

106TH CONGRESS  
2D SESSION

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IN THE SENATE OF THE UNITED STATES

Mr. ROTH (for himself and Mr. MOYNIHAN) introduced the following bill;  
which was read twice and referred to the Committee on \_\_\_\_\_

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**A BILL**

To amend the Social Security Act to make corrections and refinements in the Medicare, Medicaid, and SCHIP health insurance programs, 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,*

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

6 (a) SHORT TITLE.—This Act may be cited as the  
7 “Medicare, Medicaid, and SCHIP Balanced Budget Re-  
8 finement Act of 2000”.

1 (b) AMENDMENTS TO SOCIAL SECURITY ACT.—Ex-  
 2 cept as otherwise specifically provided, whenever in this  
 3 Act an amendment is expressed in terms of an amendment  
 4 to or repeal of a section or other provision, the reference  
 5 shall be considered to be made to that section or other  
 6 provision of the Social Security Act.

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

8 (1) THE BALANCED BUDGET ACT OF 1997.—  
 9 The term “BBA” means the Balanced Budget Act  
 10 of 1997 (Public Law 105–33; 111 Stat. 251).

11 (2) THE MEDICARE, MEDICAID, AND SCHIP  
 12 BALANCED BUDGET REFINEMENT ACT OF 1999.—  
 13 The term “BBRA” means the Medicare, Medicaid,  
 14 and SCHIP Balanced Budget Refinement Act of  
 15 1999 (113 Stat. 1501A–321), as enacted into law by  
 16 section 1000(a)(6) of Public Law 106–113.

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

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

#### TITLE I—BENEFIT IMPROVEMENTS

##### Subtitle A—Beneficiary Assistance

Sec. 101. Limiting copayment amount for hospital outpatient services.

Sec. 102. Coverage of immunosuppressive drugs.

Sec. 103. Preservation of coverage of drugs and biologicals under part B of the  
 medicare program.

Sec. 104. Moratorium on reductions in current reimbursement rates for out-  
 patient drugs and biologicals; GAO study and report and HHS  
 comments.

##### Subtitle B—Improved Preventive Benefits

## 3

- Sec. 111. Coverage of biannual screening pap smear and pelvic exams.
- Sec. 112. Coverage of screening colonoscopy for average risk individuals.
- Sec. 113. Medical nutrition therapy services for beneficiaries with diabetes, a cardiovascular disease, or a renal disease.
- Sec. 114. State accreditation of diabetes self-management training programs.
- Sec. 115. Studies on preventive interventions in primary care for older Americans.
- Sec. 116. Institute of Medicine 3-year medicare prevention benefit study and report.
- Sec. 117. 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. Revision of payment for professional services provided by a critical access hospital.
- Sec. 203. Permitting critical access hospitals to operate PPS exempt distinct part psychiatric and rehabilitation units.
- Sec. 204. Exemption of critical access hospital swing beds from SNF PPS.

## Subtitle B—Other Rural Hospital 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 any of the 3 most recent 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. Provider-based rural health clinic cap exemption.
- Sec. 222. Payment for certain physician assistant services.
- Sec. 223. Temporary increase for home health services furnished in a rural area.
- Sec. 224. Refinement of medicare reimbursement for telehealth services.
- Sec. 225. MedPAC study on low-volume, isolated rural health care providers.

## TITLE III—PROVISIONS RELATING TO PART A

## Subtitle A—PPS Hospitals

- Sec. 301. Delay of reduction in PPS hospital payment update.
- Sec. 302. Revision of reduction of indirect graduate medical education payments.
- Sec. 303. Decrease in reductions for disproportionate share hospital payments.
- Sec. 304. Modification of payment rate for Puerto Rico hospitals.
- Sec. 305. MedPAC study and report on hospital area wage indexes.
- Sec. 306. MedPAC study and report regarding certain hospital costs.

## Subtitle B—PPS Exempt Hospitals

## 4

- Sec. 311. Permanent guarantee of pre-BBA payment levels for outpatient services furnished by children's hospitals.
- Sec. 312. Payment for inpatient services of rehabilitation hospitals.
- Sec. 313. Implementation of prospective payment system for long-term care hospitals.

## Subtitle C—Skilled Nursing Facilities

- Sec. 321. Revision to the skilled nursing facility (SNF) market basket update for fiscal years 2001 and 2002.
- Sec. 322. Application of SNF consolidated billing requirement limited to part A covered stays.
- Sec. 323. Reexamination of, and authority to revise, the skilled nursing facility market basket percentage increase.

## Subtitle D—Hospice Care

- Sec. 331. Revision of market basket increase for 2001 and 2002.
- Sec. 332. Study and report on physician certification requirement for hospice benefits.
- Sec. 333. Hospice demonstration program and hospice education grants.

## Subtitle E—Other Provisions

- Sec. 341. Six-month delay in implementation of rule regarding provider-based criteria.

## TITLE IV—PROVISIONS RELATING TO PART B

## Subtitle A—Hospital Outpatient Services

- Sec. 401. Application of transitional corridor to certain hospitals that did not submit a 1996 cost report.
- Sec. 402. Clarifying process and standards for determining eligibility of devices for pass-through payments under hospital outpatient PPS.
- Sec. 403. Contrast enhanced diagnostic procedures under hospital prospective payment system.
- Sec. 404. Transitional pass-through for contrast agents.

## Subtitle B—Provisions Relating to Physicians

- Sec. 411. MedPAC study on the resource-based practice expense system.
- Sec. 412. GAO studies and reports on medicare payments.
- Sec. 413. GAO study on gastrointestinal endoscopic services furnished in physicians' offices and hospital outpatient department services.

## Subtitle C—Ambulance Services

- Sec. 421. Elimination of reduction in inflation adjustments for ambulance services.
- Sec. 422. Election to forego phase-in of fee schedule for ambulance services.
- Sec. 423. Study and report on the costs of rural ambulance services.
- Sec. 424. GAO study and report on the costs of emergency and medical transportation services.

## Subtitle D—Other Services

- Sec. 431. Revision of moratorium in caps for therapy services.
- Sec. 432. Update in renal dialysis composite rate.

## 5

- Sec. 433. Full update in 2001 for durable medical equipment, oxygen, and oxygen equipment.
- Sec. 434. National limitation amount equal to 100 percent of national median for new pap smear technologies and other new clinical laboratory test technologies.
- Sec. 435. Delay and revision of PPS for ambulatory surgical centers.
- Sec. 436. Treatment of certain physician pathology services.
- Sec. 437. Modification of medicare billing requirements for certain Indian providers.
- Sec. 438. Replacement of prosthetic devices and parts.
- Sec. 439. MedPAC study and report on medicare reimbursement for services provided by certain providers.
- Sec. 440. MedPAC study and report on medicare coverage of services provided by certain non-physician providers.

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

## Subtitle A—Home Health Services

- Sec. 501. 1-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. Exclusion of certain nonroutine medical supplies under the PPS for home health services.
- Sec. 504. Treatment of branch offices; GAO study on supervision of home health care provided in isolated rural areas.
- Sec. 505. Temporary additional payments for high-cost patients.
- Sec. 506. Clarification of the homebound definition under the medicare home health benefit.

## Subtitle B—Direct Graduate Medical Education

- Sec. 511. Authority to include costs of training of clinical psychologists in payments to hospitals.

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

## Subtitle A—Medicare+Choice Payment Reforms

- Sec. 601. Increase in national per capita medicare+choice growth percentage in 2001 and 2002.
- Sec. 602. Removing application of budget neutrality for 2002.
- Sec. 603. Increase in minimum payment amount.
- Sec. 604. Allowing movement to 50:50 percent blend in 2002.
- Sec. 605. Increased update for payment areas with only one or no medicare+choice contracts.
- Sec. 606. 10-year phase-in of risk adjustment and new methodology.
- Sec. 607. Permitting premium reductions as additional benefits under medicare+choice plans.
- Sec. 608. Delay from July to November 2000, in deadline for offering and withdrawing medicare+choice plans for 2001.
- Sec. 609. Revision of payment rates for ESRD patients enrolled in medicare+choice plans.

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- Sec. 610. Modification of payment rules for certain frail elderly medicare beneficiaries.
- Sec. 611. Full implementation of risk adjustment for congestive heart failure enrollees for 2001.
- Sec. 612. Inclusion of costs of DOD military treatment facility services to medicare-eligible beneficiaries in calculation of medicare+choice payment rates.

Subtitle B—Other Medicare+Choice Reforms

- Sec. 621. Amounts in medicare trust funds available for Secretary's share of medicare+choice education and enrollment-related costs.
- Sec. 622. Special medigap enrollment antidiscrimination provision for certain beneficiaries.
- Sec. 623. Restoring effective date of elections and changes of elections of medicare+choice plans.
- Sec. 624. Permitting ESRD beneficiaries to enroll in another medicare+choice plan if the plan in which they are enrolled is terminated.
- Sec. 625. Election of uniform local coverage policy for medicare+choice plan covering multiple localities.

Subtitle C—Other Managed Care Reforms

- Sec. 631. Revised terms and conditions for extension of medicare community nursing organization (CNO) demonstration project.
- Sec. 632. Service area expansion for medicare cost contracts during transition period.

TITLE VII—MEDICAID

- Sec. 701. New prospective payment system for Federally-qualified health centers and rural health clinics.
- Sec. 702. Medicaid DSH allotments.
- Sec. 703. Permanent extension of payment of medicare part B premiums for qualified medicare beneficiaries with income up to 135 percent of poverty.
- Sec. 704. Streamlined approval of continued State-wide section 1115 medicaid waivers.
- Sec. 705. Alaska FMAP.

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

- Sec. 801. Special rule for redistribution and availability of unused fiscal year 1998 and 1999 SCHIP allotments.
- Sec. 802. Presumptive eligibility under SCHIP.
- Sec. 803. Authority to pay medicaid expansion SCHIP costs from title XXI appropriation.

TITLE IX—OTHER PROVISIONS

- Sec. 901. Increase in authorization of appropriations for the maternal and child health services block grant.
- Sec. 902. Increase in appropriations for special diabetes programs for children with type I diabetes and Indians.

1                   **TITLE I—BENEFIT**  
2                   **IMPROVEMENTS**  
3           **Subtitle A—Beneficiary Assistance**

4   **SEC. 101. LIMITING COPAYMENT AMOUNT FOR HOSPITAL**  
5                   **OUTPATIENT SERVICES.**

6           (a) IN GENERAL.—Section 1833(t)(8)(C) (42 U.S.C.  
7 1395l(t)(8)(C)) is amended—

8                   (1) in the heading, by striking “TO INPATIENT  
9 HOSPITAL DEDUCTIBLE AMOUNT”; and

10                   (2) by striking “exceed the amount” and all  
11 that follows before the period and inserting “exceed  
12 an amount equal to the greater of—

13                           “(i) one-half of the amount of the in-  
14 patient hospital deductible established  
15 under section 1813(b) for that year; or

16                           “(ii) 20 percent of the payment  
17 amount determined under this subsection  
18 for the procedure.”.

19           (b) EFFECTIVE DATE.—The amendment made by  
20 subsection (a) shall apply with respect to services fur-  
21 nished on or after January 1, 2001.

22   **SEC. 102. COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.**

23           (a) ELIMINATION OF TIME LIMITATION FOR COV-  
24 ERAGE OF IMMUNOSUPPRESSIVE DRUGS.—

1           (1) IN GENERAL.—Section 1861(s)(2)(J) (42  
2 U.S.C. 1395x(s)(2)(J)) is amended to read as fol-  
3 lows:

4           “(J) prescription drugs used in immuno-  
5 suppressive therapy furnished to an individual  
6 who—

7           “(A) receives an organ transplant for  
8 which payment is made under this title; or

9           “(B) received an organ transplant during  
10 the 36-month period immediately preceding the  
11 individual’s most recent effective date of cov-  
12 erage of benefits under this part.”.

13           (2) CONFORMING AMENDMENTS.—

14           (A) EXTENDED COVERAGE.—Section 1832  
15 (42 U.S.C. 1395k) is amended—

16           (i) by striking subsection (b); and

17           (ii) by redesignating subsection (c) as  
18 subsection (b).

19           (B) PASS-THROUGH; REPORT.—Sub-  
20 sections (c) and (d) of section 227 of BBRA  
21 (113 Stat. 1501A–355) are repealed.

22           (b) CONTINUED ENTITLEMENT FOR IMMUNO-  
23 SUPPRESSIVE DRUGS FOR CERTAIN INDIVIDUALS AFTER  
24 MEDICARE BENEFITS END.—

1           (1) IN GENERAL.—Section 226A(b)(2) (42  
2 U.S.C. 426–1(b)(2)) is amended by inserting “(ex-  
3 cept for the provision of immunosuppressive drugs  
4 pursuant to section 1861(s)(2)(J))” after “shall  
5 end”.

6           (2) APPLICATION.—In the case of an individual  
7 whose eligibility for benefits under title XVIII of the  
8 Social Security Act (42 U.S.C. 1395 et seq.) has  
9 ended except for the provision of immunosuppressive  
10 drugs pursuant to the amendment made by para-  
11 graph (1), such individual shall be deemed to be en-  
12 rolled in the original medicare fee-for-service pro-  
13 gram for purposes of receiving coverage of such  
14 drugs.

15           (3) TECHNICAL AMENDMENT.—Subsection (c)  
16 of section 226A (42 U.S.C. 426–1), as added by sec-  
17 tion 201(a)(3)(D)(ii) of the Social Security Inde-  
18 pendence and Program Improvements Act of 1994  
19 (Public Law 103–296; 108 Stat. 1497), is redesign-  
20 nated as subsection (d).

21           (c) EFFECTIVE DATE.—The amendments made by  
22 this section shall apply to immunosuppressive drugs fur-  
23 nished on or after January 1, 2000, to individuals whose  
24 period of entitlement (without regard to the amendment

1 made by subsection (b)(1)) to such drugs under title  
2 XVIII of the Social Security Act ends after such date.

3 **SEC. 103. PRESERVATION OF COVERAGE OF DRUGS AND**  
4 **BIOLOGICALS UNDER PART B OF THE MEDI-**  
5 **CARE PROGRAM.**

6 (a) IN GENERAL.—Section 1861(s)(2) (42 U.S.C.  
7 1395x(s)(2)) is amended, in each of subparagraphs (A)  
8 and (B), by striking “(including drugs and biologicals  
9 which cannot, as determined in accordance with regula-  
10 tions, be self-administered)” and inserting “(including  
11 injectable and infusable drugs and biologicals which are  
12 not usually self-administered by the patient)”.

13 (b) PRESERVING EXISTING COVERAGE OF  
14 INJECTABLE AND INFUSABLE DRUGS AND  
15 BIOLOGICALS.—

16 (1) REPORT TO CONGRESS REQUIRED BEFORE  
17 COVERAGE IS LIMITED OR TERMINATED.—Notwith-  
18 standing any other provision of law, beginning on  
19 the date of enactment of this Act, the Secretary of  
20 Health and Human Services (in this subsection re-  
21 ferred to as the “Secretary”) may not limit or termi-  
22 nate coverage (or permit an agency or organization  
23 with a contract under section 1816 or 1842 of the  
24 Social Security Act (42 U.S.C. 1395h; 42 U.S.C.  
25 1395u) to limit or terminate coverage) of any

1 injectable or infusable drug or biological that was re-  
2 imbursed (as determined under policies established  
3 by each such agency or organization) under section  
4 1861(s)(2) of such Act (42 U.S.C. 1395x(s)(2)) on  
5 January 1, 2000, solely on the basis that the drug  
6 or biological can be self-administered. This para-  
7 graph shall apply to any such drug or biological  
8 until the date that is 60 days after the date on  
9 which the Secretary submits to Congress a report  
10 described in paragraph (2) with respect to such drug  
11 or biological.

12 (2) REPORT DESCRIBED.—A report described  
13 in this paragraph is a report that describes in  
14 detail—

15 (A) the action the Secretary (or any agen-  
16 cy or organization described in paragraph (1))  
17 proposes to take with respect to the limitation  
18 or termination of coverage of an injectable or  
19 infusable drug or biological under section  
20 1861(s)(2) of the Social Security Act (42  
21 U.S.C. 1395x(s)(2)); and

22 (B) the reasons for taking such action.

23 (c) EFFECTIVE DATE.—The amendment made by  
24 subsection (a) shall apply to drugs and biologicals fur-  
25 nished on or after October 1, 2000.

1 **SEC. 104. MORATORIUM ON REDUCTIONS IN CURRENT RE-**  
2 **IMBURSEMENT RATES FOR OUTPATIENT**  
3 **DRUGS AND BIOLOGICALS; GAO STUDY AND**  
4 **REPORT AND HHS COMMENTS.**

5 (a) MORATORIUM.—Notwithstanding any other pro-  
6 vision of law, the Secretary of Health and Human Services  
7 may not implement any reduction in the rate of reimburse-  
8 ment for any outpatient drug or biological under the medi-  
9 care program under title XVIII of the Social Security Act  
10 (42 U.S.C. 1395 et seq.) during the period that begins  
11 on the date of enactment of this Act and ends on Sep-  
12 tember 15, 2001.

13 (b) GAO STUDY AND REPORT REGARDING REIM-  
14 BURSEMENT RATES FOR OUTPATIENT DRUGS AND  
15 BIOLOGICALS.—

16 (1) STUDY.—

17 (A) IN GENERAL.—The Comptroller Gen-  
18 eral of the United States shall conduct a study  
19 on the reasonableness of the reimbursement  
20 policy for outpatient drugs and biologicals  
21 under the medicare program under title XVIII  
22 of the Social Security Act (42 U.S.C. 1395 et  
23 seq.) based on the average wholesale price of  
24 such drugs.

25 (B) REQUIREMENTS.—The study described  
26 in subparagraph (A) shall include an examina-

1           tion of the purchase prices providers pay for  
2           such drugs and biologicals and an identification  
3           of the factors that affect such purchase prices.

4           (2) REPORT.—Not later than July 1, 2001, the  
5           Comptroller General of the United States shall sub-  
6           mit to the Secretary of Health and Human Services  
7           and Congress a report on the study conducted under  
8           paragraph (1) together with recommendations for  
9           such legislation and administrative actions as the  
10          Comptroller General considers appropriate regarding  
11          any adjustment in payment policy necessary to en-  
12          sure reasonable reimbursement for outpatient drugs  
13          and biologicals under the medicare program.

14          (c) COMMENTS.—Not later than 90 days after the  
15          date on which the Comptroller General of the United  
16          States submits the report under subsection (b) to the Sec-  
17          retary of Health and Human Services, the Secretary shall  
18          submit comments on such report to Congress.

19           **Subtitle B—Improved Preventive**  
20                                   **Benefits**

21           **SEC. 111. COVERAGE OF BIENNIAL SCREENING PAP SMEAR**  
22                                   **AND PELVIC EXAMS.**

23           (a) IN GENERAL.—

24                   (1) BIENNIAL SCREENING PAP SMEAR.—Sec-  
25           tion 1861(nm)(1) (42 U.S.C. 1395x(nm)(1)) is

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

3 (2) BIENNIAL SCREENING PELVIC EXAM.—Sec-  
4 tion 1861(nn)(2) (42 U.S.C. 1395x(nn)(2)) is  
5 amended by striking “3 years” and inserting “2  
6 years”.

7 (b) EFFECTIVE DATE.—The amendments made by  
8 subsection (a) shall apply to items and services furnished  
9 on or after January 1, 2001.

10 **SEC. 112. COVERAGE OF SCREENING COLONOSCOPY FOR**  
11 **AVERAGE RISK INDIVIDUALS.**

12 (a) IN GENERAL.—Section 1861(pp) (42 U.S.C.  
13 1395x(pp)) is amended—

14 (1) in paragraph (1)(C), by striking “In the  
15 case of an individual at high risk for colorectal can-  
16 cer, screening colonoscopy” and inserting “Screening  
17 colonoscopy”; and

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

20 (b) FREQUENCY LIMITS FOR SCREENING  
21 COLONOSCOPY.—Section 1834(d) (42 U.S.C. 1395m(d))  
22 is amended—

23 (1) in paragraph (2)(E)(ii), by inserting before  
24 the period at the end the following: “or, in the case  
25 of an individual who is not at high risk for colorectal

1 cancer, if the procedure is performed within the 119  
2 months after a previous screening colonoscopy”;

3 (2) in paragraph (3)—

4 (A) in the heading by striking “FOR INDI-  
5 VIDUALS AT HIGH RISK FOR COLORECTAL CAN-  
6 CER”;

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

10 (C) in subparagraph (E), by inserting be-  
11 fore the period at the end the following: “or for  
12 other individuals if the procedure is performed  
13 within the 119 months after a previous screen-  
14 ing colonoscopy or within 47 months of a pre-  
15 vious screening flexible sigmoidoscopy”.

16 (c) EFFECTIVE DATE.—The amendments made by  
17 this section apply to colorectal cancer screening services  
18 provided on or after January 1, 2001.

19 **SEC. 113. MEDICAL NUTRITION THERAPY SERVICES FOR**  
20 **BENEFICIARIES WITH DIABETES, A CARDIO-**  
21 **VASCULAR DISEASE, OR A RENAL DISEASE.**

22 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.  
23 1395x(s)(2)) is amended—

24 (1) in subparagraph (S), by striking “and” at  
25 the end;

1           (2) in subparagraph (T), by adding “and” at  
2           the end; and

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

5           “(U) medical nutrition therapy services (as de-  
6           fined in subsection (uu)(1)) in the case of a bene-  
7           ficiary with diabetes, a cardiovascular disease (in-  
8           cluding congestive heart failure, arteriosclerosis,  
9           hyperlipidemia,           hypertension,           and  
10          hypercholesterolemia), or a renal disease;”.

11          (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.  
12          1395x) is amended by adding at the end the following new  
13          subsection:

14          “Medical Nutrition Therapy Services; Registered  
15                  Dietitian or Nutrition Professional

16          “(uu)(1) The term ‘medical nutrition therapy serv-  
17          ices’ means nutritional diagnostic, therapy, and counseling  
18          services for the purpose of disease management which are  
19          furnished by a registered dietitian or nutrition profes-  
20          sional (as defined in paragraph (2)) pursuant to a referral  
21          by a physician (as defined in subsection (r)(1)).

22          “(2) Subject to paragraph (3), the term ‘registered  
23          dietitian or nutrition professional’ means an individual  
24          who—

1           “(A) holds a baccalaureate or higher degree  
2           granted by a regionally accredited college or univer-  
3           sity in the United States (or an equivalent foreign  
4           degree) with completion of the academic require-  
5           ments of a program in nutrition or dietetics, as ac-  
6           credited by an appropriate national accreditation or-  
7           ganization recognized by the Secretary for this pur-  
8           pose;

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

12          “(C)(i) is licensed or certified as a dietitian or  
13          nutrition professional by the State in which the serv-  
14          ice is performed; or

15          “(ii) in the case of an individual in a State that  
16          does not provide for such licensure or certification,  
17          meets such other criteria as the Secretary estab-  
18          lishes.

19          “(3) Subparagraphs (A) and (B) of paragraph (2)  
20          shall not apply in the case of an individual who, as of the  
21          date of enactment of this subsection, is licensed or cer-  
22          tified as a dietitian or nutrition professional by the State  
23          in which the medical nutrition therapy service is per-  
24          formed.”.

1 (c) LIMITATION ON FREQUENCY.—Section 1834 (42  
2 U.S.C. 1395m) is amended by adding at the end the fol-  
3 lowing new subsection:

4 “(m) FREQUENCY LIMITATION FOR COVERAGE OF  
5 MEDICAL NUTRITION THERAPY SERVICES.—Notwith-  
6 standing any other provision of this part, no payment may  
7 be made under this part for a medical nutrition therapy  
8 service (as defined in section 1861(uu)) provided to an in-  
9 dividual if such service is provided—

10 “(1) during the 12-month period beginning on  
11 the date that such individual first received a medical  
12 nutrition therapy service covered under this part and  
13 such individual has previously received 3 medical nu-  
14 tritional therapy services during such period; or

15 “(2) at any time after such 12-month period if  
16 such individual has previously received 3 medical nu-  
17 tritional therapy services covered under this part  
18 after such 12-month period.

19 (d) PAYMENT.—Section 1833(a)(1) (42 U.S.C.  
20 1395l(a)(1)) is amended—

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

22 (2) by inserting before the semicolon at the end  
23 the following: “, and (T) with respect to medical nu-  
24 trition therapy services (as defined in section  
25 1861(uu)(1)), the amount paid shall be 85 percent

1 of the lesser of the actual charge for the services or  
2 the amount determined under the fee schedule estab-  
3 lished under section 1848(b) for the same services if  
4 furnished by a physician”.

5 (e) CONFORMING AMENDMENTS.—Section  
6 1862(a)(1) (42 U.S.C. 1395y(a)(1)) is amended—

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

9 (2) in subparagraph (I), by striking the semi-  
10 colon at the end and inserting “, and”; and

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

13 “(J) in the case of medical nutrition therapy  
14 services (as defined in section 1861(uu)(1)), which  
15 are provided more frequently than is covered under  
16 section 1834(m);”.

17 (f) EFFECTIVE DATE.—The amendments made by  
18 this section apply to services furnished on or after July  
19 1, 2001.

20 **SEC. 114. STATE ACCREDITATION OF DIABETES SELF-MAN-**  
21 **AGEMENT TRAINING PROGRAMS.**

22 Section 1861(qq)(2) (42 U.S.C. 1395xx(qq)(2)) is  
23 amended—

1 (1) in the matter preceding subparagraph (A),  
2 by striking “paragraph (1)—” and inserting “para-  
3 graph (1):”;

4 (2) in subparagraph (A)—

5 (A) by striking “a ‘certified provider’” and  
6 inserting “A ‘certified provider’”; and

7 (B) by striking “; and” and inserting a pe-  
8 riod; and

9 (3) in subparagraph (B)—

10 (A) by striking “a physician, or such other  
11 individual” and inserting “(i) A physician, or  
12 such other individual”;

13 (B) by inserting “(I)” before “meets appli-  
14 cable standards”;

15 (C) by inserting “(II)” before “is recog-  
16 nized”;

17 (D) by inserting “, or by a program de-  
18 scribed in clause (ii),” after “recognized by an  
19 organization that represents individuals (includ-  
20 ing individuals under this title) with diabetes”;  
21 and

22 (E) by adding at the end the following new  
23 clause:

24 “(ii) Notwithstanding any reference to ‘a na-  
25 tional accreditation body’ in section 1865(b), for

1 purposes of clause (i), a program described in this  
2 clause is a program operated by a State for the pur-  
3 poses of accrediting diabetes self-management train-  
4 ing programs, if the Secretary determines that such  
5 State program has established quality standards  
6 that meet or exceed the standards established by the  
7 Secretary under clause (i) or the standards origi-  
8 nally established by the National Diabetes Advisory  
9 Board and subsequently revised as described in  
10 clause (i).”.

11 **SEC. 115. STUDIES ON PREVENTIVE INTERVENTIONS IN**  
12 **PRIMARY CARE FOR OLDER AMERICANS.**

13 (a) **STUDIES.**—The Secretary of Health and Human  
14 Services, acting through the United States Preventive  
15 Services Task Force, shall conduct a series of studies de-  
16 signed to identify preventive interventions that can be de-  
17 livered in the primary care setting and that are most valu-  
18 able to older Americans.

19 (b) **MISSION STATEMENT.**—The mission statement of  
20 the United States Preventive Services Task Force is  
21 amended to include the evaluation of services that are of  
22 particular relevance to older Americans.

23 (c) **REPORT.**—Not later than 1 year after the date  
24 of enactment of this Act, and annually thereafter, the Sec-  
25 retary of Health and Human Services shall submit a re-

1 port to Congress on the conclusions of the studies con-  
2 ducted under subsection (a), together with recommenda-  
3 tions for such legislation and administrative actions as the  
4 Secretary considers appropriate.

5 **SEC. 116. INSTITUTE OF MEDICINE 3-YEAR MEDICARE PRE-**  
6 **VENTION BENEFIT STUDY AND REPORT.**

7 (a) STUDY.—

8 (1) IN GENERAL.—The Secretary of Health and  
9 Human Services shall contract with the Institute of  
10 Medicine of the National Academy of Sciences—

11 (A) to conduct a comprehensive study of  
12 current literature and best practices in the field  
13 of health promotion and disease prevention  
14 among medicare beneficiaries, including the  
15 issues described in paragraph (2); and

16 (B) to submit the report described in sub-  
17 section (b).

18 (2) ISSUES STUDIED.—The study required  
19 under paragraph (1) shall include an assessment  
20 of—

21 (A) whether each covered benefit is—

22 (i) medically effective; and

23 (ii) a cost-effective benefit or a cost-  
24 saving benefit;

1 (B) utilization of covered benefits (includ-  
2 ing any barriers to or incentives to increase uti-  
3 lization); and

4 (C) quality of life issues associated with  
5 both health promotion and disease prevention  
6 benefits covered under the medicare program  
7 and those that are not covered under such pro-  
8 gram that would affect all medicare bene-  
9 ficiaries.

10 (b) REPORT.—

11 (1) IN GENERAL.—Not later than 3 years after  
12 the date of enactment of this Act, and every third  
13 year thereafter, the Institute of Medicine of the Na-  
14 tional Academy of Sciences shall submit to the Sec-  
15 retary of Health and Human Services and Congress  
16 a report that contains a detailed statement of the  
17 findings and conclusions of the study conducted  
18 under subsection (a) and the recommendations for  
19 legislation described in paragraph (2).

20 (2) RECOMMENDATIONS FOR LEGISLATION.—

21 The Institute of Medicine of the National Academy  
22 of Sciences, in consultation with the Partnership for  
23 Prevention, shall develop recommendations in legis-  
24 lative form that—

1 (A) prioritize the preventive benefits under  
2 the medicare program; and

3 (B) modify preventive benefits offered  
4 under the medicare program based on the study  
5 conducted under subsection (a).

6 (3) REQUIREMENTS FOR INITIAL REPORT.—

7 The initial report submitted pursuant to paragraph  
8 (1) shall address issues related to the following pre-  
9 ventive benefits:

- 10 (A) Thyroid screening.
- 11 (B) Smoking cessation therapy services.
- 12 (C) Glaucoma detection tests.
- 13 (D) Appropriate preventive treatments for  
14 precancerous skin lesions.

15 (e) DEFINITIONS.—In this section:

16 (1) COST-EFFECTIVE BENEFIT.—The term  
17 “cost-effective benefit” means a benefit or technique  
18 that has—

- 19 (A) been subject to peer review;
- 20 (B) been described in scientific journals;
- 21 and
- 22 (C) demonstrated value as measured by  
23 unit costs relative to health outcomes achieved.

1           (2) COST-SAVING BENEFIT.—The term “cost-  
2 saving benefit” means a benefit or technique that  
3 has—

4                   (A) been subject to peer review;

5                   (B) been described in scientific journals;

6           and

7                   (C) caused a net reduction in health care  
8 costs for medicare beneficiaries.

9           (3) MEDICALLY EFFECTIVE.—The term “medi-  
10 cally effective” means, with respect to a benefit or  
11 technique, that the benefit or technique has been—

12                   (A) subject to peer review;

13                   (B) described in scientific journals; and

14                   (C) determined to achieve an intended goal  
15 under normal programmatic conditions.

16           (4) MEDICARE BENEFICIARY.—The term  
17 “medicare beneficiary” means any individual who is  
18 entitled to benefits under part A or enrolled under  
19 part B of the medicare program under title XVIII  
20 of the Social Security Act, including any individual  
21 enrolled in a Medicare+Choice plan offered by a  
22 Medicare+Choice organization under part C of such  
23 program.

1 **SEC. 117. MEDPAC STUDY AND REPORT ON MEDICARE COV-**  
2 **ERAGE OF CARDIAC AND PULMONARY REHA-**  
3 **BILITATION THERAPY SERVICES.**

4 (a) STUDY.—

5 (1) IN GENERAL.—The Medicare Payment Ad-  
6 visory Commission established under section 1805 of  
7 the Social Security Act (42 U.S.C. 1395b–6) (in this  
8 section referred to as “MedPAC”) shall conduct a  
9 study on coverage of cardiac and pulmonary rehabili-  
10 tation therapy services under the medicare program  
11 under title XVIII of the Social Security Act (42  
12 U.S.C. 1395 et seq.).

13 (2) FOCUS.—In conducting the study under  
14 paragraph (1), MedPAC shall focus on the  
15 appropriate—

16 (A) qualifying diagnoses required for cov-  
17 erage of cardiac and pulmonary rehabilitation  
18 therapy services;

19 (B) level of physician direct involvement  
20 and supervision in furnishing such services; and

21 (C) level of reimbursement for such serv-  
22 ices.

23 (b) REPORT.—Not later than 18 months after the  
24 date of enactment of this Act, MedPAC shall submit a  
25 report to the Secretary of Health and Human Services and  
26 Congress on the study conducted under subsection (a) to-

1 gether with such recommendations for legislation and ad-  
2 ministrative action as MedPAC determines appropriate.

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

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

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

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

25 (b) TECHNICAL AND CONFORMING AMENDMENTS.—

1           (1) Paragraphs (1)(D)(i) and (2)(D)(i) of sec-  
2           tion 1833(a) (42 U.S.C. 1395l(a)(1)(D)(i);  
3           1395l(a)(2)(D)(i)) are each amended by striking “or  
4           which are furnished on an outpatient basis by a crit-  
5           ical access hospital”.

6           (2) Section 403(d)(2) of BBRA (113 Stat.  
7           1501A–371) is amended by striking “The amend-  
8           ment made by subsection (a) shall apply” and in-  
9           serting “Paragraphs (1) through (3) of section  
10          1834(g) of the Social Security Act (as amended by  
11          paragraph (1)) apply”.

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

13           (1) by subsection (a) applies to services fur-  
14           nished on or after the date of the enactment of  
15           BBRA;

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

19           (3) by subsection (b)(2) applies as if included  
20           in the enactment of section 403(d)(2) of BBRA  
21           (113 Stat. 1501A–371).

1 **SEC. 202. REVISION OF PAYMENT FOR PROFESSIONAL**  
2 **SERVICES PROVIDED BY A CRITICAL ACCESS**  
3 **HOSPITAL.**

4 (a) IN GENERAL.—Section 1834(g)(2)(B) (42 U.S.C.  
5 1395m(g)(2)(B)), as amended by section 403(d) of BBRA  
6 (113 Stat. 1501A–371), is amended by inserting “120  
7 percent of” after “hospital services,”.

8 (b) EFFECTIVE DATE.—The amendment made by  
9 subsection (a) shall take effect as if included in the enact-  
10 ment of section 403(d) of BBRA (113 Stat. 1501A–371).

11 **SEC. 203. PERMITTING CRITICAL ACCESS HOSPITALS TO**  
12 **OPERATE PPS EXEMPT DISTINCT PART PSY-**  
13 **CHIATRIC AND REHABILITATION UNITS.**

14 (a) CRITERIA FOR DESIGNATION AS A CRITICAL AC-  
15 CESS HOSPITAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C.  
16 1395i–4(c)(2)(B)(iii)) is amended by inserting “excluding  
17 any psychiatric or rehabilitation unit of the facility which  
18 is a distinct part of the facility,” before “provides not”.

19 (b) DEFINITION OF PPS EXEMPT DISTINCT PART  
20 PSYCHIATRIC AND REHABILITATION UNITS.—Section  
21 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended  
22 by inserting before the last sentence the following new sen-  
23 tence: “In establishing such definition, the Secretary may  
24 not exclude from such definition a psychiatric or rehabili-  
25 tation unit of a critical access hospital which is a distinct  
26 part of such hospital solely because such hospital is ex-

1   empt from the prospective payment system under this sec-  
2   tion.”.

3       (c) EFFECTIVE DATE.—The amendments made by  
4   this section shall take effect on the date of enactment of  
5   this Act.

6   **SEC. 204. EXEMPTION OF CRITICAL ACCESS HOSPITAL**  
7                   **SWING BEDS FROM SNF PPS.**

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

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

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

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

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

21           (5) by adding at the end the following new sub-  
22   paragraph:

23                   “(C) EXEMPTION FROM PPS OF SWING-  
24                   BED SERVICES FURNISHED IN CRITICAL ACCESS  
25                   HOSPITALS.—The prospective payment system

1           established under this subsection shall not  
2           apply to services furnished by a critical access  
3           hospital pursuant to an agreement under sec-  
4           tion 1883.”.

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

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

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

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

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

1     **Subtitle B—Other Rural Hospital**  
2                     **Provisions**

3     **SEC. 211. EQUITABLE TREATMENT FOR RURAL DISPROPOR-**  
4                     **TIONATE SHARE HOSPITALS.**

5             (a) APPLICATION OF UNIFORM THRESHOLD.—Sec-  
6     tion 1886(d)(5)(F)(v) (42 U.S.C. 1395ww(d)(5)(F)(v)) is  
7     amended—

8                 (1) in subclause (II), by inserting “(or 15 per-  
9             cent, for discharges occurring on or after October 1,  
10            2001)” after “30 percent”;

11                (2) in subclause (III), by inserting “(or 15 per-  
12             cent, for discharges occurring on or after October 1,  
13             2001)” after “40 percent”; and

14                (3) in subclause (IV), by inserting “(or 15 per-  
15             cent, for discharges occurring on or after October 1,  
16             2001)” after “45 percent”.

17             (b) ADJUSTMENT OF PAYMENT FORMULAS.—

18                (1) SOLE COMMUNITY HOSPITALS.—Section  
19     1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is  
20     amended—

21                     (A) in clause (iv)(VI), by inserting after  
22             “10 percent” the following: “or, for discharges  
23             occurring on or after October 1, 2001, is equal  
24             to the percent determined in accordance with  
25             clause (x)”;

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

3 “(x) For purposes of clause (iv)(VI), in the case of  
4 a hospital for a cost reporting period with a dispropor-  
5 tionate patient percentage (as defined in clause (vi))  
6 that—

7 “(I) is less than 17.3, the disproportionate  
8 share adjustment percentage is determined in ac-  
9 cordance with the following formula:  $(P-15)(.65) +$   
10  $2.5$ ;

11 “(II) is equal to or exceeds 17.3, but is less  
12 than 30.0, such adjustment percentage is equal to 4  
13 percent; or

14 “(III) is equal to or exceeds 30, such adjust-  
15 ment percentage is equal to 10 percent,

16 where ‘P’ is the hospital’s disproportionate patient per-  
17 centage (as defined in clause (vi)).”.

18 (2) RURAL REFERRAL CENTERS.—Such section  
19 is further amended—

20 (A) in clause (iv)(V), by inserting after  
21 “clause (viii)” the following: “or, for discharges  
22 occurring on or after October 1, 2001, is equal  
23 to the percent determined in accordance with  
24 clause (xi)”; and

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

3 “(xi) For purposes of clause (iv)(V), in the case of  
4 a hospital for a cost reporting period with a dispropor-  
5 tionate patient percentage (as defined in clause (vi))  
6 that—

7 “(I) is less than 17.3, the disproportionate  
8 share adjustment percentage is determined in ac-  
9 cordance with the following formula:  $(P-15)(.65) +$   
10  $2.5$ ;

11 “(II) is equal to or exceeds 17.3, but is less  
12 than 30.0, such adjustment percentage is equal to 4  
13 percent; or

14 “(III) is equal to or exceeds 30, such adjust-  
15 ment percentage is determined in accordance with  
16 the following formula:  $(P-30)(.6) + 4$ ,

17 where ‘P’ is the hospital’s disproportionate patient per-  
18 centage (as defined in clause (vi)).”.

19 (3) SMALL RURAL HOSPITALS GENERALLY.—  
20 Such section is further amended—

21 (A) in clause (iv)(III), by inserting after  
22 “4 percent” the following: “or, for discharges  
23 occurring on or after October 1, 2001, is equal  
24 to the percent determined in accordance with  
25 clause (xii)”; and

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

3 “(xii) For purposes of clause (iv)(III), in the case of  
4 a hospital for a cost reporting period with a dispropor-  
5 tionate patient percentage (as defined in clause (vi))  
6 that—

7 “(I) is less than 17.3, the disproportionate  
8 share adjustment percentage is determined in ac-  
9 cordance with the following formula:  $(P-15)(.65) +$   
10  $2.5$ ;

11 “(II) is equal to or exceeds 17.3, such adjust-  
12 ment percentage is equal to 4 percent,  
13 where ‘P’ is the hospital’s disproportionate patient per-  
14 centage (as defined in clause (vi)).”.

15 (4) HOSPITALS THAT ARE BOTH SOLE COMMU-  
16 NITY HOSPITALS AND RURAL REFERRAL CENTERS.—  
17 Such section is further amended, in clause (iv)(IV),  
18 by inserting after “clause (viii)” the following: “or,  
19 for discharges occurring on or after October 1,  
20 2001, the greater of the percentages determined  
21 under clause (x) or (xi)”.

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

24 (A) in clause (iv)(II), by inserting after “5  
25 percent” the following: “or, for discharges oc-

1 curring on or after October 1, 2001, is equal to  
2 the percent determined in accordance with  
3 clause (xiii)”; and

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

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

10 “(I) is less than 17.3, the disproportionate  
11 share adjustment percentage is determined in ac-  
12 cordance with the following formula:  $(P-15)(.65) +$   
13  $2.5$ ;

14 “(II) is equal to or exceeds 17.3, but is less  
15 than 40.0, such adjustment percentage is equal to 4  
16 percent; or

17 “(III) is equal to or exceeds 40, such adjust-  
18 ment percentage is equal to 5 percent,

19 where ‘P’ is the hospital’s disproportionate patient per-  
20 centage (as defined in clause (vi)).”.

21 (c) TECHNICAL AMENDMENT.—Section  
22 1886(d)(5)(F)(i) (42 U.S.C. 1395ww(d)(5)(F)(i)) is  
23 amended by striking “and before October 1, 1997,”.

1 **SEC. 212. OPTION TO BASE ELIGIBILITY FOR MEDICARE DE-**  
2 **PENDENT, SMALL RURAL HOSPITAL PRO-**  
3 **GRAM ON DISCHARGES DURING ANY OF THE**  
4 **3 MOST RECENT 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 any of the 3 most recent audited cost report-  
9 ing periods,” after “1987”.

10 (b) EFFECTIVE DATE.—The amendment made by  
11 this section shall apply with respect to cost reporting peri-  
12 ods beginning on or after the date of enactment of this  
13 Act.

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)—

20 (A) by striking “that for its cost reporting  
21 period beginning during 1999 is paid on the  
22 basis of the target amount applicable to the  
23 hospital under subparagraph (C) and that  
24 elects (in a form and manner determined by the  
25 Secretary) this subparagraph to apply to the  
26 hospital”; and

1 (B) by striking “substituted for such tar-  
2 get amount” and inserting “substituted, if such  
3 substitution results in a greater payment under  
4 this section for such hospital, for the amount  
5 otherwise determined under subsection  
6 (d)(5)(D)(i)”;

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

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

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

19 **SEC. 214. MEDPAC ANALYSIS OF IMPACT OF VOLUME ON**  
20 **PER UNIT COST OF RURAL HOSPITALS WITH**  
21 **PSYCHIATRIC UNITS.**

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

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

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

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

### 8 **SEC. 221. PROVIDER-BASED RURAL HEALTH CLINIC CAP** 9 **EXEMPTION.**

10 (a) IN GENERAL.—The matter in section 1833(f) (42  
11 U.S.C. 1395l(f)) preceding paragraph (1) is amended by  
12 striking “with less than 50 beds” and inserting “with an  
13 average daily patient census that does not exceed 50”.

14 (b) EFFECTIVE DATE.—The amendment made by  
15 subparagraph (A) shall apply to services furnished on or  
16 after January 1, 2001.

### 17 **SEC. 222. PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT** 18 **SERVICES.**

19 (a) PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT  
20 SERVICES.—Section 1842(b)(6)(C) (42 U.S.C.  
21 1395u(b)(6)(C)) is amended by striking “for such services  
22 provided before January 1, 2003,”.

23 (b) EFFECTIVE DATE.—The amendment made by  
24 subsection (a) shall take effect on the date of enactment  
25 of this Act.

1 **SEC. 223. TEMPORARY INCREASE FOR HOME HEALTH**  
2 **SERVICES FURNISHED IN A RURAL AREA.**

3 (a) INCREASE FOR 2001 AND 2002.—In the case of  
4 a unit of home health service furnished in a rural area  
5 (as defined in section 1886(d)(2)(D) of the Social Security  
6 Act (42 U.S.C. 1395ww(d)(2)(D))) during 2001 or 2002,  
7 the Secretary of Health and Human Services (in this sec-  
8 tion referred to as the “Secretary”) shall increase the pay-  
9 ment amount otherwise made under section 1895 of such  
10 Act (42 U.S.C. 1395fff) for such unit of service by 10  
11 percent.

12 (b) ADDITIONAL PAYMENT NOT BUILT INTO THE  
13 BASE.—The Secretary shall not include any additional  
14 payment made under subsection (a) in updating the stand-  
15 ard prospective payment amount (or amounts) applicable  
16 to units of home health services furnished during a period,  
17 as increased by the home health applicable increase per-  
18 centage for the fiscal year involved under section  
19 1895(b)(3)(B) of the Social Security Act (42 U.S.C.  
20 1395fff(b)(3)(B)).

21 (c) WAIVING BUDGET NEUTRALITY.—The Secretary  
22 shall not reduce the standard prospective payment amount  
23 (or amounts) under section 1895 of the Social Security  
24 Act (42 U.S.C. 1395fff) applicable to units of home health  
25 services furnished during a period to offset the increase

1 in payments resulting from the application of subsection  
2 (a).

3 **SEC. 224. REFINEMENT OF MEDICARE REIMBURSEMENT**  
4 **FOR TELEHEALTH SERVICES.**

5 (a) REVISION OF TELEHEALTH PAYMENT METHOD-  
6 OLOGY AND ELIMINATION OF FEE-SHARING REQUIRE-  
7 MENT.—Section 4206(b) of the Balanced Budget Act of  
8 1997 (42 U.S.C. 1395l note) is amended to read as fol-  
9 lows:

10 “(b) METHODOLOGY FOR DETERMINING AMOUNT OF  
11 PAYMENTS.—

12 “(1) IN GENERAL.—The Secretary shall pay  
13 to—

14 “(A) the physician or practitioner at a dis-  
15 tant site that provides an item or service under  
16 subsection (a) an amount equal to the amount  
17 that such physician or provider would have been  
18 paid had the item or service been provided with-  
19 out the use of a telecommunications system;  
20 and

21 “(B) the originating site a facility fee for  
22 facility services furnished in connection with  
23 such item or service.

24 “(2) APPLICATION OF PART B COINSURANCE  
25 AND DEDUCTIBLE.—Any payment made under this

1 section shall be subject to the coinsurance and de-  
2 ductible requirements under subsections (a)(1) and  
3 (b) of section 1833 of the Social Security Act (42  
4 U.S.C. 1395l).

5 “(3) DEFINITIONS.—In this subsection:

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

11 “(B) FACILITY FEE.—The term ‘facility  
12 fee’ means an amount equal to—

13 “(i) for 2000 and 2001, \$20; and

14 “(ii) for a subsequent year, the facil-  
15 ity fee under this subsection for the pre-  
16 vious year increased by the percentage in-  
17 crease in the MEI (as defined in section  
18 1842(i)(3)) for such subsequent year.

19 “(C) ORIGINATING SITE.—

20 “(i) IN GENERAL.—The term ‘origi-  
21 nating site’ means the site described in  
22 clause (ii) at which the eligible telehealth  
23 beneficiary under the medicare program is  
24 located at the time the item or service is  
25 provided via a telecommunications system.

1                   “(ii) SITES DESCRIBED.—The sites  
2                   described in this paragraph are as follows:

3                   “(I) On or before January 1,  
4                   2002, the office of a physician or a  
5                   practitioner, a critical access hospital,  
6                   a rural health clinic, and a Federally  
7                   qualified health center.

8                   “(II) On or before January 1,  
9                   2003, a hospital, a skilled nursing fa-  
10                  cility, a comprehensive outpatient re-  
11                  habilitation facility, a renal dialysis  
12                  facility, an ambulatory surgical center,  
13                  an Indian Health Service facility, and  
14                  a community mental health center.”.

15                  (b) ELIMINATION OF REQUIREMENT FOR TELEPRE-  
16                  SENTER.—Section 4206 of the Balanced Budget Act of  
17                  1997 (42 U.S.C. 1395l note) is amended—

18                  (1) in subsection (a), by striking “, notwith-  
19                  standing that the individual physician” and all that  
20                  follows before the period at the end; and

21                  (2) by adding at the end the following new sub-  
22                  section:

23                  “(e) TELEPRESENTER NOT REQUIRED.—Nothing in  
24                  this section shall be construed as requiring an eligible tele-  
25                  health beneficiary to be presented by a physician or practi-

1 tioner for the provision of an item or service via a tele-  
2 communications system.”.

3 (c) REIMBURSEMENT FOR MEDICARE BENE-  
4 FICIARIES WHO DO NOT RESIDE IN A HPSA.—Section  
5 4206(a) of the Balanced Budget Act of 1997 (42 U.S.C.  
6 1395l note), as amended by subsection (b), is amended—

7 (1) by striking “IN GENERAL.—Not later than”  
8 and inserting the following: “TELEHEALTH SERV-  
9 ICES REIMBURSED.—

10 “(1) IN GENERAL.—Not later than”;

11 (2) by striking “furnishing a service for which  
12 payment” and all that follows before the period and  
13 inserting “to an eligible telehealth beneficiary”; and

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

16 “(2) ELIGIBLE TELEHEALTH BENEFICIARY DE-  
17 FINED.—In this section, the term ‘eligible telehealth  
18 beneficiary’ means a beneficiary under the medicare  
19 program under title XVIII of the Social Security Act  
20 (42 U.S.C. 1395 et seq.) that resides in—

21 “(A) an area that is designated as a health  
22 professional shortage area under section  
23 332(a)(1)(A) of the Public Health Service Act  
24 (42 U.S.C. 254e(a)(1)(A));

1           “(B) a county that is not included in a  
2 Metropolitan Statistical Area; or

3           “(C) an inner-city area that is medically  
4 underserved (as defined in section 330(b)(3) of  
5 the Public Health Service Act (42 U.S.C.  
6 254b(b)(3))).”.

7       (d) TELEHEALTH COVERAGE FOR DIRECT PATIENT  
8 CARE.—

9           (1) IN GENERAL.—Section 4206 of the Bal-  
10 anced Budget Act of 1997 (42 U.S.C. 1395l note),  
11 as amended by subsection (c), is amended—

12           (A) in subsection (a)(1), by striking “pro-  
13 fessional consultation via telecommunications  
14 systems with a physician” and inserting “items  
15 and services for which payment may be made  
16 under such part that are furnished via a tele-  
17 communications system by a physician”; and

18           (B) by adding at the end the following new  
19 subsection:

20       “(f) COVERAGE OF ITEMS AND SERVICES.—Payment  
21 for items and services provided pursuant to subsection (a)  
22 shall include payment for professional consultations, office  
23 visits, office psychiatry services, including any service  
24 identified as of July 1, 2000, by HCPCS codes 99241–  
25 99275, 99201–99215, 90804–90815, and 90862.”.

1           (2) STUDY AND REPORT REGARDING ADDI-  
2 TIONAL ITEMS AND SERVICES.—

3           (A) STUDY.—The Secretary of Health and  
4 Human Services shall conduct a study to iden-  
5 tify items and services in addition to those de-  
6 scribed in section 4206(f) of the Balanced  
7 Budget Act of 1997 (as added by paragraph  
8 (1)) that would be appropriate to provide pay-  
9 ment under title XVIII of the Social Security  
10 Act (42 U.S.C. 1395 et seq.).

11           (B) REPORT.—Not later than 2 years after  
12 the date of enactment of this Act, the Secretary  
13 shall submit a report to Congress on the study  
14 conducted under subparagraph (A) together  
15 with such recommendations for legislation that  
16 the Secretary determines are appropriate.

17           (e) ALL PHYSICIANS AND PRACTITIONERS ELIGIBLE  
18 FOR TELEHEALTH REIMBURSEMENT.—Section 4206(a)  
19 of the Balanced Budget Act of 1997 (42 U.S.C. 1395l  
20 note), as amended by subsection (d), is amended—

21           (1) in paragraph (1), by striking “(described in  
22 section 1842(b)(18)(C) of such Act (42 U.S.C.  
23 1395u(b)(18)(C))”; and

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

1           “(3) PRACTITIONER DEFINED.—For purposes  
2 of paragraph (1), the term ‘practitioner’ includes—

3           “(A) a practitioner described in section  
4 1842(b)(18)(C) of the Social Security Act (42  
5 U.S.C. 1395u(b)(18)(C)); and

6           “(B) a physical, occupational, or speech  
7 therapist.”.

8           (f) TELEHEALTH SERVICES PROVIDED USING  
9 STORE-AND-FORWARD TECHNOLOGIES.—Section  
10 4206(a)(1) of the Balanced Budget Act of 1997 (42  
11 U.S.C. 1395l note), as amended by subsection (e), is  
12 amended by adding at the end the following new para-  
13 graph:

14           “(4) USE OF STORE-AND-FORWARD TECH-  
15 NOLOGIES.—For purposes of paragraph (1), in the  
16 case of any Federal telemedicine demonstration pro-  
17 gram in Alaska or Hawaii, the term ‘telecommuni-  
18 cations system’ includes store-and-forward tech-  
19 nologies that provide for the asynchronous trans-  
20 mission of health care information in single or multi-  
21 media formats.”.

22           (g) CONSTRUCTION RELATING TO HOME HEALTH  
23 SERVICES.—Section 4206(a) of the Balanced Budget Act  
24 of 1997 (42 U.S.C. 1395l note), as amended by subsection

1 (f), is amended by adding at the end the following new  
2 paragraph:

3 “(5) CONSTRUCTION RELATING TO HOME  
4 HEALTH SERVICES.—

5 “(A) IN GENERAL.—Nothing in this sec-  
6 tion or in section 1895 of the Social Security  
7 Act (42 U.S.C. 1395fff) shall be construed as  
8 preventing a home health agency that is receiv-  
9 ing payment under the prospective payment  
10 system described in such section from fur-  
11 nishing a home health service via a tele-  
12 communications system.

13 “(B) LIMITATION.—The Secretary shall  
14 not consider a home health service provided in  
15 the manner described in subparagraph (A) to  
16 be a home health visit for purposes of—

17 “(i) determining the amount of pay-  
18 ment to be made under the prospective  
19 payment system established under section  
20 1895 of the Social Security Act (42 U.S.C.  
21 1395fff); or

22 “(ii) any requirement relating to the  
23 certification of a physician required under  
24 section 1814(a)(2)(C) of such Act (42  
25 U.S.C. 1395f(a)(2)(C)).”.

1 (h) FIVE-YEAR APPLICATION.—The amendments  
2 made by this section shall apply to items and services pro-  
3 vided on or after April 1, 2001, and before April 1, 2006.

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

6 (a) STUDY.—The Medicare Payment Advisory Com-  
7 mission established under section 1805 of the Social Secu-  
8 rity Act (42 U.S.C. 1395b–6) (in this section referred to  
9 as “MedPAC”) shall conduct a study on the effect of low  
10 patient and procedure volume on the financial status of  
11 low-volume, isolated rural health care providers partici-  
12 pating in the medicare program under title XVIII of the  
13 Social Security Act (42 U.S.C. 1395 et seq.).

14 (b) REPORT.—Not later than 18 months after the  
15 date of enactment of this Act, MedPAC shall submit a  
16 report to the Secretary of Health and Human Services and  
17 Congress on the study conducted under subsection (a)  
18 indicating—

19 (1) whether low-volume, isolated rural health  
20 care providers are having, or may have, significantly  
21 decreased medicare margins or other financial dif-  
22 ficulties resulting from any of the payment meth-  
23 odologies described in subsection (c);

24 (2) whether the status as a low-volume, isolated  
25 rural health care provider should be designated

1 under the medicare program and any criteria that  
2 should be used to qualify for such a status; and

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

8 (c) PAYMENT METHODOLOGIES DESCRIBED.—The  
9 payment methodologies described in this subsection are  
10 the following:

11 (1) The prospective payment system for hos-  
12 pital outpatient department services under section  
13 1833(t) of the Social Security Act (42 U.S.C.  
14 1395l).

15 (2) The fee schedule for ambulance services  
16 under section 1834(l) of such Act (42 U.S.C.  
17 1395m(l)).

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

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

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

4           **TITLE III—PROVISIONS**  
5           **RELATING TO PART A**  
6           **Subtitle A—PPS Hospitals**

7           **SEC. 301. DELAY OF REDUCTION IN PPS HOSPITAL PAY-**  
8           **MENT UPDATE.**

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

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

16           (2) in subclause (XVII)—

17           (A) by striking “minus 1.1 percentage  
18 points”; and

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

20           (3) by redesignating subclause (XVIII) as sub-  
21 clause (XIX);

22           (4) in subclause (XIX), as so redesignated, by  
23 striking “fiscal year 2003” and inserting “fiscal year  
24 2004”; and

1           (5) by inserting after subclause (XVII) the fol-  
2           lowing new subclause:

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

6           (b) SPECIAL RULE FOR PAYMENT FOR INPATIENT  
7 HOSPITAL SERVICES FOR FISCAL YEAR 2001.—Notwith-  
8 standing the amendments made by subsection (a), for pur-  
9 poses of making payments for fiscal year 2001 for inpa-  
10 tient hospital services furnished by subsection (d) hos-  
11 pitals (as defined in section 1886(d)(1)(B) of the Social  
12 Security Act (42 U.S.C. 1395ww(d)(1)(B))), the “applica-  
13 ble percentage increase” referred to in section  
14 1886(b)(3)(B)(i) of such Act (42 U.S.C.  
15 1395ww(b)(3)(B)(i))—

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

21           (2) for discharges occurring on or after April 1,  
22           2001, and before October 1, 2001, shall be equal  
23           to—

1 (A) the market basket percentage increase  
2 plus 1.1 percentage points for hospitals (other  
3 than sole community hospitals) in all areas; and

4 (B) the market basket percentage increase  
5 for sole community hospitals.

6 **SEC. 302. REVISION OF REDUCTION OF INDIRECT GRAD-**  
7 **UATE MEDICAL EDUCATION PAYMENTS.**

8 (a) REVISION.—Section 1886(d)(5)(B)(ii) (42 U.S.C.  
9 1395ww(d)(5)(B)(ii)) is amended—

10 (1) in subclause (V)—

11 (A) by striking “fiscal year 2001” and in-  
12 serting “each of fiscal years 2001 and 2002”;  
13 and

14 (B) by striking “equal to 1.54” and insert-  
15 ing “equal to 1.6”; and

16 (2) in subclause (VI), by striking “2001” and  
17 inserting “2002”.

18 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR  
19 2001.—Notwithstanding paragraph (5)(B)(ii)(V) of sec-  
20 tion 1886(d) of the Social Security Act (42 U.S.C.  
21 1395ww(d)(5)(B)(ii)(V)) (as amended by subsection (a)),  
22 for purposes of making payments for fiscal year 2001 for  
23 subsection (d) hospitals (as defined in paragraph (1)(B)  
24 of such section) with indirect costs of medical education,

1 the indirect teaching adjustment factor referred to in  
2 paragraph (5)(B)(ii) of such section shall be determined—

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

8 (2) for discharges occurring on or after April 1,  
9 2001, and before October 1, 2001, as if “c” in such  
10 paragraph equalled 1.66.

11 (c) CONFORMING AMENDMENT RELATING TO DE-  
12 TERMINATION OF STANDARDIZED AMOUNT.—Section  
13 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is  
14 amended—

15 (1) by striking “1997” and inserting “1997,”;  
16 and

17 (2) by inserting “, or any additional payments  
18 under such paragraph resulting from the application  
19 of section 302 of the Medicare, Medicaid, and  
20 SCHIP Balanced Budget Refinement Act of 2000”  
21 after “Balanced Budget Refinement Act of 1999”.

22 (d) CLERICAL AMENDMENTS.—Section  
23 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)), as amended  
24 by subsection (a), is amended by moving the indentation  
25 of each of the following 2 ems to the left:

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

2 (2) Subclauses (I) through (VI) of clause (ii).

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

5 **SEC. 303. DECREASE IN REDUCTIONS FOR DISPROPOR-**  
6 **TIONATE SHARE HOSPITAL PAYMENTS.**

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

9 (1) in subclause (III), by striking “each of fis-  
10 cal years 2000 and 2001” and inserting “fiscal year  
11 2000”;

12 (2) by redesignating subclauses (IV) and (V) as  
13 subclauses (V) and (IV), respectively;

14 (3) in subclause (V), as redesignated, by strik-  
15 ing “4 percent” and inserting “3 percent”; and

16 (4) by inserting after subclause (III) the fol-  
17 lowing new subclause:

18 “(IV) during fiscal year 2001, such additional  
19 payment amount shall be reduced by 2 percent;”.

20 (b) SPECIAL RULE FOR DSH PAYMENT.—Notwith-  
21 standing the amendments made by subsection (a), for pur-  
22 poses of making disproportionate share payments for sub-  
23 section (d) hospitals (as defined in section 1886(d)(1)(B)  
24 of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))  
25 for fiscal year 2001, the additional payment amount other-

1 wise determined under clause (ii) of section 1886(d)(5)(F)  
2 of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F))—

3 (1) for discharges occurring on or after October  
4 1, 2000, and before April 1, 2001, shall be adjusted  
5 as provided by clause (ix)(III) of such section as in  
6 effect on the day before the date of enactment of  
7 this Act; and

8 (2) for discharges occurring on or after April 1,  
9 2001, and before October 1, 2001, shall, instead of  
10 being adjusted as provided by clause (ix)(IV) of such  
11 section as in effect after the date of enactment of  
12 this Act, shall be decreased by 1 percent.

13 (c) CONFORMING AMENDMENTS RELATING TO DE-  
14 TERMINATION OF STANDARDIZED AMOUNT.—Section  
15 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)), is  
16 amended—

17 (1) by striking “1989 or” and inserting  
18 “1989,”; and

19 (2) by inserting “, or the enactment of section  
20 303 of the Medicare, Medicaid, and SCHIP Bal-  
21 anced Budget Further Refinement Act of 2000”  
22 after “Omnibus Budget Reconciliation Act of 1990”.

1 **SEC. 304. MODIFICATION OF PAYMENT RATE FOR PUERTO**  
2 **RICO HOSPITALS.**

3 (a) MODIFICATION OF PAYMENT RATE.—Section  
4 1886(d)(9)(A) (42 U.S.C. 1395ww(d)(9)(A)) is  
5 amended—

6 (1) in clause (i), by striking “October 1, 1997,  
7 50 percent (” and inserting “October 1, 2000, 25  
8 percent (for discharges between October 1, 1997,  
9 and September 30, 2000, 50 percent,”; and

10 (2) in clause (ii), in the matter preceding sub-  
11 clause (I), by striking “after October 1, 1997, 50  
12 percent (” and inserting “after October 1, 2000, 75  
13 percent (for discharges between October 1, 1997,  
14 and September 30, 2000, 50 percent,”.

15 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR  
16 2001.—

17 (1) IN GENERAL.—Notwithstanding the amend-  
18 ment made by subsection (a), for purposes of mak-  
19 ing payments for the operating costs of inpatient  
20 hospital services of a section 1886(d) Puerto Rico  
21 hospital for fiscal year 2001, the amount referred to  
22 in the matter preceding clause (i) of section  
23 1886(d)(9)(A) of the Social Security Act (42 U.S.C.  
24 1395ww(d)(9)(A))—

25 (A) for discharges occurring on or after  
26 October 1, 2000, and before April 1, 2001,

1 shall be determined in accordance with such  
2 section as in effect on the day before the date  
3 of enactment of this Act; and

4 (B) for discharges occurring on or after  
5 April 1, 2001, and before October 1, 2001,  
6 shall be determined—

7 (i) using 0 percent of the Puerto Rico  
8 adjusted DRG prospective payment rate  
9 referred to in clause (i) of such section;  
10 and

11 (ii) using 100 percent of the dis-  
12 charge-weighted average referred to in  
13 clause (ii) of such section.

14 (2) SECTION 1886(d) PUERTO RICO HOSPITAL.—  
15 For purposes of this subsection, the term “section  
16 1886(d) Puerto Rico hospital” has the meaning  
17 given the term “subsection (d) Puerto Rico hospital”  
18 in the last sentence of section 1886(d)(9)(A) of the  
19 Social Security Act (42 U.S.C. 1395ww(d)(9)(A)).

20 **SEC. 305. MEDPAC STUDY AND REPORT ON HOSPITAL AREA**  
21 **WAGE INDEXES.**

22 (a) STUDY.—

23 (1) IN GENERAL.—The Medicare Payment Ad-  
24 visory Commission established under section 1805 of  
25 the Social Security Act (42 U.S.C. 1395b–6) (in this

1 section referred to as “MedPAC”) shall conduct a  
2 study on the hospital area wage indexes used in  
3 making payments to hospitals under section 1886(d)  
4 of the Social Security Act (42 U.S.C. 1395ww(d)),  
5 including an assessment of the accuracy of those in-  
6 dexes in reflecting geographic differences in wage  
7 and wage-related costs of hospitals.

8 (2) CONSIDERATIONS.—In conducting the study  
9 under paragraph (1), MedPAC shall consider—

10 (A) the appropriate method for deter-  
11 mining hospital area wage indexes;

12 (B) the appropriate portion of hospital  
13 payments that should be adjusted by the appli-  
14 cable area wage index;

15 (C) the appropriate method for adjusting  
16 the wage index by occupational mix; and

17 (D) the feasibility and impact of making  
18 changes (as determined appropriate by  
19 MedPAC) to the methods used to determine  
20 such indexes, including the need for a data sys-  
21 tem required to implement such changes.

22 (b) REPORT.—Not later than 18 months after the  
23 date of enactment of this Act, MedPAC shall submit a  
24 report to the Secretary of Health and Human Services and  
25 Congress on the study conducted under subsection (a) to-

1 gether with such recommendations for legislation and ad-  
2 ministrative action as MedPAC determines appropriate.

3 **SEC. 306. MEDPAC STUDY AND REPORT REGARDING CER-**  
4 **TAIN HOSPITAL COSTS.**

5 (a) STUDY.—

6 (1) IN GENERAL.—The Medicare Payment Ad-  
7 visory Commission established under section 1805 of  
8 the Social Security Act (42 U.S.C. 1395b–6) (in this  
9 section referred to as “MedPAC”) shall conduct a  
10 study on—

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

20 (i) complying with new blood safety  
21 measure requirements; and

22 (ii) providing such services using new  
23 technologies;

24 (B) the extent to which the prospective  
25 payment system for such services under such

1 section provides adequate and timely recogni-  
2 tion of such increased costs;

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

11 (D) the feasibility and advisability of es-  
12 tablishing mechanisms under such payment sys-  
13 tem to provide for more timely and accurate  
14 recognition of such cost increases in the future.

15 (2) CONSULTATION.—In conducting the study  
16 under this section, MedPAC shall consult with rep-  
17 resentatives of the blood community, including

18 (A) hospitals;

19 (B) organizations involved in the collection,  
20 processing, and delivery of blood; and

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

23 (b) REPORT.—Not later than 1 year after the date  
24 of enactment of this Act, MedPAC shall submit a report  
25 to the Secretary of Health and Human Services and Con-

1 gress on the study conducted under subsection (a) to-  
2 gether with such recommendations for legislation and ad-  
3 ministrative action as MedPAC determines appropriate.

## 4 **Subtitle B—PPS Exempt Hospitals**

### 5 **SEC. 311. PERMANENT GUARANTEE OF PRE-BBA PAYMENT** 6 **LEVELS FOR OUTPATIENT SERVICES FUR-** 7 **NISHED BY CHILDREN'S HOSPITALS.**

8 (a) IN GENERAL.—Section 1833(t) (42 U.S.C.  
9 1395l(t)) is amended—

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

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

16 (b) EFFECTIVE DATE.—The amendments made by  
17 subsection (a) apply as if included in the enactment of  
18 section 202 of BBRA.

### 19 **SEC. 312. PAYMENT FOR INPATIENT SERVICES OF REHA-** 20 **BILITATION HOSPITALS.**

21 (a) ASSISTANCE WITH ADMINISTRATIVE COSTS AS-  
22 SOCIATED WITH COMPLETION OF PATIENT ASSESS-  
23 MENT.—Section 1886(j)(3)(B) (42 U.S.C.  
24 1395ww(j)(3)(B)) is amended by striking “98 percent”

1 and inserting “100 percent for fiscal year 2001 and 98  
2 percent for fiscal year 2002”.

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

5 (1) IN GENERAL.—Paragraph (1) of section  
6 1886(j) (42 U.S.C. 1395ww(j)) is amended—

7 (A) in subparagraph (A), by inserting  
8 “other than a facility making an election under  
9 subparagraph (F)” before “, in a cost reporting  
10 period”;

11 (B) in subparagraph (B), by inserting “or,  
12 in the case of a facility making an election  
13 under subparagraph (F), for any cost reporting  
14 period described in such subparagraph,” after  
15 “2002,”; and

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

18 “(F) ELECTION TO APPLY FULL PROSPEC-  
19 TIVE PAYMENT SYSTEM.—A rehabilitation facil-  
20 ity may elect, at least 30 days before the first  
21 date on which the payment methodology under  
22 this subsection applies, to have payment made  
23 to the facility under this subsection under the  
24 provisions of subparagraph (B) (rather than  
25 subparagraph (A)) for each cost reporting pe-

1           riod to which such payment methodology ap-  
2           plies.”.

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

8           (c) EFFECTIVE DATE.—The amendments made by  
9           this section take effect as if included in the enactment of  
10          BBA.

11   **SEC. 313. IMPLEMENTATION OF PROSPECTIVE PAYMENT**  
12                           **SYSTEM FOR LONG-TERM CARE HOSPITALS.**

13          (a) MODIFICATION OF REQUIREMENT.—In devel-  
14          oping the prospective payment system required under sec-  
15          tion 123 of BBRA (113 Stat. 1501A–331), the Secretary  
16          of Health and Human Services shall examine the feasi-  
17          bility and the impact of basing payment under such sys-  
18          tem on the use of existing (or refined) hospital diagnosis-  
19          related groups (DRGs) and the use of the most recently  
20          available hospital discharge data.

21          (b) DEFAULT IMPLEMENTATION OF SYSTEM BASED  
22          ON EXISTING DRG METHODOLOGY.—If the Secretary is  
23          unable to implement the prospective payment system de-  
24          scribed in subsection (a) by October 1, 2002, the Secretary  
25          shall implement a prospective payment system for long-

1 term care hospitals that bases payment under such a sys-  
2 tem using existing hospital diagnosis-related groups  
3 (DRGs), consistent with subsection (a), for such services  
4 furnished on or after that date.

5 **Subtitle C—Skilled Nursing**  
6 **Facilities**

7 **SEC. 321. REVISION TO THE SKILLED NURSING FACILITY**  
8 **(SNF) MARKET BASKET UPDATE FOR FISCAL**  
9 **YEARS 2001 AND 2002.**

10 (a) REVISION.—Section 1888(e)(4)(E)(ii)(II) of the  
11 Social Security Act (42 U.S.C. 1395yy(e)(4)(E)(ii)(II)) is  
12 amended by striking “minus 1 percentage point” and in-  
13 serting “plus 1 percentage point”.

14 (b) SPECIAL RULE FOR PAYMENT FOR SKILLED  
15 NURSING FACILITY SERVICES FOR FISCAL YEAR 2001.—  
16 Notwithstanding the amendment made by subsection (a),  
17 for purposes of making payments for covered skilled nurs-  
18 ing facility services under section 1888(e) of the Social  
19 Security Act (42 U.S.C. 1395yy(e)) for fiscal year 2001,  
20 the Federal per diem rate referred to in paragraph  
21 (4)(E)(ii) of such section—

22 (1) for the period beginning on October 1,  
23 2000, and ending on March 31, 2001, shall be the  
24 rate determined in accordance with subclause (II) of

1 such paragraph as in effect on the day before the  
2 date of enactment of this Act; and

3 (2) for the period beginning on April 1, 2001,  
4 and ending on September 30, 2001, shall be the rate  
5 computed for fiscal year 2000 pursuant to subclause  
6 (I) of such paragraph increased by the skilled nurs-  
7 ing facility market basket percentage change for fis-  
8 cal year 2001 plus 3 percentage points.

9 **SEC. 322. APPLICATION OF SNF CONSOLIDATED BILLING**  
10 **REQUIREMENT LIMITED TO PART A COV-**  
11 **ERED STAYS.**

12 (a) IN GENERAL.—Section 1862(a)(18) (42 U.S.C.  
13 1395y(a)(18)) is amended by inserting after “(as deter-  
14 mined under regulations)” the following: “during a period  
15 in which the resident is provided covered post-hospital ex-  
16 tended care services”.

17 (b) CONFORMING AMENDMENTS.—(1) Section  
18 1842(b)(6)(E) (42 U.S.C. 1395u(b)(6)(E)) is amended by  
19 striking “in the case of an item or service (other than serv-  
20 ices described in section 1888(e)(2)(A)(ii))” and inserting  
21 “in the case of services described in section  
22 1861(s)(2)(D)”.

23 (2) Section 1866(a)(1)(H)(ii)(I) (42 U.S.C.  
24 1395cc(a)(1)(H)(ii)(I)) is amended by inserting after  
25 “who is a resident of the skilled nursing facility” the fol-

1 lowing: “during a period in which the resident is provided  
2 covered post-hospital extended care services (or, for serv-  
3 ices described in section 1861(s)(2)(D), that are furnished  
4 to such an individual without regard to such period)”.

5 (c) EFFECTIVE DATE.—The amendment made by  
6 subsection (a) applies to services furnished on or after  
7 January 1, 2001.

8 (d) OVERSIGHT.—The Secretary of Health and  
9 Human Services, through the Office of the Inspector Gen-  
10 eral in the Department of Health and Human Services  
11 or otherwise, shall monitor payments made under part B  
12 of the title XVIII of the Social Security Act for items and  
13 services furnished to residents of skilled nursing facilities  
14 during a time in which the residents are not being pro-  
15 vided medicare covered post-hospital extended care serv-  
16 ices to ensure that there is not duplicate billing for serv-  
17 ices or excessive services provided.

18 **SEC. 323. REEXAMINATION OF, AND AUTHORITY TO REVISE,**  
19 **THE SKILLED NURSING FACILITY MARKET**  
20 **BASKET PERCENTAGE INCREASE.**

21 (a) REEXAMINATION.—

22 (1) IN GENERAL.—The Secretary of Health and  
23 Human Services shall reexamine the skilled nursing  
24 facility market basket percentage (as defined in  
25 paragraph (5)(B) of section 1888(e) of the Social

1 Security Act (42 U.S.C. 1395yy(e)) that was used in  
2 making the update to the first fiscal year under  
3 paragraph (4)(B) of such section under the prospec-  
4 tive payment system for skilled nursing facility serv-  
5 ices.

6 (2) SPECIFIC ELEMENTS.—In conducting the  
7 reexamination under paragraph (1), the Secretary of  
8 Health and Human Services shall account for costs  
9 based on actual data and actual medicare skilled  
10 nursing facility cost increases.

11 (b) AUTHORITY.—Notwithstanding any other provi-  
12 sion of law, the Secretary of Health and Human Services  
13 shall make adjustments to payments under the prospective  
14 payment system under section 1888(e) of the Social Secu-  
15 rity Act (42 U.S.C. 1395yy(e)) for covered skilled nursing  
16 facility services furnished in fiscal year 2002 to reflect any  
17 necessary adjustments to such payments as is appropriate  
18 as a result of the reexamination conducted under sub-  
19 section (a).

20 (c) PUBLICATION.—

21 (1) IN GENERAL.—Not later than April 1,  
22 2001, the Secretary of Health and Human Services  
23 shall publish for public comment a description of—

24 (A) whether the Secretary will make any  
25 adjustments pursuant to this section; and

1 (B) if so, the form of such adjustments.

2 (2) FINAL FORM.—Not later than August 1,  
3 2001, the Secretary of Health and Human Services  
4 shall publish the description described in paragraph  
5 (1) in final form.

## 6 **Subtitle D—Hospice Care**

### 7 **SEC. 331. REVISION OF MARKET BASKET INCREASE FOR** 8 **2001 AND 2002.**

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

11 (1) by redesignating subclause (VII) as sub-  
12 clause (VIII);

13 (2) in subclause (VI)—

14 (A) by striking “through 2002” and insert-  
15 ing “through 2000”; and

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

17 (3) by inserting after subclause (VI) the fol-  
18 lowing new subclause:

19 “(VII) for each of fiscal years 2001 and 2002,  
20 the market basket percentage increase for the fiscal  
21 year plus 1.0 percentage point; and”.

22 (b) REPEAL OF BBRA TEMPORARY INCREASE.—

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

1           (2) EFFECTIVE DATE.—The amendments made  
2           by paragraph (1) shall take effect as if included in  
3           the enactment of BBRA.

4           (c) TRANSITION DURING FISCAL YEAR 2001.—Not-  
5           withstanding the amendments made by subsection (a), for  
6           purposes of making payments for hospice care under sec-  
7           tion 1814(i) of the Social Security Act (42 U.S.C.  
8           1395f(i)) for fiscal year 2001, the payment rates referred  
9           to in paragraph (1)(C) of such section—

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

15           (2) for the period beginning on April 1, 2001,  
16           and ending on September 30, 2001, shall be the rate  
17           that would have been determined under paragraph  
18           (1) if “plus 3.0 percentage points” were substituted  
19           for “minus 1.0 percentage points under paragraph  
20           (1)(C)(ii)(VI) of such section for fiscal year 2001.

21           (d) TECHNICAL AMENDMENT.—Section  
22           1814(a)(7)(A)(ii) (42 U.S.C. 1395f(a)(7)(A)(ii)) is  
23           amended by striking the period at the end and inserting  
24           a semicolon.

1 **SEC. 332. STUDY AND REPORT ON PHYSICIAN CERTIFI-**  
2 **CATION REQUIREMENT FOR HOSPICE BENE-**  
3 **FITS.**

4 (a) IN GENERAL.—The Secretary of Health and  
5 Human Services shall conduct a study to examine the ap-  
6 propriateness of the certification regarding terminal ill-  
7 ness of an individual under section 1814(a)(7) of the So-  
8 cial Security Act (42 U.S.C. 1395f(a)(7)) that is required  
9 in order for such individual to receive hospice benefits  
10 under the medicare program under title XVIII of such Act  
11 (42 U.S.C. 1395 et seq.).

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

18 **SEC. 333. HOSPICE DEMONSTRATION PROGRAM AND HOS-**  
19 **PICE EDUCATION GRANTS.**

20 (a) DEFINITIONS.—In this section:

21 (1) DEMONSTRATION PROGRAM.—The term  
22 “demonstration program” means the Hospice Dem-  
23 onstration Program established by the Secretary  
24 under subsection (b)(1).

25 (2) HOSPICE CARE; HOSPICE PROGRAM.—Ex-  
26 cept as otherwise provided, the terms “hospice care”

1 and “hospice program” have the meanings given  
2 such terms in paragraphs (1) and (2) of section  
3 1861(dd) of the Social Security Act (42 U.S.C.  
4 1395x(dd)).

5 (3) MEDICARE BENEFICIARY.—The term  
6 “medicare beneficiary” means any individual who is  
7 entitled to benefits under part A or enrolled under  
8 part B of the medicare program, including any indi-  
9 vidual enrolled in a Medicare+Choice plan offered  
10 by a Medicare+Choice organization under part C of  
11 such program.

12 (4) MEDICARE PROGRAM.—The term “medicare  
13 program” means the health benefits program under  
14 title XVIII of the Social Security Act (42 U.S.C.  
15 1395 et seq.).

16 (5) SECRETARY.—The term “Secretary” means  
17 the Secretary of Health and Human Services, acting  
18 through the Administrator of the Health Care Fi-  
19 nancing Administration.

20 (6) SERIOUSLY ILL.—The term “seriously ill”  
21 has the meaning given such term by the Secretary  
22 (in consultation with hospice programs and academic  
23 experts in end-of-life care), except that the Secretary  
24 may not limit such term to individuals that are ter-

1 minally ill (as defined in section 1861(dd)(3) of the  
2 Social Security Act (42 U.S.C. 1395x(dd)(3))).

3 (b) HOSPICE DEMONSTRATION PROGRAM.—

4 (1) ESTABLISHMENT.—Not later than 2 years  
5 after the date of enactment of this Act, the Sec-  
6 retary shall establish a Hospice Demonstration Pro-  
7 gram in accordance with the provisions of this sub-  
8 section to increase the utility of hospice care for se-  
9 riously ill medicare beneficiaries.

10 (2) PARTICIPATION.—

11 (A) HOSPICE PROGRAMS.—Except as pro-  
12 vided in paragraph (4)(A), only a hospice pro-  
13 gram with an agreement under section 1866 of  
14 the Social Security Act (42 U.S.C. 1395cc), a  
15 consortium of such hospice programs, or a  
16 State hospice association may participate in the  
17 demonstration program.

18 (B) MEDICARE BENEFICIARIES.—The Sec-  
19 retary shall permit any seriously ill medicare  
20 beneficiary residing in the service area of a hos-  
21 pice program participating in the demonstration  
22 program to participate in the demonstration  
23 program on a voluntary basis.

24 (3) HOSPICE CARE UNDER DEMONSTRATION  
25 PROGRAM.—The provisions of section 1814(i) of the

1 Social Security Act (42 U.S.C. 1395f(i)) shall apply  
2 to the payment for hospice care provided under the  
3 demonstration program, except that—

4 (A) notwithstanding section 1862(a)(1)(C)  
5 of such Act (42 U.S.C. 1395y(a)(1)(C)), the  
6 Secretary shall provide for reimbursement for  
7 hospice care provided under the supportive and  
8 comfort care benefit established under para-  
9 graph (4);

10 (B) any licensed nurse practitioner or phy-  
11 sician assistant may admit a seriously ill medi-  
12 care beneficiary as the primary care provider  
13 when necessary and within the scope of practice  
14 of such practitioner or assistant under State  
15 law;

16 (C) if a community does not have a quali-  
17 fied social worker, any professional (other than  
18 a social worker) who has the necessary knowl-  
19 edge, skills, and ability to provide medical social  
20 services may provide such services;

21 (D) the Secretary shall waive any require-  
22 ment that nursing facilities used for respite  
23 care have skilled nurses on the premises 24  
24 hours per day;

1           (E) the Secretary shall permit respite care  
2 to be provided to a seriously ill medicare bene-  
3 ficiary at home; and

4           (F) the Secretary shall waive reimburse-  
5 ment regulations to provide—

6                 (i) reimbursement for consultations  
7 and preadmission informational visits, even  
8 if the seriously ill medicare beneficiary  
9 does not elect hospice care (including the  
10 supportive and comfort care benefit under  
11 paragraph (4)) at that time;

12                 (ii) except with respect to the sup-  
13 portive and comfort care benefit under  
14 paragraph (4), a minimum payment for  
15 hospice care provided under the dem-  
16 onstration program based on the provision  
17 of hospice care to a seriously ill medicare  
18 beneficiary for a period of 14 days that—

19                         (I) the Secretary shall pay to any  
20 hospice program participating in the  
21 demonstration program and providing  
22 hospice care (regardless of the length  
23 of stay of the seriously ill medicare  
24 beneficiary); and

1 (II) may not be less than the  
2 amount of payment that would have  
3 been made for hospice care if payment  
4 had been made at the daily rate of  
5 payment for such care under section  
6 1814(i) of the Social Security Act (42  
7 U.S.C. 1395f(i));

8 (iii) an increase in the reimbursement  
9 rates for hospice care to offset—

10 (I) changes in hospice care and  
11 oversight under the demonstration  
12 program; and

13 (II) the higher costs of providing  
14 hospice care in rural areas due to lack  
15 of economies of scale or large geo-  
16 graphic areas;

17 (iv) direct payment of any nurse prac-  
18 titioner or physician assistant practicing  
19 within the scope of State law in relation to  
20 hospice care provided by such practitioner  
21 or assistant; and

22 (v) a per diem rate of payment for in-  
23 home care under subparagraph (E) that  
24 reflects the range of care needs of the seri-  
25 ously ill medicare beneficiary and that—

1 (I) in the case of a seriously ill  
2 medicare beneficiary that needs rou-  
3 tine care, is not less than 150 percent,  
4 and not more than 200 percent, of the  
5 routine home care rate for hospice  
6 care; and

7 (II) in the case of a seriously ill  
8 medicare beneficiary that needs acute  
9 care, is equal to the continuous home  
10 care day rate for hospice care.

11 (4) SUPPORTIVE AND COMFORT CARE BEN-  
12 EFIT.—

13 (A) IN GENERAL.—For purposes of the  
14 demonstration program, the Secretary shall es-  
15 tablish a supportive and comfort care benefit  
16 for any seriously ill medicare beneficiary elect-  
17 ing hospice care.

18 (B) PARTICIPATION.—Any individual or  
19 entity with an agreement under section 1866 of  
20 the Social Security Act (42 U.S.C. 1395cc) may  
21 furnish items or services covered under the sup-  
22 portive and comfort care benefit.

23 (C) BENEFIT.—Under the supportive and  
24 comfort care benefit, any seriously ill medicare  
25 beneficiary may—

1 (i) continue to receive benefits for dis-  
2 ease and symptom modifying treatment  
3 under the medicare program (and the Sec-  
4 retary may not require or prohibit any spe-  
5 cific treatment or decision);

6 (ii) receive case management and hos-  
7 pice care through a hospice program par-  
8 ticipating in the demonstration program  
9 (for which payment shall be made under  
10 paragraph (3)(F)(ii)); and

11 (iii) receive information and experi-  
12 ence in order to better understand the util-  
13 ity of hospice care.

14 (D) PAYMENT.—The Secretary shall estab-  
15 lish procedures under which the Secretary pays  
16 for items and services furnished to seriously ill  
17 medicare beneficiaries under the supportive and  
18 comfort care benefit on a fee-for-service basis.

19 (5) CONDUCT OF DEMONSTRATION PROGRAM.—

20 (A) SITES.—The demonstration program  
21 shall be conducted in 3 sites, only 1 of which  
22 may be multistate.

23 (B) SELECTION OF SITES.—

24 (i) IN GENERAL.—Except as provided  
25 in clause (ii), the Secretary shall select

1 demonstration sites, on the basis of pro-  
2 posals submitted under subparagraph (C),  
3 that are located in geographic areas that—

4 (I) include both urban and rural  
5 hospice programs; and

6 (II) are geographically diverse  
7 and readily accessible to a significant  
8 number of medicare beneficiaries.

9 (ii) EXCEPTIONS.—

10 (I) UNDERSERVED URBAN  
11 AREAS.—If a geographic area does  
12 not have any rural hospice program  
13 available to participate in the dem-  
14 onstration program, such area may  
15 substitute an underserved urban area,  
16 but the Secretary shall give priority to  
17 those proposals that include a rural  
18 hospice program.

19 (II) SPECIFIC SITE.—The Sec-  
20 retary shall select 1 demonstration  
21 site in the State in which, according  
22 to the Hospital Referral Region of  
23 Residence, 1994–1995, as listed in the  
24 Dartmouth Atlas of Health Care  
25 1998, the largest metropolitan area of

1 such State had the lowest percentage  
2 of medicare beneficiary deaths in a  
3 hospital compared to the largest met-  
4ropolitan area of each other State and  
5 the percentage of enrollees who expe-  
6rienced intensive care during the last  
7 6 months of life was 21.5 percent.

8 (C) PROPOSALS.—

9 (i) IN GENERAL.—Under the dem-  
10onstration program, the Secretary shall ac-  
11cept proposals by any State hospice asso-  
12ciation, hospice program, or consortium of  
13hospice programs at such time, in such  
14manner, and in such form as the Secretary  
15may reasonably require.

16 (ii) RESEARCH DESIGNS.—The Sec-  
17retary shall permit research designs that  
18use time series, sequential implementation  
19of the intervention, randomization by wait  
20list, or any other design that allows the  
21strongest possible implementation of the  
22demonstration program.

23 (D) FACILITATION OF EVALUATION.—The  
24Secretary shall design the demonstration pro-

1           gram to facilitate the evaluation conducted  
2           under paragraph (7).

3           (6) DURATION.—The Secretary shall conduct  
4           the demonstration program for a period of 3 years.

5           (7) EVALUATION.—During the 18-month period  
6           following the completion of the demonstration pro-  
7           gram, the Secretary shall conduct an evaluation of  
8           the demonstration program in order to determine—

9                   (A) the short-term and long-term costs and  
10                  benefits of changing hospice care provided  
11                  under the medicare program to include the  
12                  items, services, and reimbursement options pro-  
13                  vided under the demonstration program;

14                   (B) whether any increase in payments for  
15                  hospice care provided under the medicare pro-  
16                  gram is offset by savings in other parts of the  
17                  medicare program;

18                   (C) the projected cost of implementing the  
19                  demonstration program on a national basis; and

20                   (D) in consultation with hospice organiza-  
21                  tions and hospice programs (including organiza-  
22                  tions and programs that represent rural areas),  
23                  whether a payment system based on diagnosis-  
24                  related groups is useful for administering the

1 hospice care provided under the medicare pro-  
2 gram.

3 (8) REPORTS TO CONGRESS.—

4 (A) INTERIM REPORT.—Not later than 2  
5 years after the implementation of the dem-  
6 onstration program, the Secretary, in consulta-  
7 tion with participants in the program, shall sub-  
8 mit to the to the Committee on Ways and  
9 Means of the House of Representatives and to  
10 the Committee on Finance of the Senate an in-  
11 terim report on the demonstration program.

12 (B) FINAL REPORT.—Not later than 2  
13 years after the date on which the demonstration  
14 program ends, the Secretary shall submit to the  
15 committees described in subparagraph (A) a  
16 final report on the demonstration program that  
17 includes the results of the evaluation conducted  
18 under paragraph (7) and recommendations for  
19 appropriate legislative changes.

20 (9) WAIVER OF MEDICARE REQUIREMENTS.—

21 The Secretary shall waive compliance with such re-  
22 quirements of the medicare program to the extent  
23 and for the period the Secretary finds necessary for  
24 the conduct of the demonstration program.

1           (10) SPECIAL RULES FOR PAYMENT OF  
2 MEDICARE+CHOICE ORGANIZATIONS.—The Sec-  
3 retary shall establish procedures under which the  
4 Secretary provides for an appropriate adjustment in  
5 the monthly payments made under section 1853 of  
6 the Social Security Act (42 U.S.C. 1395w-23) to  
7 any Medicare+Choice organization offering a  
8 Medicare+Choice plan to reflect the participation of  
9 each medicare beneficiary enrolled in such plan in  
10 the demonstration program.

11 (c) HOSPICE EDUCATION GRANT PROGRAM.—

12           (1) ESTABLISHMENT.—The Secretary shall es-  
13 tablish a Hospice Education Grant Program under  
14 which the Secretary awards education grants to hos-  
15 pice programs participating in the demonstration  
16 program for the purpose of providing information  
17 about—

18                   (A) hospice care under the medicare pro-  
19 gram; and

20                   (B) the benefits available to medicare  
21 beneficiaries under the demonstration program.

22           (2) USE OF FUNDS.—Grants awarded under  
23 paragraph (1) shall be used—

24                   (A) to provide—

1 (i) individual or group education to  
2 medicare beneficiaries and the families of  
3 such beneficiaries; and

4 (ii) individual or group education of  
5 the medical and mental health community  
6 caring for medicare beneficiaries; and

7 (B) to test strategies to improve the gen-  
8 eral public knowledge about hospice care under  
9 the medicare program and the benefits available  
10 to seriously ill medicare beneficiaries under the  
11 demonstration program.

12 (d) FUNDING.—

13 (1) HOSPICE DEMONSTRATION PROGRAM.—

14 (A) IN GENERAL.—Except as provided in  
15 subparagraph (B), expenditures made for the  
16 demonstration program shall be in lieu of the  
17 funds that would have been provided to partici-  
18 pating hospices under section 1814(i) of the So-  
19 cial Security Act (42 U.S.C. 1395f(i)).

20 (B) SUPPORTIVE AND COMFORT CARE  
21 BENEFIT.—The Secretary shall pay any ex-  
22 penses for the supportive and comfort care ben-  
23 efit established under subsection (a)(4) from  
24 the Federal Hospital Insurance Trust Fund es-  
25 tablished under section 1817 of the Social Secu-

1           rity Act (42 U.S.C. 1395i) and the Federal  
2           Supplementary Medical Insurance Trust Fund  
3           established under section 1841 of such Act (42  
4           U.S.C. 1395t), in such proportion as the Sec-  
5           retary determines is appropriate.

6           (2) HOSPICE EDUCATION GRANTS.—The Sec-  
7           retary is authorized to expend such sums as may be  
8           necessary for the purposes of carrying out the Hos-  
9           pice Education Grant program established under  
10          subsection (c)(1) from the Research and Demonstra-  
11          tion Budget of the Health Care Financing Adminis-  
12          tration.

## 13           **Subtitle E—Other Provisions**

### 14   **SEC. 341. SIX-MONTH DELAY IN IMPLEMENTATION OF RULE** 15                           **REGARDING PROVIDER-BASED CRITERIA.**

16          The Secretary of Health and Human Services may  
17          not implement the provider-based criteria contained in the  
18          final rule that was published in the Federal Register by  
19          the Health Care Financing Administration on April 7,  
20          2000 (65 Fed. Reg. 18434) until after July 9, 2001.

1                   **TITLE IV—PROVISIONS**  
2                   **RELATING TO PART B**  
3           **Subtitle A—Hospital Outpatient**  
4                   **Services**

5   **SEC. 401. APPLICATION OF TRANSITIONAL CORRIDOR TO**  
6                   **CERTAIN HOSPITALS THAT DID NOT SUBMIT**  
7                   **A 1996 COST REPORT.**

8           (a) **IN GENERAL.**—Section 1833(t)(7)(F)(ii)(I) (42  
9 U.S.C. 1395l(t)(7)(F)(ii)(I)) is amended by inserting “(or,  
10 in the case of a hospital that did not submit a cost report  
11 for such period, during the first cost reporting period end-  
12 ing in a year after 1996 and before 2001 for which the  
13 hospital submitted a cost report)” after “1996”.

14           (b) **EFFECTIVE DATE.**—The amendment made by  
15 subsection (a) shall take effect as if included in the enact-  
16 ment of section 202 of BBRA.

17   **SEC. 402. CLARIFYING PROCESS AND STANDARDS FOR DE-**  
18                   **TERMINING ELIGIBILITY OF DEVICES FOR**  
19                   **PASS-THROUGH PAYMENTS UNDER HOSPITAL**  
20                   **OUTPATIENT PPS.**

21           (a) **IN GENERAL.**—Section 1833(t)(6) (42 U.S.C.  
22 1395l(t)(6)) is amended—

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

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

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

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

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

10 “(ii) ESTABLISHING CRITERIA FOR  
11 ADDITIONAL CATEGORIES.—

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

19 “(II) STANDARD.—Such cat-  
20 egories shall be established under this  
21 clause in a manner such that no med-  
22 ical device is described by more than  
23 one category. Such criteria shall in-  
24 clude a test of whether the average  
25 cost of devices that would be included

1 in a category and are in use at the  
2 time the category is established is not  
3 insignificant, as described in subpara-  
4 graph (A)(iv)(II).

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

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

20 “(iii) PERIOD FOR WHICH CATEGORY  
21 IS IN EFFECT.—A category of medical de-  
22 vices established under clause (i) or clause  
23 (ii) shall be in effect for a period of at  
24 least 2 years, but not more than 3 years,  
25 that begins—

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

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

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

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

20                         “(II) the device is described by a  
21                         category established and in effect  
22                         under clause (ii) and an application  
23                         under section 515 of the Federal  
24                         Food, Drug, and Cosmetic Act has  
25                         been approved with respect to the de-

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

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

13 “(C) LIMITED PERIOD OF PAYMENT.—

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

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

1 this part is made as an outpatient  
2 hospital service before such first date;  
3 or

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

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

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

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

24 (b) CONFORMING AMENDMENTS.—Section 1833(t)  
25 (42 U.S.C. 1395l(t)) amended—

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

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

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

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

18          (d) TRANSITION.—In the case of a medical device  
19          provided as part of a service (or group of services) fur-  
20          nished during the period beginning on the date that is 30  
21          days after the date of the enactment of this Act and end-  
22          ing on the day before the initial categories are imple-  
23          mented under subparagraph (B)(i) of section 1833(t)(6)  
24          of the Social Security Act (as amended by subsection (a)),  
25          payment shall be made for such device under such section

1 in accordance with the provisions in effect before the date  
2 of the enactment of this Act, except that (notwithstanding  
3 subparagraph (C)(ii) of such section, as so amended) pay-  
4 ment shall also be made for such a device that is not in-  
5 cluded in a program memorandum described in such sub-  
6 paragraph if the Secretary determines that the device is  
7 likely to be described by such an initial category.

8 **SEC. 403. CONTRAST ENHANCED DIAGNOSTIC PROCE-**  
9 **DURES UNDER HOSPITAL PROSPECTIVE PAY-**  
10 **MENT SYSTEM.**

11 (a) SEPARATE CLASSIFICATION.—Section 1833(t)(2)  
12 (42 U.S.C. 1395l(t)(2)) is amended—

13 (1) by striking “and” at the end of subpara-  
14 graph (E);

15 (2) by striking the period at the end of sub-  
16 paragraph (F) and inserting “; and”; and

17 (3) by inserting after subparagraph (F) the fol-  
18 lowing new subparagraph:

19 “(G) the Secretary shall create additional  
20 groups of covered OPD services that classify  
21 separately those procedures that utilize contrast  
22 media from those that do not.”.

23 (b) EFFECTIVE DATE.—The amendments made by  
24 this section shall be effective as if included in the enact-  
25 ment of BBA.

1 **SEC. 404. TRANSITIONAL PASS-THROUGH FOR CONTRAST**  
2 **AGENTS.**

3 (a) IN GENERAL.—Section 1833(t)(6) (42 U.S.C.  
4 1395l(t)(6)), as amended by section 402, is amended—

5 (1) in subparagraph (A)(iv)—

6 (A) in the heading, by striking “AND  
7 BIOLOGICALS” and inserting “BIOLOGICALS,  
8 AND CONTRAST AGENTS”;

9 (B) in the matter preceding subclause (I),  
10 by striking “or biological” and inserting “bio-  
11 logical, or contrast agent”;

12 (C) in subclause (I), by striking “or bio-  
13 logical” and inserting “biological, or contrast  
14 agent”; and

15 (D) in subclause (II), by striking “or bio-  
16 logical” and inserting “, biological, or contrast  
17 agent”;

18 (2) in subparagraph (C)—

19 (A) in the heading, by striking “AND  
20 BIOLOGICALS” and inserting “BIOLOGICALS,  
21 AND CONTRAST AGENTS”; and

22 (B) by striking “or biological” the first,  
23 third, fourth, and fifth place it appears and in-  
24 serting “, biological, or contrast agent”; and

25 (3) in subparagraph (D)—

1 (A) in the matter preceding clause (i), by  
2 striking “or biological” and inserting “biologi-  
3 cal, or contrast agent”; and

4 (B) in clause (i), by striking “or biologi-  
5 cal” each place it appears and inserting “, bio-  
6 logical, or contrast agent”.

7 (b) EFFECTIVE DATE.—The amendments made by  
8 subsection (a) shall take effect on January 1, 2001.

9 **Subtitle B—Provisions Relating to**  
10 **Physicians**

11 **SEC. 411. MEDPAC STUDY ON THE RESOURCE-BASED PRAC-**  
12 **TICE EXPENSE SYSTEM.**

13 (a) STUDY.—The Medicare Payment Advisory Com-  
14 mission established under section 1805 of the Social Secu-  
15 rity Act (42 U.S.C. 1395b–6) (in this section referred to  
16 as “MedPAC”) shall conduct a study on the refinements  
17 to the practice expense relative value units during the  
18 transition to a resource-based practice expense system for  
19 physician payments under the medicare program under  
20 title XVIII of the Social Security Act (42 U.S.C. 1395  
21 et seq.) (in this section referred to as the “medicare pro-  
22 gram”).

23 (b) REPORT.—Not later than July 1, 2001, MedPAC  
24 shall submit a report to the Secretary of Health and  
25 Human Services and Congress on the study conducted

1 under subsection (a) together with recommendations  
2 regarding—

3 (1) any change or adjustment that is appro-  
4 priate to ensure full access to a spectrum of care for  
5 beneficiaries under the medicare program; and

6 (2) the appropriateness of payments to physi-  
7 cians.

8 **SEC. 412. GAO STUDIES AND REPORTS ON MEDICARE PAY-**  
9 **MENTS.**

10 (a) GAO STUDY ON HCFA POST-PAYMENT AUDIT  
11 PROCESS.—

12 (1) STUDY.—The Comptroller General of the  
13 United States shall conduct a study on the post-pay-  
14 ment audit process under the medicare program  
15 under title XVIII of the Social Security Act (42  
16 U.S.C. 1395 et seq.) (in this section referred to as  
17 the “medicare program”) as such process applies to  
18 physicians, including the proper level of resources  
19 that the Health Care Financing Administration  
20 should devote to educating physicians regarding—

21 (A) coding and billing;

22 (B) documentation requirements; and

23 (C) the calculation of overpayments.

24 (2) REPORT.—Not later than 18 months after  
25 the date of enactment of this Act, the Comptroller

1 General shall submit a report to the Secretary of  
2 Health and Human Services and Congress on the  
3 study conducted under paragraph (1) together with  
4 specific recommendations for changes or improve-  
5 ments in the post-payment audit process described  
6 in such paragraph.

7 (b) GAO STUDY ON ADMINISTRATION AND OVER-  
8 SIGHT.—

9 (1) STUDY.—The Comptroller General of the  
10 United States shall conduct a study on the aggre-  
11 gate effects of regulatory, audit, oversight, and pa-  
12 perwork burdens on physicians and other health care  
13 providers participating in the medicare program.

14 (2) REPORT.—Not later than 18 months after  
15 the date of enactment of this Act, the Comptroller  
16 General shall submit a report to the Secretary of  
17 Health and Human Services and Congress on the  
18 study conducted under paragraph (1) together with  
19 recommendations regarding any area in which—

20 (A) a reduction in paperwork, an ease of  
21 administration, or an appropriate change in  
22 oversight and review may be accomplished; or

23 (B) additional payments or education are  
24 needed to assist physicians and other health

1 care providers in understanding and complying  
2 with any legal or regulatory requirements.

3 **SEC. 413. GAO STUDY ON GASTROINTESTINAL ENDOSCOPIC**  
4 **SERVICES FURNISHED IN PHYSICIANS' OF-**  
5 **FICES AND HOSPITAL OUTPATIENT DEPART-**  
6 **MENT SERVICES.**

7 (a) STUDY.—The Comptroller General of the United  
8 States shall conduct a study on the appropriateness of fur-  
9 nishing gastrointestinal endoscopic physicians' services in  
10 physicians' offices. In conducting this study, the Comp-  
11 troller General shall—

12 (1) review available scientific and clinical evi-  
13 dence regarding the safety of performing procedures  
14 in physicians' offices and hospital outpatient depart-  
15 ments;

16 (2) assess whether resource-based practice ex-  
17 pense relative values established by the Secretary of  
18 Health and Human Services under the medicare  
19 physician fee schedule under section 1848 of the So-  
20 cial Security Act (42 U.S.C. 1395w-4) for gastro-  
21 intestinal endoscopic services furnished in physi-  
22 cians' offices and hospital outpatient departments  
23 create an incentive to furnish such services in physi-  
24 cians' offices instead of hospital outpatient depart-  
25 ments; and

1           (3) assess the implications for access to care for  
2           medicare beneficiaries if gastrointestinal endoscopic  
3           services in physicians' offices were not covered under  
4           the medicare program.

5           (b) REPORT.—Not later than July 1, 2002, the  
6           Comptroller General of the United States shall submit a  
7           report to the Secretary of Health and Human Services and  
8           Congress on the study conducted under subsection (a) to-  
9           gether with such recommendations for legislation and ad-  
10          ministrative action as the Comptroller General determines  
11          appropriate.

## 12           **Subtitle C—Ambulance Services**

### 13           **SEC. 421. ELIMINATION OF REDUCTION IN INFLATION AD-** 14           **JUSTMENTS FOR AMBULANCE SERVICES.**

15          Subparagraphs (A) and (B) of section 1834(l)(3) (42  
16          U.S.C. 1395m(l)(3)(A)) are each amended by striking “re-  
17          duced in the case of 2001 and 2002 by 1.0 percentage  
18          points” and inserting “increased in the case of 2001 by  
19          1.0 percentage point”.

### 20           **SEC. 422. ELECTION TO FOREGO PHASE-IN OF FEE SCHED-** 21           **ULE FOR AMBULANCE SERVICES.**

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

24                   “(8) ELECTION TO FOREGO PHASE-IN OF FEE  
25           SCHEDULE.—

1           “(A) IN GENERAL.—If the Secretary pro-  
2           vides for a phase-in of the fee schedule estab-  
3           lished under this subsection, a supplier of am-  
4           bulance services may make an election to re-  
5           ceive payments at any time during such phase-  
6           in based only on such fee schedule as in effect  
7           after such phase-in, and the Secretary shall  
8           begin to make payments to the supplier based  
9           only on such fee schedule not later than the  
10          date that is 60 days after the date on which the  
11          supplier notifies the Secretary of such election.

12           “(B) WAIVER OF BUDGET NEUTRALITY.—  
13          The Secretary shall apply paragraph (3)(A) as  
14          if this paragraph had not been enacted.”.

15 **SEC. 423. STUDY AND REPORT ON THE COSTS OF RURAL**  
16 **AMBULANCE SERVICES.**

17          (a) STUDY.—The Secretary of Health and Human  
18          Services (in this section referred to as the “Secretary”),  
19          in consultation with the Office of Rural Health Policy,  
20          shall conduct a study on the means by which rural areas  
21          with low population densities can be identified for the pur-  
22          pose of designating areas in which the cost of providing  
23          ambulance services would be expected to be higher than  
24          similar services provided in more heavily populated areas  
25          because of low usage. Such study shall also include an

1 analysis of the additional costs of providing ambulance  
2 services in areas designated under the previous sentence.

3 (b) REPORT.—Not later than June 30, 2001, the  
4 Secretary shall submit a report to Congress on the study  
5 conducted under subsection (a), together with a regulation  
6 based on that study which adjusts the fee schedule pay-  
7 ment rates for ambulance services provided in low density  
8 rural areas based on the increased cost of providing such  
9 services in such areas.

10 **SEC. 424. GAO STUDY AND REPORT ON THE COSTS OF**  
11 **EMERGENCY AND MEDICAL TRANSPOR-**  
12 **TATION SERVICES.**

13 (a) STUDY.—The Comptroller General of the United  
14 States shall conduct a study on the costs of providing  
15 emergency and medical transportation services across the  
16 range of acuity levels of conditions for which such trans-  
17 portation services are provided.

18 (b) REPORT.—Not later than 18 months after the  
19 date of enactment of this Act, the Comptroller General  
20 shall submit a report to the Secretary of Health and  
21 Human Services and Congress on the study conducted  
22 under subsection (a), together with recommendations for  
23 any changes in methodology or payment level necessary  
24 to fairly compensate suppliers of emergency and medical  
25 transportation services and to ensure the access of bene-

1 ficiaries under the medicare program under title XVIII of  
2 the Social Security Act (42 U.S.C. 1395 et seq.) to such  
3 services.

## 4 **Subtitle D—Other Services**

### 5 **SEC. 431. REVISION OF MORATORIUM IN CAPS FOR THER-** 6 **APY SERVICES.**

7 (a) EXTENSION OF MORATORIUM.—Section  
8 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended by strik-  
9 ing “during 2000 and 2001” and inserting “during the  
10 period beginning on January 1, 2000, and ending on the  
11 date that is 18 months after the date on which the Sec-  
12 retary submits the report required under section  
13 4541(d)(2) of the Balanced Budget Act of 1997 to Con-  
14 gress”.

15 (b) EXTENSION OF REPORTING DATE.—Section  
16 4541(d)(2) of BBA (42 U.S.C. 1395l note), as amended  
17 by section 221(c) of BBRA (113 Stat. 1501A–351), is  
18 amended by striking “January 1, 2001” and inserting  
19 “January 1, 2002” in the matter preceding subparagraph  
20 (A).

### 21 **SEC. 432. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.**

22 The last sentence of section 1881(b)(7) (42 U.S.C.  
23 1395rr(b)(7)) is amended by striking “for such services  
24 furnished on or after January 1, 2001, by 1.2 percent”

1 and inserting “for such services furnished on or after Jan-  
2 uary 1, 2001, by 2.4 percent”.

3 **SEC. 433. FULL UPDATE IN 2001 FOR DURABLE MEDICAL**  
4 **EQUIPMENT, OXYGEN, AND OXYGEN EQUIP-**  
5 **MENT.**

6 (a) UPDATE FOR COVERED ITEMS.—Section  
7 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

8 (1) by redesignating subparagraph (D) as sub-  
9 paragraph (F);

10 (2) in subparagraph (C)—

11 (A) by striking “through 2002” and insert-  
12 ing “through 2000”; and

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

14 (3) by inserting after subparagraph (C) the fol-  
15 lowing new subparagraphs:

16 “(D) for 2001, the percentage increase in  
17 the consumer price index for all urban con-  
18 sumers (U.S. urban average) for the 12-month  
19 period ending with June 2000;

20 “(E) for 2002, 0 percentage points; and”.

21 (b) ORTHOTICS AND PROSTHETICS.—Section  
22 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A)) is amended—

23 (1) by redesignating clause (vi) as clause (viii);

24 (2) in clause (v)—

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 clause (v) the following  
5 new clauses:

6 “(vi) for 2001, the percentage in-  
7 crease in the consumer price index for all  
8 urban consumers (United States City aver-  
9 age) for the 12-month period ending with  
10 June 2000;

11 “(vi) for 2002, 1 percent; and”.

12 (c) PARENTERAL AND ENTERAL NUTRIENTS, SUP-  
13 PLIES, AND EQUIPMENT.—Section 4551(b) of BBA (42  
14 U.S.C. 1395m note) is amended by striking “through  
15 2002” and inserting “, 1999, 2000, and 2002”.

16 (d) OXYGEN AND OXYGEN EQUIPMENT.—Section  
17 1834(a)(9)(B) (42 U.S.C. 1395m(a)(9)(B)) is amended—

18 (1) in clause (v), by striking “and” at the end;

19 (2) in clause (vi)—

20 (A) by striking “each subsequent year”  
21 and inserting “2000”; and

22 (B) by striking the period at the end and  
23 inserting a semicolon; and

24 (3) by adding at the end the following new  
25 clauses:



1 has previously been established under this subpara-  
2 graph)”.  
3

3 **SEC. 435. DELAY AND REVISION OF PPS FOR AMBULATORY**  
4 **SURGICAL CENTERS.**

5 (a) DELAY IN IMPLEMENTATION OF PROSPECTIVE  
6 PAYMENT SYSTEM.—The Secretary of Health and Human  
7 Services may not implement a revised prospective payment  
8 system for services of ambulatory surgical facilities under  
9 section 1833(i) of the Social Security Act (42 U.S.C.  
10 1395l(i)) before January 1, 2002.

11 (b) EXTENDING PHASE-IN TO 4 YEARS.—Section  
12 226 of the BBRA (113 Stat. 1501A–354) is amended by  
13 striking paragraphs (1) and (2) and inserting the fol-  
14 lowing:

15 “(1) in the first year of its implementation,  
16 only a proportion (specified by the Secretary and not  
17 to exceed  $\frac{1}{4}$ ) of the payment for such services shall  
18 be made in accordance with such system and the re-  
19 mainder shall be made in accordance with current  
20 regulations; and

21 “(2) in each of the following 2 years a propor-  
22 tion (specified by the Secretary and not to exceed  
23  $\frac{1}{2}$ , and  $\frac{3}{4}$ , respectively) of the payment for such  
24 services shall be made under such system and the

1 remainder shall be made in accordance with current  
2 regulations.”.

3 (c) DEADLINE FOR USE OF 1999 OR LATER COST  
4 SURVEYS.—Section 226 of BBRA (113 Stat. 1501A–354)  
5 is amended by adding at the end the following:

6 “By not later than January 1, 2003, the Secretary shall  
7 incorporate data from a 1999 Medicare cost survey or a  
8 subsequent cost survey for purposes of implementing or  
9 revising such system.”.

10 **SEC. 436. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY**  
11 **SERVICES.**

12 (a) IN GENERAL.—Section 1848(i) (42 U.S.C.  
13 1395w–4(i)) is amended by adding at the end the fol-  
14 lowing new paragraph:

15 “(4) TREATMENT OF CERTAIN PHYSICIAN PA-  
16 THOLOGY SERVICES.—

17 “(A) IN GENERAL.—Notwithstanding any  
18 other provision of law, when an independent  
19 laboratory furnishes the technical component of  
20 a physician pathology service with respect to a  
21 fee-for-service medicare beneficiary who is a pa-  
22 tient of a grandfathered hospital, such compo-  
23 nent shall be treated as a service for which pay-  
24 ment shall be made to the laboratory under this  
25 section and not as—

1           “(i) an inpatient hospital service for  
2           which payment is made to the hospital  
3           under section 1886(d); or

4           “(ii) a hospital outpatient service for  
5           which payment is made to the hospital  
6           under the prospective payment system  
7           under section 1834(t).

8           “(B) DEFINITIONS.—In this paragraph:

9           “(i) GRANDFATHERED HOSPITAL.—  
10          The term ‘grandfathered hospital’ means a  
11          hospital that had an arrangement with an  
12          independent laboratory—

13                 “(I) that was in effect as of July  
14                 22, 1999; and

15                 “(II) under which the laboratory  
16                 furnished the technical component of  
17                 physician pathology services with re-  
18                 spect to patients of the hospital and  
19                 submitted a claim for payment for  
20                 such component to a carrier with a  
21                 contract under section 1842 (and not  
22                 to the hospital).

23           “(ii) FEE-FOR-SERVICE MEDICARE  
24          BENEFICIARY.—The term ‘fee-for-service

1 medicare beneficiary’ means an individual  
2 who is not enrolled—

3 “(I) in a Medicare+Choice plan  
4 under part C;

5 “(II) in a plan offered by an eli-  
6 gible organization under section 1876;

7 “(III) with a PACE provider  
8 under section 1894;

9 “(IV) in a medicare managed  
10 care demonstration project; or

11 “(V) in the case of a service fur-  
12 nished to an individual on an out-  
13 patient basis, in a health care prepay-  
14 ment plan under section  
15 1833(a)(1)(A).”.

16 (b) EFFECTIVE DATE.—The amendment made by  
17 this section shall apply to services furnished on or after  
18 January 1, 2001.

19 **SEC. 437. MODIFICATION OF MEDICARE BILLING REQUIRE-**  
20 **MENTS FOR CERTAIN INDIAN PROVIDERS.**

21 (a) IN GENERAL.—Section 1880(a) (42 U.S.C.  
22 1395qq(a)) is amended by adding at the end the following  
23 new sentence: “A hospital or a free-standing ambulatory  
24 care clinic (as defined by the Secretary), whether operated  
25 by the Indian Health Service or by an Indian tribe or trib-

1 al organization (as those terms are defined in section 4  
2 of the Indian Health Care Improvement Act), shall be eli-  
3 gible for payments for services for which payment is made  
4 pursuant to section 1848, notwithstanding sections  
5 1814(c) and 1835(d), if and for so long as it meets all  
6 of the requirements which are applicable generally to such  
7 payments, services, hospitals, and clinics.”.

8 (b) **EFFECTIVE DATE.**—The amendments made by  
9 this section shall apply to services furnished on or after  
10 January 1, 2001.

11 **SEC. 438. REPLACEMENT OF PROSTHETIC DEVICES AND**  
12 **PARTS.**

13 (a) **IN GENERAL.**—Section 1834(h)(1) of the Social  
14 Security Act (42 U.S.C. 1395m(h)(1)) is amended by add-  
15 ing at the end the following new subparagraph:

16 “(F) **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 2 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

1                   and necessary for purposes of section  
2                   1862(a)(1)(A);  
3                   except that if the device, or part, being re-  
4                   placed is less than 2 years old (calculated  
5                   from the date on which the beneficiary  
6                   began to use the device or part), the Sec-  
7                   retary may also require the beneficiary to  
8                   provide confirmation of necessity of the re-  
9                   placement device, or, as the case may be,  
10                  the replacement part, by a prosthetist se-  
11                  lected by the beneficiary.”.

12           (b) PREEMPTION OF RULE.—The provisions of sec-  
13   tion 1834(h)(1)(F) of the Social Security Act (42 U.S.C.  
14   1395m(h)(1)(F)), as added by subsection (a), shall super-  
15   sede any rule that as of the date of enactment of this Act  
16   may have applied a 5-year replacement rule with regard  
17   to prosthetic devices.

18           (c) EFFECTIVE DATE.—The amendment made by  
19   subsection (a) shall apply to items furnished on or after  
20   the date of enactment of this Act.

21   **SEC. 439. MEDPAC STUDY AND REPORT ON MEDICARE RE-**  
22                                   **IMBURSEMENT FOR SERVICES PROVIDED BY**  
23                                   **CERTAIN PROVIDERS.**

24           (a) STUDY.—The Medicare Payment Advisory Com-  
25   mission (referred to in this section as “MedPAC”) shall

1 conduct a study on the appropriateness of the current pay-  
2 ment rates under the medicare program under title XVIII  
3 of the Social Security Act (42 U.S.C. 1395 et seq.) for  
4 services provided by a—

5 (1) certified nurse-midwife (as defined in sub-  
6 section (gg)(2) of section 1861 of the Social Security  
7 Act (42 U.S.C. 1395x);

8 (2) physician assistant (as defined in subsection  
9 (aa)(5)(A) of such section);

10 (3) nurse practitioner (as defined in such sub-  
11 section); and

12 (4) clinical nurse specialist (as defined in sub-  
13 section (aa)(5)(B) of such section).

14 (b) REPORT.—Not later than 18 months after the  
15 date of enactment of this Act, MedPAC shall submit a  
16 report to the Secretary of Health and Human Services and  
17 Congress on the study conducted under subsection (a), to-  
18 gether with any recommendations for legislation that  
19 MedPAC determines to be appropriate as a result of such  
20 study.

21 **SEC. 440. MEDPAC STUDY AND REPORT ON MEDICARE COV-**  
22 **ERAGE OF SERVICES PROVIDED BY CERTAIN**  
23 **NON-PHYSICIAN PROVIDERS.**

24 (a) STUDY.—

1           (1) IN GENERAL.—The Medicare Payment Ad-  
2           visory Commission (referred to in this section as  
3           “MedPAC”) shall conduct a study to determine the  
4           appropriateness of providing coverage under the  
5           medicare program under title XVIII of the Social  
6           Security Act (42 U.S.C. 1395 et seq.) for services  
7           provided by a—

- 8                   (A) certified first nurse assistant;  
9                   (B) marriage counselor;  
10                  (C) pastoral care counselor; and  
11                  (D) licensed professional counselor of men-  
12           tal health.

13           (2) COSTS TO PROGRAM.—The study shall con-  
14           sider the short-term and long-term benefits, and  
15           costs to the medicare program, of providing the cov-  
16           erage described in paragraph (1).

17           (b) REPORT.—Not later than 18 months after the  
18           date of enactment of this Act, MedPAC shall submit a  
19           report to the Secretary of Health and Human Services and  
20           Congress on the study conducted under subsection (a), to-  
21           gether with any recommendations for legislation that  
22           MedPAC determines to be appropriate as a result of such  
23           study.

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

4   **SEC. 501. 1-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 the 12-month period  
17                                   beginning after the period described  
18                                   in subclause (I), such amount (or  
19                                   amounts) shall be equal to the amount  
20                                   (or amounts) determined under sub-  
21                                   clause (I), updated under subpara-  
22                                   graph (B).”.

23           (b) CHANGE IN REPORT.—Section 302(c) of BBRA  
24 is amended by striking “Not later than” and all that fol-

1 lows through “(42 U.S.C. 1395fff)” and inserting “Not  
2 later than October 1, 2001”.

3 **SEC. 502. RESTORATION OF FULL HOME HEALTH MARKET**  
4 **BASKET UPDATE FOR HOME HEALTH SERV-**  
5 **ICES FOR FISCAL YEAR 2001.**

6 (a) IN GENERAL.—Section 1861(v)(1)(L)(x) (42  
7 U.S.C. 1395x(v)(1)(L)(x)) is amended—

8 (1) by striking “2001,”; and

9 (2) by adding at the end the following: “With  
10 respect to cost reporting periods beginning during  
11 fiscal year 2001, the update to any limit under this  
12 subparagraph shall be the home health market bas-  
13 ket index.”.

14 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR  
15 2001 BASED ON ADJUSTED PROSPECTIVE PAYMENT  
16 AMOUNTS.—

17 (1) IN GENERAL.—Notwithstanding the amend-  
18 ments made by subsection (a), for purposes of mak-  
19 ing payments under section 1895(b) of the Social  
20 Security Act (42 U.S.C. 1395fff(b)) for home health  
21 services for fiscal year 2001, the Secretary of Health  
22 and Human Services shall—

23 (A) with respect to episodes and visits end-  
24 ing on or after October 1, 2000, and before  
25 April 1, 2001, use the final standardized and

1 budget neutral prospective payment amounts  
2 for 60 day episodes and standardized average  
3 per visit amounts for fiscal year 2001 as pub-  
4 lished by the Secretary in Federal Register of  
5 the July 3, 2000 (65 Federal Register 41128-  
6 41214); and

7 (B) with respect to episodes and visits end-  
8 ing on or after April 1, 2001, and before Octo-  
9 ber 1, 2001, use such amounts increased by an  
10 actuarially determined amount that represents  
11 the different distributions of episodes and visits  
12 in the first and second 6 month periods of fiscal  
13 year 2001 due to implementation of the home  
14 health prospective payment system under sec-  
15 tion 1895 of such Act (42 U.S.C. 1395fff).

16 (2) NO EFFECT ON OTHER PAYMENTS OR DE-  
17 TERMINATIONS.—The Secretary shall not take the  
18 provisions of paragraph (1) into account for pur-  
19 poses of payments, determinations, or budget neu-  
20 trality adjustments under section 1895 of the Social  
21 Security Act.

22 (c) ADJUSTMENT FOR CASE MIX CHANGES.—

23 (1) IN GENERAL.—Section 1895(b)(3)(B) (42  
24 U.S.C. 1395fff(b)(3)(B)) is amended by adding at  
25 the end the following new clause:

1                   “(vi) ADJUSTMENT FOR CASE MIX  
2                   CHANGES.—Insofar as the Secretary deter-  
3                   mines that the adjustments under para-  
4                   graph (4)(A)(i) for a previous fiscal year  
5                   (or estimates that such adjustments for a  
6                   future fiscal year) did (or are likely to) re-  
7                   sult in a change in aggregate payments  
8                   under this subsection during the fiscal year  
9                   that are a result of changes in the coding  
10                  or classification of different units of serv-  
11                  ices that do not reflect real changes in case  
12                  mix, the Secretary may adjust the stand-  
13                  ard prospective payment amount (or  
14                  amounts) under paragraph (3) for subse-  
15                  quent fiscal years so as to eliminate the ef-  
16                  fect of such coding or classification  
17                  changes.”.

18                  (2) EFFECTIVE DATE.—The amendment made  
19                  by paragraph (1) applies to episodes concluding on  
20                  or after October 1, 2001.

21 **SEC. 503. EXCLUSION OF CERTAIN NONROUTINE MEDICAL**  
22 **SUPPLIES UNDER THE PPS FOR HOME**  
23 **HEALTH SERVICES.**

24                  (a) EXCLUSION.—

1           (1) IN GENERAL.—Section 1895 (42 U.S.C.  
2   1395fff) is amended by adding at the end the fol-  
3   lowing new subsection:

4           “(e) EXCLUSION OF NONROUTINE MEDICAL SUP-  
5   PLIES.—

6           “(1) IN GENERAL.—Notwithstanding the pre-  
7   ceding provisions of this section, in the case of all  
8   nonroutine medical supplies (as defined by the Sec-  
9   retary) furnished by a home health agency during a  
10   year (beginning with 2001) for which payment is  
11   otherwise made on the basis of the prospective pay-  
12   ment amount under this section, payment under this  
13   section shall be based instead on the lesser of—

14           “(A) the actual charge for the nonroutine  
15   medical supply; or

16           “(B) the amount determined under the fee  
17   schedule established by the Secretary for pur-  
18   poses of making payment for such items under  
19   part B for nonroutine medical supplies fur-  
20   nished during that year.

21           “(2) BUDGET NEUTRALITY ADJUSTMENT.—The  
22   Secretary shall provide for an appropriate propor-  
23   tional reduction in payments under this section so  
24   that, beginning with fiscal year 2001, the aggregate  
25   amount of such reductions is equal to the aggregate

1 increase in payments attributable to the exclusion ef-  
2 fected under paragraph (1).”.

3 (2) CONFORMING AMENDMENT.—Section  
4 1895(b)(1) of the Social Security Act (42 U.S.C.  
5 1395fff(b)(1)) is amended by striking “The Sec-  
6 retary” and inserting “Subject to subsection (e), the  
7 Secretary”.

8 (3) EFFECTIVE DATE.—The amendments made  
9 by this subsection shall apply to supplies furnished  
10 on or after January 1, 2001.

11 (b) EXCLUSION FROM CONSOLIDATED BILLING.—

12 (1) IN GENERAL.—For items provided during  
13 the applicable period, the Secretary of Health and  
14 Human Services shall administer the medicare pro-  
15 gram under title XVIII of the Social Security Act  
16 (42 U.S.C. 1395 et seq.) as if—

17 (A) section 1842(b)(6)(F) of such Act (42  
18 U.S.C. 1395u(b)(6)(F)) was amended by strik-  
19 ing “(including medical supplies described in  
20 section 1861(m)(5), but excluding durable med-  
21 ical equipment to the extent provided for in  
22 such section)” and inserting “(excluding med-  
23 ical supplies and durable medical equipment de-  
24 scribed in section 1861(m)(5))”; and

1 (B) section 1862(a)(21) of such Act (42  
2 U.S.C. 1395y(a)(21)) was amended by striking  
3 “(including medical supplies described in sec-  
4 tion 1861(m)(5), but excluding durable medical  
5 equipment to the extent provided for in such  
6 section)” and inserting “(excluding medical  
7 supplies and durable medical equipment de-  
8 scribed in section 1861(m)(5))”.

9 (2) APPLICABLE PERIOD DEFINED.—For pur-  
10 poses of paragraph (1), the term “applicable period”  
11 means the period beginning on January 1, 2001,  
12 and ending on the later of—

13 (A) the date that is 18 months after the  
14 date of enactment of this Act; or

15 (B) the date determined appropriate by the  
16 Secretary of Health and Human Services.

17 (c) STUDY ON EXCLUSION OF CERTAIN NONROUTINE  
18 MEDICAL SUPPLIES UNDER THE PPS FOR HOME  
19 HEALTH SERVICES.—

20 (1) STUDY.—The Secretary of Health and  
21 Human Services (in this subsection referred to as  
22 the “Secretary”) shall conduct a study to identify  
23 any nonroutine medical supply that may be appro-  
24 priately and cost-effectively excluded from the pro-  
25 spective payment system for home health services

1 under section 1895 of the Social Security Act (42  
2 U.S.C. 1395fff). Specifically, the Secretary shall  
3 consider whether wound care and ostomy supplies  
4 should be excluded from such prospective payment  
5 system.

6 (2) REPORT.—Not later than 18 months after  
7 the date of enactment of this Act, the Secretary  
8 shall submit to Congress a report on the study con-  
9 ducted under paragraph (1), including a list of any  
10 nonroutine medical supplies that should be excluded  
11 from the prospective payment system for home  
12 health services under section 1895 of the Social Se-  
13 curity Act (42 U.S.C. 1395fff).

14 (d) EXCLUSION OF OTHER NONROUTINE MEDICAL  
15 SUPPLIES.—Upon submission of the report under sub-  
16 section (c)(2), the Secretary shall (if necessary) revise the  
17 definition of nonroutine medical supply, as defined for  
18 purposes of section 1895(e) (as added by subsection (a)),  
19 based on the list of nonroutine medical supplies included  
20 in such report.

21 **SEC. 504. TREATMENT OF BRANCH OFFICES; GAO STUDY**  
22 **ON SUPERVISION OF HOME HEALTH CARE**  
23 **PROVIDED IN ISOLATED RURAL AREAS.**

24 (a) TREATMENT OF BRANCH OFFICES.—

1           (1) IN GENERAL.—Notwithstanding any other  
2 provision of law, in determining for purposes of title  
3 XVIII of the Social Security Act whether an office  
4 of a home health agency constitutes a branch office  
5 or a separate home health agency, neither the time  
6 nor distance between a parent office of the home  
7 health agency and a branch office shall be the sole  
8 determinant of a home health agency’s branch office  
9 status.

10           (2) CONSIDERATION OF FORMS OF TECH-  
11 NOLOGY IN DEFINITION OF SUPERVISION.—The Sec-  
12 retary of Health and Human Services may include  
13 forms of technology in determining what constitutes  
14 “supervision” for purposes of determining a home  
15 heath agency’s branch office status under paragraph  
16 (1).

17           (b) GAO STUDY.—

18           (1) STUDY.—The Comptroller General of the  
19 United States shall conduct a study of the provision  
20 of adequate supervision to maintain quality of home  
21 health services delivered under the medicare pro-  
22 gram in isolated rural areas. The study shall evalu-  
23 ate the methods that home health agency branches  
24 and subunits use to maintain adequate supervision  
25 in the delivery of services to clients residing in those

1 areas, how these methods of supervision compare to  
2 requirements that subunits independently meet  
3 medicare conditions of participation, and the re-  
4 sources utilized by subunits to meet such conditions.

5 (2) REPORT.—Not later than January 1, 2002,  
6 the Comptroller General shall submit to Congress a  
7 report on the study conducted under paragraph (1).  
8 The report shall include recommendations on wheth-  
9 er exceptions are needed for subunits and branches  
10 of home health agencies under the medicare program  
11 to maintain access to the home health benefit or  
12 whether alternative policies should be developed to  
13 assure adequate supervision and access and rec-  
14 ommendations on whether a national standard for  
15 supervision is appropriate.

16 **SEC. 505. TEMPORARY ADDITIONAL PAYMENTS FOR HIGH-**  
17 **COST PATIENTS.**

18 (a) INCREASE FOR FISCAL YEARS 2001 AND 2002.—  
19 For each of fiscal years 2001 and 2002, the Secretary of  
20 Health and Human Services shall increase the addition  
21 or adjustment for outliers under section 1895(b)(5) of the  
22 Social Security Act (42 U.S.C. 1395fff(b)(5)) applicable  
23 to home health services furnished during a fiscal year by  
24 such proportion as will result in an aggregate increase in

1 such addition or adjustment for the fiscal year estimated  
2 to equal \$150,000,000.

3 (b) ADDITIONAL PAYMENT NOT BUILT INTO THE  
4 BASE.—The Secretary of Health and Human Services  
5 shall not include any additional payment made under sub-  
6 section (a) in updating the standard prospective payment  
7 amount (or amounts) applicable to units of home health  
8 services furnished during a period, as increased by the  
9 home health applicable increase percentage for the fiscal  
10 year involved under section 1895(b)(3)(B) of the Social  
11 Security Act (42 U.S.C. 1395fff(b)(3)(B)).

12 (c) WAIVING BUDGET NEUTRALITY.—The Secretary  
13 of Health and Human Services shall not reduce the stand-  
14 ard prospective payment amount (or amounts) under sec-  
15 tion 1895 of the Social Security Act (42 U.S.C. 1395fff),  
16 including under subsection (b)(3)(C) of such Act, applica-  
17 ble to units of home health services furnished during a  
18 period to offset the increase in payments resulting from  
19 the application of subsection (a).

20 **SEC. 506. CLARIFICATION OF THE HOMEBOUND DEFINI-**  
21 **TION UNDER THE MEDICARE HOME HEALTH**  
22 **BENEFIT.**

23 (a) IN GENERAL.—Sections 1814(a) and 1835(a) (42  
24 U.S.C. 1395f(a) and 1395n(a)) are each amended—

1           (1) in the last sentence, by striking “, and that  
2           absences of the individual from home are infrequent  
3           or of relatively short duration, or are attributable to  
4           the need to receive medical treatment”; and

5           (2) by adding at the end the following new sen-  
6           tences: “Any absence of an individual from the home  
7           attributable to the need to receive health care treat-  
8           ment, including regular absences for the purpose of  
9           participating in therapeutic, psychosocial, or medical  
10          treatment in an adult day-care program that is li-  
11          censed or certified by a State, or accredited, to fur-  
12          nish adult day-care services in the State shall not  
13          disqualify an individual from being considered to be  
14          ‘confined to his home’. Any other absence of an indi-  
15          vidual from the home shall not so disqualify an indi-  
16          vidual if the absence is of infrequent or short dura-  
17          tion. For purposes of the preceding sentence, any  
18          absence for the purpose of visiting a family member  
19          who is unable to visit the individual or for the pur-  
20          pose of attending a religious service shall be deemed  
21          to be an absence of infrequent and short duration.”.

22          (b) EFFECTIVE DATE.—The amendments made by  
23          subsection (a) shall apply to items and services provided  
24          on or after the date of enactment of this Act.

1           **Subtitle B—Direct Graduate**  
2                   **Medical Education**

3   **SEC. 511. AUTHORITY TO INCLUDE COSTS OF TRAINING OF**  
4                   **CLINICAL PSYCHOLOGISTS IN PAYMENTS TO**  
5                   **HOSPITALS.**

6           Effective for cost reporting periods beginning on or  
7 after October 1, 1999, for purposes of payments to hos-  
8 pitals under the medicare program under title XVIII of  
9 the Social Security Act (42 U.S.C. 1395 et seq.) for costs  
10 of approved educational activities (as defined in section  
11 413.85 of title 42 of the Code of Federal Regulations),  
12 such approved educational activities shall include the clin-  
13 ical portion of professional educational training programs,  
14 recognized by the Secretary, for clinical psychologists.

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. INCREASE IN NATIONAL PER CAPITA**  
10 **MEDICARE+CHOICE GROWTH PERCENTAGE**  
11 **IN 2001 AND 2002.**

12 Section 1853(c)(6)(B) (42 U.S.C. 1395w-  
13 23(c)(6)(B)) is amended—

14 (1) in clause (iv), by striking “for 2001, 0.5  
15 percentage points” and inserting “for 2001, 0 per-  
16 centage points”; and

17 (2) in clause (v), by striking “for 2002, 0.3 per-  
18 centage points” and inserting “for 2002, 0 percent-  
19 age points”.

20 **SEC. 602. REMOVING APPLICATION OF BUDGET NEU-**  
21 **TRALITY FOR 2002.**

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

1 (1) in paragraph (1)(A), in the matter following  
2 clause (ii), by inserting “(except for 2002)” after  
3 “multiplied”; and

4 (2) in paragraph (5), by inserting “(except for  
5 2002)” after “for each year”.

6 **SEC. 603. INCREASE IN MINIMUM PAYMENT AMOUNT.**

7 Section 1853(c)(1)(B)(ii) (42 U.S.C. 1395w-  
8 23(c)(1)(B)(ii)) is amended—

9 (1) by striking “(ii) For a succeeding year” and  
10 inserting “(ii)(I) Subject to subclause (II), for a suc-  
11 ceeding year”; and

12 (2) by adding at the end the following new sub-  
13 clause:

14 “(II) For 2001 for any area in any  
15 Metropolitan Statistical Area with a popu-  
16 lation of more than 250,000, \$475 (and  
17 for any area outside such an area, \$425).”.

18 **SEC. 604. ALLOWING MOVEMENT TO 50:50 PERCENT BLEND**

19 **IN 2002.**

20 Section 1853(c)(2) (42 U.S.C. 1395w-23(c)(2)) is  
21 amended—

22 (1) by striking the period at the end of sub-  
23 paragraph (F) and inserting a semicolon; and

24 (2) by adding after and below subparagraph  
25 (F) the following:

1 “except that a Medicare+Choice organization may  
2 elect to apply subparagraph (F) (rather than sub-  
3 paragraph (E)) for 2002.”.

4 **SEC. 605. INCREASED UPDATE FOR PAYMENT AREAS WITH**  
5 **ONLY ONE OR NO MEDICARE+CHOICE CON-**  
6 **TRACTS.**

7 (a) IN GENERAL.—Section 1853(c)(1)(C)(ii) (42  
8 U.S.C. 1395w-23(c)(1)(C)(ii)) is amended—

9 (1) by striking “(ii) For a subsequent year”  
10 and inserting “(ii)(I) Subject to subclause (II), for  
11 a subsequent year”; and

12 (2) by adding at the end the following new sub-  
13 clause:

14 “(II) During 2002 and 2003, in the  
15 case of a Medicare+Choice payment area  
16 in which there is no more than 1 contract  
17 entered into under this part as of July 1  
18 before the beginning of the year, 102.5  
19 percent of the annual Medicare+Choice  
20 capitation rate under this paragraph for  
21 the area for the previous year.”.

22 (b) CONSTRUCTION.—The amendments made by sub-  
23 section (a) shall not affect the payment of a first time  
24 bonus under section 1853(i) of the Social Security Act (42  
25 U.S.C. 1395w-23(i)).

1 **SEC. 606. 10-YEAR PHASE-IN OF RISK ADJUSTMENT AND**  
2 **NEW METHODOLOGY.**

3 Section 1853(a)(3)(C)(ii) (42 U.S.C. 1395w-  
4 23(c)(1)(C)(ii)) is amended—

5 (1) in subclause (I), by striking “and” at the  
6 end;

7 (2) in subclause (II), by striking “2002.” and  
8 inserting “2002 and 2003.”; and

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

10 “(IV) 30 percent of such capita-  
11 tion rate in 2004 (in which such  
12 methodology should reflect a blend of  
13 20 percent of only data from inpatient  
14 settings and 10 percent of data from  
15 all settings);

16 “(V) 40 percent of such amount  
17 in 2005 (in which such methodology  
18 should reflect a blend of 10 percent of  
19 only data from inpatient settings and  
20 30 percent of data from all settings);

21 “(VI) 50 percent of such amount  
22 in 2006 (in which such methodology  
23 should reflect data from all settings);

24 “(VII) 60 percent of such  
25 amount in 2007 (in which such meth-

1 odology should reflect data from all  
2 settings);

3 “(VIII) 70 percent of such  
4 amount in 2008 (in which such meth-  
5 odology should reflect data from all  
6 settings);

7 “(IX) 80 percent of such amount  
8 in 2009 (in which such methodology  
9 should reflect data from all settings);

10 “(X) 90 percent of such amount  
11 in 2010 (in which such methodology  
12 should reflect data from all settings);  
13 and

14 “(XI) 100 percent of such  
15 amount in any subsequent year (in  
16 which such methodology should reflect  
17 data from all settings).”.

18 **SEC. 607. 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 by adding at the end the fol-  
25 lowing new subparagraph:

1 “(F) PREMIUM REDUCTIONS.—

2 “(i) IN GENERAL.—Subject to clause  
3 (ii), as part of providing any additional  
4 benefits required under subparagraph (A),  
5 a Medicare+Choice organization may elect  
6 a reduction in its payments under section  
7 1853(a)(1)(A) with respect to a  
8 Medicare+Choice plan and the Secretary  
9 shall apply such reduction to reduce the  
10 premium under section 1839 of each en-  
11 rollee in such plan as provided in section  
12 1840(i).

13 “(ii) AMOUNT OF REDUCTION.—The  
14 amount of the reduction under clause (i)  
15 with respect to any enrollee in a  
16 Medicare+Choice plan—

17 “(I) may not exceed 120 percent  
18 of the premium described under sec-  
19 tion 1839(a)(3); and

20 “(II) shall apply uniformly to  
21 each enrollee of the Medicare+Choice  
22 plan to which such reduction ap-  
23 plies.”.

24 (2) CONFORMING AMENDMENTS.—

1 (A) ADJUSTMENT OF PAYMENTS TO  
2 MEDICARE+CHOICE ORGANIZATIONS.—Section  
3 1853(a)(1)(A) (42 U.S.C. 1395w-23(a)(1)(A))  
4 is amended by inserting “reduced by the  
5 amount of any reduction elected under section  
6 1854(f)(1)(F) and” after “for that area,”.

7 (B) ADJUSTMENT AND PAYMENT OF PART  
8 B PREMIUMS.—

9 (i) ADJUSTMENT OF PREMIUMS.—  
10 Section 1839(a)(2) (42 U.S.C.  
11 1395r(a)(2)) is amended by striking  
12 “shall” and all that follows and inserting  
13 the following: “shall be the amount deter-  
14 mined under paragraph (3), adjusted as  
15 required in accordance with subsections  
16 (b), (c), and (f), and to reflect 80 percent  
17 of any reduction elected under section  
18 1854(f)(1)(F).”.

19 (ii) PAYMENT OF PREMIUMS.—Section  
20 1840 (42 U.S.C. 1395s) is amended by  
21 adding at the end the following new sub-  
22 section:

23 “(i) In the case of an individual enrolled in a  
24 Medicare+Choice plan, the Secretary shall provide for  
25 necessary adjustments of the monthly beneficiary pre-

1 mium to reflect 80 percent of any reduction elected under  
 2 section 1854(f)(1)(F). This premium adjustment may be  
 3 provided directly or as an adjustment to any social secu-  
 4 rity, railroad retirement, and civil service retirement bene-  
 5 fits, to the extent which the Secretary determines that  
 6 such an adjustment is appropriate and feasible with the  
 7 concurrence of the agencies responsible for the administra-  
 8 tion of such benefits.”.

9 (C) INFORMATION COMPARING PLAN PRE-  
 10 MIUMS UNDER PART C.—Section 1851(d)(4)(B)  
 11 (42 U.S.C. 1395w-21(d)(4)(B)) is amended—

12 (i) by striking “PREMIUMS.—The”  
 13 and inserting “PREMIUMS.—

14 “(i) IN GENERAL.—The”; and

15 (ii) by adding at the end the following  
 16 new clause:

17 “(ii) REDUCTIONS.—The reduction in  
 18 premiums, if any.”.

19 (b) EFFECTIVE DATE.—The amendments made by  
 20 subsection (a) shall apply to years beginning with 2002.

21 **SEC. 608. DELAY FROM JULY TO NOVEMBER 2000, IN DEAD-**  
 22 **LINE FOR OFFERING AND WITHDRAWING**  
 23 **MEDICARE+CHOICE PLANS FOR 2001.**

24 Notwithstanding any other provision of law, the dead-  
 25 line for a Medicare+Choice organization to withdraw the

1 offering of a Medicare+Choice plan under part C of title  
2 XVIII of the Social Security Act (or otherwise to submit  
3 information required for the offering of such a plan) for  
4 2001 is delayed from July 1, 2000, to November 15, 2000,  
5 and any such organization that provided notice of with-  
6 drawal of such a plan during 2000 before the date of en-  
7 actment of this Act may rescind such withdrawal at any  
8 time before November 15, 2000.

9 **SEC. 609. REVISION OF PAYMENT RATES FOR ESRD PA-**  
10 **TIENTS ENROLLED IN MEDICARE+CHOICE**  
11 **PLANS.**

12 (a) IN GENERAL.—Section 1853(a)(1)(B) (42 U.S.C.  
13 1395w–23(a)(1)(B)) is amended by adding at the end the  
14 following: “In establishing such rates the Secretary shall  
15 provide for appropriate adjustments to increase each rate  
16 to reflect the demonstration rate (including the risk-ad-  
17 justment methodology associated with such rate) of the  
18 social health maintenance organization end-stage renal  
19 disease demonstrations established by section 2355 of the  
20 Deficit Reduction Act of 1984 (Public Law 98–369; 98  
21 Stat. 1103), as amended by section 13567(b) of the Omni-  
22 bus Budget Reconciliation Act of 1993 (Public Law 103–  
23 66; 107 Stat. 608), and shall compute such rates by tak-  
24 ing into account such factors as renal treatment modality,

1 age, and the underlying cause of the end-stage renal dis-  
2 ease.”.

3 (b) **EFFECTIVE DATE.**—The amendment made by  
4 subsection (a) shall apply to payments for months begin-  
5 ning with January 2002.

6 (c) **PUBLICATION.**—The Secretary of Health and  
7 Human Services, not later than 6 months after the date  
8 of enactment of this Act, shall publish for public comment  
9 a description of the appropriate adjustments described in  
10 the last sentence of section 1853(a)(1)(B) of the Social  
11 Security Act (42 U.S.C. 1395w–23(a)(1)(B)), as added by  
12 subsection (a). The Secretary shall publish such adjust-  
13 ments in final form by not later than July 1, 2001, so  
14 that the amendment made by subsection (a) is imple-  
15 mented on a timely basis consistent with subsection (b).

16 **SEC. 610. MODIFICATION OF PAYMENT RULES FOR CER-**  
17 **TAIN FRAIL ELDERLY MEDICARE BENE-**  
18 **FICIARIES.**

19 (a) **MODIFICATION OF PAYMENT RULES.**—Section  
20 1853 (42 U.S.C. 1395w–23) is amended—

21 (1) in subsection (a)—

22 (A) in paragraph (1)(A), by striking “sub-  
23 sections (e), (g), and (i)” and inserting “sub-  
24 sections (e), (g), (i), and (j)”;

1 (B) in paragraph (3)(D), by inserting  
2 “paragraph (4) and” after “Subject to”; and

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

5 “(4) EXEMPTION FROM RISK-ADJUSTMENT SYS-  
6 TEM FOR FRAIL ELDERLY BENEFICIARIES EN-  
7 ROLLED IN SPECIALIZED PROGRAMS.—

8 “(A) IN GENERAL.—In applying the risk-  
9 adjustment factors established under paragraph  
10 (3) during the period described in subparagraph  
11 (B), the limitation under paragraph  
12 (3)(C)(ii)(I) shall apply to a frail elderly  
13 Medicare+Choice beneficiary (as defined in  
14 subsection (j)(3)) who is enrolled in a  
15 Medicare+Choice plan under a specialized pro-  
16 gram for the frail elderly (as defined in sub-  
17 section (j)(2)) during the entire period.

18 “(B) PERIOD OF APPLICATION.—The pe-  
19 riod described in this subparagraph begins with  
20 January 2001, and ends with the first month  
21 for which the Secretary certifies to Congress  
22 that a comprehensive risk adjustment method-  
23 ology under paragraph (3)(C) that takes into  
24 account the factors described in subsection  
25 (j)(1)(B) is being fully implemented.”; and

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

3           “(j) SPECIAL RULES FOR FRAIL ELDERLY EN-  
4           ROLLED IN SPECIALIZED PROGRAMS FOR THE FRAIL EL-  
5           DERLY.—

6           “(1) DEVELOPMENT AND IMPLEMENTATION OF  
7           NEW PAYMENT SYSTEM.—

8           “(A) IN GENERAL.—The Secretary shall  
9           develop and implement (as soon as possible  
10          after the date of enactment of the Medicare,  
11          Medicaid, and SCHIP Balanced Budget Refine-  
12          ment Act of 2000) a payment methodology for  
13          frail elderly Medicare+Choice beneficiaries en-  
14          rolled in a Medicare+Choice plan under a spe-  
15          cialized program for the frail elderly (as defined  
16          in paragraph (2)(A)).

17          “(B) FACTORS DESCRIBED.—The method-  
18          ology developed and implemented under sub-  
19          paragraph (A) shall take into account the prev-  
20          alence, mix, and severity of chronic conditions  
21          among frail elderly Medicare+Choice bene-  
22          ficiaries and shall include—

23                  “(i) medical diagnostic factors from  
24                  all provider settings (including hospital  
25                  and nursing facility settings);

1                   “(ii) functional indicators of health  
2                   status; and

3                   “(iii) such other factors as may be  
4                   necessary to achieve appropriate payments  
5                   for plans serving such beneficiaries.

6                   “(2) SPECIALIZED PROGRAM FOR THE FRAIL  
7                   ELDERLY DEFINED.—

8                   “(A) IN GENERAL.—In this part, the term  
9                   ‘specialized program for the frail elderly’ means  
10                  a program that the Secretary determines—

11                  “(i) is offered under this part as a  
12                  distinct part of a Medicare+Choice plan;

13                  “(ii) primarily enrolls frail elderly  
14                  Medicare+Choice beneficiaries; and

15                  “(iii) has a clinical delivery system  
16                  that is specifically designed to serve the  
17                  special needs of such beneficiaries and to  
18                  coordinate short-term and long-term care  
19                  for such beneficiaries through the use of a  
20                  team described in subparagraph (B) and  
21                  through the provision of primary care serv-  
22                  ices to such beneficiaries by means of such  
23                  a team at the nursing facility involved.

24                  “(B) SPECIALIZED TEAM DESCRIBED.—A  
25                  team described in this subparagraph—

1 “(i) includes—  
2 “(I) a physician; and  
3 “(II) a nurse practitioner or geri-  
4 atric care manager; and  
5 “(ii) has as members individuals  
6 who—  
7 “(I) have special training in the  
8 care and management of the frail el-  
9 derly beneficiaries; and  
10 “(II) specialize in the care and  
11 management of such beneficiaries.

12 “(3) FRAIL ELDERLY MEDICARE+CHOICE BEN-  
13 EFICIARY DEFINED.—In this part, the term ‘frail el-  
14 derly Medicare+Choice beneficiary’ means a  
15 Medicare+Choice eligible individual who—

16 “(A) is residing in a skilled nursing facility  
17 (as defined in section 1819(a)) or a nursing fa-  
18 cility (as defined in section 1919(a)) for an in-  
19 definite period and without any intention of re-  
20 siding outside the facility; and

21 “(B) has a severity of condition that  
22 makes the individual frail (as determined under  
23 guidelines approved by the Secretary).”.

1 (b) EFFECTIVE DATE.—The amendments made by  
2 this section shall take effect on the date of enactment of  
3 this Act.

4 **SEC. 611. FULL IMPLEMENTATION OF RISK ADJUSTMENT**  
5 **FOR CONGESTIVE HEART FAILURE ENROLL-**  
6 **EES FOR 2001.**

7 (a) IN GENERAL.—Section 1853(a)(3)(C) (42 U.S.C.  
8 1395w-23(a)(3)(C)) is amended—

9 (1) in clause (ii), by striking “Such risk adjust-  
10 ment” and inserting “Except as provided in clause  
11 (iii), such risk adjustment”; and

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

14 “(iii) FULL IMPLEMENTATION OF  
15 RISK ADJUSTMENT FOR CONGESTIVE  
16 HEART FAILURE ENROLLEES FOR 2001.—

17 “(I) EXEMPTION FROM PHASE-  
18 IN.—Subject to subclause (II), the  
19 Secretary shall fully implement the  
20 risk adjustment methodology de-  
21 scribed in clause (i) with respect to  
22 each individual who has had a quali-  
23 fying congestive heart failure inpa-  
24 tient diagnosis (as determined by the  
25 Secretary under such risk adjustment

1 methodology) during the period begin-  
2 ning on July 1, 1999, and ending on  
3 June 30, 2000, and who is enrolled in  
4 a coordinated care plan that is the  
5 only coordinated care plan offered on  
6 January 1, 2001, in the service area  
7 of the individual.

8 “(II) PERIOD OF APPLICATION.—  
9 Subclause (I) shall only apply during  
10 the 1-year period beginning on Janu-  
11 ary 1, 2001.”.

12 (b) EXCLUSION FROM DETERMINATION OF THE  
13 BUDGET NEUTRALITY FACTOR.—Section 1853(c)(5) (42  
14 U.S.C. 1395w–23(c)(5)) is amended by striking “sub-  
15 section (i)” and inserting “subsections (a)(3)(C)(iii) and  
16 (i)”.

17 **SEC. 612. INCLUSION OF COSTS OF DOD MILITARY TREAT-**  
18 **MENT FACILITY SERVICES TO MEDICARE-ELI-**  
19 **GIBLE BENEFICIARIES IN CALCULATION OF**  
20 **MEDICARE+CHOICE PAYMENT RATES.**

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

23 (1) in subparagraph (A), by striking “subpara-  
24 graph (B)” and inserting “subparagraphs (B) and  
25 (E)”; and

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

3           “(E) INCLUSION OF COSTS OF CERTAIN  
4 DOD MILITARY TREATMENT FACILITY SERVICES  
5 TO MEDICARE-ELIGIBLE BENEFICIARIES.—

6           “(i) IN GENERAL.—In determining  
7 the area-specific Medicare+Choice capita-  
8 tion rate under subparagraph (A) for a  
9 year (beginning with 2001), the annual per  
10 capita rate of payment for 1997 deter-  
11 mined under section 1876(a)(1)(C) for a  
12 Medicare+Choice payment area that is  
13 within 1 or more MTF affected areas (as  
14 defined in clause (ii)) shall be increased by  
15 the sum of the MTF percentages (as de-  
16 scribed in clause (iii)) for the MTF af-  
17 fected area or areas. The increase under  
18 this subparagraph shall not be taken into  
19 account in computing the national stand-  
20 ardized annual Medicare+Choice capita-  
21 tion rate under paragraph (4)(B).

22           “(ii) MTF AFFECTED AREA DE-  
23 FINED.—In this subparagraph, the term  
24 ‘MTF affected area’ means, with respect to  
25 a military treatment facility (as defined in

1 subsection (a)(6) of section 1896), an area  
2 that includes the following:

3 “(I) The Medicare+Choice pay-  
4 ment area in which a military treat-  
5 ment facility that was part of the  
6 medicare subvention demonstration  
7 project under such section as of July  
8 1, 2000, is located.

9 “(II) Any Medicare+Choice pay-  
10 ment area which is contiguous to the  
11 area described in subclause (I) and lo-  
12 cated not farther than 40 miles from  
13 the facility.

14 “(iii) MTF PERCENTAGE.—For pur-  
15 poses of clause (i), the MTF percentage  
16 for an MTF affected area is equal to the  
17 ratio of—

18 “(I) the aggregate amount of  
19 costs incurred by the Department of  
20 Defense in furnishing items and serv-  
21 ices to individuals entitled to benefits  
22 under this title who received services  
23 from the military treatment facility  
24 described in clause (ii) for that area  
25 in 1996 (as determined pursuant to

1 section 1896(j)(1)(A)), increased by  
2 the national per capita  
3 Medicare+Choice growth percentage  
4 under paragraph (6) for 1997, to

5 “(II) the average number of indi-  
6 viduals residing in such area in 1996  
7 entitled to benefits under part A and  
8 enrolled under part B.”.

9 **Subtitle B—Other Medicare+Choice**  
10 **Reforms**

11 **SEC. 621. AMOUNTS IN MEDICARE TRUST FUNDS AVAIL-**  
12 **ABLE FOR SECRETARY'S SHARE OF**  
13 **MEDICARE+CHOICE EDUCATION AND EN-**  
14 **ROLLMENT-RELATED COSTS.**

15 (a) **RELOCATION OF PROVISIONS.**—Section  
16 1857(e)(2) (42 U.S.C. 1395w-27(e)(2)) is amended to  
17 read as follows:

18 “(2) **COST-SHARING IN ENROLLMENT-RELATED**  
19 **COSTS.**—A Medicare+Choice organization shall pay  
20 the fee established by the Secretary under section  
21 1851(j)(3)(A).”.

22 (b) **FUNDING FOR EDUCATION AND ENROLLMENT**  
23 **ACTIVITIES.**—Section 1851 (42 U.S.C. 1395w-21) is  
24 amended by adding at the end the following new sub-  
25 section:

1       “(j) FUNDING FOR BENEFICIARY EDUCATION AND  
2 ENROLLMENT ACTIVITIES.—

3               “(1) SECRETARY’S ESTIMATE OF TOTAL  
4 COSTS.—The Secretary shall annually estimate the  
5 total cost for a fiscal year of carrying out this sec-  
6 tion, section 4360 of the Omnibus Budget Reconcili-  
7 ation Act of 1990 (relating to the health insurance  
8 counseling and assistance program), and related ac-  
9 tivities.

10               “(2) TOTAL AMOUNT AVAILABLE.—The total  
11 amount available to the Secretary for a fiscal year  
12 for the costs of the activities described in paragraph  
13 (1) shall be equal to the lesser of—

14                       “(A) the amount estimated for such fiscal  
15 year under paragraph (1); or

16                       “(B) for—

17                               “(i) fiscal year 2001, \$115,000,000;

18                               and

19                               “(ii) fiscal year 2002 and each subse-  
20 quent fiscal year, the amount for the pre-  
21 vious fiscal year, adjusted to account for  
22 inflation, any change in the number of  
23 beneficiaries under this title, and any other  
24 relevant factors.

1           “(3) COST-SHARING IN ENROLLMENT-RELATED  
2 COSTS.—

3           “(A) AMOUNTS FROM MEDICARE+CHOICE  
4 ORGANIZATIONS.—

5           “(i) IN GENERAL.—The Secretary is  
6 authorized to charge a fee to each  
7 Medicare+Choice organization with a con-  
8 tract under this part that is equal to the  
9 organization’s pro rata share (as deter-  
10 mined by the Secretary) of the  
11 Medicare+Choice portion (as defined in  
12 clause (ii)) of the total amount available  
13 under paragraph (2) for a fiscal year. Any  
14 amounts collected shall be available with-  
15 out further appropriation to the Secretary  
16 for the costs of the activities described in  
17 paragraph (1).

18           “(ii) MEDICARE+CHOICE PORTION  
19 DEFINED.—For purposes of clause (i), the  
20 term ‘Medicare+Choice portion’ means, for  
21 a fiscal year, the ratio, as estimated by the  
22 Secretary, of—

23           “(I) the average number of indi-  
24 viduals enrolled in Medicare+Choice  
25 plans during the fiscal year; to

1                   “(II) the average number of indi-  
2                   viduals entitled to benefits under part  
3                   A, and enrolled under part B, during  
4                   the fiscal year.

5                   “(B) SECRETARY’S SHARE.—

6                   “(i) AMOUNTS AVAILABLE FROM  
7                   TRUST FUNDS.—The Secretary’s share of  
8                   expenses shall be payable from funds in  
9                   the Federal Hospital Insurance Trust  
10                  Fund and the Federal Supplementary  
11                  Medical Insurance Trust Fund, in such  
12                  proportion as the Secretary shall deem to  
13                  be fair and equitable after taking into con-  
14                  sideration the expenses attributable to the  
15                  administration of this part with respect to  
16                  parts A and B. The Secretary shall make  
17                  such transfers of moneys between such  
18                  Trust Funds as may be appropriate to set-  
19                  tle accounts between the Trust Funds in  
20                  cases where expenses properly payable  
21                  from one such Trust Fund have been paid  
22                  from the other such Trust Fund.

23                  “(ii) SECRETARY’S SHARE OF EX-  
24                  PENSES DEFINED.—For purposes of clause  
25                  (i), the term ‘Secretary’s share of ex-

1                   penses’ means, for a fiscal year, an amount  
2                   equal to—

3                               “(I) the total amount available to  
4                   the Secretary under paragraph (2) for  
5                   the fiscal year; less

6                               “(II) the amount collected under  
7                   subparagraph (A) for the fiscal  
8                   year.”.

9   **SEC. 622. SPECIAL MEDIGAP ENROLLMENT ANTIDISCRIMI-**  
10                               **NATION PROVISION FOR CERTAIN BENE-**  
11                               **FICIARIES.**

12           (a) DISENROLLMENT WINDOW IN ACCORDANCE  
13 WITH       BENEFICIARY’S       CIRCUMSTANCE.—Section  
14 1882(s)(3) (42 U.S.C. 1395ss(s)(3)) is amended—

15                   (1) in subparagraph (A), in the matter fol-  
16           lowing clause (iii), by striking “, subject to subpara-  
17           graph (E), seeks to enroll under the policy not later  
18           than 63 days after the date of termination of enroll-  
19           ment described in such subparagraph” and inserting  
20           “seeks to enroll under the policy during the period  
21           specified in subparagraph (E)”; and

22                   (2) by striking subparagraph (E) and inserting  
23           the following new subparagraph:

24                   “(E) For purposes of subparagraph (A), the time pe-  
25           riod specified in this subparagraph is—

1           “(i) in the case of an individual described in  
2           subparagraph (B)(i), the period beginning on the  
3           date the individual receives a notice of termination  
4           or cessation of all supplemental health benefits (or,  
5           if no such notice is received, notice that a claim has  
6           been denied because of such a termination or ces-  
7           sation) and ending on the date that is 63 days after  
8           the applicable notice;

9           “(ii) in the case of an individual described in  
10          clause (ii), (iii), (v), or (vi) of subparagraph (B)  
11          whose enrollment is terminated involuntarily, the pe-  
12          riod beginning on the date that the individual re-  
13          ceives a notice of termination and ending on the  
14          date that is 63 days after the date the applicable  
15          coverage is terminated;

16          “(iii) in the case of an individual described in  
17          subparagraph (B)(iv)(I), the period beginning on the  
18          earlier of (I) the date that the individual receives a  
19          notice of termination, a notice of the issuer’s bank-  
20          ruptcy or insolvency, or other such similar notice, if  
21          any, and (II) the date that the applicable coverage  
22          is terminated, and ending on the date that is 63  
23          days after the date the coverage is terminated;

24          “(iv) in the case of an individual described in  
25          clause (ii), (iii), (iv)(II), (iv)(III), (v), or (vi) of sub-

1 paragraph (B) who disenrolls voluntarily, the period  
2 beginning on the date that is 60 days before the ef-  
3 fective date of the disenrollment and ending on the  
4 date that is 63 days after such effective date; and

5 “(v) in the case of an individual described in  
6 subparagraph (B) but not described in the preceding  
7 provisions of this subparagraph, the period begin-  
8 ning on the effective date of the disenrollment and  
9 ending on the date that is 63 days after such effec-  
10 tive date.”.

11 (b) EXTENDED MEDIGAP ACCESS FOR INTERRUPTED  
12 TRIAL PERIODS.—Section 1882(s)(3) (42 U.S.C.  
13 1395ss(s)(3)), as amended by subsection (a), is amended  
14 by adding at the end the following new subparagraph:

15 “(F)(i) Subject to clause (ii), for purposes of this  
16 paragraph—

17 “(I) in the case of an individual described in  
18 subparagraph (B)(v) (or deemed to be so described,  
19 pursuant to this subparagraph) whose enrollment  
20 with an organization or provider described in sub-  
21 clause (II) of such subparagraph is involuntarily ter-  
22 minated within the first 12 months of such enroll-  
23 ment, and who, without an intervening enrollment,  
24 enrolls with another such organization or provider,  
25 such subsequent enrollment shall be deemed to be an

1 initial enrollment described in such subparagraph;  
2 and

3 “(II) in the case of an individual described in  
4 clause (vi) of subparagraph (B) (or deemed to be so  
5 described, pursuant to this subparagraph) whose en-  
6 rollment with a plan or in a program described in  
7 such clause is involuntarily terminated within the  
8 first 12 months of such enrollment, and who, with-  
9 out an intervening enrollment, enrolls in another  
10 such plan or program, such subsequent enrollment  
11 shall be deemed to be an initial enrollment described  
12 in such clause.

13 “(ii) For purposes of clauses (v) and (vi) of subpara-  
14 graph (B), no enrollment of an individual with an organi-  
15 zation or provider described in clause (v)(II), or with a  
16 plan or in a program described in clause (vi), may be  
17 deemed to be an initial enrollment under this clause after  
18 the 2-year period beginning on the date on which the indi-  
19 vidual first enrolled with such an organization, provider,  
20 plan, or program.”.

21 **SEC. 623. RESTORING EFFECTIVE DATE OF ELECTIONS AND**  
22 **CHANGES OF ELECTIONS OF**  
23 **MEDICARE+CHOICE PLANS.**

24 (a) OPEN ENROLLMENT.—Section 1851(f)(2) (42  
25 U.S.C. 1395w-21(f)(2)) is amended by striking “, except

1 that if such election or change is made after the 10th day  
2 of any calendar month, then the election or change shall  
3 not take effect until the first day of the second calendar  
4 month following the date on which the election or change  
5 is made”.

6 (b) EFFECTIVE DATE.—The amendment made by  
7 this section shall apply to elections and changes of cov-  
8 erage made on or after January 1, 2001.

9 **SEC. 624. PERMITTING ESRD BENEFICIARIES TO ENROLL**  
10 **IN ANOTHER MEDICARE+CHOICE PLAN IF**  
11 **THE PLAN IN WHICH THEY ARE ENROLLED IS**  
12 **TERMINATED.**

13 (a) IN GENERAL.—Section 1851(a)(3)(B) (42 U.S.C.  
14 1395w-21(a)(3)(B)) is amended by striking “except that”  
15 and all that follows and inserting the following: “except  
16 that—

17 “(i) an individual who develops end-  
18 stage renal disease while enrolled in a  
19 Medicare+Choice plan may continue to be  
20 enrolled in that plan; and

21 “(ii) in the case of such an individual  
22 who is enrolled in a Medicare+Choice plan  
23 under clause (i) (or subsequently under  
24 this clause), if the enrollment is discon-  
25 tinued under circumstances described in

1 section 1851(e)(4)(A), then the individual  
2 will be treated as a ‘Medicare+Choice eli-  
3 gible individual’ for purposes of electing to  
4 continue enrollment in another  
5 Medicare+Choice plan.”.

6 (b) EFFECTIVE DATE.—

7 (1) IN GENERAL.—The amendment made by  
8 subsection (a) shall apply to terminations and  
9 discontinuations occurring on or after the date of  
10 enactment of this Act.

11 (2) APPLICATION TO PRIOR PLAN TERMI-  
12 NATIONS.—Clause (ii) of section 1851(a)(3)(B) of  
13 the Social Security Act (as inserted by subsection  
14 (a)) also shall apply to individuals whose enrollment  
15 in a Medicare+Choice plan was terminated or dis-  
16 continued after December 31, 1997, and before the  
17 date of enactment of this Act. In applying this para-  
18 graph, such an individual shall be treated, for pur-  
19 poses of part C of title XVIII of the Social Security  
20 Act, as having discontinued enrollment in such a  
21 plan as of the date of enactment of this Act.

1 **SEC. 625. ELECTION OF UNIFORM LOCAL COVERAGE POL-**  
2 **ICY FOR MEDICARE+CHOICE PLAN COVERING**  
3 **MULTIPLE LOCALITIES.**

4 Section 1852(a)(2) (42 U.S.C. 1395w-22(a)(2)) is  
5 amended by adding at the end the following new subpara-  
6 graph:

7 “(C) ELECTION OF UNIFORM COVERAGE  
8 POLICY.—With respect to each item or service  
9 furnished by a Medicare+Choice organization  
10 that offers a Medicare+Choice plan in a geo-  
11 graphic area that includes at least 15 States  
12 and in which more than 1 local coverage policy  
13 is applied with respect to different parts of the  
14 area, the organization may elect to have the  
15 local coverage policy for the part of the area  
16 that affords the broadest coverage to  
17 Medicare+Choice enrollees (as determined by  
18 the Secretary) with respect to such item or  
19 service apply with respect to all  
20 Medicare+Choice enrollees enrolled in the  
21 plan.”.

1     **Subtitle C—Other Managed Care**  
2                     **Reforms**

3     **SEC. 631. 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 (42 U.S.C.  
8 1395mm note) 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 subsections:

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 project 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 project during 1999, except that the  
24                    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 shall be the basic  
5           capitation rate paid for such services for 1999,  
6           reduced by 10 percent in the case of the dem-  
7           onstration sites located in Arizona, Minnesota,  
8           and Illinois, and 15 percent for the demonstra-  
9           tion site located in New York.

10           “(B) TARGETED CASE MANAGEMENT  
11           FEE.—A case management fee shall be paid  
12           only for enrollees who are classified as ‘mod-  
13           erate’ or ‘at risk’ through a baseline health as-  
14           sessment (as required for Medicare+Choice  
15           plans under section 1852(e) of the Social Secu-  
16           rity Act (42 U.S.C. 1395ww-22(e)).

17           “(C) GREATER UNIFORMITY IN CLINICAL  
18           FEATURES AMONG SITES.—The project shall  
19           implement for each site—

20                   “(i) protocols for periodic telephonic  
21                   contact with enrollees based on—

22                           “(I) the results of such standard-  
23                           ized written health assessment; and

24                           “(II) the application of appro-  
25                           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 preadmission planning, concurrent  
9           management during inpatient hospital  
10          stays, and post-discharge assessment, plan-  
11          ning, and followup; and

12          “(iv) standardized patient educational  
13          materials for specified diseases and health  
14          conditions.

15          “(D)    QUALITY    IMPROVEMENT.—The  
16          project shall implement at each site once during  
17          the 15-month period—

18                 “(i) surveys on enrollee satisfaction;  
19                 and

20                 “(ii) reports on specified quality indi-  
21                 cators for the enrolled population.

22          “(c) EVALUATION.—

23                 “(1) PRELIMINARY REPORT.—Not later than  
24          July 1, 2001, the Secretary of Health and Human  
25          Services shall submit to the Committees on Ways

1 and Means and Commerce of the House of Rep-  
2 resentatives and the Committee on Finance of the  
3 Senate a preliminary report that—

4 “(A) evaluates such demonstration projects  
5 for the period beginning July 1, 1997, and end-  
6 ing December 31, 1999, on a site-specific basis  
7 with respect to the impact on per beneficiary  
8 spending, specific health utilization measures,  
9 and enrollee satisfaction; and

10 “(B) includes a similar evaluation of such  
11 projects for the portion of the extension period  
12 that occurs after September 30, 2000.

13 “(2) FINAL REPORT.—The Secretary shall sub-  
14 mit a final report to such Committees on such dem-  
15 onstration projects not later than July 1, 2002.  
16 Such report shall include the same elements as the  
17 preliminary report required by paragraph (1), but  
18 for the period after December 31, 1999.

19 “(3) METHODOLOGY FOR SPENDING COMPARI-  
20 SONS.—Any evaluation of the impact of the dem-  
21 onstration projects on per beneficiary spending in-  
22 cluded in such reports shall be based on a compari-  
23 son of—

24 “(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 (42 U.S.C.  
9                   1395j et seq.) and who are not enrolled in such  
10                  a project, in a Medicare+Choice plan under  
11                  part C of such title (42 U.S.C. 1395w-21 et  
12                  seq.), a plan offered by an eligible organization  
13                  under section 1876 of such Act (42 U.S.C.  
14                  1395mm), or a health care prepayment plan  
15                  under section 1833(a)(1)(A) of such Act (42  
16                  U.S.C. 1395l(a)(1)(A)).”.

17               (b) **EFFECTIVE DATE.**—The amendments made by  
18               subsection (a) shall be effective as if included in the enact-  
19               ment of section 532 of BBRA (42 U.S.C. 1395mm note).

20               **SEC. 632. SERVICE AREA EXPANSION FOR MEDICARE COST**  
21   **CONTRACTS DURING TRANSITION PERIOD.**

22               Section 1876(h)(5) (42 U.S.C. 1395mm(h)(5)) is  
23               amended—

24                   (1) by redesignating subparagraph (B) as sub-  
25               paragraph (C); and

1           (2) by inserting after subparagraph (A), the fol-  
2           lowing new subparagraph:

3           “(B) Subject to subparagraph (C), the Secretary  
4           shall approve an application for a modification to a rea-  
5           sonable cost contract under this section in order to expand  
6           the service area of such contract if—

7           “(i) such application is submitted to the Sec-  
8           retary on or before September 1, 2003; and

9           “(ii) the Secretary determines that the organi-  
10          zation with the contract continues to meet the re-  
11          quirements applicable to such organizations and con-  
12          tracts under this section.”.

## 13                           **TITLE VII—MEDICAID**

### 14   **SEC. 701. NEW PROSPECTIVE PAYMENT SYSTEM FOR FED-** 15                           **ERALLY-QUALIFIED HEALTH CENTERS AND** 16                           **RURAL HEALTH CLINICS.**

17           (a) IN GENERAL.—Section 1902(a) (42 U.S.C.  
18   1396a(a)) is amended—

19           (1) in paragraph (13)—

20                   (A) in subparagraph (A), by adding “and”  
21                   at the end;

22                   (B) in subparagraph (B), by striking  
23                   “and” at the end; and

24                   (C) by striking subparagraph (C); and

1           (2) by inserting after paragraph (14) the fol-  
2           lowing new paragraph:

3           “(15) provide for payment for services de-  
4           scribed in subparagraph (B) or (C) of section  
5           1905(a)(2) under the plan in accordance with sub-  
6           section (aa);”.

7           (b) NEW PROSPECTIVE PAYMENT SYSTEM.—Section  
8           1902 (42 U.S.C. 1396a) is amended by adding at the end  
9           the following:

10          “(aa) PAYMENT FOR SERVICES PROVIDED BY FED-  
11          ERALLY-QUALIFIED HEALTH CENTERS AND RURAL  
12          HEALTH CLINICS.—

13                 “(1) IN GENERAL.—Beginning with fiscal year  
14                 2001 and each succeeding fiscal year, the State plan  
15                 shall provide for payment for services described in  
16                 section 1905(a)(2)(C) furnished by a Federally-  
17                 qualified health center and services described in sec-  
18                 tion 1905(a)(2)(B) furnished by a rural health clinic  
19                 in accordance with the provisions of this subsection.

20                 “(2) FISCAL YEAR 2001.—Subject to paragraph  
21                 (4), for services furnished during fiscal year 2001,  
22                 the State plan shall provide for payment for such  
23                 services in an amount (calculated on a per visit  
24                 basis) that is equal to 100 percent of the average of  
25                 the costs of the center or clinic of furnishing such

1 services during fiscal years 1999 and 2000 which  
2 are reasonable and related to the cost of furnishing  
3 such services, or based on such other tests of reason-  
4 ableness as the Secretary prescribes in regulations  
5 under section 1833(a)(3), or, in the case of services  
6 to which such regulations do not apply, the same  
7 methodology used under section 1833(a)(3), ad-  
8 justed to take into account any increase or decrease  
9 in the scope of such services furnished by the center  
10 or clinic during fiscal year 2001.

11 “(3) FISCAL YEAR 2002 AND SUCCEEDING FIS-  
12 CAL YEARS.—Subject to paragraph (4), for services  
13 furnished during fiscal year 2002 or a succeeding  
14 fiscal year, the State plan shall provide for payment  
15 for such services in an amount (calculated on a per  
16 visit basis) that is equal to the amount calculated for  
17 such services under this subsection for the preceding  
18 fiscal year—

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

23 “(B) adjusted to take into account any in-  
24 crease or decrease in the scope of such services

1           furnished by the center or clinic during that fis-  
2           cal year.

3           “(4) ESTABLISHMENT OF INITIAL YEAR PAY-  
4           MENT AMOUNT FOR NEW CENTERS OR CLINICS.—In  
5           any case in which an entity first qualifies as a Fed-  
6           erally-qualified health center or rural health clinic  
7           after fiscal year 2000, the State plan shall provide  
8           for payment for services described in section  
9           1905(a)(2)(C) furnished by the center or services  
10          described in section 1905(a)(2)(B) furnished by the  
11          clinic in the first fiscal year in which the center or  
12          clinic so qualifies in an amount (calculated on a per  
13          visit basis) that is equal to 100 percent of the costs  
14          of furnishing such services during such fiscal year  
15          based on the rates established under this subsection  
16          for the fiscal year for other such centers or clinics  
17          located in the same or adjacent area with a similar  
18          case load or, in the absence of such a center or clin-  
19          ic, in accordance with the regulations and method-  
20          ology referred to in paragraph (2) or based on such  
21          other tests of reasonableness as the Secretary may  
22          specify. For each fiscal year following the fiscal year  
23          in which the entity first qualifies as a Federally-  
24          qualified health center or rural health clinic, the

1 State plan shall provide for the payment amount to  
2 be calculated in accordance with paragraph (3).

3 “(5) ADMINISTRATION IN THE CASE OF MAN-  
4 AGED CARE.—

5 “(A) IN GENERAL.—In the case of services  
6 furnished by a Federally-qualified health center  
7 or rural health clinic pursuant to a contract be-  
8 tween the center or clinic and a managed care  
9 entity (as defined in section 1932(a)(1)(B)), the  
10 State plan shall provide for payment to the cen-  
11 ter or clinic by the State of a supplemental pay-  
12 ment equal to the amount (if any) by which the  
13 amount determined under paragraphs (2), (3),  
14 and (4) of this subsection exceeds the amount  
15 of the payments provided under the contract.

16 “(B) PAYMENT SCHEDULE.—The supple-  
17 mental payment required under subparagraph  
18 (A) shall be made pursuant to a payment  
19 schedule agreed to by the State and the Feder-  
20 ally-qualified health center or rural health clin-  
21 ic.

22 “(6) ALTERNATIVE PAYMENT METHODOLO-  
23 GIES.—Notwithstanding any other provision of this  
24 section, the State plan may provide for payment in  
25 any fiscal year to a Federally-qualified health center

1 for services described in section 1905(a)(2)(C) or to  
2 a rural health clinic for services described in section  
3 1905(a)(2)(B) in an amount which is determined  
4 under an alternative payment methodology that—

5 “(A) is agreed to by the State and the cen-  
6 ter or clinic; and

7 “(B) results in payment to the center or  
8 clinic of an amount which is at least equal to  
9 the amount otherwise required to be paid to the  
10 center or clinic under this section.”.

11 (c) CONFORMING AMENDMENTS.—

12 (1) Section 4712 of the BBA (Public Law 105–  
13 33; 111 Stat. 508) is amended by striking sub-  
14 section (c).

15 (2) Section 1915(b) (42 U.S.C. 1396n(b)) is  
16 amended by striking “1902(a)(13)(E)” and insert-  
17 ing “1902(a)(15), 1902(aa),”.

18 (d) GAO STUDY OF FUTURE REBASING.—The  
19 Comptroller General of the United States shall provide for  
20 a study on the need for, and how to, rebase or refine costs  
21 for making payment under the medicaid program for serv-  
22 ices provided by Federally-qualified health centers and  
23 rural health centers (as provided under the amendments  
24 made by this section). The Comptroller General shall pro-  
25 vide for submittal of a report on such study to Congress

1 by not later than 4 years after the date of the enactment  
2 of this Act.

3 (e) EFFECTIVE DATE.—The amendments made by  
4 this section take effect on October 1, 2000, and apply to  
5 services furnished on or after such date.

6 **SEC. 702. MEDICAID DSH ALLOTMENTS.**

7 (a) ONE-YEAR FREEZE IN MEDICAID DSH ALLOT-  
8 MENTS.—Section 1923(f)(2) (42 U.S.C. 1396r-4(f)(2)) is  
9 amended—

10 (1) in the matter preceding the table, by insert-  
11 ing “(and the DSH allotment for a State for fiscal  
12 year 2001 is the same as the DSH allotment for the  
13 State for fiscal year 2000, as determined under the  
14 following table)” after “2002”; and

15 (2) in the table—

16 (A) by striking the column in the table re-  
17 lating to FY 01 (fiscal year 2001); and

18 (B) by striking the heading in such table  
19 relating to FY 00 (fiscal year 2000) and insert-  
20 ing “FYS 00, 01”.

21 (b) EFFECTIVE DATE.—The amendments made by  
22 this section take effect on October 1, 2000.

1 **SEC. 703. PERMANENT EXTENSION OF PAYMENT OF MEDI-**  
2 **CARE PART B PREMIUMS FOR QUALIFIED**  
3 **MEDICARE BENEFICIARIES WITH INCOME UP**  
4 **TO 135 PERCENT OF POVERTY.**

5 (a) IN GENERAL.—Section 1902(a)(10)(E)(iv) (42  
6 U.S.C. 1396a(a)(10)(E)(iv)) is amended—

7 (1) in the matter preceding subclause (I), by  
8 striking “(but only for premiums payable with re-  
9 spect to months during the period beginning with  
10 January 1998, and ending with December 2002)”;

11 (2) in subclause (I), by inserting “only for pre-  
12 miums payable with respect to months beginning  
13 with January 1998,” after “(I)”; and

14 (3) in subclause (II), by inserting “only for pre-  
15 miums payable with respect to months during the  
16 period beginning with January 1998, and ending  
17 with December 2002,” after “(II)”.

18 (b) CONFORMING AMENDMENT.—Section 1933(c)(1)  
19 (42 U.S.C. 1396u–3(c)(1)) is amended—

20 (1) in subparagraph (D), by striking “and” at  
21 the end;

22 (2) in subparagraph (E), by striking the period  
23 and inserting “; and”; and

24 (3) by adding at the end the following new sub-  
25 paragraph:

1           “(F) fiscal year 2003 and each fiscal year  
2           thereafter, the amount specified under this  
3           paragraph for the preceding fiscal year in-  
4           creased by the percentage increase (if any) in  
5           the medical care expenditure category of the  
6           Consumer Price Index for All Urban Con-  
7           sumers (United States city average).”.

8 **SEC. 704. STREAMLINED APPROVAL OF CONTINUED STATE-**  
9 **WIDE SECTION 1115 MEDICAID WAIVERS.**

10       (a) IN GENERAL.—Section 1115 (42 U.S.C. 1315)  
11 is amended by adding at the end the following new sub-  
12 section:

13       “(f) An application by the chief executive officer of  
14 a State for an extension of a waiver project the State is  
15 operating under an extension under subsection (e) (in this  
16 subsection referred to as the ‘waiver project’) shall be sub-  
17 mitted and approved or disapproved in accordance with  
18 the following:

19           “(1) The application for an extension of the  
20 waiver project shall be submitted to the Secretary at  
21 least 120 days prior to the expiration of the current  
22 period of the waiver project.

23           “(2) Not later than 45 days after the date such  
24 application is received by the Secretary, the Sec-  
25 retary shall notify the State if the Secretary intends

1 to review the existing terms and conditions of the  
2 waiver project. A failure to provide such notification  
3 shall be deemed to be an approval of the application.

4 “(3) Not later than 45 days after the date of  
5 a notification made in accordance with paragraph  
6 (2), the Secretary shall inform the State of proposed  
7 changes in the terms and conditions of the waiver  
8 project. A failure to provide such information shall  
9 be deemed to be an approval of the application.

10 “(4) During the 30-day period that begins on  
11 the date information described in paragraph (3) is  
12 provided to a State, the Secretary shall negotiate re-  
13 vised terms and conditions of the waiver project with  
14 the State.

15 “(5)(A) Not later than 120 days after the date  
16 an application for an extension of the waiver project  
17 is submitted to the Secretary (or such later date  
18 agreed to by the chief executive officer of the State),  
19 the Secretary shall—

20 “(i) approve the application subject to such  
21 modifications in the terms and conditions—

22 “(I) as have been agreed to by the  
23 Secretary and the State; or

24 “(II) in the absence of such agree-  
25 ment, as are determined by the Secretary

1 to be reasonable consistent with the overall  
2 objectives of the waiver project; or

3 “(ii) disapprove the application.

4 “(B) A failure by the Secretary to approve or  
5 disapprove an application submitted under this sub-  
6 section in accordance with the requirements of sub-  
7 paragraph (A) shall be deemed to be an approval of  
8 the application subject to such modifications in the  
9 terms and conditions as have been agreed to (if any)  
10 by the Secretary and the State.

11 “(6) An approval of an application for an exten-  
12 sion of a waiver project under this subsection shall  
13 be for a period requested by the State, not to exceed  
14 3 years.

15 “(7) An extension of a waiver project under this  
16 subsection shall be subject to the final reporting and  
17 evaluation requirements of paragraphs (4) and (5)  
18 of subsection (e).”.

19 (b) EFFECTIVE DATE.—The amendment made by  
20 subsection (a) applies to requests for extensions of dem-  
21 onstration projects pending or submitted on or after the  
22 date of enactment of this Act.

23 **SEC. 705. ALASKA FMAP.**

24 (a) IN GENERAL.—The first sentence of section  
25 1905(b) (42 U.S.C. 1396d(b)) is amended—

1 (1) by striking “and (3)” and inserting “(3)”;  
2 and

3 (2) by striking the period and inserting “, and  
4 (4) only with respect to each of fiscal years 2001  
5 through 2005, for purposes of this title and title  
6 XXI, the State percentage used to determine the  
7 Federal medical assistance percentage for Alaska  
8 shall be that percentage which bears the same ratio  
9 to 45 percent as the square of the adjusted per cap-  
10 ita income of Alaska (determined by dividing the  
11 State’s 3-year average per capita income by 1.05)  
12 bears to the square of the per capita income of the  
13 50 States.”.

14 (b) EFFECTIVE DATE.—The amendments made by  
15 subsection (a) take effect October 1, 2000.

16 **TITLE VIII—STATE CHILDREN’S**  
17 **HEALTH INSURANCE PRO-**  
18 **GRAM (SCHIP)**

19 **SEC. 801. SPECIAL RULE FOR REDISTRIBUTION AND AVAIL-**  
20 **ABILITY OF UNUSED FISCAL YEAR 1998 AND**  
21 **1999 SCHIP ALLOTMENTS.**

22 (a) CHANGE IN RULES FOR REDISTRIBUTION AND  
23 RETENTION OF UNUSED SCHIP ALLOTMENTS FOR FIS-  
24 CAL YEARS 1998 AND 1999.—Section 2104 (42 U.S.C.

1 1397dd) is amended by adding at the end the following  
2 new subsection:

3 “(g) RULE FOR REDISTRIBUTION AND EXTENDED  
4 AVAILABILITY OF FISCAL YEARS 1998 AND 1999 ALLOT-  
5 MENTS.—

6 “(1) AMOUNT REDISTRIBUTED.—

7 “(A) IN GENERAL.—In the case of a State  
8 that expends all of its allotment under sub-  
9 section (b) or (c) for fiscal year 1998 by the  
10 end of fiscal year 2000, or for fiscal year 1999  
11 by the end of fiscal year 2001, the Secretary  
12 shall redistribute to the State under subsection  
13 (f) (from the fiscal year 1998 or 1999 allot-  
14 ments of other States, respectively, as deter-  
15 mined by the application of paragraphs (2) and  
16 (3) with respect to the respective fiscal year))  
17 the following amount:

18 “(i) STATE.—In the case of 1 of the  
19 50 States or the District of Columbia, with  
20 respect to—

21 “(I) the fiscal year 1998 allot-  
22 ment, the amount by which the  
23 State’s expenditures under this title in  
24 fiscal years 1998, 1999, and 2000 ex-

1           ceed the State's allotment for fiscal  
2           year 1998 under subsection (b); or

3                   “(II) the fiscal year 1999 allot-  
4           ment, the amount by which the  
5           State's expenditures under this title in  
6           fiscal years 1999, 2000, and 2001 ex-  
7           ceed the State's allotment for fiscal  
8           year 1999 under subsection (b).

9                   “(ii) TERRITORY.—In the case of a  
10          commonwealth or territory described in  
11          subsection (c)(3), an amount that bears  
12          the same ratio to 1.05 percent of the total  
13          amount described in paragraph (2)(B)(i)(I)  
14          as the ratio of the commonwealth's or ter-  
15          ritory's fiscal year 1998 or 1999 allotment  
16          under subsection (c) (as the case may be)  
17          bears to the total of all such allotments for  
18          such fiscal year under such subsection.

19                   “(B) EXPENDITURE RULES.—An amount  
20          redistributed to a State under this paragraph  
21          with respect to fiscal year 1998 or 1999—

22                   “(i) shall not be included in the deter-  
23          mination of the State's allotment for any  
24          fiscal year under this section;

1           “(ii) notwithstanding subsection (e),  
2           shall remain available for expenditure by  
3           the State through the end of fiscal year  
4           2002; and

5           “(iii) shall be counted as being ex-  
6           pended with respect to a fiscal year allot-  
7           ment in accordance with applicable regula-  
8           tions of the Secretary.

9           “(2) EXTENSION OF AVAILABILITY OF PORTION  
10          OF UNEXPENDED FISCAL YEARS 1998 AND 1999 AL-  
11          LOTMENTS.—

12           “(A) IN GENERAL.—Notwithstanding sub-  
13          section (e):

14           “(i) FISCAL YEAR 1998 ALLOTMENT.—  
15          Of the amounts allotted to a State pursu-  
16          ant to this section for fiscal year 1998 that  
17          were not expended by the State by the end  
18          of fiscal year 2000, the amount specified in  
19          subparagraph (B) for fiscal year 1998 for  
20          such State shall remain available for ex-  
21          penditure by the State through the end of  
22          fiscal year 2002.

23           “(ii) FISCAL YEAR 1999 ALLOT-  
24          MENT.—Of the amounts allotted to a State  
25          pursuant to this subsection for fiscal year

1 1999 that were not expended by the State  
2 by the end of fiscal year 2001, the amount  
3 specified in subparagraph (B) for fiscal  
4 year 1999 for such State shall remain  
5 available for expenditure by the State  
6 through the end of fiscal year 2002.

7 “(B) AMOUNT REMAINING AVAILABLE FOR  
8 EXPENDITURE.—The amount specified in this  
9 subparagraph for a State for a fiscal year is  
10 equal to—

11 “(i) the amount by which (I) the total  
12 amount available for redistribution under  
13 subsection (f) from the allotments for that  
14 fiscal year, exceeds (II) the total amounts  
15 redistributed under paragraph (1) for that  
16 fiscal year; multiplied by

17 “(ii) the ratio of the amount of such  
18 State’s unexpended allotment for that fis-  
19 cal year to the total amount described in  
20 clause (i)(I) for that fiscal year.

21 “(C) USE OF UP TO 10 PERCENT OF RE-  
22 TAINED 1998 ALLOTMENTS FOR OUTREACH AC-  
23 TIVITIES.—Notwithstanding section  
24 2105(c)(2)(A), with respect to any State de-  
25 scribed in subparagraph (A)(i), the State may

1 use up to 10 percent of the amount specified in  
2 subparagraph (B) for fiscal year 1998 for ex-  
3 penditures for outreach activities approved by  
4 the Secretary.

5 “(3) DETERMINATION OF AMOUNTS.—For pur-  
6 poses of calculating the amounts described in para-  
7 graphs (1) and (2) relating to the allotment for fis-  
8 cal year 1998 or fiscal year 1999, the Secretary  
9 shall use the amounts reported by the States not  
10 later than November 30, 2000, or November 30,  
11 2001, respectively, on HCFA Form 64 or HCFA  
12 Form 21, as approved by the Secretary.”.

13 (b) EFFECTIVE DATE.—The amendments made by  
14 this section shall take effect as if included in the enact-  
15 ment of section 4901 of BBA (111 Stat. 552).

16 **SEC. 802. PRESUMPTIVE ELIGIBILITY UNDER SCHIP.**

17 (a) APPLICATION UNDER SCHIP.—Section  
18 2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is amended by add-  
19 ing at the end the following new subparagraph:

20 “(D) Section 1920A (relating to presump-  
21 tive eligibility).”.

22 (b) TECHNICAL AMENDMENTS.—Section 1920A (42  
23 U.S.C. 1396r–1a) is amended—

1 (1) in subsection (b)(3)(A)(ii), by striking  
2 “paragraph (1)(A)” and inserting “paragraph (2)”;  
3 and

4 (2) in subsection (c)(2), in the matter preceding  
5 subparagraph (A), by striking “subsection  
6 (b)(1)(A)” and inserting “subsection (b)(2)”.

7 (c) EFFECTIVE DATE.—

8 (1) IN GENERAL.—The amendment made by  
9 subsection (a) takes effect October 1, 2000, and ap-  
10 plies to allotments under title XXI of the Social Se-  
11 curity Act (42 U.S.C. 1397aa et seq.) for fiscal year  
12 2001 and each succeeding fiscal year thereafter.

13 (2) TECHNICAL AMENDMENTS.—The amend-  
14 ments made by subsection (b) take effect as if in-  
15 cluded in the enactment of section 4912 of BBA  
16 (111 Stat. 571).

17 **SEC. 803. AUTHORITY TO PAY MEDICAID EXPANSION SCHIP**  
18 **COSTS FROM TITLE XXI APPROPRIATION.**

19 (a) AUTHORITY TO PAY MEDICAID EXPANSION  
20 SCHIP COSTS FROM TITLE XXI APPROPRIATION.—Sec-  
21 tion 2105(a) (42 U.S.C. 1397ee(a)) is amended—

22 (1) by redesignating subparagraphs (A) through  
23 (D) of paragraph (2) as clauses (i) through (iv), re-  
24 spectively, and indenting appropriately;

1           (2) by redesignating paragraph (1) as subpara-  
2 graph (B), and indenting appropriately;

3           (3) by redesignating paragraph (2) as subpara-  
4 graph (C), and indenting appropriately;

5           (4) by striking “(a) IN GENERAL.—” and the  
6 remainder of the text that precedes subparagraph  
7 (B), as so redesignated, and inserting the following:

8 “(a) PAYMENTS.—

9           “(1) IN GENERAL.—Subject to the succeeding  
10 provisions of this section, the Secretary shall pay to  
11 each State with a plan approved under this title,  
12 from its allotment under section 2104, an amount  
13 for each quarter equal to the enhanced FMAP of ex-  
14 penditures in the quarter—

15           “(A) for child health assistance under the  
16 plan for targeted low-income children in the  
17 form of providing medical assistance for which  
18 payment is made on the basis of an enhanced  
19 FMAP under the fourth sentence of section  
20 1905(b);” and

21           (5) by adding after subparagraph (C), as so re-  
22 designated, the following new paragraph:

23           “(2) ORDER OF PAYMENTS.—Payments under  
24 paragraph (1) from a State’s allotment shall be  
25 made in the following order:

1           “(A) First, for expenditures for items de-  
2           scribed in paragraph (1)(A).

3           “(B) Second, for expenditures for items  
4           described in paragraph (1)(B).

5           “(C) Third, for expenditures for items de-  
6           scribed in paragraph (1)(C).”.

7           (b) ELIMINATION OF REQUIREMENT TO REDUCE  
8           TITLE XXI ALLOTMENT BY MEDICAID EXPANSION  
9           SCHIP COSTS.—Section 2104 (42 U.S.C. 1397dd) is  
10          amended by striking subsection (d).

11          (c) AUTHORITY TO TRANSFER TITLE XXI APPRO-  
12          PRIATIONS TO TITLE XIX APPROPRIATION ACCOUNT AS  
13          REIMBURSEMENT FOR MEDICAID EXPENDITURES FOR  
14          MEDICAID EXPANSION SCHIP SERVICES.—Notwith-  
15          standing any other provision of law, all amounts appro-  
16          priated under title XXI and allotted to a State pursuant  
17          to subsection (b) or (c) of section 2104 of the Social Secu-  
18          rity Act (42 U.S.C. 1397dd) for fiscal years 1998 through  
19          2000 (including any amounts that, but for this provision,  
20          would be considered to have expired) and not expended  
21          in providing child health assistance or related services for  
22          which payment may be made pursuant to subparagraph  
23          (B) or (C) of section 2105(a)(1) of such Act (42 U.S.C.  
24          1397ee(a)(1)) (as amended by subsection (a)), shall be  
25          available to reimburse the Grants to States for Medicaid

1 account in an amount equal to the total payments made  
2 to such State under section 1903(a) of such Act (42  
3 U.S.C. 1396b(a)) for expenditures in such years for med-  
4 ical assistance described in subparagraph (A) of section  
5 2105(a)(1) of such Act (42 U.S.C. 1397ee(a)(1)) (as so  
6 amended).

7 (d) CONFORMING AMENDMENTS.—

8 (1) Section 1905(b) (42 U.S.C. 1396d(b)) is  
9 amended in the fourth sentence by striking “the  
10 State’s allotment under section 2104 (not taking  
11 into account reductions under section 2104(d)(2))  
12 for the fiscal year reduced by the amount of any  
13 payments made under section 2105 to the State  
14 from such allotment for such fiscal year” and insert-  
15 ing “the State’s available allotment under section  
16 2104”.

17 (2) Section 1905(u)(1)(B) (42 U.S.C.  
18 1396d(u)(1)(B)) is amended by striking “and sec-  
19 tion 2104(d)”.

20 (3) Section 2104 (42 U.S.C. 1397dd), as  
21 amended by subsection (b), is further amended—

22 (A) in subsection (b)(1), by striking “and  
23 subsection (d)”;

24 (B) in subsection (c)(1), by striking “sub-  
25 ject to subsection (d)”.

1           (4) Section 2105(c) (42 U.S.C. 1397ee(c)) is  
2 amended—

3           (A) in paragraph (2)(A), by striking all  
4 that follows “Except as provided in this para-  
5 graph,” and inserting “the amount of payment  
6 that may be made under subsection (a) for a  
7 fiscal year for expenditures for items described  
8 in paragraph (1)(C) of such subsection shall  
9 not exceed 10 percent of the total amount of ex-  
10 penditures for which payment is made under  
11 subparagraphs (A), (B), and (C) of paragraph  
12 (1) of such subsection.”;

13           (B) in paragraph (2)(B), by striking “de-  
14 scribed in subsection (a)(2)” and inserting “de-  
15 scribed in subsection (a)(1)(C)”;

16           (C) in paragraph (6)(B), by striking “Ex-  
17 cept as otherwise provided by law,” and insert-  
18 ing “Except as provided in subsection (a)(1)(A)  
19 or any other provision of law,”.

20           (5) Section 2110(a) (42 U.S.C. 1397jj(a)) is  
21 amended by striking “section 2105(a)(2)(A)” and  
22 inserting “section 2105(a)(1)(C)(i)”.

23           (e)           TECHNICAL           AMENDMENT.—Section  
24 2105(d)(2)(B)(ii) (42 U.S.C. 1397ee(d)(2)(B)(ii)) is  
25 amended by striking “enhanced FMAP under section

1 1905(u)” and inserting “enhanced FMAP under the  
2 fourth sentence of section 1905(b)”.

3 (f) EFFECTIVE DATE.—The amendments made by  
4 this section shall be effective as if included in the enact-  
5 ment of section 4901 of the BBA (111 Stat. 552).

## 6 **TITLE IX—OTHER PROVISIONS**

### 7 **SEC. 901. INCREASE IN AUTHORIZATION OF APPROPRIA-** 8 **TIONS FOR THE MATERNAL AND CHILD** 9 **HEALTH SERVICES BLOCK GRANT.**

10 (a) IN GENERAL.—Section 501(a) (42 U.S.C.  
11 701(a)) is amended in the matter preceding paragraph (1)  
12 by striking “\$705,000,000 for fiscal year 1994” and in-  
13 serting “\$1,000,000,000 for fiscal year 2001”.

14 (b) EFFECTIVE DATE.—The amendment made by  
15 subsection (a) takes effect on October 1, 2000.

### 16 **SEC. 902. INCREASE IN APPROPRIATIONS FOR SPECIAL DI-** 17 **ABETES PROGRAMS FOR CHILDREN WITH** 18 **TYPE I DIABETES AND INDIANS.**

19 (a) SPECIAL DIABETES PROGRAMS FOR CHILDREN  
20 WITH TYPE I DIABETES.—Section 330B(b) of the Public  
21 Health Service Act (42 U.S.C. 254c-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 \$70,000,000 for each of fiscal  
6 years 2001 and 2002 (which shall be combined with  
7 amounts transferred under paragraph (1) for each  
8 such fiscal years).”.

9 (b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—  
10 Section 330C(c) of the Public Health Service Act (42  
11 U.S.C. 254c-3(c)) is amended—

12 (1) by striking “Notwithstanding” and insert-  
13 ing the following:

14 “(1) TRANSFERRED FUNDS.—Notwith-  
15 standing”; and

16 (2) by adding at the end the following:

17 “(2) APPROPRIATIONS.—For the purpose of  
18 making grants under this section, there is appro-  
19 priated, out of any money in the Treasury not other-  
20 wise appropriated \$70,000,000 for each of fiscal  
21 years 2001 and 2002 (which shall be combined with  
22 amounts transferred under paragraph (1) for each  
23 such fiscal years).”.