

106<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

# H. R. 5601

To amend titles XVIII, XIX, and XXI of the Social Security Act to provide benefits improvements and beneficiary protections in the Medicare and Medicaid programs and the State child health insurance program (SCHIP), as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

OCTOBER 30, 2000

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

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## A BILL

To amend titles XVIII, XIX, and XXI of the Social Security Act to provide benefits improvements and beneficiary protections in the Medicare and Medicaid programs and the State child health insurance program (SCHIP), as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes.

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

1 **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECU-**  
2 **RITY ACT; REFERENCES TO OTHER ACTS;**  
3 **TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the  
5 “Medicare, Medicaid, and SCHIP Benefits Improvement  
6 and Protection Act of 2000”.

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

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

14 (1) **BALANCED BUDGET ACT OF 1997.**—The  
15 term “BBA” means the Balanced Budget Act of  
16 1997 (Public Law 105–33; 111 Stat. 251).

17 (2) **MEDICARE, MEDICAID, AND SCHIP BAL-**  
18 **ANCED BUDGET REFINEMENT ACT OF 1999.**—The  
19 term “BBRA” means the Medicare, Medicaid, and  
20 SCHIP Balanced Budget Refinement Act of 1999  
21 (Appendix F, 113 Stat. 1501A–321), as enacted into  
22 law by section 1000(a)(6) of Public Law 106–113.

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

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

## TITLE I—MEDICARE BENEFICIARY IMPROVEMENTS

## Subtitle A—Improved Preventive Benefits

- Sec. 101. Coverage of biennial screening pap smear and pelvic exams.
- Sec. 102. Coverage of screening for glaucoma.
- Sec. 103. Coverage of screening colonoscopy for average risk individuals.
- Sec. 104. Modernization of screening mammography benefit.
- Sec. 105. Coverage of medical nutrition therapy services for beneficiaries with diabetes or a renal disease.
- Sec. 106. Extension of part A coverage for workers with disabilities.

## Subtitle B—Other Beneficiary Improvements

- Sec. 111. Acceleration of reduction of beneficiary copayment for hospital outpatient department services.
- Sec. 112. Preservation of coverage of drugs and biologicals under part B of the medicare program.
- Sec. 113. Elimination of time limitation on medicare benefits for immunosuppressive drugs.
- Sec. 114. Imposition of billing limits on drugs.
- Sec. 115. Improving availability of QMB/SLMB application forms.

## Subtitle C—Demonstration Projects and Studies

- Sec. 121. Demonstration project for disease management for severely chronically ill medicare beneficiaries.
- Sec. 122. Cancer prevention and treatment demonstration for ethnic and racial minorities.
- Sec. 123. Study on medicare coverage of routine thyroid screening.
- Sec. 124. MedPAC study on consumer coalitions.
- Sec. 125. Study on limitation on State payment for medicare cost-sharing affecting access to services for qualified medicare beneficiaries.
- Sec. 126. Waiver of 24-month waiting period for medicare coverage of individuals disabled with amyotrophic lateral sclerosis (ALS).
- Sec. 127. Studies on preventive interventions in primary care for older Americans.
- Sec. 128. MedPAC study and report on medicare coverage of cardiac and pulmonary rehabilitation therapy services.

## TITLE II—RURAL HEALTH CARE IMPROVEMENTS

## Subtitle A—Critical Access Hospital Provisions

- Sec. 201. Clarification of no beneficiary cost-sharing for clinical diagnostic laboratory tests furnished by critical access hospitals.
- Sec. 202. Assistance with fee schedule payment for professional services under all-inclusive rate.
- Sec. 203. Exemption of critical access hospital swing beds from SNF PPS.
- Sec. 204. Payment in critical access hospitals for emergency room on-call physicians.
- Sec. 205. Treatment of ambulance services furnished by certain critical access hospitals.
- Sec. 206. GAO study on certain eligibility requirements for critical access hospitals.

## Subtitle B—Other Rural Hospitals Provisions

- Sec. 211. Equitable treatment for rural disproportionate share hospitals.
- Sec. 212. Option to base eligibility for medicare dependent, small rural hospital program on discharges during 2 of the 3 most recently audited cost reporting periods.
- Sec. 213. Extension of option to use rebased target amounts to all sole community hospitals.
- Sec. 214. MedPAC analysis of impact of volume on per unit cost of rural hospitals with psychiatric units.

#### Subtitle C—Other Rural Provisions

- Sec. 221. Assistance for providers of ambulance services in rural areas.
- Sec. 222. Payment for certain physician assistant services.
- Sec. 223. Revision of medicare reimbursement for telehealth services.
- Sec. 224. Expanding access to rural health clinics.
- Sec. 225. MedPAC study on low-volume, isolated rural health care providers.

### TITLE III—PROVISIONS RELATING TO PART A

#### Subtitle A—Inpatient Hospital Services

- Sec. 301. Eliminating reduction in pps hospital payment update.
- Sec. 302. Additional modification in transition for indirect medical education (IME) percentage adjustment.
- Sec. 303. Decrease in reductions for disproportionate share hospital (DSH) payments.
- Sec. 304. Wage index improvements.
- Sec. 305. Payment for inpatient services of rehabilitation hospitals.
- Sec. 306. Payment for inpatient services of psychiatric hospitals.
- Sec. 307. Payment for inpatient services of long-term care hospitals.
- Sec. 308. Increase in base payment to Puerto Rico acute care hospitals.

#### Subtitle B—Adjustments to PPS Payments for Skilled Nursing Facilities

- Sec. 311. Elimination of reduction in skilled nursing facility (SNF) market basket update in 2001.
- Sec. 312. Increase in nursing component of PPS Federal rate.
- Sec. 313. Application of SNF consolidated billing requirement limited to part A covered stays.
- Sec. 314. Adjustment of rehabilitation RUGs to correct anomaly in payment rates.
- Sec. 315. Establishment of process for geographic reclassification.

#### Subtitle C—Hospice Care

- Sec. 321. Full market basket increase for 2001 and 2002.
- Sec. 322. Clarification of physician certification.
- Sec. 323. MedPAC report on access to, and use of, hospice benefit.

#### Subtitle D—Other Provisions

- Sec. 331. Relief from medicare part A late enrollment penalty for group buy-in for State and local retirees.
- Sec. 332. Hospital geographic reclassification for labor costs for other PPS systems.

### TITLE IV—PROVISIONS RELATING TO PART B

#### Subtitle A—Hospital Outpatient Services

- Sec. 401. Revision of hospital outpatient PPS payment update.
- Sec. 402. Clarifying process and standards for determining eligibility of devices for pass-through payments under hospital outpatient PPS.
- Sec. 403. Application of OPD PPS transitional corridor payments to certain hospitals that did not submit a 1996 cost report.
- Sec. 404. Application of rules for determining provider-based status for certain entities.
- Sec. 405. Treatment of children's hospitals under prospective payment system.
- Sec. 406. Inclusion of temperature monitored cryoablation in transitional pass-through for certain medical devices, drugs, and biologicals under OPD PPS.

#### Subtitle B—Provisions Relating to Physicians' Services

- Sec. 411. GAO studies relating to physicians' services.
- Sec. 412. Physician group practice demonstration.
- Sec. 413. Study on enrollment procedures for groups that retain independent contractor physicians.

#### Subtitle C—Other Services

- Sec. 421. 1-year extension of moratorium on therapy caps; report on standards for supervision of physical therapy assistants.
- Sec. 422. Update in renal dialysis composite rate.
- Sec. 423. Payment for ambulance services.
- Sec. 424. Ambulatory surgical centers.
- Sec. 425. Full update for durable medical equipment.
- Sec. 426. Full update for orthotics and prosthetics.
- Sec. 427. Establishment of special payment provisions and requirements for prosthetics and certain custom fabricated orthotic items.
- Sec. 428. Replacement of prosthetic devices and parts.
- Sec. 429. Revised part B payment for drugs and biologicals and related services.
- Sec. 430. Contrast enhanced diagnostic procedures under hospital prospective payment system.
- Sec. 431. Qualifications for community mental health centers.
- Sec. 432. Modification of medicare billing requirements for certain Indian providers.
- Sec. 433. GAO study on coverage of surgical first assisting services of certified registered nurse first assistants.
- Sec. 434. MedPAC study and report on medicare reimbursement for services provided by certain providers.
- Sec. 435. MedPAC study and report on medicare coverage of services provided by certain nonphysician providers.
- Sec. 436. GAO study and report on the costs of emergency and medical transportation services.
- Sec. 437. GAO studies and reports on medicare payments.
- Sec. 438. MedPAC study on access to outpatient pain management services.

### TITLE V—PROVISIONS RELATING TO PARTS A AND B

#### Subtitle A—Home Health Services

- Sec. 501. 2-year additional delay in application of 15 percent reduction on payment limits for home health services.

- Sec. 502. Restoration of full home health market basket update for home health services for fiscal year 2001.
- Sec. 503. Temporary two-month extension of periodic interim payments.
- Sec. 504. Use of telehealth in delivery of home health services.
- Sec. 505. Study on costs to home health agencies of purchasing nonroutine medical supplies.
- Sec. 506. Treatment of branch offices; GAO study on supervision of home health care provided in isolated rural areas.
- Sec. 507. Clarification of the homebound definition under the medicare home health benefit.

#### Subtitle B—Direct Graduate Medical Education

- Sec. 511. Increase in floor for direct graduate medical education payments.
- Sec. 512. Change in distribution formula for Medicare+Choice-related nursing and allied health education costs.

#### Subtitle C—Changes in Medicare Coverage and Appeals Process

- Sec. 521. Revisions to medicare appeals process.
- Sec. 522. Revisions to medicare coverage process.

#### Subtitle D—Improving Access to New Technologies

- Sec. 531. Reimbursement improvements for new clinical laboratory tests and durable medical equipment.
- Sec. 532. Retention of HCPCS level III codes.
- Sec. 533. Recognition of new medical technologies under inpatient hospital PPS.

#### Subtitle E—Other Provisions

- Sec. 541. Increase in reimbursement for bad debt.
- Sec. 542. Treatment of certain physician pathology services under medicare.
- Sec. 543. Extension of advisory opinion authority.
- Sec. 544. Change in annual MedPAC reporting.
- Sec. 545. Development of patient assessment instruments.
- Sec. 546. GAO report on impact of the Emergency Medical Treatment and Active Labor Act (EMTALA) on hospital emergency departments.
- Sec. 547. Application of Bloodborne Pathogen standard to certain hospitals.

### TITLE VI—PROVISIONS RELATING TO PART C (MEDICARE+CHOICE PROGRAM) AND OTHER MEDICARE MAN- AGED CARE PROVISIONS

#### Subtitle A—Medicare+Choice Payment Reforms

- Sec. 601. Increase in minimum payment amount.
- Sec. 602. Increase in minimum percentage increase.
- Sec. 603. 10-year phase-in of risk adjustment.
- Sec. 604. Transition to revised Medicare+Choice payment rates.
- Sec. 605. Revision of payment rates for ESRD patients enrolled in Medicare+Choice plans.
- Sec. 606. Permitting premium reductions as additional benefits under Medicare+Choice plans.
- Sec. 607. Full implementation of risk adjustment for congestive heart failure enrollees for 2001.
- Sec. 608. Expansion of application of Medicare+Choice new entry bonus.

Sec. 609. Report on inclusion of certain costs of the Department of Veterans Affairs and military facility services in calculating Medicare+Choice payment rates.

#### Subtitle B—Other Medicare+Choice Reforms

- Sec. 611. Payment of additional amounts for new benefits covered during a contract term.
- Sec. 612. Restriction on implementation of significant new regulatory requirements mid-year.
- Sec. 613. Timely approval of marketing material that follows model marketing language.
- Sec. 614. Avoiding duplicative regulation.
- Sec. 615. Election of uniform local coverage policy for Medicare+Choice plan covering multiple localities.
- Sec. 616. Eliminating health disparities in Medicare+Choice program.
- Sec. 617. Medicare+Choice program compatibility with employer or union group health plans.
- Sec. 618. Special medigap enrollment antidiscrimination provision for certain beneficiaries.
- Sec. 619. Restoring effective date of elections and changes of elections of Medicare+Choice plans.
- Sec. 620. Permitting ESRD beneficiaries to enroll in another Medicare+Choice plan if the plan in which they are enrolled is terminated.
- Sec. 621. Providing choice for skilled nursing facility services under the Medicare+Choice program.
- Sec. 622. Providing for accountability of Medicare+Choice plans.
- Sec. 623. Civil monetary penalties for contract default by a Medicare+Choice organization.

#### Subtitle C—Other Managed Care Reforms

- Sec. 631. 1-year extension of social health maintenance organization (SHMO) demonstration project.
- Sec. 632. Revised terms and conditions for extension of medicare community nursing organization (CNO) demonstration project.
- Sec. 633. Extension of medicare municipal health services demonstration projects.
- Sec. 634. Service area expansion for medicare cost contracts during transition period.

### TITLE VII—MEDICAID

- Sec. 701. DSH payments.
- Sec. 702. New prospective payment system for Federally-qualified health centers and rural health clinics.
- Sec. 703. Streamlined approval of continued State-wide section 1115 medicaid waivers.
- Sec. 704. Medicaid county-organized health systems.
- Sec. 705. Deadline for issuance of final regulation relating to medicaid upper payment limits.
- Sec. 706. Alaska FMAP.
- Sec. 707. Optional coverage of legal immigrants under the medicaid program.
- Sec. 708. Additional entities qualified to determine medicaid presumptive eligibility for low-income children.
- Sec. 709. Improving welfare-to-work transition.

## TITLE VIII—STATE CHILDREN’S HEALTH INSURANCE PROGRAM

Sec. 801. Special rule for redistribution and availability of unused fiscal year 1998 and 1999 SCHIP allotments.

Sec. 802. Authority to pay medicaid expansion SCHIP costs from title XXI appropriation.

## TITLE IX—OTHER PROVISIONS

## Subtitle A—PACE Program

Sec. 901. Extension of transition for current waivers.

Sec. 902. Continuing of certain operating arrangements permitted.

Sec. 903. Flexibility in exercising waiver authority.

## Subtitle B—Outreach to Eligible Low-Income Medicare Beneficiaries

Sec. 911. Outreach on availability of medicare cost-sharing assistance to eligible low-income medicare beneficiaries.

## Subtitle C—Maternal and Child Health Block Grant

Sec. 921. Increase in authorization of appropriations for the maternal and child health services block grant.

## Subtitle D—Diabetes

Sec. 931. Increase in appropriations for special diabetes programs for type I diabetes and Indians.

Sec. 932. Appropriations for Ricky Ray Hemophilia Relief Fund.

1                   **TITLE I—MEDICARE**  
 2                   **BENEFICIARY IMPROVEMENTS**  
 3                   **Subtitle A—Improved Preventive**  
 4                   **Benefits**

5                   **SEC. 101. COVERAGE OF BIENNIAL SCREENING PAP SMEAR**  
 6                   **AND PELVIC EXAMS.**

7                   (a) IN GENERAL.—

8                   (1) BIENNIAL SCREENING PAP SMEAR.—Section  
 9                   1861(nn)(1) (42 U.S.C. 1395x(nn)(1)) is amended  
 10                  by striking “3 years” and inserting “2 years”.

11                  (2) BIENNIAL SCREENING PELVIC EXAM.—Sec-  
 12                  tion 1861(nn)(2) (42 U.S.C. 1395x(nn)(2)) is

1 amended by striking “3 years” and inserting “2  
2 years”.

3 (b) EFFECTIVE DATE.—The amendments made by  
4 subsection (a) apply to items and services furnished on  
5 or after July 1, 2001.

6 **SEC. 102. COVERAGE OF SCREENING FOR GLAUCOMA.**

7 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.  
8 1395x(s)(2)) is amended—

9 (1) by striking “and” at the end of subpara-  
10 graph (S);

11 (2) by inserting “and” at the end of subpara-  
12 graph (T); and

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

14 “(U) screening for glaucoma (as defined in sub-  
15 section (uu)) for individuals determined to be at  
16 high risk for glaucoma, individuals with a family his-  
17 tory of glaucoma and individuals with diabetes;”.

18 (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.  
19 1395x) is amended by adding at the end the following new  
20 subsection:

21 “Screening for Glaucoma

22 “(uu) The term ‘screening for glaucoma’ means a di-  
23 lated eye examination with an intraocular pressure meas-  
24 urement, and a direct ophthalmoscopy or a slit-lamp bio-  
25 microscopic examination for the early detection of glau-

1 coma which is furnished by or under the direct supervision  
2 of an optometrist or ophthalmologist who is legally author-  
3 ized to furnish such services under State law (or the State  
4 regulatory mechanism provided by State law) of the State  
5 in which the services are furnished, as would otherwise  
6 be covered if furnished by a physician or as an incident  
7 to a physician’s professional service, if the individual in-  
8 volved has not had such an examination in the preceding  
9 year.”.

10 (c) CONFORMING AMENDMENT.—Section  
11 1862(a)(1)(F) (42 U.S.C. 1395y(a)(1)(F)) is amended—

12 (1) by striking “and,”; and

13 (2) by adding at the end the following: “and, in  
14 the case of screening for glaucoma, which is per-  
15 formed more frequently than is provided under sec-  
16 tion 1861(uu),”.

17 (d) EFFECTIVE DATE.—The amendments made by  
18 this section shall apply to services furnished on or after  
19 January 1, 2002.

20 **SEC. 103. COVERAGE OF SCREENING COLONOSCOPY FOR**  
21 **AVERAGE RISK INDIVIDUALS.**

22 (a) IN GENERAL.—Section 1861(pp) (42 U.S.C.  
23 1395x(pp)) is amended—

24 (1) in paragraph (1)(C), by striking “In the  
25 case of an individual at high risk for colorectal can-

1 cer, screening colonoscopy” and inserting “Screening  
2 colonoscopy”; and

3 (2) in paragraph (2), by striking “In paragraph  
4 (1)(C), an” and inserting “An”.

5 (b) FREQUENCY LIMITS FOR SCREENING  
6 COLONOSCOPY.—Section 1834(d) (42 U.S.C. 1395m(d))  
7 is amended—

8 (1) in paragraph (2)(E)(ii), by inserting before  
9 the period at the end the following: “or, in the case  
10 of an individual who is not at high risk for colorectal  
11 cancer, if the procedure is performed within the 119  
12 months after a previous screening colonoscopy”;

13 (2) in paragraph (3)—

14 (A) in the heading by striking “FOR INDIVIDUALS AT HIGH RISK FOR COLORECTAL CAN-  
15 CER”;

16 (B) in subparagraph (A), by striking “for  
17 individuals at high risk for colorectal cancer (as  
18 defined in section 1861(pp)(2))”;

19 (C) in subparagraph (E), by inserting be-  
20 fore the period at the end the following: “or for  
21 other individuals if the procedure is performed  
22 within the 119 months after a previous screen-  
23 ing colonoscopy or within 47 months after a  
24 previous screening flexible sigmoidoscopy”.

1 (c) EFFECTIVE DATE.—The amendments made by  
2 this section apply to colorectal cancer screening services  
3 provided on or after July 1, 2001.

4 **SEC. 104. MODERNIZATION OF SCREENING MAMMOGRAPHY**  
5 **BENEFIT.**

6 (a) INCLUSION IN PHYSICIAN FEE SCHEDULE.—Sec-  
7 tion 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)) is amended by  
8 inserting “(13),” after “(4),”.

9 (b) CONFORMING AMENDMENT.—Section 1834(c)  
10 (42 U.S.C. 1395m(c)) is amended to read as follows:

11 “(c) PAYMENT AND STANDARDS FOR SCREENING  
12 MAMMOGRAPHY.—

13 “(1) IN GENERAL.—With respect to expenses  
14 incurred for screening mammography (as defined in  
15 section 1861(jj)), payment may be made only—

16 “(A) for screening mammography con-  
17 ducted consistent with the frequency permitted  
18 under paragraph (2); and

19 “(B) if the screening mammography is  
20 conducted by a facility that has a certificate (or  
21 provisional certificate) issued under section 354  
22 of the Public Health Service Act.

23 “(2) FREQUENCY COVERED.—

24 “(A) IN GENERAL.—Subject to revision by  
25 the Secretary under subparagraph (B)—

1           “(i) no payment may be made under  
2 this part for screening mammography per-  
3 formed on a woman under 35 years of age;

4           “(ii) payment may be made under this  
5 part for only one screening mammography  
6 performed on a woman over 34 years of  
7 age, but under 40 years of age; and

8           “(iii) in the case of a woman over 39  
9 years of age, payment may not be made  
10 under this part for screening mammog-  
11 raphy performed within 11 months fol-  
12 lowing the month in which a previous  
13 screening mammography was performed.

14           “(B) REVISION OF FREQUENCY.—

15           “(i) REVIEW.—The Secretary, in con-  
16 sultation with the Director of the National  
17 Cancer Institute, shall review periodically  
18 the appropriate frequency for performing  
19 screening mammography, based on age  
20 and such other factors as the Secretary be-  
21 lieves to be pertinent.

22           “(ii) REVISION OF FREQUENCY.—The  
23 Secretary, taking into consideration the re-  
24 view made under clause (i), may revise  
25 from time to time the frequency with

1           which screening mammography may be  
2           paid for under this subsection.”.

3           (c) EFFECTIVE DATE.—The amendments made by  
4 subsections (a) and (b) apply with respect to screening  
5 mammographies furnished on or after January 1, 2002.

6           (d) PAYMENT FOR NEW TECHNOLOGIES.—

7           (1) TESTS FURNISHED IN 2001.—

8           (A) SCREENING.—For a screening mam-  
9 mography (as defined in section 1861(jj) of the  
10 Social Security Act (42 U.S.C. 1395(jj))) fur-  
11 nished during the period beginning on April 1,  
12 2001, and ending on December 31, 2001, that  
13 uses a new technology, payment for such  
14 screening mammography shall be made as fol-  
15 lows:

16           (i) In the case of a technology which  
17 directly takes a digital image (without in-  
18 volving film) and subsequently analyzes  
19 such resulting image with software to iden-  
20 tify possible problem areas, in an amount  
21 equal to 150 percent of the amount of pay-  
22 ment under section 1848 of such Act (42  
23 U.S.C. 1395w-4) for a bilateral diagnostic  
24 mammography (under HCPCS code  
25 76091) for such year.

1           (ii) In the case of a technology which  
2           allows conversion of a standard film mam-  
3           mogram into a digital image and subse-  
4           quently analyzes such resulting image with  
5           software to identify possible problem areas,  
6           in an amount equal to the limit that would  
7           otherwise be applied under section  
8           1834(c)(3) of such Act (42 U.S.C.  
9           1395m(c)(3)) for 2001, increased by \$15.

10           (B) BILATERAL DIAGNOSTIC MAMMOG-  
11           RAPHY.—For a bilateral diagnostic mammog-  
12           raphy (under HCPCS code 76091) furnished  
13           during the period beginning on April 1, 2001,  
14           and ending on December 31, 2001, that uses a  
15           new technology described in subparagraph  
16           (A)(i), payment for such mammography shall  
17           be the amount of payment provided for under  
18           such subparagraph.

19           The Secretary of Health and Human Services may  
20           implement the provisions of this paragraph by pro-  
21           gram memorandum or otherwise.

22           (2) CONSIDERATION OF NEW HCPCS CODE FOR  
23           NEW TECHNOLOGIES AFTER 2001.—The Secretary  
24           shall determine, for such screening mammographies  
25           performed after 2001, whether the assignment of a

1 new HCPCS code is appropriate for screening mam-  
2 mography that uses a new technology. If the Sec-  
3 retary determines that a new code is appropriate for  
4 such screening mammography, the Secretary shall  
5 provide for such new code for such tests furnished  
6 after 2001.

7 (3) NEW TECHNOLOGY DESCRIBED.—For pur-  
8 poses of this subsection, a new technology with re-  
9 spect to a screening mammography is an advance in  
10 technology with respect to the test or equipment  
11 that results in the following:

12 (A) A significant increase or decrease in  
13 the resources used in the test or in the manu-  
14 facture of the equipment.

15 (B) A significant improvement in the per-  
16 formance of the test or equipment.

17 (C) A significant advance in medical tech-  
18 nology that is expected to significantly improve  
19 the treatment of medicare beneficiaries.

20 (4) HCPCS CODE DEFINED.—The term  
21 “HCPCS code” means an alphanumeric code under  
22 the Health Care Financing Administration Common  
23 Procedure Coding System (HCPCS).

1 **SEC. 105. COVERAGE OF MEDICAL NUTRITION THERAPY**  
2 **SERVICES FOR BENEFICIARIES WITH DIABE-**  
3 **TES OR A RENAL DISEASE.**

4 (a) **COVERAGE.**—Section 1861(s)(2) (42 U.S.C.  
5 1395x(s)(2)), as amended by section 102(a), is amended—

6 (1) in subparagraph (T), by striking “and” at  
7 the end;

8 (2) in subparagraph (U), by inserting “and” at  
9 the end; and

10 (3) by adding at the end the following new sub-  
11 paragraph:

12 “(V) medical nutrition therapy services (as de-  
13 fined in subsection (vv)(1)) in the case of a bene-  
14 ficiary with diabetes or a renal disease who—

15 “(i) has not received diabetes outpatient  
16 self-management training services within a time  
17 period determined by the Secretary; and

18 “(ii) meets such other criteria determined  
19 by the Secretary after consideration of protocols  
20 established by dietitian or nutrition professional  
21 organizations;”.

22 (b) **SERVICES DESCRIBED.**—Section 1861 (42 U.S.C.  
23 1395x), as amended by section 102(b), is amended by add-  
24 ing at the end the following:

1 “Medical Nutrition Therapy Services; Registered  
2 Dietitian or Nutrition Professional

3 “(vv)(1) The term ‘medical nutrition therapy serv-  
4 ices’ means nutritional diagnostic, therapy, and counseling  
5 services for the purpose of disease management which are  
6 furnished by a registered dietitian or nutrition profes-  
7 sional (as defined in paragraph (2)) pursuant to a referral  
8 by a physician (as defined in subsection (r)(1)).

9 “(2) Subject to paragraph (3), the term ‘registered  
10 dietitian or nutrition professional’ means an individual  
11 who—

12 “(A) holds a baccalaureate or higher degree  
13 granted by a regionally accredited college or univer-  
14 sity in the United States (or an equivalent foreign  
15 degree) with completion of the academic require-  
16 ments of a program in nutrition or dietetics, as ac-  
17 credited by an appropriate national accreditation or-  
18 ganization recognized by the Secretary for this pur-  
19 pose;

20 “(B) has completed at least 900 hours of super-  
21 vised dietetics practice under the supervision of a  
22 registered dietitian or nutrition professional; and

23 “(C)(i) is licensed or certified as a dietitian or  
24 nutrition professional by the State in which the serv-  
25 ices are performed; or

1           “(ii) in the case of an individual in a State that  
2           does not provide for such licensure or certification,  
3           meets such other criteria as the Secretary estab-  
4           lishes.

5           “(3) Subparagraphs (A) and (B) of paragraph (2)  
6           shall not apply in the case of an individual who, as of the  
7           date of the enactment of this subsection, is licensed or cer-  
8           tified as a dietitian or nutrition professional by the State  
9           in which medical nutrition therapy services are per-  
10          formed.”.

11          (c) PAYMENT.—Section 1833(a)(1) (42 U.S.C.  
12 1395l(a)(1)) is amended—

13           (1) by striking “and” before “(S)”; and

14           (2) by inserting before the semicolon at the end  
15          the following: “, and (T) with respect to medical nu-  
16          trition therapy services (as defined in section  
17          1861(vv)), the amount paid shall be 80 percent of  
18          the lesser of the actual charge for the services or 85  
19          percent of the amount determined under the fee  
20          schedule established under section 1848(b) for the  
21          same services if furnished by a physician”.

22          (d) APPLICATION OF LIMITS ON BILLING.—Section  
23 1842(b)(18)(C) (42 U.S.C. 1395u(b)(18)(C)) is amended  
24 by adding at the end the following new clause:

1           “(vi) A registered dietitian or nutrition profes-  
2           sional.”.

3           (e) EFFECTIVE DATE.—The amendments made by  
4 this section apply to services furnished on or after Janu-  
5 ary 1, 2002.

6           (f) STUDY.—Not later than July 1, 2003, the Sec-  
7 retary of Health and Human Services shall submit to Con-  
8 gress a report that contains recommendations with respect  
9 to the expansion to other medicare beneficiary populations  
10 of the medical nutrition therapy services benefit (furnished  
11 under the amendments made by this section).

12 **SEC. 106. EXTENSION OF PART A COVERAGE FOR WORKERS**  
13 **WITH DISABILITIES.**

14           (a) CONTINUATION OF COVERAGE.—

15           (1) IN GENERAL.—Section 226 (42 U.S.C. 426)  
16 is amended—

17           (A) in the third sentence of subsection (b),  
18 by inserting “, except as provided in subsection  
19 (j)” after “but not in excess of 24 such  
20 months”; and

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

22           “(j) The 24-month limitation on deemed entitlement  
23 under the third sentence of subsection (b) shall not  
24 apply—

1           “(1) for months occurring during the 10-year  
2 period beginning with the first month that begins  
3 after the date of enactment of this subsection; and

4           “(2) for subsequent months, in the case of an  
5 individual who was entitled to benefits under sub-  
6 section (b) as of the last month of such 10-year pe-  
7 riod and would continue (but for such 24-month lim-  
8 itation) to be so entitled.”.

9           (2) CONFORMING AMENDMENT.—Section  
10 1818A(a)(2)(C) (42 U.S.C. 1395i–2a(a)(2)(C)) is  
11 amended—

12           (A) by striking “solely”; and

13           (B) by inserting “or the expiration of the  
14 last month of the 10-year period described in  
15 section 226(j)” before the semicolon.

16           (b) GAO REPORT.—Not later than 8 years after the  
17 date of the enactment of this section, the Comptroller  
18 General of the United States shall submit a report to the  
19 Congress that—

20           (1) examines the effectiveness and cost of sub-  
21 section (j) of section 226 (42 U.S.C. 426); and

22           (2) recommends whether such subsection (j)  
23 should continue to be applied beyond the 10-year pe-  
24 riod described in the subsection.

1 (c) EFFECTIVE DATE.—The amendments made by  
2 subsection (a) apply to months beginning with the first  
3 month that begins after the date of enactment of this sec-  
4 tion.

5 (d) TREATMENT OF CERTAIN INDIVIDUALS.—An in-  
6 dividual enrolled under section 1818A (42 U.S.C.  
7 1395i2a) shall be treated with respect to premium pay-  
8 ment obligations under such section as though the indi-  
9 vidual had continued to be entitled to benefits under sec-  
10 tion 226(b) for—

11 (1) months described in section 226(j)(1) (42  
12 U.S.C. 426(j)(1)) (as added by subsection (a)); and

13 (2) subsequent months, in the case of an indi-  
14 vidual who was so enrolled as of the last month de-  
15 scribed in section 226(j)(2) (42 U.S.C. 426(j)(2))  
16 (as so added).

17 (e) REPEAL OF PARTIAL EXTENSION PROVISION AND  
18 STUDY REQUIREMENT.—Section 202 of Public Law 106-  
19 170 is repealed.

20 **SEC. 107. MEDICAID RECOGNITION FOR SERVICES OF PHY-**  
21 **SICIAN ASSISTANTS.**

22 (a) IN GENERAL.—Section 1905(a) (42 U.S.C.  
23 1396d(a)) is amended—

1 (1) by redesignating paragraphs (22) through  
 2 (27) as paragraphs (23) through (28), respectively;  
 3 and

4 (2) by inserting after paragraph (21) the fol-  
 5 lowing new paragraph:

6 “(22) services furnished by a physician assist-  
 7 ant (as defined in section 1861(aa)(5)) which the as-  
 8 sistant is legally authorized to perform under State  
 9 law and with the supervision of a physician;”.

10 (b) CONFORMING AMENDMENTS.—(1) Section  
 11 1902(a)(10)(C)(iv) (42 U.S.C. 1396a(a)(10)(C)(iv)) is  
 12 amended by striking “(24)” and inserting “(25)”.

13 (2) Section 1929(e)(2)(A) (42 U.S.C.  
 14 1396t(e)(2)(A)) is amended by striking “1905(a)(23)”  
 15 and inserting “1905(a)(24)”.

16 (3) Section 1917(c)(1)(C)(ii) (42 U.S.C.  
 17 1396(p)(c)(1)(C)(ii)) is amended by striking “(22), or  
 18 (24)” and inserting “(23), or (25)”.

## 19 **Subtitle B—Other Beneficiary** 20 **Improvements**

### 21 **SEC. 111. ACCELERATION OF REDUCTION OF BENEFICIARY** 22 **COPAYMENT FOR HOSPITAL OUTPATIENT DE-** 23 **PARTMENT SERVICES.**

24 (a) REDUCING THE UPPER LIMIT ON BENEFICIARY  
 25 COPAYMENT.—

1           (1) IN GENERAL.—Section 1833(t)(8)(C) (42  
2 U.S.C. 1395l(t)(8)(C)) is amended to read as fol-  
3 lows:

4                   “(C) LIMITATION ON COPAYMENT  
5 AMOUNT.—

6                   “(i) TO INPATIENT HOSPITAL DE-  
7 DUCTIBLE AMOUNT.—In no case shall the  
8 copayment amount for a procedure per-  
9 formed in a year exceed the amount of the  
10 inpatient hospital deductible established  
11 under section 1813(b) for that year.

12                   “(ii) TO SPECIFIED PERCENTAGE.—  
13 The Secretary shall reduce the national  
14 unadjusted copayment amount for a cov-  
15 ered OPD service (or group of such serv-  
16 ices) furnished in a year in a manner so  
17 that the effective copayment rate (deter-  
18 mined on a national unadjusted basis) for  
19 that service in the year does not exceed the  
20 following percentage:

21                           “(I) For procedures performed in  
22                           2001, 60 percent.

23                           “(II) For procedures performed  
24                           in 2002 or 2003, 55 percent.

1                   “(III) For procedures performed  
2                   in 2004, 50 percent.

3                   “(IV) For procedures performed  
4                   in 2005, 45 percent.

5                   “(V) For procedures performed  
6                   in 2006 and thereafter, 40 percent.”.

7                   (2) EFFECTIVE DATE.—The amendment made  
8                   by paragraph (1) applies with respect to services  
9                   furnished on or after January 1, 2001.

10                  (b) CONSTRUCTION REGARDING LIMITING IN-  
11 CREASES IN COST-SHARING.—Nothing in this Act or the  
12 Social Security Act shall be construed as preventing a hos-  
13 pital from waiving the amount of any coinsurance for out-  
14 patient hospital services under the medicare program  
15 under title XVIII of the Social Security Act that may have  
16 been increased as a result of the implementation of the  
17 prospective payment system under section 1833(t) of the  
18 Social Security Act (42 U.S.C. 1395l(t)).

19                  (c) GAO STUDY OF REDUCTION IN MEDIGAP PRE-  
20 MIUM LEVELS RESULTING FROM REDUCTIONS IN COIN-  
21 SURANCE.—The Comptroller General of the United States  
22 shall work, in concert with the National Association of In-  
23 surance Commissioners, to evaluate the extent to which  
24 the premium levels for medicare supplemental policies re-  
25 flect the reductions in coinsurance resulting from the

1 amendment made by subsection (a). Not later than April  
2 1, 2004, the Comptroller General shall submit to Congress  
3 a report on such evaluation and the extent to which the  
4 reductions in beneficiary coinsurance effected by such  
5 amendment have resulted in actual savings to medicare  
6 beneficiaries.

7 **SEC. 112. PRESERVATION OF COVERAGE OF DRUGS AND**  
8 **BIOLOGICALS UNDER PART B OF THE MEDI-**  
9 **CARE PROGRAM.**

10 (a) IN GENERAL.—Section 1861(s)(2) (42 U.S.C.  
11 1395x(s)(2)) is amended, in each of subparagraphs (A)  
12 and (B), by striking “(including drugs and biologicals  
13 which cannot, as determined in accordance with regula-  
14 tions, be self-administered)” and inserting “(including  
15 drugs and biologicals which are not usually self-adminis-  
16 tered by the patient)”.

17 (b) EFFECTIVE DATE.—The amendment made by  
18 subsection (a) applies to drugs and biologicals adminis-  
19 tered on or after the date of the enactment of this Act.

20 **SEC. 113. ELIMINATION OF TIME LIMITATION ON MEDI-**  
21 **CARE BENEFITS FOR IMMUNOSUPPRESSIVE**  
22 **DRUGS.**

23 (a) IN GENERAL.—Section 1861(s)(2)(J) (42 U.S.C.  
24 1395x(s)(2)(J)) is amended by striking “, but only” and  
25 all that follows up to the semicolon at the end.

1 (b) CONFORMING AMENDMENTS.—

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

4 (A) by striking subsection (b); and

5 (B) by redesignating subsection (c) as sub-  
6 section (b).

7 (2) PASS-THROUGH; REPORT.—Section 227 of  
8 BBRA is amended by striking subsection (d).

9 (c) EFFECTIVE DATE.—The amendment made by  
10 subsection (a) shall apply to drugs furnished on or after  
11 the date of the enactment of this Act.

12 **SEC. 114. IMPOSITION OF BILLING LIMITS ON DRUGS.**

13 (a) IN GENERAL.—Section 1842(o) (42 U.S.C.  
14 1395u(o)) is amended by adding at the end the following  
15 new paragraph:

16 “(3)(A) Payment for a charge for any drug or biologi-  
17 cal for which payment may be made under this part may  
18 be made under this part only on an assignment-related  
19 basis.

20 “(B) The provisions of subsection (b)(18)(B) shall  
21 apply to charges for such drugs or biologicals in the same  
22 manner as they apply to services furnished by a practi-  
23 tioner described in subsection (b)(18)(C).”.

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

4 **SEC. 115. IMPROVING AVAILABILITY OF QMB/SLMB APPLI-**  
5 **CATION FORMS.**

6 (a) THROUGH LOCAL SOCIAL SECURITY OFFICES.—

7 (1) IN GENERAL.—Section 1804 (42 U.S.C.  
8 1395b–2) is amended by adding at the end the fol-  
9 lowing new subsection:

10 “(d) AVAILABILITY OF APPLICATION FORMS FOR  
11 MEDICAL ASSISTANCE FOR MEDICARE COST-SHARING.—

12 The Secretary shall make available to the Commissioner  
13 of Social Security appropriate forms for applying for med-  
14 ical assistance for medicare cost-sharing under a State  
15 plan under title XIX. Such Commissioner, through local  
16 offices of the Social Security Administration shall—

17 “(1) notify applicants and beneficiaries who  
18 present at a local office orally of the availability of  
19 such forms and make such forms available to such  
20 individuals upon request; and

21 “(2) provide assistance to such individuals in  
22 completing such forms and, upon request, in submit-  
23 ting such forms to the appropriate State agency.”.

24 (2) CONFORMING AMENDMENT.—Section  
25 1902(a)(8) (42 U.S.C. 1396a(a)(8)) is amended by

1 inserting before the semicolon at the end the fol-  
2 lowing: “and provide application forms for medical  
3 assistance for medicare cost-sharing under the plan  
4 to the Secretary in order to make them available  
5 through Federal offices under section 1804(d) within  
6 the State”.

7 (b) STREAMLINING APPLICATION PROCESS.—

8 (1) REQUIREMENT.—Section 1902(a)(8) (42  
9 U.S.C. 1396a(a)(8)) is amended by striking “, and  
10 that” and inserting “permit individuals to apply for  
11 and obtain medical assistance for medicare cost-  
12 sharing using the simplified uniform application  
13 form developed under section 1905(p)(5), make  
14 available such forms to such individuals, permit such  
15 individuals to apply for such assistance by mail  
16 (and, at the State option, by telephone or other elec-  
17 tronic means) and not require them to apply in per-  
18 son, and provide that”.

19 (2) SIMPLIFIED APPLICATION FORM.—Section  
20 1905(p) (42 U.S.C. 1396d(p)) is amended by adding  
21 at the end the following new paragraph:

22 “(5)(A) The Secretary shall develop a simplified ap-  
23 plication form for use by individuals (including both quali-  
24 fied medicare beneficiaries and specified low-income medi-  
25 care beneficiaries) in applying for medical assistance for

1 medicare cost-sharing under this title. Such form shall be  
2 easily readable by applicants and uniform nationally.

3 “(B) In developing such form, the Secretary shall  
4 consult with beneficiary groups and the States.

5 “(C) The Secretary shall make such application  
6 forms available—

7 “(i) to the Commissioner of Social Security for  
8 distribution through local social security offices;

9 “(ii) at such other sites at the Secretary deter-  
10 mines appropriate; and

11 “(iii) to persons upon request.”.

12 (c) EFFECTIVE DATES.—

13 (1) The amendments made by subsection (a)  
14 take effect on January 1, 2004.

15 (2) EFFECTIVE DATE.—The amendments made  
16 by subsection (b) take effect 1 year after the date  
17 of the enactment of this Act, regardless of whether  
18 regulations have been promulgated to carry out such  
19 amendments by such date. Secretary of Health and  
20 Human Services shall develop the uniform applica-  
21 tion form under the amendment made by subsection  
22 (b)(2) by not later than 9 months after the date of  
23 the enactment of this Act.

1                   **Subtitle C—Demonstration**  
2                   **Projects and Studies**

3 **SEC. 121. DEMONSTRATION PROJECT FOR DISEASE MAN-**  
4                   **AGEMENT FOR SEVERELY CHRONICALLY ILL**  
5                   **MEDICARE BENEFICIARIES.**

6           (a) IN GENERAL.—The Secretary of Health and  
7 Human Services shall conduct a demonstration project  
8 under this section (in this section referred to as the  
9 “project”) to demonstrate the impact on costs and health  
10 outcomes of applying disease management to medicare  
11 beneficiaries with diagnosed, advanced-stage congestive  
12 heart failure, diabetes, or coronary heart disease. In no  
13 case may the number of participants in the project exceed  
14 30,000 at any time.

15           (b) VOLUNTARY PARTICIPATION.—

16               (1) ELIGIBILITY.—Medicare beneficiaries are  
17 eligible to participate in the project only if—

18                   (A) they meet specific medical criteria  
19 demonstrating the appropriate diagnosis and  
20 the advanced nature of their disease;

21                   (B) their physicians approve of participa-  
22 tion in the project; and

23                   (C) they are not enrolled in a  
24 Medicare+Choice plan.

1           (2) BENEFITS.—A beneficiary who is enrolled  
2           in the project shall be eligible—

3                   (A) for disease management services re-  
4                   lated to their chronic health condition; and

5                   (B) for payment for all costs for prescrip-  
6                   tion drugs without regard to whether or not  
7                   they relate to the chronic health condition, ex-  
8                   cept that the project may provide for modest  
9                   cost-sharing with respect to prescription drug  
10                  coverage.

11          (c) CONTRACTS WITH DISEASE MANAGEMENT ORGA-  
12          NIZATIONS.—

13               (1) IN GENERAL.—The Secretary of Health and  
14               Human Services shall carry out the project through  
15               contracts with up to three disease management orga-  
16               nizations. The Secretary shall not enter into such a  
17               contract with an organization unless the organiza-  
18               tion demonstrates that it can produce improved  
19               health outcomes and reduce aggregate medicare ex-  
20               penditures consistent with paragraph (2).

21               (2) CONTRACT PROVISIONS.—Under such  
22               contracts—

23                   (A) such an organization shall be required  
24                   to provide for prescription drug coverage de-  
25                   scribed in subsection (b)(2)(B);

1           (B) such an organization shall be paid a  
2           fee negotiated and established by the Secretary  
3           in a manner so that (taking into account sav-  
4           ings in expenditures under parts A and B of  
5           the medicare program under title XVIII of the  
6           Social Security Act) there will be a net reduc-  
7           tion in expenditures under the medicare pro-  
8           gram as a result of the project; and

9           (C) such an organization shall guarantee,  
10          through an appropriate arrangement with a re-  
11          insurance company or otherwise, the net reduc-  
12          tion in expenditures described in subparagraph  
13          (B).

14          (3) PAYMENTS.—Payments to such organiza-  
15          tions shall be made in appropriate proportion from  
16          the Trust Funds established under title XVIII of the  
17          Social Security Act.

18          (d) APPLICATION OF MEDIGAP PROTECTIONS TO  
19          DEMONSTRATION PROJECT ENROLLEES.—(1) Subject to  
20          paragraph (2), the provisions of section 1882(s)(3) (other  
21          than clauses (i) through (iv) of subparagraph (B)) and  
22          1882(s)(4) of the Social Security Act shall apply to enroll-  
23          ment (and termination of enrollment) in the demonstra-  
24          tion project under this section, in the same manner as they  
25          apply to enrollment (and termination of enrollment) with

1 a Medicare+Choice organization in a Medicare+Choice  
2 plan.

3 (2) In applying paragraph (1)—

4 (A) any reference in clause (v) or (vi) of section  
5 1882(s)(3)(B) of such Act to 12 months is deemed  
6 a reference to the period of the demonstration  
7 project; and

8 (B) the notification required under section  
9 1882(s)(3)(D) of such Act shall be provided in a  
10 manner specified by the Secretary of Health and  
11 Human Services.

12 (e) DURATION.—The project shall last for not longer  
13 than 3 years.

14 (f) WAIVER.—The Secretary of Health and Human  
15 Services shall waive such provisions of title XVIII of the  
16 Social Security Act as may be necessary to provide for  
17 payment for services under the project in accordance with  
18 subsection (c)(3).

19 (g) REPORT.—The Secretary of Health and Human  
20 Services shall submit to Congress an interim report on the  
21 project not later than 2 years after the date it is first im-  
22 plemented and a final report on the project not later than  
23 6 months after the date of its completion. Such reports  
24 shall include information on the impact of the project on

1 costs and health outcomes and recommendations on the  
2 cost-effectiveness of extending or expanding the project.

3 **SEC. 122. CANCER PREVENTION AND TREATMENT DEM-**  
4 **ONSTRATION FOR ETHNIC AND RACIAL MI-**  
5 **NORITIES.**

6 (a) DEMONSTRATION.—

7 (1) IN GENERAL.—The Secretary of Health and  
8 Human Services (in this section referred to as the  
9 “Secretary”) shall conduct demonstration projects  
10 (in this section referred to as “demonstration  
11 projects”) for the purpose of developing models and  
12 evaluating methods that—

13 (A) improve the quality of items and serv-  
14 ices provided to target individuals in order to  
15 facilitate reduced disparities in early detection  
16 and treatment of cancer;

17 (B) improve clinical outcomes, satisfaction,  
18 quality of life, and appropriate use of medicare-  
19 covered services and referral patterns among  
20 those target individuals with cancer;

21 (C) eliminate disparities in the rate of pre-  
22 ventive cancer screening measures, such as pap  
23 smears and prostate cancer screenings, among  
24 target individuals; and

1 (D) promote collaboration with community-  
2 based organizations to ensure cultural com-  
3 petency of health care professionals and lin-  
4 guistic access for persons with limited English  
5 proficiency.

6 (2) TARGET INDIVIDUAL DEFINED.—In this  
7 section, the term “target individual” means an indi-  
8 vidual of a racial and ethnic minority group, as de-  
9 fined by section 1707 of the Public Health Service  
10 Act, who is entitled to benefits under part A, and  
11 enrolled under part B, of title XVIII of the Social  
12 Security Act.

13 (b) PROGRAM DESIGN.—

14 (1) INITIAL DESIGN.—Not later than 1 year  
15 after the date of the enactment of this Act, the Sec-  
16 retary shall evaluate best practices in the private  
17 sector, community programs, and academic research  
18 of methods that reduce disparities among individuals  
19 of racial and ethnic minority groups in the preven-  
20 tion and treatment of cancer and shall design the  
21 demonstration projects based on such evaluation.

22 (2) NUMBER AND PROJECT AREAS.—Not later  
23 than 2 years after the date of the enactment of this  
24 Act, the Secretary shall implement at least 9 dem-  
25 onstration projects, including the following:

1 (A) 2 projects for each of the 4 major ra-  
2 cial and ethnic minority groups (American Indi-  
3 ans (including Alaska Natives, Eskimos, and  
4 Aleuts); Asian Americans and Pacific Islanders;  
5 Blacks; and Hispanics. The 2 projects must  
6 target different ethnic subpopulations.

7 (B) 1 project within the Pacific Islands.

8 (C) At least 1 project each in a rural area  
9 and inner-city area.

10 (3) EXPANSION OF PROJECTS; IMPLEMENTA-  
11 TION OF DEMONSTRATION PROJECT RESULTS.—If  
12 the initial report under subsection (c) contains an  
13 evaluation that demonstration projects—

14 (A) reduce expenditures under the medi-  
15 care program under title XVIII of the Social  
16 Security Act; or

17 (B) do not increase expenditures under the  
18 medicare program and reduce racial and ethnic  
19 health disparities in the quality of health care  
20 services provided to target individuals and in-  
21 crease satisfaction of beneficiaries and health  
22 care providers;

23 the Secretary shall continue the existing demonstra-  
24 tion projects and may expand the number of dem-  
25 onstration projects.

1 (c) REPORT TO CONGRESS.—

2 (1) IN GENERAL.—Not later than 2 years after  
3 the date the Secretary implements the initial dem-  
4 onstration projects, and biannually thereafter, the  
5 Secretary shall submit to Congress a report regard-  
6 ing the demonstration projects.

7 (2) CONTENTS OF REPORT.—Each report under  
8 paragraph (1) shall include the following:

9 (A) A description of the demonstration  
10 projects.

11 (B) An evaluation of—

12 (i) the cost-effectiveness of the dem-  
13 onstration projects;

14 (ii) the quality of the health care serv-  
15 ices provided to target individuals under  
16 the demonstration projects; and

17 (iii) beneficiary and health care pro-  
18 vider satisfaction under the demonstration  
19 projects.

20 (C) Any other information regarding the  
21 demonstration projects that the Secretary de-  
22 termines to be appropriate.

23 (d) WAIVER AUTHORITY.—The Secretary shall waive  
24 compliance with the requirements of title XVIII of the So-  
25 cial Security Act to such extent and for such period as

1 the Secretary determines is necessary to conduct dem-  
2 onstration projects.

3 (e) FUNDING.—

4 (1) DEMONSTRATION PROJECTS.—

5 (A) STATE PROJECTS.—Except as provided  
6 in subparagraph (B), the Secretary shall pro-  
7 vide for the transfer from the Federal Hospital  
8 Insurance Trust Fund and the Federal Supple-  
9 mentary Insurance Trust Fund under title  
10 XVIII of the Social Security Act, in such pro-  
11 portions as the Secretary determines to be ap-  
12 propriate, of such funds as are necessary for  
13 the costs of carrying out the demonstration  
14 projects.

15 (B) TERRITORY PROJECTS.—In the case of  
16 a demonstration project described in subsection  
17 (b)(2)(B), amounts shall be available only as  
18 provided in any Federal law making appropria-  
19 tions for the territories.

20 (2) LIMITATION.—In conducting demonstration  
21 projects, the Secretary shall ensure that the aggre-  
22 gate payments made by the Secretary do not exceed  
23 the sum of the amount which the Secretary would  
24 have paid under the program for the prevention and

1 treatment of cancer if the demonstration projects  
2 were not implemented, plus \$25,000,000.

3 **SEC. 123. STUDY ON MEDICARE COVERAGE OF ROUTINE**  
4 **THYROID SCREENING.**

5 (a) STUDY.—The Secretary of Health and Human  
6 Services shall request the National Academy of Sciences,  
7 and as appropriate in conjunction with the United States  
8 Preventive Services Task Force, to conduct a study on the  
9 addition of coverage of routine thyroid screening using a  
10 thyroid stimulating hormone test as a preventive benefit  
11 provided to medicare beneficiaries under title XVIII of the  
12 Social Security Act for some or all medicare beneficiaries.  
13 In conducting the study, the Academy shall consider the  
14 short-term and long-term benefits, and costs to the medi-  
15 care program, of such addition.

16 (b) REPORT.—Not later than 2 years after the date  
17 of the enactment of this Act, the Secretary of Health and  
18 Human Services shall submit a report on the findings of  
19 the study conducted under subsection (a) to the Com-  
20 mittee on Ways and Means and the Committee on Com-  
21 merce of the House of Representatives and the Committee  
22 on Finance of the Senate.

23 **SEC. 124. MEDPAC STUDY ON CONSUMER COALITIONS.**

24 (a) STUDY.—The Medicare Payment Advisory Com-  
25 mission shall conduct a study that examines the use of

1 consumer coalitions in the marketing of Medicare+Choice  
2 plans under the medicare program under title XVIII of  
3 the Social Security Act. The study shall examine—

4 (1) the potential for increased efficiency in the  
5 medicare program through greater beneficiary  
6 knowledge of their health care options, decreased  
7 marketing costs of Medicare+Choice organizations,  
8 and creation of a group market;

9 (2) the implications of Medicare+Choice plans  
10 and medicare supplemental policies (under section  
11 1882 of the Social Security Act (42 U.S.C. 1395ss))  
12 offering medicare beneficiaries in the same geo-  
13 graphic location different benefits and premiums  
14 based on their affiliation with a consumer coalition;

15 (3) how coalitions should be governed, how they  
16 should be accountable to the Secretary of Health  
17 and Human Services, and how potential conflicts of  
18 interest in the activities of consumer coalitions  
19 should be avoided; and

20 (4) how such coalitions should be funded.

21 (b) REPORT.—Not later than 1 year after the date  
22 of the enactment of this Act, the Commission shall submit  
23 to Congress a report on the study conducted under sub-  
24 section (a). The report shall include a recommendation on  
25 whether and how a demonstration project might be con-

1 ducted for the operation of consumer coalitions under the  
2 medicare program.

3 (c) CONSUMER COALITION DEFINED.—For purposes  
4 of this section, the term “consumer coalition” means a  
5 nonprofit, community-based group of organizations that—

6 (1) provides information to medicare bene-  
7 ficiaries about their health care options under the  
8 medicare program; and

9 (2) negotiates benefits and premiums for medi-  
10 care beneficiaries who are members or otherwise af-  
11 filiated with the group of organizations with  
12 Medicare+Choice organizations offering  
13 Medicare+Choice plans, issuers of medicare supple-  
14 mental policies, issuers of long-term care coverage,  
15 and pharmacy benefit managers.

16 **SEC. 125. STUDY ON LIMITATION ON STATE PAYMENT FOR**  
17 **MEDICARE COST-SHARING AFFECTING AC-**  
18 **CESS TO SERVICES FOR QUALIFIED MEDI-**  
19 **CARE BENEFICIARIES.**

20 (a) IN GENERAL.—The Secretary of Health and  
21 Human Services shall conduct a study to determine if ac-  
22 cess to certain services (including mental health services)  
23 for qualified medicare beneficiaries has been affected by  
24 limitations on a State’s payment for medicare cost-sharing  
25 for such beneficiaries under section 1902(n) of the Social

1 Security Act (42 U.S.C. 1396a(n)). As part of such study,  
2 the Secretary shall analyze the effect of such payment lim-  
3 itation on providers who serve a disproportionate share of  
4 such beneficiaries.

5 (b) REPORT.—Not later than 1 year after the date  
6 of the enactment of this Act, the Secretary shall submit  
7 to Congress a report on the study under subsection (a).  
8 The report shall include recommendations regarding any  
9 changes that should be made to the State payment limits  
10 under section 1902(n) for qualified medicare beneficiaries  
11 to ensure appropriate access to services.

12 **SEC. 126. WAIVER OF 24-MONTH WAITING PERIOD FOR**  
13 **MEDICARE COVERAGE OF INDIVIDUALS DIS-**  
14 **ABLED WITH AMYOTROPHIC LATERAL SCLE-**  
15 **ROSIS (ALS).**

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

18 (1) by redesignating subsection (h) as sub-  
19 section (j) and by moving such subsection to the end  
20 of the section, and

21 (2) by inserting after subsection (g) the fol-  
22 lowing new subsection:

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

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

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

7           “(3) Subsection (f) shall not be applied.”.

8           (b) CONFORMING AMENDMENT.—Section 1837 (42  
9           U.S.C. 1395p) is amended by adding at the end the fol-  
10          lowing new subsection:

11          “(j) In applying this section in the case of an indi-  
12          vidual who is entitled to benefits under part A pursuant  
13          to the operation of section 226(h), the following special  
14          rules apply:

15                 “(1) The initial enrollment period under sub-  
16                 section (d) shall begin on the first day of the first  
17                 month in which the individual satisfies the require-  
18                 ment of section 1836(1).

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

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

1 **SEC. 127. STUDIES ON PREVENTIVE INTERVENTIONS IN**  
2 **PRIMARY CARE FOR OLDER AMERICANS.**

3 (a) STUDIES.—The Secretary of Health and Human  
4 Services, acting through the United States Preventive  
5 Services Task Force, shall conduct a series of studies de-  
6 signed to identify preventive interventions that can be de-  
7 livered in the primary care setting and that are most valu-  
8 able to older Americans.

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

13 (c) REPORT.—Not later than 1 year after the date  
14 of the enactment of this Act, and annually thereafter, the  
15 Secretary of Health and Human Services shall submit to  
16 Congress a report on the conclusions of the studies con-  
17 ducted under subsection (a), together with recommenda-  
18 tions for such legislation and administrative actions as the  
19 Secretary considers appropriate.

20 **SEC. 128. MEDPAC STUDY AND REPORT ON MEDICARE COV-**  
21 **ERAGE OF CARDIAC AND PULMONARY REHA-**  
22 **BILITATION THERAPY SERVICES.**

23 (a) STUDY.—

24 (1) IN GENERAL.—The Medicare Payment Ad-  
25 visory Commission shall conduct a study on coverage  
26 of cardiac and pulmonary rehabilitation therapy

1 services under the medicare program under title  
2 XVIII of the Social Security Act.

3 (2) FOCUS.—In conducting the study under  
4 paragraph (1), the Commission shall focus on the  
5 appropriate—

6 (A) qualifying diagnoses required for cov-  
7 erage of cardiac and pulmonary rehabilitation  
8 therapy services;

9 (B) level of physician direct involvement  
10 and supervision in furnishing such services; and

11 (C) level of reimbursement for such serv-  
12 ices.

13 (b) REPORT.—Not later than 18 months after the  
14 date of the enactment of this Act, the Commission shall  
15 submit to Congress a report on the study conducted under  
16 subsection (a) together with such recommendations for  
17 legislation and administrative action as the Commission  
18 determines appropriate.

1 **TITLE II—RURAL HEALTH CARE**  
2 **IMPROVEMENTS**  
3 **Subtitle A—Critical Access**  
4 **Hospital Provisions**

5 **SEC. 201. CLARIFICATION OF NO BENEFICIARY COST-SHAR-**  
6 **ING FOR CLINICAL DIAGNOSTIC LABORA-**  
7 **TORY TESTS FURNISHED BY CRITICAL AC-**  
8 **CESS HOSPITALS.**

9 (a) PAYMENT CLARIFICATION.—Section 1834(g) (42  
10 U.S.C. 1395m(g)) is amended by adding at the end the  
11 following new paragraph:

12 “(4) NO BENEFICIARY COST-SHARING FOR  
13 CLINICAL DIAGNOSTIC LABORATORY SERVICES.—No  
14 coinsurance, deductible, copayment, or other cost-  
15 sharing otherwise applicable under this part shall  
16 apply with respect to clinical diagnostic laboratory  
17 services furnished as an outpatient critical access  
18 hospital service. Nothing in this title shall be con-  
19 strued as providing for payment for clinical diag-  
20 nostic laboratory services furnished as part of out-  
21 patient critical access hospital services, other than  
22 on the basis described in this subsection.”.

23 (b) TECHNICAL AND CONFORMING AMENDMENTS.—

24 (1) Paragraphs (1)(D)(i) and (2)(D)(i) of sec-  
25 tion 1833(a) (42 U.S.C. 1395l(a)) are each amended

1 by striking “or which are furnished on an outpatient  
2 basis by a critical access hospital”.

3 (2) Section 403(d)(2) of BBRA (113 Stat.  
4 1501A–371) is amended by striking “The amend-  
5 ment made by subsection (a) shall apply” and in-  
6 serting “Paragraphs (1) through (3) of section  
7 1834(g) of the Social Security Act (as amended by  
8 paragraph (1)) apply”.

9 (c) EFFECTIVE DATES.—The amendment made—

10 (1) by subsection (a) applies to services fur-  
11 nished on or after the date of the enactment of  
12 BBRA;

13 (2) by subsection (b)(1) applies as if included  
14 in the enactment of section 403(e)(1) of BBRA (113  
15 Stat. 1501A–371); and

16 (3) by subsection (b)(2) applies as if included  
17 in the enactment of section 403(d)(2) of BBRA  
18 (113 Stat. 1501A–371).

19 **SEC. 202. ASSISTANCE WITH FEE SCHEDULE PAYMENT FOR**  
20 **PROFESSIONAL SERVICES UNDER ALL-INCLU-**  
21 **SIVE RATE.**

22 (a) IN GENERAL.—Section 1834(g)(2)(B) (42 U.S.C.  
23 1395m(g)(2)(B)) is amended by inserting “115 percent  
24 of” before “such amounts”.

1 (b) EFFECTIVE DATE.—The amendment made by  
2 subsection (a) applies with respect to items and services  
3 furnished on or after April 1, 2001.

4 **SEC. 203. EXEMPTION OF CRITICAL ACCESS HOSPITAL**  
5 **SWING BEDS FROM SNF PPS.**

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

8 (1) in the heading, by striking “TRANSITION  
9 FOR” and inserting “TREATMENT OF”;

10 (2) in subparagraph (A), by striking “IN GEN-  
11 ERAL.—The” and inserting “TRANSITION.—Subject  
12 to subparagraph (C), the”;

13 (3) in subparagraph (A), by inserting “(other  
14 than critical access hospitals)” after “facilities de-  
15 scribed in subparagraph (B)”;

16 (4) in subparagraph (B), by striking “, for  
17 which payment” and all that follows before the pe-  
18 riod; and

19 (5) by adding at the end the following new sub-  
20 paragraph:

21 “(C) EXEMPTION FROM PPS OF SWING-  
22 BED SERVICES FURNISHED IN CRITICAL ACCESS  
23 HOSPITALS.—The prospective payment system  
24 established under this subsection shall not  
25 apply to services furnished by a critical access

1 hospital pursuant to an agreement under sec-  
2 tion 1883.”.

3 (b) PAYMENT ON A REASONABLE COST BASIS FOR  
4 SWING BED SERVICES FURNISHED BY CRITICAL ACCESS  
5 HOSPITALS.—Section 1883(a) (42 U.S.C. 1395tt(a)) is  
6 amended—

7 (1) in paragraph (2)(A), by inserting “(other  
8 than a critical access hospital)” after “any hospital”;  
9 and

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

12 “(3) Notwithstanding any other provision of this title,  
13 a critical access hospital shall be paid for covered skilled  
14 nursing facility services furnished under an agreement en-  
15 tered into under this section on the basis of the reasonable  
16 costs of such services (as determined under section  
17 1861(v)).”.

18 (c) EFFECTIVE DATE.—The amendments made by  
19 this section shall apply to cost reporting periods beginning  
20 on or after the date of the enactment of this Act.

21 **SEC. 204. PAYMENT IN CRITICAL ACCESS HOSPITALS FOR**  
22 **EMERGENCY ROOM ON-CALL PHYSICIANS.**

23 (a) IN GENERAL.—Section 1834(g) (42 U.S.C.  
24 1395m(g)), as amended by section 201(a), is further

1 amended by adding at the end the following new para-  
2 graph:

3           “(5) **COVERAGE OF COSTS FOR EMERGENCY**  
4 **ROOM ON-CALL PHYSICIANS.**—In determining the  
5 reasonable costs of outpatient critical access hospital  
6 services under paragraphs (1) and (2)(A), the Sec-  
7 retary shall recognize as allowable costs, amounts  
8 (as defined by the Secretary) for reasonable com-  
9 pensation and related costs for emergency room phy-  
10 sicians who are on-call (as defined by the Secretary)  
11 but who are not present on the premises of the crit-  
12 ical access hospital involved, and are not otherwise  
13 furnishing physicians’ services and are not on-call at  
14 any other provider or facility.”.

15       (b) **EFFECTIVE DATE.**—The amendment made by  
16 subsection (a) applies to cost reporting periods beginning  
17 on or after October 1, 2001.

18 **SEC. 205. TREATMENT OF AMBULANCE SERVICES FUR-**  
19 **NISHED BY CERTAIN CRITICAL ACCESS HOS-**  
20 **PITALS.**

21       (a) **IN GENERAL.**—Section 1834(l) (42 U.S.C.  
22 1395m(l)) is amended by adding at the end the following  
23 new paragraph:

24           “(8) **SERVICES FURNISHED BY CRITICAL AC-**  
25 **CESS HOSPITALS.**—Notwithstanding any other provi-

1 sion of this subsection, the Secretary shall pay the  
2 reasonable costs incurred in furnishing ambulance  
3 services if such services are furnished—

4 “(A) by a critical access hospital (as de-  
5 fined in section 1861(mm)(1)), or

6 “(B) by an entity that is owned and oper-  
7 ated by a critical access hospital,

8 but only if the critical access hospital or entity is the  
9 only provider or supplier of ambulance services that  
10 is located within a 35-mile drive of such critical ac-  
11 cess hospital.”.

12 (b) CONFORMING AMENDMENT.—Section

13 1833(a)(1)(R) (42 U.S.C. 1395l(a)(1)(R)) is amended—

14 (1) by striking “ambulance service,” and insert-  
15 ing “ambulance services, (i)”; and

16 (2) by inserting before the comma at the end  
17 the following: “and (ii) with respect to ambulance  
18 services described in section 1834(l)(8), the amounts  
19 paid shall be the amounts determined under section  
20 1834(g) for outpatient critical access hospital serv-  
21 ices”.

22 (c) EFFECTIVE DATE.—The amendments made by  
23 this section apply to services furnished on or after the date  
24 of the enactment of this Act.

1 **SEC. 206. GAO STUDY ON CERTAIN ELIGIBILITY REQUIRE-**  
2 **MENTS FOR CRITICAL ACCESS HOSPITALS.**

3 (a) STUDY.—The Comptroller General of the United  
4 States shall conduct a study on the eligibility requirements  
5 for critical access hospitals under section 1820(c) of the  
6 Social Security Act (42 U.S.C. 1395i–4(c)) with respect  
7 to limitations on average length of stay and number of  
8 beds in such a hospital, including an analysis of—

9 (1) the feasibility of having a distinct part unit  
10 as part of a critical access hospital for purposes of  
11 the medicare program under title XVIII of such Act,  
12 and

13 (2) the effect of seasonal variations in patient  
14 admissions on critical access hospital eligibility re-  
15 quirements with respect to limitations on average  
16 annual length of stay and number of beds.

17 (b) REPORT.—Not later than 1 year after the date  
18 of the enactment of this Act, the Comptroller General shall  
19 submit to Congress a report on the study conducted under  
20 subsection (a) together with recommendations  
21 regarding—

22 (1) whether distinct part units should be per-  
23 mitted as part of a critical access hospital under the  
24 medicare program;



1           (3) in subclause (IV), by inserting “(or 15 per-  
2           cent, for discharges occurring on or after October 1,  
3           2001)” after “45 percent”.

4           (b) ADJUSTMENT OF PAYMENT FORMULAS.—

5           (1) SOLE COMMUNITY HOSPITALS.—Section  
6           1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is  
7           amended—

8           (A) in clause (iv)(VI), by inserting after  
9           “10 percent” the following: “or, for discharges  
10           occurring on or after October 1, 2001, is equal  
11           to the percent determined in accordance with  
12           clause (x)”;

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

15           “(x) For purposes of clause (iv)(VI),  
16           in the case of a hospital for a cost report-  
17           ing period with a disproportionate patient  
18           percentage (as defined in clause (vi))  
19           that—

20           “(I) is less than 19.3, the dis-  
21           proportionate share adjustment per-  
22           centage is determined in accordance  
23           with the following formula:  $(P-$   
24            $15)(.65)-2.5$ ;

1                   “(II) is equal to or exceeds 19.3,  
2                   but is less than 30.0, such adjustment  
3                   percentage is equal to 5.25 percent; or

4                   “(III) is equal to or exceeds 30,  
5                   such adjustment percentage is equal  
6                   to 10 percent, where P is the hos-  
7                   pital’s disproportionate patient per-  
8                   centage (as defined in clause (vi)).”.

9                   (2) RURAL REFERRAL CENTERS.—Such section  
10                  is further amended—

11                  (A) in clause (iv)(V), by inserting after  
12                  clause (viii) the following: or, for discharges oc-  
13                  curring on or after October 1, 2001, is equal to  
14                  the percent determined in accordance with  
15                  clause (xi); and

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

18                  “(xi) For purposes of clause (iv)(V),  
19                  in the case of a hospital for a cost report-  
20                  ing period with a disproportionate patient  
21                  percentage (as defined in clause (vi))  
22                  that—

23                  “(I) is less than 19.3, the dis-  
24                  proportionate share adjustment per-  
25                  centage is determined in accordance

1 with the following formula:  $(P-15)(.65)-2.5$ ;

2  
3 “(II) is equal to or exceeds 19.3,  
4 but is less than 30.0, such adjustment  
5 percentage is equal to 5.25 percent; or

6 “(III) is equal to or exceeds 30,  
7 such adjustment percentage is deter-  
8 mined in accordance with the fol-  
9 lowing formula:  $(P-30)(.6)-5.25$ ,  
10 where P is the hospital’s dispropor-  
11 tionate patient percentage (as defined  
12 in clause (vi)).”.

13 (3) SMALL RURAL HOSPITALS GENERALLY.—

14 Such section is further amended—

15 (A) in clause (iv)(III), by inserting after  
16 “4 percent” the following: “or, for discharges  
17 occurring on or after October 1, 2001, is equal  
18 to the percent determined in accordance with  
19 clause (xii)”;

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

22 “(xii) For purposes of clause (iv)(III),  
23 in the case of a hospital for a cost report-  
24 ing period with a disproportionate patient

1 percentage (as defined in clause (vi))  
2 that—

3 “(I) is less than 19.3, the dis-  
4 proportionate share adjustment per-  
5 centage is determined in accordance  
6 with the following formula:  $(P-$   
7  $15)(.65)-2.5$ ;

8 “(II) is equal to or exceeds 19.3,  
9 such adjustment percentage is equal  
10 to 5.25 percent, where P is the hos-  
11 pital’s disproportionate patient per-  
12 centage (as defined in clause (vi)).”.

13 (4) HOSPITALS THAT ARE BOTH SOLE COMMU-  
14 NITY HOSPITALS AND RURAL REFERRAL CENTERS.—  
15 Such section is further amended, in clause (iv)(IV),  
16 by inserting after clause (viii) the following: “or, for  
17 discharges occurring on or after October 1, 2001,  
18 the greater of the percentages determined under  
19 clause (x) or (xi)”.

20 (5) URBAN HOSPITALS WITH LESS THAN 100  
21 BEDS.—Such section is further amended—

22 (A) in clause (iv)(II), by inserting after 5  
23 percent the following: “or, for discharges occur-  
24 ring on or after October 1, 2001, is equal to the

1 percent determined in accordance with clause  
2 (xiii); and

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

5 “(xiii) For purposes of clause (iv)(II),  
6 in the case of a hospital for a cost report-  
7 ing period with a disproportionate patient  
8 percentage (as defined in clause (vi))  
9 that—

10 “(I) is less than 19.3, the dis-  
11 proportionate share adjustment per-  
12 centage is determined in accordance  
13 with the following formula:  $(P-$   
14  $15)(.65)-2.5$ ;

15 “(II) is equal to or exceeds 19.3,  
16 such adjustment percentage is equal  
17 to 5.25 percent; where P is the hos-  
18 pital’s disproportionate patient per-  
19 centage (as defined in clause (vi)).”.

1 **SEC. 212. OPTION TO BASE ELIGIBILITY FOR MEDICARE DE-**  
2 **PENDENT, SMALL RURAL HOSPITAL PRO-**  
3 **GRAM ON DISCHARGES DURING 2 OF THE 3**  
4 **MOST RECENTLY AUDITED COST REPORTING**  
5 **PERIODS.**

6 (a) IN GENERAL.—Section 1886(d)(5)(G)(iv)(IV)  
7 (42 U.S.C. 1395ww(d)(5)(G)(iv)(IV)) is amended by in-  
8 serting “, or 2 of the 3 most recently audited cost report-  
9 ing periods for which the Secretary has a settled cost re-  
10 port,” after “1987”.

11 (b) EFFECTIVE DATE.—The amendment made by  
12 this section shall apply with respect to cost reporting peri-  
13 ods beginning on or after April 1, 2001.

14 **SEC. 213. EXTENSION OF OPTION TO USE REBASED TARGET**  
15 **AMOUNTS TO ALL SOLE COMMUNITY HOS-**  
16 **PITALS.**

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

19 (1) in the matter preceding subclause (I), by  
20 striking “that for its cost reporting period beginning  
21 during 1999” and all that follows through “for such  
22 target amount” and inserting “there shall be sub-  
23 stituted for the amount otherwise determined under  
24 subsection (d)(5)(D)(i), if such substitution results  
25 in a greater amount of payment under this section  
26 for the hospital”;

1           (2) in subclause (I), by striking “target amount  
2 otherwise applicable” and all that follows through  
3 “target amount’”)” and inserting “the amount other-  
4 wise applicable to the hospital under subsection  
5 (d)(5)(D)(i) (referred to in this clause as the ‘sub-  
6 section (d)(5)(D)(i) amount’)”; and

7           (3) in each of subclauses (II) and (III), by  
8 striking “subparagraph (C) target amount” and in-  
9 serting “subsection (d)(5)(D)(i) amount”.

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

13 **SEC. 214. MEDPAC ANALYSIS OF IMPACT OF VOLUME ON**  
14 **PER UNIT COST OF RURAL HOSPITALS WITH**  
15 **PSYCHIATRIC UNITS.**

16       The Medicare Payment Advisory Commission, in its  
17 study conducted pursuant to subsection (a) of section 411  
18 of BBRA (113 Stat. 1501A–377), shall include—

19           (1) in such study an analysis of the impact of  
20 volume on the per unit cost of rural hospitals with  
21 psychiatric units; and

22           (2) in its report under subsection (b) of such  
23 section a recommendation on whether special treat-  
24 ment for such hospitals may be warranted.

## 1 **Subtitle C—Other Rural Provisions**

### 2 **SEC. 221. ASSISTANCE FOR PROVIDERS OF AMBULANCE** 3 **SERVICES IN RURAL AREAS.**

4 (a) TRANSITIONAL ASSISTANCE IN CERTAIN MILE-  
5 AGE RATES.—Section 1834(l) (42 U.S.C. 1395m(l)) is  
6 amended by adding at the end the following new para-  
7 graph:

8 “(8) TRANSITIONAL ASSISTANCE FOR RURAL  
9 PROVIDERS.—In the case of ground ambulance serv-  
10 ices furnished on or after the date on which the Sec-  
11 retary implements the fee schedule under this sub-  
12 section and before January 1, 2004, for which the  
13 transportation originates in a rural area (as defined  
14 in section 1886(d)(2)(D)) or in a rural census tract  
15 of a metropolitan statistical area (as determined  
16 under the most recent modification of the Goldsmith  
17 Modification, originally published in the Federal  
18 Register on February 27, 1992 (57 Fed. Reg.  
19 6725)), the fee schedule established under this sub-  
20 section shall provide that, with respect to the pay-  
21 ment rate for mileage for a trip above 17 miles, and  
22 up to 50 miles, the rate otherwise established shall  
23 be increased by not less than  $\frac{1}{2}$  of the additional  
24 payment per mile established for the first 17 miles  
25 of such a trip originating in a rural area.”.

1 (b) GAO STUDIES ON THE COSTS OF AMBULANCE  
2 SERVICES FURNISHED IN RURAL AREAS.—

3 (1) STUDY.—The Comptroller General of the  
4 United States shall conduct a study on each of the  
5 matters described in paragraph (2).

6 (2) MATTERS DESCRIBED.—The matters re-  
7 ferred to in paragraph (1) are the following:

8 (A) The cost of efficiently providing ambu-  
9 lance services for trips originating in rural  
10 areas, with special emphasis on collection of  
11 cost data from rural providers.

12 (B) The means by which rural areas with  
13 low population densities can be identified for  
14 the purpose of designating areas in which the  
15 cost of providing ambulance services would be  
16 expected to be higher than similar services pro-  
17 vided in more heavily populated areas because  
18 of low usage. Such study shall also include an  
19 analysis of the additional costs of providing am-  
20 bulance services in areas designated under the  
21 previous sentence.

22 (3) REPORT.—Not later than June 30, 2002,  
23 the Comptroller General shall submit to Congress a  
24 report on the results of the studies conducted under  
25 paragraph (1) and shall include recommendations on

1 steps that should be taken to assure access to ambu-  
2 lance services in rural areas.

3 (c) ADJUSTMENT IN RURAL RATES.—In providing  
4 for adjustments under subparagraph (D) of section  
5 1834(l)(2) of the Social Security Act (42 U.S.C.  
6 1395m(l)(2)) for years beginning with 2004, the Secretary  
7 of Health and Human Services shall take into consider-  
8 ation the recommendations contained in the report under  
9 subsection (b)(2) and shall adjust the fee schedule pay-  
10 ment rates under such section for ambulance services pro-  
11 vided in low density rural areas based on the increased  
12 cost (if any) of providing such services in such areas.

13 (d) EFFECTIVE DATE.—The amendment made by  
14 subsection (a) applies to services furnished on or after the  
15 date the Secretary implements the fee schedule under sec-  
16 tion 1834(l) of the Social Security Act (42 U.S.C.  
17 1395m(l)). In applying such amendment to services fur-  
18 nished on or after such date and before January 1, 2002,  
19 the amount of the rate increase provided under such  
20 amendment shall be equal to \$1.25 per mile.

21 **SEC. 222. PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT**  
22 **SERVICES.**

23 (a) PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT  
24 SERVICES.—Section 1842(b)(6)(C) (42 U.S.C.  
25 1395u(b)(6)(C)) is amended—



1 the individual physician or practitioner providing the  
2 telehealth service is not at the same location as the  
3 beneficiary. For purposes of the preceding sentence,  
4 in the case of any Federal telemedicine demonstra-  
5 tion program conducted in Alaska or Hawaii, the  
6 term ‘telecommunications system’ includes store-  
7 and-forward technologies that provide for the asyn-  
8 chronous transmission of health care information in  
9 single or multimedia formats.

10 “(2) PAYMENT AMOUNT.—

11 “(A) DISTANT SITE.—The Secretary shall  
12 pay to a physician or practitioner located at a  
13 distant site that furnishes a telehealth service  
14 to an eligible telehealth individual an amount  
15 equal to the amount that such physician or  
16 practitioner would have been paid under this  
17 title had such service been furnished without  
18 the use of a telecommunications system.

19 “(B) FACILITY FEE FOR ORIGINATING  
20 SITE.—With respect to a telehealth service, sub-  
21 ject to section 1833(a)(1)(U), there shall be  
22 paid to the originating site a facility fee equal  
23 to—

1           “(i) for the period beginning on July  
2           1, 2001, and ending on December 31,  
3           2001, and for 2002, \$20; and

4           “(ii) for a subsequent year, the facil-  
5           ity fee specified in clause (i) or this clause  
6           for the preceding year increased by the  
7           percentage increase in the MEI (as defined  
8           in section 1842(i)(3)) for such subsequent  
9           year.

10          “(C) TELEPRESENTER NOT REQUIRED.—  
11          Nothing in this subsection shall be construed as  
12          requiring an eligible telehealth individual to be  
13          presented by a physician or practitioner at the  
14          originating site for the furnishing of a service  
15          via a telecommunications system, unless it is  
16          medically necessary (as determined by the phy-  
17          sician or practitioner at the distant site).

18          “(3) LIMITATION ON BENEFICIARY CHARGES.—

19          “(A) PHYSICIAN AND PRACTITIONER.—  
20          The provisions of section 1848(g) and subpara-  
21          graphs (A) and (B) of section 1842(b)(18) shall  
22          apply to a physician or practitioner receiving  
23          payment under this subsection in the same  
24          manner as they apply to physicians or practi-  
25          tioners under such sections.

1           “(B) ORIGINATING SITE.—The provisions  
2 of section 1842(b)(18) shall apply to originating  
3 sites receiving a facility fee in the same manner  
4 as they apply to practitioners under such sec-  
5 tion.

6           “(4) DEFINITIONS.—For purposes of this sub-  
7 section:

8           “(A) DISTANT SITE.—The term ‘distant  
9 site’ means the site at which the physician or  
10 practitioner is located at the time the service is  
11 provided via a telecommunications system.

12           “(B) ELIGIBLE TELEHEALTH INDIVIDUAL.—The term ‘eligible telehealth indi-  
13 vidual’ means an individual enrolled under this  
14 part who receives a telehealth service furnished  
15 at an originating site.

16           “(C) ORIGINATING SITE.—

17           “(i) IN GENERAL.—The term ‘origi-  
18 nating site’ means only those sites de-  
19 scribed in clause (ii) at which the eligible  
20 telehealth individual is located at the time  
21 the service is furnished via a telecommuni-  
22 cations system and only if such site is  
23 located—  
24

1           “(I) in an area that is designated  
2           as a rural health professional shortage  
3           area under section 332(a)(1)(A) of  
4           the Public Health Service Act (42  
5           U.S.C. 254e(a)(1)(A));

6           “(II) in a county that is not in-  
7           cluded in a Metropolitan Statistical  
8           Area; or

9           “(III) from an entity that partici-  
10          pates in a Federal telemedicine dem-  
11          onstration project that has been ap-  
12          proved by (or receives funding from)  
13          the Secretary of Health and Human  
14          Services as of December 31, 2000.

15          “(ii) SITES DESCRIBED.—The sites  
16          referred to in clause (i) are the following  
17          sites:

18                 “(I) The office of a physician or  
19                 practitioner.

20                 “(II) A critical access hospital  
21                 (as defined in section 1861(mm)(1)).

22                 “(III) A rural health clinic (as  
23                 defined in section 1861(aa)(s)).

1                   “(IV) A Federally qualified  
2 health center (as defined in section  
3 1861(aa)(4)).

4                   “(V) A hospital (as defined in  
5 section 1861(e)).

6                   “(D) PHYSICIAN.—The term ‘physi-  
7 cian’ has the meaning given that term in  
8 section 1861(r).

9                   “(E) PRACTITIONER.—The term  
10 ‘practitioner’ has the meaning given that  
11 term in section 1842(b)(18)(C).

12                   “(F) TELEHEALTH SERVICE.—

13                   “(i) IN GENERAL.—The term ‘tele-  
14 health service’ means professional con-  
15 sultations, office visits, and office psychi-  
16 atry services (identified as of July 1, 2000,  
17 by HCPCS codes 99241–99275, 99201–  
18 99215, 90804–90809, and 90862 (and as  
19 subsequently modified by the Secretary)),  
20 and any additional service specified by the  
21 Secretary.

22                   “(ii) YEARLY UPDATE.—The Sec-  
23 retary shall establish a process that pro-  
24 vides, on an annual basis, for the addition  
25 or deletion of services (and HCPCS codes),

1 as appropriate, to those specified in clause  
2 (i) for authorized payment under para-  
3 graph (1).”.

4 (c) CONFORMING AMENDMENT.—Section 1833(a)(1)  
5 (42 U.S.C. 1395l(1)), as amended by section 105(c), is  
6 further amended—

7 (1) by striking “and (T)” and inserting “(T)”;  
8 and

9 (2) by inserting before the semicolon at the end  
10 the following: “, and (U) with respect to facility fees  
11 described in section 1834(m)(2)(B), the amounts  
12 paid shall be 80 percent of the lesser of the actual  
13 charge or the amounts specified in such section”.

14 (d) STUDY AND REPORT ON ADDITIONAL COV-  
15 ERAGE.—

16 (1) STUDY.—The Secretary of Health and  
17 Human Services shall conduct a study to identify—

18 (A) settings and sites for the provision of  
19 telehealth services that are in addition to those  
20 permitted under section 1834(m) of the Social  
21 Security Act, as added by subsection (b);

22 (B) practitioners that may be reimbursed  
23 under such section for furnishing telehealth  
24 services that are in addition to the practitioners

1           that may be reimbursed for such services under  
2           such section; and

3           (C) geographic areas in which telehealth  
4           services may be reimbursed that are in addition  
5           to the geographic areas where such services  
6           may be reimbursed under such section.

7           (2) REPORT.—Not later than 2 years after the  
8           date of the enactment of this Act, the Secretary  
9           shall submit to Congress a report on the study con-  
10          ducted under paragraph (1) together with such rec-  
11          ommendations for legislation that the Secretary de-  
12          termines are appropriate.

13          (e) EFFECTIVE DATE.—The amendments made by  
14          subsections (b) and (c) shall be effective for services fur-  
15          nished on or after July 1, 2001.

16 **SEC. 224. EXPANDING ACCESS TO RURAL HEALTH CLINICS.**

17          (a) IN GENERAL.—The matter in section 1833(f) (42  
18          U.S.C. 1395l(f)) preceding paragraph (1) is amended by  
19          striking “rural hospitals” and inserting “hospitals”.

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

1 **SEC. 225. MEDPAC STUDY ON LOW-VOLUME, ISOLATED**  
2 **RURAL HEALTH CARE PROVIDERS.**

3 (a) **STUDY.**—The Medicare Payment Advisory Com-  
4 mission shall conduct a study on the effect of low patient  
5 and procedure volume on the financial status of low-vol-  
6 ume, isolated rural health care providers participating in  
7 the medicare program under title XVIII of the Social Se-  
8 curity Act.

9 (b) **REPORT.**—Not later than 18 months after the  
10 date of the enactment of this Act, the Commission shall  
11 submit to Congress a report on the study conducted under  
12 subsection (a) indicating—

13 (1) whether low-volume, isolated rural health  
14 care providers are having, or may have, significantly  
15 decreased medicare margins or other financial dif-  
16 ficulties resulting from any of the payment meth-  
17 odologies described in subsection (c);

18 (2) whether the status as a low-volume, isolated  
19 rural health care provider should be designated  
20 under the medicare program and any criteria that  
21 should be used to qualify for such a status; and

22 (3) any changes in the payment methodologies  
23 described in subsection (c) that are necessary to pro-  
24 vide appropriate reimbursement under the medicare  
25 program to low-volume, isolated rural health care  
26 providers (as designated pursuant to paragraph (2)).

1           (c) PAYMENT METHODOLOGIES DESCRIBED.—The  
2 payment methodologies described in this subsection are  
3 the following:

4           (1) The prospective payment system for hos-  
5 pital outpatient department services under section  
6 1833(t) of the Social Security Act (42 U.S.C.  
7 1395l(t)).

8           (2) The fee schedule for ambulance services  
9 under section 1834(l) of such Act (42 U.S.C.  
10 1395m(l)).

11           (3) The prospective payment system for inpa-  
12 tient hospital services under section 1886 of such  
13 Act (42 U.S.C. 1395ww).

14           (4) The prospective payment system for routine  
15 service costs of skilled nursing facilities under sec-  
16 tion 1888(e) of such Act (42 U.S.C. 1395yy(e)).

17           (5) The prospective payment system for home  
18 health services under section 1895 of such Act (42  
19 U.S.C. 1395fff).

1                   **TITLE III—PROVISIONS**  
2                   **RELATING TO PART A**  
3                   **Subtitle A—Inpatient Hospital**  
4                   **Services**

5   **SEC. 301. ELIMINATING REDUCTION IN PPS HOSPITAL PAY-**  
6                   **MENT UPDATE.**

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

9                   (1) in subclause (XVI), by striking “minus 1.1  
10                   percentage points for hospitals (other than sole com-  
11                   munity hospitals) in all areas, and the market bas-  
12                   ket percentage increase for sole community hos-  
13                   pitals,” and inserting “for hospitals in all areas,”;

14                   (2) in subclause (XVII)—

15                           (A) by striking “minus 1.1 percentage  
16                           points”; and

17                           (B) by striking “and” at the end;

18                   (3) by redesignating subclause (XVIII) as sub-  
19                   clause (XIX);

20                   (4) in subclause (XIX), as so redesignated, by  
21                   striking “fiscal year 2003” and inserting “fiscal year  
22                   2004”; and

23                   (5) by inserting after subclause (XVII) the fol-  
24                   lowing new subclause:

1           “(XVIII) for fiscal year 2003, the market bas-  
2           ket percentage increase minus 0.55 percentage  
3           points for hospitals in all areas, and”.

4           (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR  
5           2001.—Notwithstanding the amendment made by sub-  
6           section (a), for purposes of making payments for fiscal  
7           year 2001 for inpatient hospital services furnished by sub-  
8           section (d) hospitals (as defined in section 1886(d)(1)(B)  
9           of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)),  
10          the “applicable percentage increase” referred to in section  
11          1886(b)(3)(B)(i) of such Act (42 U.S.C.  
12          1395ww(b)(3)(B)(i))—

13           (1) for discharges occurring on or after October  
14          1, 2000, and before April 1, 2001, shall be deter-  
15          mined in accordance with subclause (XVI) of such  
16          section as in effect on the day before the date of the  
17          enactment of this Act; and

18           (2) for discharges occurring on or after April 1,  
19          2001, and before October 1, 2001, shall be equal  
20          to—

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

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

1           (c) CONSIDERATION OF PRICE OF BLOOD AND  
2 BLOOD PRODUCTS IN MARKET BASKET INDEX.—The  
3 Secretary of Health and Human Services shall, when next  
4 (after the date of the enactment of this Act) rebasing and  
5 revising the hospital market basket index (as defined in  
6 section 1886(b)(3)(B)(iii) of the Social Security Act (42  
7 U.S.C. 1395ww(b)(3)(B)(iii))), consider the prices of  
8 blood and blood products purchased by hospitals and de-  
9 termine whether those prices are adequately reflected in  
10 such index.

11           (d) MEDPAC STUDY AND REPORT REGARDING CER-  
12 TAIN HOSPITAL COSTS.—

13           (1) STUDY.—The Medicare Payment Advisory  
14 Commission shall conduct a study on—

15                   (A) any increased costs incurred by sub-  
16 section (d) hospitals (as defined in paragraph  
17 (1)(B) of section 1886(d) of the Social Security  
18 Act (42 U.S.C. 1395ww(d))) in providing inpa-  
19 tient hospital services to medicare beneficiaries  
20 under title XVIII of such Act during the period  
21 beginning on October 1, 1983, and ending on  
22 September 30, 1999, that were attributable  
23 to—

24                           (i) complying with new blood safety  
25 measure requirements; and

1 (ii) providing such services using new  
2 technologies;

3 (B) the extent to which the prospective  
4 payment system for such services under such  
5 section provides adequate and timely recogni-  
6 tion of such increased costs;

7 (C) the prospects for (and to the extent  
8 practicable, the magnitude of) cost increases  
9 that hospitals will incur in providing such serv-  
10 ices that are attributable to complying with new  
11 blood safety measure requirements and pro-  
12 viding such services using new technologies dur-  
13 ing the 10 years after the date of the enact-  
14 ment of this Act; and

15 (D) the feasibility and advisability of es-  
16 tablishing mechanisms under such payment sys-  
17 tem to provide for more timely and accurate  
18 recognition of such cost increases in the future.

19 (2) CONSULTATION.—In conducting the study  
20 under this subsection, the Commission shall consult  
21 with representatives of the blood community,  
22 including—

23 (A) hospitals;

24 (B) organizations involved in the collection,  
25 processing, and delivery of blood; and

1 (C) organizations involved in the develop-  
2 ment of new blood safety technologies.

3 (3) REPORT.—Not later than 1 year after the  
4 date of the enactment of this Act, the Commission  
5 shall submit to Congress a report on the study con-  
6 ducted under paragraph (1) together with such rec-  
7 ommendations for legislation and administrative ac-  
8 tion as the Commission determines appropriate.

9 (e) ADJUSTMENT FOR INPATIENT CASE MIX  
10 CHANGES.—

11 (1) IN GENERAL.—Section 1886(d)(3)(A) (42  
12 U.S.C. 1395ww(d)(3)(A)) is amended by adding at  
13 the end the following new clause:

14 “(vi) Insofar as the Secretary determines that  
15 the adjustments under paragraph (4)(C)(i) for a  
16 previous fiscal year (or estimates that such adjust-  
17 ments for a future fiscal year) did (or are likely to)  
18 result in a change in aggregate payments under this  
19 subsection during the fiscal year that are a result of  
20 changes in the coding or classification of discharges  
21 that do not reflect real changes in case mix, the Sec-  
22 retary may adjust the average standardized amounts  
23 computed under this paragraph for subsequent fiscal  
24 years so as to eliminate the effect of such coding or  
25 classification changes.”.

1           (2) EFFECTIVE DATE.—The amendment made  
2           by paragraph (1) applies to discharges occurring on  
3           or after October 1, 2001.

4 **SEC. 302. ADDITIONAL MODIFICATION IN TRANSITION FOR**  
5                           **INDIRECT MEDICAL EDUCATION (IME) PER-**  
6                           **CENTAGE ADJUSTMENT.**

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

9                   (1) in subclause (V) by striking “and” at the  
10           end;

11                   (2) by redesignating subclause (VI) as sub-  
12           clause (VII);

13                   (3) in subclause (VII) as so redesignated, by  
14           striking “2001” and inserting “2002”; and

15                   (4) by inserting after subclause (V) the fol-  
16           lowing new subclause:

17                           “(VI) during fiscal year 2002, ‘c’ is equal  
18           to 1.6; and”.

19           (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR  
20 2001.—Notwithstanding paragraph (5)(B)(ii)(V) of sec-  
21 tion 1886(d) of the Social Security Act (42 U.S.C.  
22 1395ww(d)(5)(B)(ii)(V)), for purposes of making pay-  
23 ments for subsection (d) hospitals (as defined in para-  
24 graph (1)(B) of such section) with indirect costs of med-  
25 ical education, the indirect teaching adjustment factor re-

1 ferred to in paragraph (5)(B)(ii) of such section shall be  
2 determined, for discharges occurring on or after April 1,  
3 2001, and before October 1, 2001, as if “c” in paragraph  
4 (5)(B)(ii)(V) of such section equalled 1.66 rather than  
5 1.54.

6 (c) CONFORMING AMENDMENT RELATING TO DE-  
7 TERMINATION OF STANDARDIZED AMOUNT.—Section  
8 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is  
9 amended by inserting “or of section 302 of the Medicare,  
10 Medicaid, and SCHIP Benefits Improvement and Protec-  
11 tion Act of 2000” after “Balanced Budget Refinement Act  
12 of 1999”.

13 (d) CLERICAL AMENDMENTS.—Section  
14 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)), as amended  
15 by subsection (a), is further amended by moving the in-  
16 dentation of each of the following 2 ems to the left:

17 (1) Clauses (ii), (v), and (vi).

18 (2) Subclauses (I) (II), (III), (IV), (V), and  
19 (VII) of clause (ii).

20 (3) Subclauses (I) and (II) of clause (vi) and  
21 the flush sentence at the end of such clause.

22 **SEC. 303. DECREASE IN REDUCTIONS FOR DISPROPOR-**  
23 **TIONATE SHARE HOSPITAL (DSH) PAYMENTS.**

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

1           (1) in subclause (III), by striking “each of” and  
2           by inserting “and 2 percent, respectively” after “3  
3           percent”; and

4           (2) in subclause (IV), by striking “4 percent”  
5           and inserting “3 percent”.

6           (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR  
7           2001.—Notwithstanding the amendment made by sub-  
8           section (a)(1), for purposes of making disproportionate  
9           share payments for subsection (d) hospitals (as defined  
10          in section 1886(d)(1)(B) of the Social Security Act (42  
11          U.S.C. 1395ww(d)(1)(B)) for fiscal year 2001, the addi-  
12          tional payment amount otherwise determined under clause  
13          (ii) of section 1886(d)(5)(F) of the Social Security Act  
14          (42 U.S.C. 1395ww(d)(5)(F))—

15           (1) for discharges occurring on or after October  
16           1, 2000, and before April 1, 2001, shall be adjusted  
17           as provided by clause (ix)(III) of such section as in  
18           effect on the day before the date of the enactment  
19           of this Act; and

20           (2) for discharges occurring on or after April 1,  
21           2001, and before October 1, 2001, shall, instead of  
22           being reduced by 3 percent as provided by clause  
23           (ix)(III) of such section as in effect after the date  
24           of the enactment of this Act, be reduced by 1 per-  
25           cent.

1 (c) CONFORMING AMENDMENTS RELATING TO DE-  
2 TERMINATION OF STANDARDIZED AMOUNT.—Section  
3 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)), is  
4 amended—

5 (1) by striking “1989 or” and inserting  
6 “1989,”; and

7 (2) by inserting “, or the enactment of section  
8 303 of the Medicare, Medicaid, and SCHIP Benefits  
9 Improvement and Protection Act of 2000” after  
10 “Omnibus Budget Reconciliation Act of 1990”.

11 (d) TECHNICAL AMENDMENT.—

12 (1) IN GENERAL.—Section 1886(d)(5)(F)(i) (42  
13 U.S.C. 1395ww(d)(5)(F)(i)) is amended by striking  
14 “and before October 1, 1997,”.

15 (2) EFFECTIVE DATE.—The amendment made  
16 by paragraph (1) is effective as if included in the en-  
17 actment of BBA.

18 (e) REFERENCE TO CHANGES IN DSH FOR RURAL  
19 HOSPITALS.—For additional changes in the DSH pro-  
20 gram for rural hospitals, see section 211.

21 **SEC. 304. WAGE INDEX IMPROVEMENTS.**

22 (a) DURATION OF WAGE INDEX RECLASSIFICATION;  
23 USE OF 3-YEAR WAGE DATA.—Section 1886(d)(10)(D)  
24 (42 U.S.C. 1395ww(d)(10)(D)) is amended by adding at  
25 the end the following new clauses:

1       “(v) Any decision of the Board to reclassify a sub-  
2 section (d) hospital for purposes of the adjustment factor  
3 described in subparagraph (C)(i)(II) for fiscal year 2001  
4 or any fiscal year thereafter shall be effective for a period  
5 of 3 fiscal years, except that the Secretary shall establish  
6 procedures under which a subsection (d) hospital may  
7 elect to terminate such reclassification before the end of  
8 such period.

9       “(vi) Such guidelines shall provide that, in making  
10 decisions on applications for reclassification for the pur-  
11 poses described in clause (v) for fiscal year 2003 and any  
12 succeeding fiscal year, the Board shall base any compari-  
13 son of the average hourly wage for the hospital with the  
14 average hourly wage for hospitals in an area on—

15               “(I) an average of the average hourly wage  
16 amount for the hospital from the most recently pub-  
17 lished hospital wage survey data of the Secretary (as  
18 of the date on which the hospital applies for reclassi-  
19 fication) and such amount from each of the two im-  
20 mediately preceding surveys; and

21               “(II) an average of the average hourly wage  
22 amount for hospitals in such area from the most re-  
23 cently published hospital wage survey data of the  
24 Secretary (as of the date on which the hospital ap-

1       plies for reclassification) and such amount from each  
2       of the two immediately preceding surveys.”.

3       (b) PROCESS TO PERMIT STATEWIDE WAGE INDEX  
4       CALCULATION AND APPLICATION.—

5               (1) IN GENERAL.—The Secretary of Health and  
6       Human Services shall establish a process (based on  
7       the voluntary process utilized by the Secretary of  
8       Health and Human Services under section 1848 of  
9       the Social Security Act (42 U.S.C. 1395w–4) for  
10      purposes of computing and applying a statewide geo-  
11      graphic wage index) under which an appropriate  
12      statewide entity may apply to have all the geo-  
13      graphic areas in a State treated as a single geo-  
14      graphic area for purposes of computing and applying  
15      the area wage index under section 1886(d)(3)(E) of  
16      such Act (42 U.S.C. 1395ww(d)(3)(E)). Such proc-  
17      ess shall be established by October 1, 2001, for re-  
18      classifications beginning in fiscal year 2003.

19              (2) PROHIBITION ON INDIVIDUAL HOSPITAL RE-  
20      CLASSIFICATION.—Notwithstanding any other provi-  
21      sion of law, if the Secretary applies a statewide geo-  
22      graphic wage index under paragraph (1) with re-  
23      spect to a State, any application submitted by a hos-  
24      pital in that State under section 1886(d)(10) of the

1 Social Security Act (42 U.S.C. 1395ww(d)(10)) for  
2 geographic reclassification shall not be considered.

3 (c) COLLECTION OF INFORMATION ON OCCUPA-  
4 TIONAL MIX.—

5 (1) IN GENERAL.—The Secretary of Health and  
6 Human Services shall provide for the collection of  
7 data every 3 years on occupational mix for employ-  
8 ees of each subsection (d) hospital (as defined in  
9 section 1886(d)(1)(D) of the Social Security Act (42  
10 U.S.C. 1395ww(d)(1)(D))) in the provision of inpa-  
11 tient hospital services, in order to construct an occu-  
12 pational mix adjustment in the hospital area wage  
13 index applied under section 1886(d)(3)(E) of such  
14 Act (42 U.S.C. 1395ww(d)(3)(E)).

15 (2) APPLICATION.—The third sentence of sec-  
16 tion 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is  
17 amended by striking “To the extent determined fea-  
18 sible by the Secretary, such survey shall measure”  
19 and inserting “Not less often than once every 3  
20 years the Secretary (through such survey or other-  
21 wise) shall measure”.

22 (3) EFFECTIVE DATE.—By not later than Sep-  
23 tember 30, 2003, for application beginning October  
24 1, 2004, the Secretary shall first complete—

1 (A) the collection of data under paragraph  
2 (1); and

3 (B) the measurement under the third sen-  
4 tence of section 1886(d)(3)(E), as amended by  
5 paragraph (2).

6 **SEC. 305. PAYMENT FOR INPATIENT SERVICES OF REHA-**  
7 **BILITATION HOSPITALS.**

8 (a) ASSISTANCE WITH ADMINISTRATIVE COSTS AS-  
9 SOCIATED WITH COMPLETION OF PATIENT ASSESS-  
10 MENT.—Section 1886(j)(3)(B) (42 U.S.C.  
11 1395ww(j)(3)(B)) is amended by striking “98 percent”  
12 and inserting “98 percent for fiscal year 2001 and 100  
13 percent for fiscal year 2002”.

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

16 (1) IN GENERAL.—Paragraph (1) of section  
17 1886(j) (42 U.S.C. 1395ww(j)) is amended—

18 (A) in subparagraph (A), by inserting  
19 “other than a facility making an election under  
20 subparagraph (F)” before “in a cost reporting  
21 period”;

22 (B) in subparagraph (B), by inserting “or,  
23 in the case of a facility making an election  
24 under subparagraph (F), for any cost reporting

1 period described in such subparagraph,” after  
2 “2002,”; and

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

5 “(F) ELECTION TO APPLY FULL PROSPEC-  
6 TIVE PAYMENT SYSTEM.—A rehabilitation facil-  
7 ity may elect, not later than 30 days before its  
8 first cost reporting period for which the pay-  
9 ment methodology under this subsection applies  
10 to the facility, to have payment made to the fa-  
11 cility under this subsection under the provisions  
12 of subparagraph (B) (rather than subparagraph  
13 (A)) for each cost reporting period to which  
14 such payment methodology applies.”.

15 (2) CLARIFICATION.—Paragraph (3)(B) of such  
16 section is amended by inserting “but not taking into  
17 account any payment adjustment resulting from an  
18 election permitted under paragraph (1)(F)” after  
19 “paragraphs (4) and (6)”.

20 (c) EFFECTIVE DATE.—The amendments made by  
21 this section take effect as if included in the enactment of  
22 BBA.

1 **SEC. 306. PAYMENT FOR INPATIENT SERVICES OF PSY-**  
2 **CHIATRIC HOSPITALS.**

3 With respect to hospitals described in clause (i) of  
4 section 1886(d)(1)(B) of the Social Security Act (42  
5 U.S.C. 1395ww(d)(1)(B)) and psychiatric units described  
6 in the matter following clause (v) of such section, in mak-  
7 ing incentive payments to such hospitals under section  
8 1886(b)(1)(A) of such Act (42 U.S.C. 1395ww(b)(1)(A))  
9 for cost reporting periods beginning on or after October  
10 1, 2000, and before October 1, 2001, the Secretary of  
11 Health and Human Services, in clause (ii) of such section,  
12 shall substitute “3 percent” for “2 percent”.

13 **SEC. 307. PAYMENT FOR INPATIENT SERVICES OF LONG-**  
14 **TERM CARE HOSPITALS.**

15 (a) INCREASED TARGET AMOUNTS AND CAPS FOR  
16 LONG-TERM CARE HOSPITALS BEFORE IMPLEMENTA-  
17 TION OF THE PROSPECTIVE PAYMENT SYSTEM.—

18 (1) IN GENERAL.—Section 1886(b)(3) (42  
19 U.S.C. 1395ww(b)(3)) is amended—

20 (A) in subparagraph (H)(ii)(III), by insert-  
21 ing “subject to subparagraph (J),” after  
22 “2002,”; and

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

1       “(J) For cost reporting periods beginning during fis-  
2 cal year 2001, for a hospital described in subsection  
3 (d)(1)(B)(iv)—

4               “(i) the limiting or cap amount otherwise deter-  
5 mined under subparagraph (H) shall be increased by  
6 2 percent; and

7               “(ii) the target amount otherwise determined  
8 under subparagraph (A) shall be increased by 25  
9 percent (subject to the limiting or cap amount deter-  
10 mined under subparagraph (H), as increased by  
11 clause (i)).”.

12               (2) APPLICATION.—The amendments made by  
13 subsection (a) and by section 122 of BBRA (113  
14 Stat. 1501A–331) shall not be taken into account in  
15 the development and implementation of the prospec-  
16 tive payment system under section 123 of BBRA  
17 (113 Stat. 1501A–331).

18               (b) IMPLEMENTATION OF PROSPECTIVE PAYMENT  
19 SYSTEM FOR LONG-TERM CARE HOSPITALS.—

20               (1) MODIFICATION OF REQUIREMENT.—In de-  
21 veloping the prospective payment system for pay-  
22 ment for inpatient hospital services provided in long-  
23 term care hospitals described in section  
24 1886(d)(1)(B)(iv) of the Social Security Act (42  
25 U.S.C. 1395ww(d)(1)(B)(iv)) under the medicare

1 program under title XVIII of such Act required  
2 under section 123 of BBRA, the Secretary of Health  
3 and Human Services shall examine the feasibility  
4 and the impact of basing payment under such a sys-  
5 tem on the use of existing (or refined) hospital diag-  
6 nosis-related groups (DRGs) that have been modi-  
7 fied to account for different resource use of long-  
8 term care hospital patients as well as the use of the  
9 most recently available hospital discharge data. The  
10 Secretary shall examine and may provide for appro-  
11 priate adjustments to the long-term hospital pay-  
12 ment system, including adjustments to DRG  
13 weights, area wage adjustments, geographic reclassi-  
14 fication, outliers, updates, and a disproportionate  
15 share adjustment consistent with section  
16 1886(d)(5)(F) of the Social Security Act (42 U.S.C.  
17 1395ww(d)(5)(F)).

18 (2) DEFAULT IMPLEMENTATION OF SYSTEM  
19 BASED ON EXISTING DRG METHODOLOGY.—If the  
20 Secretary is unable to implement the prospective  
21 payment system under section 123 of the BBRA by  
22 October 1, 2002, the Secretary shall implement a  
23 prospective payment system for such hospitals that  
24 bases payment under such a system using existing  
25 hospital diagnosis-related groups (DRGs), modified

1 where feasible to account for resource use of long-  
 2 term care hospital patients using the most recently  
 3 available hospital discharge data for such services  
 4 furnished on or after that date.

5 **SEC. 308. INCREASE IN BASE PAYMENT TO PUERTO RICO**  
 6 **ACUTE CARE HOSPITALS.**

7 (a) IN GENERAL.—Section 1886(d)(9)(A) (42 U.S.C.  
 8 1395ww(d)(9)(A)) is amended—

9 (1) in clause (i), by striking “on or after Octo-  
 10 ber 1, 1997, 50 percent (” and inserting “on or  
 11 after October 1, 2000, 25 percent (and for dis-  
 12 charges between October 1, 1997, and September  
 13 30, 2000, 50 percent”); and

14 (2) in clause (ii), in the matter preceding sub-  
 15 clause (I), by striking “on or after October 1, 1997,  
 16 50 percent (” and inserting “on or after October 1,  
 17 2000, 75 percent (and for discharges between Octo-  
 18 ber 1, 1997, and September 30, 2000, 50 percent”.

19 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR  
 20 2001.—

21 (1) IN GENERAL.—Notwithstanding the amend-  
 22 ment made by subsection (a), for purposes of mak-  
 23 ing payments for the operating costs of inpatient  
 24 hospital services of a Puerto Rico hospital for fiscal  
 25 year 2001, the amount referred to in the matter pre-

1 ceding clause (i) of section 1886(d)(9)(A) of the So-  
2 cial Security Act (42 U.S.C. 1395ww(d)(9)(A))—

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

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

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

15 (ii) using 100 percent of the dis-  
16 charge-weighted average referred to in  
17 clause (ii) of such section.

18 (2) PUERTO RICO HOSPITAL.—For purposes of  
19 this subsection, the term “Puerto Rico hospital”  
20 means a subsection (d) Puerto Rico hospital as de-  
21 fined in the last sentence of section 1886(d)(9)(A)  
22 of the Social Security Act (42 U.S.C.  
23 1395ww(d)(9)(A)).

1 **Subtitle B—Adjustments to PPS**  
2 **Payments for Skilled Nursing**  
3 **Facilities**

4 **SEC. 311. ELIMINATION OF REDUCTION IN SKILLED NURS-**  
5 **ING FACILITY (SNF) MARKET BASKET UP-**  
6 **DATE IN 2001.**

7 (a) IN GENERAL.—Section 1888(e)(4)(E)(ii) (42  
8 U.S.C. 1395yy(e)(4)(E)(ii)) is amended—

9 (1) by redesignating subclauses (II) and (III)  
10 as subclauses (III) and (IV), respectively;

11 (2) in subclause (III), as so redesignated—

12 (A) by striking “each of fiscal years 2001  
13 and 2002” and inserting “each of fiscal years  
14 2002 and 2003”; and

15 (B) by striking “minus 1 percentage  
16 point” and inserting “minus 0.5 percentage  
17 points”; and

18 (3) by inserting after subclause (I) the fol-  
19 lowing new subclause:

20 “(II) for fiscal year 2001, the  
21 rate computed for the previous fiscal  
22 year increased by the skilled nursing  
23 facility market basket percentage  
24 change for the fiscal year;”.

1           (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR  
2 2001.—Notwithstanding the amendments made by sub-  
3 section (a), for purposes of making payments for covered  
4 skilled nursing facility services under section 1888(e) of  
5 the Social Security Act (42 U.S.C. 1395yy(e)) for fiscal  
6 year 2001, the Federal per diem rate referred to in para-  
7 graph (4)(E)(ii) of such section—

8           (1) for the period beginning on October 1,  
9 2000, and ending on March 31, 2001, shall be the  
10 rate determined in accordance with the law as in ef-  
11 fect on the day before the date of the enactment of  
12 this Act; and

13           (2) for the period beginning on April 1, 2001,  
14 and ending on September 30, 2001, shall be the rate  
15 that would have been determined under such section  
16 if “plus 1 percentage point” had been substituted  
17 for “minus 1 percentage point” under subclause (II)  
18 of such paragraph (as in effect on the day before the  
19 date of the enactment of this Act).

20           (c) RELATION TO TEMPORARY INCREASE IN  
21 BBRA.—The increases provided under section 101 of  
22 BBRA (113 Stat. 1501A–325) shall be in addition to any  
23 increase resulting from the amendments made by sub-  
24 section (a).

1           (d) GAO REPORT ON ADEQUACY OF SNF PAYMENT  
2 RATES.—Not later than July 1, 2002, the Comptroller  
3 General of the United States shall submit to Congress a  
4 report on the adequacy of medicare payment rates to  
5 skilled nursing facilities and the extent to which medicare  
6 contributes to the financial viability of such facilities. Such  
7 report shall take into account the role of private payors,  
8 medicaid, and case mix on the financial performance of  
9 these facilities, and shall include an analysis (by specific  
10 RUG classification) of the number and characteristics of  
11 such facilities.

12           (e) HCFA STUDY OF CLASSIFICATION SYSTEMS FOR  
13 SNF RESIDENTS.—

14           (1) STUDY.—The Secretary of Health and  
15 Human Services shall conduct a study of the dif-  
16 ferent systems for categorizing patients in medicare  
17 skilled nursing facilities in a manner that accounts  
18 for the relative resource utilization of different pa-  
19 tient types.

20           (2) REPORT.—Not later than January 1, 2005,  
21 the Secretary shall submit to Congress a report on  
22 the study conducted under subsection (a). Such re-  
23 port shall include such recommendations regarding  
24 changes in law as may be appropriate.

1 **SEC. 312. INCREASE IN NURSING COMPONENT OF PPS FED-**  
2 **ERAL RATE.**

3 (a) IN GENERAL.—The Secretary of Health and  
4 Human Services shall increase by 16.66 percent the nurs-  
5 ing component of the case-mix adjusted Federal prospec-  
6 tive payment rate specified in Tables 3 and 4 of the final  
7 rule published in the Federal Register by the Health Care  
8 Financing Administration on July 31, 2000 (65 Fed. Reg.  
9 46770), effective for services furnished on or after April  
10 1, 2001, and before October 1, 2002.

11 (b) GAO AUDIT OF NURSING STAFF RATIOS.—

12 (1) AUDIT.—The Comptroller General of the  
13 United States shall conduct an audit of nursing  
14 staffing ratios in a representative sample of medi-  
15 care skilled nursing facilities. Such sample shall  
16 cover selected States and shall include broad rep-  
17 resentation with respect to size, ownership, location,  
18 and medicare volume. Such audit shall include an  
19 examination of payroll records and medicaid cost re-  
20 ports of individual facilities.

21 (2) REPORT.—Not later than August 1, 2002,  
22 the Comptroller General shall submit to Congress a  
23 report on the audits conducted under paragraph (1).  
24 Such report shall include an assessment of the im-  
25 pact of the increased payments under this subtitle  
26 on increased nursing staff ratios and shall make rec-

1           ommendations as to whether increased payments  
2           under subsection (a) should be continued.

3 **SEC. 313. APPLICATION OF SNF CONSOLIDATED BILLING**  
4                           **REQUIREMENT LIMITED TO PART A COV-**  
5                           **ERED STAYS.**

6           (a) IN GENERAL.—Section 1862(a)(18) (42 U.S.C.  
7 1395y(a)(18)) is amended by striking “or of a part of a  
8 facility that includes a skilled nursing facility (as deter-  
9 mined under regulations),” and inserting “during a period  
10 in which the resident is provided covered post-hospital ex-  
11 tended care services (or, for services described in section  
12 1861(s)(2)(D), which are furnished to such an individual  
13 without regard to such period),”.

14           (b) CONFORMING AMENDMENTS.—(1) Section  
15 1842(b)(6)(E) (42 U.S.C. 1395u(b)(6)(E)) is amended—

16                   (A) by inserting “by, or under arrangements  
17                   made by, a skilled nursing facility” after “fur-  
18                   nished”;

19                   (B) by striking “or of a part of a facility that  
20                   includes a skilled nursing facility (as determined  
21                   under regulations)”;

22                   (C) by striking “(without regard to whether or  
23                   not the item or service was furnished by the facility,  
24                   by others under arrangement with them made by the

1 facility, under any other contracting or consulting  
2 arrangement, or otherwise”).

3 (2) Section 1842(t) (42 U.S.C. 1395u(t)) is amended  
4 by striking “by a physician” and “or of a part of a facility  
5 that includes a skilled nursing facility (as determined  
6 under regulations),”.

7 (3) Section 1866(a)(1)(H)(ii)(I) (42 U.S.C.  
8 1395cc(a)(1)(H)(ii)(I)) is amended by inserting after  
9 “who is a resident of the skilled nursing facility” the fol-  
10 lowing: “during a period in which the resident is provided  
11 covered post-hospital extended care services (or, for serv-  
12 ices described in section 1861(s)(2)(D), that are furnished  
13 to such an individual without regard to such period)”.

14 (c) EFFECTIVE DATE.—The amendments made by  
15 subsections (a) and (b) apply to services furnished on or  
16 after January 1, 2001.

17 (d) OVERSIGHT.—The Secretary of Health and  
18 Human Services, through the Office of the Inspector Gen-  
19 eral in the Department of Health and Human Services  
20 or otherwise, shall monitor payments made under part B  
21 of the title XVIII of the Social Security Act for items and  
22 services furnished to residents of skilled nursing facilities  
23 during a time in which the residents are not being pro-  
24 vided medicare covered post-hospital extended care serv-

1 ices to ensure that there is not duplicate billing for serv-  
 2 ices or excessive services provided.

3 **SEC. 314. ADJUSTMENT OF REHABILITATION RUGS TO COR-**  
 4 **RECT ANOMALY IN PAYMENT RATES.**

5 (a) ADJUSTMENT FOR REHABILITATION RUGS.—

6 (1) IN GENERAL.—For purposes of computing  
 7 payments for covered skilled nursing facility services  
 8 under paragraph (1) of section 1888(e) of the Social  
 9 Security Act (42 U.S.C. 1395yy(e)) for such services  
 10 furnished on or after April 1, 2001, and before the  
 11 date described in section 101(c)(2) of BBRA (113  
 12 Stat. 1501A–324), the Secretary of Health and  
 13 Human Services shall increase by 6.7 percent the  
 14 adjusted Federal per diem rate otherwise determined  
 15 under paragraph (4) of such section (but for this  
 16 section) for covered skilled nursing facility services  
 17 for RUG–III rehabilitation groups described in para-  
 18 graph (2) furnished to an individual during the pe-  
 19 riod in which such individual is classified in such a  
 20 RUG–III category.

21 (2) REHABILITATION GROUPS DESCRIBED.—

22 The RUG–III rehabilitation groups for which the  
 23 adjustment described in paragraph (1) applies are  
 24 RUC, RUB, RUA, RVC, RVB, RVA, RHC, RHB,  
 25 RHA, RMC, RMB, RMA, RLB, and RLA, as speci-

1       fied in Tables 3 and 4 of the final rule published in  
2       the Federal Register by the Health Care Financing  
3       Administration on July 31, 2000 (65 Fed. Reg.  
4       46770).

5       (b) CORRECTION WITH RESPECT TO REHABILITA-  
6       TION RUGs.—

7           (1) IN GENERAL.—Section 101(b) of BBRA  
8       (113 Stat. 1501A–324) is amended by striking  
9       “CA1, RHC, RMC, and RMB” and inserting “and  
10      CA1”.

11          (2) EFFECTIVE DATE.—The amendment made  
12      by paragraph (1) applies to services furnished on or  
13      after April 1, 2001.

14      (c) REVIEW BY OFFICE OF INSPECTOR GENERAL.—  
15      The Inspector General of the Department of Health and  
16      Human Services shall review the medicare payment struc-  
17      ture for services classified within rehabilitation resource  
18      utilization groups (RUGs) (as in effect after the date of  
19      the enactment of the BBRA) to assess whether payment  
20      incentives exist for the delivery of inadequate care. Not  
21      later than October 1, 2001, the Inspector General shall  
22      submit to Congress a report on such review.

1 **SEC. 315. ESTABLISHMENT OF PROCESS FOR GEOGRAPHIC**  
 2 **RECLASSIFICATION.**

3 (a) IN GENERAL.—The Secretary of Health and  
 4 Human Services may establish a procedure for the geo-  
 5 graphic reclassification of a skilled nursing facility for pur-  
 6 poses of payment for covered skilled nursing facility serv-  
 7 ices under the prospective payment system established  
 8 under section 1888(e) of the Social Security Act (42  
 9 U.S.C. 1395yy(e)). Such procedure may be based upon the  
 10 method for geographic reclassifications for inpatient hos-  
 11 pitals established under section 1886(d)(10) of the Social  
 12 Security Act (42 U.S.C. 1395ww(d)(10)).

13 (b) REQUIREMENT FOR SKILLED NURSING FACILITY  
 14 WAGE DATA.—In no case may the Secretary implement  
 15 the procedure under subsection (a) before such time as  
 16 the Secretary has collected data necessary to establish an  
 17 area wage index for skilled nursing facilities based on  
 18 wage data from such facilities.

19 **Subtitle C—Hospice Care**

20 **SEC. 321. FULL MARKET BASKET INCREASE FOR 2001 AND**  
 21 **2002.**

22 (a) IN GENERAL.—Section 1814(i)(1)(C)(ii) (42  
 23 U.S.C. 1395f(i)(1)(C)(ii)) is amended—

24 (1) by redesignating subclause (VII) as sub-  
 25 clause (VIII);

26 (2) in subclause (VI)—

1 (A) by striking “through 2002” and insert-  
2 ing “through 2000”; and

3 (B) by striking “and” at the end; and

4 (3) by inserting after subclause (VI) the fol-  
5 lowing new subclause:

6 “(VII) for each of fiscal years 2001 and 2002,  
7 the market basket percentage increase for the fiscal  
8 year; and”.

9 (b) TRANSITION DURING FISCAL YEAR 2001.—Not-  
10 withstanding the amendments made by subsection (a), for  
11 purposes of making payments for hospice care under sec-  
12 tion 1814(i) of the Social Security Act (42 U.S.C.  
13 1395f(i)) for fiscal year 2001, the payment rates referred  
14 to in paragraph (1)(C) of such section—

15 (1) for the period beginning on October 1,  
16 2000, and ending on March 31, 2001, shall be the  
17 rate determined in accordance with the law as in ef-  
18 fect on the day before the date of the enactment of  
19 this Act; and

20 (2) for the period beginning on April 1, 2001,  
21 and ending on September 30, 2001, shall be the rate  
22 that would have been determined under paragraph  
23 (1) if “plus 1.0 percentage points” were substituted  
24 for “minus 1.0 percentage points” under paragraph  
25 (1)(C)(ii)(VI) of such section for fiscal year 2001.

1 (c) CONFORMING AMENDMENTS TO BBRA.—

2 (1) IN GENERAL.—Section 131 of BBRA (113  
3 Stat. 1501A–333) is repealed.

4 (2) EFFECTIVE DATE.—The amendment made  
5 by paragraph (1) shall take effect as if included in  
6 the enactment of BBRA.

7 (d) TECHNICAL AMENDMENT.—Section  
8 1814(a)(7)(A)(ii) (42 U.S.C. 1395f(a)(7)(A)(ii)) is  
9 amended by striking the period at the end and inserting  
10 a semicolon.

11 **SEC. 322. CLARIFICATION OF PHYSICIAN CERTIFICATION.**

12 (a) CERTIFICATION BASED ON NORMAL COURSE OF  
13 ILLNESS.—

14 (1) IN GENERAL.—Section 1814(a) (42 U.S.C.  
15 1395f(a)) is amended by adding at the end the fol-  
16 lowing new sentence: “The certification regarding  
17 terminal illness of an individual under paragraph (7)  
18 shall be based on the physician’s or medical direc-  
19 tor’s clinical judgment regarding the normal course  
20 of the individual’s illness.”.

21 (2) EFFECTIVE DATE.—The amendment made  
22 by paragraph (1) applies to certifications made on or  
23 after the date of the enactment of this Act.

24 (b) STUDY AND REPORT ON PHYSICIAN CERTIFI-  
25 CATION REQUIREMENT FOR HOSPICE BENEFITS.—

1           (1) STUDY.—The Secretary of Health and  
2 Human Services shall conduct a study to examine  
3 the appropriateness of the certification regarding  
4 terminal illness of an individual under section  
5 1814(a)(7) of the Social Security Act (42 U.S.C.  
6 1395f(a)(7)) that is required in order for such indi-  
7 vidual to receive hospice benefits under the medicare  
8 program under title XVIII of such Act. In con-  
9 ducting such study, the Secretary shall take into ac-  
10 count the effect of the amendment made by sub-  
11 section (a).

12           (2) REPORT.—Not later than 2 years after the  
13 date of the enactment of this Act, the Secretary of  
14 Health and Human Services shall submit to Con-  
15 gress a report on the study conducted under para-  
16 graph (1), together with any recommendations for  
17 legislation that the Secretary deems appropriate.

18 **SEC. 323. MEDPAC REPORT ON ACCESS TO, AND USE OF,**  
19 **HOSPICE BENEFIT.**

20           (a) IN GENERAL.—The Medicare Payment Advisory  
21 Commission shall conduct a study to examine the factors  
22 affecting the use of hospice benefits under the medicare  
23 program under title XVIII of the Social Security Act, in-  
24 cluding a delay in the time (relative to death) of entry  
25 into a hospice program, and differences in such use be-

1 tween urban and rural hospice programs and based upon  
2 the presenting condition of the patient.

3 (b) REPORT.—Not later than 18 months after the  
4 date of the enactment of this Act, the Commission shall  
5 submit to Congress a report on the study conducted under  
6 subsection (a), together with any recommendations for leg-  
7 islation that the Commission deems appropriate.

## 8 **Subtitle D—Other Provisions**

### 9 **SEC. 331. RELIEF FROM MEDICARE PART A LATE ENROLL-** 10 **MENT PENALTY FOR GROUP BUY-IN FOR** 11 **STATE AND LOCAL RETIREES.**

12 (a) IN GENERAL.—Section 1818 (42 U.S.C. 1395i-  
13 2) is amended—

14 (1) in subsection (c)(6), by inserting before the  
15 semicolon at the end the following: “and shall be  
16 subject to reduction in accordance with subsection  
17 (d)(6)”;

18 (2) by adding at the end of subsection (d) the  
19 following new paragraph:

20 “(6)(A) In the case where a State, a political subdivi-  
21 sion of a State, or an agency or instrumentality of a State  
22 or political subdivision thereof determines to pay, for the  
23 life of each individual, the monthly premiums due under  
24 paragraph (1) on behalf of each of the individuals in a  
25 qualified State or local government retiree group who

1 meets the conditions of subsection (a), the amount of any  
2 increase otherwise applicable under section 1839(b) (as  
3 applied and modified by subsection (c)(6) of this section)  
4 with respect to the monthly premium for benefits under  
5 this part for an individual who is a member of such group  
6 shall be reduced by the total amount of taxes paid under  
7 section 3101(b) of the Internal Revenue Code of 1986 by  
8 such individual and under section 3111(b) by the employ-  
9 ers of such individual on behalf of such individual with  
10 respect to employment (as defined in section 3121(b) of  
11 such Code).

12 “(B) For purposes of this paragraph, the term ‘quali-  
13 fied State or local government retiree group’ means all of  
14 the individuals who retire prior to a specified date that  
15 is before January 1, 2002, from employment in 1 or more  
16 occupations or other broad classes of employees of—

17 “(i) the State;

18 “(ii) a political subdivision of the State; or

19 “(iii) an agency or instrumentality of the State  
20 or political subdivision of the State.”.

21 (b) EFFECTIVE DATE.—The amendments made by  
22 subsection (a) apply to premiums for months beginning  
23 with July 1, 2001.

1 **SEC. 332. HOSPITAL GEOGRAPHIC RECLASSIFICATION FOR**  
2 **LABOR COSTS FOR OTHER PPS SYSTEMS.**

3 (a) HOSPITAL GEOGRAPHIC RECLASSIFICATION FOR  
4 LABOR COSTS APPLICABLE TO OTHER PPS SYSTEMS.—

5 (1) IN GENERAL.—Notwithstanding the geo-  
6 graphic adjustment factor otherwise established  
7 under title XVIII of the Social Security Act for  
8 items and services paid under a prospective payment  
9 system described in paragraph (2), in the case of a  
10 hospital with an application that has been approved  
11 by the Medicare Geographic Classification Review  
12 Board under section 1886(d)(10)(C) of such Act (42  
13 U.S.C. 1395ww(d)(10)(C)) to change the hospital's  
14 geographic classification for a fiscal year for pur-  
15 poses of the factor used to adjust the prospective  
16 payment rate for area differences in hospital wage  
17 levels that applies to such hospital under section  
18 1886(d)(3)(E) of such Act, the Secretary shall sub-  
19 stitute such change in the hospital's geographic ad-  
20 justment that would otherwise be applied to an enti-  
21 ty or department of the hospital that is provider  
22 based to account for variations in costs which are at-  
23 tributable to wages and wage-related costs for items  
24 and services paid under the prospective payment sys-  
25 tems described in paragraph (2).

1           (2) PROSPECTIVE PAYMENT SYSTEMS COV-  
2           ERED.—For purposes of this section, items and serv-  
3           ices furnished under the following prospective pay-  
4           ment systems are covered:

5           (A) SNF PROSPECTIVE PAYMENT SYS-  
6           TEM.—The prospective payment system for cov-  
7           ered skilled nursing facility services under sec-  
8           tion 1888(e) of the Social Security Act (42  
9           U.S.C. 1395yy(e)).

10          (B) HOME HEALTH SERVICES PROSPEC-  
11          TIVE PAYMENT SYSTEM.—The prospective pay-  
12          ment system for home health services under  
13          section 1895(b) of such Act (42 U.S.C.  
14          1395fff(b)).

15          (C) INPATIENT REHABILITATION HOSPITAL  
16          SERVICES.—The prospective payment system  
17          for inpatient rehabilitation services under sec-  
18          tion 1888(j) of such Act (42 U.S.C.  
19          1395ww(j)).

20          (D) INPATIENT LONG-TERM CARE HOS-  
21          PITAL SERVICES.—The prospective payment  
22          system for inpatient hospital services of long-  
23          term care hospitals under section 123 of the  
24          BBRA.

1 (E) INPATIENT PSYCHIATRIC HOSPITAL  
2 SERVICES.—The prospective payment system  
3 for inpatient hospital services of psychiatric  
4 hospitals and units under section 124 of the  
5 BBRA.

6 (b) EFFECTIVE DATE.—Subsection (a) applies to fis-  
7 cal years beginning with fiscal year 2002.

8 **TITLE IV—PROVISIONS**  
9 **RELATING TO PART B**  
10 **Subtitle A—Hospital Outpatient**  
11 **Services**

12 **SEC. 401. REVISION OF HOSPITAL OUTPATIENT PPS PAY-**  
13 **MENT UPDATE.**

14 (a) IN GENERAL.—Section 1833(t)(3)(C)(iii) (42  
15 U.S.C. 1395l(t)(3)(C)(iii)) is amended by striking “in  
16 each of 2000, 2001, and 2002” and inserting “in each  
17 of 2000 and 2002”.

18 (b) ADJUSTMENT FOR CASE MIX CHANGES.—

19 (1) IN GENERAL.—Section 1833(t)(3)(C) (42  
20 U.S.C. 1395l(t)(3)(C)) is amended—

21 (A) by redesignating clause (iii) as clause  
22 (iv); and

23 (B) by inserting after clause (ii) the fol-  
24 lowing new clause:

1           “(iii) ADJUSTMENT FOR SERVICE MIX  
2           CHANGES.—Insofar as the Secretary deter-  
3           mines that the adjustments for service mix  
4           under paragraph (2) for a previous year  
5           (or estimates that such adjustments for a  
6           future year) did (or are likely to) result in  
7           a change in aggregate payments under this  
8           subsection during the year that are a re-  
9           sult of changes in the coding or classifica-  
10          tion of covered OPD services that do not  
11          reflect real changes in service mix, the Sec-  
12          retary may adjust the conversion factor  
13          computed under this subparagraph for  
14          subsequent years so as to eliminate the ef-  
15          fect of such coding or classification  
16          changes.”.

17           (2) EFFECTIVE DATE.—The amendments made  
18          by paragraph (1) shall take effect as if included in  
19          the enactment of BBA.

20 **SEC. 402. CLARIFYING PROCESS AND STANDARDS FOR DE-**  
21 **TERMINING ELIGIBILITY OF DEVICES FOR**  
22 **PASS-THROUGH PAYMENTS UNDER HOSPITAL**  
23 **OUTPATIENT PPS.**

24           (a) IN GENERAL.—Section 1833(t)(6) (42 U.S.C.  
25 1395l(t)(6)) is amended—

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

3           (2) by striking subparagraph (B) and inserting  
4           the following new subparagraphs:

5                   “(B) USE OF CATEGORIES IN DETER-  
6                   MINING ELIGIBILITY OF A DEVICE FOR PASS-  
7                   THROUGH PAYMENTS.—The following provi-  
8                   sions apply for purposes of determining whether  
9                   a medical device qualifies for additional pay-  
10                  ments under clause (ii) or (iv) of subparagraph  
11                  (A):

12                           “(i) ESTABLISHMENT OF INITIAL CAT-  
13                           EGORIES.—The Secretary shall initially es-  
14                           tablish under this clause categories of med-  
15                           ical devices based on type of device by  
16                           April 1, 2001. Such categories shall be es-  
17                           tablished in a manner such that each med-  
18                           ical device that meets the requirements of  
19                           clause (ii) or (iv) of subparagraph (A) as  
20                           of January 1, 2001, is included in such a  
21                           category and no such device is included in  
22                           more than one category. For purposes of  
23                           the preceding sentence, whether a medical  
24                           device meets such requirements as of such  
25                           date shall be determined on the basis of

1 the program memoranda issued before  
2 such date or if the Secretary determines  
3 the medical device would have been in-  
4 cluded in the program memoranda but for  
5 the requirement of subparagraph  
6 (A)(iv)(I). The categories may be estab-  
7 lished under this clause by program memo-  
8 randum or otherwise, after consultation  
9 with groups representing hospitals, manu-  
10 facturers of medical devices, and other af-  
11 fected parties.

12 “(ii) ESTABLISHING CRITERIA FOR  
13 ADDITIONAL CATEGORIES.—

14 “(I) IN GENERAL.—The Sec-  
15 retary shall establish criteria that will  
16 be used for creation of additional cat-  
17 egories (other than those established  
18 under clause (i)) through rulemaking  
19 (which may include use of an interim  
20 final rule with comment period).

21 “(II) STANDARD.—Such cat-  
22 egories shall be established under this  
23 clause in a manner such that no med-  
24 ical device is described by more than  
25 one category. Such criteria shall in-

1 include a test of whether the average  
2 cost of devices that would be included  
3 in a category and are in use at the  
4 time the category is established is not  
5 insignificant, as described in subpara-  
6 graph (A)(iv)(II).

7 “(III) DEADLINE.—Criteria shall  
8 first be established under this clause  
9 by July 1, 2001. The Secretary may  
10 establish in compelling circumstances  
11 categories under this clause before the  
12 date such criteria are established.

13 “(IV) ADDING CATEGORIES.—  
14 The Secretary shall promptly establish  
15 a new category of medical devices  
16 under this clause for any medical de-  
17 vice that meets the requirements of  
18 subparagraph (A)(iv) and for which  
19 none of the categories in effect (or  
20 that were previously in effect) is ap-  
21 propriate.

22 “(iii) PERIOD FOR WHICH CATEGORY  
23 IS IN EFFECT.—A category of medical de-  
24 vices established under clause (i) or clause  
25 (ii) shall be in effect for a period of at

1 least 2 years, but not more than 3 years,  
2 that begins—

3 “(I) in the case of a category es-  
4 tablished under clause (i), on the first  
5 date on which payment was made  
6 under this paragraph for any device  
7 described by such category (including  
8 payments made during the period be-  
9 fore April 1, 2001); and

10 “(II) in the case of any other  
11 category, on the first date on which  
12 payment is made under this para-  
13 graph for any medical device that is  
14 described by such category.

15 “(iv) REQUIREMENTS TREATED AS  
16 MET.—A medical device shall be treated as  
17 meeting the requirements of subparagraph  
18 (A)(iv) if—

19 “(I) the device is described by a  
20 category established and in effect  
21 under clause (i); or

22 “(II) the device is described by a  
23 category established and in effect  
24 under clause (ii) and an application  
25 under section 515 of the Federal

1 Food, Drug, and Cosmetic Act has  
2 been approved with respect to the de-  
3 vice, or the device has been cleared for  
4 market under section 510(k) of such  
5 Act, or the device is exempt from the  
6 requirements of section 510(k) of  
7 such Act pursuant to subsection (l) or  
8 (m) of section 510 of such Act or sec-  
9 tion 520(g) of such Act.

10 Nothing in this clause shall be construed  
11 as requiring an application or prior ap-  
12 proval (other than that described in sub-  
13 clause (II)) in order for a covered device to  
14 qualify for payment under this paragraph.

15 “(C) LIMITED PERIOD OF PAYMENT.—

16 “(i) DRUGS AND BIOLOGICALS.—The  
17 payment under this paragraph with respect  
18 to a drug or biological shall only apply dur-  
19 ing a period of at least 2 years, but not  
20 more than 3 years, that begins—

21 “(I) on the first date this sub-  
22 section is implemented in the case of  
23 a drug or biological described in  
24 clause (i), (ii), or (iii) of subparagraph  
25 (A) and in the case of a drug or bio-

1 logical described in subparagraph  
2 (A)(iv) and for which payment under  
3 this part is made as an outpatient  
4 hospital service before such first date;  
5 or

6 “(II) in the case of a drug or bio-  
7 logical described in subparagraph  
8 (A)(iv) not described in subclause (I),  
9 on the first date on which payment is  
10 made under this part for the drug or  
11 biological as an outpatient hospital  
12 service.

13 “(ii) MEDICAL DEVICES.—Payment  
14 shall be made under this paragraph with  
15 respect to a medical device only if such  
16 device—

17 “(I) is described by a category of  
18 medical devices established and in ef-  
19 fect under subparagraph (B); and

20 “(II) is provided as part of a  
21 service (or group of services) paid for  
22 under this subsection and provided  
23 during the period for which such cat-  
24 egory is in effect under such subpara-  
25 graph.”.

1 (b) CONFORMING AMENDMENTS.—Section 1833(t)  
2 (42 U.S.C. 1395l(t)) is further amended—

3 (1) in paragraph (6)(A)(iv)(II), by striking “the  
4 cost of the device, drug, or biological” and inserting  
5 “the cost of the drug or biological or the average  
6 cost of the category of devices”;

7 (2) in paragraph (6)(D) (as redesignated by  
8 subsection (a)(1)), by striking “subparagraph  
9 (D)(iii)” in the matter preceding clause (i) and in-  
10 serting “subparagraph (E)(iii)”; and

11 (3) in paragraph (12)(E), by striking “addi-  
12 tional payments (consistent with paragraph (6)(B))”  
13 and inserting “additional payments, the determina-  
14 tion and deletion of initial and new categories (con-  
15 sistent with subparagraphs (B) and (C) of para-  
16 graph (6))”.

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

20 (d) TRANSITION.—

21 (1) IN GENERAL.—In the case of a medical de-  
22 vice provided as part of a service (or group of serv-  
23 ices) furnished during the period before initial cat-  
24 egories are implemented under subparagraph (B)(i)  
25 of section 1833(t)(6) of the Social Security Act (as

1 amended by subsection (a)), payment shall be made  
2 for such device under such section in accordance  
3 with the provisions in effect before the date of the  
4 enactment of this Act, except that, beginning on the  
5 date that is 30 days after the date of the enactment  
6 of this Act, payment shall also be made for such a  
7 device that is not included in a program memo-  
8 randum described in such subparagraph if the Sec-  
9 retary of Health and Human Services determines  
10 that the device is likely to be described by such an  
11 initial category or would have been included in such  
12 program memoranda but for the requirement of sub-  
13 paragraph (A)(iv)(I) of that section.

14 (2) APPLICATION OF CURRENT PROCESS.—Not-  
15 withstanding any other provision of law, the Sec-  
16 retary shall continue to accept applications with re-  
17 spect to medical devices under the process estab-  
18 lished pursuant to paragraph (6) of section 1833(t)  
19 of the Social Security Act (as in effect on the day  
20 before the date of the enactment of this Act)  
21 through December 1, 2000, and any device—

22 (A) with respect to which an application  
23 was submitted (pursuant to such process) on or  
24 before such date; and

1 (B) that meets the requirements of clause  
2 (ii) or (iv) of subparagraph (A) of such para-  
3 graph (as determined pursuant to such proc-  
4 ess),  
5 shall be treated as a device with respect to which an  
6 initial category is required to be established under  
7 subparagraph (B)(i) of such paragraph (as amended  
8 by subsection (a)(2)).

9 **SEC. 403. APPLICATION OF OPD PPS TRANSITIONAL COR-**  
10 **RIDOR PAYMENTS TO CERTAIN HOSPITALS**  
11 **THAT DID NOT SUBMIT A 1996 COST REPORT.**

12 (a) IN GENERAL.—Section 1833(t)(7)(F)(ii)(I) (42  
13 U.S.C. 1395l(t)(7)(F)(ii)(I)) is amended by inserting “(or  
14 in the case of a hospital that did not submit a cost report  
15 for such period, during the first subsequent cost reporting  
16 period ending before 2001 for which the hospital sub-  
17 mitted a cost report)” after “1996”.

18 (b) EFFECTIVE DATE.—The amendment made by  
19 subsection (a) shall take effect as if included in the enact-  
20 ment of BBRA.

21 **SEC. 404. APPLICATION OF RULES FOR DETERMINING PRO-**  
22 **VIDER-BASED STATUS FOR CERTAIN ENTI-**  
23 **TIES.**

24 (a) GRANDFATHER.—Notwithstanding any other pro-  
25 vision of law, for purposes of making determinations of

1 provider-based status under title XVIII of the Social Secu-  
2 rity Act on or after October 1, 2000, any facility or organi-  
3 zation that is treated as provider-based in relation to a  
4 hospital or critical access hospital under such title as of  
5 October 1, 2000—

6 (1) shall continue to be treated as provider-  
7 based in relation to such hospital or critical access  
8 hospital under such title during the 2-year period  
9 beginning on October 1, 2000; and

10 (2) the requirements, limitations, and exclu-  
11 sions specified in paragraphs (d), (e), (f), and (h) of  
12 section 413.65 of title 42, Code of Federal Regula-  
13 tions shall not apply to such facility or organization  
14 in relation to such hospital or critical access hospital  
15 until after the end of such 2-year period.

16 (b) TEMPORARY CRITERIA.—For purposes of title  
17 XVIII of the Social Security Act—

18 (1) a facility or organization for which a deter-  
19 mination of provider-based status in relation to a  
20 hospital or critical access hospital is requested on or  
21 after October 1, 2000, and before October 1, 2002,  
22 may not be treated as not having provider-based sta-  
23 tus in relation to such a hospital for any period be-  
24 fore a determination is made with respect to such  
25 status pursuant to such request; and

1           (2) in making a determination with respect to  
2 such status for any facility or organization in rela-  
3 tionship to such a hospital on or after October 1,  
4 2000, the following rules apply:

5           (A) The facility or organization shall be  
6 treated as satisfying any requirements and  
7 standards for geographic location in relation to  
8 such a hospital if the facility or organization—

9           (i) satisfies the requirements of sec-  
10 tion 413.65(d)(7) of title 42, Code of Fed-  
11 eral Regulations; or

12           (ii) is located not more than 35 miles  
13 from the main campus of the hospital or  
14 critical access hospital.

15           (B) The facility or organization shall be  
16 treated as satisfying any of the requirements  
17 and standards for geographic location in rela-  
18 tion to such a hospital if the facility or organi-  
19 zation is owned and operated by a hospital or  
20 critical access hospital that—

21           (i) is owned or operated by a unit of  
22 State or local government, is a public or  
23 private nonprofit corporation that is for-  
24 mally granted governmental powers by a  
25 unit of State or local government, or is a

1 private hospital that has a contract with a  
2 State or local government that includes the  
3 operation of clinics located off the main  
4 campus of the hospital to assure access in  
5 a well-defined service area to health care  
6 services for low-income individuals who are  
7 not entitled to benefits under title XVIII  
8 (or medical assistance under a State plan  
9 under title XIX) of such Act; and

10 (ii) has a disproportionate share ad-  
11 justment percentage (as determined under  
12 section 1886(d)(5)(F) of such Act (42  
13 U.S.C. 1395ww(d)(5)(F))) greater than  
14 11.75 percent or is described in clause  
15 (i)(II) of such section.

16 (c) DEFINITIONS.—For purposes of this section, the  
17 terms “hospital” and “critical access hospital” have the  
18 meanings given such terms in subsections (e) and  
19 (mm)(1), respectively, of section 1861 of the Social Secu-  
20 rity Act (42 U.S.C. 1395x).

21 **SEC. 405. TREATMENT OF CHILDREN’S HOSPITALS UNDER**  
22 **PROSPECTIVE PAYMENT SYSTEM.**

23 (a) IN GENERAL.—Section 1833(t) (42 U.S.C.  
24 1395l(t)) is amended—

1 (1) in the heading of paragraph (7)(D)(ii), by  
2 inserting “AND CHILDREN’S HOSPITALS” after “CAN-  
3 CER HOSPITALS”; and

4 (2) in paragraphs (7)(D)(ii) and (11), by strik-  
5 ing “section 1886(d)(1)(B)(v)” and inserting  
6 “clause (iii) or (v) of section 1886(d)(1)(B)”.

7 (b) EFFECTIVE DATE.—The amendments made by  
8 subsection (a) apply as if included in the enactment of  
9 section 202 of BBRA (113 Stat. 1501A–342).

10 **SEC. 406. INCLUSION OF TEMPERATURE MONITORED**  
11 **CRYOABLATION IN TRANSITIONAL PASS-**  
12 **THROUGH FOR CERTAIN MEDICAL DEVICES,**  
13 **DRUGS, AND BIOLOGICALS UNDER OPD PPS.**

14 (a) IN GENERAL.—Section 1833(t)(6)(A)(ii) (42  
15 U.S.C. 1395l(t)(6)(A)(ii)) is amended by inserting “or  
16 temperature monitored cryoablation” after “device of  
17 brachytherapy”.

18 (b) EFFECTIVE DATE.—The amendment made by  
19 subsection (a) applies to devices furnished on or after  
20 April 1, 2001.

1     **Subtitle B—Provisions Relating to**  
2                     **Physicians’ Services**

3     **SEC. 411. GAO STUDIES RELATING TO PHYSICIANS’ SERV-**  
4                     **ICES.**

5             (a) STUDY OF SPECIALIST PHYSICIANS’ SERVICES  
6 FURNISHED IN PHYSICIANS’ OFFICES AND HOSPITAL  
7 OUTPATIENT DEPARTMENT SERVICES.—

8                     (1) STUDY.—The Comptroller General of the  
9 United States shall conduct a study to examine the  
10 appropriateness of furnishing in physicians’ offices  
11 specialist physicians’ services (such as gastro-  
12 intestinal endoscopic physicians’ services) which are  
13 ordinarily furnished in hospital outpatient depart-  
14 ments. In conducting this study, the Comptroller  
15 General shall—

16                             (A) review available scientific and clinical  
17 evidence about the safety of performing proce-  
18 dures in physicians’ offices and hospital out-  
19 patient departments;

20                             (B) assess whether resource-based practice  
21 expense relative values established by the Sec-  
22 retary of Health and Human Services under the  
23 medicare physician fee schedule under section  
24 1848 of the Social Security Act (42 U.S.C.  
25 1395w-4) for such specialist physicians’ serv-

1           ices furnished in physicians' offices and hospital  
2           outpatient departments create an incentive to  
3           furnish such services in physicians' offices in-  
4           stead of hospital outpatient departments; and

5                   (C) assess the implications for access to  
6           care for medicare beneficiaries if the medicare  
7           program were not to cover such services in phy-  
8           sicians' offices.

9           (2) REPORT.—Not later than July 1, 2001, the  
10          Comptroller General shall submit to Congress a re-  
11          port on such study and include such recommenda-  
12          tions as the Comptroller General determines to be  
13          appropriate.

14          (b) STUDY OF THE RESOURCE-BASED PRACTICE EX-  
15          PENSE SYSTEM.—

16                   (1) STUDY.—The Comptroller General of the  
17          United States shall conduct a study on the refine-  
18          ments to the practice expense relative value units  
19          during the transition to a resource-based practice ex-  
20          pense system for physician payments under the  
21          medicare program under title XVIII of the Social  
22          Security Act. Such study shall examine how the Sec-  
23          retary of Health and Human Services has accepted  
24          and used the practice expense data submitted under  
25          section 212 of BBRA (113 Stat. 1501A–350).

1           (2) REPORT.—Not later than July 1, 2001, the  
2           Comptroller General shall submit to Congress a re-  
3           port on the study conducted under paragraph (1) to-  
4           gether with recommendations regarding—

5                   (A) improvements in the process for ac-  
6                   ceptance and use of practice expense data  
7                   under section 212 of BBRA;

8                   (B) any change or adjustment that is ap-  
9                   propriate to ensure full access to a spectrum of  
10                  care for beneficiaries under the medicare pro-  
11                  gram; and

12                  (C) the appropriateness of payments to  
13                  physicians.

14 **SEC. 412. PHYSICIAN GROUP PRACTICE DEMONSTRATION.**

15           (a) IN GENERAL.—Title XVIII is amended by insert-  
16           ing after section 1866 the following new sections:

17           “DEMONSTRATION OF APPLICATION OF PHYSICIAN  
18           VOLUME INCREASES TO GROUP PRACTICES

19           “SEC. 1866A. (a) DEMONSTRATION PROGRAM AU-  
20           THORIZED.—

21                   “(1) IN GENERAL.—The Secretary shall con-  
22                   duct demonstration projects to test and, if proven ef-  
23                   fective, expand the use of incentives to health care  
24                   groups participating in the program under this title  
25                   that—

1           “(A) encourage coordination of the care  
2           furnished to individuals under the programs  
3           under parts A and B by institutional and other  
4           providers, practitioners, and suppliers of health  
5           care items and services;

6           “(B) encourage investment in administra-  
7           tive structures and processes to ensure efficient  
8           service delivery; and

9           “(C) reward physicians for improving  
10          health outcomes.

11          Such projects shall focus on the efficiencies of fur-  
12          nishing health care in a group-practice setting as  
13          compared to the efficiencies of furnishing health care  
14          in other health care delivery systems.

15          “(2) ADMINISTRATION BY CONTRACT.—Except  
16          as otherwise specifically provided, the Secretary may  
17          administer the program under this section in accord-  
18          ance with section 1866B.

19          “(3) DEFINITIONS.—For purposes of this sec-  
20          tion, terms have the following meanings:

21                 “(A) PHYSICIAN.—Except as the Secretary  
22                 may otherwise provide, the term ‘physician’  
23                 means any individual who furnishes services  
24                 which may be paid for as physicians’ services  
25                 under this title.

1           “(B) HEALTH CARE GROUP.—The term  
2           ‘health care group’ means a group of physicians  
3           (as defined in subparagraph (A)) organized at  
4           least in part for the purpose of providing physi-  
5           cians’ services under this title. As the Secretary  
6           finds appropriate, a health care group may in-  
7           clude a hospital and any other individual or en-  
8           tity furnishing items or services for which pay-  
9           ment may be made under this title that is affili-  
10          ated with the health care group under an ar-  
11          rangement structured so that such individual or  
12          entity participates in a demonstration under  
13          this section and will share in any bonus earned  
14          under subsection (d).

15          “(b) ELIGIBILITY CRITERIA.—

16               “(1) IN GENERAL.—The Secretary is authorized  
17               to establish criteria for health care groups eligible to  
18               participate in a demonstration under this section, in-  
19               cluding criteria relating to numbers of health care  
20               professionals in, and of patients served by, the  
21               group, scope of services provided, and quality of  
22               care.

23               “(2) PAYMENT METHOD.—A health care group  
24               participating in the demonstration under this section  
25               shall agree with respect to services furnished to

1 beneficiaries within the scope of the demonstration  
2 (as determined under subsection (c))—

3 “(A) to be paid on a fee-for-service basis;  
4 and

5 “(B) that payment with respect to all such  
6 services furnished by members of the health  
7 care group to such beneficiaries shall (where de-  
8 termined appropriate by the Secretary) be made  
9 to a single entity.

10 “(3) DATA REPORTING.—A health care group  
11 participating in a demonstration under this section  
12 shall report to the Secretary such data, at such  
13 times and in such format as the Secretary requires,  
14 for purposes of monitoring and evaluation of the  
15 demonstration under this section.

16 “(c) PATIENTS WITHIN SCOPE OF DEMONSTRATION.—  
17

18 “(1) IN GENERAL.—The Secretary shall specify,  
19 in accordance with this subsection, the criteria for  
20 identifying those patients of a health care group who  
21 shall be considered within the scope of the dem-  
22 onstration under this section for purposes of applica-  
23 tion of subsection (d) and for assessment of the ef-  
24 fectiveness of the group in achieving the objectives  
25 of this section.

1           “(2) OTHER CRITERIA.—The Secretary may es-  
2           tablish additional criteria for inclusion of bene-  
3           ficiaries within a demonstration under this section,  
4           which may include frequency of contact with physi-  
5           cians in the group or other factors or criteria that  
6           the Secretary finds to be appropriate.

7           “(3) NOTICE REQUIREMENTS.—In the case of  
8           each beneficiary determined to be within the scope  
9           of a demonstration under this section with respect to  
10          a specific health care group, the Secretary shall en-  
11          sure that such beneficiary is notified of the incen-  
12          tives, and of any waivers of coverage or payment  
13          rules, applicable to such group under such dem-  
14          onstration.

15          “(d) INCENTIVES.—

16                 “(1) PERFORMANCE TARGET.—The Secretary  
17                 shall establish for each health care group partici-  
18                 pating in a demonstration under this section—

19                         “(A) a base expenditure amount, equal to  
20                         the average total payments under parts A and  
21                         B for patients served by the health care group  
22                         on a fee-for-service basis in a base period deter-  
23                         mined by the Secretary; and

24                         “(B) an annual per capita expenditure tar-  
25                         get for patients determined to be within the

1 scope of the demonstration, reflecting the base  
2 expenditure amount adjusted for risk and ex-  
3 pected growth rates.

4 “(2) INCENTIVE BONUS.—The Secretary shall  
5 pay to each participating health care group (subject  
6 to paragraph (4)) a bonus for each year under the  
7 demonstration equal to a portion of the medicare  
8 savings realized for such year relative to the per-  
9 formance target.

10 “(3) ADDITIONAL BONUS FOR PROCESS AND  
11 OUTCOME IMPROVEMENTS.—At such time as the  
12 Secretary has established appropriate criteria based  
13 on evidence the Secretary determines to be suffi-  
14 cient, the Secretary shall also pay to a participating  
15 health care group (subject to paragraph (4)) an ad-  
16 ditional bonus for a year, equal to such portion as  
17 the Secretary may designate of the saving to the  
18 program under this title resulting from process im-  
19 provements made by and patient outcome improve-  
20 ments attributable to activities of the group.

21 “(4) LIMITATION.—The Secretary shall limit  
22 bonus payments under this section as necessary to  
23 ensure that the aggregate expenditures under this  
24 title (inclusive of bonus payments) with respect to  
25 patients within the scope of the demonstration do

1 not exceed the amount which the Secretary esti-  
2 mates would be expended if the demonstration  
3 projects under this section were not implemented.

4 “PROVISIONS FOR ADMINISTRATION OF DEMONSTRATION  
5 PROGRAM

6 “SEC. 1866B. (a) GENERAL ADMINISTRATIVE AU-  
7 THORITY.—

8 “(1) BENEFICIARY ELIGIBILITY.—Except as  
9 otherwise provided by the Secretary, an individual  
10 shall only be eligible to receive benefits under the  
11 program under section 1866A (in this section re-  
12 ferred to as the ‘demonstration program’) if such  
13 individual—

14 “(A) is enrolled in under the program  
15 under part B and entitled to benefits under  
16 part A; and

17 “(B) is not enrolled in a Medicare+Choice  
18 plan under part C, an eligible organization  
19 under a contract under section 1876 (or a simi-  
20 lar organization operating under a demonstra-  
21 tion project authority), an organization with an  
22 agreement under section 1833(a)(1)(A), or a  
23 PACE program under section 1894.

24 “(2) SECRETARY’S DISCRETION AS TO SCOPE  
25 OF PROGRAM.—The Secretary may limit the imple-  
26 mentation of the demonstration program to—

1           “(A) a geographic area (or areas) that the  
2           Secretary designates for purposes of the pro-  
3           gram, based upon such criteria as the Secretary  
4           finds appropriate;

5           “(B) a subgroup (or subgroups) of bene-  
6           ficiaries or individuals and entities furnishing  
7           items or services (otherwise eligible to partici-  
8           pate in the program), selected on the basis of  
9           the number of such participants that the Sec-  
10          retary finds consistent with the effective and ef-  
11          ficient implementation of the program;

12          “(C) an element (or elements) of the pro-  
13          gram that the Secretary determines to be suit-  
14          able for implementation; or

15          “(D) any combination of any of the limits  
16          described in subparagraphs (A) through (C).

17          “(3) VOLUNTARY RECEIPT OF ITEMS AND  
18          SERVICES.—Items and services shall be furnished to  
19          an individual under the demonstration program only  
20          at the individual’s election.

21          “(4) AGREEMENTS.—The Secretary is author-  
22          ized to enter into agreements with individuals and  
23          entities to furnish health care items and services to  
24          beneficiaries under the demonstration program.

1           “(5) PROGRAM STANDARDS AND CRITERIA.—  
2           The Secretary shall establish performance standards  
3           for the demonstration program including, as applica-  
4           ble, standards for quality of health care items and  
5           services, cost-effectiveness, beneficiary satisfaction,  
6           and such other factors as the Secretary finds appro-  
7           priate. The eligibility of individuals or entities for  
8           the initial award, continuation, and renewal of  
9           agreements to provide health care items and services  
10          under the program shall be conditioned, at a min-  
11          imum, on performance that meets or exceeds such  
12          standards.

13           “(6) ADMINISTRATIVE REVIEW OF DECISIONS  
14          AFFECTING INDIVIDUALS AND ENTITIES FUR-  
15          NISHING SERVICES.—An individual or entity fur-  
16          nishing services under the demonstration program  
17          shall be entitled to a review by the program adminis-  
18          trator (or, if the Secretary has not contracted with  
19          a program administrator, by the Secretary) of a de-  
20          cision not to enter into, or to terminate, or not to  
21          renew, an agreement with the entity to provide  
22          health care items or services under the program.

23           “(7) SECRETARY’S REVIEW OF MARKETING MA-  
24          TERIALS.—An agreement with an individual or enti-  
25          ty furnishing services under the demonstration pro-

1       gram shall require the individual or entity to guar-  
2       antee that it will not distribute materials that mar-  
3       ket items or services under the program without the  
4       Secretary's prior review and approval.

5               “(8) PAYMENT IN FULL.—

6                       “(A) IN GENERAL.—Except as provided in  
7                       subparagraph (B), an individual or entity re-  
8                       ceiving payment from the Secretary under a  
9                       contract or agreement under the demonstration  
10                      program shall agree to accept such payment as  
11                      payment in full, and such payment shall be in  
12                      lieu of any payments to which the individual or  
13                      entity would otherwise be entitled under this  
14                      title.

15                     “(B) COLLECTION OF DEDUCTIBLES AND  
16                     COINSURANCE.—Such individual or entity may  
17                     collect any applicable deductible or coinsurance  
18                     amount from a beneficiary.

19               “(b) CONTRACTS FOR PROGRAM ADMINISTRATION.—

20                       “(1) IN GENERAL.—The Secretary may admin-  
21                       ister the demonstration program through a contract  
22                       with a program administrator in accordance with the  
23                       provisions of this subsection.

24                       “(2) SCOPE OF PROGRAM ADMINISTRATOR CON-  
25                       TRACTS.—The Secretary may enter into such con-

1 tracts for a limited geographic area, or on a regional  
2 or national basis.

3 “(3) ELIGIBLE CONTRACTORS.—The Secretary  
4 may contract for the administration of the program  
5 with—

6 “(A) an entity that, under a contract  
7 under section 1816 or 1842, determines the  
8 amount of and makes payments for health care  
9 items and services furnished under this title; or

10 “(B) any other entity with substantial ex-  
11 perience in managing the type of program con-  
12 cerned.

13 “(4) CONTRACT AWARD, DURATION, AND RE-  
14 NEWAL.—

15 “(A) IN GENERAL.—A contract under this  
16 subsection shall be for an initial term of up to  
17 three years, renewable for additional terms of  
18 up to three years.

19 “(B) NONCOMPETITIVE AWARD AND RE-  
20 NEWAL FOR ENTITIES ADMINISTERING PART A  
21 OR PART B PAYMENTS.—The Secretary may  
22 enter or renew a contract under this subsection  
23 with an entity described in paragraph (3)(A)  
24 without regard to the requirements of section 5  
25 of title 41, United States Code.

1           “(5) APPLICABILITY OF FEDERAL ACQUISITION  
2 REGULATION.—The Federal Acquisition Regulation  
3 shall apply to program administration contracts  
4 under this subsection.

5           “(6) PERFORMANCE STANDARDS.—The Sec-  
6 retary shall establish performance standards for the  
7 program administrator including, as applicable,  
8 standards for the quality and cost-effectiveness of  
9 the program administered, and such other factors as  
10 the Secretary finds appropriate. The eligibility of en-  
11 tities for the initial award, continuation, and renewal  
12 of program administration contracts shall be condi-  
13 tioned, at a minimum, on performance that meets or  
14 exceeds such standards.

15           “(7) FUNCTIONS OF PROGRAM ADMINIS-  
16 TRATOR.—A program administrator shall perform  
17 any or all of the following functions, as specified by  
18 the Secretary:

19           “(A) AGREEMENTS WITH ENTITIES FUR-  
20 NISHING HEALTH CARE ITEMS AND SERV-  
21 ICES.—Determine the qualifications of entities  
22 seeking to enter or renew agreements to provide  
23 services under the demonstration program, and  
24 as appropriate enter or renew (or refuse to

1 enter or renew) such agreements on behalf of  
2 the Secretary.

3 “(B) ESTABLISHMENT OF PAYMENT  
4 RATES.—Negotiate or otherwise establish, sub-  
5 ject to the Secretary’s approval, payment rates  
6 for covered health care items and services.

7 “(C) PAYMENT OF CLAIMS OR FEES.—Ad-  
8 minister payments for health care items or serv-  
9 ices furnished under the program.

10 “(D) PAYMENT OF BONUSES.—Using such  
11 guidelines as the Secretary shall establish, and  
12 subject to the approval of the Secretary, make  
13 bonus payments as described in subsection  
14 (c)(2)(A)(ii) to entities furnishing items or serv-  
15 ices for which payment may be made under the  
16 program.

17 “(E) OVERSIGHT.—Monitor the compli-  
18 ance of individuals and entities with agreements  
19 under the program with the conditions of par-  
20 ticipation.

21 “(F) ADMINISTRATIVE REVIEW.—Conduct  
22 reviews of adverse determinations specified in  
23 subsection (a)(6).

24 “(G) REVIEW OF MARKETING MATE-  
25 RIALS.—Conduct a review of marketing mate-

1           rials proposed by an entity furnishing services  
2           under the program.

3           “(H) ADDITIONAL FUNCTIONS.—Perform  
4           such other functions as the Secretary may  
5           specify.

6           “(8) LIMITATION OF LIABILITY.—The provi-  
7           sions of section 1157(b) shall apply with respect to  
8           activities of contractors and their officers, employ-  
9           ees, and agents under a contract under this sub-  
10          section.

11          “(9) INFORMATION SHARING.—Notwithstanding  
12          section 1106 and section 552a of title 5, United  
13          States Code, the Secretary is authorized to disclose  
14          to an entity with a program administration contract  
15          under this subsection such information (including  
16          medical information) on individuals receiving health  
17          care items and services under the program as the  
18          entity may require to carry out its responsibilities  
19          under the contract.

20          “(c) RULES APPLICABLE TO BOTH PROGRAM  
21          AGREEMENTS AND PROGRAM ADMINISTRATION CON-  
22          TRACTS.—

23          “(1) RECORDS, REPORTS, AND AUDITS.—The  
24          Secretary is authorized to require entities with  
25          agreements to provide health care items or services

1 under the demonstration program, and entities with  
2 program administration contracts under subsection  
3 (b), to maintain adequate records, to afford the Sec-  
4 retary access to such records (including for audit  
5 purposes), and to furnish such reports and other  
6 materials (including audited financial statements  
7 and performance data) as the Secretary may require  
8 for purposes of implementation, oversight, and eval-  
9 uation of the program and of individuals' and enti-  
10 ties' effectiveness in performance of such agreements  
11 or contracts.

12 “(2) BONUSES.—Notwithstanding any other  
13 provision of law, but subject to subparagraph  
14 (B)(ii), the Secretary may make bonus payments  
15 under the demonstration program from the Federal  
16 Health Insurance Trust Fund and the Federal Sup-  
17 plementary Medical Insurance Trust Fund in  
18 amounts that do not exceed the amounts authorized  
19 under the program in accordance with the following:

20 “(A) PAYMENTS TO PROGRAM ADMINIS-  
21 TRATORS.—The Secretary may make bonus  
22 payments under the program to program ad-  
23 ministrators.

24 “(B) PAYMENTS TO ENTITIES FURNISHING  
25 SERVICES.—

1                   “(i) IN GENERAL.—Subject to clause  
2                   (ii), the Secretary may make bonus pay-  
3                   ments to individuals or entities furnishing  
4                   items or services for which payment may  
5                   be made under the demonstration pro-  
6                   gram, or may authorize the program ad-  
7                   ministrator to make such bonus payments  
8                   in accordance with such guidelines as the  
9                   Secretary shall establish and subject to the  
10                  Secretary’s approval.

11                  “(ii) LIMITATIONS.—The Secretary  
12                  may condition such payments on the  
13                  achievement of such standards related to  
14                  efficiency, improvement in processes or  
15                  outcomes of care, or such other factors as  
16                  the Secretary determines to be appropriate.

17                  “(3) ANTIDISCRIMINATION LIMITATION.—The  
18                  Secretary shall not enter into an agreement with an  
19                  entity to provide health care items or services under  
20                  the demonstration program, or with an entity to ad-  
21                  minister the program, unless such entity guarantees  
22                  that it will not deny, limit, or condition the coverage  
23                  or provision of benefits under the program, for indi-  
24                  viduals eligible to be enrolled under such program,  
25                  based on any health status-related factor described

1 in section 2702(a)(1) of the Public Health Service  
2 Act.

3 “(d) LIMITATIONS ON JUDICIAL REVIEW.—The fol-  
4 lowing actions and determinations with respect to the  
5 demonstration program shall not be subject to review by  
6 a judicial or administrative tribunal:

7 “(1) Limiting the implementation of the pro-  
8 gram under subsection (a)(2).

9 “(2) Establishment of program participation  
10 standards under subsection (a)(5) or the denial or  
11 termination of, or refusal to renew, an agreement  
12 with an entity to provide health care items and serv-  
13 ices under the program.

14 “(3) Establishment of program administration  
15 contract performance standards under subsection  
16 (b)(6), the refusal to renew a program administra-  
17 tion contract, or the noncompetitive award or re-  
18 newal of a program administration contract under  
19 subsection (b)(4)(B).

20 “(5) Establishment of payment rates, through  
21 negotiation or otherwise, under a program agree-  
22 ment or a program administration contract.

23 “(6) A determination with respect to the pro-  
24 gram (where specifically authorized by the program  
25 authority or by subsection (c)(2))—

1           “(A) as to whether cost savings have been  
2           achieved, and the amount of savings; or

3           “(B) as to whether, to whom, and in what  
4           amounts bonuses will be paid.

5           “(e) APPLICATION LIMITED TO PARTS A AND B.—  
6 None of the provisions of this section or of the demonstra-  
7 tion program shall apply to the programs under part C.

8           “(f) REPORTS TO CONGRESS.—Not later than two  
9 years after the date of the enactment of this section, and  
10 biennially thereafter for six years, the Secretary shall re-  
11 port to Congress on the use of authorities under the dem-  
12 onstration program. Each report shall address the impact  
13 of the use of those authorities on expenditures, access, and  
14 quality under the programs under this title.”.

15           (b) GAO REPORT.—Not later than 2 years after the  
16 date on which the demonstration project under section  
17 1866A of the Social Security Act, as added by subsection  
18 (a), is implemented, the Comptroller General of the United  
19 States shall submit to Congress a report on such dem-  
20 onstration project. The report shall include such rec-  
21 ommendations with respect to changes to the demonstra-  
22 tion project that the Comptroller General determines ap-  
23 propriate.

1 **SEC. 413. STUDY ON ENROLLMENT PROCEDURES FOR**  
2 **GROUPS THAT RETAIN INDEPENDENT CON-**  
3 **TRACTOR PHYSICIANS.**

4 (a) **IN GENERAL.**—The Comptroller General of the  
5 United States shall conduct a study of the current medi-  
6 care enrollment process for groups that retain independent  
7 contractor physicians with particular emphasis on hos-  
8 pital-based physicians, such as emergency department  
9 staffing groups. In conducting the evaluation, the Comp-  
10 troller General shall consult with groups that retain inde-  
11 pendent contractor physicians and shall—

12 (1) review the issuance of individual medicare  
13 provider numbers and the possible medicare program  
14 integrity vulnerabilities of the current process;

15 (2) review direct and indirect costs associated  
16 with the current process incurred by the medicare  
17 program and groups that retain independent con-  
18 tractor physicians;

19 (3) assess the effect on program integrity by  
20 the enrollment of groups that retain independent  
21 contractor hospital-based physicians; and

22 (4) develop suggested procedures for the enroll-  
23 ment of these groups.

24 (b) **REPORT.**—Not later than 1 year after the date  
25 of the enactment of this Act, the Comptroller General shall

1 submit to Congress a report on the study conducted under  
 2 subsection (a).

### 3 **Subtitle C—Other Services**

#### 4 **SEC. 421. 1-YEAR EXTENSION OF MORATORIUM ON THER-** 5 **APY CAPS; REPORT ON STANDARDS FOR SU-** 6 **PERVISION OF PHYSICAL THERAPY ASSIST-** 7 **ANTS.**

8 (a) IN GENERAL.—Section 1833(g)(4) (42 U.S.C.  
 9 1395l(g)(4)) is amended by striking “2000 and 2001.”  
 10 and inserting “2000, 2001, and 2002.”

11 (b) CONFORMING AMENDMENT TO CONTINUE FO-  
 12 CUSED MEDICAL REVIEWS OF CLAIMS DURING MORATO-  
 13 RIUM PERIOD.—Section 221(a)(2) of BBRA (113 Stat.  
 14 1501A–351) is amended by striking “(under the amend-  
 15 ment made by paragraph (1)(B))”.

16 (c) STUDY ON STANDARDS FOR SUPERVISION OF  
 17 PHYSICAL THERAPIST ASSISTANTS.—

18 (1) STUDY.—The Secretary of Health and  
 19 Human Services shall conduct a study of the  
 20 implications—

21 (A) of eliminating the “in the room” su-  
 22 pervision requirement for medicare payment for  
 23 services of physical therapy assistants who are  
 24 supervised by physical therapists; and

1 (B) of such requirement on the cap im-  
2 posed under section 1833(g) of the Social Secu-  
3 rity Act (42 U.S.C. 1395l(g)) on physical ther-  
4 apy services.

5 (2) REPORT.—Not later than 18 months after  
6 the date of the enactment of this Act, the Secretary  
7 shall submit to Congress a report on the study con-  
8 ducted under paragraph (1).

9 **SEC. 422. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.**

10 (a) UPDATE.—

11 (1) IN GENERAL.—The last sentence of section  
12 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by  
13 striking “for such services furnished on or after  
14 January 1, 2001, by 1.2 percent” and inserting “for  
15 such services furnished on or after January 1, 2001,  
16 by 2.4 percent”.

17 (2) PROHIBITION ON EXEMPTIONS.—

18 (A) IN GENERAL.—Subject to subpara-  
19 graph (B), the Secretary of Health and Human  
20 Services may not provide for an exception under  
21 section 1881(b)(7) of the Social Security Act  
22 (42 U.S.C. 1395rr(b)(7)) on or after December  
23 31, 2000.

24 (B) SPECIAL RULES FOR 2000.—

1 (i) IN GENERAL.—Any exemption rate  
2 under such section 1881(b)(7) in effect on  
3 December 31, 2000, shall continue in ef-  
4 fect so long as such rate is greater than  
5 the composite rate as updated by the  
6 amendment made by paragraph (1).

7 (ii) RESUBMISSION OF CERTAIN AP-  
8 PPLICATIONS.—In the case of an application  
9 for an exemption rate under such section  
10 that was filed by a facility during 2000  
11 that was not approved by the Secretary of  
12 Health and Human Services, the facility  
13 may submit an application for an exemp-  
14 tion rate for that year by not later than  
15 July 1, 2001.

16 (b) DEVELOPMENT OF ESRD MARKET BASKET.—

17 (1) DEVELOPMENT.—The Secretary of Health  
18 and Human Services shall collect data and develop  
19 an ESRD market basket whereby the Secretary can  
20 estimate, before the beginning of a year, the percent-  
21 age by which the costs for the year of the mix of  
22 labor and nonlabor goods and services included in  
23 the ESRD composite rate under section 1881(b)(7)  
24 of the Social Security Act (42 U.S.C. 1395rr(b)(7))  
25 will exceed the costs of such mix of goods and serv-

1 ices for the preceding year. In developing such index,  
2 the Secretary may take into account measures of  
3 changes in—

4 (A) technology used in furnishing dialysis  
5 services;

6 (B) the manner or method of furnishing  
7 dialysis services; and

8 (C) the amounts by which the payments  
9 under such section for all services billed by a  
10 facility for a year exceed the aggregate allow-  
11 able audited costs of such services for such fa-  
12 cility for such year.

13 (2) REPORT.—The Secretary of Health and  
14 Human Services shall submit to Congress a report  
15 on the index developed under paragraph (1) no later  
16 than July 1, 2002, and shall include in the report  
17 recommendations on the appropriateness of an an-  
18 nual or periodic update mechanism for renal dialysis  
19 services under the medicare program under title  
20 XVIII of the Social Security Act based on such  
21 index.

22 (c) INCLUSION OF ADDITIONAL SERVICES IN COM-  
23 POSITE RATE.—

24 (1) DEVELOPMENT.—The Secretary of Health  
25 and Human Services shall develop a system which

1 includes, to the maximum extent feasible, in the  
2 composite rate used for payment under section  
3 1881(b)(7) of the Social Security Act (42 U.S.C.  
4 1395rr(b)(7)), payment for clinical diagnostic lab-  
5 oratory tests and drugs (including drugs paid under  
6 section 1881(b)(11)(B) of such Act (42 U.S.C.  
7 1395rr(b)(11)(B)) that are routinely used in fur-  
8 nishing dialysis services to medicare beneficiaries but  
9 which are currently separately billable by renal dialy-  
10 sis facilities.

11 (2) REPORT.—The Secretary shall include, as  
12 part of the report submitted under subsection (b)(2),  
13 a report on the system developed under paragraph  
14 (1) and recommendations on the appropriateness of  
15 incorporating the system into medicare payment for  
16 renal dialysis services.

17 (d) GAO STUDY ON ACCESS TO SERVICES.—

18 (1) STUDY.—The Comptroller General of the  
19 United States shall study access of medicare bene-  
20 ficiaries to renal dialysis services. Such study shall  
21 include whether there is a sufficient supply of facili-  
22 ties to furnish needed renal dialysis services, whether  
23 medicare payment levels are appropriate, taking into  
24 account audited costs of facilities for all services fur-  
25 nished, to ensure continued access to such services,

1 and improvements in access (and quality of care)  
2 that may result in the increased use of long nightly  
3 and short daily hemodialysis modalities.

4 (2) REPORT.—Not later than January 1, 2003,  
5 the Comptroller General shall submit to Congress a  
6 report on the study conducted under paragraph (1).

7 **SEC. 423. PAYMENT FOR AMBULANCE SERVICES.**

8 (a) RESTORATION OF FULL CPI INCREASE FOR  
9 2001.—Section 1834(l)(3) (42 U.S.C. 1395m(l)(3)) is  
10 amended by striking “reduced in the case of 2001 and  
11 2002” each place it appears and inserting “reduced in the  
12 case of 2002”.

13 (b) MILEAGE PAYMENTS.—Section 1834(l)(2)(E)  
14 (42 U.S.C. 1395m(l)(2)(E)) is amended by inserting be-  
15 fore the period at the end the following: “, except that,  
16 beginning on the date on which the Secretary implements  
17 such fee schedule, such phase-in shall provide for full pay-  
18 ment of any national mileage rate for ambulance services  
19 provided by suppliers that are paid by carriers in any of  
20 the 50 States where payment by a carrier for such services  
21 for all such suppliers in such State did not, prior to the  
22 implementation of the fee schedule, include a separate  
23 amount for all mileage within the county from which the  
24 beneficiary is transported”.

1 (c) EFFECTIVE DATE.—The amendment made by  
2 subsection (a) applies to services furnished on or after the  
3 date on which the Secretary of Health and Human Serv-  
4 ices implements the fee schedule under section 1834(l) of  
5 the Social Security Act (42 U.S.C. 1395m(l)).

6 **SEC. 424. AMBULATORY SURGICAL CENTERS.**

7 (a) DELAY IN IMPLEMENTATION OF PROSPECTIVE  
8 PAYMENT SYSTEM.—The Secretary of Health and Human  
9 Services may not implement a revised prospective payment  
10 system for services of ambulatory surgical facilities under  
11 section 1833(i) of the Social Security Act (42 U.S.C.  
12 1395l(i)) before January 1, 2002.

13 (b) EXTENDING PHASE-IN TO 4 YEARS.—Section  
14 226 of the BBRA (113 Stat. 1501A–354) is amended by  
15 striking paragraphs (1) and (2) and inserting the fol-  
16 lowing:

17 “(1) in the first year of its implementation,  
18 only a proportion (specified by the Secretary and not  
19 to exceed  $\frac{1}{4}$ ) of the payment for such services shall  
20 be made in accordance with such system and the re-  
21 mainder shall be made in accordance with current  
22 regulations; and

23 “(2) in each of the following 2 years a propor-  
24 tion (specified by the Secretary and not to exceed  
25  $\frac{1}{2}$ , and  $\frac{3}{4}$ , respectively) of the payment for such

1 services shall be made under such system and the  
2 remainder shall be made in accordance with current  
3 regulations.”.

4 (c) DEADLINE FOR USE OF 1999 OR LATER COST  
5 SURVEYS.—Section 226 of BBRA (113 Stat. 1501A–354)  
6 is amended by adding at the end the following:  
7 “By not later than January 1, 2003, the Secretary shall  
8 incorporate data from a 1999 medicare cost survey or a  
9 subsequent cost survey for purposes of implementing or  
10 revising such system.”.

11 **SEC. 425. FULL UPDATE FOR DURABLE MEDICAL EQUIP-**  
12 **MENT.**

13 (a) IN GENERAL.—Section 1834(a)(14) (42 U.S.C.  
14 1395m(a)(14)) is amended—

15 (1) by redesignating subparagraph (D) as sub-  
16 paragraph (F);

17 (2) in subparagraph (C)—

18 (A) by striking “through 2002” and insert-  
19 ing “through 2000”; and

20 (B) by striking “and” at the end; and

21 (3) by inserting after subparagraph (C) the fol-  
22 lowing new subparagraphs:

23 “(D) for 2001, the percentage increase in  
24 the Consumer Price Index for all urban con-

1           sumers (U.S. city average) for the 12-month  
2           period ending with June 2000;

3           “(E) for 2002, 0 percentage points; and”.

4           (b) CONFORMING AMENDMENTS TO BBRA.—Sub-  
5           section (a) of section 228 of BBRA (113 Stat. 1501A–  
6           356) is amended—

7           (1) in the matter preceding paragraph (1), by  
8           striking “for such items”;

9           (2) in paragraph (1), by inserting “oxygen and  
10          oxygen equipment for” after “(1)”; and

11          (3) in paragraph (2), by inserting “all such cov-  
12          ered items for” after “(2)”.

13          (c) EFFECTIVE DATE.—The amendments made by  
14          subsection (b) shall take effect as if included in the enact-  
15          ment of BBRA.

16       **SEC. 426. FULL UPDATE FOR ORTHOTICS AND PROS-**  
17       **THETICS.**

18          Section 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A))  
19          is amended—

20          (1) by redesignating clause (vi) as clause (viii);

21          (2) in clause (v)—

22                  (A) by striking “through 2002” and insert-  
23                  ing “through 2000”; and

24                  (B) by striking “and” at the end; and

1           (3) by inserting after clause (v) the following  
2 new clause:

3                   “(vi) for 2001, the percentage in-  
4 crease in the consumer price index for all  
5 urban consumers (U.S. city average) for  
6 the 12-month period ending with June  
7 2000;

8                   “(vii) for 2002, 1 percent; and”.

9 **SEC. 427. ESTABLISHMENT OF SPECIAL PAYMENT PROVI-**  
10 **SIONS AND REQUIREMENTS FOR PROS-**  
11 **THETICS AND CERTAIN CUSTOM FABRICATED**  
12 **ORTHOTIC ITEMS.**

13           (a) IN GENERAL.—Section 1834(h)(1) (42 U.S.C.  
14 1395m(h)(1)) is amended by adding at the end the fol-  
15 lowing:

16                   “(F) SPECIAL PAYMENT RULES FOR CER-  
17 TAIN PROSTHETICS AND CUSTOM FABRICATED  
18 ORTHOTICS.—

19                   “(i) IN GENERAL.—No payment shall  
20 be made under this subsection for an item  
21 of custom fabricated orthotics described in  
22 clause (ii) or for an item of prosthetics un-  
23 less such item is—

24                           “(I) furnished by a qualified  
25 practitioner; and

1           “(II) fabricated by a qualified  
2 practitioner or a qualified supplier at  
3 a facility that meets such criteria as  
4 the Secretary determines appropriate.

5           “(ii) DESCRIPTION OF CUSTOM FAB-  
6 RICATED ITEM.—

7           “(I) IN GENERAL.—An item de-  
8 scribed in this clause is an item of  
9 custom fabricated orthotics that re-  
10 quires education, training, and experi-  
11 ence to custom fabricate and that is  
12 included in a list established by the  
13 Secretary in subclause (II). Such an  
14 item does not include shoes and shoe  
15 inserts.

16           “(II) LIST OF ITEMS.—The Sec-  
17 retary, in consultation with appro-  
18 priate experts in orthotics (including  
19 national organizations representing  
20 manufacturers of orthotics), shall es-  
21 tablish and update as appropriate a  
22 list of items to which this subpara-  
23 graph applies. No item may be in-  
24 cluded in such list unless the item is

1 individually fabricated for the patient  
2 over a positive model of the patient.

3 “(iii) QUALIFIED PRACTITIONER DE-  
4 FINED.—In this subparagraph, the term  
5 ‘qualified practitioner’ means a physician  
6 or other individual who—

7 “(I) is a qualified physical thera-  
8 pist or a qualified occupational thera-  
9 pist;

10 “(II) in the case of a State that  
11 provides for the licensing of orthotics  
12 and prosthetics, is licensed in  
13 orthotics or prosthetics by the State  
14 in which the item is supplied; or

15 “(III) in the case of a State that  
16 does not provide for the licensing of  
17 orthotics and prosthetics, is specifi-  
18 cally trained and educated to provide  
19 or manage the provision of prosthetics  
20 and custom-designed or fabricated  
21 orthotics, and is certified by the  
22 American Board for Certification in  
23 Orthotics and Prosthetics, Inc. or by  
24 the Board for Orthotist/Prosthetist  
25 Certification, or is credentialed and

1 approved by a program that the Sec-  
2 retary determines, in consultation  
3 with appropriate experts in orthotics  
4 and prosthetics, has training and edu-  
5 cation standards that are necessary to  
6 provide such prosthetics and orthotics.

7 “(iv) QUALIFIED SUPPLIER DE-  
8 FINED.—In this subparagraph, the term  
9 ‘qualified supplier’ means any entity that  
10 is accredited by the American Board for  
11 Certification in Orthotics and Prosthetics,  
12 Inc. or by the Board for Orthotist/Pros-  
13 thetist Certification, or accredited and ap-  
14 proved by a program that the Secretary  
15 determines has accreditation and approval  
16 standards that are essentially equivalent to  
17 those of such Board.”.

18 (b) EFFECTIVE DATE.—Not later than 1 year after  
19 the date of the enactment of this Act, the Secretary of  
20 Health and Human Services shall promulgate revised reg-  
21 ulations to carry out the amendment made by subsection  
22 (a) using a negotiated rulemaking process under sub-  
23 chapter III of chapter 5 of title 5, United States Code.

24 (c) GAO STUDY AND REPORT.—

1           (1) STUDY.—The Comptroller General of the  
2           United States shall conduct a study on HCFA Rul-  
3           ing 96–1, issued on September 1, 1996, with respect  
4           to distinguishing orthotics from durable medical  
5           equipment under the medicare program under title  
6           XVIII of the Social Security Act. The study shall as-  
7           sess the following matters:

8                   (A) The compliance of the Secretary of  
9                   Health and Human Services with the Adminis-  
10                  trative Procedures Act (under chapter 5 of title  
11                  5, United States Code) in making such ruling.

12                  (B) The potential impact of such ruling on  
13                  the health care furnished to medicare bene-  
14                  ficiaries under the medicare program, especially  
15                  those beneficiaries with degenerative musculo-  
16                  skeletal conditions.

17                  (C) The potential for fraud and abuse  
18                  under the medicare program if payment were  
19                  provided for orthotics used as a component of  
20                  durable medical equipment only when made  
21                  under the special payment provision for certain  
22                  prosthetics and custom fabricated orthotics  
23                  under section 1834(h)(1)(F) of the Social Secu-  
24                  rity Act, as added by subsection (a) and fur-

1 nished by qualified practitioners under that sec-  
2 tion.

3 (D) The impact on payments under titles  
4 XVIII and XIX of the Social Security Act if  
5 such ruling were overturned.

6 (2) REPORT.—Not later than 6 months after  
7 the date of the enactment of this Act, the Comp-  
8 troller General shall submit to Congress a report on  
9 the study conducted under paragraph (1).

10 **SEC. 428. REPLACEMENT OF PROSTHETIC DEVICES AND**  
11 **PARTS.**

12 (a) IN GENERAL.—Section 1834(h)(1) (42 U.S.C.  
13 1395m(h)(1)), as amended by section 427(a), is further  
14 amended by adding at the end the following new subpara-  
15 graph:

16 “(G) REPLACEMENT OF PROSTHETIC DE-  
17 VICES AND PARTS.—

18 “(i) IN GENERAL.—Payment shall be  
19 made for the replacement of prosthetic de-  
20 vices which are artificial limbs, or for the  
21 replacement of any part of such devices,  
22 without regard to continuous use or useful  
23 lifetime restrictions if an ordering physi-  
24 cian determines that the provision of a re-  
25 placement device, or a replacement part of

1 such a device, is necessary because of any  
2 of the following:

3 “(I) A change in the physio-  
4 logical condition of the patient.

5 “(II) An irreparable change in  
6 the condition of the device, or in a  
7 part of the device.

8 “(III) The condition of the de-  
9 vice, or the part of the device, re-  
10 quires repairs and the cost of such re-  
11 pairs would be more than 60 percent  
12 of the cost of a replacement device, or,  
13 as the case may be, of the part being  
14 replaced.

15 “(ii) CONFIRMATION MAY BE RE-  
16 QUIRED IF REPLACEMENT DEVICE OR  
17 PART IS LESS THAN 3 YEARS OLD.—If a  
18 physician determines that a replacement  
19 device, or a replacement part, is necessary  
20 pursuant to clause (i)—

21 “(I) such determination shall be  
22 controlling; and

23 “(II) such replacement device or  
24 part shall be deemed to be reasonable  
25 and necessary for purposes of section

1 1862(a)(1)(A); except that if the de-  
2 vice, or part, being replaced is less  
3 than 3 years old (calculated from the  
4 date on which the beneficiary began to  
5 use the device or part), the Secretary  
6 may also require confirmation of ne-  
7 cessity of the replacement device, or,  
8 as the case may be, the replacement  
9 part.”.

10 (b) PREEMPTION OF RULE.—The provisions of sec-  
11 tion 1834(h)(1)(G) as added by subsection (a) shall super-  
12 sede any rule that as of the date of the enactment of this  
13 Act may have applied a 5-year replacement rule with re-  
14 gard to prosthetic devices.

15 (c) EFFECTIVE DATE.—The amendment made by  
16 subsection (a) shall apply to items replaced on or after  
17 April 1, 2001.

18 **SEC. 429. REVISED PART B PAYMENT FOR DRUGS AND**  
19 **BIOLOGICALS AND RELATED SERVICES.**

20 (a) RECOMMENDATIONS FOR REVISED PAYMENT  
21 METHODOLOGY FOR DRUGS AND BIOLOGICALS.—

22 (1) STUDY.—

23 (A) IN GENERAL.—The Comptroller Gen-  
24 eral of the United States shall conduct a study  
25 on the reimbursement for drugs and biologicals

1 under the current medicare payment method-  
2 ology (provided under section 1842(o) of the  
3 Social Security Act (42 U.S.C. 1395u(o)) and  
4 for related services under part B of title XVIII  
5 of such Act. In the study, the Comptroller Gen-  
6 eral shall—

7 (i) identify the average prices at  
8 which such drugs and biologicals are ac-  
9 quired by physicians and other suppliers;

10 (ii) quantify the difference between  
11 such average prices and the reimbursement  
12 amount under such section; and

13 (iii) determine the extent to which (if  
14 any) payment under such part is adequate  
15 to compensate physicians, providers of  
16 services, or other suppliers of such drugs  
17 and biologicals for costs incurred in the ad-  
18 ministration, handling, or storage of such  
19 drugs or biologicals.

20 (B) CONSULTATION.—In conducting the  
21 study under subparagraph (A), the Comptroller  
22 General shall consult with physicians, providers  
23 of services, and suppliers of drugs and  
24 biologicals under the medicare program under  
25 title XVIII of such Act, as well as other organi-

1 zations involved in the distribution of such  
2 drugs and biologicals to such physicians, pro-  
3 viders of services, and suppliers.

4 (2) REPORT.—Not later than 9 months after  
5 the date of the enactment of this Act, the Comp-  
6 troller General shall submit to Congress and to the  
7 Secretary of Health and Human Services a report  
8 on the study conducted under this subsection, and  
9 shall include in such report recommendations for re-  
10 vised payment methodologies described in paragraph  
11 (3).

12 (3) RECOMMENDATIONS FOR REVISED PAY-  
13 MENT METHODOLOGIES.—

14 (A) IN GENERAL.—The Comptroller Gen-  
15 eral shall provide specific recommendations for  
16 revised payment methodologies for reimburse-  
17 ment for drugs and biologicals and for related  
18 services under the medicare program. The  
19 Comptroller General may include in the  
20 recommendations—

21 (i) proposals to make adjustments  
22 under subsection (c) of section 1848 of the  
23 Social Security Act (42 U.S.C. 1395w-4)  
24 for the practice expense component of the  
25 physician fee schedule under such section

1 for the costs incurred in the administra-  
2 tion, handling, or storage of certain cat-  
3 egories of such drugs and biologicals, if ap-  
4 propriate; and

5 (ii) proposals for new payments to  
6 providers of services or suppliers for such  
7 costs, if appropriate.

8 (B) ENSURING PATIENT ACCESS TO  
9 CARE.—In making recommendations under this  
10 paragraph, the Comptroller General shall en-  
11 sure that any proposed revised payment meth-  
12 odology is designed to ensure that medicare  
13 beneficiaries continue to have appropriate ac-  
14 cess to health care services under the medicare  
15 program.

16 (C) MATTERS CONSIDERED.—In making  
17 recommendations under this paragraph, the  
18 Comptroller General shall consider—

19 (i) the method and amount of reim-  
20 bursement for similar drugs and biologicals  
21 made by large group health plans;

22 (ii) as a result of any revised payment  
23 methodology, the potential for patients to  
24 receive inpatient or outpatient hospital

1 services in lieu of services in a physician's  
2 office; and

3 (iii) the effect of any revised payment  
4 methodology on the delivery of drug thera-  
5 pies by hospital outpatient departments.

6 (D) COORDINATION WITH BBRA STUDY.—

7 In making recommendations under this para-  
8 graph, the Comptroller General shall conclude  
9 and take into account the results of the study  
10 provided for under section 213(a) of BBRA  
11 (113 Stat. 1501A–350).

12 (b) IMPLEMENTATION OF NEW PAYMENT METHOD-  
13 OLOGY.—

14 (1) IN GENERAL.—Notwithstanding any other  
15 provision of law, based on the recommendations con-  
16 tained in the report under subsection (a), the Sec-  
17 retary of Health and Human Services, subject to  
18 paragraph (2), shall revise the payment methodology  
19 under section 1842(o) of the Social Security Act (42  
20 U.S.C. 1395u(o)) for drugs and biologicals furnished  
21 under part B of the medicare program. To the ex-  
22 tent the Secretary determines appropriate, the Sec-  
23 retary may provide for the adjustments to payments  
24 amounts referred to in subsection (a)(3)(A)(i) or ad-

1       ditional payments referred to in subsection  
2       (a)(2)(A)(ii).

3           (2) LIMITATION.—In revising the payment  
4       methodology under paragraph (1), in no case may  
5       the estimated aggregate payments for drugs and  
6       biologicals under the revised system (including addi-  
7       tional payments referred to in subsection  
8       (a)(3)(A)(ii)) exceed the aggregate amount of pay-  
9       ment for such drugs and biologicals, as projected by  
10      the Secretary, that would have been made under the  
11      payment methodology in effect under such section  
12      1842(o).

13      (c) TEMPORARY INJUNCTION AGAINST REDUCTIONS  
14      IN PAYMENT RATES.—Notwithstanding any other provi-  
15      sion of law, the Administrator of the Health Care Financ-  
16      ing Administration may not directly or indirectly increase  
17      or decrease the rates of reimbursement (in effect on Octo-  
18      ber 1, 2000) for drugs and biologicals under the current  
19      medicare payment methodology (provided under section  
20      1842(o) of such Act (42 U.S.C. 1395u(o)) until such time  
21      as the Secretary has reviewed the report submitted under  
22      subsection (a)(2).

1 **SEC. 430. CONTRAST ENHANCED DIAGNOSTIC PROCE-**  
2 **DURES UNDER HOSPITAL PROSPECTIVE PAY-**  
3 **MENT SYSTEM.**

4 (a) SEPARATE CLASSIFICATION.—Section 1833(t)(2)  
5 (42 U.S.C. 1395l(t)(2)) is amended—

6 (1) by striking “and” at the end of subpara-  
7 graph (E);

8 (2) by striking the period at the end of sub-  
9 paragraph (F) and inserting “; and”; and

10 (3) by inserting after subparagraph (F) the fol-  
11 lowing new subparagraph:

12 “(G) the Secretary shall create additional  
13 groups of covered OPD services that classify  
14 separately those procedures that utilize contrast  
15 media from those that do not.”.

16 (b) CONFORMING AMENDMENT.—Section 1861(t)(1)  
17 (42 U.S.C. 1395x(t)(1)) is amended by inserting “(includ-  
18 ing contrast agents)” after “only such drugs”.

19 (c) EFFECTIVE DATE.—The amendments made by  
20 this section apply to items and services furnished on or  
21 after January 1, 2001.

22 **SEC. 431. QUALIFICATIONS FOR COMMUNITY MENTAL**  
23 **HEALTH CENTERS.**

24 (a) MEDICARE PROGRAM.—Section 1861(ff)(3)(B)  
25 (42 U.S.C. 1395x(ff)(3)(B)) is amended by striking “enti-

1 ty” and all that follows and inserting the following: “entity  
2 that—

3 “(i)(I) provides the mental health services de-  
4 scribed in section 1913(c)(1) of the Public Health  
5 Service Act; or

6 “(II) in the case of an entity operating in a  
7 State that by law precludes the entity from pro-  
8 viding itself the service described in subparagraph  
9 (E) of such section, provides for such service by con-  
10 tract with an approved organization or entity (as de-  
11 termined by the Secretary);

12 “(ii) meets applicable licensing or certification  
13 requirements for community mental health centers  
14 in the State in which it is located; and

15 “(iii) meets such additional conditions as the  
16 Secretary shall specify to ensure (I) the health and  
17 safety of individuals being furnished such services,  
18 (II) the effective and efficient furnishing of such  
19 services, and (III) the compliance of such entity with  
20 the criteria described in section 1931(c)(1) of the  
21 Public Health Service Act.”.

22 (b) EFFECTIVE DATE.—The amendment made by  
23 subsection (a) applies with respect to community mental  
24 health centers with respect to services furnished on or

1 after the first day of the third month beginning after the  
2 date of the enactment of this Act.

3 **SEC. 432. MODIFICATION OF MEDICARE BILLING REQUIRE-**  
4 **MENTS FOR CERTAIN INDIAN PROVIDERS.**

5 (a) IN GENERAL.—Section 1880(a) (42 U.S.C.  
6 1395qq(a)) is amended by adding at the end the following  
7 new sentence: “A hospital or a free-standing ambulatory  
8 care clinic (as defined by the Secretary), whether operated  
9 by the Indian Health Service or by an Indian tribe or trib-  
10 al organization (as those terms are defined in section 4  
11 of the Indian Health Care Improvement Act), shall be eli-  
12 gible for payments for services for which payment is made  
13 pursuant to section 1848, notwithstanding sections  
14 1814(c) and 1835(d), if and for so long as it meets all  
15 of the requirements which are applicable generally to such  
16 payments, services, hospitals, and clinics.”.

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

20 **SEC. 433. GAO STUDY ON COVERAGE OF SURGICAL FIRST**  
21 **ASSISTING SERVICES OF CERTIFIED REG-**  
22 **ISTERED NURSE FIRST ASSISTANTS.**

23 (a) STUDY.—The Comptroller General of the United  
24 States shall conduct a study on the effect on the medicare  
25 program under title XVIII of the Social Security Act and

1 on medicare beneficiaries of coverage under the program  
2 of surgical first assisting services of certified registered  
3 nurse first assistants. The Comptroller General shall con-  
4 sider the following when conducting the study:

5 (1) Any impact on the quality of care furnished  
6 to medicare beneficiaries by reason of such coverage.

7 (2) Appropriate education and training require-  
8 ments for certified registered nurse first assistants  
9 who furnish such first assisting services.

10 (3) Appropriate rates of payment under the  
11 program to such certified registered nurse first as-  
12 sistants for furnishing such services, taking into ac-  
13 count the costs of compensation, overhead, and su-  
14 pervision attributable to certified registered nurse  
15 first assistants.

16 (b) REPORT.—Not later than 1 year after the date  
17 of the enactment of this Act, the Comptroller General shall  
18 submit to Congress a report on the study conducted under  
19 subsection (a).

20 **SEC. 434. MEDPAC STUDY AND REPORT ON MEDICARE RE-**  
21 **IMBURSEMENT FOR SERVICES PROVIDED BY**  
22 **CERTAIN PROVIDERS.**

23 (a) STUDY.—The Medicare Payment Advisory Com-  
24 mission shall conduct a study on the appropriateness of  
25 the current payment rates under the medicare program

1 under title XVIII of the Social Security Act for services  
2 provided by a—

3 (1) certified nurse-midwife (as defined in sub-  
4 section (gg)(2) of section 1861 of such Act (42  
5 U.S.C. 1395x);

6 (2) physician assistant (as defined in subsection  
7 (aa)(5)(A) of such section);

8 (3) nurse practitioner (as defined in such sub-  
9 section); and

10 (4) clinical nurse specialist (as defined in sub-  
11 section (aa)(5)(B) of such section).

12 (b) REPORT.—Not later than 18 months after the  
13 date of the enactment of this Act, the Commission shall  
14 submit to Congress a report on the study conducted under  
15 subsection (a), together with any recommendations for leg-  
16 islation that the Commission determines to be appropriate  
17 as a result of such study.

18 **SEC. 435. MEDPAC STUDY AND REPORT ON MEDICARE COV-**  
19 **ERAGE OF SERVICES PROVIDED BY CERTAIN**  
20 **NONPHYSICIAN PROVIDERS.**

21 (a) STUDY.—

22 (1) IN GENERAL.—The Medicare Payment Ad-  
23 visory Commission shall conduct a study to deter-  
24 mine the appropriateness of providing coverage

1 under the medicare program under title XVIII of the  
2 Social Security Act for services provided by a—

3 (A) surgical technologist;

4 (B) marriage counselor;

5 (C) marriage and family therapist;

6 (D) pastoral care counselor; and

7 (E) licensed professional counselor of men-  
8 tal health.

9 (2) COSTS TO PROGRAM.—The study shall con-  
10 sider the short-term and long-term benefits, and  
11 costs to the medicare program, of providing the cov-  
12 erage described in paragraph (1).

13 (b) REPORT.—Not later than 18 months after the  
14 date of the enactment of this Act, the Commission shall  
15 submit to Congress a report on the study conducted under  
16 subsection (a), together with any recommendations for leg-  
17 islation that the Commission determines to be appropriate  
18 as a result of such study.

19 **SEC. 436. GAO STUDY AND REPORT ON THE COSTS OF**  
20 **EMERGENCY AND MEDICAL TRANSPOR-**  
21 **TATION SERVICES.**

22 (a) STUDY.—The Comptroller General of the United  
23 States shall conduct a study on the costs of providing  
24 emergency and medical transportation services across the

1 range of acuity levels of conditions for which such trans-  
2 portation services are provided.

3 (b) REPORT.—Not later than 18 months after the  
4 date of the enactment of this Act, the Comptroller General  
5 shall submit to Congress a report on the study conducted  
6 under subsection (a), together with recommendations for  
7 any changes in methodology or payment level necessary  
8 to fairly compensate suppliers of emergency and medical  
9 transportation services and to ensure the access of bene-  
10 ficiaries under the medicare program under title XVIII of  
11 the Social Security Act.

12 **SEC. 437. GAO STUDIES AND REPORTS ON MEDICARE PAY-**  
13 **MENTS.**

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

16 (1) STUDY.—The Comptroller General of the  
17 United States shall conduct a study on the post-pay-  
18 ment audit process under the medicare program  
19 under title XVIII of the Social Security Act as such  
20 process applies to physicians, including the proper  
21 level of resources that the Health Care Financing  
22 Administration should devote to educating physi-  
23 cians regarding—

24 (A) coding and billing;

25 (B) documentation requirements; and

1 (C) the calculation of overpayments.

2 (2) REPORT.—Not later than 18 months after  
3 the date of the enactment of this Act, the Comp-  
4 troller General shall submit to Congress a report on  
5 the study conducted under paragraph (1) together  
6 with specific recommendations for changes or im-  
7 provements in the post-payment audit process de-  
8 scribed in such paragraph.

9 (b) GAO STUDY ON ADMINISTRATION AND OVER-  
10 SIGHT.—

11 (1) STUDY.—The Comptroller General of the  
12 United States shall conduct a study on the aggre-  
13 gate effects of regulatory, audit, oversight, and pa-  
14 perwork burdens on physicians and other health care  
15 providers participating in the medicare program  
16 under title XVIII of the Social Security Act.

17 (2) REPORT.—Not later than 18 months after  
18 the date of the enactment of this Act, the Comp-  
19 troller General shall submit to Congress a report on  
20 the study conducted under paragraph (1) together  
21 with recommendations regarding any area in  
22 which—

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

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

5 **SEC. 438. MEDPAC STUDY ON ACCESS TO OUTPATIENT PAIN**  
6           **MANAGEMENT SERVICES.**

7           (a) **STUDY.**—The Medicare Payment Advisory Com-  
8           mission shall conduct a study on the barriers to coverage  
9           and payment for outpatient interventional pain medicine  
10          procedures under the medicare program under title XVIII  
11          of the Social Security Act. Such study shall examine—

12           (1) the specific barriers imposed under the  
13          medicare program on the provision of pain manage-  
14          ment procedures in hospital outpatient departments,  
15          ambulatory surgery centers, and physicians' offices;  
16          and

17           (2) the consistency of medicare payment poli-  
18          cies for pain management procedures in those dif-  
19          ferent settings.

20          (b) **REPORT.**—Not later than 1 year after the date  
21          of the enactment of this Act, the Commission shall submit  
22          to Congress a report on the study.

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

4   **SEC. 501. 2-YEAR ADDITIONAL DELAY IN APPLICATION OF**  
5                   **15 PERCENT REDUCTION ON PAYMENT LIM-**  
6                   **ITS FOR HOME HEALTH SERVICES.**

7           (a) IN GENERAL.—Section 1895(b)(3)(A)(i) (42  
8 U.S.C. 1395fff(b)(3)(A)(i)) is amended—

9                   (1) by redesignating subclause (II) as subclause  
10                  (III);

11                  (2) in subclause (III), as redesignated, by strik-  
12                  ing “described in subclause (I)” and inserting “de-  
13                  scribed in subclause (II)”;

14                  (3) by inserting after subclause (I) the fol-  
15                  lowing new subclause:

16                                   “(II) For each of the two 12-  
17                                   month periods beginning after the pe-  
18                                   riod described in subclause (I), such  
19                                   amount (or amounts) shall be equal to  
20                                   the amount (or amounts) determined  
21                                   under subclause (I), updated under  
22                                   subparagraph (B).”.

23           (b) CHANGE IN REPORT.—Section 302(c) of BBRA  
24 (113 Stat. 1501A–360) is amended—

1           (1) by striking “Not later than” and all that  
2 follows through “(42 U.S.C. 1395fff)” and inserting  
3 “Not later than April 1, 2002”; and

4           (2) by striking “Secretary” and inserting  
5 “Comptroller General of the United States”.

6           (c) CASE MIX ADJUSTMENT CORRECTIONS.—

7           (1) IN GENERAL.—Section 1895(b)(3)(B) (42  
8 U.S.C. 1395fff(b)(3)(B)) is amended by adding at  
9 the end the following new clause:

10                   “(iv) ADJUSTMENT FOR CASE MIX  
11                   CHANGES.—Insofar as the Secretary deter-  
12                   mines that the adjustments under para-  
13                   graph (4)(A)(i) for a previous fiscal year  
14                   (or estimates that such adjustments for a  
15                   future fiscal year) did (or are likely to) re-  
16                   sult in a change in aggregate payments  
17                   under this subsection during the fiscal year  
18                   that are a result of changes in the coding  
19                   or classification of different units of serv-  
20                   ices that do not reflect real changes in case  
21                   mix, the Secretary may adjust the stand-  
22                   ard prospective payment amount (or  
23                   amounts) under paragraph (3) for subse-  
24                   quent fiscal years so as to eliminate the ef-

1           fect of such coding or classification  
2           changes.”.

3           (2) EFFECTIVE DATE.—The amendment made  
4           by paragraph (1) applies to episodes concluding on  
5           or after October 1, 2001.

6 **SEC. 502. RESTORATION OF FULL HOME HEALTH MARKET**  
7                   **BASKET UPDATE FOR HOME HEALTH SERV-**  
8                   **ICES FOR FISCAL YEAR 2001.**

9           (a) IN GENERAL.—Section 1861(v)(1)(L)(x) (42  
10 U.S.C. 1395x(v)(1)(L)(x)) is amended—

11           (1) by striking “2001,”; and

12           (2) by adding at the end the following: “With  
13           respect to cost reporting periods beginning during  
14           fiscal year 2001, the update to any limit under this  
15           subparagraph shall be the home health market bas-  
16           ket index.”.

17           (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR  
18 2001 BASED ON ADJUSTED PROSPECTIVE PAYMENT  
19 AMOUNTS.—

20           (1) IN GENERAL.—Notwithstanding the amend-  
21           ments made by subsection (a), for purposes of mak-  
22           ing payments under section 1895(b) of the Social  
23           Security Act (42 U.S.C. 1395fff(b)) for home health  
24           services for fiscal year 2001, the Secretary of Health  
25           and Human Services shall—

1 (A) with respect to episodes and visits end-  
2 ing on or after October 1, 2000, and before  
3 April 1, 2001, use the final standardized and  
4 budget neutral prospective payment amounts  
5 for 60 day episodes and standardized average  
6 per visit amounts for fiscal year 2001 as pub-  
7 lished by the Secretary in the Federal Register  
8 of July 3, 2000 (65 Federal Register 41128–  
9 41214); and

10 (B) with respect to episodes and visits end-  
11 ing on or after April 1, 2001, and before Octo-  
12 ber 1, 2001, use such amounts increased by 2.2  
13 percent.

14 (2) NO EFFECT ON OTHER PAYMENTS OR DE-  
15 TERMINATIONS.—The Secretary shall not take the  
16 provisions of paragraph (1) into account for pur-  
17 poses of payments, determinations, or budget neu-  
18 trality adjustments under section 1895 of the Social  
19 Security Act.

20 **SEC. 503. TEMPORARY TWO-MONTH EXTENSION OF PERI-**  
21 **ODIC INTERIM PAYMENTS.**

22 (a) TEMPORARY EXTENSION.—Notwithstanding sub-  
23 section (d) of section 4603 of BBA (42 U.S.C. 1395fff  
24 note), as amended by section 5101(c)(2) of the Tax and  
25 Trade Relief Extension Act of 1998 (contained in division

1 J of Public Law 105–277), the amendments made by sub-  
2 section (b) of such section 4603 shall not take effect until  
3 December 1, 2000, in the case of a home health agency  
4 that was receiving periodic interim payments under sec-  
5 tion 1815(e)(2) as of September 30, 2000.

6 (b) PAYMENT RULE.—The amount of such periodic  
7 interim payment made to a home health agency by reason  
8 of subsection (a) during each of November and December,  
9 2000, shall be equal to the amount of such payment made  
10 to the agency in their last full monthly periodic interim  
11 payment. Such amount of payment shall be included in  
12 the tentative settlement of the last cost report for the  
13 home health agency under the payment system in effect  
14 prior to the implementation of the prospective payment  
15 system under section 1895(b) of the Social Security Act  
16 (42 U.S.C. 1395fff(b)).

17 **SEC. 504. USE OF TELEHEALTH IN DELIVERY OF HOME**  
18 **HEALTH SERVICES.**

19 Section 1895 (42 U.S.C. 1395fff) is amended by add-  
20 ing at the end the following new subsection:

21 “(e) CONSTRUCTION RELATED TO HOME HEALTH  
22 SERVICES.—

23 “(1) TELECOMMUNICATIONS.—Nothing in this  
24 section shall be construed as preventing a home  
25 health agency furnishing a home health unit of serv-

1 ice for which payment is made under the prospective  
 2 payment system established by this section for such  
 3 units of service from furnishing services via a tele-  
 4 communication system if such services—

5 “(A) do not substitute for in-person home  
 6 health services ordered as part of a plan of care  
 7 certified by a physician pursuant to section  
 8 1814(a)(2)(C) or section 1835(a)(2)(A); and

9 “(B) are not considered a home health  
 10 visit for purposes of eligibility or payment  
 11 under this title.

12 “(2) PHYSICIAN CERTIFICATION.—Nothing in  
 13 this section shall be construed as waiving the re-  
 14 quirement for a physician certification under section  
 15 1814(a)(2)(C) or section 1835(a)(2)(A) of such Act  
 16 (42 U.S.C. 1395f(a)(2)(C), 1395n(a)(2)(A)) for the  
 17 payment for home health services, whether or not  
 18 furnished via a telecommunications system.”.

19 **SEC. 505. STUDY ON COSTS TO HOME HEALTH AGENCIES**  
 20 **OF PURCHASING NONROUTINE MEDICAL**  
 21 **SUPPLIES.**

22 (a) STUDY.—The Comptroller General of the United  
 23 States shall conduct a study on variations in prices paid  
 24 by home health agencies furnishing home health services  
 25 under the medicare program under title XVIII of the So-

1 cial Security Act in purchasing nonroutine medical sup-  
2 plies, including ostomy supplies, and volumes if such sup-  
3 plies used, shall determine the effect (if any) of variations  
4 on prices and volumes in the provision of such services.

5 (b) REPORT.—Not later than October 1, 2001, the  
6 Comptroller General shall submit to Congress a report on  
7 the study conducted under subsection (a), and shall in-  
8 clude in the report recommendations respecting whether  
9 payment for nonroutine medical supplies furnished in con-  
10 nection with home health services should be made sepa-  
11 rately from the prospective payment system for such serv-  
12 ices.

13 **SEC. 506. TREATMENT OF BRANCH OFFICES; GAO STUDY**  
14 **ON SUPERVISION OF HOME HEALTH CARE**  
15 **PROVIDED IN ISOLATED RURAL AREAS.**

16 (a) TREATMENT OF BRANCH OFFICES.—

17 (1) IN GENERAL.—Notwithstanding any other  
18 provision of law, in determining for purposes of title  
19 XVIII of the Social Security Act whether an office  
20 of a home health agency constitutes a branch office  
21 or a separate home health agency, neither the time  
22 nor distance between a parent office of the home  
23 health agency and a branch office shall be the sole  
24 determinant of a home health agency's branch office  
25 status.

1           (2) CONSIDERATION OF FORMS OF TECH-  
2           NOLOGY IN DEFINITION OF SUPERVISION.—The Sec-  
3           retary of Health and Human Services may include  
4           forms of technology in determining what constitutes  
5           “supervision” for purposes of determining a home  
6           health agency’s branch office status under para-  
7           graph (1).

8           (b) GAO STUDY.—

9           (1) STUDY.—The Comptroller General of the  
10          United States shall conduct a study of the provision  
11          of adequate supervision to maintain quality of home  
12          health services delivered under the medicare pro-  
13          gram under title XVIII of the Social Security Act in  
14          isolated rural areas. The study shall evaluate the  
15          methods that home health agency branches and  
16          subunits use to maintain adequate supervision in the  
17          delivery of services to clients residing in those areas,  
18          how these methods of supervision compare to re-  
19          quirements that subunits independently meet medi-  
20          care conditions of participation, and the resources  
21          utilized by subunits to meet such conditions.

22          (2) REPORT.—Not later than January 1, 2002,  
23          the Comptroller General shall submit to Congress a  
24          report on the study conducted under paragraph (1).  
25          The report shall include recommendations on wheth-

1 er exceptions are needed for subunits and branches  
2 of home health agencies under the medicare program  
3 to maintain access to the home health benefit or  
4 whether alternative policies should be developed to  
5 assure adequate supervision and access and rec-  
6 ommendations on whether a national standard for  
7 supervision is appropriate.

8 **SEC. 507. CLARIFICATION OF THE HOMEBOUND DEFINI-**  
9 **TION UNDER THE MEDICARE HOME HEALTH**  
10 **BENEFIT.**

11 (a) CLARIFICATION.—

12 (1) IN GENERAL.—Sections 1814(a) and  
13 1835(a) (42 U.S.C. 1395f(a) and 1395n(a)) are  
14 each amended—

15 (A) in the last sentence, by striking “, and  
16 that absences of the individual from home are  
17 infrequent or of relatively short duration, or are  
18 attributable to the need to receive medical  
19 treatment”; and

20 (B) by adding at the end the following new  
21 sentences: “Any absence of an individual from  
22 the home attributable to the need to receive  
23 health care treatment, including regular ab-  
24 sences for the purpose of participating in thera-  
25 peutic, psychosocial, or medical treatment in an

1 adult day-care program that is licensed or cer-  
2 tified by a State, or accredited, to furnish adult  
3 day-care services in the State shall not dis-  
4 qualify an individual from being considered to  
5 be ‘confined to his home’. Any other absence of  
6 an individual from the home shall not so dis-  
7 qualify an individual if the absence is of infre-  
8 quent or of relatively short duration. For pur-  
9 poses of the preceding sentence, any absence for  
10 the purpose of attending a religious service  
11 shall be deemed to be an absence of infrequent  
12 or short duration.”.

13 (2) EFFECTIVE DATE.—The amendments made  
14 by paragraph (1) shall apply to items and services  
15 provided on or after the date of enactment of this  
16 Act.

17 (b) STUDY.—

18 (1) IN GENERAL.—The Comptroller General of  
19 the United States shall conduct an evaluation of the  
20 effect of the amendment on the cost of and access  
21 to home health services under the medicare program  
22 under title XVIII of the Social Security Act.

23 (2) REPORT.—Not later than 1 year after the  
24 date of the enactment of this Act, the Comptroller

1 General shall submit to Congress a report on the  
2 study conducted under paragraph (1).

3 **SEC. 508. BONUS PAYMENTS FOR RURAL HOME HEALTH**  
4 **AGENCIES IN 2001 AND 2002.**

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

9 “(7) ADDITIONAL PAYMENT AMOUNT FOR  
10 SERVICES FURNISHED IN RURAL AREAS IN 2001 AND  
11 2002.—In the case of home health services furnished  
12 in a rural area (as defined in section 1886(d)(2)(D))  
13 during April 1, 2001 through December 31, 2001,  
14 or 2002, the Secretary shall provide for an addition  
15 or adjustment to the payment amount otherwise  
16 made under this section for services furnished in a  
17 rural area in an amount equal to 10 percent of the  
18 amount otherwise determined under this sub-  
19 section.”.

20 (b) WAIVING BUDGET NEUTRALITY.—Section  
21 1895(b)(3) (42 U.S.C. 1395fff(b)(3)) is amended by add-  
22 ing at the end the following new subparagraph:

23 “(D) NO ADJUSTMENT FOR ADDITIONAL  
24 PAYMENTS FOR RURAL SERVICES.—The Sec-  
25 retary shall not reduce the standard prospective

1 payment amount (or amounts) under this para-  
 2 graph applicable to home health services fur-  
 3 nished during a period to offset the increase in  
 4 payments resulting from the application of  
 5 paragraph (7) (relating to services furnished in  
 6 rural areas).”.

## 7 **Subtitle B—Direct Graduate** 8 **Medical Education**

### 9 **SEC. 511. INCREASE IN FLOOR FOR DIRECT GRADUATE** 10 **MEDICAL EDUCATION PAYMENTS.**

11 Section 1886(h)(2)(D)(iii) (42 U.S.C.  
 12 1395ww(h)(2)(D)(iii)) is amended—

13 (1) in the heading, by striking “IN FISCAL YEAR  
 14 2001 AT 70 PERCENT OF” and inserting “FOR”; and

15 (2) by inserting after “70 percent” the fol-  
 16 lowing: “, and for the cost reporting period begin-  
 17 ning during fiscal year 2002 shall not be less than  
 18 85 percent,”.

### 19 **SEC. 512. CHANGE IN DISTRIBUTION FORMULA FOR** 20 **MEDICARE+CHOICE-RELATED NURSING AND** 21 **ALLIED HEALTH EDUCATION COSTS.**

22 (a) IN GENERAL.—Section 1886(l)(2)(C) (42 U.S.C.  
 23 1395ww(l)(2)(C)) is amended by striking all that follows  
 24 “multiplied by” and inserting the following: “the ratio  
 25 of—

1           “(i) the product of (I) the Secretary’s  
2           estimate of the ratio of the amount of pay-  
3           ments made under section 1861(v) to the  
4           hospital for nursing and allied health edu-  
5           cation activities for the hospital’s cost re-  
6           porting period ending in the second pre-  
7           ceding fiscal year, to the hospital’s total in-  
8           patient days for such period, and (II) the  
9           total number of inpatient days (as estab-  
10          lished by the Secretary) for such period  
11          which are attributable to services furnished  
12          to individuals who are enrolled under a  
13          risk sharing contract with an eligible orga-  
14          nization under section 1876 and who are  
15          entitled to benefits under part A or who  
16          are enrolled with a Medicare+Choice orga-  
17          nization under part C; to

18                   “(ii) the sum of the products deter-  
19                   mined under clause (i) for such cost re-  
20                   porting periods.”.

21          (b) EFFECTIVE DATE.—The amendment made by  
22          subsection (a) applies to portions of cost reporting periods  
23          occurring on or after January 1, 2001.

1     **Subtitle C—Changes in Medicare**  
2     **Coverage and Appeals Process**

3     **SEC. 521. REVISIONS TO MEDICARE APPEALS PROCESS.**

4         (a) CONDUCT OF RECONSIDERATIONS OF DETER-  
5     MINATIONS BY INDEPENDENT CONTRACTORS.—Section  
6     1869 (42 U.S.C. 1395ff) is amended to read as follows:

7                     “DETERMINATIONS; APPEALS

8             “SEC. 1869. (a) INITIAL DETERMINATIONS.—

9                     “(1) PROMULGATIONS OF REGULATIONS.—The  
10     Secretary shall promulgate regulations and make ini-  
11     tial determinations with respect to benefits under  
12     part A or part B in accordance with those regula-  
13     tions for the following:

14                     “(A) The initial determination of whether  
15     an individual is entitled to benefits under such  
16     parts.

17                     “(B) The initial determination of the  
18     amount of benefits available to the individual  
19     under such parts.

20                     “(C) Any other initial determination with  
21     respect to a claim for benefits under such parts,  
22     including an initial determination by the Sec-  
23     retary that payment may not be made, or may  
24     no longer be made, for an item or service under  
25     such parts, an initial determination made by a

1 utilization and quality control peer review orga-  
2 nization under section 1154(a)(2), and an ini-  
3 tial determination made by an entity pursuant  
4 to a contract (other than a contract under sec-  
5 tion 1852) with the Secretary to administer  
6 provisions of this title or title XI.

7 “(2) DEADLINES FOR MAKING INITIAL DETER-  
8 MINATIONS.—

9 “(A) IN GENERAL.—Subject to subpara-  
10 graph (B), in promulgating regulations under  
11 paragraph (1), initial determinations shall be  
12 concluded by not later than the 45-day period  
13 beginning on the date the fiscal intermediary or  
14 the carrier, as the case may be, receives a claim  
15 for benefits from an individual as described in  
16 paragraph (1). Notice of such determination  
17 shall be mailed to the individual filing the claim  
18 before the conclusion of such 45-day period.

19 “(B) CLEAN CLAIMS.—Subparagraph (A)  
20 shall not apply with respect to any claim that  
21 does not meet the requirements of section  
22 1816(c)(2) or section 1842(c)(2).

23 “(3) REDETERMINATIONS.—

24 “(A) IN GENERAL.—In promulgating regu-  
25 lations under paragraph (1) with respect to ini-

1           tial determinations, such regulations shall pro-  
2           vide for a fiscal intermediary or a carrier to  
3           make a redetermination with respect to a claim  
4           for benefits that is denied in whole or in part.

5           “(B) LIMITATIONS.—

6           “(i) APPEALS RIGHTS.—No initial de-  
7           termination may be reconsidered or ap-  
8           pealed under subsection (b) unless the fis-  
9           cal intermediary or carrier has made a re-  
10          determination of that initial determination  
11          under this paragraph.

12          “(ii) DECISION MAKER.—No redeter-  
13          mination may be made by any individual  
14          involved in the initial determination.

15          “(C) DEADLINES.—

16          “(i) FILING FOR REDETERMINA-  
17          TION.—A redetermination under subpara-  
18          graph (A) shall be available only if notice  
19          is filed with the Secretary to request the  
20          redetermination by not later than the end  
21          of the 120-day period beginning on the  
22          date the individual receives notice of the  
23          initial determination under paragraph (2).

24          “(ii) CONCLUDING REDETERMINA-  
25          TIONS.—Except as provided in subsections

1 (d) through (f), redeterminations shall be  
2 made in accordance with the medical needs  
3 of the individual, but no later than 30 days  
4 after the fiscal intermediary or the carrier,  
5 as the case may be, receives a request for  
6 a redetermination. Notice of such deter-  
7 mination shall be mailed to the individual  
8 filing the claim before the conclusion of  
9 such 30-day period.

10 “(D) CONSTRUCTION.—For purposes of  
11 the succeeding provisions of this section a rede-  
12 termination under this paragraph shall be con-  
13 sidered to be part of the initial determination.

14 “(b) APPEAL RIGHTS.—

15 “(1) IN GENERAL.—

16 “(A) RECONSIDERATION OF INITIAL DE-  
17 TERMINATION.—(i) Subject to subparagraph  
18 (D), any individual dissatisfied with any initial  
19 determination under subsection (a)(1) shall be  
20 entitled to reconsideration of the determination,  
21 and, subject to subparagraphs (D) and (E), a  
22 hearing thereon by the Secretary to the same  
23 extent as is provided in section 205(b) and to  
24 judicial review of the Secretary’s final decision  
25 after such hearing as is provided in section

1           205(g). For purposes of the preceding sentence,  
2           any reference to the Commissioner of Social Se-  
3           curity or the Social Security Administration in  
4           subsection (g) or (l) of section 205 shall be con-  
5           sidered a reference to the Secretary or the De-  
6           partment of Health and Human Services, re-  
7           spectively.

8                   “(ii) In making determinations under  
9                   this subsection, local and national coverage  
10                  determinations that involve the consider-  
11                  ation of medical facts of application of  
12                  medical judgment shall not be binding on  
13                  qualified independent contractors, adminis-  
14                  trative law judges or the Departmental Ap-  
15                  peals Board when determining whether a  
16                  particular item or service is covered with  
17                  respect to an individual making a claim for  
18                  benefit or the amount, duration or scope of  
19                  an item or service to which an individual  
20                  making a claim for benefits is eligible.

21                   “(B) REPRESENTATION BY PROVIDER OR  
22                  SUPPLIER.—

23                   “(i) IN GENERAL.—Sections 206(a),  
24                  1102 and 1871 shall not be construed as  
25                  authorizing the Secretary to prohibit an in-

1           dividual from being represented under this  
2           section by a person that furnishes or sup-  
3           plies the individual, directly or indirectly,  
4           with services or items, solely on the basis  
5           that the person furnishes or supplies the  
6           individual with such a service or item.

7           “(ii) MANDATORY WAIVER OF RIGHT  
8           TO PAYMENT FROM BENEFICIARY.—Any  
9           person that furnishes services or items to  
10          an individual may not represent an indi-  
11          vidual under this section with respect to  
12          the issue described in section 1879(a)(2)  
13          unless the person has waived any rights for  
14          payment from the beneficiary with respect  
15          to the services or items involved in the ap-  
16          peal.

17          “(iii) PROHIBITION ON PAYMENT FOR  
18          REPRESENTATION.—If a person furnishes  
19          services or items to an individual and rep-  
20          resents the individual under this section,  
21          the person may not impose any financial li-  
22          ability on such individual in connection  
23          with such representation.

24          “(iv) REQUIREMENTS FOR REP-  
25          RESENTATIVES OF A BENEFICIARY.—The

1 provisions of section 205(j) and section  
2 206 (other than subsection (a)(4) of such  
3 section) regarding representation of claim-  
4 ants shall apply to representation of an in-  
5 dividual with respect to appeals under this  
6 section in the same manner as they apply  
7 to representation of an individual under  
8 those sections.

9 “(C) SUCCESSION OF RIGHTS IN CASES OF  
10 ASSIGNMENT.—The right of an individual to an  
11 appeal under this section with respect to an  
12 item or service may be assigned to the provider  
13 of services or supplier of the item or service  
14 upon the written consent of such individual  
15 using a standard form established by the Sec-  
16 retary for such an assignment.

17 “(D) TIME LIMITS FOR FILING APPEALS.—

18 “(i) RECONSIDERATIONS.—Reconsid-  
19 eration under subparagraph (A) shall be  
20 available only if the individual described in  
21 subparagraph (A) files notice with the Sec-  
22 retary to request reconsideration by not  
23 later than the end of the 180-day period  
24 beginning on the date the individual re-  
25 ceives notice of the redetermination under

1 subsection (a)(3), or within such additional  
2 time as the Secretary may allow.

3 “(ii) HEARINGS CONDUCTED BY THE  
4 SECRETARY.—The Secretary shall establish  
5 in regulations time limits for the filing of  
6 a request for a hearing by the Secretary in  
7 accordance with provisions in sections 205  
8 and 206.

9 “(E) AMOUNTS IN CONTROVERSY.—

10 “(i) IN GENERAL.—A hearing (by the  
11 Secretary) shall not be available to an indi-  
12 vidual under this section if the amount in  
13 controversy is less than \$100, and judicial  
14 review shall not be available to the indi-  
15 vidual if the amount in controversy is less  
16 than \$1,000.

17 “(ii) AGGREGATION OF CLAIMS.—In  
18 determining the amount in controversy, the  
19 Secretary, under regulations, shall allow  
20 two or more appeals to be aggregated if  
21 the appeals involve—

22 “(I) the delivery of similar or re-  
23 lated services to the same individual  
24 by one or more providers of services  
25 or suppliers, or

1                   “(II) common issues of law and  
2 fact arising from services furnished to  
3 two or more individuals by one or  
4 more providers of services or sup-  
5 pliers.

6                   “(F) EXPEDITED PROCEEDINGS.—

7                   “(i) EXPEDITED DETERMINATION.—

8 In the case of an individual who has re-  
9 ceived notice by a provider of services that  
10 the provider of services plans—

11                   “(I) to terminate services pro-  
12 vided to an individual and a physician  
13 certifies that failure to continue the  
14 provision of such services is likely to  
15 place the individual’s health at signifi-  
16 cant risk, or

17                   “(II) to discharge the individual  
18 from the provider of services, the indi-  
19 vidual may request, in writing or oral-  
20 ly, an expedited determination or an  
21 expedited reconsideration of an initial  
22 determination made under subsection  
23 (a)(1), as the case may be, and the  
24 Secretary shall provide such expedited

1 determination or expedited reconsideration.  
2

3 “(ii) EXPEDITED HEARING.—In a  
4 hearing by the Secretary under this section, in which the moving party alleges  
5 that no material issues of fact are in dispute, the Secretary shall make an expedited  
6 determination as to whether any such  
7 facts are in dispute and, if not, shall  
8 render a decision expeditiously.  
9

10  
11 “(G) REOPENING AND REVISION OF DETERMINATIONS.—The Secretary may reopen or  
12 revise any initial determination or reconsidered  
13 determination described in this subsection  
14 under guidelines established by the Secretary in  
15 regulations.  
16

17 “(c) CONDUCT OF RECONSIDERATIONS BY INDEPENDENT CONTRACTORS.—  
18

19 “(1) IN GENERAL.—The Secretary shall enter  
20 into contracts with qualified independent contractors  
21 to conduct reconsiderations of initial determinations  
22 made under subparagraphs (B) and (C) of subsection (a)(1), if such determinations involve either  
23 whether a particular item or service is covered with  
24 respect to an individual making a claim for benefit  
25

1 or the amount, duration or scope of an item or serv-  
2 ice to which an individual making a claim for bene-  
3 fits is eligible. Contracts shall be for an initial term  
4 of three years and shall be renewable on a triennial  
5 basis thereafter. This subsection shall not apply to  
6 claims for persons that involve only the amount of  
7 payment or the type of payment available with re-  
8 spect to an item or service.

9 “(2) QUALIFIED INDEPENDENT CON-  
10 TRACTOR.—For purposes of this subsection, the  
11 term ‘qualified independent contractor’ means an en-  
12 tity or organization that is independent of any orga-  
13 nization under contract with the Secretary that  
14 makes initial determinations under subsection  
15 (a)(1), and that meets the requirements established  
16 by the Secretary consistent with paragraph (3).

17 “(3) REQUIREMENTS.—Any qualified inde-  
18 pendent contractor entering into a contract with the  
19 Secretary under this subsection shall meet the all of  
20 the following requirements:

21 “(A) IN GENERAL.—The qualified inde-  
22 pendent contractor shall perform such duties  
23 and functions and assume such responsibilities  
24 as may be required by the Secretary to carry  
25 out the provisions of this subsection, and shall

1 have sufficient training and expertise in medical  
2 science and legal matters to make reconsider-  
3 ations under this subsection.

4 “(B) RECONSIDERATIONS.—

5 “(i) IN GENERAL.—Subject to sub-  
6 section (b)(1)(A)(ii), the qualified inde-  
7 pendent contractor shall review initial de-  
8 terminations. In the case an initial deter-  
9 mination made with respect to whether an  
10 item or service is reasonable and necessary  
11 for the diagnosis or treatment of illness or  
12 injury (under section 1862(a)(1)(A)), such  
13 review shall include consideration of the  
14 facts and circumstances of the initial de-  
15 termination by a panel of physicians or  
16 other appropriate health care professionals  
17 and any decisions with respect to the re-  
18 consideration shall be based on applicable  
19 information, including clinical experience  
20 and medical, technical, and scientific evi-  
21 dence.

22 “(C) DEADLINES FOR DECISIONS.—

23 “(i) RECONSIDERATIONS.—Except as  
24 provided in clauses (iii) and (iv), and in ac-  
25 cordance with subsections (d), (e), and (f),

1 the qualified independent contractor shall  
2 conduct and conclude a reconsideration  
3 under subparagraph (B), and mail the no-  
4 tice of the decision with respect to the re-  
5 consideration in accordance with the med-  
6 ical needs of the individual but not later  
7 than the end of the 30-day period begin-  
8 ning on the date a request for reconsider-  
9 ation has been timely filed.

10 “(ii) CONSEQUENCES OF FAILURE TO  
11 MEET DEADLINE.—In the case of a failure  
12 by the qualified independent contractor to  
13 mail the notice of the decision by the end  
14 of the period described in clause (i), or by  
15 the end of the applicable period described  
16 in subsections (d) through (f), or to pro-  
17 vide notice by the end of the period de-  
18 scribed in clause (iii), as the case may be,  
19 the party requesting the reconsideration or  
20 appeal may request a hearing before the  
21 Secretary, notwithstanding any require-  
22 ments for a reconsidered determination for  
23 purposes of the party’s right to such hear-  
24 ing.

1           “(iii)   EXPEDITED    RECONSIDER-  
2           ATIONS.—The qualified independent con-  
3           tractor shall perform an expedited recon-  
4           sideration under subsection (b)(1)(F) as  
5           follows:

6                   “(I) DEADLINE FOR DECISION.—

7                   Notwithstanding section 216(j) and  
8                   subject to clause (iv), not later than  
9                   the end of the 72-hour period begin-  
10                  ning on the date the qualified inde-  
11                  pendent contractor has received a re-  
12                  quest for such reconsideration and has  
13                  received such medical or other records  
14                  needed for such reconsideration, the  
15                  qualified independent contractor shall  
16                  provide notice (by telephone and in  
17                  writing) to the individual and the pro-  
18                  vider of services and attending physi-  
19                  cian of the individual of the results of  
20                  the reconsideration. Such reconsider-  
21                  ation shall be conducted regardless of  
22                  whether the provider of services or  
23                  supplier will charge the individual for  
24                  continued services or whether the indi-

1                   vidual will be liable for payment for  
2                   such continued services.

3                   “(II) CONSULTATION WITH BEN-  
4                   EFICIARY.—In such reconsideration,  
5                   the qualified independent contractor  
6                   shall solicit the views of the individual  
7                   involved.

8                   “(III) SPECIAL RULE FOR HOS-  
9                   PITAL DISCHARGES.—A reconsider-  
10                  ation of a discharge from a hospital  
11                  shall be conducted under this clause  
12                  in accordance with the provisions of  
13                  paragraphs (2), (3), and

14                  “(4) of section 1154(e) as in effect on the date  
15                  that precedes the date of the enactment of this sub-  
16                  paragraph.

17                  “(iv) EXTENSION.—An individual re-  
18                  questing a reconsideration under this sub-  
19                  paragraph may be granted such additional  
20                  time as the individual specifies (not to ex-  
21                  ceed 14 days) for the qualified independent  
22                  contractor to conclude the reconsideration.  
23                  The individual may request such additional  
24                  time orally or in writing.

1                   “(D) LIMITATION ON INDIVIDUAL REVIEW-  
2                   ING DETERMINATIONS.—

3                   “(i) PHYSICIANS AND HEALTH CARE  
4                   PROFESSIONAL.—No physician or health  
5                   care professional under the employ of a  
6                   qualified independent contractor may  
7                   review—

8                   “(I) determinations regarding  
9                   health care services furnished to a pa-  
10                  tient if the physician or health care  
11                  professional was directly responsible  
12                  for furnishing such services; or

13                  “(II) determinations regarding  
14                  health care services provided in or by  
15                  an institution, organization, or agen-  
16                  cy, if the physician or any member of  
17                  the family of the physician or health  
18                  care professional has, directly or indi-  
19                  rectly, a significant financial interest  
20                  in such institution, organization, or  
21                  agency.

22                  “(ii) FAMILY DESCRIBED.—For pur-  
23                  poses of this paragraph, the family of a  
24                  physician or health care professional in-  
25                  cludes the spouse (other than a spouse who

1 is legally separated from the physician or  
2 health care professional under a decree of  
3 divorce or separate maintenance), children  
4 including stepchildren and legally adopted  
5 children), grandchildren, parents, and  
6 grandparents of the physician or health  
7 care professional.

8 “(E) EXPLANATION OF DECISION.—Any  
9 decision with respect to a reconsideration of a  
10 qualified independent contractor shall be in  
11 writing, and shall include a detailed explanation  
12 of the decision as well as a discussion of the  
13 pertinent facts and applicable regulations ap-  
14 plied in making such decision, and in the case  
15 of a determination of whether an item or serv-  
16 ice is reasonable and necessary for the diag-  
17 nosis or treatment of illness or injury (under  
18 section 1862(a)(1)(A)) an explanation of the  
19 medical and scientific rationale for the decision.

20 “(F) NOTICE REQUIREMENTS.—Whenever  
21 a qualified independent contractor makes a de-  
22 cision with respect to a reconsideration under  
23 this subsection, the qualified independent con-  
24 tractor shall promptly notify the entity respon-

1           sible for the payment of claims under part A or  
2           part B of such decision.

3           “(G) DISSEMINATION OF DECISIONS ON  
4           RECONSIDERATIONS.—Each qualified inde-  
5           pendent contractor shall make available all deci-  
6           sions with respect to reconsiderations of such  
7           qualified independent contractors to fiscal inter-  
8           mediaries (under section 1816), carriers (under  
9           section 1842), peer review organizations (under  
10          part B of title XI), Medicare+Choice organiza-  
11          tions offering Medicare+Choice plans under  
12          part C, other entities under contract with the  
13          Secretary to make initial determinations under  
14          part A or part B or title XI, and to the public.  
15          The Secretary shall establish a methodology  
16          under which qualified independent contractors  
17          shall carry out this subparagraph.

18          “(H) ENSURING CONSISTENCY IN DECI-  
19          SIONS.—Each qualified independent contractor  
20          shall monitor its decisions with respect to re-  
21          considerations to ensure the consistency of such  
22          decisions with respect to requests for reconsid-  
23          eration of similar or related matters.

24          “(I) DATA COLLECTION.—

1           “(i) IN GENERAL.—Consistent with  
2           the requirements of clause (ii), a qualified  
3           independent contractor shall collect such  
4           information relevant to its functions, and  
5           keep and maintain such records in such  
6           form and manner as the Secretary may re-  
7           quire to carry out the purposes of this sec-  
8           tion and shall permit access to and use of  
9           any such information and records as the  
10          Secretary may require for such purposes.

11          “(ii) TYPE OF DATA COLLECTED.—  
12          Each qualified independent contractor  
13          shall keep accurate records of each deci-  
14          sion made, consistent with standards es-  
15          tablished by the Secretary for such pur-  
16          pose. Such records shall be maintained in  
17          an electronic database in a manner that  
18          provides for identification of the following:

19                 “(I) Specific claims that give rise  
20                 to appeals.

21                 “(II) Situations suggesting the  
22                 need for increased education for pro-  
23                 viders of services, physicians, or sup-  
24                 pliers.

1                   “(III) Situations suggesting the  
2                   need for changes in national or local  
3                   coverage policy.

4                   “(IV) Situations suggesting the  
5                   need for changes in local medical re-  
6                   view policies.

7                   “(iii) ANNUAL REPORTING.—Each  
8                   qualified independent contractor shall sub-  
9                   mit annually to the Secretary (or otherwise  
10                  as the Secretary may request) records  
11                  maintained under this paragraph for the  
12                  previous year.

13                  “(J) HEARINGS BY THE SECRETARY.—The  
14                  qualified independent contractor shall (i) pre-  
15                  pare such information as is required for an ap-  
16                  peal of a decision of the contractor with respect  
17                  to a reconsideration to the Secretary for a hear-  
18                  ing, including as necessary, explanations of  
19                  issues involved in the decision and relevant poli-  
20                  cies, and

21                               “(ii) participate in such hearings as  
22                               required by the Secretary.

23                  “(4) NUMBER OF QUALIFIED INDEPENDENT  
24                  CONTRACTORS.—The Secretary shall enter into con-

1 tracts with not fewer than 12 qualified independent  
2 contractors under this subsection.

3 “(5) LIMITATION ON QUALIFIED INDEPENDENT  
4 CONTRACTOR LIABILITY.—No qualified independent  
5 contractor having a contract with the Secretary  
6 under this subsection and no person who is em-  
7 ployed by, or who has a fiduciary relationship with,  
8 any such qualified independent contractor or who  
9 furnishes professional services to such qualified inde-  
10 pendent contractor, shall be held by reason of the  
11 performance of any duty, function, or activity re-  
12 quired or authorized pursuant to this subsection or  
13 to a valid contract entered into under this sub-  
14 section, to have violated any criminal law, or to be  
15 civilly liable under any law of the United States or  
16 of any State (or political subdivision thereof) pro-  
17 vided due care was exercised in the performance of  
18 such duty, function, or activity.

19 “(d) MEDICAL EXIGENT PROCESS FOR CONTRAC-  
20 TORS.—

21 “(1) IN GENERAL.—An individual may request,  
22 either orally or in writing, a medically exigent review  
23 under subsection (b). Such request shall be made to  
24 the contractor who made the initial determination.

1           “(2) CONDITIONS FOR GRANTING A MEDICAL  
2 EXIGENT REVIEW.—

3           “(A) the contractor determines that the  
4 application of the standard time frame for con-  
5 ducting a redetermination under subsection  
6 (a)(3) could seriously jeopardize the life or  
7 health of the individual or such individual’s  
8 ability to attain, maintain, or regain maximum  
9 function, or

10           “(B) the individual submits a certification  
11 from a physician that the jeopardy could occur.

12           “(3) DEADLINE FOR MEDICAL EXIGENT RE-  
13 VIEWS.—If an individual is granted a medical exi-  
14 gent review under this subsection, the review shall  
15 be conducted and notice of the review shall be made,  
16 in accordance with the individual’s medical needs,  
17 but no later than 72 hours after the request was  
18 made.

19           “(4) FAILURE TO MEET TIME FRAMES.—In the  
20 event the contractor who made the initial determina-  
21 tion to meet the time frame in paragraph (3), the  
22 individual may proceed to the next level of review.

23           “(e) MEDICAL EXIGENT PROCESS FOR QUALIFIED  
24 INDEPENDENT CONTRACTORS.—

1           “(1) IN GENERAL.—An individual may request,  
2 either orally or in writing, a medically exigent recon-  
3 sideration of a determination made under subsection  
4 (d). Such request shall be made to the qualified  
5 independent contractor.

6           “(2) CONDITIONS FOR GRANTING A MEDICAL  
7 EXIGENT REVIEW.—

8           “(A) the qualified independent contractor  
9 determines that the application of the standard  
10 time frame for conducting a review could seri-  
11 ously jeopardize the life or health of the indi-  
12 vidual or such individual’s ability to attain,  
13 maintain, or regain maximum function, or

14           “(B) the individual submits a certification  
15 from a physician that the jeopardy could occur.

16           “(3) DEADLINE FOR MEDICAL EXIGENT RE-  
17 VIEWS.—If an individual is granted a medical exi-  
18 gent reconsideration under this paragraph, the re-  
19 view shall be conducted and notice of the review  
20 shall be made, in accordance with the individuals  
21 medical needs, but no later than 72 hours after the  
22 request was made.

23           “(4) FAILURE TO MEET TIME FRAMES.—In the  
24 event the qualified independent contractor or the  
25 Secretary fails to meet the time frame in paragraph

1 (3), the individual may proceed to the next level of  
2 review.

3 “(f) TIME FRAME FOR REVIEW BY SECRETARY.—

4 The Secretary shall conduct all reviews in a time frame  
5 that is in accordance with the medical exigencies of the  
6 case.

7 “(g) ADMINISTRATIVE PROVISIONS.—

8 “(1) LIMITATION ON REVIEW OF CERTAIN REG-  
9 ULATIONS.—A regulation or instruction that relates  
10 to a method for determining the amount of payment  
11 under part B and that was initially issued before  
12 January 1, 1981, shall not be subject to judicial re-  
13 view.

14 “(2) OUTREACH.—The Secretary shall perform  
15 such outreach activities as are necessary to inform  
16 individuals entitled to benefits under this title and  
17 providers of services and suppliers with respect to  
18 their rights of, and the process for, appeals made  
19 under this section. The Secretary shall use the toll-  
20 free telephone number maintained by the Secretary  
21 under section 1804(b) to provide information re-  
22 garding appeal rights and respond to inquiries re-  
23 garding the status of appeals.

24 “(3) CONTINUING EDUCATION REQUIREMENT  
25 FOR QUALIFIED INDEPENDENT CONTRACTORS AND

1 ADMINISTRATIVE LAW JUDGES.—The Secretary shall  
2 provide to each qualified independent contractor,  
3 and, in consultation with the Commissioner of Social  
4 Security, to administrative law judges that decide  
5 appeals of reconsiderations of initial determinations  
6 or other decisions or determinations under this sec-  
7 tion, such continuing education with respect to cov-  
8 erage of items and services under this title or poli-  
9 cies of the Secretary with respect to part B of title  
10 XI as is necessary for such qualified independent  
11 contractors and administrative law judges to make  
12 informed decisions with respect to appeals.

13 “(4) REPORTS.—

14 “(A) ANNUAL REPORT TO CONGRESS.—

15 The Secretary shall submit to Congress an an-  
16 nual report describing the number of appeals  
17 for the previous year, identifying issues that re-  
18 quire administrative or legislative actions, and  
19 including any recommendations of the Secretary  
20 with respect to such actions. The Secretary  
21 shall include in such report an analysis of de-  
22 terminations by qualified independent contrac-  
23 tors with respect to inconsistent decisions and  
24 an analysis of the causes of any such inconsis-  
25 tencies.

1           “(B) SURVEY.—Not less frequently than  
2           every 5 years, the Secretary shall conduct a  
3           survey of a valid sample of individuals entitled  
4           to benefits under this title who have filed ap-  
5           peals of determinations under this section, pro-  
6           viders of services, and suppliers to determine  
7           the satisfaction of such individuals or entities  
8           with the process for appeals of determinations  
9           provided for under this section and education  
10          and training provided by the Secretary with re-  
11          spect to that process. The Secretary shall sub-  
12          mit to Congress a report describing the results  
13          of the survey, and shall include any rec-  
14          ommendations for administrative or legislative  
15          actions that the Secretary determines appro-  
16          priate.

17          “(b) APPLICABILITY OF REQUIREMENTS AND LIM-  
18          TATIONS ON LIABILITY OF QUALIFIED INDEPENDENT  
19          CONTRACTORS TO MEDICARE+CHOICE INDEPENDENT  
20          APPEALS CONTRACTORS.—Section 1852(g)(4) (42 U.S.C.  
21          1395w 22(g)(4)) is amended by adding at the end the fol-  
22          lowing: The provisions of section 1869(c)(5) shall apply  
23          to independent outside entities under contract with the  
24          Secretary under this paragraph.

1       “(c) CONFORMING AMENDMENT.—Section 1154(e)  
2 (42 U.S.C. 1320e–3(e)) is amended by striking para-  
3 graphs (2), (3), and (4).

4       “(d) EFFECTIVE DATE.—The amendments made by  
5 this section apply with respect to initial determinations  
6 made on or after October 1, 2002.”.

7 **SEC. 522. REVISIONS TO MEDICARE COVERAGE PROCESS.**

8       (a) REVIEW OF DETERMINATIONS.—Section 1869  
9 (42 U.S.C. 1395ff), as amended by section 521, is further  
10 amended by adding at the end the following new sub-  
11 section:

12       “(h) REVIEW OF COVERAGE DETERMINATIONS.—

13               “(1) NATIONAL COVERAGE DETERMINATIONS.—

14                       “(A) IN GENERAL.—Review of any na-  
15 tional coverage determination shall be subject to  
16 the following limitations:

17                               “(i) Such a determination shall not be  
18 reviewed by any administrative law judge.

19                               “(ii) Such a determination shall not  
20 be held unlawful or set aside on the ground  
21 that a requirement of section 553 of title  
22 5, United States Code, or section 1871(b)  
23 of this title, relating to publication in the  
24 Federal Register or opportunity for public  
25 comment, was not satisfied.

1           “(iii) Upon the filing of a complaint  
2           by an aggrieved party, the Secretary shall  
3           provide for the review of a national cov-  
4           erage determination by the advisory panel  
5           established pursuant to paragraph (3)  
6           (hereinafter referred to as the “Panel”). In  
7           conducting such a review, the Panel shall  
8           review the record to evaluate whether the  
9           determination is in accord with sound med-  
10          ical practice, taking into account medical,  
11          technological, or clinical advancements,  
12          and any other medical, scientific, or other  
13          relevant information that the Panel deems  
14          reliable and may consider information that  
15          was not available or was not considered at  
16          the time of the determination. The Panel  
17          shall make a recommendation to the Sec-  
18          retary as to whether the determination  
19          should be upheld, modified, or set aside,  
20          and the Secretary shall have 30 days from  
21          the receipt of such recommendation to  
22          issue a decision.

23           “(iv) A decision of the Secretary  
24          under (h)(1)(A)(iii) constitutes a final

1           agency action and is subject to judicial re-  
2           view.

3           “(B) DEFINITION OF NATIONAL COVERAGE  
4           DETERMINATION.—For purposes of this section,  
5           the term ‘national coverage determination’  
6           means a determination by the Secretary with  
7           respect to whether or not a particular item or  
8           service is covered nationally under this title, but  
9           does not include a determination of what code,  
10          if any, is assigned to a particular item or serv-  
11          ice covered under this title or a determination  
12          with respect to the amount of payment made  
13          for a particular item or service so covered.

14          “(2) LOCAL COVERAGE DETERMINATION.—

15                 “(A) Upon the filing of a complaint by an  
16                 aggrieved party (except in the cases of issues  
17                 regarding the coding or supporting documenta-  
18                 tion), the Secretary shall provide for the review  
19                 of a local coverage determination by the Panel  
20                 as provided in (h)(3) except that for purposes  
21                 of a review under this subclause, the Panel  
22                 shall also consider any special circumstances  
23                 that may be relevant to the practice of medicine  
24                 in the locality. The Panel shall make a rec-  
25                 ommendation to the Secretary as to whether

1 the determination should be upheld, modified,  
2 or set aside, and the Secretary shall have 30  
3 days from the receipt of such recommendation  
4 to issue a decision to uphold the determination  
5 or to remand it to the fiscal intermediary or  
6 carrier for revision. A fiscal intermediary or  
7 carrier shall have 30 days from the receipt of  
8 any remand instructions from the Secretary in  
9 which to complete such revision. The decision of  
10 the Secretary shall have effect only with respect  
11 to the local coverage determination. Such a de-  
12 cision constitutes a final agency action and is  
13 subject to judicial review.

14 “(B) DEFINITION OF LOCAL COVERAGE  
15 DETERMINATION.—For purposes of this section,  
16 the term ‘local coverage determination’ means a  
17 determination by a fiscal intermediary or a car-  
18 rier under part A or part B, as applicable, re-  
19 specting whether or not a particular item or  
20 service is covered on an intermediary- or car-  
21 rier-wide basis under such parts, in accordance  
22 with section 1862(a)(1)(A).

23 “(3) ESTABLISHMENT OF MEDICAL ADVISORY  
24 PANEL.—For the purposes of providing expert clin-  
25 ical and scientific advice and recommendations to

1 the Secretary regarding reconsiderations of national  
2 or local coverage determinations under paragraphs  
3 (1) and (2), the Secretary shall establish panels of  
4 experts or use panels of experts (or members of such  
5 panels) established before the date of enactment [in-  
6 sert name of Act] or both. The Secretary shall ap-  
7 point as members of any such panel persons the Sec-  
8 retary determines to have an appropriate level of ex-  
9 pertise in the subject matter, but shall not appoint  
10 any individual who is in the regular full-time employ  
11 of the Health Care Financing Administration or nay  
12 individual who participated in the initial coverage  
13 determination that is the subject of a reconsider-  
14 ation request.

15 “(4) PENDING NATIONAL COVERAGE DETER-  
16 MINATIONS.—

17 “(A) IN GENERAL.—In the event the Sec-  
18 retary has not issued a national coverage or  
19 noncoverage determination with respect to a  
20 particular type or class of items or services, an  
21 aggrieved person (as described in paragraph  
22 (5)) may submit to the Secretary a request to  
23 make such a determination with respect to such  
24 items or services. By not later than the end of  
25 the 90-day period beginning on the date the

1 Secretary receives such a request (notwith-  
2 standing the receipt by the Secretary of new  
3 evidence (if any) during such 90-day period),  
4 the Secretary shall take one of the following ac-  
5 tions:

6 “(i) Issue a national coverage deter-  
7 mination, with or without limitations.

8 “(ii) Issue a national noncoverage de-  
9 termination.

10 “(iii) Issue a determination that no  
11 national coverage or noncoverage deter-  
12 mination is appropriate as of the end of  
13 such 90-day period with respect to national  
14 coverage of such items or services.

15 “(iv) Issue a notice that states that  
16 the Secretary has not completed a review  
17 of the request for a national coverage de-  
18 termination and that includes an identi-  
19 fication of the remaining steps in the Sec-  
20 retary’s review process and a deadline by  
21 which the Secretary will complete the re-  
22 view and take an action described in sub-  
23 clause (I), (II), or (III).

24 “(B) In the case of an action described in  
25 clause (i)(IV), if the Secretary fails to take an

1           action referred to in such clause by the deadline  
2           specified by the Secretary under such clause,  
3           then the Secretary is deemed to have taken an  
4           action described in clause (i)(III) as of the  
5           deadline.

6           “(C) When issuing a determination under  
7           clause (i), the Secretary shall include an expla-  
8           nation of the basis for the determination. An  
9           action taken under clause (i) (other than sub-  
10          clause (IV)) is deemed to be a national coverage  
11          determination for purposes of review under sub-  
12          paragraph (A).

13          “(5) STANDING.—An action under this sub-  
14          section seeking review of a national coverage deter-  
15          mination or local coverage determination may be ini-  
16          tiated only by individuals entitled to benefits under  
17          part A, or enrolled under part B, or both, who are  
18          in need of the items or services that are the subject  
19          of the coverage determination.

20          “(6) PUBLICATION ON THE INTERNET OF DECI-  
21          SIONS OF HEARINGS OF THE SECRETARY.—Each de-  
22          cision of a hearing by the Secretary with respect to  
23          a national coverage determination shall be made  
24          public, and the Secretary shall publish each decision  
25          on the Medicare Internet site of the Department of

1 Health and Human Services. The Secretary shall re-  
2 move from such decision any information that would  
3 identify any individual, provider of services, or sup-  
4 plier.

5 “(7) ANNUAL REPORT ON NATIONAL COVERAGE  
6 DETERMINATIONS.—

7 “(A) IN GENERAL.—Not later than De-  
8 cember 1 of each year, beginning in 2001, the  
9 Secretary shall submit to Congress a report  
10 that sets forth a detailed compilation of the ac-  
11 tual time periods that were necessary to com-  
12 plete and fully implement national coverage de-  
13 terminations that were made in the previous fis-  
14 cal year for items, services, or medical devices  
15 not previously covered as a benefit under this  
16 title, including, with respect to each new item,  
17 service, or medical device, a statement of the  
18 time taken by the Secretary to make and imple-  
19 ment the necessary coverage, coding, and pay-  
20 ment determinations, including the time taken  
21 to complete each significant step in the process  
22 of making and implementing such determina-  
23 tions.

24 “(B) PUBLICATION OF REPORTS ON THE  
25 INTERNET.—The Secretary shall publish each

1 report submitted under clause (i) on the medi-  
2 care Internet site of the Department of Health  
3 and Human Services.

4 “(8) CONSTRUCTION.—Nothing in this sub-  
5 section shall be construed as permitting administra-  
6 tive or judicial review pursuant to this section inso-  
7 far as such review is explicitly prohibited or re-  
8 stricted under another provision of law.”.

9 (b) ESTABLISHMENT OF A PROCESS FOR COVERAGE  
10 DETERMINATIONS.—Section 1862(a) (42 U.S.C.  
11 1395y(a)) is amended by adding at the end the following  
12 new sentence: “In making a national coverage determina-  
13 tion (as defined in paragraph (1)(B) of section 1869(f))  
14 the Secretary shall ensure that the public is afforded no-  
15 tice and opportunity to comment prior to implementation  
16 by the Secretary of the determination; meetings of advi-  
17 sory committees established under section 1114(f) with re-  
18 spect to the determination are made on the record; in  
19 making the determination, the Secretary has considered  
20 applicable information (including clinical experience and  
21 medical, technical, and scientific evidence) with respect to  
22 the subject matter of the determination; and in the deter-  
23 mination, provide a clear statement of the basis for the  
24 determination (including responses to comments received  
25 from the public), the assumptions underlying that basis,

1 and make available to the public the data (other than pro-  
2 prietary data) considered in making the determination.

3 (c) IMPROVEMENTS TO THE MEDICARE ADVISORY  
4 COMMITTEE PROCESS.—Section 1114 (42 U.S.C. 1314)  
5 is amended by adding at the end the following new sub-  
6 section:

7 “(i)(1) Any advisory committee appointed under sub-  
8 section (f) to advise the Secretary on matters relating to  
9 the interpretation, application, or implementation of sec-  
10 tion 1862(a)(1) shall assure the full participation of a  
11 nonvoting member in the deliberations of the advisory  
12 committee, and shall provide such nonvoting member ac-  
13 cess to all information and data made available to voting  
14 members of the advisory committee, other than informa-  
15 tion that—

16 “(A) is exempt from disclosure pursuant to sub-  
17 section q(a) of section 552 of title 5, United States  
18 Code, by reason of subsection (b)(4) of such section  
19 (relating to trade secrets); or

20 “(B) the Secretary determines would present a  
21 conflict of interest relating to such nonvoting mem-  
22 ber.

23 “(2) If an advisory committee described in paragraph  
24 (1) organizes into panels of experts according to types of  
25 items or services considered by the advisory committee,

1 any such panel of experts may report any recommendation  
2 with respect to such items or services directly to the Sec-  
3 retary without the prior approval of the advisory com-  
4 mittee or an executive committee thereof.”.

5 (d) EFFECTIVE DATE.—The amendments made by  
6 this section apply with respect to—

7 (1) a review of any national or local coverage  
8 determination filed,

9 (2) a request to make such a determination  
10 made,

11 (3) a national coverage determination made, on  
12 or after October 1, 2001.

## 13 **Subtitle D—Improving Access to** 14 **New Technologies**

### 15 **SEC. 531. REIMBURSEMENT IMPROVEMENTS FOR NEW** 16 **CLINICAL LABORATORY TESTS AND DURA-** 17 **BLE MEDICAL EQUIPMENT.**

18 (a) PAYMENT RULE FOR NEW LABORATORY  
19 TESTS.—Section 1833(h)(4)(B)(viii) (42 U.S.C.  
20 1395l(h)(4)(B)(viii)) is amended by inserting before the  
21 period at the end the following: “(or 100 percent of such  
22 median in the case of a clinical diagnostic laboratory test  
23 performed on or after January 1, 2001, that the Secretary  
24 determines is a new test for which no limitation amount

1 has previously been established under this subpara-  
2 graph)''.

3 (b) ESTABLISHMENT OF CODING AND PAYMENT  
4 PROCEDURES FOR NEW CLINICAL DIAGNOSTIC LABORA-  
5 TORY TESTS AND OTHER ITEMS ON A FEE SCHEDULE.—  
6 Not later than 1 year after the date of the enactment of  
7 this Act, the Secretary of Health and Human Services  
8 shall establish procedures for coding and payment deter-  
9 minations for the categories of new clinical diagnostic lab-  
10 oratory tests and new durable medical equipment under  
11 part B of the title XVIII of the Social Security Act that  
12 permit public consultation in a manner consistent with the  
13 procedures established for implementing coding modifica-  
14 tions for ICD–9–CM.

15 (c) REPORT ON PROCEDURES USED FOR ADVANCED,  
16 IMPROVED TECHNOLOGIES.—Not later than 1 year after  
17 the date of the enactment of this Act, the Secretary of  
18 Health and Human Services shall submit to Congress a  
19 report that identifies the specific procedures used by the  
20 Secretary under part B of title XVIII of the Social Secu-  
21 rity Act to adjust payments for clinical diagnostic labora-  
22 tory tests and durable medical equipment which are classi-  
23 fied to existing codes where, because of an advance in  
24 technology with respect to the test or equipment, there has  
25 been a significant increase or decrease in the resources

1 used in the test or in the manufacture of the equipment,  
2 and there has been a significant improvement in the per-  
3 formance of the test or equipment. The report shall in-  
4 clude such recommendations for changes in law as may  
5 be necessary to assure fair and appropriate payment levels  
6 under such part for such improved tests and equipment  
7 as reflects increased costs necessary to produce improved  
8 results.

9 **SEC. 532. RETENTION OF HCPCS LEVEL III CODES.**

10 (a) IN GENERAL.—The Secretary of Health and  
11 Human Services shall maintain and continue the use of  
12 level III codes of the HCPCS coding system (as such sys-  
13 tem was in effect on August 16, 2000) through December  
14 31, 2003, and shall make such codes available to the pub-  
15 lic.

16 (b) DEFINITION.—For purposes of this section, the  
17 term “HCPCS Level III codes” means the alphanumeric  
18 codes for local use under the Health Care Financing Ad-  
19 ministration Common Procedure Coding System  
20 (HCPCS).

21 **SEC. 533. RECOGNITION OF NEW MEDICAL TECHNOLOGIES**  
22 **UNDER INPATIENT HOSPITAL PPS.**

23 (a) EXPEDITING RECOGNITION OF NEW TECH-  
24 NOLOGIES INTO INPATIENT PPS CODING SYSTEM.—

1           (1) REPORT.—Not later than April 1, 2001, the  
2           Secretary of Health and Human Services shall sub-  
3           mit to Congress a report on methods of expeditiously  
4           incorporating new medical services and technologies  
5           into the clinical coding system used with respect to  
6           payment for inpatient hospital services furnished  
7           under the medicare program under title XVIII of the  
8           Social Security Act, together with a detailed descrip-  
9           tion of the Secretary’s preferred methods to achieve  
10          this purpose.

11          (2) IMPLEMENTATION.—Not later than October  
12          1, 2001, the Secretary shall implement the preferred  
13          methods described in the report transmitted pursu-  
14          ant to paragraph (1).

15          (b) ENSURING APPROPRIATE PAYMENTS FOR HOS-  
16          PITALS INCORPORATING NEW MEDICAL SERVICES AND  
17          TECHNOLOGIES.—

18          (1) ESTABLISHMENT OF MECHANISM.—Section  
19          1886(d)(5) (42 U.S.C. 1395ww(d)(5)) is amended  
20          by adding at the end the following new subpara-  
21          graphs:

22          “(K)(i) Effective for discharges beginning on or after  
23          October 1, 2001, the Secretary shall establish a mecha-  
24          nism to recognize the costs of new medical services and  
25          technologies under the payment system established under

1 this subsection. Such mechanism shall be established after  
2 notice and opportunity for public comment (in the publica-  
3 tions required by subsection (e)(5) for a fiscal year or oth-  
4 erwise).

5 “(ii) The mechanism established pursuant to clause  
6 (i) shall—

7 “(I) apply to a new medical service or tech-  
8 nology if, based on the estimated costs incurred with  
9 respect to discharges involving such service or tech-  
10 nology, the DRG prospective payment rate otherwise  
11 applicable to such discharges under this subsection  
12 is inadequate;

13 “(II) provide for the collection of data with re-  
14 spect to the costs of a new medical service or tech-  
15 nology described in subclause (I) for a period of not  
16 less than two years and not more than three years  
17 beginning on the date on which an inpatient hospital  
18 code is issued with respect to the service or tech-  
19 nology;

20 “(III) subject to paragraph (4)(C)(iii), provide  
21 for additional payment to be made under this sub-  
22 section with respect to discharges involving a new  
23 medical service or technology described in subclause  
24 (I) that occur during the period described in sub-  
25 clause (II) in an amount that adequately reflects the

1 estimated average cost of such service or technology;  
2 and

3 “(IV) provide that discharges involving such a  
4 service or technology that occur after the close of the  
5 period described in subclause (II) will be classified  
6 within a new or existing diagnosis-related group with  
7 a weighting factor under paragraph (4)(B) that is  
8 derived from cost data collected with respect to dis-  
9 charges occurring during such period.

10 “(iii) For purposes of clause (ii)(II), the term ‘inpa-  
11 tient hospital code’ means any code that is used with re-  
12 spect to inpatient hospital services for which payment may  
13 be made under this subsection and includes an alpha-  
14 numeric code issued under the International Classification  
15 of Diseases, 9th Revision, Clinical Modification (‘ICD–9–  
16 CM’) and its subsequent revisions.

17 “(iv) For purposes of clause (ii)(III), the term ‘addi-  
18 tional payment’ means, with respect to a discharge for a  
19 new medical service or technology described in clause  
20 (ii)(I), an amount that exceeds the prospective payment  
21 rate otherwise applicable under this subsection to dis-  
22 charges involving such service or technology that would  
23 be made but for this subparagraph.

24 “(v) The requirement under clause (ii)(III) for an ad-  
25 ditional payment may be satisfied by means of a new-tech-

1 nology group (described in subparagraph (L)), an add-on  
2 payment, a payment adjustment, or any other similar  
3 mechanism for increasing the amount otherwise payable  
4 with respect to a discharge under this subsection. The Sec-  
5 retary may not establish a separate fee schedule for such  
6 additional payment for such services and technologies, by  
7 utilizing a methodology established under subsection (a)  
8 or (h) of section 1834 to determine the amount of such  
9 additional payment, or by other similar mechanisms or  
10 methodologies.

11       “(vi) For purposes of this subparagraph and sub-  
12 paragraph (L), a medical service or technology will be con-  
13 sidered a ‘new medical service or technology’ if the service  
14 or technology meets criteria established by the Secretary  
15 after notice and an opportunity for public comment.

16       “(L)(i) In establishing the mechanism under sub-  
17 paragraph (K), the Secretary may establish new-tech-  
18 nology groups into which a new medical service or tech-  
19 nology will be classified if, based on the estimated average  
20 costs incurred with respect to discharges involving such  
21 service or technology, the DRG prospective payment rate  
22 otherwise applicable to such discharges under this sub-  
23 section is inadequate.

24       “(ii) Such groups—

1           “(I) shall not be based on the costs associated  
2           with a specific new medical service or technology;  
3           but

4           “(II) shall, in combination with the applicable  
5           standardized amounts and the weighting factors as-  
6           signed to such groups under paragraph (4)(B), re-  
7           flect such cost cohorts as the Secretary determines  
8           are appropriate for all new medical services and  
9           technologies that are likely to be provided as inpa-  
10          tient hospital services in a fiscal year.

11          “(iii) The methodology for classifying specific hos-  
12          pital discharges within a diagnosis-related group under  
13          paragraph (4)(A) or a new-technology group shall provide  
14          that a specific hospital discharge may not be classified  
15          within both a diagnosis-related group and a new-tech-  
16          nology group.”.

17                (2) PRIOR CONSULTATION.—The Secretary of  
18          Health and Human Services shall consult with  
19          groups representing hospitals, physicians, and manu-  
20          facturers of new medical technologies before pub-  
21          lishing the notice of proposed rulemaking required  
22          by section 1886(d)(5)(K)(i) of the Social Security  
23          Act (as added by paragraph (1)).

24                (3) CONFORMING AMENDMENT.—Section  
25          1886(d)(4)(C)(i) (42 U.S.C. 1395ww(d)(4)(C)(i)) is

1 amended by striking “technology,” and inserting  
2 “technology (including a new medical service or  
3 technology under paragraph (5)(K)),”.

## 4 **Subtitle E—Other Provisions**

### 5 **SEC. 541. INCREASE IN REIMBURSEMENT FOR BAD DEBT.**

6 Section 1861(v)(1)(T) (42 U.S.C. 1395x(v)(1)(T)) is  
7 amended—

8 (1) in clause (ii), by striking “and” at the end;

9 (2) in clause (iii)—

10 (A) by striking “during a subsequent fiscal  
11 year” and inserting “during fiscal year 2000”;

12 and

13 (B) by striking the period at the end and  
14 inserting “, and”; and

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

17 “(iv) for cost reporting periods beginning dur-  
18 ing a subsequent fiscal year, by 30 percent of such  
19 amount otherwise allowable.”.

### 20 **SEC. 542. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY**

#### 21 **SERVICES UNDER MEDICARE.**

22 (a) IN GENERAL.—When an independent laboratory  
23 furnishes the technical component of a physician pathol-  
24 ogy service to a fee-for-service medicare beneficiary who  
25 is an inpatient or outpatient of a covered hospital, the Sec-

1 retary of Health and Human Services shall treat such  
2 component as a service for which payment shall be made  
3 to the laboratory under section 1848 of the Social Security  
4 Act (42 U.S.C. 1395w-4) and not as an inpatient hospital  
5 service for which payment is made to the hospital under  
6 section 1886(d) of such Act (42 U.S.C. 1395ww(d)) or  
7 as an outpatient hospital service for which payment is  
8 made to the hospital under section 1833(t) of such Act  
9 (42 U.S.C. 1395l(t)).

10 (b) DEFINITIONS.—For purposes of this section:

11 (1) COVERED HOSPITAL.—The term “covered  
12 hospital” means, with respect to an inpatient or an  
13 outpatient, a hospital that had an arrangement with  
14 an independent laboratory that was in effect as of  
15 July 22, 1999, under which a laboratory furnished  
16 the technical component of physician pathology serv-  
17 ices to fee-for-service medicare beneficiaries who  
18 were hospital inpatients or outpatients, respectively,  
19 and submitted claims for payment for such compo-  
20 nent to a medicare carrier (that has a contract with  
21 the Secretary under section 1842 of the Social Secu-  
22 rity Act, 42 U.S.C. 1395u) and not to such hospital.

23 (2) FEE-FOR-SERVICE MEDICARE BENE-  
24 FICIARY.—The term “fee-for-service medicare bene-  
25 ficiary” means an individual who—

1 (A) is entitled to benefits under part A, or  
2 enrolled under part B, or both, of such title;  
3 and

4 (B) is not enrolled in any of the following:

5 (i) A Medicare+Choice plan under  
6 part C of such title.

7 (ii) A plan offered by an eligible orga-  
8 nization under section 1876 of such Act  
9 (42 U.S.C. 1395mm).

10 (iii) A program of all-inclusive care  
11 for the elderly (PACE) under section 1894  
12 of such Act (42 U.S.C. 1395eee).

13 (iv) A social health maintenance orga-  
14 nization (SHMO) demonstration project  
15 established under section 4018(b) of the  
16 Omnibus Budget Reconciliation Act of  
17 1987 (Public Law 100–203).

18 (c) EFFECTIVE DATE.—This section applies to serv-  
19 ices furnished during the 2-year period beginning on Jan-  
20 uary 1, 2001.

21 (d) GAO REPORT.—

22 (1) STUDY.—The Comptroller General of the  
23 United States shall conduct a study of the effects of  
24 the previous provisions of this section on hospitals  
25 and laboratories and access of fee-for-service medi-

1 care beneficiaries to the technical component of phy-  
2 sician pathology services.

3 (2) REPORT.—Not later than April 1, 2002, the  
4 Comptroller General shall submit to Congress a re-  
5 port on such study. The report shall include rec-  
6 ommendations about whether such provisions should  
7 be extended after the end of the period specified in  
8 subsection (c) for either or both inpatient and out-  
9 patient hospital services, and whether the provisions  
10 should be extended to other hospitals.

11 **SEC. 543. EXTENSION OF ADVISORY OPINION AUTHORITY.**

12 Section 1128D(b)(6) (42 U.S.C. 1320a–7d(b)(6)) is  
13 amended by striking “and before the date which is 4 years  
14 after such date of enactment”.

15 **SEC. 544. CHANGE IN ANNUAL MEDPAC REPORTING.**

16 (a) REVISION OF DEADLINES FOR SUBMISSION OF  
17 REPORTS.—

18 (1) IN GENERAL.—Section 1805(b)(1)(D) (42  
19 U.S.C. 1395b–6(b)(1)(D)) is amended by striking  
20 “June 1 of each year (beginning with 1998),” and  
21 inserting “June 15 of each year,”.

22 (2) EFFECTIVE DATE.—The amendment made  
23 by paragraph (1) applies beginning with 2001.

24 (b) REQUIREMENT FOR ON THE RECORD VOTES ON  
25 RECOMMENDATIONS.—Section 1805(b) (42 U.S.C.

1 1395b–6(b)) is amended by adding at the end the fol-  
2 lowing new paragraph:

3           “(7) VOTING AND REPORTING REQUIRE-  
4           MENTS.—With respect to each recommendation con-  
5           tained in a report submitted under paragraph (1),  
6           each member of the Commission shall vote on the  
7           recommendation, and the Commission shall include,  
8           by member, the results of that vote in the report  
9           containing the recommendation.”.

10 **SEC. 545. DEVELOPMENT OF PATIENT ASSESSMENT IN-**  
11 **STRUMENTS.**

12           (a) DEVELOPMENT.—

13           (1) IN GENERAL.—Not later than January 1,  
14           2005, the Secretary of Health and Human Services  
15           shall submit to the Committee on Ways and Means  
16           and the Committee on Commerce of the House of  
17           Representatives and the Committee on Finance of  
18           the Senate a report on the development of standard  
19           instruments for the assessment of the health and  
20           functional status of patients, for whom items and  
21           services described in subsection (b) are furnished,  
22           and include in the report a recommendation on the  
23           use of such standard instruments for payment pur-  
24           poses.

1           (2) DESIGN FOR COMPARISON OF COMMON ELE-  
2           MENTS.—The Secretary shall design such standard  
3           instruments in a manner such that—

4                   (A) elements that are common to the items  
5                   and services described in subsection (b) may be  
6                   readily comparable and are statistically compat-  
7                   ible;

8                   (B) only elements necessary to meet pro-  
9                   gram objectives are collected; and

10                   (C) the standard instruments supersede  
11                   any other assessment instrument used before  
12                   that date.

13           (3) CONSULTATION.—In developing an assess-  
14           ment instrument under paragraph (1), the Secretary  
15           shall consult with the Medicare Payment Advisory  
16           Commission, the Agency for Healthcare Research  
17           and Quality, and qualified organizations rep-  
18           resenting providers of services and suppliers under  
19           title XVIII.

20           (b) DESCRIPTION OF SERVICES.—For purposes of  
21           subsection (a), items and services described in this sub-  
22           section are those items and services furnished to individ-  
23           uals entitled to benefits under part A, or enrolled under  
24           part B, or both of title XVIII of the Social Security Act

1 for which payment is made under such title, and include  
2 the following:

3 (1) Inpatient and outpatient hospital services.

4 (2) Inpatient and outpatient rehabilitation serv-  
5 ices.

6 (3) Covered skilled nursing facility services.

7 (4) Home health services.

8 (5) Physical or occupational therapy or speech-  
9 language pathology services.

10 (6) Items and services furnished to such indi-  
11 viduals determined to have end stage renal disease.

12 (7) Partial hospitalization services and other  
13 mental health services.

14 (8) Any other service for which payment is  
15 made under such title as the Secretary determines to  
16 be appropriate.

17 **SEC. 546. GAO REPORT ON IMPACT OF THE EMERGENCY**  
18 **MEDICAL TREATMENT AND ACTIVE LABOR**  
19 **ACT (EMTALA) ON HOSPITAL EMERGENCY DE-**  
20 **PARTMENTS.**

21 (a) REPORT.—The Comptroller General of the  
22 United States shall submit a report to the Committee on  
23 Commerce and the Committee on Ways and Means of the  
24 House of Representatives and the Committee on Finance  
25 of the Senate by May 1, 2001, on the effect of the Emer-

1 gency Medical Treatment and Active Labor Act on hos-  
2 pitals, emergency physicians, and physicians covering  
3 emergency department call throughout the United States.

4 (b) REPORT REQUIREMENTS.—The report should  
5 evaluate—

6 (1) the extent to which hospitals, emergency  
7 physicians, and physicians covering emergency de-  
8 partment call provide uncompensated services in re-  
9 lation to the requirements of EMTALA;

10 (2) the extent to which the regulatory require-  
11 ments and enforcement of EMTALA have expanded  
12 beyond the legislation’s original intent;

13 (3) estimates for the total dollar amount of  
14 EMTALA-related care uncompensated costs to  
15 emergency physicians, physicians covering emer-  
16 gency department call, hospital emergency depart-  
17 ments, and other hospital services;

18 (4) the extent to which different portions of the  
19 United States may be experiencing different levels of  
20 uncompensated EMTALA-related care;

21 (5) the extent to which EMTALA would be  
22 classified as an unfunded mandate if it were enacted  
23 today;

1           (6) the extent to which States have programs to  
2 provide financial support for such uncompensated  
3 care;

4           (7) possible sources of funds, including medi-  
5 care hospital bad debt accounts, that are available to  
6 hospitals to assist with the cost of such uncompen-  
7 sated care; and

8           (8) the financial strain that illegal immigration  
9 populations, the uninsured, and the underinsured  
10 place on hospital emergency departments, other hos-  
11 pital services, emergency physicians, and physicians  
12 covering emergency department call.

13       (c) DEFINITION.—In this section, the terms “Emer-  
14 gency Medical Treatment and Active Labor Act” and  
15 “EMTALA” mean section 1867 of the Social Security Act  
16 (42 U.S.C. 1395dd).

17 **SEC. 547. APPLICATION OF BLOODBORNE PATHOGEN**  
18 **STANDARD TO CERTAIN HOSPITALS.**

19       (a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc)  
20 is amended—

21           (1) in subsection (a)(1)—

22               (A) in subparagraph (R), by striking  
23 “and” at the end;

24               (B) in subparagraph (S), by striking the  
25 period at the end and inserting “, and”; and

1 (C) by inserting after subparagraph (S)  
2 the following new subparagraph:

3 “(T) in the case of hospitals that are not other-  
4 wise subject to regulation by the Occupational Safe-  
5 ty and Health Administration, to comply with the  
6 Bloodborne Pathogens standard under section  
7 1910.1030 of title 29 of the Code of Federal Regula-  
8 tions (or as subsequently redesignated).”; and

9 (2) by adding at the end of subsection (b) the  
10 following new paragraph:

11 “(4) With respect to a failure to comply with the re-  
12 quirement of subsection (a)(1)(T), the Secretary shall not  
13 terminate an agreement under this section but shall im-  
14 pose a monetary fine in an amount similar to the amount  
15 of civil penalties that may be imposed under section 17  
16 of the Occupational Safety and Health Act of 1970 for  
17 a violation of the standard referred to in such subsection  
18 by a hospital subject to regulation by the Occupational  
19 Safety and Health Administration. Such penalty shall be  
20 imposed and collected in the same manner as civil money  
21 penalties under subsection (a) of section 1128A are im-  
22 posed and collected under that section.”.

23 (b) EFFECTIVE DATE.—The amendments made by  
24 this section apply to hospitals as of January 1, 2002.

1 **TITLE VI—PROVISIONS RELAT-**  
2 **ING TO PART C**  
3 **(MEDICARE+CHOICE PRO-**  
4 **GRAM) AND OTHER MEDI-**  
5 **CARE MANAGED CARE PROVI-**  
6 **SIONS**

7 **Subtitle A—Medicare+Choice**  
8 **Payment Reforms**

9 **SEC. 601. INCREASED PAYMENT FOR ACCOUNTABLE**  
10 **MEDICARE+CHOICE PLANS.**

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

12 (1) in subsection (a)(1)(A), by striking “and  
13 (i)” and inserting “(i), and (j)”; and

14 (2) by adding at the end the following new sub-  
15 section:

16 “(j) INCREASED PAYMENT FOR ACCOUNTABLE  
17 MEDICARE+CHOICE COORDINATED CARE PLANS.—

18 “(1) IN GENERAL.—In the case of a  
19 Medicare+Choice coordinated care plan that enters  
20 into a 3-year contract for the period of 2001  
21 through 2003, the amount of the monthly payment  
22 otherwise made under this section (taking into ac-  
23 count, if applicable, subsection (i)), shall be in-  
24 creased for each year of the contract period by the  
25 amount necessary to ensure that the total monthly

1 payment is equal to the greater of the adjusted min-  
2 imum amount specified in paragraph (2) or an  
3 amount equal to the otherwise applicable rate in-  
4 creased by  $\frac{1}{3}$  of 1 percent.

5 “(2) ADJUSTED MINIMUM AMOUNT.—For pur-  
6 poses of this subsection, the adjusted minimum  
7 amount shall equal—

8 “(A) in 2001—

9 “(i) for any payment area in a Metro-  
10 politan Statistical Area or a Primary Met-  
11 ropolitan Statistical Area, \$525 per month;  
12 and

13 “(ii) for any other payment area,  
14 \$475;

15 however, in the case of a payment area outside  
16 the 50 States and the District of Columbia,  
17 such amount shall not exceed 110 percent of  
18 the minimum amount for such area for 2000.

19 “(B) in 2002 and 2003, the adjusted min-  
20 imum amount for months during the previous  
21 year increased by the national per capita  
22 Medicare+Choice growth percentage, described  
23 in subsection (c)(6)(A) for that succeeding year.

24 “(3) PENALTY FOR CONTRACT TERMINATION.—

25 In the case of a Medicare+Choice coordinated care

1 plan described in paragraph (1) whose contract is  
2 terminated prior to the end of the 3-year contract  
3 period, the Medicare+Choice organizations that of-  
4 fered such plan shall return to the Secretary an  
5 amount equal to twice the total of the increased pay-  
6 ments provided under this section. Such moneys  
7 shall be deposited in the Federal Hospital Insurance  
8 Trust Funds and the Federal Supplementary Med-  
9 ical Insurance Trust Funds in such proportion as  
10 the Secretary deems to be fair and equitable.”.

11 **SEC. 602. INCREASE IN MINIMUM PERCENTAGE INCREASE.**

12 Section 1853(c)(1)(C)(ii) (42 U.S.C. 1395w-  
13 23(c)(1)(C)(ii)) is amended by inserting “(or 103 percent  
14 in the case of 2001)” after “102 percent”.

15 **SEC. 603. 10-YEAR PHASE-IN OF RISK ADJUSTMENT.**

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

18 (1) in subclause (I), by striking “and 2001”  
19 and inserting “and each succeeding year through the  
20 first year in which risk adjustment is based on data  
21 from inpatient hospital and ambulatory settings”;  
22 and

23 (2) by amending subclause (II) to read as fol-  
24 lows:

1                   “(II) beginning after such first  
2                   year, insofar as such risk adjustment  
3                   is based on data from inpatient hos-  
4                   pital and ambulatory settings, the  
5                   methodology shall be phased in equal  
6                   increments over a 10-year period that  
7                   begins with such first year.”.

8 **SEC. 604. TRANSITION TO REVISED MEDICARE+CHOICE**  
9                   **PAYMENT RATES.**

10           (a)           ANNOUNCEMENT           OF           REVISED  
11 MEDICARE+CHOICE PAYMENT RATES.—Within 2 weeks  
12 after the date of the enactment of this Act, the Secretary  
13 of Health and Human Services shall determine, and shall  
14 announce (in a manner intended to provide notice to inter-  
15 ested parties) Medicare+Choice capitation rates under  
16 section 1853 of the Social Security Act (42 U.S.C.  
17 1395w-23) for 2001, revised in accordance with the provi-  
18 sions of this Act.

19           (b) REENTRY INTO PROGRAM PERMITTED FOR  
20 MEDICARE+CHOICE PROGRAMS IN 2000.—A  
21 Medicare+Choice organization that provided notice to the  
22 Secretary of Health and Human Services before the date  
23 of the enactment of this Act that it was terminating its  
24 contract under part C of title XVIII of the Social Security  
25 Act or was reducing the service area of a

1 Medicare+Choice plan offered under such part shall be  
2 permitted to continue participation under such part, or to  
3 maintain the service area of such plan, for 2001 if it pro-  
4 vides the Secretary with the information described in sec-  
5 tion 1854(a)(1) of the Social Security Act (42 U.S.C.  
6 1395w-24(a)(1)) within 2 weeks after the date revised  
7 rates are announced by the Secretary under subsection  
8 (a).

9 (c) REVISED SUBMISSION OF PROPOSED PREMIUMS  
10 AND RELATED INFORMATION.—If—

11 (1) a Medicare+Choice organization provided  
12 notice to the Secretary of Health and Human Serv-  
13 ices as of July 3, 2000, that it was renewing its con-  
14 tract under part C of title XVIII of the Social Secu-  
15 rity Act for all or part of the service area or areas  
16 served under its current contract, and

17 (2) any part of the service area or areas ad-  
18 dressed in such notice includes a payment area for  
19 which the Medicare+Choice capitation rate under  
20 section 1853(c) of such Act (42 U.S.C. 1395w-  
21 23(c)) for 2001, as determined under subsection (a),  
22 is higher than the rate previously determined for  
23 such year,

24 such organization shall revise its submission of the infor-  
25 mation described in section 1854(a)(1) of the Social Secu-

1 rity Act (42 U.S.C. 1395w-24(a)(1)), and shall submit  
2 such revised information to the Secretary, within 2 weeks  
3 after the date revised rates are announced by the Sec-  
4 retary under subsection (a).

5 (d) DISREGARD OF NEW RATE ANNOUNCEMENT IN  
6 APPLYING PASS-THROUGH FOR NEW NATIONAL COV-  
7 ERAGE DETERMINATIONS.—For purposes of applying sec-  
8 tion 1852(a)(5) of the Social Security Act (42 U.S.C.  
9 1395w-22(a)(5)), the announcement of revised rates  
10 under subsection (a) shall not be treated as an announce-  
11 ment under section 1853(b) of such Act (42 U.S.C.  
12 1395w-23(b)).

13 **SEC. 605. REVISION OF PAYMENT RATES FOR ESRD PA-**  
14 **TIENTS ENROLLED IN MEDICARE+CHOICE**  
15 **PLANS.**

16 (a) IN GENERAL.—Section 1853(a)(1)(B) (42 U.S.C.  
17 1395w-23(a)(1)(B)) is amended by adding at the end the  
18 following: “In establishing such rates, the Secretary shall  
19 provide for appropriate adjustments to increase each rate  
20 to reflect the demonstration rate (including the risk ad-  
21 justment methodology associated with such rate) of the  
22 social health maintenance organization end-stage renal  
23 disease capitation demonstrations (established by section  
24 2355 of the Deficit Reduction Act of 1984, as amended  
25 by section 13567(b) of the Omnibus Budget Reconciliation

1 Act of 1993), and shall compute such rates by taking into  
 2 account such factors as renal treatment modality, age, and  
 3 the underlying cause of the end-stage renal disease.”.

4 (b) EFFECTIVE DATE.—The amendment made by  
 5 subsection (a) shall apply to payments for months begin-  
 6 ning with January 2002.

7 (c) PUBLICATION.—Not later than 6 months after  
 8 the date of the enactment of this Act, the Secretary of  
 9 Health and Human Services shall publish for public com-  
 10 ment a description of the appropriate adjustments de-  
 11 scribed in the last sentence of section 1853(a)(1)(B) of  
 12 the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B)),  
 13 as added by subsection (a). The Secretary shall publish  
 14 such adjustments in final form by not later than July 1,  
 15 2001, so that the amendment made by subsection (a) is  
 16 implemented on a timely basis consistent with subsection  
 17 (b).

18 **SEC. 606. PERMITTING PREMIUM REDUCTIONS AS ADDI-**  
 19 **TIONAL BENEFITS UNDER**  
 20 **MEDICARE+CHOICE PLANS.**

21 (a) IN GENERAL.—

22 (1) AUTHORIZATION OF PART B PREMIUM RE-  
 23 DUCTIONS.—Section 1854(f)(1) (42 U.S.C. 1395w–  
 24 24(f)(1)) is amended—

1 (A) by redesignating subparagraph (E) as  
2 subparagraph (F); and

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

5 “(E) PREMIUM REDUCTIONS.—

6 “(i) IN GENERAL.—Subject to clause  
7 (ii), as part of providing any additional  
8 benefits required under subparagraph (A),  
9 a Medicare+Choice organization may elect  
10 a reduction in its payments under section  
11 1853(a)(1)(A) with respect to a  
12 Medicare+Choice plan and the Secretary  
13 shall apply such reduction to reduce the  
14 premium under section 1839 of each en-  
15 rollee in such plan as provided in section  
16 1840(i).

17 “(ii) AMOUNT OF REDUCTION.—The  
18 amount of the reduction under clause (i)  
19 with respect to any enrollee in a  
20 Medicare+Choice plan—

21 “(I) may not exceed 125 percent  
22 of the premium described under sec-  
23 tion 1839(a)(3); and

24 “(II) shall apply uniformly to  
25 each enrollee of the Medicare+Choice

1                   plan to which such reduction ap-  
2                   plies.”.

3           (2) CONFORMING AMENDMENTS.—

4                   (A) ADJUSTMENT OF PAYMENTS TO  
5           MEDICARE+CHOICE ORGANIZATIONS.—Section  
6           1853(a)(1)(A) (42 U.S.C. 1395w-23(a)(1)(A))  
7           is amended by inserting “reduced by the  
8           amount of any reduction elected under section  
9           1854(f)(1)(E) and” after “for that area,”.

10                   (B) ADJUSTMENT AND PAYMENT OF PART  
11           B PREMIUMS.—

12                   (i) ADJUSTMENT OF PREMIUMS.—  
13           Section 1839(a)(2) (42 U.S.C.  
14           1395r(a)(2)) is amended by striking  
15           “shall” and all that follows and inserting  
16           the following: “shall be the amount deter-  
17           mined under paragraph (3), adjusted as  
18           required in accordance with subsections  
19           (b), (c), and (f), and to reflect 80 percent  
20           of any reduction elected under section  
21           1854(f)(1)(E).”.

22                   (ii) PAYMENT OF PREMIUMS.—Section  
23           1840 (42 U.S.C. 1395s) is amended by  
24           adding at the end the following new sub-  
25           section:

1       “(i) In the case of an individual enrolled in a  
 2 Medicare+Choice plan, the Secretary shall provide for  
 3 necessary adjustments of the monthly beneficiary pre-  
 4 mium to reflect 80 percent of any reduction elected under  
 5 section 1854(f)(1)(E). This premium adjustment may be  
 6 provided directly or as an adjustment to any social secu-  
 7 rity, railroad retirement, and civil service retirement bene-  
 8 fits, to the extent which the Secretary determines that  
 9 such an adjustment is appropriate with the concurrence  
 10 of the agencies responsible for the administration of such  
 11 benefits.”.

12                   (C) INFORMATION COMPARING PLAN PRE-  
 13 MIUMS UNDER PART C.—Section 1851(d)(4)(B)  
 14 (42 U.S.C. 1395w-21(d)(4)(B)) is amended—

15                   (i) by striking “PREMIUMS.—The”  
 16 and inserting “PREMIUMS.—

17                   “(i) IN GENERAL.—The”; and

18                   (ii) by adding at the end the following  
 19 new clause:

20                   “(ii) REDUCTIONS.—The reduction in  
 21 part B premiums, if any.”.

22                   (D) TREATMENT OF REDUCTION FOR PUR-  
 23 POSES OF DETERMINING GOVERNMENT CON-  
 24 TRIBUTION UNDER PART B.—Section 1844 (42

1 U.S.C. 1395w) is amended by adding at the  
2 end the following new subsection:

3 “(c) The Secretary shall determine the Government  
4 contribution under subparagraphs (A) and (B) of sub-  
5 section (a)(1) without regard to any premium reduction  
6 resulting from an election under section 1854(f)(1)(E).”.

7 (b) EFFECTIVE DATE.—The amendments made by  
8 subsection (a) shall apply to years beginning with 2002.

9 **SEC. 607. FULL IMPLEMENTATION OF RISK ADJUSTMENT**  
10 **FOR CONGESTIVE HEART FAILURE ENROLL-**  
11 **EES FOR 2001.**

12 (a) IN GENERAL.—Section 1853(a)(3)(C) (42 U.S.C.  
13 1395w–23(a)(3)(C)) is amended—

14 (1) in clause (ii), by striking “Such risk adjust-  
15 ment” and inserting “Except as provided in clause  
16 (iii), such risk adjustment”; and

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

19 “(iii) FULL IMPLEMENTATION OF  
20 RISK ADJUSTMENT FOR CONGESTIVE  
21 HEART FAILURE ENROLLEES FOR 2001.—

22 “(I) EXEMPTION FROM PHASE-  
23 IN.—Subject to subclause (II), the  
24 Secretary shall fully implement the  
25 risk adjustment methodology de-

1 scribed in clause (i) with respect to  
2 each individual who has had a quali-  
3 fying congestive heart failure inpa-  
4 tient diagnosis (as determined by the  
5 Secretary under such risk adjustment  
6 methodology) during the period begin-  
7 ning on July 1, 1999, and ending on  
8 June 30, 2000, and who is enrolled in  
9 a coordinated care plan that is the  
10 only coordinated care plan offered on  
11 January 1, 2001, in the service area  
12 of the individual.

13 “(II) PERIOD OF APPLICATION.—  
14 Subclause (I) shall only apply during  
15 the 1-year period beginning on Janu-  
16 ary 1, 2001.”.

17 (b) EXCLUSION FROM DETERMINATION OF THE  
18 BUDGET NEUTRALITY FACTOR.—Section 1853(c)(5) (42  
19 U.S.C. 1395w–23(c)(5)) is amended by striking “sub-  
20 section (i)” and inserting “subsections (a)(3)(C)(iii) and  
21 (i)”.

22 **SEC. 608. EXPANSION OF APPLICATION OF**  
23 **MEDICARE+CHOICE NEW ENTRY BONUS.**

24 (a) IN GENERAL.—Section 1853(i)(1) (42 U.S.C.  
25 1395w–23(i)(1)) is amended in the matter preceding sub-

1 paragraph (A) by inserting “, or filed notice with the Sec-  
2 retary as of October 3, 2000, that they will not be offering  
3 such a plan as of January 1, 2001” after “January 1,  
4 2000”.

5 (b) EFFECTIVE DATE.—The amendment made by  
6 subsection (a) shall apply as if included in the enactment  
7 of BBRA.

8 **SEC. 609. REPORT ON INCLUSION OF CERTAIN COSTS OF**  
9 **THE DEPARTMENT OF VETERANS AFFAIRS**  
10 **AND MILITARY FACILITY SERVICES IN CAL-**  
11 **CULATING MEDICARE+CHOICE PAYMENT**  
12 **RATES.**

13 The Secretary of Health and Human Services shall  
14 report to Congress by not later than January 1, 2003,  
15 on a method to phase-in the costs of military facility serv-  
16 ices furnished by the Department of Veterans Affairs, and  
17 the costs of military facility services furnished by the De-  
18 partment of Defense, to medicare-eligible beneficiaries in  
19 the calculation of an area’s Medicare+Choice capitation  
20 payment. Such report shall include on a county-by-county  
21 basis—

22 (1) the actual or estimated cost of such services  
23 to medicare-eligible beneficiaries;

1           (2) the change in Medicare+Choice capitation  
2           payment rates if such costs are included in the cal-  
3           culation of payment rates;

4           (3) one or more proposals for the implementa-  
5           tion of payment adjustments to Medicare+Choice  
6           plans in counties where the payment rate has been  
7           affected due to the failure to calculate the cost of  
8           such services to medicare-eligible beneficiaries; and

9           (4) a system to ensure that when a  
10          Medicare+Choice enrollee receives covered services  
11          through a facility of the Department of Veterans Af-  
12          fairs or the Department of Defense there is an ap-  
13          propriate payment recovery to the medicare program  
14          under title XVIII of the Social Security Act.

## 15 **Subtitle B—Other Medicare+Choice** 16 **Reforms**

### 17 **SEC. 611. PAYMENT OF ADDITIONAL AMOUNTS FOR NEW** 18 **BENEFITS COVERED DURING A CONTRACT** 19 **TERM.**

20          (a) IN GENERAL.—Section 1853(c)(7) (42 U.S.C.  
21 1395w-23(c)(7)) is amended to read as follows:

22               “(7) ADJUSTMENT FOR NATIONAL COVERAGE  
23               DETERMINATIONS AND LEGISLATIVE CHANGES IN  
24               BENEFITS.—If the Secretary makes a determination  
25               with respect to coverage under this title or there is

1 a change in benefits required to be provided under  
2 this part that the Secretary projects will result in a  
3 significant increase in the costs to Medicare+Choice  
4 of providing benefits under contracts under this part  
5 (for periods after any period described in section  
6 1852(a)(5)), the Secretary shall adjust appropriately  
7 the payments to such organizations under this part.  
8 Such projection and adjustment shall be based on an  
9 analysis by the Chief Actuary of the Health Care Fi-  
10 nancing Administration of the actuarial costs associ-  
11 ated with the new benefits.”.

12 (b) CONFORMING AMENDMENT.—Section 1852(a)(5)  
13 (42 U.S.C. 1395w–22(a)(5)) is amended—

14 (1) in the heading, by inserting “AND LEGISLA-  
15 TIVE CHANGES IN BENEFITS” after “NATIONAL COV-  
16 ERAGE DETERMINATIONS”;

17 (2) by inserting “or legislative change in bene-  
18 fits required to be provided under this part” after  
19 “national coverage determination”;

20 (3) in subparagraph (A), by inserting “or legis-  
21 lative change in benefits” after “such determina-  
22 tion”;

23 (4) in subparagraph (B), by inserting “or legis-  
24 lative change” after “if such coverage determina-  
25 tion”; and

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

2 “The projection under the previous sentence shall be  
3 based on an analysis by the Chief Actuary of the  
4 Health Care Financing Administration of the actu-  
5 arial costs associated with the coverage determina-  
6 tion or legislative change in benefits.”.

7 (c) EFFECTIVE DATE.—The amendments made by  
8 this section are effective on the date of the enactment of  
9 this Act and apply to national coverage determinations  
10 and legislative changes in benefits occurring on or after  
11 such date.

12 **SEC. 612. RESTRICTION ON IMPLEMENTATION OF SIGNIFI-**  
13 **CANT NEW REGULATORY REQUIREMENTS**  
14 **MIDYEAR.**

15 (a) IN GENERAL.—Section 1856(b) (42 U.S.C.  
16 1395w–26(b)) is amended by adding at the end the fol-  
17 lowing new paragraph:

18 “(4) PROHIBITION OF MIDYEAR IMPLEMENTA-  
19 TION OF SIGNIFICANT NEW REGULATORY REQUIRE-  
20 MENTS.—The Secretary may not implement, other  
21 than at the beginning of a calendar year, regulations  
22 under this section that impose new, significant regu-  
23 latory requirements on a Medicare+Choice organiza-  
24 tion or plan.”.

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

4 **SEC. 613. TIMELY APPROVAL OF MARKETING MATERIAL**  
5 **THAT FOLLOWS MODEL MARKETING LAN-**  
6 **GUAGE.**

7 (a) IN GENERAL.—Section 1851(h) (42 U.S.C.  
8 1395w-21(h)) is amended—

9 (1) in paragraph (1)(A), by inserting “(or 10  
10 days in the case described in paragraph (5))” after  
11 “45 days”; and

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

14 “(5) SPECIAL TREATMENT OF MARKETING MA-  
15 TERIAL FOLLOWING MODEL MARKETING LAN-  
16 GUAGE.—In the case of marketing material of an or-  
17 ganization that uses, without modification, proposed  
18 model language specified by the Secretary, the pe-  
19 riod specified in paragraph (1)(A) shall be reduced  
20 from 45 days to 10 days.”.

21 (b) EFFECTIVE DATE.—The amendments made by  
22 subsection (a) apply to marketing material submitted on  
23 or after January 1, 2001.

1 **SEC. 614. AVOIDING DUPLICATIVE REGULATION.**

2 (a) IN GENERAL.—Section 1856(b)(3)(B) (42 U.S.C.  
3 1395w–26(b)(3)(B)) is amended—

4 (1) in clause (i), by inserting “(including cost-  
5 sharing requirements)” after “Benefit require-  
6 ments”; and

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

9 “(iv) Requirements relating to mar-  
10 keting materials and summaries and sched-  
11 ules of benefits regarding a  
12 Medicare+Choice plan.”.

13 (b) EFFECTIVE DATE.—The amendments made by  
14 subsection (a) take effect on the date of the enactment  
15 of this Act.

16 **SEC. 615. ELECTION OF UNIFORM LOCAL COVERAGE POL-**  
17 **ICY FOR MEDICARE+CHOICE PLAN COVERING**  
18 **MULTIPLE LOCALITIES.**

19 Section 1852(a)(2) (42 U.S.C. 1395w–22(a)(2)) is  
20 amended by adding at the end the following new subpara-  
21 graph:

22 “(C) ELECTION OF UNIFORM COVERAGE  
23 POLICY.—In the case of a Medicare+Choice or-  
24 ganization that offers a Medicare+Choice plan  
25 in an area in which more than one local cov-  
26 erage policy is applied with respect to different

1 parts of the area, the organization may elect to  
2 have the local coverage policy for the part of  
3 the area that is most beneficial to  
4 Medicare+Choice enrollees (as identified by the  
5 Secretary) apply with respect to all  
6 Medicare+Choice enrollees enrolled in the  
7 plan.”.

8 **SEC. 616. ELIMINATING HEALTH DISPARITIES IN**  
9 **MEDICARE+CHOICE PROGRAM.**

10 (a) **QUALITY ASSURANCE PROGRAM FOCUS ON RA-**  
11 **CIAL AND ETHNIC MINORITIES.**—Subparagraphs (A) and  
12 (B) of section 1852(e)(2) (42 U.S.C. 1395w–22(e)(2)) are  
13 each amended by adding at the end the following:

14 “Such program shall include a separate focus  
15 (with respect to all the elements described in  
16 this subparagraph) on racial and ethnic minori-  
17 ties.”.

18 (b) **REPORT.**—Section 1852(e) (42 U.S.C. 1395w–  
19 22(e)) is amended by adding at the end the following new  
20 paragraph:

21 “(5) **REPORT TO CONGRESS.**—

22 “(A) **IN GENERAL.**—Not later than 2 years  
23 after the date of the enactment of this para-  
24 graph, and biennially thereafter, the Secretary  
25 shall submit to Congress a report regarding

1           how quality assurance programs conducted  
2           under this subsection focus on racial and ethnic  
3           minorities.

4           “(B) CONTENTS OF REPORT.—Each such  
5           report shall include the following:

6                   “(i) A description of the means by  
7                   which such programs focus on such racial  
8                   and ethnic minorities.

9                   “(ii) An evaluation of the impact of  
10                  such programs on eliminating health dis-  
11                  parities and on improving health outcomes,  
12                  continuity and coordination of care, man-  
13                  agement of chronic conditions, and con-  
14                  sumer satisfaction.

15                  “(iii) Recommendations on ways to re-  
16                  duce clinical outcome disparities among ra-  
17                  cial and ethnic minorities.”.

18 **SEC. 617. MEDICARE+CHOICE PROGRAM COMPATIBILITY**  
19 **WITH EMPLOYER OR UNION GROUP HEALTH**  
20 **PLANS.**

21           (a) IN GENERAL.—Section 1857 (42 U.S.C. 1395w-  
22 27) is amended by adding at the end the following new  
23 subsection:

24           “(i) MEDICARE+CHOICE PROGRAM COMPATIBILITY  
25 WITH EMPLOYER OR UNION GROUP HEALTH PLANS.—

1 To facilitate the offering of Medicare+Choice plans under  
 2 contracts between Medicare+Choice organizations and  
 3 employers, labor organizations, or the trustees of a fund  
 4 established by 1 or more employers or labor organizations  
 5 (or combination thereof) to furnish benefits to the entity's  
 6 employees, former employees (or combination thereof) or  
 7 members or former members (or combination thereof) of  
 8 the labor organizations, the Secretary may waive or mod-  
 9 ify requirements that hinder the design of, the offering  
 10 of, or the enrollment in such Medicare+Choice plans.”.

11 (b) EFFECTIVE DATE.—The amendment made by  
 12 subsection (a) applies with respect to years beginning with  
 13 2001.

14 **SEC. 618. SPECIAL MEDIGAP ENROLLMENT ANTIDISCRIMI-**  
 15 **NATION PROVISION FOR CERTAIN BENE-**  
 16 **FICIARIES.**

17 (a) DISENROLLMENT WINDOW IN ACCORDANCE  
 18 WITH BENEFICIARY'S CIRCUMSTANCE.—Section  
 19 1882(s)(3) (42 U.S.C. 1395ss(s)(3)) is amended—

20 (1) in subparagraph (A), in the matter fol-  
 21 lowing clause (iii), by striking “, subject to subpara-  
 22 graph (E), seeks to enroll under the policy not later  
 23 than 63 days after the date of the termination of en-  
 24 rollment described in such subparagraph” and in-

1       serting “seeks to enroll under the policy during the  
2       period specified in subparagraph (E)”]; and

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

5       “(E) For purposes of subparagraph (A), the time pe-  
6       riod specified in this subparagraph is—

7               “(i) in the case of an individual described in  
8       subparagraph (B)(i), the period beginning on the  
9       date the individual receives a notice of termination  
10      or cessation of all supplemental health benefits (or,  
11      if no such notice is received, notice that a claim has  
12      been denied because of such a termination or ces-  
13      sation) and ending on the date that is 63 days after  
14      the applicable notice;

15              “(ii) in the case of an individual described in  
16      clause (ii), (iii), (v), or (vi) of subparagraph (B)  
17      whose enrollment is terminated involuntarily, the pe-  
18      riod beginning on the date that the individual re-  
19      ceives a notice of termination and ending on the  
20      date that is 63 days after the date the applicable  
21      coverage is terminated;

22              “(iii) in the case of an individual described in  
23      subparagraph (B)(iv)(I), the period beginning on the  
24      earlier of (I) the date that the individual receives a  
25      notice of termination, a notice of the issuer’s bank-

1 ruptcy or insolvency, or other such similar notice, if  
2 any, and (II) the date that the applicable coverage  
3 is terminated, and ending on the date that is 63  
4 days after the date the coverage is terminated;

5 “(iv) in the case of an individual described in  
6 clause (ii), (iii), (iv)(II), (iv)(III), (v), or (vi) of sub-  
7 paragraph (B) who disenrolls voluntarily, the period  
8 beginning on the date that is 60 days before the ef-  
9 fective date of the disenrollment and ending on the  
10 date that is 63 days after such effective date; and

11 “(v) in the case of an individual described in  
12 subparagraph (B) but not described in the preceding  
13 provisions of this subparagraph, the period begin-  
14 ning on the effective date of the disenrollment and  
15 ending on the date that is 63 days after such effec-  
16 tive date.”.

17 (b) EXTENDED MEDIGAP ACCESS FOR INTERRUPTED  
18 TRIAL PERIODS.—Section 1882(s)(3) (42 U.S.C.  
19 1395ss(s)(3)), as amended by subsection (a), is further  
20 amended by adding at the end the following new subpara-  
21 graph:

22 “(F)(i) Subject to clause (ii), for purposes of this  
23 paragraph—

24 “(I) in the case of an individual described in  
25 subparagraph (B)(v) (or deemed to be so described,

1       pursuant to this subparagraph) whose enrollment  
2       with an organization or provider described in sub-  
3       clause (II) of such subparagraph is involuntarily ter-  
4       minated within the first 12 months of such enroll-  
5       ment, and who, without an intervening enrollment,  
6       enrolls with another such organization or provider,  
7       such subsequent enrollment shall be deemed to be an  
8       initial enrollment described in such subparagraph;  
9       and

10               “(II) in the case of an individual described in  
11       clause (vi) of subparagraph (B) (or deemed to be so  
12       described, pursuant to this subparagraph) whose en-  
13       rollment with a plan or in a program described in  
14       such clause is involuntarily terminated within the  
15       first 12 months of such enrollment, and who, with-  
16       out an intervening enrollment, enrolls in another  
17       such plan or program, such subsequent enrollment  
18       shall be deemed to be an initial enrollment described  
19       in such clause.

20               “(ii) For purposes of clauses (v) and (vi) of subpara-  
21       graph (B), no enrollment of an individual with an organi-  
22       zation or provider described in clause (v)(II), or with a  
23       plan or in a program described in clause (vi), may be  
24       deemed to be an initial enrollment under this clause after  
25       the 2-year period beginning on the date on which the indi-

1 vidual first enrolled with such an organization, provider,  
2 plan, or program.”.

3 **SEC. 619. RESTORING EFFECTIVE DATE OF ELECTIONS AND**  
4 **CHANGES OF ELECTIONS OF**  
5 **MEDICARE+CHOICE PLANS.**

6 (a) OPEN ENROLLMENT.—Section 1851(f)(2) (42  
7 U.S.C. 1395w–21(f)(2)) is amended by striking “, except  
8 that if such election or change is made after the 10th day  
9 of any calendar month, then the election or change shall  
10 not take effect until the first day of the second calendar  
11 month following the date on which the election or change  
12 is made”.

13 (b) EFFECTIVE DATE.—The amendment made by  
14 this section shall apply to elections and changes of cov-  
15 erage made on or after January 1, 2001.

16 **SEC. 620. PERMITTING ESRD BENEFICIARIES TO ENROLL**  
17 **IN ANOTHER MEDICARE+CHOICE PLAN IF**  
18 **THE PLAN IN WHICH THEY ARE ENROLLED IS**  
19 **TERMINATED.**

20 (a) IN GENERAL.—Section 1851(a)(3)(B) (42 U.S.C.  
21 1395w–21(a)(3)(B)) is amended by striking “except that”  
22 and all that follows and inserting the following: “except  
23 that—

24 “(i) an individual who develops end-  
25 stage renal disease while enrolled in a

1 Medicare+Choice plan may continue to be  
2 enrolled in that plan; and

3 “(ii) in the case of such an individual  
4 who is enrolled in a Medicare+Choice plan  
5 under clause (i) (or subsequently under  
6 this clause), if the enrollment is discon-  
7 tinued under circumstances described in  
8 section 1851(e)(4)(A), then the individual  
9 will be treated as a ‘Medicare+Choice eli-  
10 gible individual’ for purposes of electing to  
11 continue enrollment in another  
12 Medicare+Choice plan.”.

13 (b) EFFECTIVE DATE.—

14 (1) IN GENERAL.—The amendment made by  
15 subsection (a) shall apply to terminations and  
16 discontinuations occurring on or after the date of  
17 the enactment of this Act.

18 (2) APPLICATION TO PRIOR PLAN TERMI-  
19 NATIONS.—Clause (ii) of section 1851(a)(3)(B) of  
20 the Social Security Act (as inserted by subsection  
21 (a)) also shall apply to individuals whose enrollment  
22 in a Medicare+Choice plan was terminated or dis-  
23 continued after December 31, 1998, and before the  
24 date of the enactment of this Act. In applying this  
25 paragraph, such an individual shall be treated, for

1 purposes of part C of title XVIII of the Social Secu-  
 2 rity Act, as having discontinued enrollment in such  
 3 a plan as of the date of the enactment of this Act.

4 **SEC. 621. PROVIDING CHOICE FOR SKILLED NURSING FA-**  
 5 **CILITY SERVICES UNDER THE**  
 6 **MEDICARE+CHOICE PROGRAM.**

7 (a) IN GENERAL.—Section 1852 (42 U.S.C. 1395w-  
 8 22) is amended by adding at the end the following new  
 9 subsection:

10 “(1) RETURN TO HOME SKILLED NURSING FACILI-  
 11 TIES FOR COVERED POST-HOSPITAL EXTENDED CARE  
 12 SERVICES.—

13 “(1) ENSURING RETURN TO HOME SNF.—

14 “(A) IN GENERAL.—In providing coverage  
 15 of post-hospital extended care services, a  
 16 Medicare+Choice plan shall provide for such  
 17 coverage through a home skilled nursing facility  
 18 if the following conditions are met:

19 “(i) ENROLLEE ELECTION.—The en-  
 20 rollee elects to receive such coverage  
 21 through such facility.

22 “(ii) SNF AGREEMENT.—The facility  
 23 has a contract with the Medicare+Choice  
 24 organization for the provision of such serv-  
 25 ices, or the facility agrees to accept sub-

1           stantially similar payment under the same  
2           terms and conditions that apply to simi-  
3           larly situated skilled nursing facilities that  
4           are     under     contract     with     the  
5           Medicare+Choice organization for the pro-  
6           vision of such services and through which  
7           the enrollee would otherwise receive such  
8           services.

9           “(B) MANNER OF PAYMENT TO HOME  
10          SNF.—The organization shall provide payment  
11          to the home skilled nursing facility consistent  
12          with the contract or the agreement described in  
13          subparagraph (A)(ii), as the case may be.

14          “(2) NO LESS FAVORABLE COVERAGE.—The  
15          coverage provided under paragraph (1) (including  
16          scope of services, cost-sharing, and other criteria of  
17          coverage) shall be no less favorable to the enrollee  
18          than the coverage that would be provided to the en-  
19          rollee with respect to a skilled nursing facility the  
20          post-hospital extended care services of which are  
21          otherwise covered under the Medicare+Choice plan.

22          “(3) RULE OF CONSTRUCTION.—Nothing in  
23          this subsection shall be construed to do the fol-  
24          lowing:

1           “(A) To require coverage through a skilled  
2 nursing facility that is not otherwise qualified  
3 to provide benefits under part A for medicare  
4 beneficiaries not enrolled in a Medicare+Choice  
5 plan.

6           “(B) To prevent a skilled nursing facility  
7 from refusing to accept, or imposing conditions  
8 upon the acceptance of, an enrollee for the re-  
9 ceipt of post-hospital extended care services.

10          “(4) DEFINITIONS.—In this subsection:

11           “(A) HOME SKILLED NURSING FACIL-  
12 ITY.—The term ‘home skilled nursing facility’  
13 means, with respect to an enrollee who is enti-  
14 tled to receive post-hospital extended care serv-  
15 ices under a Medicare+Choice plan, any of the  
16 following skilled nursing facilities:

17           “(i) SNF RESIDENCE AT TIME OF AD-  
18 MISSION.—The skilled nursing facility in  
19 which the enrollee resided at the time of  
20 admission to the hospital preceding the re-  
21 ceipt of such post-hospital extended care  
22 services.

23           “(ii) SNF IN CONTINUING CARE RE-  
24 TIREMENT COMMUNITY.—A skilled nursing  
25 facility that is providing such services

1 through a continuing care retirement com-  
2 munity (as defined in subparagraph (B))  
3 which provided residence to the enrollee at  
4 the time of such admission.

5 “(iii) SNF RESIDENCE OF SPOUSE AT  
6 TIME OF DISCHARGE.—The skilled nursing  
7 facility in which the spouse of the enrollee  
8 is residing at the time of discharge from  
9 such hospital.

10 “(B) CONTINUING CARE RETIREMENT  
11 COMMUNITY.—The term ‘continuing care retire-  
12 ment community’ means, with respect to an en-  
13 rollee in a Medicare+Choice plan, an arrange-  
14 ment under which housing and health-related  
15 services are provided (or arranged) through an  
16 organization for the enrollee under an agree-  
17 ment that is effective for the life of the enrollee  
18 or for a specified period.”.

19 (b) EFFECTIVE DATE.—The amendment made by  
20 subsection (a) applies with respect to contracts entered  
21 into or renewed on or after the date of the enactment of  
22 this Act.

23 (c) MEDPAC STUDY.—

24 (1) STUDY.—The Medicare Payment Advisory  
25 Commission shall conduct a study analyzing the ef-

1       fects of the amendment made by subsection (a) on  
2       Medicare+Choice organizations. In conducting such  
3       study, the Commission shall examine the effects (if  
4       any) such amendment has had on—

5               (A) the scope of additional benefits pro-  
6               vided under the Medicare+Choice program;

7               (B) the administrative and other costs in-  
8               curred by Medicare+Choice organizations;

9               (C) the contractual relationships between  
10              such organizations and skilled nursing facilities.

11             (2) REPORT.—Not later than 2 years after the  
12             date of the enactment of this Act, the Commission  
13             shall submit to Congress a report on the study con-  
14             ducted under paragraph (1).

15 **SEC. 622. PROVIDING FOR ACCOUNTABILITY OF**  
16 **MEDICARE+CHOICE PLANS.**

17             (a) MANDATORY REVIEW OF ACR SUBMISSIONS BY  
18             THE CHIEF ACTUARY OF THE HEALTH CARE FINANCING  
19             ADMINISTRATION.—Section 1854(a)(5)(A) (42 U.S.C.  
20             1395w-24(a)(5)(A)) is amended—

21               (1) by striking “value” and inserting “values”;  
22             and

23               (2) by adding at the end the following: “The  
24             Chief Actuary of the Health Care Financing Admin-  
25             istration shall review the actuarial assumptions and

1 data used by the Medicare+Choice organization with  
 2 respect to such rates, amounts, and values so sub-  
 3 mitted to determine the appropriateness of such as-  
 4 sumptions and data.”.

5 (b) EFFECTIVE DATE.—The amendment made by  
 6 subsection (a) applies to submissions made on or after  
 7 January 1, 2001.

8 **SEC. 623. CIVIL MONETARY PENALTIES FOR CONTRACT DE-**  
 9 **FAULT BY A MEDICARE+CHOICE ORGANIZA-**  
 10 **TION.**

11 (a) IN GENERAL.—Section 1857(g)(3) is amended by  
 12 adding at the end the following new subparagraph:

13 “(D) Civil monetary penalties of up to  
 14 \$25,000 per enrollee or \$100,000 per organiza-  
 15 tion, whichever is greater, where the finding  
 16 under subsection (c)(2)(A) is based on the orga-  
 17 nization’s defaulting on its contract.”.

18 **Subtitle C—Other Managed Care**  
 19 **Reforms**

20 **SEC. 631. 1-YEAR EXTENSION OF SOCIAL HEALTH MAINTENANCE ORGANIZATION (SHMO) DEMONSTRATION PROJECT.**

23 Section 4018(b)(1) of the Omnibus Budget Reconcili-  
 24 ation Act of 1987, as amended by section 531(a)(1) of

1 BBRA (113 Stat. 1501A–388), is amended by striking  
2 “18 months” and inserting “30 months”.

3 **SEC. 632. REVISED TERMS AND CONDITIONS FOR EXTEN-**  
4 **SION OF MEDICARE COMMUNITY NURSING**  
5 **ORGANIZATION (CNO) DEMONSTRATION**  
6 **PROJECT.**

7 (a) IN GENERAL.—Section 532 of BBRA (113 Stat.  
8 1501A–388) is amended—

9 (1) in subsection (a), by striking the second  
10 sentence; and

11 (2) by striking subsection (b) and inserting the  
12 following new subsection:

13 “(b) TERMS AND CONDITIONS.—

14 “(1) JANUARY THROUGH SEPTEMBER 2000.—  
15 For the 9-month period beginning with January  
16 2000, any such demonstration project shall be con-  
17 ducted under the same terms and conditions as ap-  
18 plied to such demonstration during 1999.

19 “(2) OCTOBER 2000 THROUGH DECEMBER  
20 2001.—For the 15-month period beginning with Oc-  
21 tober 2000, any such demonstration project shall be  
22 conducted under the same terms and conditions as  
23 applied to such demonstration during 1999, except  
24 that the following modifications shall apply:

1           “(A) BASIC CAPITATION RATE.—The basic  
2           capitation rate paid for services covered under  
3           the project (other than case management serv-  
4           ices) per enrollee per month and furnished  
5           during—

6                   “(i) the period beginning with October  
7                   1, 2000, and ending with December 31,  
8                   2000, shall be determined by actuarially  
9                   adjusting the actual capitation rate paid  
10                  for such services in 1999 for inflation, uti-  
11                  lization, and other changes to the CNO  
12                  service package, and by reducing such ad-  
13                  justed capitation rate by 10 percent in the  
14                  case of the demonstration sites located in  
15                  Arizona, Minnesota, and Illinois, and 15  
16                  percent for the demonstration site located  
17                  in New York; and

18                   “(ii) 2001 shall be determined by ac-  
19                   tuarily adjusting the capitation rate de-  
20                   termined under clause (i) for inflation, uti-  
21                   lization, and other changes to the CNO  
22                   service package.

23           “(B) TARGETED CASE MANAGEMENT  
24           FEE.—Effective October 1, 2000—

1           “(i) the case management fee per en-  
2           rollee per month for—

3                   “(I) the period described in sub-  
4                   paragraph (A)(i) shall be determined  
5                   by actuarially adjusting the case man-  
6                   agement fee for 1999 for inflation;  
7                   and

8                   “(II) 2001 shall be determined  
9                   by actuarially adjusting the amount  
10                  determined under subclause (I) for in-  
11                  flation; and

12                  “(ii) such case management fee shall  
13                  be paid only for enrollees who are classified  
14                  as moderately frail or frail pursuant to cri-  
15                  teria established by the Secretary.

16                  “(C) GREATER UNIFORMITY IN CLINICAL  
17                  FEATURES AMONG SITES.—Each project shall  
18                  implement for each site—

19                   “(i) protocols for periodic telephonic  
20                   contact with enrollees based on—

21                           “(I) the results of such standard-  
22                           ized written health assessment; and

23                           “(II) the application of appro-  
24                           priate care planning approaches;

1           “(ii) disease management programs  
2           for targeted diseases (such as congestive  
3           heart failure, arthritis, diabetes, and hy-  
4           pertension) that are highly prevalent in the  
5           enrolled populations;

6           “(iii) systems and protocols to track  
7           enrollees through hospitalizations, includ-  
8           ing pre-admission planning, concurrent  
9           management during inpatient hospital  
10          stays, and post-discharge assessment, plan-  
11          ning, and follow-up; and

12          “(iv) standardized patient educational  
13          materials for specified diseases and health  
14          conditions.

15          “(D)    QUALITY    IMPROVEMENT.—Each  
16          project shall implement at each site once during  
17          the 15-month period—

18                 “(i) enrollee satisfaction surveys; and

19                 “(ii) reporting on specified quality in-  
20                 dicators for the enrolled population.

21          “(c) EVALUATION.—

22                 “(1) PRELIMINARY REPORT.—Not later than  
23          July 1, 2001, the Secretary of Health and Human  
24          Services shall submit to the Committees on Ways  
25          and Means and Commerce of the House of Rep-

1 representatives and the Committee on Finance of the  
2 Senate a preliminary report that—

3 “(A) evaluates such demonstration projects  
4 for the period beginning July 1, 1997, and end-  
5 ing December 31, 1999, on a site-specific basis  
6 with respect to the impact on per beneficiary  
7 spending, specific health utilization measures,  
8 and enrollee satisfaction; and

9 “(B) includes a similar evaluation of such  
10 projects for the portion of the extension period  
11 that occurs after September 30, 2000.

12 “(2) FINAL REPORT.—The Secretary shall sub-  
13 mit a final report to such Committees on such dem-  
14 onstration projects not later than July 1, 2002.  
15 Such report shall include the same elements as the  
16 preliminary report required by paragraph (1), but  
17 for the period after December 31, 1999.

18 “(3) METHODOLOGY FOR SPENDING COMPARI-  
19 SONS.—Any evaluation of the impact of the dem-  
20 onstration projects on per beneficiary spending in-  
21 cluded in such reports shall include a comparison  
22 of—

23 “(A) data for all individuals who—

1                   “(i) were enrolled in such demonstra-  
2                   tion projects as of the first day of the pe-  
3                   riod under evaluation; and

4                   “(ii) were enrolled for a minimum of  
5                   6 months thereafter; with

6                   “(B) data for a matched sample of individ-  
7                   uals who are enrolled under part B of title  
8                   XVIII of the Social Security Act and are not  
9                   enrolled in such a project, or in a  
10                  Medicare+Choice plan under part C of such  
11                  title, a plan offered by an eligible organization  
12                  under section 1876 of such Act, or a health  
13                  care prepayment plan under section  
14                  1833(a)(1)(A) of such Act.”.

15           (b) EFFECTIVE DATE.—The amendments made by  
16           subsection (a) shall be effective as if included in the enact-  
17           ment of section 532 of BBRA (113 Stat. 1501A–388).

18   **SEC. 633. EXTENSION OF MEDICARE MUNICIPAL HEALTH**  
19                                   **SERVICES DEMONSTRATION PROJECTS.**

20           Section 9215(a) of the Consolidated Omnibus Budget  
21           Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as  
22           amended by section 6135 of the Omnibus Budget Rec-  
23           onciliation Act of 1989, section 13557 of the Omnibus  
24           Budget Reconciliation Act of 1993, section 4017 of BBA,  
25           and section 534 of BBRA (113 Stat. 1501A–390), is

1 amended by striking “December 31, 2002” and inserting  
2 “December 31, 2004”.

3 **SEC. 634. SERVICE AREA EXPANSION FOR MEDICARE COST**  
4 **CONTRACTS DURING TRANSITION PERIOD.**

5 Section 1876(h)(5) (42 U.S.C. 1395mm(h)(5)) is  
6 amended—

7 (1) by redesignating subparagraph (B) as sub-  
8 paragraph (C); and

9 (2) by inserting after subparagraph (A), the fol-  
10 lowing new subparagraph:

11 “(B) Subject to subparagraph (C), the Secretary  
12 shall approve an application for a modification to a rea-  
13 sonable cost contract under this section in order to expand  
14 the service area of such contract if—

15 “(i) such application is submitted to the Sec-  
16 retary on or before September 1, 2003; and

17 “(ii) the Secretary determines that the organi-  
18 zation with the contract continues to meet the re-  
19 quirements applicable to such organizations and con-  
20 tracts under this section.”.

21 **TITLE VII—MEDICAID**

22 **SEC. 701. DSH PAYMENTS.**

23 (a) CONTINUATION OF MEDICAID DSH ALLOTMENTS  
24 AT FISCAL YEAR 2000 LEVELS FOR FISCAL YEARS 2001  
25 AND 2002.—Section 1923(f) (42 U.S.C. 1396r-4(f)), as

1 amended by section 601 of the Medicare, Medicaid, and  
2 SCHIP Balanced Budget Refinement Act of 1999 (as en-  
3 acted into law by section 1000(a)(6) of Public Law 106-  
4 113), is amended—

5 (1) in paragraph (2)—

6 (A) by striking “2002” in the heading and  
7 inserting “2000”;

8 (B) in the matter preceding the table, by  
9 striking “2002” and inserting “2000”; and

10 (C) in the table in such paragraph, by  
11 striking the columns labeled “FY 01” and “FY  
12 02” relating to fiscal years 2001 and 2002; and

13 (2) in paragraph (3)—

14 (A) by striking “2003” in the heading and  
15 inserting “2001”; and

16 (B) by striking “2003” and inserting  
17 “2001”.

18 (b) SPECIAL RULE FOR MEDICAID DSH ALLOTMENT  
19 FOR EXTREMELY LOW DSH STATES.—Section  
20 1923(f)(3) (42 U.S.C. 1396r-4(f)(3)) is amended—

21 (1) in subparagraph (A), by striking “subpara-  
22 graph (B)” and inserting “subparagraphs (B) and  
23 (C)”; and

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

1           “(C) SPECIAL RULE FOR EXTREMELY LOW  
2           DSH STATES.—In the case of a State in which  
3           the total expenditures under the State plan (in-  
4           cluding Federal and State shares) for dis-  
5           proportionate share hospital adjustments under  
6           this section for fiscal year 1999, as reported to  
7           the Administrator of the Health Care Financing  
8           Administration as of August 31, 2000, is great-  
9           er than 0 but less than 1 percent of the State’s  
10          total amount of expenditures under the State  
11          plan for medical assistance during the fiscal  
12          year, the DSH allotment for fiscal year 2001  
13          shall be increased to 1 percent of the State’s  
14          total amount of expenditures under such plan  
15          for such assistance during such fiscal year. In  
16          subsequent fiscal years, such increased allot-  
17          ment is subject to an increase for inflation as  
18          provided in subparagraph (A).”.

19          (c) DISTRICT OF COLUMBIA.—Effective beginning  
20          with fiscal year 2001, the item in the table in section  
21          1923(f) (42 U.S.C. 1396r-4(f)) relating to District of Co-  
22          lumbia for FY 2000, is amended by striking “32” and  
23          inserting “49”.

24          (d) CONTINGENT ALLOTMENT FOR TENNESSEE.—  
25          Section 1923(f) (42 U.S.C. 1396r-4(f)) is amended—

1           (1) in paragraph (3)(A), by striking “or this  
2 paragraph” and inserting “, this paragraph, or para-  
3 graph (4)”; and

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

6           “(4) CONTINGENT ALLOTMENT ADJUSTMENT  
7 FOR TENNESSEE.—If the State-wide waiver ap-  
8 proved under section 1115 for the State of Ten-  
9 nessee with respect to requirements under this title  
10 as in effect on the date of the enactment of this sub-  
11 section is revoked or terminated, the DSH allotment  
12 for Tennessee for fiscal year 2001 is deemed to be  
13 equal to \$286,442,437.”.

14           (e) ASSURING IDENTIFICATION OF MEDICAID MAN-  
15 AGED CARE PATIENTS.—

16           (1) IN GENERAL.—Section 1932 (42 U.S.C.  
17 1396u–2) is amended by adding at the end the fol-  
18 lowing new subsection:

19           “(g) IDENTIFICATION OF PATIENTS FOR PURPOSES  
20 OF MAKING DSH PAYMENTS.—Each contract with a  
21 managed care entity under section 1903(m) or under sec-  
22 tion 1905(t)(3) shall require the entity either—

23           “(1) to report to the State information nec-  
24 essary to determine the hospital services provided  
25 under the contract (and the identity of hospitals pro-

1       viding such services) for purposes of applying sec-  
2       tions 1886(d)(5)(F) and 1923; or

3               “(2) to include a sponsorship code in the identi-  
4       fication card issued to individuals covered under this  
5       title in order that a hospital may identify a patient  
6       as being entitled to benefits under this title.”.

7               (2) CLARIFICATION OF COUNTING MANAGED  
8       CARE MEDICAID PATIENTS.—Section 1923 (42  
9       U.S.C. 1396r-4) is amended—

10              (A) in subsection (a)(2)(D), by inserting  
11              after “the proportion of low-income and med-  
12              icaid patients” the following: “(including such  
13              patients who receive benefits through a man-  
14              aged care entity)”;

15              (B) in subsection (b)(2), by inserting after  
16              “a State plan approved under this title in a pe-  
17              riod” the following: “(regardless of whether  
18              such patients receive medical assistance on a  
19              fee-for-service basis or through a managed care  
20              entity)”;

21              (C) in subsection (b)(3)(A)(i), by inserting  
22              after “under a State plan under this title” the  
23              following: “(regardless of whether the services  
24              were furnished on a fee-for-service basis or  
25              through a managed care entity)”.

1 (3) EFFECTIVE DATES.—

2 (A) The amendment made by paragraph  
3 (1) applies to contracts as of January 1, 2001.

4 (B) The amendments made by paragraph  
5 (2) apply to payments made on or after Janu-  
6 ary 1, 2001.

7 (f) APPLICATION OF MEDICAID DSH TRANSITION  
8 RULE TO PUBLIC HOSPITALS IN ALL STATES.—

9 (1) IN GENERAL.—During the period described  
10 in paragraph (3), with respect to a State, section  
11 4721(e) of the Balanced Budget Act of 1997 (Public  
12 Law 105–33; 111 Stat. 514), as amended by section  
13 607 of BBRA (113 Stat. 1501A–321) shall be ap-  
14 plied as though—

15 (A) “September 30, 2002” were sub-  
16 stituted for “July 1, 1997” each place it ap-  
17 pears;

18 (B) “hospitals owned or operated by a  
19 State (as defined for purposes of title XIX of  
20 such Act), or by an instrumentality or a unit of  
21 government within a State (as so defined)”  
22 were substituted for “the State of California”;

23 (C) paragraph (3) were redesignated as  
24 paragraph (4);

1 (D) “and” were omitted from the end of  
2 paragraph (2); and

3 (E) the following new paragraph were in-  
4 serted after paragraph (2):

5 “(3) ‘(as defined in subparagraph (B) but with-  
6 out regard to clause (ii) of that subparagraph and  
7 subject to subsection (d))’ were substituted for ‘(as  
8 defined in subparagraph (B))’ in subparagraph (A)  
9 of such section; and”.

10 (2) SPECIAL RULE.—With respect to California,  
11 section 4721(e) of the Balanced Budget Act of 1997  
12 (Public Law 105–33; 111 Stat. 514) shall be applied  
13 without regard to paragraph (1).

14 (3) PERIOD DESCRIBED.—The period described  
15 in this paragraph is the period that begins, with re-  
16 spect to a State, on the first day of the first State  
17 fiscal year that begins after September 30, 2002,  
18 and ends on the last day of the succeeding State fis-  
19 cal year.

20 (4) APPLICATION TO WAIVERS.—With respect  
21 to a State operating under a waiver of the require-  
22 ments of title XIX of the Social Security Act (42  
23 U.S.C. 1396 et seq.) under section 1115 of such Act  
24 (42 U.S.C. 1315), the amount by which any pay-  
25 ment adjustment made by the State under title XIX

1 of such Act (42 U.S.C. 1396 et seq.), after the ap-  
2 plication of section 4721(e) of the Balanced Budget  
3 Act of 1997 under paragraph (1) to such State, ex-  
4 ceeds the costs of furnishing hospital services pro-  
5 vided by hospitals described in such section shall be  
6 fully reflected as an increase in the baseline expendi-  
7 ture limit for such waiver.

8 (g) ASSISTANCE FOR CERTAIN PUBLIC HOS-  
9 PITALS.—

10 (1) IN GENERAL.—Beginning with fiscal year  
11 2002, notwithstanding section 1923(f) of the Social  
12 Security Act (42 U.S.C. 1396r-4(f)) and subject to  
13 paragraph (3), with respect to a State, payment ad-  
14 justments made under title XIX of the Social Secu-  
15 rity Act (42 U.S.C. 1396 et seq.) to a hospital de-  
16 scribed in paragraph (2) shall be made without re-  
17 gard to the DSH allotment limitation for the State  
18 determined under section 1923(f) of that Act (42  
19 U.S.C. 1396r-4(f)).

20 (2) HOSPITAL DESCRIBED.—A hospital is de-  
21 scribed in this paragraph if the hospital—

22 (A) is owned or operated by a State (as de-  
23 fined for purposes of title XIX of the Social Se-  
24 curity Act), or by an instrumentality or a unit  
25 of government within a State (as so defined);

1 (B) as of October 1, 2000—

2 (i) is in existence and operating as a  
3 hospital described in subparagraph (A);  
4 and

5 (ii) is not receiving disproportionate  
6 share hospital payments from the State in  
7 which it is located under title XIX of such  
8 Act; and

9 (C) has a low-income utilization rate (as  
10 defined in section 1923(b)(3) of the Social Se-  
11 curity Act (42 U.S.C. 1396r-4(b)(3))) in excess  
12 of 65 percent.

13 (3) LIMITATION ON EXPENDITURES.—

14 (A) IN GENERAL.—With respect to any fis-  
15 cal year, the aggregate amount of Federal fi-  
16 nancial participation that may be provided for  
17 payment adjustments described in paragraph  
18 (1) for that fiscal year for all States may not  
19 exceed the amount described in subparagraph  
20 (B) for the fiscal year.

21 (B) AMOUNT DESCRIBED.—The amount  
22 described in this subparagraph for a fiscal year  
23 is as follows:

24 (i) For fiscal year 2002, \$15,000,000.

1 (ii) For fiscal year 2003,  
2 \$176,000,000.

3 (iii) For fiscal year 2004,  
4 \$269,000,000.

5 (iv) For fiscal year 2005,  
6 \$330,000,000.

7 (v) For fiscal year 2006 and each fis-  
8 cal year thereafter, \$375,000,000.

9 (h) DSH PAYMENT ACCOUNTABILITY STANDARDS.—

10 Not later than September 30, 2002, the Secretary of  
11 Health and Human Services shall implement account-  
12 ability standards to ensure that Federal funds provided  
13 with respect to disproportionate share hospital adjust-  
14 ments made under section 1923 of the Social Security Act  
15 (42 U.S.C. 1396r-4) are used to reimburse States and  
16 hospitals eligible for such payment adjustments for pro-  
17 viding uncompensated health care to low-income patients  
18 and are otherwise made in accordance with the require-  
19 ments of section 1923 of that Act.

20 **SEC. 702. NEW PROSPECTIVE PAYMENT SYSTEM FOR FED-**  
21 **ERALLY-QUALIFIED HEALTH CENTERS AND**  
22 **RURAL HEALTH CLINICS.**

23 (a) IN GENERAL.—Section 1902(a) (42 U.S.C.  
24 1396a(a)) is amended—

25 (1) in paragraph (13)—

1 (A) in subparagraph (A), by adding “and”  
2 at the end;

3 (B) in subparagraph (B), by striking  
4 “and” at the end; and

5 (C) by striking subparagraph (C); and

6 (2) by inserting after paragraph (14) the fol-  
7 lowing new paragraph:

8 “(15) provide for payment for services de-  
9 scribed in clause (B) or (C) of section 1905(a)(2)  
10 under the plan in accordance with subsection (aa);”.

11 (b) NEW PROSPECTIVE PAYMENT SYSTEM.—Section  
12 1902 (42 U.S.C. 1396a) is amended by adding at the end  
13 the following:

14 “(aa) PAYMENT FOR SERVICES PROVIDED BY FED-  
15 ERALLY-QUALIFIED HEALTH CENTERS AND RURAL  
16 HEALTH CLINICS.—

17 “(1) IN GENERAL.—Beginning with fiscal year  
18 2001 and each succeeding fiscal year, the State plan  
19 shall provide for payment for services described in  
20 section 1905(a)(2)(C) furnished by a Federally-  
21 qualified health center and services described in sec-  
22 tion 1905(a)(2)(B) furnished by a rural health clinic  
23 in accordance with the provisions of this subsection.

24 “(2) FISCAL YEAR 2001.—Subject to paragraph  
25 (4), for services furnished during fiscal year 2001,

1 the State plan shall provide for payment for such  
2 services in an amount (calculated on a per visit  
3 basis) that is equal to 100 percent of the average of  
4 the costs of the center or clinic of furnishing such  
5 services during fiscal years 1999 and 2000 which  
6 are reasonable and related to the cost of furnishing  
7 such services, or based on such other tests of reason-  
8 ableness as the Secretary prescribes in regulations  
9 under section 1833(a)(3), or, in the case of services  
10 to which such regulations do not apply, the same  
11 methodology used under section 1833(a)(3), ad-  
12 justed to take into account any increase or decrease  
13 in the scope of such services furnished by the center  
14 or clinic during fiscal year 2001.

15 “(3) FISCAL YEAR 2002 AND SUCCEEDING FIS-  
16 CAL YEARS.—Subject to paragraph (4), for services  
17 furnished during fiscal year 2002 or a succeeding  
18 fiscal year, the State plan shall provide for payment  
19 for such services in an amount (calculated on a per  
20 visit basis) that is equal to the amount calculated for  
21 such services under this subsection for the preceding  
22 fiscal year—

23 “(A) increased by the percentage increase  
24 in the MEI (as defined in section 1842(i)(3))

1 applicable to primary care services (as defined  
2 in section 1842(i)(4)) for that fiscal year; and

3 “(B) adjusted to take into account any in-  
4 crease or decrease in the scope of such services  
5 furnished by the center or clinic during that fis-  
6 cal year.

7 “(4) ESTABLISHMENT OF INITIAL YEAR PAY-  
8 MENT AMOUNT FOR NEW CENTERS OR CLINICS.—In  
9 any case in which an entity first qualifies as a Fed-  
10 erally-qualified health center or rural health clinic  
11 after fiscal year 2000, the State plan shall provide  
12 for payment for services described in section  
13 1905(a)(2)(C) furnished by the center or services  
14 described in section 1905(a)(2)(B) furnished by the  
15 clinic in the first fiscal year in which the center or  
16 clinic so qualifies in an amount (calculated on a per  
17 visit basis) that is equal to 100 percent of the costs  
18 of furnishing such services during such fiscal year  
19 based on the rates established under this subsection  
20 for the fiscal year for other such centers or clinics  
21 located in the same or adjacent area with a similar  
22 case load or, in the absence of such a center or clin-  
23 ic, in accordance with the regulations and method-  
24 ology referred to in paragraph (2) or based on such  
25 other tests of reasonableness as the Secretary may

1 specify. For each fiscal year following the fiscal year  
2 in which the entity first qualifies as a Federally-  
3 qualified health center or rural health clinic, the  
4 State plan shall provide for the payment amount to  
5 be calculated in accordance with paragraph (3).

6 “(5) ADMINISTRATION IN THE CASE OF MAN-  
7 AGED CARE.—

8 “(A) IN GENERAL.—In the case of services  
9 furnished by a Federally-qualified health center  
10 or rural health clinic pursuant to a contract be-  
11 tween the center or clinic and a managed care  
12 entity (as defined in section 1932(a)(1)(B)), the  
13 State plan shall provide for payment to the cen-  
14 ter or clinic by the State of a supplemental pay-  
15 ment equal to the amount (if any) by which the  
16 amount determined under paragraphs (2), (3),  
17 and (4) of this subsection exceeds the amount  
18 of the payments provided under the contract.

19 “(B) PAYMENT SCHEDULE.—The supple-  
20 mental payment required under subparagraph  
21 (A) shall be made pursuant to a payment  
22 schedule agreed to by the State and the Feder-  
23 ally-qualified health center or rural health clin-  
24 ic, but in no case less frequently than every 4  
25 months.

1           “(6) ALTERNATIVE PAYMENT METHODOLO-  
2           GIES.—Notwithstanding any other provision of this  
3           section, the State plan may provide for payment in  
4           any fiscal year to a Federally-qualified health center  
5           for services described in section 1905(a)(2)(C) or to  
6           a rural health clinic for services described in section  
7           1905(a)(2)(B) in an amount which is determined  
8           under an alternative payment methodology that—

9                   “(A) is agreed to by the State and the cen-  
10                  ter or clinic; and

11                   “(B) results in payment to the center or  
12                  clinic of an amount which is at least equal to  
13                  the amount otherwise required to be paid to the  
14                  center or clinic under this section.”.

15           (c) CONFORMING AMENDMENTS.—

16                   (1) Section 4712 of the BBA (Public Law 105–  
17                  33; 111 Stat. 508) is amended by striking sub-  
18                  section (c).

19                   (2) Section 1915(b) (42 U.S.C. 1396n(b)) is  
20                  amended by striking “1902(a)(13)(C)” and inserting  
21                  “1902(a)(15), 1902(aa),”.

22           (d) GAO STUDY OF FUTURE REBASING.—The  
23           Comptroller General of the United States shall provide for  
24           a study on the need for, and how to, rebase or refine costs  
25           for making payment under the medicaid program for serv-

1 ices provided by Federally-qualified health centers and  
2 rural health clinics (as provided under the amendments  
3 made by this section). The Comptroller General shall pro-  
4 vide for submittal of a report on such study to Congress  
5 by not later than 4 years after the date of the enactment  
6 of this Act.

7 (e) EFFECTIVE DATE.—The amendments made by  
8 this section take effect on October 1, 2000, and apply to  
9 services furnished on or after such date.

10 **SEC. 703. STREAMLINED APPROVAL OF CONTINUED STATE-**  
11 **WIDE SECTION 1115 MEDICAID WAIVERS.**

12 (a) IN GENERAL.—Section 1115 (42 U.S.C. 1315)  
13 is amended by adding at the end the following new sub-  
14 section:

15 “(f) An application by the chief executive officer of  
16 a State for an extension of a waiver project the State is  
17 operating under an extension under subsection (e) (in this  
18 subsection referred to as the ‘waiver project’) shall be sub-  
19 mitted and approved or disapproved in accordance with  
20 the following:

21 “(1) The application for an extension of the  
22 waiver project shall be submitted to the Secretary at  
23 least 120 days prior to the expiration of the current  
24 period of the waiver project.

1           “(2) Not later than 45 days after the date such  
2 application is received by the Secretary, the Sec-  
3 retary shall notify the State if the Secretary intends  
4 to review the terms and conditions of the waiver  
5 project. A failure to provide such notification shall  
6 be deemed to be an approval of the application.

7           “(3) Not later than 45 days after the date a no-  
8 tification is made in accordance with paragraph (2),  
9 the Secretary shall inform the State of proposed  
10 changes in the terms and conditions of the waiver  
11 project. A failure to provide such information shall  
12 be deemed to be an approval of the application.

13           “(4) During the 30-day period that begins on  
14 the date information described in paragraph (3) is  
15 provided to a State, the Secretary shall negotiate re-  
16 vised terms and conditions of the waiver project with  
17 the State.

18           “(5)(A) Not later than 120 days after the date  
19 an application for an extension of the waiver project  
20 is submitted to the Secretary (or such later date  
21 agreed to by the chief executive officer of the State),  
22 the Secretary shall—

23                   “(i) approve the application subject to such  
24 modifications in the terms and conditions—

1                   “(I) as have been agreed to by the  
2                   Secretary and the State; or

3                   “(II) in the absence of such agree-  
4                   ment, as are determined by the Secretary  
5                   to be reasonable, consistent with the over-  
6                   all objectives of the waiver project, and not  
7                   in violation of applicable law; or

8                   “(ii) disapprove the application.

9                   “(B) A failure by the Secretary to approve or  
10                  disapprove an application submitted under this sub-  
11                  section in accordance with the requirements of sub-  
12                  paragraph (A) shall be deemed to be an approval of  
13                  the application subject to such modifications in the  
14                  terms and conditions as have been agreed to (if any)  
15                  by the Secretary and the State.

16                  “(6) An approval of an application for an exten-  
17                  sion of a waiver project under this subsection shall  
18                  be for a period not to exceed 3 years.

19                  “(7) An extension of a waiver project under this  
20                  subsection shall be subject to the final reporting and  
21                  evaluation requirements of paragraphs (4) and (5)  
22                  of subsection (e) (taking into account the extension  
23                  under this subsection with respect to any timing re-  
24                  quirements imposed under those paragraphs).”.

1 (b) EFFECTIVE DATE.—The amendment made by  
2 subsection (a) applies to requests for extensions of dem-  
3 onstration projects pending or submitted on or after the  
4 date of the enactment of this Act.

5 **SEC. 704. MEDICAID COUNTY-ORGANIZED HEALTH SYS-**  
6 **TEMS.**

7 (a) IN GENERAL.—Section 9517(c)(3)(C) of the  
8 Comprehensive Omnibus Budget Reconciliation Act of  
9 1985 is amended by striking “10 percent” and inserting  
10 “14 percent”.

11 (b) EFFECTIVE DATE.—The amendment made by  
12 subsection (a) takes effect on the date of the enactment  
13 of this Act.

14 **SEC. 705. DEADLINE FOR ISSUANCE OF FINAL REGULATION**  
15 **RELATING TO MEDICAID UPPER PAYMENT**  
16 **LIMITS.**

17 (a) IN GENERAL.—Not later than December 31,  
18 2000, the Secretary of Health and Human Services (in  
19 this section referred to as the “Secretary”), notwith-  
20 standing any requirement of the Administrative Proce-  
21 dures Act under chapter 5 of title 5, United States Code,  
22 or any other provision of law, shall issue under sections  
23 447.272, 447.304, and 447.321 of title 42, Code of Fed-  
24 eral Regulations (and any other section of part 447 of title  
25 42, Code of Federal Regulations that the Secretary deter-

1 mines is appropriate), a final regulation based on the pro-  
2 posed rule announced on October 5, 2000, that—

3 (1) modifies the upper payment limit test ap-  
4 plied to State medicaid spending for inpatient hos-  
5 pital services, outpatient hospital services, nursing  
6 facility services, intermediate care facility services  
7 for the mentally retarded, and clinic services by ap-  
8 plying an aggregate upper payment limit to pay-  
9 ments made to government facilities that are not  
10 State-owned or operated facilities; and

11 (2) provides for a transition period in accord-  
12 ance with subsection (b).

13 (b) TRANSITION PERIOD.—

14 (1) IN GENERAL.—The final regulation required  
15 under subsection (a) shall provide that, with respect  
16 to a State described in paragraph (3), the State  
17 shall be considered to be in compliance with the final  
18 regulation required under subsection (a) so long as,  
19 for each State fiscal year during the period de-  
20 scribed in paragraph (4), the State reduces pay-  
21 ments under a State medicaid plan payment provi-  
22 sion or methodology described in paragraph (3), or  
23 reduces the actual dollar payment levels described in  
24 paragraph (3)(B), so that the amount of the pay-  
25 ments that would otherwise have been made under

1 such provision, methodology, or payment levels by  
2 the State for any State fiscal year during such pe-  
3 riod is reduced by 15 percent in the first such State  
4 fiscal year, and by an additional 15 percent in each  
5 of next 5 State fiscal years.

6 (2) REQUIREMENT.—Notwithstanding para-  
7 graph (1), the final regulation required under sub-  
8 section (a) shall provide that, for any period (or por-  
9 tion of a period) that occurs on or after October 1,  
10 2008, medicaid payments made by a State described  
11 in paragraph (3) shall comply with such final regula-  
12 tion.

13 (3) STATE DESCRIBED.—A State described in  
14 this paragraph is a State with a State medicaid plan  
15 payment provision or methodology which—

16 (A) was approved, deemed to have been ap-  
17 proved, or was in effect on or before October 1,  
18 1992 (including any subsequent amendments or  
19 successor provisions or methodologies and  
20 whether or not a State plan amendment was  
21 made to carry out such provision or method-  
22 ology after such date) or under which claims for  
23 Federal financial participation were filed and  
24 paid on or before such date; and

1 (B) provides for payments that are in ex-  
2 cess of the upper payment limit test established  
3 under the final regulation required under sub-  
4 section (a) (or which would be noncompliant  
5 with such final regulation if the actual dollar  
6 payment levels made under the payment provi-  
7 sion or methodology in the State fiscal year  
8 which begins during 1999 were continued).

9 (4) PERIOD DESCRIBED.—The period described  
10 in this paragraph is the period that begins on the  
11 first State fiscal year that begins after September  
12 30, 2002, and ends on September 30, 2008.

13 **SEC. 706. ALASKA FMAP.**

14 Notwithstanding the first sentence of section 1905(b)  
15 of the Social Security Act (42 U.S.C. 1396d(b)), only with  
16 respect to each of fiscal years 2001 through 2005, for pur-  
17 poses of titles XIX and XXI of the Social Security Act,  
18 the State percentage used to determine the Federal med-  
19 ical assistance percentage for Alaska shall be that percent-  
20 age which bears the same ratio to 45 percent as the square  
21 of the adjusted per capita income of Alaska (determined  
22 by dividing the State's 3-year average per capita income  
23 by 1.05) bears to the square of the per capita income of  
24 the 50 States.

1 **SEC. 707. OPTIONAL COVERAGE OF LEGAL IMMIGRANTS**  
2 **UNDER THE MEDICAID PROGRAM.**

3 (a) IN GENERAL.—Section 1903(v) (42 U.S.C.  
4 1396b(v)) is amended—

5 (1) in paragraph (1), by striking “paragraph  
6 (2)” and inserting “paragraphs (2) and (4)”; and

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

9 “(4)(A) A State may elect (in a plan amendment  
10 under this title) to provide medical assistance under this  
11 title, notwithstanding sections 401(a), 402(b), 403, and  
12 421 of the Personal Responsibility and Work Opportunity  
13 Reconciliation Act of 1996, for aliens who are lawfully re-  
14 siding in the United States (including battered aliens de-  
15 scribed in section 431(c) of such Act) and who are other-  
16 wise eligible for such assistance, within either or both of  
17 the following eligibility categories, but only if they have  
18 lawfully resided in the United States for 2 years:

19 “(i) PREGNANT WOMEN.—Women during preg-  
20 nancy (and during the 60-day period beginning on  
21 the last day of the pregnancy).

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

25 “(B) In the case of a State that has elected to provide  
26 medical assistance to a category of aliens under subpara-

1 graph (A), no debt shall accrue under an affidavit of sup-  
2 port against any sponsor of such an alien who has lawfully  
3 resided in the United States for 2 years on the basis of  
4 provision of assistance to such category.”.

5 (b) EFFECTIVE DATE.—The amendments made by  
6 subsection (a) take effect on October 1, 2000, and apply  
7 to medical assistance and child health assistance furnished  
8 on or after such date.

9 **SEC. 708. ADDITIONAL ENTITIES QUALIFIED TO DETER-**  
10 **MINE MEDICAID PRESUMPTIVE ELIGIBILITY**  
11 **FOR LOW-INCOME CHILDREN.**

12 (a) IN GENERAL.—Section 1920A(b)(3)(A)(i) (42  
13 U.S.C. 1396r-1a(b)(3)(A)(i)) is amended—

14 (1) by striking “or (II)” and inserting “, (II)”;  
15 and

16 (2) by inserting “eligibility of a child for med-  
17 ical assistance under the State plan under this title,  
18 or eligibility of a child for child health assistance  
19 under the program funded under title XXI, (III) is  
20 an elementary school or secondary school, as such  
21 terms are defined in section 14101 of the Elemen-  
22 tary and Secondary Education Act of 1965 (20  
23 U.S.C. 8801), an elementary or secondary school op-  
24 erated or supported by the Bureau of Indian Affairs,  
25 a State or tribal child support enforcement agency,

1 a child care resource and referral agency, an organi-  
2 zation that is providing emergency food and shelter  
3 under a grant under the Stewart B. McKinney  
4 Homeless Assistance Act, or a State or tribal office  
5 or entity involved in enrollment in the program  
6 under this title, under part A of title IV, under title  
7 XXI, or that determines eligibility for any assistance  
8 or benefits provided under any program of public or  
9 assisted housing that receives Federal funds, includ-  
10 ing the program under section 8 or any other section  
11 of the United States Housing Act of 1937 (42  
12 U.S.C. 1437 et seq.) or under the Native American  
13 Housing Assistance and Self-Determination Act of  
14 1996 (25 U.S.C. 4101 et seq.), or (IV) any other en-  
15 tity the State so deems, as approved by the Sec-  
16 retary” before the semicolon.

17 (b) TECHNICAL AMENDMENTS.—Section 1920A (42  
18 U.S.C. 1396r–1a) is amended—

19 (1) in subsection (b)(3)(A)(i), by striking “42  
20 U.S.C. 9821” and inserting “42 U.S.C. 9831”;

21 (2) in subsection (b)(3)(A)(ii), by striking  
22 “paragraph (1)(A)” and inserting “paragraph (2)”;  
23 and

1           (3) in subsection (c)(2), in the matter preceding  
2       subparagraph (A), by striking “subsection  
3       (b)(1)(A)” and inserting “subsection (b)(2)”.

4       (c) APPLICATION TO PRESUMPTIVE ELIGIBILITY FOR  
5 PREGNANT WOMEN UNDER MEDICAID.—Section 1920(b)  
6 (42 U.S.C. 1396r–1(b)) is amended by adding at the end  
7 after and below paragraph (2) the following flush sen-  
8 tence:

9       “The term ‘qualified provider’ includes a qualified entity  
10 as defined in section 1920A(b)(3).”.

11       (d) APPLICATION UNDER TITLE XXI.—Section  
12 2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is amended by add-  
13 ing at the end the following new subparagraph:

14                   “(D) Section 1920A (relating to presump-  
15                   tive eligibility).”.

16 **SEC. 709. IMPROVING WELFARE-TO-WORK TRANSITION.**

17       (a) 1 YEAR EXTENSION.—Section 1925(f) (42  
18 U.S.C. 1396r–6(f)) is amended by striking “2001” and  
19 inserting “2002”.

20       (b) SIMPLIFICATION OPTIONS.—

21           (1) STATE OPTION TO WAIVE REPORTING RE-  
22       QUIREMENTS.—Section 1925(b)(2) of such Act (42  
23       U.S.C. 1396r–6(b)(2)) is amended by adding at the  
24       end the following new subparagraph:

1           “(C) STATE OPTION TO WAIVE REPORTING  
2           REQUIREMENTS.—A State may elect to waive  
3           the reporting requirements under subparagraph  
4           (B) and, in the case of such a waiver for pur-  
5           poses of notices required under subparagraph  
6           (A), to exclude from such notices any reference  
7           to any requirement under subparagraph (B).”.

8           (2) EXEMPTION FOR STATES COVERING NEEDY  
9           FAMILIES UP TO 185 PERCENT OF POVERTY.—Sec-  
10          tion 1925 (42 U.S.C. 1396r-6) is amended—

11           (A) in each of subsections (a)(1) and  
12           (b)(1), by inserting “but subject to subsection  
13           (g),” after “Notwithstanding any other provi-  
14           sion of this title,”; and

15           (B) by adding at the end the following new  
16           subsection:

17          “(g) EXEMPTION FOR STATE COVERING NEEDY  
18          FAMILIES UP TO 185 PERCENT OF POVERTY.—

19           “(1) IN GENERAL.—At State option, the provi-  
20           sions of this section shall not apply to a State that  
21           uses the authority under section 1931(b)(2)(C) to  
22           make medical assistance available under the State  
23           plan under this title, at a minimum, to all individ-  
24           uals described in section 1931(b)(1) in families with  
25           gross incomes (determined without regard to work-

1 related child care expenses of such individuals) at or  
 2 below 185 percent of the income official poverty line  
 3 (as defined by the Office of Management and Budget,  
 4 and revised annually in accordance with section  
 5 673(2) of the Omnibus Budget Reconciliation Act of  
 6 1981) applicable to a family of the size involved.

7 “(2) APPLICATION TO OTHER PROVISIONS OF  
 8 THIS TITLE.—The State plan of a State described in  
 9 paragraph (1) shall be deemed to meet the require-  
 10 ments of sections 1902(a)(10)(A)(i)(I) and  
 11 1902(e)(1).”.

12 (3) EFFECTIVE DATE.—The amendments made  
 13 by this subsection take effect on October 1, 2000.

14 **TITLE VIII—STATE CHILDREN’S**  
 15 **HEALTH INSURANCE PROGRAM**

16 **SEC. 801. SPECIAL RULE FOR REDISTRIBUTION AND AVAIL-**  
 17 **ABILITY OF UNUSED FISCAL YEAR 1998 AND**  
 18 **1999 SCHIP ALLOTMENTS.**

19 (a) CHANGE IN RULES FOR REDISTRIBUTION AND  
 20 RETENTION OF UNUSED SCHIP ALLOTMENTS FOR FIS-  
 21 CAL YEARS 1998 AND 1999.—Section 2104 (42 U.S.C.  
 22 1397dd) is amended by adding at the end the following  
 23 new subsection:

1           “(g) RULE FOR REDISTRIBUTION AND EXTENDED  
2 AVAILABILITY OF FISCAL YEARS 1998 AND 1999 ALLOT-  
3 MENTS.—

4           “(1) AMOUNT REDISTRIBUTED.—

5           “(A) IN GENERAL.—In the case of a State  
6 that expends all of its allotment under sub-  
7 section (b) or (c) for fiscal year 1998 by the  
8 end of fiscal year 2000, or for fiscal year 1999  
9 by the end of fiscal year 2001, the Secretary  
10 shall redistribute to the State under subsection  
11 (f) (from the fiscal year 1998 or 1999 allot-  
12 ments of other States, respectively, as deter-  
13 mined by the application of paragraphs (2) and  
14 (3) with respect to the respective fiscal year))  
15 the following amount:

16           “(i) STATE.—In the case of 1 of the  
17 50 States or the District of Columbia, with  
18 respect to—

19           “(I) the fiscal year 1998 allot-  
20 ment, the amount by which the  
21 State’s expenditures under this title in  
22 fiscal years 1998, 1999, and 2000 ex-  
23 ceed the State’s allotment for fiscal  
24 year 1998 under subsection (b); or

1           “(II) the fiscal year 1999 allot-  
2           ment, the amount by which the  
3           State’s expenditures under this title in  
4           fiscal years 1999, 2000, and 2001 ex-  
5           ceed the State’s allotment for fiscal  
6           year 1999 under subsection (b).

7           “(ii) TERRITORY.—In the case of a  
8           commonwealth or territory described in  
9           subsection (c)(3), an amount that bears  
10          the same ratio to 1.05 percent of the total  
11          amount described in paragraph (2)(B)(i)(I)  
12          as the ratio of the commonwealth’s or ter-  
13          ritory’s fiscal year 1998 or 1999 allotment  
14          under subsection (c) (as the case may be)  
15          bears to the total of all such allotments for  
16          such fiscal year under such subsection.

17          “(B) EXPENDITURE RULES.—An amount  
18          redistributed to a State under this paragraph  
19          with respect to fiscal year 1998 or 1999—

20                 “(i) shall not be included in the deter-  
21                 mination of the State’s allotment for any  
22                 fiscal year under this section;

23                 “(ii) notwithstanding subsection (e),  
24                 shall remain available for expenditure by

1 the State through the end of fiscal year  
2 2002; and

3 “(iii) shall be counted as being ex-  
4 pended with respect to a fiscal year allot-  
5 ment in accordance with applicable regula-  
6 tions of the Secretary.

7 “(2) EXTENSION OF AVAILABILITY OF PORTION  
8 OF UNEXPENDED FISCAL YEARS 1998 AND 1999 AL-  
9 LOTMENTS.—

10 “(A) IN GENERAL.—Notwithstanding sub-  
11 section (e):

12 “(i) FISCAL YEAR 1998 ALLOTMENT.—  
13 Of the amounts allotted to a State pursu-  
14 ant to this section for fiscal year 1998 that  
15 were not expended by the State by the end  
16 of fiscal year 2000, the amount specified in  
17 subparagraph (B) for fiscal year 1998 for  
18 such State shall remain available for ex-  
19 penditure by the State through the end of  
20 fiscal year 2002.

21 “(ii) FISCAL YEAR 1999 ALLOT-  
22 MENT.—Of the amounts allotted to a State  
23 pursuant to this subsection for fiscal year  
24 1999 that were not expended by the State  
25 by the end of fiscal year 2001, the amount

1 specified in subparagraph (B) for fiscal  
2 year 1999 for such State shall remain  
3 available for expenditure by the State  
4 through the end of fiscal year 2002.

5 “(B) AMOUNT REMAINING AVAILABLE FOR  
6 EXPENDITURE.—The amount specified in this  
7 subparagraph for a State for a fiscal year is  
8 equal to—

9 “(i) the amount by which (I) the total  
10 amount available for redistribution under  
11 subsection (f) from the allotments for that  
12 fiscal year, exceeds (II) the total amounts  
13 redistributed under paragraph (1) for that  
14 fiscal year; multiplied by

15 “(ii) the ratio of the amount of such  
16 State’s unexpended allotment for that fis-  
17 cal year to the total amount described in  
18 clause (i)(I) for that fiscal year.

19 “(C) USE OF UP TO 10 PERCENT OF  
20 RETAINED 1998 ALLOTMENTS FOR OUTREACH  
21 ACTIVITIES.—Notwithstanding section  
22 2105(c)(2)(A), with respect to any State de-  
23 scribed in subparagraph (A)(i), the State may  
24 use up to 10 percent of the amount specified in  
25 subparagraph (B) for fiscal year 1998 for ex-



1           (4) by striking “(a) IN GENERAL.—” and the  
2 remainder of the text that precedes subparagraph  
3 (C), as so redesignated, and inserting the following:

4           “(a) PAYMENTS.—

5           “(1) IN GENERAL.—Subject to the succeeding  
6 provisions of this section, the Secretary shall pay to  
7 each State with a plan approved under this title,  
8 from its allotment under section 2104, an amount  
9 for each quarter equal to the enhanced FMAP (or,  
10 in the case of expenditures described in subpara-  
11 graph (B), the Federal medical assistance percent-  
12 age (as defined in the first sentence of section  
13 1905(b))) of expenditures in the quarter—

14           “(A) for child health assistance under the  
15 plan for targeted low-income children in the  
16 form of providing medical assistance for which  
17 payment is made on the basis of an enhanced  
18 FMAP under the fourth sentence of section  
19 1905(b);

20           “(B) for the provision of medical assist-  
21 ance on behalf of a child during a presumptive  
22 eligibility period under section 1920A;” and

23           (5) by adding after subparagraph (D), as so re-  
24 designated, the following new paragraph:

1           “(2) ORDER OF PAYMENTS.—Payments under  
2           paragraph (1) from a State’s allotment shall be  
3           made in the following order:

4                   “(A) First, for expenditures for items de-  
5                   scribed in paragraph (1)(A).

6                   “(B) Second, for expenditures for items  
7                   described in paragraph (1)(B).

8                   “(C) Third, for expenditures for items de-  
9                   scribed in paragraph (1)(C).

10                   “(D) Fourth, for expenditures for items  
11                   described in paragraph (1)(D).”.

12           (b) ELIMINATION OF REQUIREMENT TO REDUCE  
13           TITLE XXI ALLOTMENT BY MEDICAID EXPANSION  
14           SCHIP COSTS.—Section 2104 (42 U.S.C. 1397dd) is  
15           amended by striking subsection (d).

16           (c) AUTHORITY TO TRANSFER TITLE XXI APPRO-  
17           PRIATIONS TO TITLE XIX APPROPRIATION ACCOUNT AS  
18           REIMBURSEMENT FOR MEDICAID EXPENDITURES FOR  
19           MEDICAID EXPANSION SCHIP SERVICES.—Notwith-  
20           standing any other provision of law, all amounts appro-  
21           priated under title XXI and allotted to a State pursuant  
22           to subsection (b) or (c) of section 2104 of the Social Secu-  
23           rity Act (42 U.S.C. 1397dd) for fiscal years 1998 through  
24           2000 (including any amounts that, but for this provision,  
25           would be considered to have expired) and not expended

1 in providing child health assistance or related services for  
2 which payment may be made pursuant to subparagraph  
3 (C) or (D) of section 2105(a)(1) of such Act (42 U.S.C.  
4 1397ee(a)(1)) (as amended by subsection (a)), shall be  
5 available to reimburse the Grants to States for Medicaid  
6 account in an amount equal to the total payments made  
7 to such State under section 1903(a) of such Act (42  
8 U.S.C. 1396b(a)) for expenditures in such years for med-  
9 ical assistance described in subparagraphs (A) and (B) of  
10 section 2105(a)(1) of such Act (42 U.S.C. 1397ee(a)(1)  
11 (as so amended).

12 (d) CONFORMING AMENDMENTS.—

13 (1) Section 1905(b) (42 U.S.C. 1396d(b)) is  
14 amended in the fourth sentence by striking “the  
15 State’s allotment under section 2104 (not taking  
16 into account reductions under section 2104(d)(2))  
17 for the fiscal year reduced by the amount of any  
18 payments made under section 2105 to the State  
19 from such allotment for such fiscal year” and insert-  
20 ing “the State’s available allotment under section  
21 2104”.

22 (2) Section 1905(u)(1)(B) (42 U.S.C.  
23 1396d(u)(1)(B)) is amended by striking “and sec-  
24 tion 2104(d)”.

1           (3) Section 2104 (42 U.S.C. 1397dd), as  
2 amended by subsection (b), is further amended—

3           (A) in subsection (b)(1), by striking “and  
4 subsection (d)”;

5           (B) in subsection (c)(1), by striking “sub-  
6 ject to subsection (d),”.

7           (4) Section 2105(c) (42 U.S.C. 1397ee(c)) is  
8 amended—

9           (A) in paragraph (2)(A), by striking all  
10 that follows “Except as provided in this para-  
11 graph,” and inserting “the amount of payment  
12 that may be made under subsection (a) for a  
13 fiscal year for expenditures for items described  
14 in paragraph (1)(D) of such subsection shall  
15 not exceed 10 percent of the total amount of ex-  
16 penditures for which payment is made under  
17 subparagraphs (A), (C), and (D) of paragraph  
18 (1) of such subsection.”;

19           (B) in paragraph (2)(B), by striking “de-  
20 scribed in subsection (a)(2)” and inserting “de-  
21 scribed in subsection (a)(1)(D)”;

22           (C) in paragraph (6)(B), by striking “Ex-  
23 cept as otherwise provided by law,” and insert-  
24 ing “Except as provided in subparagraph (A) or

1 (B) of subsection (a)(1) or any other provision  
2 of law.”.

3 (5) Section 2110(a) (42 U.S.C. 1397jj(a)) is  
4 amended by striking “section 2105(a)(2)(A)” and  
5 inserting “section 2105(a)(1)(D)(i)”.

6 (e) TECHNICAL AMENDMENT.—Section  
7 2105(d)(2)(B)(ii) (42 U.S.C. 1397ee(d)(2)(B)(ii)) is  
8 amended by striking “enhanced FMAP under section  
9 1905(u)” and inserting “enhanced FMAP under the  
10 fourth sentence of section 1905(b)”.

11 (f) EFFECTIVE DATE.—The amendments made by  
12 this section shall be effective as if included in the enact-  
13 ment of section 4901 of the BBA (111 Stat. 552).

14 **SEC. 803. OPTIONAL COVERAGE OF CERTAIN LEGAL IMMI-**  
15 **GRANTS UNDER SCHIP.**

16 (a) IN GENERAL.—Section 2107(e)(1) (42 U.S.C.  
17 1397gg(e)(1)) as amended in section 707(d), is further  
18 amended by adding at the end the following new subpara-  
19 graph:

20 “(E) Section 1903(v)(4) (relating to op-  
21 tional coverage of categories of lawfully residing  
22 alien children) but only if the State has elected  
23 to apply such section to the category of children  
24 under title XIX.”.

1 (b) EFFECTIVE DATE.—The amendment made by  
2 subsection (a) takes effect October 1, 2000, and applies  
3 to medical assistance and child health assistance furnished  
4 on or after such date.

5 **TITLE IX—OTHER PROVISIONS**  
6 **Subtitle A—PACE Program**

7 **SEC. 901. EXTENSION OF TRANSITION FOR CURRENT WAIV-**  
8 **ERS.**

9 Section 4803(d)(2) of BBA is amended—

10 (1) in subparagraph (A), by striking “24  
11 months” and inserting “36 months”;

12 (2) in subparagraph (A), by striking “the initial  
13 effective date of regulations described in subsection  
14 (a)” and inserting “July 1, 2000”; and

15 (3) in subparagraph (B), by striking “3 years”  
16 and inserting “4 years”.

17 **SEC. 902. CONTINUING OF CERTAIN OPERATING ARRANGE-**  
18 **MENTS PERMITTED.**

19 (a) IN GENERAL.—Section 1894(f)(2) (42 U.S.C.  
20 1395eee(f)(2)) is amended by adding at the end the fol-  
21 lowing new subparagraph:

22 “(C) CONTINUATION OF MODIFICATIONS  
23 OR WAIVERS OF OPERATIONAL REQUIREMENTS  
24 UNDER DEMONSTRATION STATUS.—If a PACE  
25 program operating under demonstration author-

1           ity has contractual or other operating arrange-  
2           ments which are not otherwise recognized in  
3           regulation and which were in effect on July 1,  
4           2000, the Secretary (in close consultation with,  
5           and with the concurrence of, the State admin-  
6           istering agency) shall permit any such program  
7           to continue such arrangements so long as such  
8           arrangements are found by the Secretary and  
9           the State to be reasonably consistent with the  
10          objectives of the PACE program.”.

11          (b) CONFORMING AMENDMENT.—Section 1934(f)(2)  
12 (42 U.S.C. 1396u-4(f)(2)) is amended by adding at the  
13 end the following new subparagraph:

14                   “(C) CONTINUATION OF MODIFICATIONS  
15                   OR WAIVERS OF OPERATIONAL REQUIREMENTS  
16                   UNDER DEMONSTRATION STATUS.—If a PACE  
17                   program operating under demonstration author-  
18                   ity has contractual or other operating arrange-  
19                   ments which are not otherwise recognized in  
20                   regulation and which were in effect on July 1  
21                   2000, the Secretary (in close consultation with,  
22                   and with the concurrence of, the State admin-  
23                   istering agency) shall permit any such program  
24                   to continue such arrangements so long as such  
25                   arrangements are found by the Secretary and

1           the State to be reasonably consistent with the  
2           objectives of the PACE program.”.

3           (c) EFFECTIVE DATE.—The amendments made by  
4 this section shall be effective as included in the enactment  
5 of BBA.

6 **SEC. 903. FLEXIBILITY IN EXERCISING WAIVER AUTHORITY.**

7           In applying sections 1894(f)(2)(B) and  
8 1934(f)(2)(B) of the Social Security Act (42 U.S.C.  
9 1395eee(f)(2)(B), 1396u-4(f)(2)(B)), the Secretary of  
10 Health and Human Services—

11           (1) shall approve or deny a request for a modi-  
12           fication or a waiver of provisions of the PACE pro-  
13           tocol not later than 90 days after the date the Sec-  
14           retary receives the request; and

15           (2) may exercise authority to modify or waive  
16           such provisions in a manner that responds promptly  
17           to the needs of PACE programs relating to areas of  
18           employment and the use of community-based pri-  
19           mary care physicians.

1 **Subtitle B—Outreach to Eligible**  
2 **Low-Income Medicare Bene-**  
3 **ficiaries**

4 **SEC. 911. OUTREACH ON AVAILABILITY OF MEDICARE**  
5 **COST-SHARING ASSISTANCE TO ELIGIBLE**  
6 **LOW-INCOME MEDICARE BENEFICIARIES.**

7 (a) OUTREACH.—

8 (1) IN GENERAL.—Title XI (42 U.S.C. 1301 et  
9 seq.) is amended by inserting after section 1143 the  
10 following new section:

11 “OUTREACH EFFORTS TO INCREASE AWARENESS OF THE  
12 AVAILABILITY OF MEDICARE COST-SHARING

13 “SEC. 1144. (a) OUTREACH.—

14 “(1) IN GENERAL.—The Commissioner of So-  
15 cial Security (in this section referred to as the ‘Com-  
16 missioner’) shall conduct outreach efforts to—

17 “(A) identify individuals entitled to bene-  
18 fits under the medicare program under title  
19 XVIII who may be eligible for medical assist-  
20 ance for payment of the cost of medicare cost-  
21 sharing under the medicaid program pursuant  
22 to sections 1902(a)(10)(E) and 1933; and

23 “(B) notify such individuals of the avail-  
24 ability of such medical assistance under such  
25 sections.

1           “(2) CONTENT OF NOTICE.—Any notice fur-  
2           nished under paragraph (1) shall state that eligi-  
3           bility for medicare cost-sharing assistance under  
4           such sections is conditioned upon—

5                   “(A) the individual providing to the State  
6           information about income and resources (in the  
7           case of an individual residing in a State that  
8           imposes an assets test for such eligibility); and

9                   “(B) meeting the applicable eligibility cri-  
10          teria.

11          “(b) COORDINATION WITH STATES.—

12               “(1) IN GENERAL.—In conducting the outreach  
13           efforts under this section, the Commissioner shall—

14                   “(A) furnish the agency of each State re-  
15           sponsible for the administration of the medicaid  
16           program and any other appropriate State agen-  
17           cy with information consisting of the name and  
18           address of individuals residing in the State that  
19           the Commissioner determines may be eligible  
20           for medical assistance for payment of the cost  
21           of medicare cost-sharing under the medicaid  
22           program pursuant to sections 1902(a)(10)(E)  
23           and 1933; and

24                   “(B) update any such information not less  
25           frequently than once per year.

1           “(2) INFORMATION IN PERIODIC UPDATES.—  
2           The periodic updates described in paragraph (1)(B)  
3           shall include information on individuals who are or  
4           may be eligible for the medical assistance described  
5           in paragraph (1)(A) because such individuals have  
6           experienced reductions in benefits under title II.”.

7           (2) AMENDMENT TO TITLE XIX.—Section  
8           1905(p) (42 U.S.C. 1396d(p)) is amended by adding  
9           at the end the following new paragraph:

10          “(5) For provisions relating to outreach efforts to in-  
11          crease awareness of the availability of medicare cost-shar-  
12          ing, see section 1144.”.

13          (b) GAO REPORT.—The Comptroller General of the  
14          United States shall conduct a study of the impact of sec-  
15          tion 1144 of the Social Security Act (as added by sub-  
16          section (a)(1)) on the enrollment of individuals for medi-  
17          care cost-sharing under the medicaid program. Not later  
18          than 18 months after the date that the Commissioner of  
19          Social Security first conducts outreach under section 1144  
20          of such Act, the Comptroller General shall submit to Con-  
21          gress a report on such study. The report shall include such  
22          recommendations for legislative changes as the Comp-  
23          troller General deems appropriate.

1 (c) EFFECTIVE DATE.—The amendments made by  
2 subsections (a) shall take effect one year after the date  
3 of the enactment of this Act.

4 **Subtitle C—Maternal and Child**  
5 **Health Block Grant**

6 **SEC. 921. INCREASE IN AUTHORIZATION OF APPROPRIA-**  
7 **TIONS FOR THE MATERNAL AND CHILD**  
8 **HEALTH SERVICES BLOCK GRANT.**

9 (a) IN GENERAL.—Section 501(a) (42 U.S.C.  
10 701(a)) is amended in the matter preceding paragraph (1)  
11 by striking “\$705,000,000 for fiscal year 1994” and in-  
12 serting “\$850,000,000 for fiscal year 2001”.

13 (b) EFFECTIVE DATE.—The amendment made by  
14 subsection (a) takes effect on October 1, 2000.

15 **Subtitle D—Diabetes**

16 **SEC. 931. INCREASE IN APPROPRIATIONS FOR SPECIAL DI-**  
17 **ABETES PROGRAMS FOR TYPE I DIABETES**  
18 **AND INDIANS.**

19 (a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIA-  
20 BETES.—Section 330B(b) of the Public Health Service  
21 Act (42 U.S.C. 254e–2(b)) is amended—

22 (1) by striking “Notwithstanding” and insert-  
23 ing the following:

24 “(1) TRANSFERRED FUNDS.—Notwith-  
25 standing”; and

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

2 “(2) APPROPRIATIONS.—For the purpose of  
3 making grants under this section, there is appro-  
4 priated, out of any funds in the Treasury not other-  
5 wise appropriated—

6 “(A) \$70,000,000 for each of fiscal years  
7 2001 and 2002 (which shall be combined with  
8 amounts transferred under paragraph (1) for  
9 each such fiscal years); and

10 “(B) \$100,000,000 for fiscal year 2003.”.

11 (b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—  
12 Section 330C(c) of such Act (42 U.S.C. 254c-3(c)) is  
13 amended—

14 (1) by striking “Notwithstanding” and insert-  
15 ing the following:

16 “(1) TRANSFERRED FUNDS.—Notwith-  
17 standing”; and

18 (2) by adding at the end the following:

19 “(2) APPROPRIATIONS.—For the purpose of  
20 making grants under this section, there is appro-  
21 priated, out of any money in the Treasury not other-  
22 wise appropriated—

23 “(A) \$70,000,000 for each of fiscal years  
24 2001 and 2002 (which shall be combined with

1 amounts transferred under paragraph (1) for  
2 each such fiscal years); and

3 “(B) \$100,000,000 for fiscal year 2003.”.

4 (c) EXTENSION OF FINAL REPORT ON GRANT PRO-  
5 GRAMS.—Section 4923(b)(2) of BBA is amended by strik-  
6 ing “2002” and inserting “2003”.

7 **SEC. 932. APPROPRIATIONS FOR RICKY RAY HEMOPHILIA**  
8 **RELIEF FUND.**

9 Section 101(e) of the Ricky Ray Hemophilia Relief  
10 Fund Act of 1998 (42 U.S.C. 300c–22 note) is amended  
11 by adding at the end the following: “There is appropriated  
12 to the Fund \$475,000,000 for fiscal year 2001, to remain  
13 available until expended.”.

14 **Subtitle E—Nurse Staffing and**  
15 **Quality Improvement Act of 2000**

16 **SEC. 941. SHORT TITLE.**

17 This subtitle may be cited as the “Nursing Home  
18 Staffing and Quality Improvement Act of 2000”.

19 **SEC. 942. GRANTS TO STATES FOR IMPROVEMENTS IN**  
20 **NURSING HOME STAFFING AND QUALITY.**

21 (a) SECRETARY’S AUTHORITY TO AWARD GRANTS.—  
22 The Secretary shall establish a program of competitive  
23 grants to States, in accordance with the provisions of this  
24 section, for the purpose of improving the quality of care  
25 furnished in nursing homes operating in the State.

1 (b) APPLICATIONS AND ELIGIBILITY FOR GRANTS.—

2 (1) INITIAL APPLICATION.—A State seeking a  
3 grant to conduct a project under this section shall  
4 submit an application containing such information  
5 and assurances as the Secretary may require,  
6 including—

7 (A) a commitment to submit annual re-  
8 ports describing the State's progress in increas-  
9 ing staffing levels and making other quality im-  
10 provements in nursing homes in the State; and

11 (B) a description of a plan for evaluation  
12 of the activities carried out under the grant, in-  
13 cluding a plan for measurement of progress to-  
14 ward the goals and objectives of the program,  
15 consistent with the principles of the Govern-  
16 ment Performance and Results Act.

17 (2) CONSULTATION WITH PUBLIC.—Before sub-  
18 mitting an application for a grant under this section,  
19 States shall solicit and consider the views of mem-  
20 bers of the public, nursing home residents or their  
21 representatives, and other persons concerned with  
22 the administration of nursing homes within the  
23 State with respect to the design of the proposed  
24 State program.

25 (3) ELIGIBILITY.—

1           (A) INITIAL ELIGIBILITY.—A State shall  
2 not be eligible for a grant award under this sec-  
3 tion unless it makes assurances satisfactory to  
4 the Secretary that the skilled nursing facilities  
5 (as defined in section 1819(a)) and nursing fa-  
6 cilities (as defined in section 1919(a)) within  
7 the State will reach or exceed the minimum  
8 staff level described in subsection (d)(2) within  
9 two years after enactment of this Act and will  
10 maintain such level throughout the remainder  
11 of the grant program.

12           (B) CONTINUING ELIGIBILITY.—A State  
13 shall not be eligible for the continuation of  
14 grant funding under a multi-year grant under  
15 this section unless the State demonstrates to  
16 the Secretary's satisfaction that it continues to  
17 meet the requirement described in subpara-  
18 graph (A) and has made sufficient progress in  
19 meeting the goals described in its grant applica-  
20 tion.

21           (c) USE OF GRANT FUNDS.—Funds received by a  
22 State under this section may be provided to entities in-  
23 cluding nursing homes, labor management partnerships,  
24 and educational institutions, and may be used for any or  
25 all of the following purposes:

1           (1) To enable a nursing home to recruit addi-  
2           tional nursing staff or to retain existing nursing  
3           staff (including through the use of reasonable finan-  
4           cial incentives or reasonable benefit enhancements).

5           (2) To increase education and training of nurs-  
6           ing staff (including designing or implementing pro-  
7           grams to promote the career advancement of cer-  
8           tified nurse aides).

9           (3) To provide bonuses to nursing homes meet-  
10          ing State quality standards or avoiding serious qual-  
11          ity violations for a period of one or more years.

12          (4) Such other nursing home staffing and qual-  
13          ity improvement initiatives as the Secretary may ap-  
14          prove.

15          (d) DISTRIBUTION OF FUNDS.—

16           (1) IN GENERAL.—Subject to subsection (b), in  
17           awarding grants under this section, the Secretary  
18           shall award no more than 25 percent of the funds  
19           to States in which, as of the date of the enactment  
20           of this section, skilled nursing facilities (as defined  
21           in section 1819(a)) and nursing facilities (as defined  
22           in section 1919(a)) have reached or exceeded the  
23           minimum staff level specified in paragraph (2) (as  
24           determined by the Secretary).

25           (2) MINIMUM NURSING HOME STAFF LEVEL.—

1           (A) IN GENERAL.—Subject to subpara-  
2 graph (B), for purposes of subsection (b) and  
3 paragraph (1), the level specified in this para-  
4 graph for a skilled nursing facility or nursing  
5 facility is a staff level sufficient to ensure that  
6 each resident receives from a certified nurse  
7 aide at least 2 hours per day of direct care (in-  
8 cluding repositioning the resident and changing  
9 wet clothes, assisting with feeding, exercise, and  
10 toileting, and working to enhance a resident’s  
11 independence with respect to activities of daily  
12 living).

13           (B) SECRETARY’S AUTHORITY TO IN-  
14 CREASE MINIMUM STAFF LEVEL.—The Sec-  
15 retary may establish a minimum staff level that  
16 is higher than that specified in subparagraph  
17 (A). Any such revised staff level shall be effec-  
18 tive no earlier than six months after the date on  
19 which Secretary provides notice to States of the  
20 new requirement.

21           (3) MULTI-YEAR GRANT FUNDS.—The Sec-  
22 retary shall award any multi-year grant under this  
23 section from amounts appropriated (or available pur-  
24 suant to subsection (e)(2)) for the first fiscal year  
25 of the grant.

1 (e) APPROPRIATIONS AND AVAILABILITY OF CIVIL  
2 MONEY PENALTY (CPM) COLLECTIONS.—

3 (1) APPROPRIATIONS.—There are appropriated  
4 for all costs to the Secretary for carrying out the  
5 program under this section \$200,000,000 for each of  
6 fiscal years 2001 through 2005, such funds to re-  
7 main available to the Secretary through the end of  
8 the first succeeding fiscal year.

9 (2) AVAILABILITY OF CMP COLLECTIONS.—In  
10 addition to the amounts appropriated pursuant to  
11 paragraph (1), there shall be available to the Sec-  
12 retary for such costs for such fiscal years any  
13 amounts deposited in the Nursing Facility Civil  
14 Money Penalties Collection Account established  
15 under section 4.

16 **SEC. 943. ENHANCED NURSING FACILITY REPORTING RE-**  
17 **QUIREMENTS.**

18 (a) MEDICARE.—

19 (1) SUBMISSION OF NURSING STAFF LEVEL  
20 DATA TO THE SECRETARY.—Section 1819(b) (42  
21 U.S.C. 1395i–3(b)) is amended by adding at the end  
22 the following new paragraph:

23 “(8) DATA ON STAFFING LEVELS.—

24 “(A) SUBMISSION TO SECRETARY.—A  
25 skilled nursing facility shall submit to the Sec-

1           retary, in such form and manner and at such  
2           intervals as the Secretary may require, data  
3           with respect to nursing staff of the facility.  
4           Such data shall include the total number of  
5           nursing staff hours furnished during the period  
6           specified by the Secretary (including totals for  
7           each shift worked during such period) by the  
8           facility to residents for which payment is made  
9           under section 1888(e), broken down by total  
10          certified nurse aide hours, total licensed prac-  
11          tical or vocational nurse hours, and total reg-  
12          istered nurse hours, and shall also include the  
13          average wage rate for each class of nursing  
14          staff employed by the facility.

15                 “(B) PUBLICATION.—The Secretary shall  
16          provide for the publication on the Internet Site  
17          of the Department of Health and Human Serv-  
18          ices known as Nursing Home Compare the fa-  
19          cility-specific nursing staff information collected  
20          pursuant to subparagraph (A). The Secretary  
21          shall update such information periodically.”.

22                 (2) POSTING OF INFORMATION ON NURSING FA-  
23          CILITY STAFFING.—Section 1819(b) (42 U.S.C.  
24          1395i–3(b)), as amended by paragraph (1), is fur-

1 ther amended by adding at the end the following  
2 new paragraph:

3 “(9) INFORMATION ON NURSE STAFFING.—

4 “(A) IN GENERAL.—A skilled nursing fa-  
5 cility shall post daily for each nursing unit of  
6 the facility and for each shift the current num-  
7 ber of licensed and unlicensed nursing staff di-  
8 rectly responsible for resident care. The infor-  
9 mation shall be displayed in a uniform manner  
10 (as specified by the Secretary) and in a clearly  
11 visible place.

12 “(B) PUBLICATION OF DATA.—A skilled  
13 nursing facility shall, upon request, make avail-  
14 able to the public the nursing staff data de-  
15 scribed in subparagraph (A).”.

16 (3) INFORMATION CONCERNING PATIENT CLAS-  
17 SIFICATION.—Section 1819(b)(4)(C) (42 U.S.C.  
18 1395i-3(b)(4)(C)) is amended by adding at the end  
19 the following new clause:

20 “(iii) INFORMATION CONCERNING  
21 RESIDENTS.—The skilled nursing facility  
22 shall provide the Secretary, in such form  
23 and manner and at such intervals as the  
24 Secretary may require, a classification of  
25 all residents of the skilled nursing facility

1           that accords with the patient classification  
2           system       described       in       section  
3           1888(e)(3)(B)(ii), or such successor system  
4           as the Secretary may identify.”.

5       (b) MEDICAID.—

6           (1) IN GENERAL.—Section 1919(b) (42 U.S.C.  
7       1396r) is amended by adding at the end the fol-  
8       lowing new paragraph:

9           “(8) DATA ON STAFFING LEVELS.—

10           “(A) SUBMISSION TO SECRETARY.—A  
11       nursing facility shall submit to the Secretary, in  
12       such form and manner and at such intervals as  
13       the Secretary may require, data with respect to  
14       nursing staff of the facility. Such data shall in-  
15       clude the total number of nursing staff hours  
16       furnished during the period specified by the  
17       Secretary (including totals for each shift  
18       worked during such period) by the facility to  
19       residents for which payment is made under this  
20       title, broken down by total certified nurse aide  
21       hours, total licensed practical or vocational  
22       nurse hours, and total registered nurse hours,  
23       and shall also include the average wage rate for  
24       each class of nursing staff employed by the fa-  
25       cility.

1           “(B) PUBLICATION.—The Secretary shall  
2 provide for the publication on the Internet Site  
3 of the Department of Health and Human Serv-  
4 ices known as Nursing Home Compare the fa-  
5 cility-specific nursing staff information collected  
6 pursuant to subparagraph (A). The Secretary  
7 shall update such information periodically.”.

8           (2) POSTING OF INFORMATION ON NURSING FA-  
9 CILITY STAFFING.—Section 1919(b) (42 U.S.C.  
10 1395r(b)), as amended by paragraph (1), is further  
11 amended by adding at the end the following new  
12 paragraph:

13           “(9) INFORMATION ON NURSE STAFFING.—

14           “(A) IN GENERAL.—A nursing facility  
15 shall post daily for each nursing unit of the fa-  
16 cility and for each shift the current number of  
17 licensed and unlicensed nursing staff directly  
18 responsible for resident care. The information  
19 shall be displayed in a uniform manner (as  
20 specified by the Secretary) and in a clearly visi-  
21 ble place.

22           “(B) PUBLICATION OF DATA.—A nursing  
23 facility shall, upon request, make available to  
24 the public the nursing staff data described in  
25 subparagraph (A).”.

1           (3) INFORMATION CONCERNING PATIENT CLAS-  
2           SIFICATION.—Section 1919(b)(4)(C) (42 U.S.C.  
3           1396r(b)(4)(C)) is amended by adding at the end  
4           the following new clause:

5                   “(iv) INFORMATION CONCERNING  
6                   RESIDENTS.—The nursing facility shall  
7                   provide the Secretary, in such form and  
8                   manner and at such intervals as the Sec-  
9                   retary may require, a classification of all  
10                  residents of the nursing facility that ac-  
11                  cords with the patient classification system  
12                  described in section 1888(e)(3)(B)(ii), or  
13                  such successor system as the Secretary  
14                  may identify.”.

15 **SEC. 944. NURSING FACILITY CIVIL MONEY PENALTY COL-**  
16 **LECTIONS.**

17           (a) ESTABLISHMENT OF NURSING FACILITY CIVIL  
18           MONEY PENALTY COLLECTIONS ACCOUNT.—Section  
19           1128A (42 U.S.C. 1320a–7a) is amended by adding at  
20           the end the following new subsection:

21                   “(o) ESTABLISHMENT OF NURSING FACILITY CIVIL  
22                   MONEY PENALTY COLLECTIONS ACCOUNT.—There is  
23                   hereby established an account to be known as the “Nurs-  
24                   ing Facility Civil Money Penalties Collection Account”  
25                   (hereafter in this subsection referred to as the “Ac-

1 count”). Notwithstanding any other provision of law, there  
2 shall be deposited into the Account the Secretary’s share  
3 of any civil monetary penalties collected under sections  
4 1819 and 1919, all such amounts to be available without  
5 fiscal year limitation for repaying the Secretary’s share  
6 of amounts owed to nursing facilities or skilled nursing  
7 facilities pursuant to the final sentence of sections  
8 1819(h)(2)(B)(ii) and 1919(h)(2)(B)(ii), and for award-  
9 ing grants under section 2 of the Nursing Home Staffing  
10 and Quality Improvement Act of 2000.”.

11 (b) AUTHORITY TO COLLECT CMPS IMME-  
12 DIATELY.—

13 (1) MEDICARE.—Section 1819(h)(2)(B)(ii) (42  
14 U.S.C. 1395i–3(h)(2)(B)(ii)) is amended by insert-  
15 ing before the final period “, except that, notwith-  
16 standing section 1128A(c)(2) or any other provision  
17 of law, the Secretary, upon determining that a civil  
18 money penalty should be imposed against a skilled  
19 nursing facility pursuant to this paragraph, shall  
20 take immediate action to collect such penalty (except  
21 where the Secretary finds that such action could  
22 jeopardize the health or welfare of residents of the  
23 skilled nursing facility). In collecting such penalty,  
24 the Secretary may deduct the amount of the penalty  
25 from amounts otherwise payable to the facility under

1 this title or take such other actions as the Secretary  
2 considers appropriate. If the Secretary's imposition  
3 of a penalty under this paragraph is set aside, in  
4 whole or in part, as a result of a hearing under sec-  
5 tion 1128A(c)(2) (or an appeal therefrom) or by a  
6 court of competent jurisdiction, and the Secretary  
7 elects not to pursue an appeal of such judgment; or  
8 has exhausted all appeals, the Secretary shall repay  
9 any amount owed to the skilled nursing facility with  
10 accrued interest.”

11 (2) MEDICAID.—Section 1919(h)(3)(B)(ii) (42  
12 U.S.C. 1396r(h)(3)(B)(ii)) is amended by inserting  
13 before the final period “, except that, notwith-  
14 standing section 1128A(c)(2) or any other provision  
15 of law, the Secretary, upon determining that a civil  
16 money penalty should be imposed against a nursing  
17 facility pursuant to this paragraph, shall take imme-  
18 diate action to collect the penalty (except where the  
19 Secretary finds that such action could jeopardize the  
20 health or welfare of residents of the nursing facility).  
21 In collecting such penalty, the Secretary may direct  
22 the State to deduct the amount of the penalty from  
23 amounts otherwise payable to the nursing facility  
24 under this title or take such other actions as the  
25 Secretary, in consultation with the State, considers

1 appropriate. If the Secretary’s imposition of a pen-  
 2 alty under this paragraph is set aside, in whole or  
 3 in part, as a result of a hearing under section  
 4 1128A(c)(2) (or an appeal therefrom) or by a court  
 5 of competent jurisdiction, and the Secretary elects  
 6 not to pursue an appeal of such judgment, or has  
 7 exhausted all appeals, the Secretary shall repay, or  
 8 shall direct the State to repay, any amount owed to  
 9 the nursing facility with accrued interest.”

## 10 **Subtitle F—Family Opportunities** 11 **Act**

### 12 **SEC. 951. SHORT TITLE.**

13 This subtitle may be cited as the “Family Oppor-  
 14 tunity Act of 2000”.

### 15 **SEC. 952. OPPORTUNITY FOR FAMILIES OF DISABLED CHIL-** 16 **DREN TO PURCHASE MEDICAID COVERAGE** 17 **FOR SUCH CHILDREN.**

18 (a) STATE OPTION TO ALLOW FAMILIES OF DIS-  
 19 ABLED CHILDREN TO PURCHASE MEDICAID COVERAGE  
 20 FOR SUCH CHILDREN.—

21 (1) IN GENERAL.—Section 1902 (42 U.S.C.  
 22 1396a), as amended by the Foster Care Independ-  
 23 ence Act of 1999 (Public Law 106–169; 113 Stat.  
 24 1822) and the Ticket to Work and Work Incentives

1 Improvement Act of 1999 (Public Law 106–170;  
2 113 Stat. 1860), is amended—

3 (A) in subsection (a)(10)(A)(ii)—

4 (i) by striking “or” at the end of sub-  
5 clause (XVI);

6 (ii) by adding “or” at the end of sub-  
7 clause (XVII); and

8 (iii) by adding at the end the fol-  
9 lowing new subclause:

10 “(XVIII) who are disabled chil-  
11 dren described in subsection (aa);”;

12 and

13 (B) by adding at the end the following new  
14 subsection:

15 “(aa) Individuals described in this subsection are  
16 individuals—

17 “(1) who have not attained 18 years of age;

18 “(2) who would be considered disabled under  
19 section 1614(a)(3)(C) (determined without regard to  
20 the reference to age in that section) but for having  
21 earnings or deemed income or resources (as deter-  
22 mined under title XVI for children) that exceed the  
23 requirements for receipt of supplemental security in-  
24 come benefits; and

1           “(3) whose family income does not exceed such  
2 income level as the State establishes and does not  
3 exceed—

4           “(A) 300 percent of the income official  
5 poverty line (as defined by the Office of Man-  
6 agement and Budget, and revised annually in  
7 accordance with section 673(2) of the Omnibus  
8 Budget Reconciliation Act of 1981) applicable  
9 to a family of the size involved; or

10          “(B) such higher percent of such poverty  
11 line as a State may establish, except that no  
12 Federal financial participation shall be provided  
13 under section 1903(a) for any medical assist-  
14 ance provided to an individual who would not be  
15 described in this subsection but for this  
16 clause.”.

17          (2) INTERACTION WITH EMPLOYER-SPONSORED  
18 FAMILY COVERAGE.—Section 1902(aa) (42 U.S.C.  
19 1396a(aa)), as added by paragraph (1), is amended  
20 by adding at the end the following new paragraph:  
21          “(3)(A) If an employer of a parent of an individual  
22 described in paragraph (1) offers family coverage under  
23 a group health plan (as defined in section 2791(a) of the  
24 Public Health Service Act), the State may—

1           “(i) require such parent to apply for, enroll in,  
2           and pay premiums for, such coverage as a condition  
3           of such parent’s child being or remaining eligible for  
4           medical assistance under subsection  
5           (a)(10)(A)(ii)(XVIII) if the parent is determined eli-  
6           gible for such coverage and the employer contributes  
7           at least 50 percent of the total cost of annual pre-  
8           miums for such coverage; and

9           “(ii) if such coverage is obtained—

10           “(I) subject to paragraph (2) of section  
11           1916(h), reduce the premium imposed by the  
12           State under that section (if any) in an amount  
13           that reasonably reflects the premium contribu-  
14           tion made by the parent for private coverage on  
15           behalf of a child with a disability; and

16           “(II) treat such coverage as a third party  
17           liability under subsection (a)(25).

18           “(B) In the case of a parent to which subparagraph  
19 (A) applies—

20           “(i) if the family income of such parent does  
21           not exceed 300 percent of the income official poverty  
22           line (referred to in paragraph (1)(C)(i)), a State  
23           may provide for payment of any portion of the an-  
24           nual premium for such family coverage that the par-  
25           ent is required to pay; and

1           “(ii) any payments made by the State under  
2           clause (i) shall be considered, for purposes of section  
3           1903(a), to be payments for medical assistance.”.

4           (b) STATE OPTION TO IMPOSE INCOME-RELATED  
5           PREMIUMS.—Section 1916 (42 U.S.C. 1396o), as amend-  
6           ed by the Ticket to Work and Work Incentives Improve-  
7           ment Act of 1999 (Public Law 106–170; 113 Stat. 1860),  
8           is amended—

9           (1) in subsection (a), by striking “subsection  
10           (g)” and inserting “subsections (g) and (h)”; and

11           (2) by adding at the end the following new sub-  
12           section:

13           “(h)(1) With respect to disabled children provided  
14           medical           assistance           under           section  
15           1902(a)(10)(A)(ii)(XVIII), subject to paragraph (2), a  
16           State may (in a uniform manner for such children) require  
17           the families of such children to pay monthly premiums set  
18           on a sliding scale based on family income.

19           “(2) A premium requirement imposed under para-  
20           graph (1) may only apply to the extent that—

21           “(A) the aggregate amount of such premium  
22           and any premium that the parent is required to pay  
23           for family coverage under section 1902(aa)(3)(A)(i)  
24           does not exceed 5 percent of the family’s income;  
25           and

1           “(B) the requirement is imposed consistent with  
2           section 1902(aa)(3)(A)(ii)(I).

3           “(3) A State shall not require prepayment of a pre-  
4           mium imposed pursuant to paragraph (1) and shall not  
5           terminate eligibility of a child under section  
6           1902(a)(10)(A)(ii)(XVIII) for medical assistance under  
7           this title on the basis of failure to pay any such premium  
8           until such failure continues for a period of not less than  
9           60 days from the date on which the premium became past  
10          due. The State may waive payment of any such premium  
11          in any case where the State determines that requiring  
12          such payment would create an undue hardship.”.

13          (c) CONFORMING AMENDMENT.—Section 1903(f)(4)  
14          (42 U.S.C. 1396b(f)(4)) is amended in the matter pre-  
15          ceding subparagraph (A) by inserting  
16          “1902(a)(10)(A)(ii)(XVIII),” after  
17          “1902(a)(10)(A)(ii)(XVI),”.

18          (d) EFFECTIVE DATE.—The amendments made by  
19          this section shall apply to medical assistance for items and  
20          services furnished on or after October 1, 2000.

1 **SEC. 953. TREATMENT OF INPATIENT PSYCHIATRIC HOS-**  
2 **PITAL SERVICES FOR INDIVIDUALS UNDER**  
3 **AGE 21 IN HOME OR COMMUNITY-BASED**  
4 **SERVICES WAIVERS.**

5 (a) IN GENERAL.—Section 1915(c) (42 U.S.C.  
6 1396n(c)) is amended—

7 (1) in paragraph (1)—

8 (A) in the first sentence, by inserting “, or  
9 inpatient psychiatric hospital services for indi-  
10 viduals under age 21,” after “intermediate care  
11 facility for the mentally retarded”; and

12 (B) in the second sentence, by inserting “,  
13 or inpatient psychiatric hospital services for in-  
14 dividuals under age 21” before the period;

15 (2) in paragraph (2)(B), by striking “or serv-  
16 ices in an intermediate care facility for the mentally  
17 retarded” each place it appears and inserting “,  
18 services in an intermediate care facility for the men-  
19 tally retarded, or inpatient psychiatric hospital serv-  
20 ices for individuals under age 21”;

21 (3) by striking paragraph (2)(C) and inserting  
22 the following:

23 “(C) such individuals who are determined to be  
24 likely to require the level of care provided in a hos-  
25 pital, nursing facility, or intermediate care facility  
26 for the mentally retarded, or inpatient psychiatric

1 hospital services for individuals under age 21, are  
2 informed of the feasible alternatives, if available  
3 under the waiver, at the choice of such individuals,  
4 to the provision of inpatient hospital services, nurs-  
5 ing facility services, services in an intermediate care  
6 facility for the mentally retarded, or inpatient psy-  
7 chiatric hospital services for individuals under age  
8 21;” and

9 (4) in paragraph (7)(A)—

10 (A) by inserting “, or inpatient psychiatric  
11 hospital services for individuals under age 21,”  
12 after “intermediate care facility for the men-  
13 tally retarded”; and

14 (B) by inserting “, or who would require  
15 inpatient psychiatric hospital services for indi-  
16 viduals under age 21” before the period.

17 (b) EFFECTIVE DATE.—The amendments made by  
18 subsection (a) apply with respect to medical assistance  
19 provided on or after October 1, 2000.

20 **SEC. 954. DEMONSTRATION OF COVERAGE UNDER THE**  
21 **MEDICAID PROGRAM OF CHILDREN WITH PO-**  
22 **TENTIALLY SEVERE DISABILITIES.**

23 (a) STATE APPLICATION.—A State may apply to the  
24 Secretary of Health and Human Services (in this section  
25 referred to as the “Secretary”) for approval of a dem-

1 onstration project (in this section referred to as a “dem-  
2 onstration project”) under which up to a specified max-  
3 imum number of children with a potentially severe dis-  
4 ability (as defined in subsection (b)) are provided medical  
5 assistance under the State medicaid plan under title XIX  
6 of the Social Security Act (42 U.S.C. 1396 et seq.).

7 (b) CHILD WITH A POTENTIALLY SEVERE DIS-  
8 ABILITY DEFINED.—

9 (1) IN GENERAL.—In this section, the term  
10 “child with a potentially severe disability” means,  
11 with respect to a demonstration project, an indi-  
12 vidual who—

13 (A) has not attained 21 years of age;

14 (B) has a physical or mental condition,  
15 disease, disorder (including a congenital birth  
16 defect or a metabolic condition), injury, or de-  
17 velopmental disability that was incurred before  
18 the individual attained such age; and

19 (C) is reasonably expected, but for the re-  
20 ceipt of medical assistance under the State  
21 medicaid plan, to reach the level of disability  
22 defined under section 1614(a)(3) of the Social  
23 Security Act (42 U.S.C. 1382c(a)(3)), (deter-  
24 mined without regard to the reference to age in  
25 subparagraph (C) of that section).

1           (2) EXCEPTION.—Such term does not include  
2           an individual who would be considered disabled  
3           under section 1614(a)(3)(C) of the Social Security  
4           Act (42 U.S.C. 1382c(a)(3)(C)) (determined without  
5           regard to the reference to age in that section).

6           (c) APPROVAL OF DEMONSTRATION PROJECTS.—

7           (1) IN GENERAL.—Subject to paragraph (3),  
8           the Secretary shall approve applications under sub-  
9           section (a) that meet the requirements of paragraph  
10          (2) and such additional terms and conditions as the  
11          Secretary may require. The Secretary may waive the  
12          requirement of section 1902(a)(1) of the Social Se-  
13          curity Act (42 U.S.C. 1396a(a)(1)) to allow for sub-  
14          State demonstrations.

15          (2) TERMS AND CONDITIONS OF DEMONSTRA-  
16          TION PROJECTS.—The Secretary may not approve a  
17          demonstration project under this section unless the  
18          State provides assurances satisfactory to the Sec-  
19          retary that the following conditions are or will be  
20          met:

21                  (A) INDEPENDENT EVALUATION.—The  
22                  State provides for an independent evaluation of  
23                  the project to be conducted during fiscal year  
24                  2005.

1           (B) CONSULTATION FOR DEVELOPMENT  
2 OF CRITERIA.—The State consults with appro-  
3 priate pediatric health professionals in estab-  
4 lishing the criteria for determining whether a  
5 child has a potentially severe disability.

6           (C) ANNUAL REPORT.—The State submits  
7 an annual report to the Secretary (in a uniform  
8 form and manner established by the Secretary)  
9 on the use of funds provided under the grant  
10 that includes the following:

11           (i) Enrollment and financial statistics  
12           on—

13           (I) the total number of children  
14           with a potentially severe disability en-  
15           rolled in the demonstration project,  
16           disaggregated by disability;

17           (II) the services provided by cat-  
18           egory or code and the cost of each  
19           service so categorized or coded; and

20           (III) the number of children en-  
21           rolled in the demonstration project  
22           who also receive services through pri-  
23           vate insurance.

24           (ii) With respect to the report sub-  
25           mitted for fiscal year 2005, the results of

1 the independent evaluation conducted  
2 under subparagraph (A).

3 (iii) Such additional information as  
4 the Secretary may require.

5 (3) LIMITATIONS ON FEDERAL FUNDING.—

6 (A) APPROPRIATION.—

7 (i) IN GENERAL.—Out of any funds in  
8 the Treasury not otherwise appropriated,  
9 there is appropriated to carry out this sec-  
10 tion \$16,667,000 for each of fiscal years  
11 2001 through 2006.

12 (ii) BUDGET AUTHORITY.—Clause (i)  
13 constitutes budget authority in advance of  
14 appropriations Acts and represents the ob-  
15 ligation of the Federal Government to pro-  
16 vide for the payment of the amounts ap-  
17 propriated under clause (i).

18 (B) LIMITATION ON PAYMENTS.—In no  
19 case may—

20 (i) the aggregate amount of payments  
21 made by the Secretary to States under this  
22 section exceed \$100,000,000;

23 (ii) the aggregate amount of payments  
24 made by the Secretary to States for ad-  
25 ministrative expenses relating to the eval-

1 uations and annual reports required under  
2 subparagraphs (A) and (C) of paragraph  
3 (2) exceed \$2,000,000 of such  
4 \$100,000,000; or

5 (iii) payments be provided by the Sec-  
6 retary for a fiscal year after fiscal year  
7 2009.

8 (C) FUNDS ALLOCATED TO STATES.—

9 (i) IN GENERAL.—The Secretary shall  
10 allocate funds to States based on their ap-  
11 plications and the availability of funds. In  
12 making such allocations, the Secretary  
13 shall ensure an equitable distribution of  
14 funds among States with large populations  
15 and States with small populations.

16 (ii) AVAILABILITY.—Funds allocated  
17 to a State under a grant made under this  
18 section for a fiscal year shall remain avail-  
19 able until expended.

20 (D) FUNDS NOT ALLOCATED TO STATES.—

21 Funds not allocated to States in the fiscal year  
22 for which they are appropriated shall remain  
23 available in succeeding fiscal years for alloca-  
24 tion by the Secretary using the allocation for-  
25 mula established under this section.



1       “(c)(1)(A) In addition to amounts appropriated  
2 under subsection (a) and retained under section 502(a)(1)  
3 for the purpose of carrying out activities described in sub-  
4 section (a)(2), there is appropriated to the Secretary, out  
5 of any money in the Treasury not otherwise appropriated,  
6 for the purpose of enabling the Secretary (through grants,  
7 contracts, or otherwise) to provide for special projects of  
8 regional and national significance for the development and  
9 support of family-to-family health information centers de-  
10 scribed in paragraph (2), \$10,000,000 for each of fiscal  
11 years 2001 through 2006.

12       “(B) Funds appropriated under subparagraph (A)  
13 shall remain available until expended.

14       “(2) The family-to-family health information centers  
15 described in this paragraph are centers that—

16               “(A) assist families of children with disabilities  
17 or special health care needs to make informed  
18 choices about health care in order to promote good  
19 treatment decisions, cost-effectiveness, and improved  
20 health outcomes for such children;

21               “(B) provide information regarding the health  
22 care needs of, and resources available for, children  
23 with disabilities or special health care needs;

24               “(C) identify successful health delivery models  
25 for such children;

1           “(D) develop with representatives of health care  
2 providers, managed care organizations, health care  
3 purchasers, and appropriate State agencies a model  
4 for collaboration between families of such children  
5 and health professionals;

6           “(E) provide training and guidance regarding  
7 caring for such children;

8           “(F) conduct outreach activities to the families  
9 of such children, health professionals, schools, and  
10 other appropriate entities and individuals; and

11           “(G) are staffed by families of children with  
12 disabilities or special health care needs who have ex-  
13 pertise in Federal and State public and private  
14 health care systems and health professionals.

15           “(3) The provisions of this title that are applicable  
16 to the funds made available to the Secretary under section  
17 502(a)(1) apply in the same manner to funds made avail-  
18 able to the Secretary under paragraph (1).”.

19 **SEC. 956. RESTORATION OF MEDICAID ELIGIBILITY FOR**  
20 **CERTAIN SSI BENEFICIARIES.**

21           (a) IN GENERAL.—Section 1902(a)(10)(A)(i)(II) (42  
22 U.S.C. 1396a(a)(10)(A)(i)(II)) is amended—

23           (1) by inserting “(aa)” after “(II)”;

24           (2) by striking “or who are” and inserting  
25 “(bb) who are”; and

1           (3) by inserting before the comma at the end  
2           the following: “, or (cc) who are under 21 years of  
3           age and with respect to whom supplemental security  
4           income benefits would be paid under title XVI but  
5           for section 1611(c)(7)”.

6           (b) EFFECTIVE DATE.—The amendments made by  
7           subsection (a) apply to medical assistance for items and  
8           services furnished on or after January 1, 2002, except  
9           that a State may elect to apply such amendments to items  
10          and services furnished on or after any date after the date  
11          of the enactment of this Act and before October 1, 2000.

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