs (E), (F), and (G) for the fiscal year; and

''(bb) any amount reserved pursuant to subparagraph (F) for the immediately preceding fiscal year that has not been obligated; and

''(II) any available amount for the immediately preceding fiscal year that has not been obligated by a State or sub-State entity.

''(v) STATE PERCENTAGE.—As used in clause (iii), the term 'State percentage' means, with respect to a fiscal year, ⅓ of the sum of—

''(I) the percentage represented by the number of individuals in the State whose income is less than the poverty line divided by the number of such individuals in the United States;

''(II) the percentage represented by the number of unemployed individuals in the State divided by the number of such individuals in the United States; and

''(III) the percentage represented by the number of individuals who are adult recipients of assistance under the State program funded under this part divided by the number of individuals in the United States who are adult recipients of assistance under any State program funded under this part.

''(vi) DISTRIBUTION OF FUNDS WITHIN STATES.—

''(I) IN GENERAL.—A State to which a grant is made under this subparagraph shall distribute not less than 85 percent of the grant funds among the political subdivisions in the State in which the percentage represented by the number of individuals in the State whose income is less than the poverty line divided by the number of such individuals in the State, and the percentage represented by the number of unemployed individuals in the State divided by the number of such individuals in the State are both above the average such percentages for the State, in accordance with a formula which—

''(aa) determines the amount to be distributed for the benefit of a political subdivision in proportion to the number (if any) of individuals residing in the political subdivision with an income that is less than the poverty line, relative to such number of individuals for the other political subdivisions in the State, and accords a weight of not less than 50 percent to this factor;

''(bb) may determine the amount to be distributed for the benefit of a political subdivision in proportion to the number of adults residing in the political subdivision who are recipients of assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act first applied to the State) for at least 30 months (whether or not consecutive) relative to the number of such adults residing in the other political subdivisions in the State; and

''(cc) may determine the amount to be distributed for the benefit of a political subdivision in proportion to the number of unemployed individuals residing in the political subdivision relative to the number of such individuals residing in the other political subdivisions in the State.

''(II) SPECIAL RULE.—Notwithstanding subclause (I), if the formula used pursuant to subclause (I) would result in the distribution of less than $100,000 during a fiscal year for the benefit of a political subdivision, then in lieu of distributing such sum in accordance with the formula, such sum shall be available for distribution under subclause (III) during the fiscal year.

''(III) PROJECTS TO HELP LONG-TERM RECIPIENTS OF ASSISTANCE INTO THE WORK FORCE.—The Governor of a State to which a grant is made under this subparagraph may distribute not more than 15 percent of the grant funds (plus any amount required to be distributed under this subclause by reason of subclause (II)) to projects that appear likely to help long-term recipients of assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act first applied to the State) enter the work force.

''(vii) ADMINISTRATION.—

''(I) IN GENERAL.—A grant made under this subparagraph to a State shall be administered by the State agency that is administering, or supervising the administration of, the State program funded under this part.

''(B) COMPETITIVE GRANTS.—

''(i) IN GENERAL.—The Secretary shall award grants in accordance with this subparagraph, in fiscal years 1998 and 2000, for projects proposed by eligible applicants, based on the following:

''(I) The effectiveness of the proposal in—

''(aa) expanding the base of knowledge about programs aimed at moving recipients of assistance under State programs funded under this part who are least job ready into the work force.

''(bb) moving recipients of assistance under State programs funded under this part who are least job ready into the work force; and

''(cc) moving recipients of assistance under State programs funded under this part who are least job ready into the work force, even in labor markets that have a shortage of low-skill jobs.

''(II) At the discretion of the Secretary, any of the following:

''(aa) The history of success of the applicant in moving individuals with multiple barriers into work.

''(bb) Evidence of the applicant's ability to leverage private, State, and local resources.

''(cc) Use by the applicant of State and local resources beyond those required by subparagraph (A).

''(dd) Plans of the applicant to coordinate with other organizations at the local and State level.

''(ee) Use by the applicant of current or former recipients of assistance under a State program funded under this part as mentors, case managers, or service providers.

''(III) Evidence that the proposal has the approval of the State agency administering the program under this part.

''(ii) ELIGIBLE APPLICANTS.—As used in clause (i), the term 'eligible applicant' means a political subdivision of a State or a community action agency, community development corporation or other non-profit organizations with demonstrated effectiveness in moving welfare recipients into the workforce that submits a proposal that is approved by the agency administering the State program funded under this part.

''(iii) DETERMINATION OF GRANT AMOUNT.—In determining the amount of a grant to be made under this subparagraph for a project proposed by an applicant, the Secretary shall provide the applicant with an amount sufficient to ensure that the project has a reasonable opportunity to be successful, taking into account the number of long-term recipients of assistance under a State program funded under this part, the level of unemployment, the job opportunities and job growth, the poverty rate, and such other factors as the Secretary deems appropriate, in the area to be served by the project.

''(iv) TARGETING OF FUNDS TO RURAL AREAS.—

''(I) IN GENERAL.—The Secretary shall use not less than 30 percent of the funds available for grants under this subparagraph for a fiscal year to award grants for expenditures in rural areas.

''(II) RURAL AREA DEFINED.—As used in subclause (I), the term 'rural area' means a city, town, or unincorporated area that has a population of 50,000 or fewer inhabitants and that is not an urbanized area immediately adjacent to a city, town, or unincorporated area that has a population of more than 50,000 inhabitants.

''(v) FUNDING.—For grants under this subparagraph for each fiscal year specified in subparagraph (H), there shall be available to the Secretary an amount equal to the sum of—

''(I) 25 percent of the sum of—

''(aa) the amount specified in subparagraph (H) for the fiscal year, minus the total of the amounts reserved pursuant to subparagraphs (E), (F), and (G) for the fiscal year; and

''(bb) any amount reserved pursuant to subparagraph (F) for the immediately preceding fiscal year that has not been obligated; and

''(II) any amount available for grants under this subparagraph for the immediately preceding fiscal year that has not been obligated.

''(C) LIMITATIONS ON USE OF FUNDS.—

''(i) ALLOWABLE ACTIVITIES.—An entity to which funds are provided under this paragraph may use the funds to move into the work force recipients of assistance under the program funded under this part of the State in which the entity is located and the noncustodial parent of any minor who is such a recipient, by means of any of the following:

''(I) Job creation through public or private sector employment wage subsidies.

''(II) On-the-job training.

''(III) Contracts with public or private providers of readiness, placement, and post-employment services.

''(IV) Job vouchers for placement, readiness, and post-employment services.

''(V) Job support services (excluding child care services) if such services are not otherwise available.

''(VI) Technical assistance and related services that lead to self-employment through the microloan demonstration program under section 7(m) of the Small Business Act (15 U.S.C. 636(m)).

Contracts or vouchers for job placement services supported by these funds must require that at least ½ of the payment occur after a eligible individual placed into the workforce has been in the workforce for 6 months.

''(ii) REQUIRED BENEFICIARIES.—An entity that operates a project with funds provided under this paragraph shall expend at least 90 percent of all funds provided to the project for the benefit of recipients of assistance under the program funded under this part of the State in which the entity is located who meet the requirements of either of the following subclauses:

''(I) At least 2 of the following apply to the recipient:

''(aa) The individual has not completed secondary school or obtained a certificate of general equivalency, and has low skills in reading and mathematics.

''(bb) The individual requires substance abuse treatment for employment.

''(cc) The individual has a poor work history. The Secretary shall prescribe such regulations as may be necessary to interpret this subclause.

''(II) The individual—

''(aa) has received assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 first apply to the State) for at least 30 months (whether or not consecutive); or

''(bb) within 12 months, will become ineligible for assistance under the State program funded under this part by reason of a durational limit on such assistance, without regard to any exemption provided pursuant to section 408(a)(7)(C) that may apply to the individual.

''(iii) LIMITATION ON APPLICABILITY OF SECTION 404.—The rules of section 404, other than subsections (b), (f), and (h) of section 404, shall not apply to a grant made under this paragraph.

''(iv) COOPERATION WITH TANF AGENCY.—On a determination by the Secretary an entity that operates a project with funds provided under this paragraph and the agency administering the State program funded under this part are not adhering to the agreement to implement any plan or project for which the funds are provided, the recipient of the funds shall remit the funds to the Secretary.

''(v) PROHIBITION AGAINST USE OF GRANT FUNDS FOR ANY OTHER FUND MATCHING REQUIREMENT.—An entity to which funds are provided under this paragraph shall not use any part of the funds to fulfill any obligation of any State, or political subdivision to contribute funds under other Federal law.

''(vi) DEADLINE FOR EXPENDITURE.—An entity to which funds are provided under this paragraph shall remit to the Secretary any part of the funds that are not expended within 3 years after the date the funds are so provided.

''(D) INDIVIDUALS WITH INCOME LESS THAN THE POVERTY LINE.—For purposes of this paragraph, the number of individuals with an income that is less than the poverty line shall be determined based on the methodology used by the Bureau of the Census to produce and publish intercensal poverty data for 1993 for States and counties.

''(E) SET-ASIDE FOR HIGH PERFORMANCE BONUS.—$100,000,000 of the amount specified in subparagraph (H) for fiscal year 1999 shall be reserved for use by the Secretary to make bonus grants (in the same manner as such grants are determined under paragraph (4)) for fiscal year 2003 to those States that receive funds under this paragraph and that are most successful in increasing the earnings of individuals described in subparagraph (C)(ii)(II).

''(F) SET-ASIDE FOR INDIAN TRIBES.—1 percent of the amount specified in subparagraph (H) for each fiscal year shall be reserved for grants to Indian tribes under section 412(a)(3).

''(G) SET-ASIDE FOR EVALUATIONS.—0.5 percent of the amount specified in subparagraph (H) for each fiscal year shall be reserved for use by the Secretary to carry out section 413(j).

''(H) FUNDING.—The amount specified in this subparagraph is—

''(i) $750,000,000 for fiscal year 1998;

''(ii) $1,250,000,000 for fiscal year 1999; and

''(iii) $1,000,000,000 for fiscal year 2000.

''(I) AVAILABILITY OF FUNDS.—Amounts appropriated pursuant to this paragraph shall remain available through fiscal year 2002.

''(J) BUDGET SCORING.—Notwithstanding section 457(b)(2) of the Balanced Budget and Emergency Deficit Control Act of 1985, the baseline shall assume that no grant shall be awarded under this paragraph or under section 412(a)(3) after fiscal year 2000.

''(K) NONDISPLACEMENT IN WORK ACTIVITIES.—

''(i) PROHIBITIONS.—

''(I) GENERAL PROHIBITION.—A participant in a work activity pursuant to this paragraph shall not displace (including a partial displacement, such as a reduction in the hours of nonovertime work, wages, or employment benefits) any individual who, as of the date of the participation, is an employee.

''(II) PROHIBITION ON IMPAIRMENT OF CONTRACTS.—A work activity pursuant to this paragraph shall not impair an existing contract for services or collective bargaining agreement, and a work activity that would be inconsistent with the terms of a collective bargaining agreement shall not be undertaken without the written concurrence of the labor organization and employer concerned.

''(III) OTHER PROHIBITIONS.—A participant in a work activity shall not be employed in a job—

''(aa) when any other individual is on layoff from the same or any substantially equivalent job;

''(bb) when the employer has terminated the employment of any regular employee or otherwise reduced the workforce of the employer with the intention of filling the vacancy so created with the participant; or

''(cc) which is created in a promotional line that will infringe in any way upon the promotional opportunities of employed individuals.

''(ii) HEALTH AND SAFETY.—Health and safety standards established under Federal and State law otherwise applicable to working conditions of employees shall be equally applicable to working conditions of participants engaged in a work activity pursuant to this paragraph. To the extent that a State workers' compensation law applies, workers' compensation shall be provided to participants on the same basis as the compensation is provided to other individuals in the State in similar employment.

''(iii) GRIEVANCE PROCEDURE.—

''(I) IN GENERAL.—Each State to which a grant is made under this paragraph shall establish and maintain a procedure for grievances or complaints alleging violations of clauses (i) or (ii) from participants and other interested or affected parties. The procedure shall include an opportunity for a hearing and be completed within 60 days after the grievance or complaint is filed.

''(II) INVESTIGATION.—

''(aa) IN GENERAL.—The Secretary of Labor shall investigate an allegation of a violation of clause (i) or (ii) if a decision relating to the violation is not reached within 60 days after the date of the filing of the grievance or complaint, and either party appeals to the Secretary of Labor, or a decision relating to the violation is reached within the 60-day period, and the party to which the decision is adverse appeals the decision to the Secretary of Labor.

''(bb) ADDITIONAL REQUIREMENT.—The Secretary of Labor shall make a final determination relating to an appeal made under item (aa) not later than 120 days after receiving the appeal.

''(III) REMEDIES.—Remedies for violation of clause (i) or (ii) shall be limited to—

''(aa) suspension or termination of payments under this paragraph;

''(bb) prohibition of placement of a participant with an employer that has violated clause (i) or (ii);

''(cc) where applicable, reinstatement of an employee, payment of lost wages and benefits, and reestablishment of other relevant terms, conditions and privileges of employment; and

''(dd) where appropriate, other equitable relief.''.

(2) CONFORMING AMENDMENT.—Section 409(a)(7)(B)(iv) of such Act (42 U.S.C. 609(a)(7)(B)(iv)) is amended to read as follows:

''(iv) EXPENDITURES BY THE STATE.—The term 'expenditures by the State' does not include—

''(I) any expenditure from amounts made available by the Federal Government;

''(II) any State funds expended for the medicaid program under title XIX;

''(III) any State funds which are used to match Federal funds provided under section 403(a)(5); or

''(IV) any State funds which are expended as a condition of receiving Federal funds other than under this part.

Notwithstanding subclause (IV) of the preceding sentence, such term includes expenditures by a State for child care in a fiscal year to the extent that the total amount of the expenditures does not exceed the amount of State expenditures in fiscal year 1994 or 1995 (whichever is the greater) that equal the non-Federal share for the programs described in section 418(a)(1)(A).''.

(b) GRANTS TO OUTLYING AREAS.—Section 1108(a)(1) of such Act (42 U.S.C. 1308(a)(1)) is amended by inserting ''(except section 403(a)(5))'' after ''title IV''.

(c) GRANTS TO INDIAN TRIBES.—Section 412(a) of such Act (42 U.S.C. 612(a)) is amended by adding at the end the following:

''(3) WELFARE-TO-WORK GRANTS.—

''(A) IN GENERAL.—The Secretary shall award a grant in accordance with this paragraph to an Indian tribe for each fiscal year specified in section 403(a)(5)(H) for which the Indian tribe is a welfare-to-work tribe, in such amount as the Secretary deems appropriate, subject to subparagraph (B) of this paragraph.

''(B) WELFARE-TO-WORK TRIBE.—An Indian tribe shall be considered a welfare-to-work tribe for a fiscal year for purposes of this paragraph if the Indian tribe meets the following requirements:

''(i) The Indian tribe has submitted to the Secretary (in the form of an addendum to the tribal family assistance plan, if any, of the Indian tribe) a plan which describes how, consistent with section 403(a)(5), the Indian tribe will use any funds provided under this paragraph during the fiscal year.

''(ii) The Indian tribe has provided the Secretary with an estimate of the amount that the Indian tribe intends to expend during the fiscal year (excluding tribal expenditures described in section 409(a)(7)(B)(iv)) for activities described in section 403(a)(5)(C)(i).

''(iii) The Indian tribe has agreed to negotiate in good faith with the Secretary of Health and Human Services with respect to the substance of any evaluation under section 413(j), and to cooperate with the conduct of any such evaluation.

''(C) LIMITATIONS ON USE OF FUNDS.—Section 403(a)(5)(C) shall apply to funds provided to Indian tribes under this paragraph in the same manner in which such section applies to funds provided under section 403(a)(5).''.

(d) FUNDS RECEIVED FROM GRANTS TO BE DISREGARDED IN APPLYING DURATIONAL LIMIT ON ASSISTANCE.—Section 408(a)(7) of such Act (42 U.S.C. 608(a)(7)) is amended by adding at the end the following:

''(G) INAPPLICABILITY TO WELFARE-TO-WORK GRANTS AND ASSISTANCE.—For purposes of subparagraph (A) of this paragraph, a grant made under section 403(a)(5) shall not be considered a grant made under section 403, and assistance from funds provided under section 403(a)(5) shall not be considered assistance.''.

(e) EVALUATIONS.—Section 413 of such Act (42 U.S.C. 613) is amended by adding at the end the following:

''(j) EVALUATION OF WELFARE-TO-WORK PROGRAMS.—

''(1) EVALUATION.—The Secretary—

''(A) shall, in consultation with the Secretary of Labor, develop a plan to evaluate how grants made under sections 403(a)(5) and 412(a)(3) have been used;

''(B) may evaluate the use of such grants by such grantees as the Secretary deems appropriate, in accordance with an agreement entered into with the grantees after good-faith negotiations; and

''(C) shall include the following outcome measures in the plan developed under subparagraph (A):

''(i) Placements in the labor force and placements in the labor force that last for at least 6 months.

''(ii) Placements in the private and public sectors.

''(iii) Earnings of individuals who obtain employment.

''(iv) Average expenditures per placement.

''(2) REPORTS TO THE CONGRESS.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Secretary, in consultation with the Secretary of Labor and the Secretary of Housing and Urban Development, shall submit to the Congress reports on the projects funded under sections 403(a)(5) and 412(a)(3) and on the evaluations of the projects.

''(B) INTERIM REPORT.—Not later than January 1, 1999, the Secretary shall submit an interim report on the matter described in subparagraph (A).

''(C) FINAL REPORT.—Not later than January 1, 2001 (or at a later date, if the Secretary informs the committees of the Congress with jurisdiction over the subject matter of the report) the Secretary shall submit a final report on the matter described in subparagraph (A).''.

SEC. 5822. CLARIFICATION OF A STATE'S ABILITY TO SANCTION AN INDIVIDUAL RECEIVING ASSISTANCE UNDER TANF FOR NONCOMPLIANCE.

(a) IN GENERAL.—Section 408 (42 U.S.C. 608) is amended—

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b), the following:

''(c) NONAPPLICATION OF ANY MINIMUM WAGE REQUIREMENTS WITH RESPECT TO INDIVIDUAL SANCTIONS.—Notwithstanding any other provision of law, any requirement imposed by law, regulation, or otherwise that requires that an individual in a family that receives assistance under the State program funded under this part receive the applicable minimum wage under section 6 of the Fair Labor Standards Act (29 U.S.C. 206), shall not prohibit a State from imposing against a family that includes such an individual any penalty that may be imposed under the State program funded under this part for failure to comply with a requirement under such program.''.

(b) RETROACTIVITY.—The amendment made by subsection (a) shall take effect as if included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2112).

CHAPTER 3—UNEMPLOYMENT COMPENSATION

SEC. 5831. INCREASE IN FEDERAL UNEMPLOYMENT ACCOUNT CEILING.

(a) IN GENERAL.—Section 902(a)(2) (42 U.S.C. 1102(a)(2)) is amended by striking ''0.25 percent'' and inserting ''0.5 percent''.

(b) EFFECTIVE DATE.—This section and the amendment made by this section—

(1) shall take effect on October 1, 2001, and

(2) shall apply to fiscal years beginning on or after that date.

SEC. 5832. SPECIAL DISTRIBUTION TO STATES FROM UNEMPLOYMENT TRUST FUND.

(a) IN GENERAL.—Section 903(a) (42 U.S.C. 1103(a)) is amended by adding at the end the following new paragraph:

''(3)(A) Notwithstanding any other provision of this section, for purposes of carrying out this subsection with respect to any excess amount (referred to in paragraph (1)) remaining in the employment security administration account as of the close of fiscal year 1999, 2000, or 2001, such amount shall—

''(i) to the extent of any amounts not in excess of $100,000,000, be subject to subparagraph (B), and

''(ii) to the extent of any amounts in excess of $100,000,000, be subject to subparagraph (C).

''(B) Paragraphs (1) and (2) shall apply with respect to any amounts described in subparagraph (A)(i), except that—

''(i) in carrying out the provisions of paragraph (2)(B) with respect to such amounts (to determine the portion of such amounts which is to be allocated to a State for a succeeding fiscal year), the ratio to be applied under such provisions shall be the same as the ratio that—

''(I) the amount of funds to be allocated to such State for such fiscal year pursuant to title III, bears to

''(II) the total amount of funds to be allocated to all States for such fiscal year pursuant to title III,

as determined by the Secretary of Labor, and

''(ii) the amounts allocated to a State pursuant to this subparagraph shall be available to such State, subject to the last sentence of subsection (c)(2).

Nothing in this paragraph shall preclude the application of subsection (b) with respect to any allocation determined under this subparagraph.

''(C) Any amounts described in clause (ii) of subparagraph (A) (remaining in the employment security administration account as of the close of any fiscal year specified in such subparagraph) shall, as of the beginning of the succeeding fiscal year, accrue to the Federal unemployment account, without regard to the limit provided in section 902(a).''.

(b) CONFORMING AMENDMENT.—Paragraph (2) of section 903(c) of the Social Security Act is amended by adding at the end, as a flush left sentence, the following:

''Any amount allocated to a State under this section for fiscal year 2000, 2001, or 2002 may be used by such State only to pay expenses incurred by it for the administration of its unemployment compensation law, and may be so used by it without regard to any of the conditions prescribed in any of the preceding provisions of this paragraph.''.

SEC. 5833. TREATMENT OF CERTAIN SERVICES PERFORMED BY INMATES.

(a) IN GENERAL.—Subsection (c) of section 3306 of the Internal Revenue Code of 1986 (defining employment) is amended—

(1) by striking ''or'' at the end of paragraph (19),

(2) by striking the period at the end of paragraph (20) and inserting ''; or'', and

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

''(21) service performed by a person committed to a penal institution.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to service performed after March 26, 1996.

DIVISION 4—EARNED INCOME CREDIT AND OTHER PROVISIONS

Subtitle L—Earned Income Credit and Other Provisions

CHAPTER 1—EARNED INCOME CREDIT

SEC. 5851. RESTRICTIONS ON AVAILABILITY OF EARNED INCOME CREDIT FOR TAXPAYERS WHO IMPROPERLY CLAIMED CREDIT IN PRIOR YEAR.

(a) IN GENERAL.—Section 32 of the Internal Revenue Code of 1986 (relating to earned income credit) is amended by redesignating subsections (k) and (l) as subsections (l) and (m), respectively, and by inserting after subsection (j) the following new subsection:

''(k) RESTRICTIONS ON TAXPAYERS WHO IMPROPERLY CLAIMED CREDIT IN PRIOR YEAR.—

''(1) TAXPAYERS MAKING PRIOR FRAUDULENT OR RECKLESS CLAIMS.—

''(A) IN GENERAL.—No credit shall be allowed under this section for any taxable year in the disallowance period.

''(B) DISALLOWANCE PERIOD.—For purposes of paragraph (1), the disallowance period is—

''(i) the period of 10 taxable years after the most recent taxable year for which there was a final determination that the taxpayer's claim of credit under this section was due to fraud, and

''(ii) the period of 2 taxable years after the most recent taxable year for which there was a final determination that the taxpayer's claim of credit under this section was due to reckless or intentional disregard of rules and regulations (but not due to fraud).

''(2) TAXPAYERS MAKING IMPROPER PRIOR CLAIMS.—In the case of a taxpayer who is denied credit under this section for any taxable year as a result of the deficiency procedures under subchapter B of chapter 63, no credit shall be allowed under this section for any subsequent taxable year unless the taxpayer provides such information as the Secretary may require to demonstrate eligibility for such credit.''.

(b) DUE DILIGENCE REQUIREMENT ON INCOME TAX RETURN PREPARERS.—Section 6695 of the Internal Revenue Code of 1986 (relating to other assessable penalties with respect to the preparation of income tax returns for other persons) is amended by adding at the end the following new subsection:

''(g) FAILURE TO BE DILIGENT IN DETERMINING ELIGIBILITY FOR EARNED INCOME CREDIT.—Any person who is an income tax preparer with respect to any return or claim for refund who fails to comply with due diligence requirements imposed by the Secretary by regulations with respect to determining eligibility for, or the amount of, the credit allowable by section 32 shall pay a penalty of $100 for each such failure.''.

(c) EXTENSION PROCEDURES APPLICABLE TO MATHEMATICAL OR CLERICAL ERRORS.—Paragraph (2) of section 6213(g) (relating to the definition of mathematical or clerical errors) is amended by striking ''and'' at the end of subparagraph (H), by striking the period at the end of subparagraph (I) and inserting '', and'', and by inserting after subparagraph (I) the following new subparagraph:

''(J) an omission of information required by section 32(k)(2) (relating to taxpayers making improper prior claims of earned income credit).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

CHAPTER 2—INCREASE IN PUBLIC DEBT LIMIT

SEC. 5861. INCREASE IN PUBLIC DEBT LIMIT.

Subsection (b) of section 3101 of title 31, United States Code, is amended by striking the dollar amount contained therein and inserting ''$5,950,000,000,000''.

CHAPTER 3—MISCELLANEOUS

SEC. 5871. SENSE OF THE SENATE REGARDING THE CORRECTION OF COST-OF-LIVING ADJUSTMENTS.

(a) FINDINGS.—The Senate makes the following findings:

(1) The final report of the Senate Finance Committee's Advisory Commission to Study the Consumer Price Index, chaired by Professor Michael Boskin, has concluded that the Consumer Price Index overstates the cost of living in the United States by 1.1 percentage points.

(2) Dr. Alan Greenspan, Chairman of the Board of Governors of the Federal Reserve System, has testified before the Senate Finance Committee that ''the best available evidence suggests that there is virtually no chance that the CPI as currently published understates'' the cost of living and that there is ''a very high probability that the upward bias ranges between ½ percentage point per year and 1½ percentage points per year''.

(3) The overstatement of the cost of living by the Consumer Price Index has been recognized by economists since at least 1961, when a report noting the existence of the overstatement was issued by a National Bureau of Economic Research Committee, chaired by Professor George J. Stigler.

(4) Congress and the President, through the indexing of Federal tax brackets, Social Security benefits, and other Federal program benefits, have undertaken to protect taxpayers and beneficiaries of such programs from the erosion of purchasing power due to inflation.

(5) Congress and the President intended the indexing of Federal tax brackets, Social Security benefits, and other Federal program benefits to accurately reflect changes in the cost of living.

(6) The overstatement of the cost of living increases the deficit and undermines the equitable administration of Federal benefits and tax policies.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that all cost-of-living adjustments required by statute should accurately reflect the best available estimate of changes in the cost of living.

Subtitle M—Welfare Reform Technical Corrections

SEC. 5900. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the ''Welfare Reform Technical Corrections Act of 1997''.

CHAPTER 1—BLOCK GRANTS FOR TEMPORARY ASSISTANCE TO NEEDY FAMILIES

SEC. 5901. AMENDMENT OF THE SOCIAL SECURITY ACT.

Except as otherwise expressly provided, wherever in this chapter an amendment or repeal 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 a section or other provision of the Social Security Act, and if the section or other provision is of part A of title IV of such Act, the reference shall be considered to be made to the section or other provision as amended by section 103, and as in effect pursuant to section 116, of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

SEC. 5902. ELIGIBLE STATES; STATE PLAN.

(a) LATER DEADLINE FOR SUBMISSION OF STATE PLANS.—Section 402(a) (42 U.S.C. 602(a)) is amended by striking ''2-year period immediately preceding'' and inserting ''27-month period ending with the close of the 1st quarter of''.

(b) CLARIFICATION OF SCOPE OF WORK PROVISIONS.—Section 402(a)(1)(A)(ii) (42 U.S.C. 602(a)(1)(A)(ii)) is amended by inserting '', consistent with section 407(e)(2)'' before the period.

(c) CORRECTION OF CROSS-REFERENCE.—Section 402(a)(1)(A)(v) (42 U.S.C. 602(a)(1)(A)(v)) is amended by striking ''403(a)(2)(B)'' and inserting ''403(a)(2)(C)(iii)''.

(d) NOTIFICATION OF PLAN AMENDMENTS.—Section 402 (42 U.S.C. 602) is amended—

(1) by redesignating subsection (b) as subsection (c) and inserting after subsection (a) the following:

''(b) PLAN AMENDMENTS.—Within 30 days after a State amends a plan submitted pursuant to subsection (a), the State shall notify the Secretary of the amendment.''; and

(2) in subsection (c) (as so redesignated), by inserting ''or plan amendment'' after ''plan''.

SEC. 5903. GRANTS TO STATES.

(a) BONUS FOR DECREASE IN ILLEGITIMACY MODIFIED TO TAKE ACCOUNT OF CERTAIN TERRITORIES.—

(1) IN GENERAL.—Section 403(a)(2)(B) (42 U.S.C. 603(a)(2)(B)) is amended to read as follows:

''(B) AMOUNT OF GRANT.—

''(i) IN GENERAL.—If, for a bonus year, none of the eligible States is Guam, the Virgin Islands, or American Samoa, then the amount of the grant shall be—

''(I) $20,000,000 if there are 5 eligible States; or

''(II) $25,000,000 if there are fewer than 5 eligible States.

''(ii) AMOUNT IF CERTAIN TERRITORIES ARE ELIGIBLE.—If, for a bonus year, Guam, the Virgin Islands, or American Samoa is an eligible State, then the amount of the grant shall be—

''(I) in the case of such a territory, 25 percent of the mandatory ceiling amount (as defined in section 1108(c)(4)) with respect to the territory; and

''(II) in the case of a State that is not such a territory—

''(aa) if there are 5 eligible States other than such territories, $20,000,000, minus ⅕ of the total amount of the grants payable under this paragraph to such territories for the bonus year; or

''(bb) if there are fewer than 5 such eligible States, $25,000,000, or such lesser amount as may be necessary to ensure that the total amount of grants payable under this paragraph for the bonus year does not exceed $100,000,000.''.

(2) CERTAIN TERRITORIES TO BE IGNORED IN RANKING OTHER STATES.—Section 403(a)(2)(C)(i)(I)(aa) (42 U.S.C. 603(a)(2)(C)(i)(I)(aa)) is amended by adding at the end the following: ''In the case of a State that is not a territory specified in subparagraph (B), the comparative magnitude of the decrease for the State shall be determined without regard to the magnitude of the corresponding decrease for any such territory.''.

(b) COMPUTATION OF BONUS BASED ON RATIOS OF OUT-OF-WEDLOCK BIRTHS TO ALL BIRTHS INSTEAD OF NUMBERS OF OUT-OF-WEDLOCK BIRTHS.—Section 403(a)(2) (42 U.S.C. 603(a)(2)) is amended—

(1) in the paragraph heading, by inserting ''RATIO'' before the period;

(2) in subparagraph (A), by striking all that follows ''bonus year'' and inserting a period; and

(3) in subparagraph (C)—

(A) in clause (i)—

(i) in subclause (I)(aa)—

(I) by striking ''number of out-of-wedlock births that occurred in the State during'' and inserting ''illegitimacy ratio of the State for''; and

(II) by striking ''number of such births that occurred during'' and inserting ''illegitimacy ratio of the State for''; and

(ii) in subclause (II)(aa)—

(I) by striking ''number of out-of-wedlock births that occurred in'' each place such term appears and inserting ''illegitimacy ratio of''; and

(II) by striking ''calculate the number of out-of-wedlock births'' and inserting ''calculate the illegitimacy ratio''; and

(B) by adding at the end the following:

''(iii) ILLEGITIMACY RATIO.—The term 'illegitimacy ratio' means, with respect to a State and a period—

''(I) the number of out-of-wedlock births to mothers residing in the State that occurred during the period; divided by

''(II) the number of births to mothers residing in the State that occurred during the period.''.

(c) USE OF CALENDAR YEAR DATA INSTEAD OF FISCAL YEAR DATA IN CALCULATING BONUS FOR DECREASE IN ILLEGITIMACY RATIO.—Section 403(a)(2)(C) (42 U.S.C. 603(a)(2)(C)) is amended—

(1) in clause (i)—

(A) in subclause (I)(bb)—

(i) by striking ''the fiscal year'' and inserting ''the calendar year for which the most recent data are available''; and

(ii) by striking ''fiscal year 1995'' and inserting ''calendar year 1995'';

(B) in subclause (II), by striking ''fiscal'' each place such term appears and inserting ''calendar''; and

(2) in clause (ii), by striking ''fiscal years'' and inserting ''calendar years''.

(d) CORRECTION OF HEADING.—Section 403(a)(3)(C)(ii) (42 U.S.C. 603(a)(3)(C)(ii)) is amended in the heading by striking ''1997'' and inserting ''1998''.

(e) CLARIFICATION OF CONTINGENCY FUND PROVISION.—Section 403(b) (42 U.S.C. 603(b)) is amended—

(1) in paragraph (6), by striking ''(5)'' and inserting ''(4)'';

(2) by striking paragraph (4) and redesignating paragraphs (5) and (6) as paragraphs (4) and (5), respectively; and

(3) by inserting after paragraph (5) the following:

''(6) ANNUAL RECONCILIATION.—

''(A) IN GENERAL.—Notwithstanding paragraph (3), if the Secretary makes a payment to a State under this subsection in a fiscal year, then the State shall remit to the Secretary, within 1 year after the end of the first subsequent period of 3 consecutive months for which the State is not a needy State, an amount equal to the amount (if any) by which—

''(i) the total amount paid to the State under paragraph (3) of this subsection in the fiscal year; exceeds

''(ii) the product of—

''(I) the Federal medical assistance percentage for the State (as defined in section 1905(b), as such section was in effect on September 30, 1995);

''(II) the State's reimbursable expenditures for the fiscal year; and

''(III) 1/12 times the number of months during the fiscal year for which the Secretary made a payment to the State under such paragraph (3).

''(B) DEFINITIONS.—As used in subparagraph (A):

''(i) REIMBURSABLE EXPENDITURES.—The term 'reimbursable expenditures' means, with respect to a State and a fiscal year, the amount (if any) by which—

''(I) countable State expenditures for the fiscal year; exceeds

''(II) historic State expenditures (as defined in section 409(a)(7)(B)(iii)), excluding any amount expended by the State for child care under subsection (g) or (i) of section 402 (as in effect during fiscal year 1994) for fiscal year 1994.

''(ii) COUNTABLE STATE EXPENDITURES.—The term 'countable expenditures' means, with respect to a State and a fiscal year—

''(I) the qualified State expenditures (as defined in section 409(a)(7)(B)(i) (other than the expenditures described in subclause (I)(bb) of such section)) under the State program funded under this part for the fiscal year; plus

''(II) any amount paid to the State under paragraph (3) during the fiscal year that is expended by the State under the State program funded under this part.''.

(f) ADMINISTRATION OF CONTINGENCY FUND TRANSFERRED TO THE SECRETARY OF HHS.—Section 403(b)(7) (42 U.S.C. 603(b)(7)) is amended to read as follows:

''(7) STATE DEFINED.—As used in this subsection, the term 'State' means each of the 50 States and the District of Columbia.''.

SEC. 5904. USE OF GRANTS.

Section 404(a)(2) (42 U.S.C. 604(a)(2)) is amended by inserting '', or (at the option of the State) August 21, 1996'' before the period.

SEC. 5905. MANDATORY WORK REQUIREMENTS.

(a) FAMILY WITH A DISABLED PARENT NOT TREATED AS A 2-PARENT FAMILY.—Section 407(b)(2) (42 U.S.C. 607(b)(2)) is amended by adding at the end the following:

''(C) FAMILY WITH A DISABLED PARENT NOT TREATED AS A 2-PARENT FAMILY.—A family that includes a disabled parent shall not be considered a 2-parent family for purposes of subsections (a) and (b) of this section.''.

(b) CORRECTION OF HEADING.—Section 407(b)(3) (42 U.S.C. 607(b)(3)) is amended in the heading by inserting ''AND NOT RESULTING FROM CHANGES IN STATE ELIGIBILITY CRITERIA'' before the period.

(c) STATE OPTION TO INCLUDE INDIVIDUALS RECEIVING ASSISTANCE UNDER A TRIBAL WORK PROGRAM IN PARTICIPATION RATE CALCULATION.—Section 407(b)(4) (42 U.S.C. 607(b)(4)) is amended—

(1) in the heading, by inserting ''OR TRIBAL WORK PROGRAM'' before the period; and

(2) by inserting ''or under a tribal work program to which funds are provided under this part'' before the period.

(d) SHARING OF 35-HOUR WORK REQUIREMENT BETWEEN PARENTS IN 2-PARENT FAMILIES.—Section 407(c)(1)(B) (42 U.S.C. 607(c)(1)(B)) is amended—

(1) in clause (i)—

(A) by striking ''is'' and inserting ''and the other parent in the family are''; and

(B) by inserting ''a total of'' before ''at least''; and

(2) in clause (ii)—

(A) by striking ''individual's spouse is'' and inserting ''individual and the other parent in the family are'';

(B) by inserting ''for a total of at least 55 hours per week'' before ''during the month''; and

(C) by striking ''20'' and inserting ''50''.

(e) CLARIFICATION OF EFFORT REQUIRED IN WORK ACTIVITIES.—Section 407(c)(1)(B) (42 U.S.C. 607(c)(1)(B)) is amended by striking ''making progress'' each place such term appears and inserting ''participating''.

(f) ADDITIONAL CONDITION UNDER WHICH 12 WEEKS OF JOB SEARCH MAY COUNT AS WORK.—Section 407(c)(2)(A)(i) (42 U.S.C. 607(c)(2)(A)(i)) is amended by inserting ''or the State is a needy State (within the meaning of section 403(b)(6))'' after ''United States''.

(g) CARETAKER RELATIVE OF CHILD UNDER AGE 6 DEEMED TO BE MEETING WORK REQUIREMENTS IF ENGAGED IN WORK FOR 20 HOURS PER WEEK.—Section 407(c)(2)(B) (42 U.S.C. 607(c)(2)(B)) is amended—

(1) in the heading, by inserting ''OR RELATIVE'' after ''PARENT'' each place such term appears; and

(2) by striking ''in a 1-parent family who is the parent'' and inserting ''who is the only parent or caretaker relative in the family''.

(h) EXTENSION TO MARRIED TEENS OF RULE THAT RECEIPT OF SUFFICIENT EDUCATION IS ENOUGH TO MEET WORK PARTICIPATION REQUIREMENTS.—Section 407(c)(2)(C) (42 U.S.C. 607(c)(2)(C)) is amended—

(1) in the heading, by striking ''TEEN HEAD OF HOUSEHOLD'' and inserting ''SINGLE TEEN HEAD OF HOUSEHOLD OR MARRIED TEEN''; and

(2) by striking ''a single'' and inserting ''married or a''.

(i) CLARIFICATION OF NUMBER OF HOURS OF PARTICIPATION IN EDUCATION DIRECTLY RELATED TO EMPLOYMENT THAT ARE REQUIRED IN ORDER FOR SINGLE TEEN HEAD OF HOUSEHOLD OR MARRIED TEEN TO BE DEEMED TO BE ENGAGED IN WORK.—Section 407(c)(2)(C)(ii) (42 U.S.C. 607(c)(2)(C)(ii)) is amended by striking ''at least'' and all that follows through ''subsection'' and inserting ''an average of at least 20 hours per week during the month''.

(j) CLARIFICATION OF REFUSAL TO WORK FOR PURPOSES OF WORK PENALTIES FOR INDIVIDUALS.—Section 407(e)(2) (42 U.S.C. 607(e)(2)) is amended by striking ''work'' and inserting ''engage in work required in accordance with this section''.

(k) CLARIFICATION OF REMOVAL OF TEEN PARENTS WITH RESPECT TO VOCATIONAL EDUCATION.—Section 407(c)(2) (42 U.S.C. 607(c)(2)) is amended—

(1) in subparagraph (C), by striking '', subject to subparagraph (D) of this paragraph,''; and

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

''(D) NUMBER OF PERSONS THAT MAY BE TREATED AS ENGAGED IN WORK BY VIRTUE OF PARTICIPATION IN VOCATIONAL EDUCATION ACTIVITIES.—For purposes of determining monthly participation rates under paragraphs (1)(B)(i) and (2)(B) of subsection (b), not more than 20 percent of individuals in all families and in 2-parent families (other than individuals in such families who are described in subparagraph (C)) may be determined to be engaged in work in the State for a month by reason of participation in vocational educational training.''.

SEC. 5906. PROHIBITIONS; REQUIREMENTS.

(a) ELIMINATION OF REDUNDANT LANGUAGE; CLARIFICATION OF HOME RESIDENCE REQUIREMENT.—Section 408(a)(1) (42 U.S.C. 608(a)(1)) is amended to read as follows:

''(1) NO ASSISTANCE FOR FAMILIES WITHOUT A MINOR CHILD.—A State to which a grant is made under section 403 shall not use any part of the grant to provide assistance to a family, unless the family includes a minor child who resides with the family (consistent with paragraph (10)) or a pregnant individual.''.

(b) CLARIFICATION OF TERMINOLOGY.—Section 408(a)(3) (42 U.S.C. 608(a)(3)) is amended—

(1) by striking ''leaves'' the 1st, 3rd, and 4th places such term appears and inserting ''ceases to receive assistance under''; and

(2) by striking ''the date the family leaves the program'' the 2nd place such term appears and inserting ''such date''.

(c) ELIMINATION OF SPACE.—Section 408(a)(5)(A)(ii) (42 U.S.C. 608(a)(5)(A)(ii)) is amended by striking ''DESCRIBED.— For'' and inserting ''DESCRIBED.—For''.

(d) CORRECTIONS TO 5-YEAR LIMIT ON ASSISTANCE.—

(1) CLARIFICATION OF LIMITATION ON HARDSHIP EXEMPTION.—Section 408(a)(7)(C)(ii) (42 U.S.C. 608(a)(7)(C)(ii)) is amended—

(A) by striking ''The number'' and inserting ''The average monthly number''; and

(B) by inserting ''during the fiscal year or the immediately preceding fiscal year (but not both), as the State may elect'' before the period.

(2) RESIDENCE EXCEPTION MADE MORE UNIFORM AND EASIER TO ADMINISTER.—Section 408(a)(7)(D) (42 U.S.C. 608(a)(7)(D)) is amended to read as follows:

''(D) DISREGARD OF MONTHS OF ASSISTANCE RECEIVED BY ADULT WHILE LIVING IN INDIAN COUNTRY OR AN ALASKAN NATIVE VILLAGE WITH 50 PERCENT UNEMPLOYMENT.—

''(i) IN GENERAL.—In determining the number of months for which an adult has received assistance under a State or tribal program funded under this part, the State or tribe shall disregard any month during which the adult lived in Indian country or an Alaskan Native village if the most reliable data available with respect to the month (or a period including the month) indicate that at least 50 percent of the adults living in Indian country or in the village were not employed.

''(ii) INDIAN COUNTRY DEFINED.—As used in clause (i), the term 'Indian country' has the meaning given such term in section 1151 of title 18, United States Code.''.

(e) REINSTATEMENT OF DEEMING AND OTHER RULES APPLICABLE TO ALIENS WHO ENTERED THE UNITED STATES UNDER AFFIDAVITS OF SUPPORT FORMERLY USED.—Section 408 (42 U.S.C. 608) is amended by striking subsection (d) and inserting the following:

''(d) SPECIAL RULES RELATING TO TREATMENT OF CERTAIN ALIENS.—For special rules relating to the treatment of certain aliens, see title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

''(e) SPECIAL RULES RELATING TO THE TREATMENT OF NON-213A ALIENS.—The following rules shall apply if a State elects to take the income or resources of any sponsor of a non-213A alien into account in determining whether the alien is eligible for assistance under the State program funded under this part, or in determining the amount or types of such assistance to be provided to the alien:

''(1) DEEMING OF SPONSOR'S INCOME AND RESOURCES.—For a period of 3 years after a non-213A alien enters the United States:

''(A) INCOME DEEMING RULE.—The income of any sponsor of the alien and of any spouse of the sponsor is deemed to be income of the alien, to the extent that the total amount of the income exceeds the sum of—

''(i) the lesser of—

''(I) 20 percent of the total of any amounts received by the sponsor or any such spouse in the month as wages or salary or as net earnings from self-employment, plus the full amount of any costs incurred by the sponsor and any such spouse in producing self-employment income in such month; or

''(II) $175;

''(ii) the cash needs standard established by the State for purposes of determining eligibility for assistance under the State program funded under this part for a family of the same size and composition as the sponsor and any other individuals living in the same household as the sponsor who are claimed by the sponsor as dependents for purposes of determining the sponsor's Federal personal income tax liability but whose needs are not taken into account in determining whether the sponsor's family has met the cash needs standard;

''(iii) any amounts paid by the sponsor or any such spouse to individuals not living in the household who are claimed by the sponsor as dependents for purposes of determining the sponsor's Federal personal income tax liability; and

''(iv) any payments of alimony or child support with respect to individuals not living in the household.

''(B) RESOURCE DEEMING RULE.—The resources of a sponsor of the alien and of any spouse of the sponsor are deemed to be resources of the alien to the extent that the aggregate value of the resources exceeds $1,500.

''(C) SPONSORS OF MULTIPLE NON-213A ALIENS.—If a person is a sponsor of 2 or more non-213A aliens who are living in the same home, the income and resources of the sponsor and any spouse of the sponsor that would be deemed income and resources of any such alien under subparagraph (A) shall be divided into a number of equal shares equal to the number of such aliens, and the State shall deem the income and resources of each such alien to include 1 such share.

''(2) INELIGIBILITY OF NON-213A ALIENS SPONSORED BY AGENCIES; EXCEPTION.—A non-213A alien whose sponsor is or was a public or private agency shall be ineligible for assistance under a State program funded under this part, during a period of 3 years after the alien enters the United States, unless the State agency administering the program determines that the sponsor either no longer exists or has become unable to meet the alien's needs.

''(3) INFORMATION PROVISIONS.—

''(A) DUTIES OF NON-213A ALIENS.—A non-213A alien, as a condition of eligibility for assistance under a State program funded under this part

during the period of 3 years after the alien enters the United States, shall be required to provide to the State agency administering the program—

''(i) such information and documentation with respect to the alien's sponsor as may be necessary in order for the State agency to make any determination required under this subsection, and to obtain any cooperation from the sponsor necessary for any such determination; and

''(ii) such information and documentation as the State agency may request and which the alien or the alien's sponsor provided in support of the alien's immigration application.

''(B) DUTIES OF FEDERAL AGENCIES.—The Secretary shall enter into agreements with the Secretary of State and the Attorney General under which any information available to them and required in order to make any determination under this subsection will be provided by them to the Secretary (who may, in turn, make the information available, upon request, to a concerned State agency).

''(4) NON-213A ALIEN DEFINED.—An alien is a non-213A alien for purposes of this subsection if the affidavit of support or similar agreement with respect to the alien that was executed by the sponsor of the alien's entry into the United States was executed other than pursuant to section 213A of the Immigration and Nationality Act.

''(5) INAPPLICABILITY TO ALIEN MINOR SPONSORED BY A PARENT.—This subsection shall not apply to an alien who is a minor child if the sponsor of the alien or any spouse of the sponsor is a parent of the alien.

''(6) INAPPLICABILITY TO CERTAIN CATEGORIES OF ALIENS.—This subsection shall not apply to an alien who is—

''(A) admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(B) paroled into the United States under section 212(d)(5) of such Act for a period of at least 1 year; or

''(C) granted political asylum by the Attorney General under section 208 of such Act.''.

SEC. 5907. PENALTIES.

(a) STATES GIVEN MORE TIME TO FILE QUARTERLY REPORTS.—Section 409(a)(2)(A) (42 U.S.C. 609(a)(2)(A)) is amended by striking ''1 month'' and inserting ''45 days''.

(b) TREATMENT OF SUPPORT PAYMENTS PASSED THROUGH TO FAMILIES AS QUALIFIED STATE EXPENDITURES.—Section 409(a)(7)(B)(i)(I)(aa) (42 U.S.C. 609(a)(7)(B)(i)(I)(aa)) is amended by inserting '', including any amount collected by the State as support pursuant to a plan approved under part D, on behalf of a family receiving assistance under the State program funded under this part, that is distributed to the family under section 457(a)(1)(B) and disregarded in determining the eligibility of the family for, and the amount of, such assistance'' before the period.

(c) DISREGARD OF EXPENDITURES MADE TO REPLACE PENALTY GRANT REDUCTIONS.—Section 409(a)(7)(B)(i) (42 U.S.C. 609(a)(7)(B)(i)) is amended by redesignating subclause (III) as subclause (IV) and by inserting after subclause (II) the following:

''(III) EXCLUSION OF AMOUNTS EXPENDED TO REPLACE PENALTY GRANT REDUCTIONS.—Such term does not include any amount expended in order to comply with paragraph (12).''.

(d) TREATMENT OF FAMILIES OF CERTAIN ALIENS AS ELIGIBLE FAMILIES.—Section 409(a)(7)(B)(i)(IV) (42 U.S.C. 609(a)(7)(B)(i)(IV)), as so redesignated by subsection (c) of this section, is amended—

(1) by striking ''and families'' and inserting ''families''; and

(2) by striking ''Act or section 402'' and inserting ''Act, and families of aliens lawfully present in the United States that would be eligible for such assistance but for the application of title IV''.

(e) ELIMINATION OF MEANINGLESS LANGUAGE.—Section 409(a)(7)(B)(ii) (42 U.S.C. 609(a)(7)(B)(ii)) is amended by striking ''reduced (if appropriate) in accordance with subparagraph (C)(ii)''.

(f) CLARIFICATION OF SOURCE OF DATA TO BE USED IN DETERMINING HISTORIC STATE EXPENDITURES.—Section 409(a)(7)(B) (42 U.S.C. 609(a)(7)(B)) is amended by adding at the end the following:

''(v) SOURCE OF DATA.—In determining expenditures by a State for fiscal years 1994 and 1995, the Secretary shall use information which was reported by the State on ACF Form 231 or (in the case of expenditures under part F) ACF Form 331, available as of the dates specified in clauses (ii) and (iii) of section 403(a)(1)(D).''.

(g) CONFORMING TITLE IV–A PENALTIES TO TITLE IV–D PERFORMANCE-BASED STANDARDS.—Section 409(a)(8) (42 U.S.C. 609(a)(8)) is amended to read as follows:

''(8) NONCOMPLIANCE OF STATE CHILD SUPPORT ENFORCEMENT PROGRAM WITH REQUIREMENTS OF PART D.—

''(A) IN GENERAL.—If the Secretary finds, with respect to a State's program under part D, in a fiscal year beginning on or after October 1, 1997—

''(i)(I) on the basis of data submitted by a State pursuant to section 454(15)(B), or on the basis of the results of a review conducted under section 452(a)(4), that the State program failed to achieve the paternity establishment percentages (as defined in section 452(g)(2)), or to meet other performance measures that may be established by the Secretary;

''(II) on the basis of the results of an audit or audits conducted under section 452(a)(4)(C)(i) that the State data submitted pursuant to section 454(15)(B) is incomplete or unreliable; or

''(III) on the basis of the results of an audit or audits conducted under section 452(a)(4)(C) that a State failed to substantially comply with 1 or more of the requirements of part D; and

''(ii) that, with respect to the succeeding fiscal year—

''(I) the State failed to take sufficient corrective action to achieve the appropriate performance levels or compliance as described in subparagraph (A)(i); or

''(II) the data submitted by the State pursuant to section 454(15)(B) is incomplete or unreliable; the amounts otherwise payable to the State under this part for quarters following the end of such succeeding fiscal year, prior to quarters following the end of the first quarter throughout which the State program has achieved the paternity establishment percentages or other performance measures as described in subparagraph (A)(i)(I), or is in substantial compliance with 1 or more of the requirements of part D as described in subparagraph (A)(i)(III), as appropriate, shall be reduced by the percentage specified in subparagraph (B).

''(B) AMOUNT OF REDUCTIONS.—The reductions required under subparagraph (A) shall be—

''(i) not less than 1 nor more than 2 percent;

''(ii) not less than 2 nor more than 3 percent, if the finding is the 2nd consecutive finding made pursuant to subparagraph (A); or

''(iii) not less than 3 nor more than 5 percent, if the finding is the 3rd or a subsequent consecutive such finding.

''(C) DISREGARD OF NONCOMPLIANCE WHICH IS OF A TECHNICAL NATURE.—For purposes of this section and section 452(a)(4), a State determined as a result of an audit—

''(i) to have failed to have substantially complied with 1 or more of the requirements of part D shall be determined to have achieved substantial compliance only if the Secretary determines that the extent of the noncompliance is of a technical nature which does not adversely affect the performance of the State's program under part D; or

''(ii) to have submitted incomplete or unreliable data pursuant to section 454(15)(B) shall be determined to have submitted adequate data only if the Secretary determines that the extent of the incompleteness or unreliability of the data is of a technical nature which does not adversely affect the determination of the level of the State's paternity establishment percentages (as defined under section 452(g)(2)) or other performance measures that may be established by the Secretary.''.

(h) CORRECTION OF REFERENCE TO 5-YEAR LIMIT ON ASSISTANCE.—Section 409(a)(9) (42 U.S.C. 609(a)(9)) is amended by striking ''408(a)(1)(B)'' and inserting ''408(a)(7)''.

(i) CORRECTION OF ERRORS IN PENALTY FOR FAILURE TO MEET MAINTENANCE OF EFFORT REQUIREMENT APPLICABLE TO THE CONTINGENCY FUND.—Section 409(a)(10) (42 U.S.C. 609(a)(10)) is amended—

(1) by striking ''the expenditures under the State program funded under this part for the fiscal year (excluding any amounts made available by the Federal Government)'' and inserting ''the qualified State expenditures (as defined in paragraph (7)(B)(i) (other than the expenditures described in subclause (I)(bb) of that paragraph)) under the State program funded under this part for the fiscal year'';

(2) by inserting ''excluding any amount expended by the State for child care under subsection (g) or (i) of section 402 (as in effect during fiscal year 1994) for fiscal year 1994,'' after ''(as defined in paragraph (7)(B)(iii) of this subsection),''; and

(3) by inserting ''that the State has not remitted under section 403(b)(6)'' before the period.

(j) PENALTY FOR STATE FAILURE TO EXPEND ADDITIONAL STATE FUNDS TO REPLACE GRANT REDUCTIONS.—Section 409(a)(12) (42 U.S.C. 609(a)(12)) is amended—

(1) in the heading—

(A) by striking ''FAILURE'' and inserting ''REQUIREMENT''; and

(B) by striking ''REDUCTIONS'' and inserting ''REDUCTIONS; PENALTY FOR FAILURE TO DO SO''; and

(2) by inserting '', and if the State fails to do so, the Secretary may reduce the grant payable to the State under section 403(a)(1) for the fiscal year that follows such succeeding fiscal year by an amount equal to not more than 2 percent of the State family assistance grant'' before the period.

(k) ELIMINATION OF CERTAIN REASONABLE CAUSE EXCEPTIONS.—Section 409(b)(2) (42 U.S.C. 609(b)(2)) is amended by striking ''(7) or (8)'' and inserting ''(6), (7), (8), (10), or (12)''.

(l) CLARIFICATION OF WHAT IT MEANS TO CORRECT A VIOLATION.—Section 409(c) (42 U.S.C. 609(c)) is amended—

(1) in each of subparagraphs (A) and (B) of paragraph (1), by inserting ''or discontinue, as appropriate,'' after ''correct'';

(2) in paragraph (2)—

(A) in the heading, by inserting ''OR DISCONTINUING'' after ''CORRECTING''; and

(B) by inserting ''or discontinues, as appropriate'' after ''corrects''; and

(3) in paragraph (3)—

(A) in the heading, by inserting ''OR DISCONTINUE'' after ''CORRECT''; and

(B) by inserting ''or discontinue, as appropriate,'' before ''the violation''.

(m) CERTAIN PENALTIES NOT AVOIDABLE THROUGH CORRECTIVE COMPLIANCE PLANS.—Section 409(c)(4) (42 U.S.C. 609(c)(4)) is amended to read as follows:

''(4) INAPPLICABILITY TO CERTAIN PENALTIES.—This subsection shall not apply to the imposition of a penalty against a State under paragraph (6), (7), (8), (10), or (12) of subsection (a).''.

(n) FAILURE TO SATISFY MINIMUM PARTICIPATION RATES.—Section 409(a)(3) (42 U.S.C. 609(a)(3)) is amended—

(1) in subparagraph (A), by striking ''not more than''; and

(2) in subparagraph (C), by inserting before the period the following: ''or if the noncompliance is due to extraordinary circumstances such as a natural disaster or regional recession. The Secretary shall provide a written report to Congress to justify any waiver or penalty reduction due to such extraordinary circumstances''.

SEC. 5908. DATA COLLECTION AND REPORTING.

Section 411(a) (42 U.S.C. 611(a)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A)—

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

''(ii) Whether a child receiving such assistance or an adult in the family is receiving—

''(I) Federal disability insurance benefits;

''(II) benefits based on Federal disability status;

''(III) aid under a State plan approved under title XIV (as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972));

''(IV) aid or assistance under a State plan approved under title XVI (as in effect without regard to such amendment) by reason of being permanently and totally disabled; or

''(V) supplemental security income benefits under title XVI (as in effect pursuant to such amendment) by reason of disability.'';

(ii) in clause (iv), by striking ''youngest child in'' and inserting ''head of'';

(iii) in each of clauses (vii) and (viii), by striking ''status'' and inserting ''level''; and

(iv) by adding at the end the following:

''(xvii) With respect to each individual in the family who has not attained 20 years of age, whether the individual is a parent of a child in the family.''; and

(B) in subparagraph (B)—

(i) in the heading, by striking ''ESTIMATES'' and inserting ''SAMPLES''; and

(ii) in clause (i), by striking ''an estimate which is obtained'' and inserting ''disaggregated case record information on a sample of families selected''; and

(2) by redesignating paragraph (6) as paragraph (7) and inserting after paragraph (5) the following:

''(6) REPORT ON FAMILIES RECEIVING ASSISTANCE.—The report required by paragraph (1) for a fiscal quarter shall include for each month in the quarter the number of families and individuals receiving assistance under the State program funded under this part (including the number of 2-parent and 1-parent families), and the total dollar value of such assistance received by all families.''.

SEC. 5909. DIRECT FUNDING AND ADMINISTRATION BY INDIAN TRIBES.

(a) PRORATING OF TRIBAL FAMILY ASSISTANCE GRANTS.—Section 412(a)(1)(A) (42 U.S.C. 612(a)(1)(A)) is amended by inserting ''which shall be reduced for a fiscal year, on a pro rata basis for each quarter, in the case of a tribal family assistance plan approved during a fiscal year for which the plan is to be in effect,'' before ''and shall''.

(b) TRIBAL OPTION TO OPERATE WORK ACTIVITIES PROGRAM.—Section 412(a)(2)(A) (42 U.S.C. 612(a)(2)(A)) is amended by striking ''The Secretary'' and all that follows through ''2002'' and inserting ''For each of fiscal years 1997, 1998, 1999, 2000, 2001, and 2002, the Secretary shall pay to each eligible Indian tribe that proposes to operate a program described in subparagraph (C)''.

(c) DISCRETION OF TRIBES TO SELECT POPULATION TO BE SERVED BY TRIBAL WORK ACTIVITIES PROGRAM.—Section 412(a)(2)(C) (42 U.S.C. 612(a)(2)(C)) is amended by striking ''members of the Indian tribe'' and inserting ''such population and such service area or areas as the tribe specifies''.

(d) REDUCTION OF APPROPRIATION FOR TRIBAL WORK ACTIVITIES PROGRAMS.—Section 412(a)(2)(D) (42 U.S.C. 612(a)(2)(D)) is amended by striking ''$7,638,474'' and inserting ''$7,633,287''.

(e) AVAILABILITY OF CORRECTIVE COMPLIANCE PLANS TO INDIAN TRIBES.—Section 412(f)(1) (42 U.S.C. 612(f)(1)) is amended by striking ''and (b)'' and inserting ''(b), and (c)''.

(f) ELIGIBILITY OF TRIBES FOR FEDERAL LOANS FOR WELFARE PROGRAMS.—Section 412 (42 U.S.C. 612) is amended by redesignating subsections (f), (g), and (h) as subsections (g), (h), and (i), respectively, and by inserting after subsection (e) the following:

''(f) ELIGIBILITY FOR FEDERAL LOANS.—Section 406 shall apply to an Indian tribe with an approved tribal assistance plan in the same manner as such section applies to a State, except that section 406(c) shall be applied by substituting 'section 412(a)' for 'section 403(a)'.''.

SEC. 5910. RESEARCH, EVALUATIONS, AND NATIONAL STUDIES.

(a) RESEARCH.—

(1) METHODS.—Section 413(a) (42 U.S.C. 613(a)) is amended by inserting '', directly or through grants, contracts, or interagency agreements,'' before ''shall conduct''.

(2) CORRECTION OF CROSS REFERENCE.—Section 413(a) (42 U.S.C. 613(a)) is amended by striking ''409'' and inserting ''407''.

(b) CORRECTION OF ERRONEOUSLY INDENTED PARAGRAPH.—Section 413(e)(1) (42 U.S.C. 613(e)(1)) is amended to read as follows:

''(1) IN GENERAL.—The Secretary shall annually rank States to which grants are made under section 403 based on the following ranking factors:

''(A) ABSOLUTE OUT-OF-WEDLOCK RATIOS.—The ratio represented by—

''(i) the total number of out-of-wedlock births in families receiving assistance under the State program under this part in the State for the most recent year for which information is available; over

''(ii) the total number of births in families receiving assistance under the State program under this part in the State for the year.

''(B) NET CHANGES IN THE OUT-OF-WEDLOCK RATIO.—The difference between the ratio described in subparagraph (A) with respect to a State for the most recent year for which such information is available and the ratio with respect to the State for the immediately preceding year.''.

(c) FUNDING OF PRIOR AUTHORIZED DEMONSTRATIONS.—Section 413(h)(1)(D) (42 U.S.C. 613(h)(1)(D)) is amended by striking ''September 30, 1995'' and inserting ''August 22, 1996''.

(d) CHILD POVERTY REPORTS.—

(1) DELAYED DUE DATE FOR INITIAL REPORT.—Section 413(i)(1) (42 U.S.C. 613(i)(1)) is amended by striking ''90 days after the date of the enactment of this part'' and inserting ''November 30, 1997''.

(2) MODIFICATION OF FACTORS TO BE USED IN ESTABLISHING METHODOLOGY FOR USE IN DETERMINING CHILD POVERTY RATES.—Section 413(i)(5) (42 U.S.C. 613(i)(5)) is amended by striking ''the county-by-county'' and inserting '', to the extent available, county-by-county''.

SEC. 5911. REPORT ON DATA PROCESSING.

Section 106(a)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2164) is amended by striking ''(whether in effect before or after October 1, 1995)''.

SEC. 5912. STUDY ON ALTERNATIVE OUTCOMES MEASURES.

Section 107(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2164) is amended by striking ''409(a)(7)(C)'' and inserting ''408(a)(7)(C)''.

SEC. 5913. LIMITATION ON PAYMENTS TO THE TERRITORIES.

(a) CERTAIN PAYMENTS TO BE DISREGARDED IN DETERMINING LIMITATION.—Section 1108(a) (42 U.S.C. 1308) is amended to read as follows:

''(a) LIMITATION ON TOTAL PAYMENTS TO EACH TERRITORY.—

''(1) IN GENERAL.—Notwithstanding any other provision of this Act (except for paragraph (2) of this subsection), the total amount certified by the Secretary of Health and Human Services under titles I, X, XIV, and XVI, under parts A and E of title IV, and under subsection (b) of this section, for payment to any territory for a fiscal year shall not exceed the ceiling amount for the territory for the fiscal year.

''(2) CERTAIN PAYMENTS DISREGARDED.—Paragraph (1) of this subsection shall be applied without regard to any payment made under section 403(a)(2), 403(a)(4), 406, or 413(f).''.

(b) CERTAIN CHILD CARE AND SOCIAL SERVICES EXPENDITURES BY TERRITORIES TREATED AS IV–A EXPENDITURES FOR PURPOSES OF MATCHING GRANT.—Section 1108(b)(1)(A) (42 U.S.C. 1308(b)(1)(A)) is amended by inserting '', including any amount paid to the State under part A of title IV that is transferred in accordance with section 404(d) and expended under the program to which transferred'' before the semicolon.

(c) ELIMINATION OF DUPLICATIVE MAINTENANCE OF EFFORT REQUIREMENT.—Section 1108 (42 U.S.C. 1308) is amended by striking subsection (e).

SEC. 5914. CONFORMING AMENDMENTS TO THE SOCIAL SECURITY ACT.

(a) AMENDMENTS TO PART D OF TITLE IV.—

(1) CORRECTIONS TO DETERMINATION OF PATERNITY ESTABLISHMENT PERCENTAGES.—Section 452 (42 U.S.C. 652) is amended—

(A) in subsection (d)(3)(A), by striking all that follows ''for purposes of'' and inserting ''section 409(a)(8), to achieve the paternity establishment percentages (as defined under section 452(g)(2)) and other performance measures that may be established by the Secretary, and to submit data under section 454(15)(B) that is complete and reliable, and to substantially comply with the requirements of this part; and''; and

(B) in subsection (g)(1), by striking ''section 403(h)'' and inserting ''section 409(a)(8)''.

(2) ELIMINATION OF OBSOLETE LANGUAGE.—Section 108(c)(8)(C) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2165) is amended by inserting ''and all that follows through 'the best interests of such child to do so''' before ''and inserting''.

(3) INSERTION OF LANGUAGE INADVERTENTLY OMITTED.—Section 108(c)(13) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2166) is amended by inserting ''and inserting 'pursuant to section 408(a)(3)''' before the period.

(4) ELIMINATION OF OBSOLETE CROSS REFERENCE.—Section 464(a)(1) (42 U.S.C. 664(a)(1)) is amended by striking ''section 402(a)(26)'' and inserting ''section 408(a)(3)''.

(b) AMENDMENTS TO PART E OF TITLE IV.—Each of the following is amended by striking ''June 1, 1995'' each place such term appears and inserting ''July 16, 1996'':

(1) Section 472(a) (42 U.S.C. 672(a)).

(2) Section 472(h) (42 U.S.C. 672(h)).

(3) Section 473(a)(2) (42 U.S.C. 673(a)(2)).

(4) Section 473(b) (42 U.S.C. 673(b)).

SEC. 5915. OTHER CONFORMING AMENDMENTS.

(a) ELIMINATION OF AMENDMENTS INCLUDED INADVERTENTLY.—Section 110(l) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2173) is amended—

(1) by striking paragraphs (1), (4), (5), and (7);

(2) by redesignating paragraphs (2), (3), (6), and (8) as paragraphs (1), (2), (3), and (4), respectively; and

(3) by adding ''and'' at the end of paragraph (3), as so redesignated.

(b) CORRECTION OF CITATION.—Section 109(f) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2177) is amended by striking ''93–186'' and inserting ''93–86''.

(c) CORRECTION OF INTERNAL CROSS REFERENCE.—Section 103(a)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2112) is amended by striking ''603(b)(2)'' and inserting ''603(b)''.

(d) CORRECTION OF REFERENCES.—Section 416 (42 U.S.C. 616) is amended by striking ''amendment made by section 2103 of the Personal Responsibility and Work Opportunity'' and inserting ''amendments made by section 103 of the

Personal Responsibility and Work Opportunity Reconciliation''.

SEC. 5916. MODIFICATIONS TO THE JOB OPPORTUNITIES FOR CERTAIN LOW-INCOME INDIVIDUALS PROGRAM.

Section 112(5) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2177) is amended in each of subparagraphs (A) and (B) by inserting ''under'' after ''funded''.

SEC. 5917. DENIAL OF ASSISTANCE AND BENEFITS FOR DRUG-RELATED CONVICTIONS.

(a) EXTENSION OF CERTAIN REQUIREMENTS COORDINATED WITH DELAYED EFFECTIVE DATE FOR SUCCESSOR PROVISIONS.—Section 115(d)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2181) is amended by striking ''convictions'' and inserting ''a conviction if the conviction is for conduct''.

(b) IMMEDIATE EFFECTIVENESS OF PROVISIONS RELATING TO RESEARCH, EVALUATIONS, AND NATIONAL STUDIES.—Section 116(a) of such Act (Public Law 104–193; 110 Stat. 2181) is amended by adding at the end the following:

''(6) RESEARCH, EVALUATIONS, AND NATIONAL STUDIES.—Section 413 of the Social Security Act, as added by the amendment made by section 103(a) of this Act, shall take effect on the date of the enactment of this Act.''.

SEC. 5918. TRANSITION RULE.

Section 116 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2181) is amended—

(1) in subsection (a)(2), by inserting ''(but subject to subsection (b)(1)(A)(ii))'' after ''this section''; and

(2) in subsection (b)(1)(A)(ii), by striking ''June 30, 1997'' and inserting ''the later of June 30, 1997, or the day before the date described in subsection (a)(2)(B) of this section''.

SEC. 5919. PROTECTING VICTIMS OF FAMILY VIOLENCE.

(a) FINDINGS.—Congress finds that—

(1) the intent of Congress in amending part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.) in section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat 2112) was to allow States to take into account the effects of the epidemic of domestic violence in establishing their welfare programs, by giving States the flexibility to grant individual, temporary waivers for good cause to victims of domestic violence who meet the criteria set forth in section 402(a)(7)(B) of the Social Security Act (42 U.S.C. 602(a)(7)(B));

(2) the allowance of waivers under such sections was not intended to be limited by other, separate, and independent provisions of part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.);

(3) under section 402(a)(7)(A)(iii) of such Act (42 U.S.C. 602(a)(7)(A)(iii)), requirements under the temporary assistance for needy families program under part A of title IV of such Act may, for good cause, be waived for so long as necessary; and

(4) good cause waivers granted pursuant to section 402(a)(7)(A)(iii) of such Act (42 U.S.C. 602(a)(7)(A)(iii)) are intended to be temporary and directed only at particular program requirements when needed on an individual case-by-case basis, and are intended to facilitate the ability of victims of domestic violence to move forward and meet program requirements when safe and feasible without interference by domestic violence.

(b) CLARIFICATION OF WAIVER PROVISIONS.—

(1) IN GENERAL.—Section 402(a)(7) (42 U.S.C. 602(a)(7)) is amended by adding at the end the following:

''(C) NO NUMERICAL LIMITS.—In implementing this paragraph, a State shall not be subject to any numerical limitation in the granting of good cause waivers under subparagraph (A)(iii).

''(D) WAIVERED INDIVIDUALS NOT INCLUDED FOR PURPOSES OF CERTAIN OTHER PROVISIONS OF THIS PART.—Any individual to whom a good cause waiver of compliance with this Act has been granted in accordance with subparagraph (A)(iii) shall not be included for purposes of determining a State's compliance with the participation rate requirements set forth in section 407, for purposes of applying the limitation described in section 408(a)(7)(C)(ii), or for purposes of determining whether to impose a penalty under paragraph (3), (5), or (9) of section 409(a).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect as if it had been included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2112).

(c) FEDERAL PARENT LOCATOR SERVICE.—

(1) IN GENERAL.—Section 453 (42 U.S.C. 653), as amended by section 5938, is further amended—

(A) in subsection (b)(2)—

(i) in the matter preceding subparagraph (A), by inserting ''or that the health, safety, or liberty or a parent or child would by unreasonably put at risk by the disclosure of such information,'' before ''provided that'';

(ii) in subparagraph (A), by inserting '', that the health, safety, or liberty or a parent or child would by unreasonably put at risk by the disclosure of such information,'' before ''and that information''; and

(iii) in subparagraph (B)(i), by striking ''be harmful to the parent or the child'' and inserting ''place the health, safety, or liberty of a parent or child unreasonably at risk''; and

(B) in subsection (c)(2), by inserting '', or to serve as the initiating court in an action to seek and order,'' before ''against a noncustodial''.

(2) STATE PLAN.—Section 454(26) (42 U.S.C. 654), as amended by section 5956, is further amended—

(A) in subparagraph (C), by striking ''result in physical or emotional harm to the party or the child'' and inserting ''place the health, safety, or liberty of a parent or child unreasonably at risk'';

(B) in subparagraph (D), by striking ''of domestic violence or child abuse against a party or the child and that the disclosure of such information could be harmful to the party or the child'' and inserting ''that the health, safety, or liberty of a parent or child would be unreasonably put at risk by the disclosure of such information''; and

(C) in subparagraph (E), by striking ''of domestic violence'' and all that follows through the semicolon and inserting ''that the health, safety, or liberty of a parent or child would be unreasonably put at risk by the disclosure of such information pursuant to section 453(b)(2), the court shall determine whether disclosure to any other person or persons of information received from the Secretary could place the health, safety, or liberty or a parent or child unreasonably at risk (if the court determines that disclosure to any other person could be harmful, the court and its agents shall not make any such disclosure);''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect 1 day after the effective date described in section 5961(a).

SEC. 5920. EFFECTIVE DATES.

(a) AMENDMENTS TO PART A OF TITLE IV OF THE SOCIAL SECURITY ACT.—The amendments made by this chapter to a provision of part A of title IV of the Social Security Act shall take effect as if the amendments had been included in section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 at the time such section became law.

(b) AMENDMENTS TO PARTS D AND E OF TITLE IV OF THE SOCIAL SECURITY ACT.—The amendments made by section 5914 of this Act shall take effect as if the amendments had been included in section 108 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 at the time such section 108 became law.

(c) AMENDMENTS TO OTHER AMENDATORY PROVISIONS.—The amendments made by section 5915(a) of this Act shall take effect as if the amendments had been included in section 110 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 at the time such section 110 became law.

(d) AMENDMENTS TO FREESTANDING PROVISIONS OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996.—The amendments made by this chapter to a provision of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 that, as of July 1, 1997, will not have become part of another statute shall take effect as if the amendments had been included in the provision at the time the provision became law.

CHAPTER 2—SUPPLEMENTAL SECURITY INCOME

SEC. 5921. CONFORMING AND TECHNICAL AMENDMENTS RELATING TO ELIGIBILITY RESTRICTIONS.

(a) DENIAL OF SSI BENEFITS FOR FUGITIVE FELONS AND PROBATION AND PAROLE VIOLATORS.—Section 1611(e)(6) (42 U.S.C. 1382(e)(6)) is amended by inserting ''and section 1106(c) of this Act'' after ''of 1986''.

(b) TREATMENT OF PRISONERS.—Section 1611(e)(1)(I)(i)(II) (42 U.S.C. 1382(e)(1)(I)(i)(II)) is amended by striking ''inmate of the institution'' and all that follows through ''this subparagraph'' and inserting ''individual who receives in the month preceding the first month throughout which such individual is an inmate of the jail, prison, penal institution, or correctional facility that furnishes information respecting such individual pursuant to subclause (I), or is confined in the institution (that so furnishes such information) as described in section 202(x)(1)(A)(ii), a benefit under this title for such preceding month, and who is determined by the Commissioner to be ineligible for benefits under this title by reason of confinement based on the information provided by such institution''.

(c) CORRECTION OF REFERENCE.—Section 1611(e)(1)(I)(i)(I) (42 U.S.C. 1382(e)(1)(I)(i)(I)) is amended by striking ''paragraph (1)'' and inserting ''this paragraph''.

SEC. 5922. CONFORMING AND TECHNICAL AMENDMENTS RELATING TO BENEFITS FOR DISABLED CHILDREN.

(a) ELIGIBILITY REDETERMINATIONS FOR CURRENT RECIPIENTS.—Section 211(d)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (42 U.S.C. 1382c note) is amended by striking ''1 year'' and inserting ''18 months''.

(b) ELIGIBILITY REDETERMINATIONS AND CONTINUING DISABILITY REVIEWS.—

(1) DISABILITY ELIGIBILITY REDETERMINATIONS REQUIRED FOR SSI RECIPIENTS WHO ATTAIN 18 YEARS OF AGE.—Section 1614(a)(3)(H)(iii) (42 U.S.C. 1382c(a)(3)(H)(iii)) is amended by striking subclauses (I) and (II) and all that follows and inserting the following:

''(I) by applying the criteria used in determining initial eligibility for individuals who are age 18 or older; and

''(II) either during the 1-year period beginning on the individual's 18th birthday or, in lieu of a continuing disability review, whenever the Commissioner determines that an individual's case is subject to a redetermination under this clause.

With respect to any redetermination under this clause, paragraph (4) shall not apply.''.

(2) CONTINUING DISABILITY REVIEW REQUIRED FOR LOW BIRTH WEIGHT BABIES.—Section 1614(a)(3)(H)(iv) (42 U.S.C. 1382c(a)(3)(H)(iv)) is amended—

(A) in subclause (I), by striking ''Not'' and inserting ''Except as provided in subclause (VI), not''; and

(B) by adding at the end the following:

''(VI) Subclause (I) shall not apply in the case of an individual described in that subclause who, at the time of the individual's initial disability determination, the Commissioner determines has an impairment that is not expected to improve within 12 months after the birth of that individual, and who the Commissioner schedules for a continuing disability review at a date that is after the individual attains 1 year of age.''.

(c) ADDITIONAL ACCOUNTABILITY REQUIREMENTS.—Section 1631(a)(2)(F) (42 U.S.C. 1383(a)(2)(F)) is amended—

(1) in clause (ii)(III)(bb), by striking ''the total amount'' and all that follows through ''1613(c)'' and inserting ''in any case in which the individual knowingly misapplies benefits from such an account, the Commissioner shall reduce future benefits payable to such individual (or to such individual and his spouse) by an amount equal to the total amount of such benefits so misapplied''; and

(2) by striking clause (iii) and inserting the following:

''(iii) The representative payee may deposit into the account established under clause (i) any other funds representing past due benefits under this title to the eligible individual, provided that the amount of such past due benefits is equal to or exceeds the maximum monthly benefit payable under this title to an eligible individual (including State supplementary payments made by the Commissioner pursuant to an agreement under section 1616 or section 212(b) of Public Law 93–66).''.

(d) REDUCTION IN CASH BENEFITS PAYABLE TO INSTITUTIONALIZED INDIVIDUALS WHOSE MEDICAL COSTS ARE COVERED BY PRIVATE INSURANCE.—Section 1611(e) (42 U.S.C. 1382(e)) is amended—

(1) in paragraph (1)(B)—

(A) in the matter preceding clause (i), by striking ''hospital, extended care facility, nursing home, or intermediate care facility'' and inserting ''medical treatment facility'';

(B) in clause (ii)—

(i) in the matter preceding subclause (I), by striking ''hospital, home or''; and

(ii) in subclause (I), by striking ''hospital, home, or'';

(C) in clause (iii), by striking ''hospital, home, or''; and

(D) in the matter following clause (iii), by striking ''hospital, extended care facility, nursing home, or intermediate care facility which is a 'medical institution or nursing facility' within the meaning of section 1917(c)'' and inserting ''medical treatment facility that provides services described in section 1917(c)(1)(C)'';

(2) in paragraph (1)(E)—

(A) in clause (i)(II), by striking ''hospital, extended care facility, nursing home, or intermediate care facility'' and inserting ''medical treatment facility''; and

(B) in clause (iii), by striking ''hospital, extended care facility, nursing home, or intermediate care facility'' and inserting ''medical treatment facility'';

(3) in paragraph (1)(G), in the matter preceding clause (i)—

(A) by striking ''or which is a hospital, extended care facility, nursing home, or intermediate care'' and inserting ''or is in a medical treatment''; and

(B) by inserting ''or, in the case of an individual who is a child under the age of 18, under any health insurance policy issued by a private provider of such insurance'' after ''title XIX''; and

(4) in paragraph (3)—

(A) by striking ''same hospital, home, or facility'' and inserting ''same medical treatment facility''; and

(B) by striking ''same such hospital, home, or facility'' and inserting ''same such facility''.

(e) CORRECTION OF U.S.C. CITATION.—Section 211(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2189) is amended by striking ''1382(a)(4)'' and inserting ''1382c(a)(4)''.

SEC. 5923. ADDITIONAL TECHNICAL AMENDMENTS TO TITLE XVI.

Section 1615(d) (42 U.S.C. 1382d(d)) is amended—

(1) in the first sentence, by inserting a comma after ''subsection (a)(1)''; and

(2) in the last sentence, by striking ''him'' and inserting ''the Commissioner''.

SEC. 5924. ADDITIONAL TECHNICAL AMENDMENTS RELATING TO TITLE XVI.

Section 1110(a)(3) (42 U.S.C. 1310(a)(3)) is amended—

(1) by inserting ''(or the Commissioner, with respect to any jointly financed cooperative agreement or grant concerning title XVI)'' after ''Secretary'' the first place it appears; and

(2) by inserting ''(or the Commissioner, as applicable)'' after ''Secretary'' the second place it appears.

SEC. 5925. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided in subsection (b), the amendments made by this part shall take effect as if included in the enactment of title II of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2185).

(b) EXCEPTION.—The amendments made by section 5925 shall take effect as if included in the enactment of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296; 108 Stat. 1464).

CHAPTER 3—CHILD SUPPORT

SEC. 5935. STATE OBLIGATION TO PROVIDE CHILD SUPPORT ENFORCEMENT SERVICES.

(a) INDIVIDUALS SUBJECT TO FEE FOR CHILD SUPPORT ENFORCEMENT SERVICES.—Section 454(6)(B) (42 U.S.C. 654(6)(B)) is amended by striking ''individuals not receiving assistance under any State program funded under part A, which'' and inserting ''an individual, other than an individual receiving assistance under a State program funded under part A or E, or under a State plan approved under title XIX, or who is required by the State to cooperate with the State agency administering the program under this part pursuant to subsection (l) or (m) of section 6 of the Food Stamp Act of 1977, and''.

(b) CORRECTION OF REFERENCE.—Section 464(a)(2)(A) (42 U.S.C. 654(a)(2)(A)) is amended in the first sentence by striking ''section 454(6)'' and inserting ''section 454(4)(A)(ii)''.

SEC. 5936. DISTRIBUTION OF COLLECTED SUPPORT.

(a) CONTINUATION OF ASSIGNMENTS.—Section 457(b) (42 U.S.C. 657(b)) is amended—

(1) by striking ''which were assigned'' and inserting ''assigned''; and

(2) by striking ''and which were in effect'' and all that follows and inserting ''and in effect on September 30, 1997 (or such earlier date, on or after August 22, 1996, as the State may choose), shall remain assigned after such date.''.

(b) STATE OPTION FOR APPLICABILITY.—

(1) IN GENERAL.—Section 457(a) (42 U.S.C. 657(a)) is amended by adding at the end the following:

''(6) STATE OPTION FOR APPLICABILITY.—Notwithstanding any other provision of this subsection, a State may elect to apply the rules described in clauses (i)(II), (ii)(II), and (v) of paragraph (2)(B) to support arrearages collected on and after October 1, 1998, and, if the State makes such an election, shall apply the provisions of this section, as in effect and applied on the day before the date of enactment of section 302 of the Personal Responsibility and Work Opportunity Act of 1996 (Public Law 104–193, 110 Stat. 2200), other than subsection (b)(1) (as so in effect), to amounts collected before October 1, 1998.''.

(2) CONFORMING AMENDMENTS.—Section 408(a)(3)(A) (42 U.S.C. 608(a)(3)(A)) is amended—

(A) in clause (i), by inserting ''(I)'' after ''(i)'';

(B) in clause (ii)—

(i) by striking ''(ii)'' and inserting ''(II)''; and

(ii) by striking the period and inserting ''; or''; and

(C) by adding at the end, the following:

''(ii) if the State elects to distribute collections under section 457(a)(6), the date the family ceases to receive assistance under the program, if the assignment is executed on or after October 1, 1998.''.

(c) DISTRIBUTION OF COLLECTIONS WITH RESPECT TO FAMILIES RECEIVING ASSISTANCE.—Section 457(a)(1) (42 U.S.C. 657(a)(1)) is amended by adding at the end the following flush language: ''In no event shall the total of the amounts paid to the Federal Government and retained by the State exceed the total of the amounts that have been paid to the family as assistance by the State.''.

(d) FAMILIES UNDER CERTAIN AGREEMENTS.—Section 457(a)(4) (42 U.S.C. 657(a)(4)) is amended to read as follows:

''(4) FAMILIES UNDER CERTAIN AGREEMENTS.—In the case of an amount collected for a family in accordance with a cooperative agreement under section 454(33), distribute the amount so collected pursuant to the terms of the agreement.''.

(e) STUDY AND REPORT.—Section 457(a)(5) (42 U.S.C. 657(a)(5)) is amended by striking ''1998'' and inserting ''1999''.

(f) CORRECTIONS OF REFERENCES.—Section 457(a)(2)(B) (42 U.S.C. 657(a)(2)(B)) is amended—

(1) in clauses (i)(I) and (ii)(I)—

(A) by striking ''(other than subsection (b)(1))'' each place it appears; and

(B) by inserting ''(other than subsection (b)(1) (as so in effect))'' after ''1996'' each place it appears; and

(2) in clause (ii)(II), by striking ''paragraph (4)'' and inserting ''paragraph (5)''.

(g) CORRECTION OF TERRITORIAL MATCH.—Section 457(c)(3)(A) (42 U.S.C. 657(c)(3)(A)) is amended by striking ''the Federal medical assistance percentage (as defined in section 1118)'' and inserting ''75 percent''.

(h) DEFINITIONS.—

(1) FEDERAL SHARE.—Section 457(c)(2) (42 U.S.C. 657(c)(2)) is amended by striking ''collected'' the second place it appears and inserting ''distributed''.

(2) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—Section 457(c)(3)(B) (42 U.S.C. 657(c)(3)(B)) is amended by striking ''as in effect on September 30, 1996'' and inserting ''as such section was in effect on September 30, 1995''.

(i) CONFORMING AMENDMENTS.—

(1) Section 464(a)(2)(A) (42 U.S.C. 664(a)(2)(A)) is amended, in the penultimate sentence, by inserting ''in accordance with section 457'' after ''owed''.

(2) Section 466(a)(3)(B) (42 U.S.C. 666(a)(3)(B)) is amended by striking ''457(b)(4) or (d)(3)'' and inserting ''457''.

SEC. 5937. CIVIL PENALTIES RELATING TO STATE DIRECTORY OF NEW HIRES.

Section 453A (42 U.S.C. 653a) is amended—

(1) in subsection (d)—

(A) in the matter preceding paragraph (1), by striking ''shall be less than'' and inserting ''shall not exceed''; and

(B) in paragraph (1), by striking ''$25'' and inserting ''$25 per failure to meet the requirements of this section with respect to a newly hired employee''; and

(2) in subsection (g)(2)(B), by striking ''extracts'' and all that follows through ''Labor'' and inserting ''information''.

SEC. 5938. FEDERAL PARENT LOCATOR SERVICE.

(a) IN GENERAL.—Section 453 (42 U.S.C. 653) is amended—

(1) in subsection (a)—

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

(B) by striking ''to obtain'' and all that follows through the period and inserting ''for the purposes specified in paragraphs (2) and (3).

''(2) For the purpose of establishing parentage, establishing, setting the amount of, modifying, or enforcing child support obligations, the

Federal Parent Locator Service shall obtain and transmit to any authorized person specified in subsection (c)—

''(A) information on, or facilitating the discovery of, the location of any individual—

''(i) who is under an obligation to pay child support;

''(ii) against whom such an obligation is sought; or

''(iii) to whom such an obligation is owed,

including the individual's social security number (or numbers), most recent address, and the name, address, and employer identification number of the individual's employer;

''(B) information on the individual's wages (or other income) from, and benefits of, employment (including rights to or enrollment in group health care coverage); and

''(C) information on the type, status, location, and amount of any assets of, or debts owed by or to, any such individual.

''(3) For the purpose of enforcing any Federal or State law with respect to the unlawful taking or restraint of a child, or making or enforcing a child custody or visitation determination, as defined in section 463(d)(1), the Federal Parent Locator Service shall be used to obtain and transmit the information specified in section 463(c) to the authorized persons specified in section 463(d)(2).'';

(2) by striking subsection (b) and inserting the following:

''(b)(1) Upon request, filed in accordance with subsection (d), of any authorized person, as defined in subsection (c) for the information described in subsection (a)(2), or of any authorized person, as defined in section 463(d)(2) for the information described in section 463(c), the Secretary shall, notwithstanding any other provision of law, provide through the Federal Parent Locator Service such information to such person, if such information—

''(A) is contained in any files or records maintained by the Secretary or by the Department of Health and Human Services; or

''(B) is not contained in such files or records, but can be obtained by the Secretary, under the authority conferred by subsection (e), from any other department, agency, or instrumentality of the United States or of any State,

and is not prohibited from disclosure under paragraph (2).

''(2) No information shall be disclosed to any person if the disclosure of such information would contravene the national policy or security interests of the United States or the confidentiality of census data. The Secretary shall give priority to requests made by any authorized person described in subsection (c)(1). No information shall be disclosed to any person if the State has notified the Secretary that the State has reasonable evidence of domestic violence or child abuse and the disclosure of such information could be harmful to the custodial parent or the child of such parent, provided that—

''(A) in response to a request from an authorized person (as defined in subsection (c) and section 463(d)(2)), the Secretary shall advise the authorized person that the Secretary has been notified that there is reasonable evidence of domestic violence or child abuse and that information can only be disclosed to a court or an agent of a court pursuant to subparagraph (B); and

''(B) information may be disclosed to a court or an agent of a court described in subsection (c)(2) or section 463(d)(2)(B), if—

''(i) upon receipt of information from the Secretary, the court determines whether disclosure to any other person of that information could be harmful to the parent or the child; and

''(ii) if the court determines that disclosure of such information to any other person could be harmful, the court and its agents shall not make any such disclosure.

''(3) Information received or transmitted pursuant to this section shall be subject to the safeguard provisions contained in section 454(26).''; and

(3) in subsection (c)—

(A) in paragraph (1), by striking ''or to seek to enforce orders providing child custody or visitation rights''; and

(B) in paragraph (2)—

(i) by inserting ''or to serve as the initiating court in an action to seek an order'' after ''issue an order''; and

(ii) by striking ''or to issue an order against a resident parent for child custody or visitation rights''.

(b) USE OF THE FEDERAL PARENT LOCATOR SERVICE.—Section 463 (42 U.S.C. 663) is amended—

(1) in subsection (a)—

(A) in the matter preceding paragraph (1)—

(i) by striking ''any State which is able and willing to do so,'' and inserting ''every State''; and

(ii) by striking ''such State'' and inserting ''each State''; and

(B) in paragraph (2), by inserting ''or visitation'' after ''custody'';

(2) in subsection (b)(2), by inserting ''or visitation'' after ''custody'';

(3) in subsection (d)—

(A) in paragraph (1), by inserting ''or visitation'' after ''custody''; and

(B) in subparagraphs (A) and (B) of paragraph (2), by inserting ''or visitation'' after ''custody'' each place it appears;

(4) in subsection (f)(2), by inserting ''or visitation'' after ''custody''; and

(5) by striking ''noncustodial'' each place it appears.

SEC. 5939. ACCESS TO REGISTRY DATA FOR RESEARCH PURPOSES.

(a) IN GENERAL.—Section 453(j)(5) (42 U.S.C. 653(j)(5)) is amended by inserting ''data in each component of the Federal Parent Locator Service maintained under this section and to'' before ''information''.

(b) CONFORMING AMENDMENTS.—Section 453 (42 U.S.C. 653) is amended—

(1) in subsection (j)(3)(B), by striking ''registries'' and inserting ''components''; and

(2) in subsection (k)(2), by striking ''subsection (j)(3)'' and inserting ''section 453A(g)(2)''.

SEC. 5940. COLLECTION AND USE OF SOCIAL SECURITY NUMBERS FOR USE IN CHILD SUPPORT ENFORCEMENT.

Section 466(a)(13) (42 U.S.C. 666(a)(13)) is amended—

(1) in subparagraph (A)—

(A) by striking ''commercial''; and

(B) by inserting ''recreational license,'' after ''occupational license,''; and

(2) in the matter following subparagraph (C), by inserting ''to be used on the face of the document while the social security number is kept on file at the agency'' after ''other than the social security number''.

SEC. 5941. ADOPTION OF UNIFORM STATE LAWS.

Section 466(f) (42 U.S.C. 666(f)) is amended by striking ''together'' and all that follows and inserting ''and as in effect on August 22, 1996, including any amendments officially adopted as of such date by the National Conference of Commissioners on Uniform State Laws.''.

SEC. 5942. STATE LAWS PROVIDING EXPEDITED PROCEDURES.

Section 466(c) (42 U.S.C. 666(c)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (E), by inserting '', part E,'' after ''part A''; and

(B) in subparagraph (G), by inserting ''any current support obligation and'' after ''to satisfy''; and

(2) in paragraph (2)(A)—

(A) in clause (i), by striking ''the tribunal and''; and

(B) in clause (ii)—

(i) by striking ''tribunal may'' and inserting ''court or administrative agency of competent jurisdiction shall''; and

(ii) by striking ''filed with the tribunal'' and inserting ''filed with the State case registry''.

SEC. 5943. VOLUNTARY PATERNITY ACKNOWLEDGEMENT.

Section 466(a)(5)(C)(i) (42 U.S.C. 666(a)(5)(C)(i)) is amended by inserting '', or through the use of video or audio equipment,'' after ''orally''.

SEC. 5944. CALCULATION OF PATERNITY ESTABLISHMENT PERCENTAGE.

Section 452(g)(2) (42 U.S.C. 652(g)(2)) is amended, in the matter following subparagraph (C), by striking ''subparagraph (A)'' and inserting ''subparagraphs (A) and (B)''.

SEC. 5945. MEANS AVAILABLE FOR PROVISION OF TECHNICAL ASSISTANCE AND OPERATION OF FEDERAL PARENT LOCATOR SERVICE.

(a) TECHNICAL ASSISTANCE.—Section 452(j) (42 U.S.C. 652(j)), is amended, in the matter preceding paragraph (1), by striking ''to cover costs incurred by the Secretary'' and inserting ''which shall be available for use by the Secretary, either directly or through grants, contracts, or interagency agreements,''.

(b) OPERATION OF FEDERAL PARENT LOCATOR SERVICE.—

(1) MEANS AVAILABLE.—Section 453(o) (42 U.S.C. 653(o)) is amended—

(A) in the heading, by striking ''RECOVERY OF COSTS'' and inserting ''USE OF SET-ASIDE FUNDS''; and

(B) by striking ''to cover costs incurred by the Secretary'' and inserting ''which shall be available for use by the Secretary, either directly or through grants, contracts, or interagency agreements,''.

(2) AVAILABILITY OF FUNDS.—Section 453(o) (42 U.S.C. 653(o)) is amended by adding at the end the following: ''Amounts appropriated under this subsection for each of fiscal years 1997 through 2001 shall remain available until expended.''.

SEC. 5946. AUTHORITY TO COLLECT SUPPORT FROM FEDERAL EMPLOYEES.

(a) RESPONSE TO NOTICE OR PROCESS.—Section 459(c)(2)(C) (42 U.S.C. 659(c)(2)(C)) is amended by striking ''respond to the order, process, or interrogatory'' and inserting ''withhold available sums in response to the order or process, or answer the interrogatory''.

(b) MONEYS SUBJECT TO PROCESS.—Section 459(h)(1) (42 U.S.C. 659(h)(1)) is amended—

(1) in the matter preceding subparagraph (A) and in subparagraph (A)(i), by striking ''paid or'' each place it appears;

(2) in subparagraph (A)—

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

(B) in clause (iii)—

(i) by inserting ''or payable'' after ''paid''; and

(ii) by striking ''but'' and inserting ''; and''; and

(C) by inserting after clause (iii), the following:

''(iv) benefits paid or payable under the Railroad Retirement System, but''; and

(3) in subparagraph (B)—

(A) in clause (i), by striking ''or'' at the end;

(B) in clause (ii), by striking the period and inserting ''; or''; and

(C) by adding at the end the following:

''(iii) of periodic benefits under title 38, United States Code, except as provided in subparagraph (A)(ii)(V).''.

(c) CONFORMING AMENDMENT.—Section 454(19)(B)(ii) (42 U.S.C. 654(19)(B)(ii)) is amended by striking ''section 462(e)'' and inserting ''section 459(i)(5)''.

SEC. 5947. DEFINITION OF SUPPORT ORDER.

Section 453(p) (42 U.S.C. 653(p)), is amended by striking ''a child and'' and inserting ''of''.

SEC. 5948. STATE LAW AUTHORIZING SUSPENSION OF LICENSES.

Section 466(a)(16) (42 U.S.C. 666(a)(16)) is amended by inserting ''and sporting'' after ''recreational''.

SEC. 5949. INTERNATIONAL SUPPORT ENFORCEMENT.

Section 454(32)(A) (42 U.S.C. 654(32)(A)) is amended by striking ''section 459A(d)(2)'' and inserting ''section 459A(d)''.

SEC. 5950. CHILD SUPPORT ENFORCEMENT FOR INDIAN TRIBES.

(a) COOPERATIVE AGREEMENTS BY INDIAN TRIBES AND STATES FOR CHILD SUPPORT ENFORCEMENT.—Section 454(33) (42 U.S.C. 654(33)) is amended—

(1) by striking ''and enforce support orders, and'' and inserting ''or enforce support orders, or'';

(2) by striking ''guidelines established by such tribe or organization'' and inserting ''guidelines established or adopted by such tribe or organization'';

(3) by striking ''funding collected'' and inserting ''collections''; and

(4) by striking ''such funding'' and inserting ''such collections''.

(b) CORRECTION OF SUBSECTION DESIGNATION.—Section 455 (42 U.S.C. 655), is amended by redesignating subsection (b), as added by section 375(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193, 110 Stat. 2256), as subsection (f).

(c) DIRECT GRANTS TO TRIBES.—Section 455(f) (42 U.S.C. 655(f)), as redesignated by subsection (b), is amended to read as follows:

''(f) The Secretary may make direct payments under this part to an Indian tribe or tribal organization that demonstrates to the satisfaction of the Secretary that it has the capacity to operate a child support enforcement program meeting the objectives of this part, including establishment of paternity, establishment, modification, and enforcement of support orders, and location of absent parents. The Secretary shall promulgate regulations establishing the requirements which must be met by an Indian tribe or tribal organization to be eligible for a grant under this subsection.''.

SEC. 5951. CONTINUATION OF RULES FOR DISTRIBUTION OF SUPPORT IN THE CASE OF A TITLE IV–E CHILD.

Section 457 (42 U.S.C. 657) is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by striking ''subsection (e)'' and inserting ''subsections (e) and (f)''; and

(2) by adding at the end, the following:

''(f) Notwithstanding the preceding provisions of this section, amounts collected by a State as child support for months in any period on behalf of a child for whom a public agency is making foster care maintenance payments under part E—

''(1) shall be retained by the State to the extent necessary to reimburse it for the foster care maintenance payments made with respect to the child during such period (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing);

''(2) shall be paid to the public agency responsible for supervising the placement of the child to the extent that the amounts collected exceed the foster care maintenance payments made with respect to the child during such period but not the amounts required by a court or administrative order to be paid as support on behalf of the child during such period; and the responsible agency may use the payments in the manner it determines will serve the best interests of the child, including setting such payments aside for the child's future needs or making all or a part thereof available to the person responsible for meeting the child's day-to-day needs; and

''(3) shall be retained by the State, if any portion of the amounts collected remains after making the payments required under paragraphs (1) and (2), to the extent that such portion is necessary to reimburse the State (with appropriate reimbursement to the Federal Government to the extent of its participation in the financing) for any past foster care maintenance payments (or payments of assistance under the State program funded under part A) which were made with respect to the child (and with respect to which past collections have not previously been retained);

and any balance shall be paid to the State agency responsible for supervising the placement of the child, for use by such agency in accordance with paragraph (2).''.

SEC. 5952. GOOD CAUSE IN FOSTER CARE AND FOOD STAMP CASES.

(a) STATE PLAN.—Section 454(4)(A)(i) (42 U.S.C. 654(4)(A)(i)) is amended—

(1) by striking ''or'' before ''(III)''; and

(2) by inserting ''or (IV) cooperation is required pursuant to section 6(l)(1) of the Food Stamp Act of 1977 (7 U.S.C. 2015(l)(1)),'' after ''title XIX,''.

(b) CONFORMING AMENDMENTS.—Section 454(29) (42 U.S.C. 654(29)) is amended—

(1) in subparagraph (A)—

(A) in the matter preceding clause (i), by striking ''part A of this title or the State program under title XIX'' and inserting ''part A, the State program under part E, the State program under title XIX, or the food stamp program, as defined under section 3(h) of the Food Stamp Act of 1977 (7 U.S.C. 2012(h)),''; and

(B) by striking clauses (i) and (ii) and all that follows through the semicolon and inserting the following:

''(i) in the case of the State program funded under part A, the State program under part E, or the State program under title XIX shall, at the option of the State, be defined, taking into account the best interests of the child, and applied in each case, by the State agency administering such program; and

''(ii) in the case of the food stamp program, as defined under section 3(h) of the Food Stamp Act of 1977 (7 U.S.C. 2012(h)), shall be defined and applied in each case under that program in accordance with section 6(l)(2) of the Food Stamp Act of 1977 (7 U.S.C. 2015(l)(2));'';

(2) in subparagraph (D), by striking ''or the State program under title XIX'' and inserting ''the State program under part E, the State program under title XIX, or the food stamp program, as defined under section 3(h) of the Food Stamp Act of 1977 (7 U.S.C. 2012(h))''; and

(3) in subparagraph (E), by striking ''individual,'' and all that follows through ''XIX,'' and inserting ''individual and the State agency administering the State program funded under part A, the State agency administering the State program under part E, the State agency administering the State program under title XIX, or the State agency administering the food stamp program, as defined under section 3(h) of the Food Stamp Act of 1977 (7 U.S.C. 2012(h)),''.

SEC. 5953. DATE OF COLLECTION OF SUPPORT.

Section 454B(c)(1) (42 U.S.C. 654B(c)(1)) is amended by adding at the end the following: ''The date of collection for amounts collected and distributed under this part is the date of receipt by the State disbursement unit, except that if current support is withheld by an employer in the month when due and is received by the State disbursement unit in a month other than the month when due, the date of withholding may be deemed to be the date of collection.''.

SEC. 5954. ADMINISTRATIVE ENFORCEMENT IN INTERSTATE CASES.

(a) PROCEDURES.—Section 466(a)(14) (42 U.S.C. 666(a)(14)) is amended to read as follows:

''(14) HIGH-VOLUME, AUTOMATED ADMINISTRATIVE ENFORCEMENT IN INTERSTATE CASES.—

''(A) IN GENERAL.—Procedures under which—

''(i) the State shall use high-volume automated administrative enforcement, to the same extent as used for intrastate cases, in response to a request made by another State to enforce support orders, and shall promptly report the results of such enforcement procedure to the requesting State;

''(ii) the State may, by electronic or other means, transmit to another State a request for assistance in enforcing support orders through high-volume, automated administrative enforcement, which request—

''(I) shall include such information as will enable the State to which the request is transmitted to compare the information about the cases to the information in the data bases of the State; and

''(II) shall constitute a certification by the requesting State—

''(aa) of the amount of support under an order the payment of which is in arrears; and

''(bb) that the requesting State has complied with all procedural due process requirements applicable to each case;

''(iii) if the State provides assistance to another State pursuant to this paragraph with respect to a case, neither State shall consider the case to be transferred to the caseload of such other State; and

''(iv) the State shall maintain records of—

''(I) the number of such requests for assistance received by the State;

''(II) the number of cases for which the State collected support in response to such a request; and

''(III) the amount of such collected support.

''(B) HIGH-VOLUME AUTOMATED ADMINISTRATIVE ENFORCEMENT.—In this part, the term 'high-volume automated administrative enforcement' means the use of automatic data processing to search various State data bases, including license records, employment service data, and State new hire registries, to determine whether information is available regarding a parent who owes a child support obligation.''.

(b) INCENTIVE PAYMENTS.—Section 458(d) (42 U.S.C. 658(d)) is amended by inserting '', including amounts collected under section 466(a)(14),'' after ''another State''.

SEC. 5955. WORK ORDERS FOR ARREARAGES.

Section 466(a)(15) (42 U.S.C. 666(a)(15)) is amended to read as follows:

''(15) PROCEDURES TO ENSURE THAT PERSONS OWING OVERDUE SUPPORT WORK OR HAVE A PLAN FOR PAYMENT OF SUCH SUPPORT.—Procedures under which the State has the authority, in any case in which an individual owes overdue support with respect to a child receiving assistance under a State program funded under part A, to issue an order or to request that a court or an administrative process established pursuant to State law issue an order that requires the individual to—

''(A) pay such support in accordance with a plan approved by the court, or, at the option of the State, a plan approved by the State agency administering the State program under this part; or

''(B) if the individual is subject to such a plan and is not incapacitated, participate in such work activities (as defined in section 407(d)) as the court, or, at the option of the State, the State agency administering the State program under this part, deems appropriate.''.

SEC. 5956. ADDITIONAL TECHNICAL STATE PLAN AMENDMENTS.

Section 454 (42 U.S.C. 654) is amended—

(1) in paragraph (8)—

(A) in the matter preceding subparagraph (A)—

(i) by striking ''noncustodial''; and

(ii) by inserting '', for the purpose of establishing parentage, establishing, setting the amount of, modifying, or enforcing child support obligations, or making or enforcing a child custody or visitation determination, as defined in section 463(d)(1)'' after ''provide that'';

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

(C) in subparagraph (B), by striking the semicolon and inserting a comma; and

(D) by inserting after subparagraph (B), the following flush language:

''and shall, subject to the privacy safeguards required under paragraph (26), disclose only the information described in sections 453 and 463 to the authorized persons specified in such sections for the purposes specified in such sections;'';

(2) in paragraph (17)—

(A) by striking ''in the case of a State which has'' and inserting ''provide that the State will have''; and

(B) by inserting ''and'' after ''section 453,''; and

(3) in paragraph (26)—

(A) in the matter preceding subparagraph (A), by striking ''will'';

(B) in subparagraph (A)—

(i) by inserting '', modify,'' after ''establish'', the second place it appears; and

(ii) by inserting '', or to make or enforce a child custody determination'' after ''support'';

(C) in subparagraph (B)—

(i) by inserting ''or the child'' after ''1 party'';

(ii) by inserting ''or the child'' after ''former party''; and

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

(D) in subparagraph (C)—

(i) by inserting ''or the child'' after ''1 party'';

(ii) by striking ''another party'' and inserting ''another person'';

(iii) by inserting ''to that person'' after ''release of the information''; and

(iv) by striking ''former party'' and inserting ''party or the child''; and

(E) by adding at the end the following:

''(D) in cases in which the prohibitions under subparagraphs (B) and (C) apply, the requirement to notify the Secretary, for purposes of section 453(b)(2), that the State has reasonable evidence of domestic violence or child abuse against a party or the child and that the disclosure of such information could be harmful to the party or the child; and

''(E) procedures providing that when the Secretary discloses information about a parent or child to a State court or an agent of a State court described in section 453(c)(2) or 463(d)(2)(B), and advises that court or agent that the Secretary has been notified that there is reasonable evidence of domestic violence or child abuse pursuant to section 453(b)(2), the court shall determine whether disclosure to any other person of information received from the Secretary could be harmful to the parent or child and, if the court determines that disclosure to any other person could be harmful, the court and its agents shall not make any such disclosure;''.

SEC. 5957. FEDERAL CASE REGISTRY OF CHILD SUPPORT ORDERS.

Section 453(h) (42 U.S.C. 653(h)) is amended—

(1) in paragraph (1), by inserting ''and order'' after ''with respect to each case''; and

(2) in paragraph (2)—

(A) in the heading, by inserting ''AND ORDER'' after ''CASE'';

(B) by inserting ''or an order'' after ''with respect to a case'' and

(C) by inserting ''or order'' after ''and the State or States which have the case''.

SEC. 5958. FULL FAITH AND CREDIT FOR CHILD SUPPORT ORDERS.

Section 1738B(f) of title 28, United States Code, is amended—

(1) in paragraph (4), by striking ''a court may'' and all that follows and inserting ''a court having jurisdiction over the parties shall issue a child support order, which must be recognized.''; and

(2) in paragraph (5), by inserting ''under subsection (d)'' after ''jurisdiction''.

SEC. 5959. DEVELOPMENT COSTS OF AUTOMATED SYSTEMS.

(a) DEFINITION OF STATE.—Section 455(a)(3)(B) (42 U.S.C. 655(a)(3)(B)) is amended—

(1) in clause (i)—

(A) by inserting ''or system described in clause (iii)'' after ''each State''; and

(B) by inserting ''or system'' after ''the State''; and

(2) by adding at the end the following:

''(iii) For purposes of clause (i), a system described in this clause is a system that has been approved by the Secretary to receive enhanced funding pursuant to the Family Support Act of 1988 (Public Law 100–485; 102 Stat. 2343) for the purpose of developing a system that meets the requirements of sections 454(16) (as in effect on and after September 30, 1995) and 454A, including systems that have received funding for such purpose pursuant to a waiver under section 1115(a).''.

(b) TEMPORARY LIMITATION ON PAYMENTS.—Section 344(b)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (42 U.S.C. 655 note) is amended—

(1) in subparagraph (B)—

(A) by inserting ''or a system described in subparagraph (C)'' after ''to a State''; and

(B) by inserting ''or system'' after ''for the State''; and

(2) in subparagraph (C), by striking ''Act,'' and all that follows and inserting ''Act, and among systems that have been approved by the Secretary to receive enhanced funding pursuant to the Family Support Act of 1988 (Public Law 100–485; 102 Stat. 2343) for the purpose of developing a system that meets the requirements of sections 454(16) (as in effect on and after September 30, 1995) and 454A, including systems that have received funding for such purpose pursuant to a waiver under section 1115(a), which shall take into account—

''(i) the relative size of such State and system caseloads under part D of title IV of the Social Security Act; and

''(ii) the level of automation needed to meet the automated data processing requirements of such part.''.

SEC. 5960. ADDITIONAL TECHNICAL AMENDMENTS.

(a) ELIMINATION OF SURPLUSAGE.—Section 466(c)(1)(F) (42 U.S.C. 666(c)(1)(F)) is amended by striking ''of section 466''.

(b) CORRECTION OF AMBIGUOUS AMENDMENT.—Section 344(a)(1)(F) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2234) is amended by inserting ''the first place such term appears'' before ''and all that follows''.

(c) CORRECTION OF ERRONEOUSLY DRAFTED PROVISION.—Section 215 of the Department of Health and Human Services Appropriations Act, 1997, (as contained in section 101(e) of the Omnibus Consolidated Appropriations Act, 1997) is amended to read as follows:

''SEC. 215. Sections 452(j) and 453(o) of the Social Security Act (42 U.S.C. 652(j) and 653(o)), as amended by section 345 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2237) are each amended by striking 'section 457(a)' and inserting 'a plan approved under this part'. Amounts available under such sections 452(j) and 453(o) shall be calculated as though the amendments made by this section were effective October 1, 1995.''.

(d) ELIMINATION OF SURPLUSAGE.—Section 456(a)(2)(B) (42 U.S.C. 656(a)(2)(B)) is amended by striking '', and'' and inserting a period.

(e) CORRECTION OF DATE.—Section 466(a)(1)(B) (42 U.S.C. 666(a)(1)(B)) is amended by striking ''October 1, 1996'' and inserting ''January 1, 1994''.

SEC. 5961. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in subsection (b), the amendments made by this chapter shall take effect as if included in the enactment of title III of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2105).

(b) EXCEPTION.—The amendments made by section 5936(b)(2) shall take effect as if the amendments had been included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2112).

CHAPTER 4—RESTRICTING WELFARE AND PUBLIC BENEFITS FOR ALIENS

Subchapter A—Eligibility for Federal Benefits

SEC. 5965. ALIEN ELIGIBILITY FOR FEDERAL BENEFITS: LIMITED APPLICATION TO MEDICARE AND BENEFITS UNDER THE RAILROAD RETIREMENT ACT.

(a) LIMITED APPLICATION TO MEDICARE.—Section 401(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1611(b)) is amended by adding at the end the following:

''(3) Subsection (a) shall not apply to any benefit payable under title XVIII of the Social Security Act (relating to the medicare program) to an alien who is lawfully present in the United States as determined by the Attorney General and, with respect to benefits payable under part A of such title, who was authorized to be employed with respect to any wages attributable to employment which are counted for purposes of eligibility for such benefits.''.

(b) LIMITED APPLICATION TO BENEFITS UNDER THE RAILROAD RETIREMENT ACT.—Section 401(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1611(b)) (as amended by subsection (a)) is amended by inserting at the end the following:

''(4) Subsection (a) shall not apply to any benefit payable under the Railroad Retirement Act of 1974 or the Railroad Unemployment Insurance Act to an alien who is lawfully present in the United States as determined by the Attorney General or to an alien residing outside the United States.''.

SEC. 5966. EXCEPTIONS TO BENEFIT LIMITATIONS: CORRECTIONS TO REFERENCE CONCERNING ALIENS WHOSE DEPORTATION IS WITHHELD.

Sections 402(a)(2)(A)(i)(III), 402(a)(2)(A)(ii)(III), 402(b)(2)(A)(iii), 403(b)(1)(C), 412(b)(1)(C), and 431(b)(5) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A)(iii), 1612(b)(2)(A)(iii), 1613(b)(1)(C), 1622(b)(1)(C), and 1641(b)(5)) are each amended by striking ''section 243(h) of such Act'' each place it appears and inserting ''section 243(h) of such Act (as in effect immediately before the effective date of section 307 of division C of Public Law 104–208) or section 241(b)(3) of such Act (as amended by section 305(a) of division C of Public Law 104–208)''.

SEC. 5967. VETERANS EXCEPTION: APPLICATION OF MINIMUM ACTIVE DUTY SERVICE REQUIREMENT; EXTENSION TO UNREMARRIED SURVIVING SPOUSE; EXPANDED DEFINITION OF VETERAN.

(a) APPLICATION OF MINIMUM ACTIVE DUTY SERVICE REQUIREMENT.—Sections 402(a)(2)(C)(i), 402(b)(2)(C)(i), 403(b)(2)(A), and 412(b)(3)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(C)(i), 1612(b)(2)(C)(i), 1613(b)(2)(A), and 1622(b)(3)(A)) are each amended by inserting ''and who fulfills the minimum active-duty service requirements of section 5303A(d) of title 38, United States Code'' after ''alienage''.

(b) EXCEPTION APPLICABLE TO UNREMARRIED SURVIVING SPOUSE.—Section 402(a)(2)(C)(iii), 402(b)(2)(C)(iii), 403(b)(2)(C), and 412(b)(3)(C) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(C)(iii), 1612(b)(2)(C)(iii), 1613(b)(2)(C), and 1622(b)(3)(C)) are each amended by inserting before the period ''or the unremarried surviving spouse of an individual described in clause (i) or (ii) who is deceased if the marriage fulfills the requirements of section 1304 of title 38, United States Code''.

(c) EXPANDED DEFINITION OF VETERAN.—Sections 402(a)(2)(C)(i), 402(b)(2)(C)(i), 403(b)(2)(A), and 412(b)(3)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(C)(i), 1612(b)(2)(C)(i), 1613(b)(2)(A), and 1622(b)(3)(A)) are each

amended by inserting ''', 1101, or 1301, or as described in section 107'' after ''section 101''.

SEC. 5968. CORRECTION OF REFERENCE CONCERNING CUBAN AND HAITIAN ENTRANTS.

Section 403(d) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613(d)) is amended—

(1) by striking ''section 501 of the Refugee'' and insert ''section 501(a) of the Refugee''; and

(2) by striking ''section 501(e)(2)'' and inserting ''section 501(e)''.

SEC. 5969. NOTIFICATION CONCERNING ALIENS NOT LAWFULLY PRESENT: CORRECTION OF TERMINOLOGY.

Section 1631(e)(9) of the Social Security Act (42 U.S.C. 1383(e)(9)) and section 27 of the United States Housing Act of 1937, as added by section 404 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, are each amended by striking ''unlawfully in the United States'' each place it appears and inserting ''not lawfully present in the United States''.

SEC. 5970. FREELY ASSOCIATED STATES: CONTRACTS AND LICENSES.

Sections 401(c)(2)(A) and 411(c)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1611(c)(2)(A) and 1621(c)(2)(A)) are each amended by inserting before the semicolon at the end '', or to a citizen of a freely associated state, if section 141 of the applicable compact of free association approved in Public Law 99–239 or 99–658 (or a successor provision) is in effect''.

SEC. 5971. CONGRESSIONAL STATEMENT REGARDING BENEFITS FOR HMONG AND OTHER HIGHLAND LAO VETERANS.

(a) FINDINGS.—The Congress makes the following findings:

(1) Hmong and other Highland Lao tribal peoples were recruited, armed, trained, and funded for military operations by the United States Department of Defense, Central Intelligence Agency, Department of State, and Agency for International Development to further United States national security interests during the Vietnam conflict.

(2) Hmong and other Highland Lao tribal forces sacrificed their own lives and saved the lives of American military personnel by rescuing downed American pilots and aircrews and by engaging and successfully fighting North Vietnamese troops.

(3) Thousands of Hmong and other Highland Lao veterans who fought in special guerilla units on behalf of the United States during the Vietnam conflict, along with their families, have been lawfully admitted to the United States in recent years.

(4) The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193), the new national welfare reform law, restricts certain welfare benefits for noncitizens of the United States and the exceptions for noncitizen veterans of the Armed Forces of the United States do not extend to Hmong veterans of the Vietnam conflict era, making Hmong veterans and their families receiving certain welfare benefits subject to restrictions despite their military service on behalf of the United States.

(b) CONGRESSIONAL STATEMENT.—It is the sense of the Congress that Hmong and other Highland Lao veterans who fought on behalf of the Armed Forces of the United States during the Vietnam conflict and have lawfully been admitted to the United States for permanent residence should be considered veterans for purposes of continuing certain welfare benefits consistent with the exceptions provided other noncitizen veterans under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

Subchapter B—General Provisions

SEC. 5972. DETERMINATION OF TREATMENT OF BATTERED ALIENS AS QUALIFIED ALIENS; INCLUSION OF ALIEN CHILD OF BATTERED PARENT AS QUALIFIED ALIEN.

(a) DETERMINATION OF STATUS BY AGENCY PROVIDING BENEFITS.—Section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) is amended in subsections (c)(1)(A) and (c)(2)(A) by striking ''Attorney General, which opinion is not subject to review by any court)'' each place it appears and inserting ''agency providing such benefits)''.

(b) GUIDANCE ISSUED BY ATTORNEY GENERAL.—Section 431(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(c)) is amended by adding at the end the following new undesignated paragraph:

''After consultation with the Secretaries of Health and Human Services, Agriculture, and Housing and Urban Development, the Commissioner of Social Security, and with the heads of such Federal agencies administering benefits as the Attorney General considers appropriate, the Attorney General shall issue guidance (in the Attorney General's sole and unreviewable discretion) for purposes of this subsection and section 421(f), concerning the meaning of the terms 'battery' and 'extreme cruelty', and the standards and methods to be used for determining whether a substantial connection exists between battery or cruelty suffered and an individual's need for benefits under a specific Federal, State, or local program.''.

(c) INCLUSION OF ALIEN CHILD OF BATTERED PARENT AS QUALIFIED ALIEN.—Section 431(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(c)) is amended—

(1) at the end of paragraph (1)(B)(iv) by striking ''or'';

(2) at the end of paragraph (2)(B) by striking the period and inserting ''; or''; and

(3) by inserting after paragraph (2)(B) and before the last sentence of such subsection the following new paragraph:

''(3) an alien child who—

''(A) resides in the same household as a parent who has been battered or subjected to extreme cruelty in the United States by that parent's spouse or by a member of the spouse's family residing in the same household as the parent and the spouse consented or acquiesced to such battery or cruelty, but only if (in the opinion of the agency providing such benefits) there is a substantial connection between such battery or cruelty and the need for the benefits to be provided; and

''(B) who meets the requirement of subparagraph (B) of paragraph (1).''.

(d) INCLUSION OF ALIEN CHILD OF BATTERED PARENT UNDER SPECIAL RULE FOR ATTRIBUTION OF INCOME.—Section 421(f)(1)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1631(f)(1)(A)) is amended—

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

(2) by striking ''and the battery or cruelty described in clause (i) or (ii)'' and inserting ''or (iii) the alien is a child whose parent (who resides in the same household as the alien child) has been battered or subjected to extreme cruelty in the United States by that parent's spouse, or by a member of the spouse's family residing in the same household as the parent and the spouse consented to, or acquiesced in, such battery or cruelty, and the battery or cruelty described in clause (i), (ii), or (iii)''.

SEC. 5973. VERIFICATION OF ELIGIBILITY FOR BENEFITS.

(a) REGULATIONS AND GUIDANCE.—Section 432(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1642(a)) is amended—

(1) by inserting at the end of paragraph (1) the following: ''Not later than 90 days after the date of the enactment of the Welfare Reform Technical Corrections Act of 1997, the Attorney General of the United States, after consultation with the Secretary of Health and Human Services, shall issue interim verification guidance.''; and

(2) by adding after paragraph (2) the following new paragraph:

''(3) Not later than 90 days after the date of the enactment of the Welfare Reform Technical Corrections Act of 1997, the Attorney General shall promulgate regulations which set forth the procedures by which a State or local government can verify whether an alien applying for a State or local public benefit is a qualified alien, a nonimmigrant under the Immigration and Nationality Act, or an alien paroled into the United States under section 212(d)(5) of the Immigration and Nationality Act for less than 1 year, for purposes of determining whether the alien is ineligible for benefits under section 411 of this Act.''.

(b) DISCLOSURE OF INFORMATION FOR VERIFICATION.—Section 384(b) of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (division C of Public Law 104–208) is amended by adding after paragraph (4) the following new paragraph:

''(5) The Attorney General is authorized to disclose information, to Federal, State, and local public and private agencies providing benefits, to be used solely in making determinations of eligibility for benefits pursuant to section 431(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.''.

SEC. 5974. QUALIFYING QUARTERS: DISCLOSURE OF QUARTERS OF COVERAGE INFORMATION; CORRECTION TO ASSURE THAT CREDITING APPLIES TO ALL QUARTERS EARNED BY PARENTS BEFORE CHILD IS 18.

(a) DISCLOSURE OF QUARTERS OF COVERAGE INFORMATION.—Section 435 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1645) is amended by adding at the end the following: ''Notwithstanding section 6103 of the Internal Revenue Code of 1986, the Commissioner of Social Security is authorized to disclose quarters of coverage information concerning an alien and an alien's spouse or parents to a government agency for the purposes of this title.''.

(b) CORRECTION TO ASSURE THAT CREDITING APPLIES TO ALL QUARTERS EARNED BY PARENTS BEFORE CHILD IS 18.—Section 435(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1645(1)) is amended by striking ''while the alien was under age 18,'' and inserting ''before the date on which the alien attains age 18,''.

SEC. 5975. STATUTORY CONSTRUCTION: BENEFIT ELIGIBILITY LIMITATIONS APPLICABLE ONLY WITH RESPECT TO ALIENS PRESENT IN THE UNITED STATES.

Section 433 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1643) is amended—

(1) by redesignated subsections (b) and (c) as subsections (c) and (d); and

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

''(b) BENEFIT ELIGIBILITY LIMITATIONS APPLICABLE ONLY WITH RESPECT TO ALIENS PRESENT IN THE UNITED STATES.—Notwithstanding any other provision of this title, the limitations on eligibility for benefits under this title shall not apply to eligibility for benefits of aliens who are not residing, or present, in the United States with respect to—

''(1) wages, pensions, annuities, and other earned payments to which an alien is entitled resulting from employment by, or on behalf of, a Federal, State, or local government agency which was not prohibited during the period of such employment or service under section 274A or other applicable provision of the Immigration and Nationality Act; or

''(2) benefits under laws administered by the Secretary of Veterans Affairs.''.

Subchapter C—Miscellaneous Clerical and Technical Amendments; Effective Date

SEC. 5976. CORRECTING MISCELLANEOUS CLERICAL AND TECHNICAL ERRORS.

(a) INFORMATION REPORTING UNDER TITLE IV OF THE SOCIAL SECURITY ACT.—Effective July 1, 1997, section 408 of the Social Security Act (42 U.S.C. 608), as amended by section 5903, and as in effect pursuant to section 116 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and as amended by section 5906(e) of this Act, is amended by adding at the end the following new subsection:

''(f) STATE REQUIRED TO PROVIDE CERTAIN INFORMATION.—Each State to which a grant is made under section 403 shall, at least 4 times annually and upon request of the Immigration and Naturalization Service, furnish the Immigration and Naturalization Service with the name and address of, and other identifying information on, any individual who the State knows is not lawfully present in the United States.''.

(b) MISCELLANEOUS CLERICAL AND TECHNICAL CORRECTIONS.—

(1) Section 411(c)(3) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1621(c)(3)) is amended by striking ''4001(c)'' and inserting ''401(c)''.

(2) Section 422(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1632(a)) is amended by striking ''benefits (as defined in section 412(c)),'' and inserting ''benefits,''.

(3) Section 412(b)(1)(C) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1622(b)(1)(C)) is amended by striking ''with-holding'' and inserting ''withholding''.

(4) The subtitle heading for subtitle D of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended to read as follows:

''Subtitle D—General Provisions''.

(5) The subtitle heading for subtitle F of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended to read as follows:

''Subtitle F—Earned Income Credit Denied to Unauthorized Employees''.

(6) Section 431(c)(2)(B) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(c)(2)(B)) is amended by striking ''clause (ii) of subparagraph (A)'' and inserting ''subparagraph (B) of paragraph (1)''.

(7) Section 431(c)(1)(B) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(c)(1)(B)) is amended—

(A) in clause (iii) by striking '', or'' and inserting ''(as in effect prior to April 1, 1997),''; and

(B) by adding after clause (iv) the following new clause:

''(v) cancellation of removal pursuant to section 240A(b)(2) of such Act;''.

SEC. 5977. EFFECTIVE DATE.

Except as otherwise provided, the amendments made by this chapter shall be effective as if included in the enactment of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

CHAPTER 5—CHILD PROTECTION

SEC. 5981. CONFORMING AND TECHNICAL AMENDMENTS RELATING TO CHILD PROTECTION.

(a) METHODS PERMITTED FOR CONDUCT OF STUDY OF CHILD WELFARE.—Section 429A(a) (42 U.S.C. 628b(a)) is amended by inserting ''(directly, or by grant, contract, or interagency agreement)'' after ''conduct''.

(b) REDESIGNATION OF PARAGRAPH.—Section 471(a) (42 U.S.C. 671(a)) is amended—

(1) by striking ''and'' at the end of paragraph (17);

(2) by striking the period at the end of paragraph (18) (as added by section 1808(a) of the Small Business Job Protection Act of 1996 (Public Law 104–188; 110 Stat. 1903)) and inserting ''; and''; and

(3) by redesignating paragraph (18) (as added by section 505(3) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2278)) as paragraph (19).

SEC. 5982. ADDITIONAL TECHNICAL AMENDMENTS RELATING TO CHILD PROTECTION.

(a) PART B AMENDMENTS.—

(1) IN GENERAL.—Part B of title IV (42 U.S.C. 620–635) is amended—

(A) in section 422(b)—

(i) by striking the period at the end of the paragraph (9) (as added by section 554(3) of the Improving America's Schools Act of 1994 (Public Law 103–382; 108 Stat. 4057)) and inserting a semicolon;

(ii) by redesignating paragraph (10) as paragraph (11); and

(iii) by redesignating paragraph (9), as added by section 202(a)(3) of the Social Security Act Amendments of 1994 (Public Law 103–432, 108 Stat. 4453), as paragraph (10);

(B) in sections 424(b) and 425(a), by striking ''422(b)(9)'' each place it appears and inserting ''422(b)(10)''; and

(C) by transferring section 429A (as added by section 503 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2277)) to the end of subpart 1.

(2) CLARIFICATION OF CONFLICTING AMENDMENTS.—Section 204(a)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432; 108 Stat. 4456) is amended by inserting ''(as added by such section 202(a))'' before ''and inserting''.

(b) PART E AMENDMENTS.—Section 472(d) (42 U.S.C. 672(d)) is amended by striking ''422(b)(9)'' and inserting ''422(b)(10)''.

SEC. 5983. EFFECTIVE DATE.

The amendments made by this chapter shall take effect as if included in the enactment of title V of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2277).

CHAPTER 6—CHILD CARE

SEC. 5985. CONFORMING AND TECHNICAL AMENDMENTS RELATING TO CHILD CARE.

(a) FUNDING.—Section 418(a) (42 U.S.C. 618(a)) is amended—

(1) in paragraph (1)—

(A) in the matter preceding subparagraph (A), by inserting ''the greater of'' after ''equal to'';

(B) in subparagraph (A)—

(i) by striking ''the sum of'';

(ii) by striking ''amounts expended'' and inserting ''expenditures''; and

(iii) by striking ''section—'' and all that follows and inserting ''subsections (g) and (i) of section 402 (as in effect before October 1, 1995); or'';

(C) in subparagraph (B)—

(i) by striking ''sections'' and inserting ''subsections''; and

(ii) by striking the semicolon at the end and inserting a period; and

(D) in the matter following subparagraph (B), by striking ''whichever is greater.''; and

(2) in paragraph (2)—

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

''(B) ALLOTMENTS TO STATES.—The total amount available for payments to States under this paragraph, as determined under subparagraph (A), shall be allotted among the States based on the formula used for determining the amount of Federal payments to each State under section 403(n) (as in effect before October 1, 1995).'';

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

''(C) FEDERAL MATCHING OF STATE EXPENDITURES EXCEEDING HISTORICAL EXPENDITURES.—The Secretary shall pay to each eligible State for a fiscal year an amount equal to the lesser of the State's allotment under subparagraph (B) or the Federal medical assistance percentage for the State for the fiscal year (as defined in section 1905(b), as such section was in effect on September 30, 1995) of so much of the State's expenditures for child care in that fiscal year as exceed the total amount of expenditures by the State (including expenditures from amounts made available from Federal funds) in fiscal year 1994 or 1995 (whichever is greater) for the programs described in paragraph (1)(A).''; and

(C) in subparagraph (D)(i)—

(i) by striking ''amounts under any grant awarded'' and inserting ''any amounts allotted''; and

(ii) by striking ''the grant is made'' and inserting ''such amounts are allotted''.

(b) DATA USED TO DETERMINE HISTORIC STATE EXPENDITURES.—Section 418(a) (42 U.S.C. 618(a)), is amended by adding at the end the following:

''(5) DATA USED TO DETERMINE STATE AND FEDERAL SHARES OF EXPENDITURES.—In making the determinations concerning expenditures required under paragraphs (1) and (2)(C), the Secretary shall use information that was reported by the State on ACF Form 231 and available as of the applicable dates specified in clauses (i)(I), (ii), and (iii)(III) of section 403(a)(1)(D).''.

(c) DEFINITION OF STATE.—Section 418(d) (42 U.S.C. 618(d)) is amended by striking ''or'' and inserting ''and''.

SEC. 5986. ADDITIONAL CONFORMING AND TECHNICAL AMENDMENTS.

The Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.) is amended—

(1) in section 658E(c)(2)(E)(ii), by striking ''tribal organization'' and inserting ''tribal organizations'';

(2) in section 658K(a)—

(A) in paragraph (1)—

(i) in subparagraph (B)—

(I) by striking clause (iv) and inserting the following:

''(iv) whether the head of the family unit is a single parent;'';

(II) in clause (v)—

(aa) in the matter preceding subclause (I), by striking ''including the amount obtained from (and separately identified)—'' and inserting ''including—''; and

(bb) by striking subclause (II) and inserting the following:

''(II) cash or other assistance under—

''(aa) the temporary assistance for needy families program under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.); and

''(bb) a State program for which State spending is counted toward the maintenance of effort requirement under section 409(a)(7) of the Social Security Act (42 U.S.C. 609(a)(7));''; and

(III) in clause (x), by striking ''week'' and inserting ''month''; and

(ii) by striking subparagraph (D) and inserting the following:

''(D) USE OF SAMPLES.—

''(i) AUTHORITY.—A State may comply with the requirement to collect the information described in subparagraph (B) through the use of disaggregated case record information on a sample of families selected through the use of scientifically acceptable sampling methods approved by the Secretary.

''(ii) SAMPLING AND OTHER METHODS.—The Secretary shall provide the States with such case sampling plans and data collection procedures as the Secretary deems necessary to produce statistically valid samples of the information described in subparagraph (B). The Secretary may develop and implement procedures for verifying the quality of data submitted by the States.''; and

(B) in paragraph (2)—

(i) in the heading, by striking ''BIANNUAL'' and inserting ''ANNUAL''; and

(ii) by striking ''6'' and inserting ''12'';

(3) in section 658L, by striking ''1997'' and inserting ''1998'';

(4) in section 658O(c)(6)(C), by striking ''(A)'' and inserting ''(B)''; and

(5) in section 658P(13), by striking ''or'' and inserting ''and''.

SEC. 5987. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided in subsection (b), this chapter and the amendments made by this chapter shall take effect as if included in the enactment of title VI of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2278).

(b) EXCEPTIONS.—The amendment made by section 5985(a)(2)(B) and the repeal made by section 5987(d) shall each take effect on October 1, 1997.

CHAPTER 7—ERISA AMENDMENTS RELATING TO MEDICAL CHILD SUPPORT ORDERS

SEC. 5991. AMENDMENTS RELATING TO SECTION 303 OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996.

(a) PRIVACY SAFEGUARDS FOR MEDICAL CHILD SUPPORT ORDERS.—Section 609(a)(3)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(a)(3)(A)) is amended by adding at the end the following: ''except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such alternate recipient,''.

(b) PAYMENT TO STATE OFFICIAL TREATED AS SATISFACTION OF PLAN'S OBLIGATION.—Section 609(a) of such Act (29 U.S.C. 1169(a)) is amended by adding at the end the following new paragraph:

''(9) PAYMENT TO STATE OFFICIAL TREATED AS SATISFACTION OF PLAN'S OBLIGATION TO MAKE PAYMENT TO ALTERNATE RECIPIENT.—Payment of benefits by a group health plan to an official of a State or a political subdivision thereof who is named in a qualified medical child support order in lieu of the alternate recipient, pursuant to paragraph (3)(A), shall be treated, for purposes of this title, as payment of benefits to the alternate recipient.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall be apply with respect to medical child support orders issued on or after the date of the enactment of this Act.

SEC. 5992. AMENDMENT RELATING TO SECTION 381 OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996.

(a) CLARIFICATION OF EFFECT OF ADMINISTRATIVE NOTICES.—Section 609(a)(2)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(a)(2)(B)) is amended by adding at the end the following new sentence: ''For purposes of this subparagraph, an administrative notice which is issued pursuant to an administrative process referred to in subclause (II) of the preceding sentence and which has the effect of an order described in clause (i) or (ii) of the preceding sentence shall be treated as such an order.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall be effective as if included in the enactment of section 381 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2257).

SEC. 5993. AMENDMENTS RELATING TO SECTION 382 OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996.

(a) ELIMINATION OF REQUIREMENT THAT ORDERS SPECIFY AFFECTED PLANS.—Section 609(a)(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(a)(3)) is amended—

(1) in subparagraph (C), by striking '', and'' and inserting a period; and

(2) by striking subparagraph (D).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to medical child support orders issued on or after the date of the enactment of this Act.

TITLE VI—COMMITTEE ON GOVERNMENTAL AFFAIRS

Subtitle A—Civil Service and Postal Provisions

SEC. 6001. INCREASED CONTRIBUTIONS TO FEDERAL CIVILIAN RETIREMENT SYSTEMS.

(a) CIVIL SERVICE RETIREMENT SYSTEM.—

(1) AGENCY CONTRIBUTIONS.—Notwithstanding section 8334(a)(1) of title 5, United States Code—

(A) during the period beginning on October 1, 1997, through September 30, 2001, each employing agency (other than the United States Postal Service, the Metropolitan Washington Airports Authority, or the government of the District of Columbia) shall contribute—

(i) 8.51 percent of the basic pay of an employee;

(ii) 9.01 percent of the basic pay of a congressional employee, a law enforcement officer, a member of the Capitol police, or a firefighter; and

(iii) 9.51 percent of the basic pay of a Member of Congress, a Claims Court judge, a United States magistrate, a judge of the United States Court of Appeals for the Armed Forces, or a bankruptcy judge; and

(B) during the period beginning on October 1, 2001, through September 30, 2002, each employing agency (other than the United States Postal Service, the Metropolitan Washington Airports Authority, or the government of the District of Columbia) shall contribute—

(i) 8.6 percent of the basic pay of an employee;

(ii) 9.1 percent of the basic pay of a congressional employee, a law enforcement officer, a member of the Capitol police, or a firefighter; and

(iii) 9.6 percent of the basic pay of a Member of Congress, a Claims Court judge, a United States magistrate, a judge of the United States Court of Appeals for the Armed Forces, or a bankruptcy judge;

in lieu of the agency contributions otherwise required under section 8334(a)(1) of title 5, United States Code.

(2) NO REDUCTION IN AGENCY CONTRIBUTIONS BY THE POSTAL SERVICE.—Agency contributions by the United States Postal Service under section 8348(h) of title 5, United States Code—

(A) shall not be reduced as a result of the amendments made under paragraph (3) of this subsection; and

(B) shall be computed as though such amendments had not been enacted.

(3) INDIVIDUAL DEDUCTIONS, WITHHOLDINGS, AND DEPOSITS.—The table under section 8334(c) of title 5, United States Code, is amended—

(A) in the matter relating to an employee by striking:

''7	After December 31, 1969.'';

and inserting the following:

''7	January 1, 1970, to December 31, 1998.
7.25	January 1, 1999, to December 31, 1999.
7.4	January 1, 2000, to December 31, 2000.
7.5	January 1, 2001, to December 31, 2002.
7	After December 31, 2002.'';

(B) in the matter relating to a Member or employee for congressional employee service by striking:

''7½	After December 31, 1969.'';

and inserting the following:

''7.5	January 1, 1970, to December 31, 1998.
7.75	January 1, 1999, to December 31, 1999.
7.9	January 1, 2000, to December 31, 2000.
8	January 1, 2001, to December 31, 2002.
7.5	After December 31, 2002.'';

(C) in the matter relating to a Member for Member service by striking:

''8	After December 31, 1969.'';

and inserting the following:

''8	January 1, 1970, to December 31, 1998.
8.25	January 1, 1999, to December 31, 1999.
8.4	January 1, 2000, to December 31, 2000.
8.5	January 1, 2001, to December 31, 2002.
8	After December 31, 2002.'';

(D) in the matter relating to a law enforcement officer for law enforcement service and firefighter for firefighter service by striking:

''7½	After December 31, 1974.'';

and inserting the following:

''7.5	January 1, 1975, to December 31, 1998.
7.75	January 1, 1999, to December 31, 1999.
7.9	January 1, 2000, to December 31, 2000.
8	January 1, 2001, to December 31, 2002.
7.5	After December 31, 2002.'';

(E) in the matter relating to a bankruptcy judge by striking:

''8	After December 31, 1983.'';

and inserting the following:

''8	January 1, 1984, to December 31, 1998.
8.25	January 1, 1999, to December 31, 1999.
8.4	January 1, 2000, to December 31, 2000.
8.5	January 1, 2001, to December 31, 2002.
8	After December 31, 2002.'';

(F) in the matter relating to a judge of the United States Court of Appeals for the Armed Forces for service as a judge of that court by striking:

''8	On and after the date of enactment of the Department of Defense Authorization Act, 1984.'';

and inserting the following:

''8	The date of enactment of the Department of Defense Authorization Act, 1984, to December 31, 1998.
8.25	January 1, 1999, to December 31, 1999.
8.4	January 1, 2000, to December 31, 2000.
8.5	January 1, 2001, to December 31, 2002.
8	After December 31, 2002.'';

(G) in the matter relating to a United States magistrate by striking:

''8	After September 30, 1987.'';

and inserting the following:

''8	October 1, 1987, to December 31, 1998.
8.25	January 1, 1999, to December 31, 1999.
8.4	January 1, 2000, to December 31, 2000.
8.5	January 1, 2001, to December 31, 2002.
8	After December 31, 2002.'';

(H) in the matter relating to a Claims Court judge by striking:

''8	After September 30, 1988.'';

and insert the following:

	''8	October 1, 1988, to December 31, 1998.
	8.25	January 1, 1999, to December 31, 1999.
	8.4	January 1, 2000, to December 31, 2000.
	8.5	January 1, 2001, to December 31, 2002.
	8	After December 31, 2002.'';

and

(I) by inserting after the matter relating to a Claims Court judge the following:

''Member of the Capitol Police.	2.5	August 1, 1920, to June 30, 1926.
	3.5	July 1, 1926, to June 30, 1942.
	5	July 1, 1942, to June 30, 1948.
	6	July 1, 1948, to October 31, 1956.
	6.5	November 1, 1956, to December 31, 1969.
	7.5	January 1, 1970, to December 31, 1998.
	7.75	January 1, 1999, to December 31, 1999.
	7.9	January 1, 2000, to December 31, 2000.
	8	January 1, 2001, to December 31, 2002.
	7.5	After December 31, 2002.''.

(4) OTHER SERVICE.—

(A) MILITARY SERVICE.—Section 8334(j) of title 5, United States Code, is amended—

(i) in paragraph (1)(A) by inserting ''and subject to paragraph (5),'' after ''Except as provided in subparagraph (B),''; and

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

''(5) Effective with respect to any period of military service after December 31, 1998, the percentage of basic pay under section 204 of title 37 payable under paragraph (1) shall be equal to the same percentage as would be applicable under subsection (c) of this section for that same period for service as an employee, subject to paragraph (1)(B).''.

(B) VOLUNTEER SERVICE.—Section 8334(l) of title 5, United States Code, is amended—

(i) in paragraph (1) by adding at the end the following: ''This paragraph shall be subject to paragraph (4).''; and

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

''(4) Effective with respect to any period of service after December 31, 1998, the percentage of the readjustment allowance or stipend (as the case may be) payable under paragraph (1) shall be equal to the same percentage as would be applicable under subsection (c) of this section for the same period for service as an employee.''.

(b) FEDERAL EMPLOYEES' RETIREMENT SYSTEM.—

(1) INDIVIDUAL DEDUCTIONS AND WITHHOLDINGS.—

(A) IN GENERAL.—Section 8422(a) of title 5, United States Code, is amended by striking paragraph (2) and inserting the following:

''(2) The percentage to be deducted and withheld from basic pay for any pay period shall be equal to—

''(A) the applicable percentage under paragraph (3), minus

''(B) the percentage then in effect under section 3101(a) of the Internal Revenue Code of 1986 (relating to rate of tax for old-age, survivors, and disability insurance).

''(3) The applicable percentage under this paragraph for civilian service shall be as follows:

''Employee ..	7	Before January 1, 1999.
	7.25	January 1, 1999, to December 31, 1999.
	7.4	January 1, 2000, to December 31, 2000.
	7.5	January 1, 2001, to December 31, 2002.
	7	After December 31, 2002.
Congressional employee.	7.5	Before January 1, 1999.
	7.75	January 1, 1999, to December 31, 1999.
	7.9	January 1, 2000, to December 31, 2000.
	8	January 1, 2001, to December 31, 2002.
	7.5	After December 31, 2002.
Member	7.5	Before January 1, 1999.
	7.75	January 1, 1999, to December 31, 1999.
	7.9	January 1, 2000, to December 31, 2000.
	8	January 1, 2001, to December 31, 2002.
	7.5	After December 31, 2002.
Law enforcement officer, firefighter, member of the Capitol Police, or air traffic controller.	7.5	Before January 1, 1999.
	7.75	January 1, 1999, to December 31, 1999.
	7.9	January 1, 2000, to December 31, 2000.
	8	January 1, 2001, to December 31, 2002.
	7.5	After December 31, 2002.''.

(B) MILITARY SERVICE.—Section 8422(e) of title 5, United States Code, is amended—

(i) in paragraph (1)(A) by inserting ''and subject to paragraph (6),'' after ''Except as provided in subparagraph (B),''; and

(ii) by adding at the end the following:

''(6) The percentage of basic pay under section 204 of title 37 payable under paragraph (1), with respect to any period of military service performed during—

''(A) January 1, 1999, through December 31, 1999, shall be 3.25 percent;

''(B) January 1, 2000, through December 31, 2000, shall be 3.4 percent; and

''(C) January 1, 2001, through December 31, 2002, shall be 3.5 percent.''.

(C) VOLUNTEER SERVICE.—Section 8422(f) of title 5, United States Code, is amended—

(i) in paragraph (1) by adding at the end the following: ''This paragraph shall be subject to paragraph (4).''; and

(ii) by adding at the end the following:

''(4) The percentage of the readjustment allowance or stipend (as the case may be) payable under paragraph (1), with respect to any period of volunteer service performed during—

''(A) January 1, 1999, through December 31, 1999, shall be 3.25 percent;

''(B) January 1, 2000, through December 31, 2000, shall be 3.4 percent; and

''(C) January 1, 2001, through December 31, 2002, shall be 3.5 percent.''.

(2) NO REDUCTION IN AGENCY CONTRIBUTIONS.—Agency contributions under section 8423 (a) and (b) of title 5, United States Code, shall not be reduced as a result of the amendments made under paragraph (1) of this subsection.

(c) CENTRAL INTELLIGENCE AGENCY RETIREMENT AND DISABILITY SYSTEM.—

(1) AGENCY CONTRIBUTIONS.—Notwithstanding section 211(a)(2) of the Central Intelligence Agency Retirement Act (50 U.S.C. 2021(a)(2))—

(A) during the period beginning on October 1, 1997, through September 30, 2001, the Central Intelligence Agency shall contribute 8.51 percent of the basic pay of an employee participating in the Central Intelligence Agency Retirement and Disability System; and

(B) during the period beginning on October 1, 2001, through September 30, 2002, the Central Intelligence Agency shall contribute 8.6 percent of the basic pay of an employee participating in the Central Intelligence Agency Retirement and Disability System.

(2) INDIVIDUAL DEDUCTIONS, WITHHOLDINGS, AND DEPOSITS.—Notwithstanding section 211(a)(1) of the Central Intelligence Agency Retirement Act (50 U.S.C. 2021(a)(1)) beginning on January 1, 1999, through December 31, 2002, the amount withheld and deducted from the basic pay of an employee participating in Central Intelligence Agency Retirement and Disability System shall be as follows:

''7.25	January 1, 1999, to December 31, 1999.
7.4	January 1, 2000, to December 31, 2000.
7.5	January 1, 2001, to December 31, 2002.
7	After December 31, 2002.''.

(3) MILITARY SERVICE.—Section 252(h)(1) of the Central Intelligence Agency Retirement Act (50 U.S.C. 2082(h)(1)), is amended to read as follows:

''(h)(1)(A) Each participant who has performed military service before the date of separation on which entitlement to an annuity under this title is based may pay to the Agency an amount equal to 7 percent of the amount of basic pay paid under section 204 of title 37, United States Code, to the participant for each period of military service after December 1956; except, the amount to be paid for military service performed beginning on January 1, 1999, through December 31, 2002, shall be as follows:

''7.25 percent of basic pay.	January 1, 1999, to December 31, 1999.
7.4 percent of basic pay.	January 1, 2000, to December 31, 2000.
7.5 percent of basic pay.	January 1, 2001, to December 31, 2002.
7 percent of basic pay.	After December 31, 2002.

''(B) The amount of such payments shall be based on such evidence of basic pay for military service as the participant may provide or, if the Director determines sufficient evidence has not been provided to adequately determine basic pay for military service, such payment shall be based upon estimates of such basic pay provided to the Director under paragraph (4).''.

(d) FOREIGN SERVICE RETIREMENT AND DISABILITY SYSTEM.—

(1) AGENCY CONTRIBUTIONS.—Notwithstanding section 805(a) (1) and (2) of the Foreign Service Act of 1980 (22 U.S.C. 4045(a) (1) and (2))—

(A) during the period beginning on October 1, 1997, through September 30, 2001, each agency employing a participant in the Foreign Service Retirement and Disability System shall contribute to the Foreign Service Retirement and Disability Fund—

(i) 8.51 percent of the basic pay of each participant covered under section 805(a)(1) of such Act participating in the Foreign Service Retirement and Disability System; and

(ii) 9.01 percent of the basic pay of each participant covered under section 805(a)(2) of such Act participating in the Foreign Service Retirement and Disability System; and

(B) during the period beginning on October 1, 2001, through September 30, 2002, each agency employing a participant in the Foreign Service Retirement and Disability System shall contribute to the Foreign Service Retirement and Disability Fund—

(i) 8.6 percent of the basic pay of each participant covered under section 805(a)(1) of such Act participating in the Foreign Service Retirement and Disability System; and

(ii) 9.1 percent of the basic pay of each participant covered under section 805(a)(2) of such Act participating in the Foreign Service Retirement and Disability System.

(2) INDIVIDUAL DEDUCTIONS, WITHHOLDINGS, AND DEPOSITS.—

(A) IN GENERAL.—Notwithstanding section 805(a)(1) of the Foreign Service Act of 1980 (22 U.S.C. 4045(a)(1)), beginning on January 1, 1999, through December 31, 2002, the amount withheld and deducted from the basic pay of a participant in the Foreign Service Retirement and Disability System shall be as follows:

''7.25	January 1, 1999, to December 31, 1999.
7.4	January 1, 2000, to December 31, 2000.
7.5	January 1, 2001, to December 31, 2002.
7	After December 31, 2002.''.

(B) FOREIGN SERVICE CRIMINAL INVESTIGATORS/INSPECTORS OF THE OFFICE OF THE INSPECTOR GENERAL, AGENCY FOR INTERNATIONAL DEVELOPMENT.—Notwithstanding section 805(a)(2) of the Foreign Service Act of 1980 (22 U.S.C. 4045(a)(2)), beginning on January 1, 1999, through December 31, 2002, the amount withheld and deducted from the basic pay of an eligible Foreign Service criminal investigator/inspector of the Office of the Inspector General, Agency for International Development participating in the Foreign Service Retirement and Disability System shall be as follows:

''7.75	January 1, 1999, to December 31, 1999.
7.9	January 1, 2000, to December 31, 2000.
8	January 1, 2001, to December 31, 2002.
7.5	After December 31, 2002.''.

(C) MILITARY SERVICE.—Section 805(e) of the Foreign Service Act of 1980 (22 U.S.C. 4045(e)) is amended—

(i) in subsection (e)(1) by striking ''Each'' and inserting ''Subject to paragraph (5), each''; and

(ii) by adding after paragraph (4) the following new paragraph:

''(5) Effective with respect to any period of military service after December 31, 1998, the percentage of basic pay under section 204 of title 37, United States Code, payable under paragraph (1) shall be equal to the same percentage as would be applicable under section 8334(c) of title 5, United States Code, for that same period for service as an employee.''.

(e) FOREIGN SERVICE PENSION SYSTEM.—

(1) INDIVIDUAL DEDUCTIONS AND WITHHOLDINGS FROM PAY.—

(A) IN GENERAL.—Section 856(a) of the Foreign Service Act of 1980 (22 U.S.C. 4071e(a)) is amended to read as follows:

''(a)(1) The employing agency shall deduct and withhold from the basic pay of each participant the applicable percentage of basic pay specified in paragraph (2) of this subsection minus the percentage then in effect under section 3101(a) of the Internal Revenue Code of 1986 (26 U.S.C. 3101(a)) (relating to the rate of tax for old age, survivors, and disability insurance).

''(2) The applicable percentage under this subsection shall be as follows:

''7.5	Before January 1, 1999.
7.75	January 1, 1999, to December 31, 1999.
7.9	January 1, 2000, to December 31, 2000.
8	January 1, 2001, to December 31, 2002.
7.5	After December 31, 2002.''.

(B) VOLUNTEER SERVICE.—Subsection 854(c) of the Foreign Service Act of 1980 (22 U.S.C. 4071c(c)) is amended to read as follows:

''(c)(1) Credit shall be given under this System to a participant for a period of prior satisfactory service as—

''(A) a volunteer or volunteer leader under the Peace Corps Act (22 U.S.C. 2501 et seq.),

''(B) a volunteer under part A of title VIII of the Economic Opportunity Act of 1964, or

''(C) a full-time volunteer for a period of service of at least 1 year's duration under part A, B, or C of title I of the Domestic Volunteer Service Act of 1973 (42 U.S.C. 4951 et seq.),

if the participant makes a payment to the Fund equal to 3 percent of pay received for the volunteer service; except, the amount to be paid for volunteer service beginning on January 1, 1999, through December 31, 2002, shall be as follows:

''3.25	January 1, 1999, to December 31, 1999.
3.4	January 1, 2000, to December 31, 2000.
3.5	January 1, 2001, to December 31, 2002.

''(2) The amount of such payments shall be determined in accordance with regulations of the Secretary of State consistent with regulations for making corresponding determinations under chapter 83, title 5, United States Code, together with interest determined under regulations issued by the Secretary of State.''.

(2) NO REDUCTION IN AGENCY CONTRIBUTIONS.—Agency contributions under section 857 of the Foreign Service Act of 1980 (22 U.S.C. 4071f) shall not be reduced as a result of the amendments made under paragraph (1) of this subsection.

(f) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall take effect on the first day of the first applicable pay period beginning on or after January 1, 1999.

SEC. 6002. GOVERNMENT CONTRIBUTIONS UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.

(a) IN GENERAL.—Section 8906 of title 5, United States Code, is amended by striking subsection (a) and all that follows through the end of paragraph (1) of subsection (b) and inserting the following:

''(a)(1) Not later than October 1 of each year, the Office of Personnel Management shall determine the weighted average of the subscription charges that will be in effect during the following contract year with respect to—

''(A) enrollments under this chapter for self alone; and

''(B) enrollments under this chapter for self and family.

''(2) In determining each weighted average under paragraph (1), the weight to be given to a particular subscription charge shall, with respect to each plan (and option) to which it is to apply, be commensurate with the number of enrollees enrolled in such plan (and option) as of March 31 of the year in which the determination is being made.

''(3) For purposes of paragraph (2), the term 'enrollee' means any individual who, during the contract year for which the weighted average is to be used under this section, will be eligible for a Government contribution for health benefits.

''(b)(1) Except as provided in paragraphs (2) and (3), the biweekly Government contribution for health benefits for an employee or annuitant enrolled in a health benefits plan under this chapter is adjusted to an amount equal to 72 percent of the weighted average under subsection (a)(1) (A) or (B), as applicable. For an employee, the adjustment begins on the first day of the employee's first pay period of each year. For an annuitant, the adjustment begins on the first day of the first period of each year for which an annuity payment is made.''.

(b) EFFECTIVE DATE.—This section shall take effect on the first day of the contract year that begins in 1999. Nothing in this subsection shall prevent the Office of Personnel Management from taking any action, before such first day, which it considers necessary in order to ensure the timely implementation of this section.

SEC. 6003. REPEAL OF AUTHORIZATION OF TRANSITIONAL APPROPRIATIONS FOR THE UNITED STATES POSTAL SERVICE.

(a) REPEAL.—

(1) IN GENERAL.—Section 2004 of title 39, United States Code, is repealed.

(2) TECHNICAL AND CONFORMING AMENDMENTS.—

(A) The table of sections for chapter 20 of such title is amended by repealing the item relating to section 2004.

(B) Section 2003(e)(2) of such title is amended by striking ''sections 2401 and 2004'' each place it appears and inserting ''section 2401''.

(b) CLARIFICATION THAT LIABILITIES FORMERLY PAID PURSUANT TO SECTION 2004 REMAIN LIABILITIES PAYABLE BY THE POSTAL SERVICE.—Section 2003 of title 39, United States Code, is amended by adding at the end the following:

''(h) Liabilities of the former Post Office Department to the Employees' Compensation Fund (appropriations for which were authorized by former section 2004, as in effect before the effective date of this subsection) shall be liabilities of the Postal Service payable out of the Fund.''.

(c) EFFECTIVE DATE.—This section and the amendments made by this section shall be effective as of October 1, 1997.

SEC. 6004. MEDICARE MEANS TESTING STANDARD APPLICABLE TO SENATORS' HEALTH COVERAGE UNDER THE FEHBP.

(a) PURPOSE.—The purpose of this section is to apply the medicare means testing requirements for part B premiums to individuals with adjusted gross incomes in excess of $100,000 as enacted under section 5542 of this Act, to United States Senators with respect to their employee contributions and Government contributions under the Federal Employees Health Benefits Program.

(b) IN GENERAL.—Section 8906 of title 5, United States Code, is amended by adding at the end the following:

''(j) Notwithstanding any other provision of this section, each employee who is a Senator and is paid at an annual rate of pay exceeding $100,000 shall pay the employee contribution and the full amount of the Government contribution which applies under this section. The Secretary of the Senate shall deduct and withhold the contributions required under this section and deposit such contributions in the Employees Health Benefits Fund.''.

(c) EFFECTIVE DATE.—This section shall take effect on the first day of the first pay period beginning on or after the date of enactment of this Act.

Subtitle B—GSA Property Sales

SEC. 6011. SALE OF GOVERNORS ISLAND, NEW YORK.

(a) IN GENERAL.—Notwithstanding any other provision of law, the Administrator of General Services shall, no earlier than fiscal year 2002, dispose of by sale at fair market value all rights, title, and interests of the United States in and to the land of, and improvements to, Governors Island, New York.

(b) RIGHT OF FIRST OFFER.—Before a sale is made under subsection (a) to any other parties, the State of New York and the city of New York shall be given the right of first offer to purchase all or part of Governors Island at fair market value as determined by the Administrator of General Services. Not later than 90 days after notification by the Administrator of General Services, such right may be exercised by either the State of New York or the city of New York or by both parties acting jointly.

(c) PROCEEDS.—Proceeds from the disposal of Governors Island under subsection (a) shall be deposited in the general fund of the Treasury and credited as miscellaneous receipts.

SEC. 6012. SALE OF AIR RIGHTS.

(a) IN GENERAL.—Notwithstanding any other provision of law, the Administrator of General Services shall sell, at fair market value and in a manner to be determined by the Administrator, the air rights adjacent to Washington Union Station described in subsection (b), including air rights conveyed to the Administrator under subsection (d). The Administrator shall complete the sale by such date as is necessary to ensure that the proceeds from the sale will be deposited in accordance with subsection (c).

(b) DESCRIPTION.—The air rights referred to in subsection (a) total approximately 16.5 acres and are depicted on the plat map of the District of Columbia as follows:

(1) Part of lot 172, square 720.

(2) Part of lots 172 and 823, square 720.

(3) Part of lot 811, square 717.

(c) PROCEEDS.—Before September 30, 2002, proceeds from the sale of air rights under subsection (a) shall be deposited in the general fund of the Treasury and credited as miscellaneous receipts.

(d) CONVEYANCE OF AMTRAK AIR RIGHTS.—

(1) GENERAL RULE.—As a condition of future Federal financial assistance, Amtrak shall convey to the Administrator of General Services on

or before December 31, 1997, at no charge, all of the air rights of Amtrak described in subsection (b).

(2) FAILURE TO COMPLY.—If Amtrak does not meet the condition established by paragraph (1), Amtrak shall be prohibited from obligating Federal funds after March 1, 1998.

TITLE VII—COMMITTEE ON LABOR AND HUMAN RESOURCES

SEC. 7001. MANAGEMENT AND RECOVERY OF RESERVES.

(a) AMENDMENT.—Section 422 of the Higher Education Act of 1965 (20 U.S.C. 1072) is amended by adding after subsection (g) the following new subsection:

''(h) RECALL OF RESERVES; LIMITATIONS ON USE OF RESERVE FUNDS AND ASSETS.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall, except as otherwise provided in this subsection, recall $1,028,000,000 from the reserve funds held by guaranty agencies under this part (which for purposes of this subsection shall include any reserve funds held by, or under the control of, any other entity) on September 1, 2002.

''(2) DEPOSIT.—Funds recalled by the Secretary under this subsection shall be deposited in the Treasury.

''(3) EQUITABLE SHARE.—The Secretary shall require each guaranty agency to return reserve funds under paragraph (1) based on such agency's equitable share of excess reserve funds held by guaranty agencies as of September 30, 1996. For purposes of this paragraph, a guaranty agency's equitable share of excess reserve funds shall be determined as follows:

''(A) The Secretary shall compute each agency's reserve ratio by dividing (i) the amount held in such agency's reserve (including funds held by, or under the control of, any other entity) as of September 30, 1996, by (ii) the original principal amount of all loans for which such agency has an outstanding insurance obligation.

''(B) If the reserve ratio of any agency as computed under subparagraph (A) exceeds 1.12 percent, the agency's equitable share shall include so much of the amounts held in such agency's reserve fund as exceed a reserve ratio of 1.12 percent.

''(C) If any additional amount is required to be recalled under paragraph (1) (after deducting the total of the equitable shares calculated under subparagraph (B)), the agencies' equitable shares shall include additional amounts—

''(i) determined by imposing on each such agency an equal percentage reduction in the amount of each agency's reserve fund remaining after deduction of the amount recalled under subparagraph (B); and

''(ii) the total of which equals the additional amount that is required to be recalled under paragraph (1) (after deducting the total of the equitable shares calculated under subparagraph (B)).

''(4) RESTRICTED ACCOUNTS.—Within 90 days after the beginning of each of fiscal years 1998 through 2002, each guaranty agency shall transfer a portion of each agency's equitable share determined under paragraph (3) to a restricted account established by the guaranty agency that is of a type selected by the guaranty agency with the approval of the Secretary. Funds transferred to such restricted accounts shall be invested in obligations issued or guaranteed by the United States or in other similarly low-risk securities. A guaranty agency shall not use the funds in such a restricted account for any purpose without the express written permission of the Secretary, except that a guaranty agency may use the earnings from such restricted account for activities to reduce student loan defaults under this part. The portion required to be transferred shall be determined as follows:

''(A) In fiscal year 1998—

''(i) all agencies combined shall transfer to a restricted account an amount equal to one-fifth of the total amount recalled under paragraph (1);

''(ii) each agency with a reserve ratio (as computed under paragraph (3)(A)) that exceeds 2 percent shall transfer to a restricted account so much of the amounts held in such agency's reserve fund as exceed a reserve ratio of 2 percent; and

''(iii) each agency shall transfer any additional amount required under clause (i) (after deducting the amount transferred under clause (ii)) by transferring an amount that represents an equal percentage of each agency's equitable share to a restricted account.

''(B) In fiscal years 1999 through 2002, each agency shall transfer an amount equal to one-fourth of the total amount remaining of the agency's equitable share (after deduction of the amount transferred under subparagraph (A)).

''(5) SHORTAGE.—If, on September 1, 2002, the total amount in the restricted accounts described in paragraph (4) is less than the amount the Secretary is required to recall under paragraph (1), the Secretary may require the return of the amount of the shortage from other reserve funds held by guaranty agencies under procedures established by the Secretary.

''(6) PROHIBITION.—The Secretary shall not have any authority to direct a guaranty agency to return reserve funds under subsection (g)(1)(A) during the period from the date of enactment of this subsection through September 30, 2002, and any reserve funds otherwise returned under subsection (g)(1) during such period shall be treated as amounts recalled under this subsection and shall not be available under subsection (g)(4).

''(7) DEFINITION.—For purposes of this subsection the term 'reserve funds' when used with respect to a guaranty agency—

''(A) includes any reserve funds held by, or under the control of, any other entity; and

''(B) does not include buildings, equipment, or other nonliquid assets.''.

(b) CONFORMING AMENDMENT.—Section 428(c)(9)(A) of the Higher Education Act of 1965 (20 U.S.C. 1078(c)(9)(A)) is amended—

(1) in the first sentence, by striking ''for the fiscal year of the agency that begins in 1993''; and

(2) by striking the third sentence.

SEC. 7002. REPEAL OF DIRECT LOAN ORIGINATION FEES TO INSTITUTIONS OF HIGHER EDUCATION.

Section 452 of the Higher Education Act of 1965 (20 U.S.C. 1087b) is amended—

(1) by striking subsection (b); and

(2) by redesignating subsections (c) and (d) as subsections (b) and (c), respectively.

SEC. 7003. FUNDS FOR ADMINISTRATIVE EXPENSES.

Subsection (a) of section 458 of the Higher Education Act of 1965 (20 U.S.C. 1087h(a)) is amended to read as follows:

''(a) ADMINISTRATIVE EXPENSES.—

''(1) IN GENERAL.—Each fiscal year, there shall be available to the Secretary from funds not otherwise appropriated, funds to be obligated for—

''(A) administrative costs under this part, including the costs of the direct student loan programs under this part, and

''(B) administrative cost allowances payable to guaranty agencies under part B and calculated in accordance with paragraph (2),

not to exceed (from such funds not otherwise appropriated) $532,000,000 in fiscal year 1998, $610,000,000 in fiscal year 1999, $705,000,000 in fiscal year 2000, $750,000,000 in fiscal year 2001, and $750,000,000 in fiscal year 2002. Administrative cost allowances under subparagraph (B) of this paragraph shall be paid quarterly and used in accordance with section 428(f). The Secretary may carry over funds available under this section to a subsequent fiscal year.

''(2) CALCULATION BASIS.—Administrative cost allowances payable to guaranty agencies under paragraph (1)(B) shall be calculated on the basis of 0.85 percent of the total principal amount of loans upon which insurance is issued on or after the date of enactment of the Balanced Budget Act of 1997, except that such allowances shall not exceed—

''(A) $170,000,000 for each of the fiscal years 1998 and 1999; or

''(B) $150,000,000 for each of the fiscal years 2000, 2001, and 2002.''.

SEC. 7004. EXTENSION OF STUDENT AID PROGRAMS.

Title IV of the Higher Education Act of 1965 (20 U.S.C. 1070 et seq.) is amended—

(1) in section 424(a), by striking ''1998.'' and ''2002.'' and inserting ''2002.'' and ''2006.'', respectively;

(2) in section 428(a)(5), by striking ''1998,'' and ''2002.'' and inserting ''2002,'' and ''2006.'', respectively; and

(3) in section 428C(e), by striking ''1998.'' and inserting ''2002.''.

TITLE VIII—COMMITTEE ON VETERANS' AFFAIRS

SEC. 8001. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This title may be cited as the ''Veterans Reconciliation Act of 1997''.

(b) TABLE OF CONTENTS.—The table of contents for this title is as follows:

Subtitle A—Extension of Temporary Authorities

SEC. 8011. ENHANCED LOAN ASSET SALE AUTHORITY.

Section 3720(h)(2) of title 38, United States Code, is amended by striking out ''December 31, 1997'' and inserting in lieu thereof ''December 31, 2002''.

SEC. 8012. HOME LOAN FEES.

Section 3729(a) of title 38, United States Code, is amended—

(1) in paragraph (4), by striking out ''October 1, 1998'' and inserting in lieu thereof ''October 1, 2002''; and

(2) in paragraph (5)(C), by striking out ''October 1, 1998'' and inserting in lieu thereof ''October 1, 2002''.

SEC. 8013. PROCEDURES APPLICABLE TO LIQUIDATION SALES ON DEFAULTED HOME LOANS GUARANTEED BY THE DEPARTMENT OF VETERANS AFFAIRS.

Section 3732(c)(11) of title 38, United States Code, is amended by striking out ''October 1,

1998'' and inserting in lieu thereof ''October 1, 2002''.

SEC. 8014. INCOME VERIFICATION AUTHORITY.

Section 5317(g) of title 38, United States Code, is amended by striking out ''September 30, 1998'' and inserting in lieu thereof ''September 30, 2002''.

SEC. 8015. LIMITATION ON PENSION FOR CERTAIN RECIPIENTS OF MEDICAID-COVERED NURSING HOME CARE.

Section 5503(f)(7) of title 38, United States Code, is amended by striking out ''September 30, 1998'' and inserting in lieu thereof ''September 30, 2002''.

Subtitle B—Copayments and Medical Care Cost Recovery

SEC. 8021. AUTHORITY TO REQUIRE THAT CERTAIN VETERANS MAKE COPAYMENTS IN EXCHANGE FOR RECEIVING HEALTH CARE BENEFITS.

(a) HOSPITAL AND MEDICAL CARE.—Section 8013(e) of the Omnibus Budget Reconciliation Act of 1990 (38 U.S.C. 1710 note) is amended by striking out ''September 30, 1998'' and inserting in lieu thereof ''September 30, 2002''.

(b) OUTPATIENT MEDICATIONS.—Section 1722A(c) of title 38, United States Code, is amended by striking out ''September 30, 1998'' and inserting in lieu thereof ''September 30, 2002''.

SEC. 8022. MEDICAL CARE COST RECOVERY AUTHORITY.

Section 1729(a)(2)(E) of title 38, United States Code, is amended by striking out ''October 1, 1998'' and inserting in lieu thereof ''October 1, 2002''.

SEC. 8023. DEPARTMENT OF VETERANS AFFAIRS MEDICAL-CARE RECEIPTS.

(a) ALLOCATION OF RECEIPTS.—(1) Chapter 17 of title 38, United States Code, is amended by inserting after section 1729 the following new section:

''§ 1729A. Department of Veterans Affairs Medical Care Collections Fund

''(a) There is in the Treasury a fund to be known as the Department of Veterans Affairs Medical Care Collections Fund.

''(b) Amounts recovered or collected after June 30, 1997, under any of the following provisions of law shall be deposited in the fund:

''(1) Section 1710(f) of this title.

''(2) Section 1710(g) of this title.

''(3) Section 1711 of this title.

''(4) Section 1722A of this title.

''(5) Section 1729 of this title.

''(6) Public Law 87–693, popularly known as the 'Federal Medical Care Recovery Act' (42 U.S.C. 2651 et seq.), to the extent that a recovery or collection under that law is based on medical care and services furnished under this chapter.

''(c)(1) Subject to the provisions of appropriations Acts, amounts in the fund shall be available to the Secretary for the following purposes:

''(A) Furnishing medical care and services under this chapter, to be available during any fiscal year for the same purposes and subject to the same limitations as apply to amounts appropriated for that fiscal year for medical care.

''(B) Expenses of the Department for the identification, billing, auditing, and collection of amounts owed the United States by reason of medical care and services furnished under this chapter.

''(2) Amounts available under paragraph (1) shall be available only for the purposes set forth in that paragraph.

''(d) The Secretary shall ensure that the amount made available to a Veterans Integrated Service Network in a fiscal year from amounts in the fund is an amount equal to the amount recovered or collected by the Veterans Integrated Service Network under a provision of law referred to in subsection (b) during the fiscal year.''.

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1729 the following new item:

''1729A. Department of Veterans Affairs Medical Care Collections Fund.''.

(b) CONFORMING AMENDMENTS.—Chapter 17 of such title is amended as follows:

(1) Section 1710(f) is amended by striking out paragraph (4) and redesignating paragraph (5) as paragraph (4).

(2) Section 1710(g) is amended by striking out paragraph (4).

(3) Section 1722A(b) is amended by striking out ''Department of Veterans Affairs Medical-Care Cost Recovery Fund'' and inserting in lieu thereof ''Department of Veterans Affairs Medical Care Collections Fund''.

(4) Section 1729 is amended by striking out subsection (g).

(c) DISPOSITION OF FUNDS IN MEDICAL-CARE COST RECOVERY FUND.—The amount of the unobligated balance remaining in the Department of Veterans Affairs Medical-Care Cost Recovery Fund (established pursuant to section 1729(g)(1) of title 38, United States Code) at the close of June 30, 1997, shall be deposited, not later than December 31, 1997, in the Department of Veterans Affairs Medical Care Collections Fund established by section 1729A(a) of title 38, United States Code, as added by subsection (a).

Subtitle C—Other Matters

SEC. 8031. ROUNDING DOWN OF COST-OF-LIVING ADJUSTMENTS IN COMPENSATION AND DIC RATES IN FISCAL YEARS 1998 THROUGH 2002.

(a) COMPENSATION COLAS.—(1) Chapter 11 of title 38, United States Code, is amended by inserting after section 1102 the following new section:

''§ 1103. Cost-of-living adjustments

''(a) In the computation of cost-of-living adjustments for fiscal years 1998 through 2002 in the rates of, and dollar limitations applicable to, compensation payable under this chapter, such adjustments shall be made by a uniform percentage that is no more than the percentage equal to the social security increase for that fiscal year, with all increased monthly rates and limitations (other than increased rates or limitations equal to a whole dollar amount) rounded down to the next lower whole dollar amount.

''(b) For purposes of this section, the term 'social security increase' means the percentage by which benefit amounts payable under title II of the Social Security Act (42 U.S.C. 401 et seq.) are increased for any fiscal year as a result of a determination under section 215(i) of such Act (42 U.S.C. 415(i)).''.

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1102 the following new item:

''1103. Cost-of-living adjustments.''.

(b) DIC COLAS.—(1) Chapter 13 of title 38, United States Code, is amended by inserting after section 1302 the following new section:

''§ 1303. Cost-of-living adjustments

''(a) In the computation of cost-of-living adjustments for fiscal years 1998 through 2002 in the rates of dependency and indemnity compensation payable under this chapter, such adjustments (except as provided in subsection (b)) shall be made by a uniform percentage that is no more than the percentage equal to the social security increase for that fiscal year, with all increased monthly rates (other than increased rates equal to a whole dollar amount) rounded down to the next lower whole dollar amount.

''(b)(1) Cost-of-living adjustments for each of fiscal years 1998 through 2002 in old-law DIC rates shall be in a whole dollar amount that is no greater than the amount by which the new-law DIC rate is increased for that fiscal year as determined under subsection (a).

''(2) For purposes of paragraph (1):

''(A) The term 'old-law DIC rates' means the dollar amounts in effect under section 1311(a)(3) of this title.

''(B) The term 'new-law DIC rate' means the dollar amount in effect under section 1311(a)(1) of this title.

''(c) For purposes of this section, the term 'social security increase' means the percentage by which benefit amounts payable under title II of the Social Security Act (42 U.S.C. 401 et seq.) are increased for any fiscal year as a result of a determination under section 215(i) of such Act (42 U.S.C. 415(i)).''.

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1302 the following new item:

''1303. Cost-of-living adjustments.''.

SEC. 8032. INCREASE IN AMOUNT OF HOME LOAN FEES FOR THE PURCHASE OF REPOSSESSED HOMES FROM THE DEPARTMENT OF VETERANS AFFAIRS.

Section 3729(a) of title 38, United States Code, is amended—

(1) in paragraph (2)—

(A) in subparagraph (A), by striking out ''or 3733(a)'';

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

(C) in subparagraph (E), by striking out the period at the end and inserting in lieu thereof ''; and''; and

(D) by adding at the end the following:

''(F) in the case of a loan made under section 3733(a) of this title, the amount of such fee shall be 2.25 percent of the total loan amount.''; and

(2) in paragraph (4), as amended by section 8012(1) of this Act, by striking out ''or (E)'' and inserting in lieu thereof ''(E), or (F)''.

SEC. 8033. WITHHOLDING OF PAYMENTS AND BENEFITS.

(a) NOTICE REQUIRED IN LIEU OF CONSENT OR COURT ORDER.—Section 3726 of title 38, United States Code, is amended—

(1) by inserting ''(a)'' before ''No officer''; and

(2) by striking out ''unless'' and all that follows and inserting in lieu thereof the following: ''unless the Secretary provides such veteran or surviving spouse with notice by certified mail with return receipt requested of the authority of the Secretary to waive the payment of indebtedness under section 5302(b) of this title.

''(b) If the Secretary does not waive the entire amount of the liability, the Secretary shall then determine whether the veteran or surviving spouse should be released from liability under section 3713(b) of this title.

''(c) If the Secretary determines that the veteran or surviving spouse should not be released from liability, the Secretary shall notify the veteran or surviving spouse of that determination and provide a notice of the procedure for appealing that determination, unless the Secretary has previously made such determination and notified the veteran or surviving spouse of the procedure for appealing the determination.''.

(b) CONFORMING AMENDMENT.—Section 5302(b) of such title is amended by inserting ''with return receipt requested'' after ''certified mail''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to any indebtedness to the United States arising pursuant to chapter 37 of title 38, United States Code, before, on, or after the date of enactment of this Act.

Mr. CHAFEE. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. CHAFEE. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

REMOVAL OF INJUNCTION OF SECRECY—TREATY DOCUMENT NO. 105–9

Mr. CHAFEE. Mr. President, as in executive session, I ask unanimous consent that the injunction of secrecy be removed from the following treaty transmitted to the Senate on June 26, 1997, by the President of the United States.

Tax Convention with South Africa (Treaty Document No. 105–9).

I further ask unanimous consent that the treaty be considered as having been read the first time; that it be referred, with accompanying papers, to the Committee on Foreign Relations and ordered to be printed; and that the President's message be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The message of the President is as follows:

To the Senate of the United States:

I transmit herewith for Senate advice and consent to ratification the Convention Between the United States of America and the Republic of South Africa for the Avoidance of Double Taxation and the Prevention of Fiscal Evasion with Respect to Taxes on Income and Capital Gains, signed at Cape Town February 17, 1997. Also transmitted is the report of the Department of State concerning the Convention.

This Convention, which generally follows the U.S. model tax treaty, provides maximum rates of tax to be applied to various types of income and protection from double taxation of income. The Convention also provides for the exchange of information to prevent fiscal evasion and sets forth standard rules to limit the benefits of the Convention so that they are available only to residents that are not engaged in treaty shopping.

I recommend that the Senate give early and favorable consideration to this Convention and give its advice and consent to ratification.

WILLIAM J. CLINTON.

THE WHITE HOUSE, *June 26, 1997*.

ORDER TO PRINT SENATE AMENDMENT TO H.R. 2015

Mr. CHAFEE. Mr. President, I ask unanimous consent that the Senate amendment to H.R. 2015 be printed as passed.

The PRESIDING OFFICER. Without objection, it is so ordered.

ORDERS FOR FRIDAY, JUNE 27, 1997

Mr. CHAFEE. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand in adjournment until the hour of 9 a.m. on Friday, June 27. I further ask unanimous consent that on Friday, immediately following the prayer, the routine requests through the morning hour be granted, and the Senate immediately resume consideration of S. 949, the Tax Fairness Relief Act, and under the previous order the Senate will begin a series of votes on or in relation to the pending amendments. I further ask unanimous consent that there be 2 minutes of debate equally divided in the usual form prior to each vote, and, lastly, with regard to any amendment offered, following the reporting of the amendment the reading of the amendment be waived.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. CHAFEE. Mr. President, for the information of all Senators, tomorrow at 9 a.m. the Senate will resume consideration of S. 949, the Tax Relief Act of 1997 and begin another lengthy series of rollcall votes. Following the disposition of the pending amendments, additional amendments may be offered. However, it is hoped that Members will refrain from offering amendments so that the Senate may complete action on this bill at a reasonable time on Friday.

The PRESIDING OFFICER. Without objection, it is so ordered.

ADJOURNMENT UNTIL 9 A.M. TOMORROW

Mr. CHAFEE. Mr. President, if there be no further business to come before the Senate, I now ask unanimous consent that the Senate stand in adjournment under the previous order.

There being no objection, the Senate, at 11:22 p.m., adjourned until Friday, June 27, 1997, at 9 a.m.

NOMINATIONS

Executive nominations received by the Senate June 26, 1997:

THE JUDICIARY

JEROME B. FRIEDMAN, OF VIRGINIA, TO BE U.S. DISTRICT JUDGE FOR THE EASTERN DISTRICT OF VIRGINIA VICE ROBERT G. DOUMAR, RETIRED.

RONNIE L. WHITE, OF MISSOURI, TO BE U.S. DISTRICT JUDGE FOR THE EASTERN DISTRICT OF MISSOURI VICE GEORGE F. GUNN, JR., RETIRED.

DEPARTMENT OF THE INTERIOR

ROBERT G. STANTON, OF VIRGINIA, TO BE DIRECTOR OF THE NATIONAL PARK SERVICE. (NEW POSITION)

DEPARTMENT OF COMMERCE

W. SCOTT GOULD, OF THE DISTRICT OF COLUMBIA, TO BE CHIEF FINANCIAL OFFICER, DEPARTMENT OF COMMERCE, VICE THOMAS R. BLOOM.

W. SCOTT GOULD, OF THE DISTRICT OF COLUMBIA, TO BE AN ASSISTANT SECRETARY OF COMMERCE, VICE THOMAS R. BLOOM.

DEPARTMENT OF AGRICULTURE

CATHERINE E. WOTEKI, OF THE DISTRICT OF COLUMBIA, TO BE UNDER SECRETARY OF AGRICULTURE FOR FOOD SAFETY. (NEW POSITION)

U.S. ENRICHMENT CORPORATION

KNEELAND C. YOUNGBLOOD, OF TEXAS, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE U.S. ENRICHMENT CORPORATION FOR A TERM EXPIRING FEBRUARY 24, 2002. (REAPPOINTMENT)

DEPARTMENT OF STATE

WENDY RUTH SHERMAN, OF MARYLAND, TO BE COUNSELOR OF THE DEPARTMENT OF STATE, AND TO HAVE THE RANK OF AMBASSADOR DURING HER TENURE OF SERVICE.

GORDON D. GIFFIN, OF GEORGIA, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO CANADA.

MAURA HARTY, OF FLORIDA, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF PARAGUAY.

CURTIS WARREN KAMMAN, OF THE DISTRICT OF COLUMBIA, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF CAREER MINISTER, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF COLOMBIA.

JAMES F. MACK, OF VIRGINIA, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE CO-OPERATIVE REPUBLIC OF GUYANA

ANNE MARIE SIGMUND, OF THE DISTRICT OF COLUMBIA, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF CAREER MINISTER, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE KYRGYZ REPUBLIC.

KEITH C. SMITH, OF CALIFORNIA, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF LITHUANIA.

DANIEL V. SPECKHARD, OF WISCONSIN, A CAREER MEMBER OF THE SENIOR EXECUTIVE SERVICE, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF BELARUS.

DEPARTMENT OF TRANSPORTATION

GEORGE DONOHUE, OF MARYLAND, TO BE DEPUTY ADMINISTRATOR OF THE FEDERAL AVIATION ADMINISTRATION, VICE LINDA HALL DASCHLE.

DEPARTMENT OF THE TREASURY

GARY GENSLER, OF MARYLAND, TO BE AN ASSISTANT SECRETARY OF THE TREASURY, VICE DARCY E. BRADBURY.

NANCY KILLEFER, OF FLORIDA, TO BE AN ASSISTANT SECRETARY OF THE TREASURY, VICE GEORGE MUNOZ.

NANCY KILLEFER, OF FLORIDA, TO BE CHIEF FINANCIAL OFFICER, DEPARTMENT OF THE TREASURY, VICE GEORGE MUNOZ.

U.S. INTERNATIONAL DEVELOPMENT COOPERATION AGENCY

GEOREGE MUNOZ, OF ILLINOIS, TO BE PRESIDENT OF THE OVERSEAS PRIVATE INVESTMENT CORPORATION, VICE RUTH R. HARKIN, RESIGNED.