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(Original Signature of Member)

106<sup>TH</sup> CONGRESS  
1<sup>ST</sup> SESSION

**H. R.** \_\_\_\_\_

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IN THE HOUSE OF REPRESENTATIVES

Mr. THOMAS introduced the following bill; which was referred to the  
Committee on \_\_\_\_\_

\_\_\_\_\_  
**A BILL**

To amend titles XVIII, XIX, and XXI of the Social Security  
Act to make corrections and refinements in the medicare,  
medicaid, and State children's health insurance pro-  
grams, as revised by the Balanced Budget Act of 1997.

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

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

4 (a) **SHORT TITLE.**—This Act may be cited as the  
5 “Medicare, Medicaid, and SCHIP Balanced Budget Re-  
6 finement Act of 1999”.

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

13 (c) **REFERENCES TO THE BALANCED BUDGET ACT**  
14 **OF 1997.**—In this Act, the term “BBA” means the Bal-  
15 anced Budget Act of 1997 (Public Law 105–33).

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

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

**TITLE I—PROVISIONS RELATING TO PART A**

**Subtitle A—Adjustments to PPS Payments for Skilled Nursing Facilities**

- Sec. 101. Temporary increase in payment for certain high cost patients.
- Sec. 102. Authorizing facilities to elect immediate transition to Federal rate.
- Sec. 103. Part A pass-through payment for certain ambulance services, pros-  
theses, and chemotherapy drugs.
- Sec. 104. Provision for part B add-ons for facilities participating in the  
NHCMQ demonstration project.
- Sec. 105. Special consideration for facilities serving specialized patient popu-  
lations.
- Sec. 106. MedPAC study on special payment for facilities located in Hawaii  
and Alaska.
- Sec. 107. Study and report regarding State licensure and certification stand-  
ards and respiratory therapy competency examinations.

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## Subtitle B—PPS Hospitals

- Sec. 111. Modification in transition for indirect medical education (IME) percentage adjustment.
- Sec. 112. Decrease in reductions for disproportionate share hospitals; data collection requirements.

## Subtitle C—PPS-Exempt Hospitals

- Sec. 121. Wage adjustment of percentile cap for PPS-exempt hospitals.
- Sec. 122. Enhanced payments for long-term care and psychiatric hospitals until development of prospective payment systems for those hospitals.
- Sec. 123. Per discharge prospective payment system for long-term care hospitals.
- Sec. 124. Per diem prospective payment system for psychiatric hospitals.
- Sec. 125. Refinement of prospective payment system for inpatient rehabilitation services.

## Subtitle D—Hospice Care

- Sec. 131. Temporary increase in payment for hospice care.
- Sec. 132. Study and report to Congress regarding modification of the payment rates for hospice care.

## Subtitle E—Other Provisions

- Sec. 141. MedPAC study on medicare payment for nonphysician health professional clinical training in hospitals.

## Subtitle F—Transitional Provisions

- Sec. 151. Exception to CMI qualifier for one year.
- Sec. 152. Reclassification of certain counties and other areas for purposes of reimbursement under the medicare program.
- Sec. 153. Wage index correction.
- Sec. 154. Calculation and application of wage index floor for a certain area.
- Sec. 155. Special rule for certain skilled nursing facilities.

## TITLE II—PROVISIONS RELATING TO PART B

## Subtitle A—Hospital Outpatient Services

- Sec. 201. Outlier adjustment and transitional pass-through for certain medical devices, drugs, and biologicals.
- Sec. 202. Establishing a transitional corridor for application of OPD PPS.
- Sec. 203. Study and report to Congress regarding the special treatment of rural and cancer hospitals in prospective payment system for hospital outpatient department services.
- Sec. 204. Limitation on outpatient hospital copayment for a procedure to the hospital deductible amount.

## Subtitle B—Physician Services

- Sec. 211. Modification of update adjustment factor provisions to reduce update oscillations and require estimate revisions.
- Sec. 212. Use of data collected by organizations and entities in determining practice expense relative values.

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- Sec. 213. GAO study on resources required to provide safe and effective out-patient cancer therapy.

## Subtitle C—Other Services

- Sec. 221. Revision of provisions relating to therapy services.  
Sec. 222. Update in renal dialysis composite rate.  
Sec. 223. Implementation of the inherent reasonableness (IR) authority.  
Sec. 224. Increase in reimbursement for pap smears.  
Sec. 225. Refinement of ambulance services demonstration project.  
Sec. 226. Phase-in of PPS for ambulatory surgical centers.  
Sec. 227. Extension of medicare benefits for immunosuppressive drugs.  
Sec. 228. Temporary increase in payment rates for durable medical equipment and oxygen.  
Sec. 229. Studies and reports.

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

## Subtitle A—Home Health Services

- Sec. 301. Adjustment to reflect administrative costs not included in the interim payment system; GAO report on costs of compliance with OASIS data collection requirements.  
Sec. 302. Delay in application of 15 percent reduction in payment rates for home health services until one year after implementation of prospective payment system.  
Sec. 303. Increase in per beneficiary limits.  
Sec. 304. Clarification of surety bond requirements.  
Sec. 305. Refinement of home health agency consolidated billing.  
Sec. 306. Technical amendment clarifying applicable market basket increase for PPS.  
Sec. 307. Study and report to Congress regarding the exemption of rural agencies and populations from inclusion in the home health prospective payment system.

## Subtitle B—Direct Graduate Medical Education

- Sec. 311. Use of national average payment methodology in computing direct graduate medical education (DGME) payments.  
Sec. 312. Initial residency period for child neurology residency training programs.

## Subtitle C—Technical Corrections

- Sec. 321. BBA technical corrections.

## TITLE IV—RURAL PROVIDER PROVISIONS

## Subtitle A—Rural Hospitals

- Sec. 401. Permitting reclassification of certain urban hospitals as rural hospitals.  
Sec. 402. Update of standards applied for geographic reclassification for certain hospitals.  
Sec. 403. Improvements in the critical access hospital (CAH) program.  
Sec. 404. 5-year extension of medicare dependent hospital (MDH) program.  
Sec. 405. Rebasing for certain sole community hospitals.  
Sec. 406. One year sole community hospital payment increase.

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- Sec. 407. Increased flexibility in providing graduate physician training in rural and other areas.
- Sec. 408. Elimination of certain restrictions with respect to hospital swing bed program.
- Sec. 409. Grant program for rural hospital transition to prospective payment.
- Sec. 410. GAO study on geographic reclassification.

Subtitle B—Other Rural Provisions

- Sec. 411. MedPAC study of rural providers.
- Sec. 412. Expansion of access to paramedic intercept services in rural areas.
- Sec. 413. Promoting prompt implementation of informatics, telemedicine, and education demonstration project.

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

Subtitle A—Provisions To Accommodate and Protect Medicare Beneficiaries

- Sec. 501. Changes in Medicare+ Choice enrollment rules.
- Sec. 502. Change in effective date of elections and changes of elections of Medicare+ Choice plans.
- Sec. 503. 2-year extension of medicare cost contracts.

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

- Sec. 511. Phase-in of new risk adjustment methodology; studies and reports on risk adjustment.
- Sec. 512. Encouraging offering of Medicare+ Choice plans in areas without plans.
- Sec. 513. Modification of 5-year re-entry rule for contract terminations.
- Sec. 514. Continued computation and publication of medicare original fee-for-service expenditures on a county-specific basis.
- Sec. 515. Flexibility to tailor benefits under Medicare+ Choice plans.
- Sec. 516. Delay in deadline for submission of adjusted community rates.
- Sec. 517. Reduction in adjustment in national per capita Medicare+ Choice growth percentage for 2002.
- Sec. 518. Deeming of Medicare+ Choice organization to meet requirements.
- Sec. 519. Timing of Medicare+ Choice health information fairs.
- Sec. 520. Quality assurance requirements for preferred provider organization plans.
- Sec. 521. Clarification of nonapplicability of certain provisions of discharge planning process to Medicare+ Choice plans.
- Sec. 522. User fee for Medicare+ Choice organizations based on number of enrolled beneficiaries.
- Sec. 523. Clarification regarding the ability of a religious fraternal benefit society to operate any Medicare+ Choice plan.
- Sec. 524. Rules regarding physician referrals for Medicare+ Choice program.

Subtitle C—Demonstration Projects and Special Medicare Populations

- Sec. 531. Extension of social health maintenance organization demonstration (SHMO) project authority.
- Sec. 532. Extension of medicare community nursing organization demonstration project.

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- Sec. 533. Medicare+ Choice competitive bidding demonstration project.
- Sec. 534. Extension of medicare municipal health services demonstration projects.
- Sec. 535. Medicare coordinated care demonstration project.
- Sec. 536. Medigap protections for PACE program enrollees.

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

- Sec. 541. Medicare+ Choice nursing and allied health professional education payments.

Subtitle E—Studies and Reports

- Sec. 551. Report on accounting for VA and DOD expenditures for medicare beneficiaries.
- Sec. 552. Medicare Payment Advisory Commission studies and reports.
- Sec. 553. GAO studies, audits, and reports.

TITLE VI—MEDICAID

- Sec. 601. Increase in DSH allotment for certain States and the District of Columbia.
- Sec. 602. Removal of fiscal year limitation on certain transitional administrative costs assistance.
- Sec. 603. Modification of the phase-out of payment for Federally-qualified health center services and rural health clinic services based on reasonable costs.
- Sec. 604. Parity in reimbursement for certain utilization and quality control services; elimination of duplicative requirements for external quality review of medicaid managed care organizations.
- Sec. 605. Inapplicability of enhanced match under the State children's health insurance program to medicaid DSH payments.
- Sec. 606. Optional deferment of the effective date for outpatient drug agreements.
- Sec. 607. Making medicaid DSH transition rule permanent.
- Sec. 608. Medicaid technical corrections.

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

- Sec. 701. Stabilizing the State children's health insurance program allotment formula.
- Sec. 702. Increased allotments for territories under the State children's health insurance program.
- Sec. 703. Improved data collection and evaluations of the State children's health insurance program.
- Sec. 704. References to SCHIP and State children's health insurance program.
- Sec. 705. SCHIP technical corrections.

1 **TITLE I—PROVISIONS RELATING**  
2 **TO PART A**  
3 **Subtitle A—Adjustments to PPS**  
4 **Payments for Skilled Nursing**  
5 **Facilities**

6 **SEC. 101. TEMPORARY INCREASE IN PAYMENT FOR CER-**  
7 **TAIN HIGH COST PATIENTS.**

8 (a) ADJUSTMENT FOR MEDICALLY COMPLEX PA-  
9 TIENTS UNTIL ESTABLISHMENT OF REFINED CASE-MIX  
10 ADJUSTMENT.—For purposes of computing payments for  
11 covered skilled nursing facility services under paragraph  
12 (1) of section 1888(e) of the Social Security Act (42  
13 U.S.C. 1395yy(e)) for such services furnished on or after  
14 April 1, 2000, and before the date described in subsection  
15 (c), the Secretary of Health and Human Services shall in-  
16 crease by 20 percent the adjusted Federal per diem rate  
17 otherwise determined under paragraph (4) of such section  
18 (but for this section) for covered skilled nursing facility  
19 services for RUG–III groups described in subsection (b)  
20 furnished to an individual during the period in which such  
21 individual is classified in such a RUG–III category.

22 (b) GROUPS DESCRIBED.—The RUG–III groups for  
23 which the adjustment described in subsection (a) applies  
24 are SE3, SE2, SE1, SSC, SSB, SSA, CC2, CC1, CB2,  
25 CB1, CA2, CA1, RHC, RMC, and RMB as specified in

1 Tables 3 and 4 of the final rule published in the Federal  
2 Register by the Health Care Financing Administration on  
3 July 30, 1999 (64 Fed. Reg. 41684).

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

6 (1) October 1, 2000; or

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

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

13 (1) IN GENERAL.—For purposes of computing  
14 payments for covered skilled nursing facility services  
15 under paragraph (1) of section 1888(e) of the Social  
16 Security Act (42 U.S.C. 1395yy(e)) for covered  
17 skilled nursing facility services furnished during fis-  
18 cal years 2001 and 2002, the Secretary of Health  
19 and Human Services shall increase by 4.0 percent  
20 for each such fiscal year the adjusted Federal per  
21 diem rate otherwise determined under paragraph (4)  
22 of such section (but for this section).

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

1 made under this subsection in updating the Federal  
2 per diem rate under section 1888(e)(4) of that Act  
3 (42 U.S.C. 1395yy(e)(4)).

4 **SEC. 102. AUTHORIZING FACILITIES TO ELECT IMMEDIATE**  
5 **TRANSITION TO FEDERAL RATE.**

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

8 (1) in paragraph (1), in the matter preceding  
9 subparagraph (A), by striking “paragraph (7)” and  
10 inserting “paragraphs (7) and (11)”; and

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

13 “(11) **PERMITTING FACILITIES TO WAIVE 3-**  
14 **YEAR TRANSITION.**—Notwithstanding paragraph  
15 (1)(A), a facility may elect to have the amount of  
16 the payment for all costs of covered skilled nursing  
17 facility services for each day of such services fur-  
18 nished in cost reporting periods beginning no earlier  
19 than 30 days before the date of such election deter-  
20 mined pursuant to paragraph (1)(B).”.

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

1 **SEC. 103. PART A PASS-THROUGH PAYMENT FOR CERTAIN**  
2 **AMBULANCE SERVICES, PROSTHESES, AND**  
3 **CHEMOTHERAPY DRUGS.**

4 (a) IN GENERAL.—Section 1888(e) (42 U.S.C.  
5 1395yy(e)) is amended—

6 (1) in paragraph (2)(A)(i)(II), by striking  
7 “services described in clause (ii)” and inserting  
8 “items and services described in clauses (ii) and  
9 (iii)”;

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

12 “(iii) EXCLUSION OF CERTAIN ADDI-  
13 TIONAL ITEMS AND SERVICES.—Items and  
14 services described in this clause are the fol-  
15 lowing:

16 “(I) Ambulance services fur-  
17 nished to an individual in conjunction  
18 with renal dialysis services described  
19 in section 1861(s)(2)(F).

20 “(II) Chemotherapy items (iden-  
21 tified as of July 1, 1999, by HCPCS  
22 codes J9000–J9020; J9040–J9151;  
23 J9170–J9185; J9200–J9201; J9206–  
24 J9208; J9211; J9230–J9245; and  
25 J9265–J9600 (and as subsequently  
26 modified by the Secretary)) and any

1 additional chemotherapy items identi-  
2 fied by the Secretary.

3 “(III) Chemotherapy administra-  
4 tion services (identified as of July 1,  
5 1999, by HCPCS codes 36260-  
6 36262; 36489; 36530-36535; 36640;  
7 36823; and 96405-96542 (and as  
8 subsequently modified by the Sec-  
9 retary)) and any additional chemo-  
10 therapy administration services identi-  
11 fied by the Secretary.

12 “(IV) Radioisotope services  
13 (identified as of July 1, 1999, by  
14 HCPCS codes 79030-79440 (and as  
15 subsequently modified by the Sec-  
16 retary)) and any additional radioiso-  
17 tope services identified by the Sec-  
18 retary.

19 “(V) Customized prosthetic de-  
20 vices (commonly known as artificial  
21 limbs or components of artificial  
22 limbs) under the following HCPCS  
23 codes (as of July 1, 1999 (and as sub-  
24 sequently modified by the Secretary)),  
25 and any additional customized pros-

1           thetic devices identified by the Sec-  
2           retary, if delivered to an inpatient for  
3           use during the stay in the skilled  
4           nursing facility and intended to be  
5           used by the individual after discharge  
6           from the facility: L5050–L5340;  
7           L5500–L5611;           L5613–L5986;  
8           L5988;   L6050–L6370;   L6400–  
9           L6880; L6920–L7274; and L7362–  
10          7366.”; and

11           (3) by adding at the end of paragraph (9) the  
12          following: “In the case of an item or service de-  
13          scribed in clause (iii) of paragraph (2)(A) that would  
14          be payable under part A but for the exclusion of  
15          such item or service under such clause, payment  
16          shall be made for the item or service, in an amount  
17          otherwise determined under part B of this title for  
18          such item or service, from the Federal Hospital In-  
19          surance Trust Fund under section 1817 (rather  
20          than from the Federal Supplementary Medical In-  
21          surance Trust Fund under section 1841).”.

22          (b) CONFORMING FOR BUDGET NEUTRALITY BEGIN-  
23          NING WITH FISCAL YEAR 2001.—

1           (1) IN GENERAL.—Section 1888(e)(4)(G) (42  
2 U.S.C. 1395yy(e)(4)(G)) is amended by adding at  
3 the end the following new clause:

4                   “(iii) ADJUSTMENT FOR EXCLUSION  
5 OF CERTAIN ADDITIONAL ITEMS AND  
6 SERVICES.—The Secretary shall provide  
7 for an appropriate proportional reduction  
8 in payments so that beginning with fiscal  
9 year 2001, the aggregate amount of such  
10 reductions is equal to the aggregate in-  
11 crease in payments attributable to the ex-  
12 clusion effected under clause (iii) of para-  
13 graph (2)(A).”.

14           (2) CONFORMING AMENDMENT.—Section  
15 1888(e)(8)(A) (42 U.S.C. 1395yy(e)(8)(A)) is  
16 amended by striking “and adjustments for variations  
17 in labor-related costs under paragraph (4)(G)(ii)”  
18 and inserting “adjustments for variations in labor-  
19 related costs under paragraph (4)(G)(ii), and adjust-  
20 ments under paragraph (4)(G)(iii)”.

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

1 **SEC. 104. PROVISION FOR PART B ADD-ONS FOR FACILI-**  
2 **TIES PARTICIPATING IN THE NHCMQ DEM-**  
3 **ONSTRATION PROJECT.**

4 (a) IN GENERAL.—Section 1888(e)(3) (42 U.S.C.  
5 1395yy(e)(3)) is amended—

6 (1) in subparagraph (A)—

7 (A) in clause (i), by inserting “or, in the  
8 case of a facility participating in the Nursing  
9 Home Case-Mix and Quality Demonstration  
10 (RUGS–III), the RUGS–III rate received by  
11 the facility during the cost reporting period be-  
12 ginning in 1997” after “to non-settled cost re-  
13 ports”; and

14 (B) in clause (ii), by striking “furnished  
15 during such period” and inserting “furnished  
16 during the applicable cost reporting period de-  
17 scribed in clause (i)”; and

18 (2) by striking subparagraph (B) and inserting  
19 the following new subparagraph:

20 “(B) UPDATE TO FIRST COST REPORTING  
21 PERIOD.—The Secretary shall update the  
22 amount determined under subparagraph (A),  
23 for each cost reporting period after the applica-  
24 ble cost reporting period described in subpara-  
25 graph (A)(i) and up to the first cost reporting  
26 period by a factor equal to the skilled nursing

1 facility market basket percentage increase  
2 minus 1.0 percentage point.”.

3 (b) EFFECTIVE DATE.—The amendments made by  
4 subsection (a) shall be effective as if included in the enact-  
5 ment of section 4432(a) of BBA.

6 **SEC. 105. SPECIAL CONSIDERATION FOR FACILITIES SERV-**  
7 **ING SPECIALIZED PATIENT POPULATIONS.**

8 (a) IN GENERAL.—Section 1888(e) (42 U.S.C.  
9 1395yy(e)), as amended by section 102(a)(1), is further  
10 amended—

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

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

16 “(12) PAYMENT RULE FOR CERTAIN FACILI-  
17 TIES.—

18 “(A) IN GENERAL.—In the case of a quali-  
19 fied acute skilled nursing facility described in  
20 subparagraph (B), the per diem amount of pay-  
21 ment shall be determined by applying the non-  
22 Federal percentage and Federal percentage  
23 specified in paragraph (2)(C)(ii).

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

4           “(i) was certified by the Secretary as  
5 a skilled nursing facility eligible to furnish  
6 services under this title before July 1,  
7 1992;

8           “(ii) is a hospital-based facility; and

9           “(iii) for the cost reporting period be-  
10 ginning in fiscal year 1998, the facility had  
11 more than 60 percent of total patient days  
12 comprised of patients who are described in  
13 subparagraph (C).

14           “(C) DESCRIPTION OF PATIENTS.—For  
15 purposes of subparagraph (B), a patient de-  
16 scribed in this subparagraph is an individual  
17 who—

18           “(i) is entitled to benefits under part  
19 A; and

20           “(ii) is immuno-compromised sec-  
21 ondary to an infectious disease, with spe-  
22 cific diagnoses as specified by the Sec-  
23 retary.”.

24           (b) EFFECTIVE DATE.—The amendments made by  
25 subsection (a) shall apply for the period beginning on the

1 date on which the first cost reporting period of the facility  
2 begins after the date of the enactment of this Act and  
3 ending on September 30, 2001, and applies to skilled  
4 nursing facilities furnishing covered skilled nursing facility  
5 services on the date of the enactment of this Act for which  
6 payment is made under title XVIII of the Social Security  
7 Act.

8 (c) REPORT TO CONGRESS.—Not later than March  
9 1, 2001, the Secretary of Health and Human Services  
10 shall assess the resource use of patients of skilled nursing  
11 facilities furnishing services under the medicare program  
12 who are immuno-compromised secondary to an infectious  
13 disease, with specific diagnoses as specified by the Sec-  
14 retary (under paragraph (12)(C), as added by subsection  
15 (a), of section 1888(e) of the Social Security Act (42  
16 U.S.C. 1395yy(e))) to determine whether any permanent  
17 adjustments are needed to the RUGs to take into account  
18 the resource uses and costs of these patients.

19 **SEC. 106. MEDPAC STUDY ON SPECIAL PAYMENT FOR FA-**  
20 **CILITIES LOCATED IN HAWAII AND ALASKA.**

21 (a) IN GENERAL.—The Medicare Payment Advisory  
22 Commission shall conduct a study of skilled nursing facili-  
23 ties furnishing covered skilled nursing facility services (as  
24 defined in section 1888(e)(2)(A) of the Social Security Act  
25 (42 U.S.C. 1395yy(e)(2)(A)) to determine the need for an

1 additional payment amount under section 1888(e)(4)(G)  
2 of such Act (42 U.S.C. 1395yy(e)(4)(G)) to take into ac-  
3 count the unique circumstances of skilled nursing facilities  
4 located in Alaska and Hawaii.

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

9 **SEC. 107. STUDY AND REPORT REGARDING STATE LICEN-**  
10 **SURE AND CERTIFICATION STANDARDS AND**  
11 **RESPIRATORY THERAPY COMPETENCY EX-**  
12 **AMINATIONS.**

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

15 (1) identifies variations in State licensure and  
16 certification standards for health care providers (in-  
17 cluding nursing and allied health professionals) and  
18 other individuals providing respiratory therapy in  
19 skilled nursing facilities;

20 (2) examines State requirements relating to res-  
21 piratory therapy competency examinations for such  
22 providers and individuals; and

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

1 under title XVIII of the Social Security Act (42  
2 U.S.C. 1395 et seq.) for such providers and individ-  
3 uals.

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

## 11 **Subtitle B—PPS Hospitals**

### 12 **SEC. 111. MODIFICATION IN TRANSITION FOR INDIRECT** 13 **MEDICAL EDUCATION (IME) PERCENTAGE** 14 **ADJUSTMENT.**

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

17 (1) in subclause (IV), by striking “and” at the  
18 end;

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

21 (3) by inserting after subclause (IV) the fol-  
22 lowing new subclause:

23 “(V) during fiscal year 2001, ‘c’ is  
24 equal to 1.54; and”; and

1           (4) in subclause (VI), as so redesignated, by  
2           striking “2000” and inserting “2001”.

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

5           (1) ADDITIONAL PAYMENT.—In addition to  
6           payments made to each subsection (d) hospital (as  
7           defined in section 1886(d)(1)(B) of the Social Secu-  
8           rity Act (42 U.S.C. 1395ww(d)(1)(B)) under section  
9           1886(d)(5)(B) of such Act (42 U.S.C.  
10          1395ww(d)(5)(B))) which receives payment for the  
11          direct costs of medical education for discharges oc-  
12          curring in fiscal year 2000, the Secretary of Health  
13          and Human Services shall make one or more pay-  
14          ments to each such hospital in an amount which, as  
15          estimated by the Secretary, is equal in the aggregate  
16          to the difference between the amount of payments to  
17          the hospital under such section for such discharges  
18          and the amount of payments that would have been  
19          paid under such section for such discharges if “c”  
20          in clause (ii)(IV) of such section equalled 1.6 rather  
21          than 1.47. Additional payments made under this  
22          subsection shall be made applying the same struc-  
23          ture as applies to payments made under section  
24          1886(d)(5)(B) of such Act.



1 (4) in subclause (IV), as so redesignated, by  
2 striking “reduced by 5 percent” and inserting “re-  
3 duced by 4 percent”.

4 (b) DATA COLLECTION.—

5 (1) IN GENERAL.—The Secretary of Health and  
6 Human Services shall require any subsection (d)  
7 hospital (as defined in section 1886(d)(1)(B) of the  
8 Social Security Act (42 U.S.C. 1395ww(d)(1)(B)))  
9 to submit to the Secretary, in the cost reports sub-  
10 mitted to the Secretary by such hospital for dis-  
11 charges occurring during a fiscal year, data on the  
12 costs incurred by the hospital for providing inpatient  
13 and outpatient hospital services for which the hos-  
14 pital is not compensated, including non-medicare  
15 bad debt, charity care, and charges for medicaid and  
16 indigent care.

17 (2) EFFECTIVE DATE.—The Secretary shall re-  
18 quire the submission of the data described in para-  
19 graph (1) in cost reports for cost reporting periods  
20 beginning on or after October 1, 2001.

## 21 **Subtitle C—PPS-Exempt Hospitals**

### 22 **SEC. 121. WAGE ADJUSTMENT OF PERCENTILE CAP FOR** 23 **PPS-EXEMPT HOSPITALS.**

24 (a) IN GENERAL.—Section 1886(b)(3)(H) (42 U.S.C.  
25 1395ww(b)(3)(H)) is amended—

## 23

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

3 (2) in clause (ii), by striking “clause (i)” and  
4 “such clause” and inserting “subclause (I)” and  
5 “such subclause” respectively;

6 (3) by striking “(H)(i)” and inserting “(ii)(I)”;

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

9 (5) by inserting after clause (ii), as so redesi-  
10 gnated, the following new clause:

11 “(iii) In applying clause (ii)(I) in the case of a hos-  
12 pital or unit, the Secretary shall provide for an appro-  
13 priate adjustment to the labor-related portion of the  
14 amount determined under such subparagraph to take into  
15 account differences between average wage-related costs in  
16 the area of the hospital and the national average of such  
17 costs within the same class of hospital.”; and

18 (6) by inserting before clause (ii), as so redesi-  
19 gnated, the following new clause:

20 “(H)(i) In the case of a hospital or unit that is within  
21 a class of hospital described in clause (iv), for a cost re-  
22 porting period beginning during fiscal years 1998 through  
23 2002, the target amount for such a hospital or unit may  
24 not exceed the amount as updated up to or for such cost  
25 reporting period under clause (ii).”.

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

4 **SEC. 122. ENHANCED PAYMENTS FOR LONG-TERM CARE**  
5 **AND PSYCHIATRIC HOSPITALS UNTIL DEVEL-**  
6 **OPMENT OF PROSPECTIVE PAYMENT SYS-**  
7 **TEMS FOR THOSE HOSPITALS.**

8 Section 1886(b)(2) (42 U.S.C. 1395ww(b)(2)) is  
9 amended—

10 (1) in subparagraph (A), by striking “In addi-  
11 tion to” and inserting “Except as provided in sub-  
12 paragraph (E), in addition to”; and

13 (2) by adding at the end the following new sub-  
14 paragraph:

15 “(E)(i) In the case of an eligible hospital that is a  
16 hospital or unit that is within a class of hospital described  
17 in clause (ii) with a 12-month cost reporting period begin-  
18 ning before the enactment of this subparagraph, in deter-  
19 mining the amount of the increase under subparagraph  
20 (A), the Secretary shall substitute for the percentage of  
21 the target amount applicable under subparagraph  
22 (A)(ii)—

23 “(I) for a cost reporting period beginning on or  
24 after October 1, 2000, and before September 30,  
25 2001, 1.5 percent; and

1           “(II) for a cost reporting period beginning on  
2           or after October 1, 2001, and before September 30,  
3           2002, 2 percent.

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

6           “(I) Hospitals described in clause (i) of sub-  
7           section (d)(1)(B) and psychiatric units described in  
8           the matter following clause (v) of such subsection.

9           “(II) Hospitals described in clause (iv) of such  
10          subsection.”.

11 **SEC. 123. PER DISCHARGE PROSPECTIVE PAYMENT SYS-**  
12 **TEM FOR LONG-TERM CARE HOSPITALS.**

13           (a) DEVELOPMENT OF SYSTEM.—

14           (1) IN GENERAL.—The Secretary of Health and  
15           Human Services shall develop a per discharge pro-  
16           spective payment system for payment for inpatient  
17           hospital services of long-term care hospitals de-  
18           scribed in section 1886(d)(1)(B)(iv) of the Social Se-  
19           curity Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under  
20           the medicare program. Such system shall include an  
21           adequate patient classification system that is based  
22           on diagnosis-related groups (DRGs) and that re-  
23           flects the differences in patient resource use and  
24           costs, and shall maintain budget neutrality.

1 (2) COLLECTION OF DATA AND EVALUATION.—

2 In developing the system described in paragraph (1),  
3 the Secretary may require such long-term care hos-  
4 pitals to submit such information to the Secretary as  
5 the Secretary may require to develop the system.

6 (b) REPORT.—Not later than October 1, 2001, the  
7 Secretary shall submit to the appropriate committees of  
8 Congress a report that includes a description of the system  
9 developed under subsection (a)(1).

10 (c) IMPLEMENTATION OF PROSPECTIVE PAYMENT  
11 SYSTEM.—Notwithstanding section 1886(b)(3) of the So-  
12 cial Security Act (42 U.S.C. 1395ww(b)(3)), the Secretary  
13 shall provide, for cost reporting periods beginning on or  
14 after October 1, 2002, for payments for inpatient hospital  
15 services furnished by long-term care hospitals under title  
16 XVIII of the Social Security Act (42 U.S.C. 1395 et seq.)  
17 in accordance with the system described in subsection (a).

18 **SEC. 124. PER DIEM PROSPECTIVE PAYMENT SYSTEM FOR**

19 **PSYCHIATRIC HOSPITALS.**

20 (a) DEVELOPMENT OF SYSTEM.—

21 (1) IN GENERAL.—The Secretary of Health and  
22 Human Services shall develop a per diem prospective  
23 payment system for payment for inpatient hospital  
24 services of psychiatric hospitals and units (as de-  
25 fined in paragraph (3)) under the medicare pro-

1       gram. Such system shall include an adequate patient  
2       classification system that reflects the differences in  
3       patient resource use and costs among such hospitals  
4       and shall maintain budget neutrality.

5           (2) COLLECTION OF DATA AND EVALUATION.—  
6       In developing the system described in paragraph (1),  
7       the Secretary may require such psychiatric hospitals  
8       and units to submit such information to the Sec-  
9       retary as the Secretary may require to develop the  
10      system.

11          (3) DEFINITION.—In this section, the term  
12      “psychiatric hospitals and units” means a psy-  
13      chiatric hospital described in clause (i) of section  
14      1886(d)(1)(B) of the Social Security Act (42 U.S.C.  
15      1395ww(d)(1)(B)) and psychiatric units described in  
16      the matter following clause (v) of such section.

17      (b) REPORT.—Not later than October 1, 2001, the  
18      Secretary shall submit to the appropriate committees of  
19      Congress a report that includes a description of the system  
20      developed under subsection (a)(1).

21      (c) IMPLEMENTATION OF PROSPECTIVE PAYMENT  
22      SYSTEM.—Notwithstanding section 1886(b)(3) of the So-  
23      cial Security Act (42 U.S.C. 1395ww(b)(3)), the Secretary  
24      shall provide, for cost reporting periods beginning on or  
25      after October 1, 2002, for payments for inpatient hospital

1 services furnished by psychiatric hospitals and units under  
2 title XVIII of the Social Security Act (42 U.S.C. 1395  
3 et seq.) in accordance with the prospective payment sys-  
4 tem established by the Secretary under this section in a  
5 budget neutral manner.

6 **SEC. 125. REFINEMENT OF PROSPECTIVE PAYMENT SYS-**  
7 **TEM FOR INPATIENT REHABILITATION SERV-**  
8 **ICES.**

9 (a) USE OF DISCHARGE AS PAYMENT UNIT.—

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

14 (2) CONFORMING AMENDMENT TO CLASSIFICA-  
15 TION.—Section 1886(j)(2)(A)(i) (42 U.S.C.  
16 1395ww(j)(2)(A)(i)) is amended to read as follows:

17 “(i) classes of patient discharges of  
18 rehabilitation facilities by functional-re-  
19 lated groups (each in this subsection re-  
20 ferred to as a ‘case mix group’), based on  
21 impairment, age, comorbidities, and func-  
22 tional capability of the patient and such  
23 other factors as the Secretary deems ap-  
24 propriate to improve the explanatory power

1 of functional independence measure-func-  
2 tion related groups; and”.

3 (3) CONSTRUCTION RELATING TO TRANSFER  
4 AUTHORITY.—Section 1886(j)(1) (42 U.S.C.  
5 1395ww(j)(1)) is amended by adding at the end the  
6 following new subparagraph:

7 “(E) CONSTRUCTION RELATING TO TRANS-  
8 FER AUTHORITY.—Nothing in this subsection  
9 shall be construed as preventing the Secretary  
10 from providing for an adjustment to payments  
11 to take into account the early transfer of a pa-  
12 tient from a rehabilitation facility to another  
13 site of care.”.

14 (b) STUDY ON IMPACT OF IMPLEMENTATION OF  
15 PROSPECTIVE PAYMENT SYSTEM.—

16 (1) STUDY.—The Secretary of Health and  
17 Human Services shall conduct a study of the impact  
18 on utilization and beneficiary access to services of  
19 the implementation of the medicare prospective pay-  
20 ment system for inpatient hospital services or reha-  
21 bilitation facilities under section 1886(j) of the So-  
22 cial Security Act (42 U.S.C. 1395ww(j)).

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

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

## 4 **Subtitle D—Hospice Care**

### 5 **SEC. 131. TEMPORARY INCREASE IN PAYMENT FOR HOS-** 6 **PICE CARE.**

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

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

15 (2) fiscal year 2002, by 0.75 percent.

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

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

4 (a) **STUDY.**—The Comptroller General of the United  
5 States shall conduct a study to determine the feasibility  
6 and advisability of updating the payment rates and the  
7 cap amount determined with respect to a fiscal year under  
8 section 1814(i) of the Social Security Act (42 U.S.C.  
9 1395f(i)) for routine home care and other services in-  
10 cluded in hospice care. Such study shall examine the cost  
11 factors used to determine such rates and such amount and  
12 shall evaluate whether such factors should be modified,  
13 eliminated, or supplemented with additional cost factors.

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

21 **Subtitle E—Other Provisions**

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

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

1 policy with respect to professional clinical training of dif-  
2 ferent classes of nonphysician health care professionals  
3 (such as nurses, nurse practitioners, allied health profes-  
4 sionals, physician assistants, and psychologists) and the  
5 basis for any differences in treatment among such classes.

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

## 10 **Subtitle F—Transitional Provisions**

### 11 **SEC. 151. EXCEPTION TO CMI QUALIFIER FOR ONE YEAR.**

12 Notwithstanding any other provision of law, for pur-  
13 poses of fiscal year 2000, the Northwest Mississippi Re-  
14 gional Medical Center located in Clarksdale, Mississippi  
15 shall be deemed to have satisfied the case mix index cri-  
16 teria under section 1886(d)(5)(C)(ii) of the Social Secu-  
17 rity Act (42 U.S.C. 1395ww(d)(5)(C)(ii)) for classification  
18 as a rural referral center.

### 19 **SEC. 152. RECLASSIFICATION OF CERTAIN COUNTIES AND** 20 **AREAS FOR PURPOSES OF REIMBURSEMENT** 21 **UNDER THE MEDICARE PROGRAM.**

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

1 section 1886(d) of the Social Security Act (42 U.S.C.  
2 1395ww(d))—

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

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

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

14 (4) to hospitals in Hamilton-Middletown, Ohio,  
15 Hamilton-Middletown, Ohio, is deemed to be located  
16 in the Cincinnati, Ohio-Kentucky-Indiana Metropoli-  
17 tan Statistical Area;

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

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

1 (b) FISCAL YEAR 2001.—Notwithstanding any other  
2 provision of law, effective for discharges occurring during  
3 fiscal year 2001, for purposes of making payments under  
4 section 1886(d) of the Social Security Act (42 U.S.C.  
5 1395ww(d))—

6 (1) Iredell County, North Carolina is deemed to  
7 be located in the Charlotte-Gastonia-Rock Hill,  
8 North Carolina-South Carolina Metropolitan Statis-  
9 tical Area;

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

13 (3) Lake County, Indiana, and Lee County, Illi-  
14 nois, are deemed to be located in the Chicago, Illi-  
15 nois Metropolitan Statistical Area;

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

19 (5) Brazoria County, Texas, is deemed to be lo-  
20 cated in the Houston, Texas Metropolitan Statistical  
21 Area; and

22 (6) Chittenden County, Vermont is deemed to  
23 be located in the Boston-Worcester-Lawrence-Low-  
24 ell-Brockton, Massachusetts-New Hampshire Metro-  
25 politan Statistical Area.

1 For purposes of that section, any reclassification under  
2 this subsection shall be treated as a decision of the Medi-  
3 care Geographic Classification Review Board under para-  
4 graph (10) of that section.

5 **SEC. 153. WAGE INDEX CORRECTION.**

6 Notwithstanding any other provision of section  
7 1886(d) of the Social Security Act (42 U.S.C.  
8 1395ww(d)), the Secretary of Health and Human Services  
9 shall calculate and apply the Hattiesburg, Mississippi Met-  
10 ropolitan Statistical Area wage index under that section  
11 for discharges occurring during fiscal year 2000 using fis-  
12 cal year 1996 wage and hour data for Wesley Medical  
13 Center for purposes of payment under that section for that  
14 fiscal year. Such recalculation shall not affect the wage  
15 index for any other area.

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

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

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

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

10 **SEC. 155. SPECIAL RULE FOR CERTAIN SKILLED NURSING**  
11 **FACILITIES.**

12 (a) IN GENERAL.—Notwithstanding any provision of  
13 section 1888(e) of the Social Security Act (42 U.S.C.  
14 1395yy(e)), for the cost reporting period beginning in fis-  
15 cal year 2000 and for the cost reporting period beginning  
16 in fiscal year 2001, if a skilled nursing facility which  
17 meets the criteria described in subsection (b) elects to be  
18 paid in accordance with subsection (c), the Secretary of  
19 Health and Human Services shall establish a per diem  
20 payment amount for such facility according to the method-  
21 ology described in subsection (c) for such cost reporting  
22 periods in lieu of the payment amount that would other-  
23 wise be established for such facility under section  
24 1888(e)(1) of such Act (42 U.S.C. 1395yy(e)(1)).

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

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

6 (2) for which at least 80 percent of the total in-  
7 patient days of the facility in the cost reporting pe-  
8 riod beginning in fiscal year 1998 were comprised of  
9 individuals entitled to benefits under such title; and

10 (3) that is located in Baldwin or Mobile Coun-  
11 ty, Alabama.

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

18 (1) substitute the allowable costs of the facility  
19 for the cost reporting period beginning in fiscal year  
20 1998 for those allowable costs of the cost reporting  
21 period beginning in fiscal year 1995; and

22 (2) exclude the update to the first cost report-  
23 ing period (from fiscal year 1995 to fiscal year  
24 1998) described in section 1888(e)(3)(B)(i) of such  
25 Act (42 U.S.C. 1395yy(e)(3)(B)(i)).

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

5   **SEC. 201. OUTLIER ADJUSTMENT AND TRANSITIONAL PASS-**  
6                   **THROUGH FOR CERTAIN MEDICAL DEVICES,**  
7                   **DRUGS, AND BIOLOGICALS.**

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

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

13                   (2) by inserting after paragraph (4) the fol-  
14                   lowing new paragraph:

15                   “(5) OUTLIER ADJUSTMENT.—

16                               “(A) IN GENERAL.—Subject to subpara-  
17                               graph (D), the Secretary shall provide for an  
18                               additional payment for each covered OPD serv-  
19                               ice (or group of services) for which a hospital’s  
20                               charges, adjusted to cost, exceed—

21                                       “(i) a fixed multiple of the sum of—

22   “(I) the applicable medicare  
23   OPD fee schedule amount determined  
24   under paragraph (3)(D), as adjusted  
25   under paragraph (4)(A) (other than

1 for adjustments under this paragraph  
2 or paragraph (6)); and

3 “(II) any transitional pass-  
4 through payment under paragraph  
5 (6); and

6 “(ii) at the option of the Secretary,  
7 such fixed dollar amount as the Secretary  
8 may establish.

9 “(B) AMOUNT OF ADJUSTMENT.—The  
10 amount of the additional payment under sub-  
11 paragraph (A) shall be determined by the Sec-  
12 retary and shall approximate the marginal cost  
13 of care beyond the applicable cutoff point under  
14 such subparagraph.

15 “(C) LIMIT ON AGGREGATE OUTLIER AD-  
16 JUSTMENTS.—

17 “(i) IN GENERAL.—The total of the  
18 additional payments made under this para-  
19 graph for covered OPD services furnished  
20 in a year (as estimated by the Secretary  
21 before the beginning of the year) may not  
22 exceed the applicable percentage (specified  
23 in clause (ii)) of the total program pay-  
24 ments estimated to be made under this  
25 subsection for all covered OPD services

1 furnished in that year. If this paragraph is  
2 first applied to less than a full year, the  
3 previous sentence shall apply only to the  
4 portion of such year.

5 “(ii) APPLICABLE PERCENTAGE.—For  
6 purposes of clause (i), the term ‘applicable  
7 percentage’ means a percentage specified  
8 by the Secretary up to (but not to ex-  
9 ceed)—

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

12 “(II) for 2004 and thereafter,  
13 3.0 percent.

14 “(D) TRANSITIONAL AUTHORITY.—In ap-  
15 plying subparagraph (A) for covered OPD serv-  
16 ices furnished before January 1, 2002, the Sec-  
17 retary may—

18 “(i) apply such subparagraph to a bill  
19 for such services related to an outpatient  
20 encounter (rather than for a specific serv-  
21 ice or group of services) using OPD fee  
22 schedule amounts and transitional pass-  
23 through payments covered under the bill;  
24 and

1                   “(ii) use an appropriate cost-to-charge  
2                   ratio for the hospital involved (as deter-  
3                   mined by the Secretary), rather than for  
4                   specific departments within the hospital.”.

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

9                   “(6) TRANSITIONAL PASS-THROUGH FOR ADDI-  
10           TIONAL COSTS OF INNOVATIVE MEDICAL DEVICES,  
11           DRUGS, AND BIOLOGICALS.—

12                   “(A) IN GENERAL.—The Secretary shall  
13           provide for an additional payment under this  
14           paragraph for any of the following that are pro-  
15           vided as part of a covered OPD service (or  
16           group of services):

17                   “(i) CURRENT ORPHAN DRUGS.—A  
18           drug or biological that is used for a rare  
19           disease or condition with respect to which  
20           the drug or biological has been designated  
21           as an orphan drug under section 526 of  
22           the Federal Food, Drug and Cosmetic Act  
23           if payment for the drug or biological as an  
24           outpatient hospital service under this part  
25           was being made on the first date that the

1 system under this subsection is imple-  
2 mented.

3 “(ii) CURRENT CANCER THERAPY  
4 DRUGS AND BIOLOGICALS AND  
5 BRACHYTHERAPY.—A drug or biological  
6 that is used in cancer therapy, including  
7 (but not limited to) a chemotherapeutic  
8 agent, an antiemetic, a hematopoietic  
9 growth factor, a colony stimulating factor,  
10 a biological response modifier, a  
11 bisphosphonate, and a device of  
12 brachytherapy, if payment for such drug,  
13 biological, or device as an outpatient hos-  
14 pital service under this part was being  
15 made on such first date.

16 “(iii) CURRENT RADIOPHARMA-  
17 CEUTICAL DRUGS AND BIOLOGICAL PROD-  
18 UCTS.—A radiopharmaceutical drug or bio-  
19 logical product used in diagnostic, moni-  
20 toring, and therapeutic nuclear medicine  
21 procedures if payment for the drug or bio-  
22 logical as an outpatient hospital service  
23 under this part was being made on such  
24 first date.

## 43

1                   “(iv) NEW MEDICAL DEVICES, DRUGS,  
2                   AND BIOLOGICALS.—A medical device,  
3                   drug, or biological not described in clause  
4                   (i), (ii), or (iii) if—

5                   “(I) payment for the device,  
6                   drug, or biological as an outpatient  
7                   hospital service under this part was  
8                   not being made as of December 31,  
9                   1996; and

10                   “(II) the cost of the device, drug,  
11                   or biological is not insignificant in re-  
12                   lation to the OPD fee schedule  
13                   amount (as calculated under para-  
14                   graph (3)(D)) payable for the service  
15                   (or group of services) involved.

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

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

1           subparagraph (A)(iv) and for which pay-  
2           ment under this part is made as an out-  
3           patient hospital service before such first  
4           date; or

5           “(ii) in the case of a device, drug, or  
6           biological described in subparagraph  
7           (A)(iv) not described in clause (i), on the  
8           first date on which payment is made under  
9           this part for the device, drug, or biological  
10          as an outpatient hospital service.

11          “(C) AMOUNT OF ADDITIONAL PAY-  
12          MENT.—Subject to subparagraph (D)(iii), the  
13          amount of the payment under this paragraph  
14          with respect to a device, drug, or biological pro-  
15          vided as part of a covered OPD service is—

16               “(i) in the case of a drug or biological,  
17               the amount by which the amount deter-  
18               mined under section 1842(o) for the drug  
19               or biological exceeds the portion of the oth-  
20               erwise applicable medicare OPD fee sched-  
21               ule that the Secretary determines is associ-  
22               ated with the drug or biological; or

23               “(ii) in the case of a medical device,  
24               the amount by which the hospital’s charges  
25               for the device, adjusted to cost, exceeds the

1 portion of the otherwise applicable medi-  
2 care OPD fee schedule that the Secretary  
3 determines is associated with the device.

4 “(D) LIMIT ON AGGREGATE ANNUAL AD-  
5 JUSTMENT.—

6 “(i) IN GENERAL.—The total of the  
7 additional payments made under this para-  
8 graph for covered OPD services furnished  
9 in a year (as estimated by the Secretary  
10 before the beginning of the year) may not  
11 exceed the applicable percentage (specified  
12 in clause (ii)) of the total program pay-  
13 ments estimated to be made under this  
14 subsection for all covered OPD services  
15 furnished in that year. If this paragraph is  
16 first applied to less than a full year, the  
17 previous sentence shall apply only to the  
18 portion of such year.

19 “(ii) APPLICABLE PERCENTAGE.—For  
20 purposes of clause (i), the term ‘applicable  
21 percentage’ means—

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

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

4                   “(iii) UNIFORM PROSPECTIVE REDUC-  
5                   TION IF AGGREGATE LIMIT PROJECTED TO  
6                   BE EXCEEDED.—If the Secretary estimates  
7                   before the beginning of a year that the  
8                   amount of the additional payments under  
9                   this paragraph for the year (or portion  
10                  thereof) as determined under clause (i)  
11                  without regard to this clause will exceed  
12                  the limit established under such clause, the  
13                  Secretary shall reduce pro rata the amount  
14                  of each of the additional payments under  
15                  this paragraph for that year (or portion  
16                  thereof) in order to ensure that the aggre-  
17                  gate additional payments under this para-  
18                  graph (as so estimated) do not exceed such  
19                  limit.”.

20                  (c) APPLICATION OF NEW ADJUSTMENTS ON A  
21                  BUDGET NEUTRAL BASIS.—Section 1833(t)(2)(E) (42  
22                  U.S.C. 1395l(t)(2)(E)) is amended by striking “other ad-  
23                  justments, in a budget neutral manner, as determined to  
24                  be necessary to ensure equitable payments, such as outlier  
25                  adjustments or” and inserting “, in a budget neutral man-

1 ner, outlier adjustments under paragraph (5) and transi-  
2 tional pass-through payments under paragraph (6) and  
3 other adjustments as determined to be necessary to ensure  
4 equitable payments, such as”.

5 (d) LIMITATION ON JUDICIAL REVIEW FOR NEW AD-  
6 JUSTMENTS.—Section 1833(t)(11), as redesignated by  
7 subsection (a)(1), is amended—

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

10 (2) by striking the period at the end of sub-  
11 paragraph (D) and inserting “; and”; and

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

13 “(E) the determination of the fixed mul-  
14 tiple, or a fixed dollar cutoff amount, the mar-  
15 ginal cost of care, or applicable percentage  
16 under paragraph (5) or the determination of in-  
17 significance of cost, the duration of the addi-  
18 tional payments (consistent with paragraph  
19 (6)(B)), the portion of the medicare OPD fee  
20 schedule amount associated with particular de-  
21 vices, drugs, or biologicals, and the application  
22 of any pro rata reduction under paragraph  
23 (6).”.

24 (e) INCLUSION OF CERTAIN IMPLANTABLE ITEMS  
25 UNDER SYSTEM.—

1 (1) IN GENERAL.—Section 1833(t) (42 U.S.C.  
2 1395l(t)) is amended—

3 (A) in paragraph (1)(B)(ii), by striking  
4 “clause (iii)” and inserting “clause (iv)” and by  
5 striking “but”;

6 (B) by redesignating clause (iii) of para-  
7 graph (1)(B) as clause (iv) and inserting after  
8 clause (ii) of such paragraph the following new  
9 clause:

10 “(iii) includes implantable items de-  
11 scribed in paragraph (3), (6), or (8) of sec-  
12 tion 1861(s); but”; and

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

17 (2) CONFORMING AMENDMENT.—(A) Section  
18 1834(a)(13) (42 U.S.C. 1395m(a)(13)) is amended  
19 by striking “1861(m)(5))” and inserting  
20 “1861(m)(5), but not including implantable items  
21 for which payment may be made under section  
22 1833(t)”.

23 (B) Section 1834(h)(4)(B) (42 U.S.C.  
24 1395m(h)(4)(B)) is amended by inserting before the  
25 semicolon the following: “and does not include an

1       implantable item for which payment may be made  
2       under section 1833(t)”.

3       (f) AUTHORIZING PAYMENT WEIGHTS BASED ON  
4 MEAN HOSPITAL COSTS.—Section 1833(t)(2)(C) (42  
5 U.S.C. 1395l(t)(2)(C)) is amended by inserting “(or, at  
6 the election of the Secretary, mean)” after “median”.

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

11       “For purposes of subparagraph (B), items and serv-  
12       ices within a group shall not be treated as ‘com-  
13       parable with respect to the use of resources’ if the  
14       highest median cost (or mean cost, if elected by the  
15       Secretary under subparagraph (C)) for an item or  
16       service within the group is more than 2 times great-  
17       er than the lowest median cost (or mean cost, if so  
18       elected) for an item or service within the group; ex-  
19       cept that the Secretary may make exceptions in un-  
20       usual cases, such as low volume items and services,  
21       but may not make such an exception in the case of  
22       a drug or biological that has been designated as an  
23       orphan drug under section 526 of the Federal Food,  
24       Drug and Cosmetic Act.”.

25       (h) ANNUAL REVIEW OF OPD PPS COMPONENTS.—

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

4           (A) by striking “may periodically review”  
5 and inserting “shall review not less often than  
6 annually”; and

7           (B) by adding at the end the following:  
8 “The Secretary shall consult with an expert  
9 outside advisory panel composed of an appro-  
10 priate selection of representatives of providers  
11 to review (and advise the Secretary concerning)  
12 the clinical integrity of the groups and weights.  
13 Such panel may use data collected or developed  
14 by entities and organizations (other than the  
15 Department of Health and Human Services) in  
16 conducting such review.”.

17           (2) EFFECTIVE DATES.—The Secretary of  
18 Health and Human Services shall first conduct the  
19 annual review under the amendment made by para-  
20 graph (1)(A) in 2001 for application in 2002 and  
21 the amendment made by paragraph (1)(B) takes ef-  
22 fect on the date of the enactment of this Act.

23           (i) NO IMPACT ON COPAYMENT.—Section 1833(t)(7)  
24 (42 U.S.C. 1395l(t)(7)), as redesignated by subsection (a),

1 is amended by adding at the end the following new sub-  
2 paragraph:

3           “(D) COMPUTATION IGNORING OUTLIER  
4           AND PASS-THROUGH ADJUSTMENTS.—The co-  
5           payment amount shall be computed under sub-  
6           paragraph (A) as if the adjustments under  
7           paragraphs (5) and (6) (and any adjustment  
8           made under paragraph (2)(E) in relation to  
9           such adjustments) had not occurred.”.

10          (j) TECHNICAL CORRECTION IN REFERENCE RELAT-  
11          ING TO HOSPITAL-BASED AMBULANCE SERVICES.—Sec-  
12          tion 1833(t)(9) (42 U.S.C. 1395l(t)(9)), as redesignated  
13          by subsection (a), is amended by striking “the matter in  
14          subsection (a)(1) preceding subparagraph (A)” and insert-  
15          ing “section 1861(v)(1)(U)”.

16          (k) EXTENSION OF PAYMENT PROVISIONS OF SEC-  
17          TION 4522 OF BBA UNTIL IMPLEMENTATION OF PPS.—  
18          Section 1861(v)(1)(S)(ii) (42 U.S.C. 1395x(v)(1)(S)(ii)) is  
19          amended in subclauses (I) and (II) by striking “and dur-  
20          ing fiscal year 2000 before January 1, 2000” and insert-  
21          ing “and until the first date that the prospective payment  
22          system under section 1833(t) is implemented” each place  
23          it appears.

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

1 to determining the amount of copayments described in  
2 paragraph (3)(A)(ii) of section 1833(t) of the Social Secu-  
3 rity Act, as added by section 4523(a) of BBA, Congress  
4 finds that such amount should be determined without re-  
5 gard to such section, in a budget neutral manner with re-  
6 spect to aggregate payments to hospitals, and that the  
7 Secretary of Health and Human Services has the author-  
8 ity to determine such amount without regard to such sec-  
9 tion.

10 (m) EFFECTIVE DATE.—Except as provided in this  
11 section, the amendments made by this section shall be ef-  
12 fective as if included in the enactment of BBA.

13 (n) STUDY OF DELIVERY OF INTRAVENOUS IMMUNE  
14 GLOBULIN (IVIG) OUTSIDE HOSPITALS AND PHYSICIANS'  
15 OFFICES.—

16 (1) STUDY.—The Secretary of Health and  
17 Human Services shall conduct a study of the extent  
18 to which intravenous immune globulin (IVIG) could  
19 be delivered and reimbursed under the medicare pro-  
20 gram outside of a hospital or physician's office. In  
21 conducting the study, the Secretary shall—

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

1 (B) determine whether covering the deliv-  
2 ery of these drugs and biologicals in a medicare  
3 patient's home raises any additional safety and  
4 health concerns for the patient;

5 (C) determine whether covering the deliv-  
6 ery of these drugs and biologicals in a patient's  
7 home can reduce overall spending under the  
8 medicare program; and

9 (D) determine whether changing the site of  
10 setting for these services would affect bene-  
11 ficiary access to care.

12 (2) REPORT.—The Secretary shall submit a re-  
13 port on such study to the Committees on Ways and  
14 Means and Commerce of the House of Representa-  
15 tives and the Committee on Finance of the Senate  
16 within 18 months after the date of the enactment of  
17 this Act. The Secretary shall include in the report  
18 recommendations regarding the appropriate manner  
19 and settings under which the medicare program  
20 should pay for these drugs and biologicals delivered  
21 outside of a hospital or physician's office.

1 **SEC. 202. ESTABLISHING A TRANSITIONAL CORRIDOR FOR**  
2 **APPLICATION OF OPD PPS.**

3 (a) IN GENERAL.—Section 1833(t) (42 U.S.C.  
4 1395l(t)), as amended by section 201(a), is further  
5 amended—

6 (1) in paragraph (4), in the matter before sub-  
7 paragraph (A), by inserting “, subject to paragraph  
8 (7),” after “is determined”; and

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

12 (3) by inserting after paragraph (6), as inserted  
13 by section 201(b), the following new paragraph:

14 “(7) TRANSITIONAL ADJUSTMENT TO LIMIT DE-  
15 CLINE IN PAYMENT.—

16 “(A) BEFORE 2002.—Subject to subpara-  
17 graph (D), for covered OPD services furnished  
18 before January 1, 2002, for which the PPS  
19 amount (as defined in subparagraph (E)) is—

20 “(i) at least 90 percent, but less than  
21 100 percent, of the pre-BBA amount (as  
22 defined in subparagraph (F)), the amount  
23 of payment under this subsection shall be  
24 increased by 80 percent of the amount of  
25 such difference;

1           “(ii) at least 80 percent, but less than  
2           90 percent, of the pre-BBA amount, the  
3           amount of payment under this subsection  
4           shall be increased by the amount by which  
5           (I) the product of 0.71 and the pre-BBA  
6           amount, exceeds (II) the product of 0.70  
7           and the PPS amount;

8           “(iii) at least 70 percent, but less  
9           than 80 percent, of the pre-BBA amount,  
10          the amount of payment under this sub-  
11          section shall be increased by the amount  
12          by which (I) the product of 0.63 and the  
13          pre-BBA amount, exceeds (II) the product  
14          of 0.60 and the PPS amount; or

15          “(iv) less than 70 percent of the pre-  
16          BBA amount, the amount of payment  
17          under this subsection shall be increased by  
18          21 percent of the pre-BBA amount.

19          “(B) 2002.—Subject to subparagraph (D),  
20          for covered OPD services furnished during  
21          2002, for which the PPS amount is—

22                 “(i) at least 90 percent, but less than  
23                 100 percent, of the pre-BBA amount, the  
24                 amount of payment under this subsection

1 shall be increased by 70 percent of the  
2 amount of such difference;

3 “(ii) at least 80 percent, but less than  
4 90 percent, of the pre-BBA amount, the  
5 amount of payment under this subsection  
6 shall be increased by the amount by which  
7 (I) the product of 0.61 and the pre-BBA  
8 amount, exceeds (II) the product of 0.60  
9 and the PPS amount; or

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

14 “(C) 2003.—Subject to subparagraph (D),  
15 for covered OPD services furnished during  
16 2003, for which the PPS amount is—

17 “(i) at least 90 percent, but less than  
18 100 percent, of the pre-BBA amount, the  
19 amount of payment under this subsection  
20 shall be increased by 60 percent of the  
21 amount of such difference; or

22 “(ii) less than 90 percent of the pre-  
23 BBA amount, the amount of payment  
24 under this subsection shall be increased by  
25 6 percent of the pre-BBA amount.

1                   “(D) HOLD HARMLESS PROVISIONS.—

2                   “ (i) TEMPORARY TREATMENT FOR  
3                   SMALL RURAL HOSPITALS.—In the case of  
4                   a hospital located in a rural area and that  
5                   has not more than 100 beds, for covered  
6                   OPD services furnished before January 1,  
7                   2004, for which the PPS amount is less  
8                   than the pre-BBA amount, the amount of  
9                   payment under this subsection shall be in-  
10                  creased by the amount of such difference.

11                  “(ii) PERMANENT TREATMENT FOR  
12                  CANCER HOSPITALS.—In the case of a hos-  
13                  pital described in section 1886(d)(1)(B)(v),  
14                  for covered OPD services for which the  
15                  PPS amount is less than the pre-BBA  
16                  amount, the amount of payment under this  
17                  subsection shall be increased by the  
18                  amount of such difference.

19                  “(E) PPS AMOUNT DEFINED.—In this  
20                  paragraph, the term ‘PPS amount’ means, with  
21                  respect to covered OPD services, the amount  
22                  payable under this title for such services (deter-  
23                  mined without regard to this paragraph), in-  
24                  cluding amounts payable as copayment under  
25                  paragraph (8), coinsurance under section

1 1866(a)(2)(A)(ii), and the deductible under sec-  
2 tion 1833(b).

3 “(F) PRE-BBA AMOUNT DEFINED.—

4 “(i) IN GENERAL.—In this paragraph,  
5 the ‘pre-BBA amount’ means, with respect  
6 to covered OPD services furnished by a  
7 hospital in a year, an amount equal to the  
8 product of the reasonable cost of the hos-  
9 pital for such services for the portions of  
10 the hospital’s cost reporting period (or pe-  
11 riods) occurring in the year and the base  
12 OPD payment-to-cost ratio for the hospital  
13 (as defined in clause (ii)).

14 “(ii) BASE PAYMENT-TO-COST-RATIO  
15 DEFINED.—For purposes of this subpara-  
16 graph, the ‘base payment-to-cost ratio’ for  
17 a hospital means the ratio of—

18 “(I) the hospital’s reimbursement  
19 under this part for covered OPD serv-  
20 ices furnished during the cost report-  
21 ing period ending in 1996, including  
22 any reimbursement for such services  
23 through cost-sharing described in sub-  
24 paragraph (E), to

1                   “(II) the reasonable cost of such  
2                   services for such period.

3                   The Secretary shall determine such ratios  
4                   as if the amendments made by section  
5                   4521 of the Balanced Budget Act of 1997  
6                   were in effect in 1996.

7                   “(G) INTERIM PAYMENTS.—The Secretary  
8                   shall make payments under this paragraph to  
9                   hospitals on an interim basis, subject to retro-  
10                  spective adjustments based on settled cost re-  
11                  ports.

12                  “(H) NO EFFECT ON COPAYMENTS.—  
13                  Nothing in this paragraph shall be construed to  
14                  affect the unadjusted copayment amount de-  
15                  scribed in paragraph (3)(B) or the copayment  
16                  amount under paragraph (8).

17                  “(I) APPLICATION WITHOUT REGARD TO  
18                  BUDGET NEUTRALITY.—The additional pay-  
19                  ments made under this paragraph—

20                         “(i) shall not be considered an adjust-  
21                         ment under paragraph (2)(E); and

22                         “(ii) shall not be implemented in a  
23                         budget neutral manner.”.

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

4 **SEC. 203. STUDY AND REPORT TO CONGRESS REGARDING**  
5 **THE SPECIAL TREATMENT OF RURAL AND**  
6 **CANCER HOSPITALS IN PROSPECTIVE PAY-**  
7 **MENT SYSTEM FOR HOSPITAL OUTPATIENT**  
8 **DEPARTMENT SERVICES.**

9 (a) STUDY.—

10 (1) IN GENERAL.—The Medicare Payment Ad-  
11 visory Commission (referred to in this section as  
12 “MedPAC”) shall conduct a study to determine the  
13 appropriateness (and the appropriate method) of  
14 providing payments to hospitals described in para-  
15 graph (2) for covered OPD services (as defined in  
16 paragraph (1)(B) of section 1833(t) of the Social  
17 Security Act (42 U.S.C. 1395l(t))) based on the pro-  
18 spective payment system established by the Sec-  
19 retary in accordance with such section.

20 (2) HOSPITALS DESCRIBED.—The hospitals de-  
21 scribed in this paragraph are the following:

22 (A) A medicare-dependent, small rural hos-  
23 pital (as defined in section 1886(d)(5)(G)(iv) of  
24 the Social Security Act (42 U.S.C.  
25 1395ww(d)(5)(G)(iv))).

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

4 (C) Rural health clinics (as defined in sec-  
5 tion 1861(aa)(2) of such Act (42 U.S.C.  
6 1395x(aa)(2)).

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

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

12 (F) Any other rural hospital that the Sec-  
13 retary determines appropriate.

14 (G) A hospital described in section  
15 1886(d)(1)(B)(v) of such Act (42 U.S.C.  
16 1395ww(d)(1)(B)(v)).

17 (b) REPORT.—Not later than 2 years after the date  
18 of the enactment of this Act, MedPAC shall submit a re-  
19 port 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.

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

1 section (b) to the Secretary of Health and Human Serv-  
2 ices, the Secretary shall submit comments on such report  
3 to Congress.

4 **SEC. 204. LIMITATION ON OUTPATIENT HOSPITAL COPAY-**  
5 **MENT FOR A PROCEDURE TO THE HOSPITAL**  
6 **DEDUCTIBLE AMOUNT.**

7 (a) IN GENERAL.—Section 1833(t)(8) (42 U.S.C.  
8 1395l(t)(8)), as redesignated by sections 201(a)(1) and  
9 202(a)(2), is amended—

10 (1) in subparagraph (A), by striking “subpara-  
11 graph (B)” and inserting “subparagraphs (B) and  
12 (C)”;

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

15 (3) by inserting after subparagraph (B) the fol-  
16 lowing new subparagraph:

17 “(C) LIMITING COPAYMENT AMOUNT TO  
18 INPATIENT HOSPITAL DEDUCTIBLE AMOUNT.—  
19 In no case shall the copayment amount for a  
20 procedure performed in a year exceed the  
21 amount of the inpatient hospital deductible es-  
22 tablished under section 1813(b) for that year.”.

23 (b) INCREASE IN PAYMENT TO REFLECT REDUC-  
24 TION IN COPAYMENT.—Section 1833(t)(4)(C) (42 U.S.C.  
25 1395l(t)(4)(C)) is amended by inserting “, plus the

1 amount of any reduction in the copayment amount attrib-  
2 utable to paragraph (8)(C)” before the period at the end.

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

## 8 **Subtitle B—Physician Services**

### 9 **SEC. 211. MODIFICATION OF UPDATE ADJUSTMENT FAC-** 10 **TOR PROVISIONS TO REDUCE UPDATE OSCIL-** 11 **LATIONS AND REQUIRE ESTIMATE REVI-** 12 **SIONS.**

13 (a) UPDATE ADJUSTMENT FACTOR.—

14 (1) IN GENERAL.—Section 1848(d) (42 U.S.C.  
15 1395w-4(d)) is amended—

16 (A) in paragraph (3)—

17 (i) in the heading, by inserting “FOR  
18 1999 AND 2000” after “UPDATE”;

19 (ii) in subparagraph (A), by striking  
20 “a year beginning with 1999” and insert-  
21 ing “1999 and 2000”; and

22 (iii) in subparagraph (C), by inserting  
23 “and paragraph (4)” after “For purposes  
24 of this paragraph”; and

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

3 “(4) UPDATE FOR YEARS BEGINNING WITH  
4 2001.—

5 “(A) IN GENERAL.—Unless otherwise pro-  
6 vided by law, subject to the budget-neutrality  
7 factor determined by the Secretary under sub-  
8 section (c)(2)(B)(ii) and subject to adjustment  
9 under subparagraph (F), the update to the sin-  
10 gle conversion factor established in paragraph  
11 (1)(C) for a year beginning with 2001 is equal  
12 to the product of—

13 “(i) 1 plus the Secretary’s estimate of  
14 the percentage increase in the MEI (as de-  
15 fined in section 1842(i)(3)) for the year  
16 (divided by 100); and

17 “(ii) 1 plus the Secretary’s estimate of  
18 the update adjustment factor under sub-  
19 paragraph (B) for the year.

20 “(B) UPDATE ADJUSTMENT FACTOR.—For  
21 purposes of subparagraph (A)(ii), subject to  
22 subparagraph (D), the ‘update adjustment fac-  
23 tor’ for a year is equal (as estimated by the  
24 Secretary) to the sum of the following:

1                   “(i) PRIOR YEAR ADJUSTMENT COM-  
2                   PONENT.—An amount determined by—

3                   “(I) computing the difference  
4                   (which may be positive or negative)  
5                   between the amount of the allowed ex-  
6                   penditures for physicians’ services for  
7                   the prior year (as determined under  
8                   subparagraph (C)) and the amount of  
9                   the actual expenditures for such serv-  
10                  ices for that year;

11                  “(II) dividing that difference by  
12                  the amount of the actual expenditures  
13                  for such services for that year; and

14                  “(III) multiplying that quotient  
15                  by 0.75.

16                  “(ii) CUMULATIVE ADJUSTMENT COM-  
17                  PONENT.—An amount determined by—

18                  “(I) computing the difference  
19                  (which may be positive or negative)  
20                  between the amount of the allowed ex-  
21                  penditures for physicians’ services (as  
22                  determined under subparagraph (C))  
23                  from April 1, 1996, through the end  
24                  of the prior year and the amount of

1 the actual expenditures for such serv-  
2 ices during that period;

3 “(II) dividing that difference by  
4 actual expenditures for such services  
5 for the prior year as increased by the  
6 sustainable growth rate under sub-  
7 section (f) for the year for which the  
8 update adjustment factor is to be de-  
9 termined; and

10 “(III) multiplying that quotient  
11 by 0.33.

12 “(C) DETERMINATION OF ALLOWED EX-  
13 PENDITURES.—For purposes of this paragraph:

14 “(i) PERIOD UP TO APRIL 1, 1999.—  
15 The allowed expenditures for physicians’  
16 services for a period before April 1, 1999,  
17 shall be the amount of the allowed expendi-  
18 tures for such period as determined under  
19 paragraph (3)(C).

20 “(ii) TRANSITION TO CALENDAR YEAR  
21 ALLOWED EXPENDITURES.—Subject to  
22 subparagraph (E), the allowed expendi-  
23 tures for—

24 “(I) the 9-month period begin-  
25 ning April 1, 1999, shall be the Sec-

1           retary's estimate of the amount of the  
2           allowed expenditures that would be  
3           permitted under paragraph (3)(C) for  
4           such period; and

5                   “(II) the year of 1999, shall be  
6           the Secretary's estimate of the  
7           amount of the allowed expenditures  
8           that would be permitted under para-  
9           graph (3)(C) for such year.

10                   “(iii) YEARS BEGINNING WITH 2000.—  
11           The allowed expenditures for a year (be-  
12           ginning with 2000) is equal to the allowed  
13           expenditures for physicians' services for  
14           the previous year, increased by the sustain-  
15           able growth rate under subsection (f) for  
16           the year involved.

17                   “(D) RESTRICTION ON UPDATE ADJUST-  
18           MENT FACTOR.—The update adjustment factor  
19           determined under subparagraph (B) for a year  
20           may not be less than  $-0.07$  or greater than  
21            $0.03$ .

22                   “(E) RECALCULATION OF ALLOWED EX-  
23           PENDITURES FOR UPDATES BEGINNING WITH  
24           2001.—For purposes of determining the update  
25           adjustment factor for a year beginning with

1           2001, the Secretary shall recompute the allowed  
2           expenditures for previous periods beginning on  
3           or after April 1, 1999, consistent with sub-  
4           section (f)(3).

5           “(F) TRANSITIONAL ADJUSTMENT DE-  
6           SIGNED TO PROVIDE FOR BUDGET NEU-  
7           TRALITY.—Under this subparagraph the Sec-  
8           retary shall provide for an adjustment to the  
9           update under subparagraph (A)—

10                   “(i) for each of 2001, 2002, 2003,  
11                   and 2004, of  $-0.2$  percent; and

12                   “(ii) for 2005 of  $+0.8$  percent.”.

13           (2) PUBLICATION CHANGE.—

14                   (A) IN GENERAL.—Section 1848(d)(1)(E)  
15                   (42 U.S.C. 1395w-4(d)(1)(E)) is amended to  
16                   read as follows:

17                   “(E) PUBLICATION AND DISSEMINATION  
18                   OF INFORMATION.—The Secretary shall—

19                           “(i) cause to have published in the  
20                           Federal Register not later than November  
21                           1 of each year (beginning with 2000) the  
22                           conversion factor which will apply to physi-  
23                           cians’ services for the succeeding year, the  
24                           update determined under paragraph (4)  
25                           for such succeeding year, and the allowed

1 expenditures under such paragraph for  
2 such succeeding year; and

3 “(ii) make available to the Medicare  
4 Payment Advisory Commission and the  
5 public by March 1 of each year (beginning  
6 with 2000) an estimate of the sustainable  
7 growth rate and of the conversion factor  
8 which will apply to physicians’ services for  
9 the succeeding year and data used in mak-  
10 ing such estimate.”.

11 (B) MEDPAC REVIEW OF CONVERSION  
12 FACTOR ESTIMATES.—Section 1805(b)(1)(D)  
13 (42 U.S.C. 1395b–6(b)(1)(D)) is amended by  
14 inserting “and including a review of the esti-  
15 mate of the conversion factor submitted under  
16 section 1848(d)(1)(E)(ii)” before the period at  
17 the end.

18 (C) ONE-TIME PUBLICATION OF INFORMA-  
19 TION ON TRANSITION.—The Secretary of  
20 Health and Human Services shall cause to have  
21 published in the Federal Register, not later  
22 than 90 days after the date of the enactment of  
23 this section, the Secretary’s determination,  
24 based upon the best available data, of—

1 (i) the allowed expenditures under  
2 subclauses (I) and (II) of subsection  
3 (d)(4)(C)(ii) of section 1848 of the Social  
4 Security Act (42 U.S.C. 1395w-4), as  
5 added by subsection (a)(1)(B), for the 9-  
6 month period beginning on April 1, 1999,  
7 and for 1999;

8 (ii) the estimated actual expenditures  
9 described in subsection (d) of such section  
10 for 1999; and

11 (iii) the sustainable growth rate under  
12 subsection (f) of such section for 2000.

13 (3) CONFORMING AMENDMENTS.—

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

16 (i) in subsection (d)(1)(A), by insert-  
17 ing “(for years before 2001) and, for years  
18 beginning with 2001, multiplied by the up-  
19 date (established under paragraph (4)) for  
20 the year involved” after “for the year in-  
21 volved”; and

22 (ii) in subsection (f)(2)(D), by insert-  
23 ing “or (d)(4)(B), as the case may be”  
24 after “(d)(3)(B)”.

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

4 (b) SUSTAINABLE GROWTH RATES.—Section 1848(f)  
5 (42 U.S.C. 1395w-4(f)) is amended—

6 (1) by amending paragraph (1) to read as fol-  
7 lows:

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

11 “(A) November 1, 2000, the sustainable  
12 growth rate for 2000 and 2001; and

13 “(B) November 1 of each succeeding year  
14 the sustainable growth rate for such succeeding  
15 year and each of the preceding 2 years.”;

16 (2) in paragraph (2)—

17 (A) in the matter before subparagraph (A),  
18 by striking “fiscal year 1998)” and inserting  
19 “fiscal year 1998 and ending with fiscal year  
20 2000) and a year beginning with 2000”;

21 (B) in subparagraphs (A) through (D), by  
22 striking “fiscal year” and inserting “applicable  
23 period” each place it appears;

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

1           “(C) APPLICABLE PERIOD.—The term ‘ap-  
2           plicable period’ means—

3                   “(i) a fiscal year, in the case of fiscal  
4                   year 1998, fiscal year 1999, and fiscal year  
5                   2000; or

6                   “(ii) a calendar year with respect to a  
7                   year beginning with 2000;  
8                   as the case may be.”;

9           (4) by redesignating paragraph (3) as para-  
10          graph (4); and

11          (5) by inserting after paragraph (2) the fol-  
12          lowing new paragraph:

13                   “(3) DATA TO BE USED.—For purposes of de-  
14                   termining the update adjustment factor under sub-  
15                   section (d)(4)(B) for a year beginning with 2001,  
16                   the sustainable growth rates taken into consideration  
17                   in the determination under paragraph (2) shall be  
18                   determined as follows:

19                           “(A) FOR 2001.—For purposes of such cal-  
20                           culations for 2001, the sustainable growth rates  
21                           for fiscal year 2000 and the years 2000 and  
22                           2001 shall be determined on the basis of the  
23                           best data available to the Secretary as of Sep-  
24                           tember 1, 2000.

1           “(B) FOR 2002.—For purposes of such cal-  
2           culations for 2002, the sustainable growth rates  
3           for fiscal year 2000 and for years 2000, 2001,  
4           and 2002 shall be determined on the basis of  
5           the best data available to the Secretary as of  
6           September 1, 2001.

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

10           “(i) the sustainable growth rates for  
11           that year and the preceding 2 years shall  
12           be determined on the basis of the best data  
13           available to the Secretary as of September  
14           1 of the year preceding the year for which  
15           the calculation is made; and

16           “(ii) the sustainable growth rate for  
17           any year before a year described in clause  
18           (i) shall be the rate as most recently deter-  
19           mined for that year under this subsection.

20           Nothing in this paragraph shall be construed as af-  
21           fecting the sustainable growth rates established for  
22           fiscal year 1998 or fiscal year 1999.”.

23           (c) STUDY AND REPORT REGARDING THE UTILIZA-  
24           TION OF PHYSICIANS’ SERVICES BY MEDICARE BENE-  
25           FICIARIES.—

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

6           (2) ISSUES TO BE STUDIED.—The issues speci-  
7           fied in this paragraph are the following:

8                   (A) The various methods for accurately es-  
9                   timating the economic impact on expenditures  
10                  for physicians' services under the original medi-  
11                  care fee-for-service program under parts A and  
12                  B of title XVIII of the Social Security Act (42  
13                  U.S.C. 1395 et seq.) resulting from—

14                           (i) improvements in medical capabili-  
15                           ties;

16                           (ii) advancements in scientific tech-  
17                           nology;

18                           (iii) demographic changes in the types  
19                           of medicare beneficiaries that receive bene-  
20                           fits under such program; and

21                           (iv) geographic changes in locations  
22                           where medicare beneficiaries receive bene-  
23                           fits under such program.

24                   (B) The rate of usage of physicians' serv-  
25                   ices under the original medicare fee-for-service

1 program under parts A and B of title XVIII of  
2 the Social Security Act (42 U.S.C. 1395 et  
3 seq.) among beneficiaries between ages 65 and  
4 74, 75 and 84, 85 and over, and disabled bene-  
5 ficiaries under age 65.

6 (C) Other factors that may be reliable pre-  
7 dictors of beneficiary utilization of physicians'  
8 services under the original medicare fee-for-  
9 service program under parts A and B of title  
10 XVIII of the Social Security Act (42 U.S.C.  
11 1395 et seq.).

12 (3) REPORT TO CONGRESS.—Not later than 3  
13 years after the date of the enactment of this Act, the  
14 Secretary of Health and Human Services shall sub-  
15 mit a report to Congress setting forth the results of  
16 the study conducted pursuant to paragraph (1), to-  
17 gether with any recommendations the Secretary de-  
18 termines are appropriate.

19 (4) MEDPAC REPORT TO CONGRESS.—Not later  
20 than 180 days after the date of submission of the  
21 report under paragraph (3), the Medicare Payment  
22 Advisory Commission shall submit a report to Con-  
23 gress that includes—

24 (A) an analysis and evaluation of the re-  
25 port submitted under paragraph (3); and

1 (B) such recommendations as it determines  
2 are appropriate.

3 (d) EFFECTIVE DATE.—The amendments made by  
4 this section shall be effective in determining the conversion  
5 factor under section 1848(d) of the Social Security Act  
6 (42 U.S.C. 1395w-4(d)) for years beginning with 2001  
7 and shall not apply to or affect any update (or any update  
8 adjustment factor) for any year before 2001.

9 **SEC. 212. USE OF DATA COLLECTED BY ORGANIZATIONS**  
10 **AND ENTITIES IN DETERMINING PRACTICE**  
11 **EXPENSE RELATIVE VALUES.**

12 (a) IN GENERAL.—The Secretary of Health and  
13 Human Services shall establish by regulation (after notice  
14 and opportunity for public comment) a process (including  
15 data collection standards) under which the Secretary will  
16 accept for use and will use, to the maximum extent prac-  
17 ticable and consistent with sound data practices, data col-  
18 lected or developed by entities and organizations (other  
19 than the Department of Health and Human Services) to  
20 supplement the data normally collected by that Depart-  
21 ment in determining the practice expense component  
22 under section 1848(c)(2)(C)(ii) of the Social Security Act  
23 (42 U.S.C. 1395w-4(c)(2)(C)(ii)) for purposes of deter-  
24 mining relative values for payment for physicians' services  
25 under the fee schedule under section 1848 of such Act

1 (42 U.S.C. 1395w-4). The Secretary shall first promul-  
2 gate such regulation on an interim final basis in a manner  
3 that permits the submission and use of data in the com-  
4 putation of practice expense relative value units for pay-  
5 ment rates for 2001.

6 (b) PUBLICATION OF INFORMATION.—The Secretary  
7 shall include, in the publication of the estimated and final  
8 updates under section 1848(c) of such Act (42 U.S.C.  
9 1395w-4(c)) for payments for 2001 and for 2002, a de-  
10 scription of the process established under subsection (a)  
11 for the use of external data in making adjustments in rel-  
12 ative value units and the extent to which the Secretary  
13 has used such external data in making such adjustments  
14 for each such year, particularly in cases in which the data  
15 otherwise used are inadequate because such data are not  
16 based upon a large enough sample size to be statistically  
17 reliable.

18 **SEC. 213. GAO STUDY ON RESOURCES REQUIRED TO PRO-**  
19 **VIDE SAFE AND EFFECTIVE OUTPATIENT**  
20 **CANCER THERAPY.**

21 (a) STUDY.—The Comptroller General of the United  
22 States shall conduct a nationwide study to determine the  
23 physician and non-physician clinical resources necessary to  
24 provide safe outpatient cancer therapy services and the ap-  
25 propriate payment rates for such services under the medi-

1 care program. In making such determination, the Comp-  
2 troller General shall—

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

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

8 (3) assess various standards to assure the pro-  
9 vision of safe outpatient cancer therapy services.

10 (b) REPORT TO CONGRESS.—The Comptroller Gen-  
11 eral shall submit to Congress a report on the study con-  
12 ducted under subsection (a). The report shall include rec-  
13 ommendations regarding practice expense adjustments to  
14 the payment methodology under part B of title XVIII of  
15 the Social Security Act, including the development and in-  
16 clusion of adequate work units to assure the adequacy of  
17 payment amounts for safe outpatient cancer therapy serv-  
18 ices. The study shall also include an estimate of the cost  
19 of implementing such recommendations.

## 20 **Subtitle C—Other Services**

### 21 **SEC. 221. REVISION OF PROVISIONS RELATING TO THER-** 22 **APY SERVICES.**

23 (a) 2-YEAR MORATORIUM ON CAPS.—

24 (1) IN GENERAL.—Section 1833(g) of the So-  
25 cial Security Act (42 U.S.C. 1395l(g)) is amended—

1 (A) in paragraphs (1) and (3), by striking  
2 “In the case” each place it appears and insert-  
3 ing “Subject to paragraph (4), in the case”;  
4 and

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

6 “(4) This subsection shall not apply to expenses in-  
7 curred with respect to services furnished during 2000 and  
8 2001.”.

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

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

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

24 (A) in subsection (p)(1), by striking “or  
25 (3)” and inserting “, (3), or (4)”; and

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

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

7 (c) REVISION OF REPORT.—

8 (1) IN GENERAL.—Section 4541(d)(2) of BBA  
9 (42 U.S.C. 1395l note) is amended to read as fol-  
10 lows:

11 “(2) REPORT.—Not later than January 1,  
12 2001, the Secretary of Health and Human Services  
13 shall submit to Congress a report that includes rec-  
14 ommendations on—

15 “(A) the establishment of a mechanism for  
16 assuring appropriate utilization of outpatient  
17 physical therapy services, outpatient occupa-  
18 tional therapy services, and speech-language pa-  
19 thology services that are covered under the  
20 medicare program under title XVIII of the So-  
21 cial Security Act (42 U.S.C. 1395); and

22 “(B) the establishment of an alternative  
23 payment policy for such services based on clas-  
24 sification of individuals by diagnostic category,  
25 functional status, prior use of services (in both

1 inpatient and outpatient settings), and such  
2 other criteria as the Secretary determines ap-  
3 propriate, in place of the uniform dollar limita-  
4 tions specified in section 1833(g) of such Act,  
5 as amended by paragraph (1).

6 The recommendations shall include how such a  
7 mechanism or policy might be implemented in a  
8 budget-neutral manner.”.

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

12 (d) STUDY AND REPORT ON UTILIZATION.—

13 (1) STUDY.—

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

17 (i) utilization patterns (including na-  
18 tionwide patterns, and patterns by region,  
19 types of settings, and diagnosis or condi-  
20 tion) of outpatient physical therapy serv-  
21 ices, outpatient occupational therapy serv-  
22 ices, and speech-language pathology serv-  
23 ices that are covered under the medicare  
24 program under title XVIII of the Social

1 Security Act (42 U.S.C. 1395) and pro-  
2 vided on or after January 1, 2000; with  
3 (ii) such patterns for such services  
4 that were provided in 1998 and 1999.

5 (B) REVIEW OF CLAIMS.—In conducting  
6 the study under this subsection the Secretary of  
7 Health and Human Services shall review a sta-  
8 tistically significant number of claims for reim-  
9 bursement for the services described in sub-  
10 paragraph (A).

11 (2) REPORT.—Not later than June 30, 2001,  
12 the Secretary of Health and Human Services shall  
13 submit a report to Congress on the study conducted  
14 under paragraph (1), together with any rec-  
15 ommendations for legislation that the Secretary de-  
16 termines to be appropriate as a result of such study.

17 **SEC. 222. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.**

18 (a) IN GENERAL.—Section 1881(b)(7) (42 U.S.C.  
19 1395rr(b)(7)) is amended by adding at the end the fol-  
20 lowing new flush sentence:

21 “The Secretary shall increase the amount of each com-  
22 posite rate payment for dialysis services furnished during  
23 2000 by 1.2 percent above such composite rate payment  
24 amounts for such services furnished on December 31,  
25 1999, and for such services furnished on or after January

1 1, 2001, by 1.2 percent above such composite rate pay-  
2 ment amounts for such services furnished on December  
3 31, 2000.”.

4 (b) CONFORMING AMENDMENT.—The second sen-  
5 tence of section 9335(a)(1) of the Omnibus Budget Rec-  
6 onciliation Act of 1986 (42 U.S.C. 1395rr note) is amend-  
7 ed by inserting “and before January 1, 2000,” after “on  
8 or after January 1, 1991,”.

9 (c) STUDY ON PAYMENT LEVEL FOR HOME HEMO-  
10 DIALYSIS.—The Medicare Payment Advisory Commission  
11 shall conduct a study on the appropriateness of the dif-  
12 ferential in payment under the medicare program for  
13 hemodialysis services furnished in a facility and such serv-  
14 ices furnished in a home. Not later than 18 months after  
15 the date of the enactment of this Act, the Commission  
16 shall submit to Congress a report on such study and shall  
17 include recommendations regarding changes in medicare  
18 payment policy in response to the study.

19 **SEC. 223. IMPLEMENTATION OF THE INHERENT REASON-**  
20 **ABLENESS (IR) AUTHORITY.**

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

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

6           (2) the Secretary has published a notice of final  
7 rulemaking in the Federal Register that relates to  
8 such authority and that responds to such report and  
9 to comments received in response to the Secretary's  
10 interim final regulation relating to such authority  
11 that was published in the Federal Register on Janu-  
12 ary 7, 1998.

13       (b) REEVALUATION OF IR CRITERIA.—In promul-  
14 gating the final regulation under subsection (a)(2), the  
15 Secretary shall—

16           (1) reevaluate the appropriateness of the cri-  
17 teria included in such interim final regulation for  
18 identifying payments which are excessive or defi-  
19 cient; and

20           (2) take appropriate steps to ensure the use of  
21 valid and reliable data when exercising such author-  
22 ity.

23       (c) TECHNICAL CORRECTION.—Section  
24 1842(b)(8)(A)(i)(I) (42 U.S.C. 1395u(b)(8)(A)(i)(I)) is  
25 amended by striking “the application of this part” and

1 inserting “the application of this title to payment under  
2 this part”.

3 **SEC. 224. INCREASE IN REIMBURSEMENT FOR PAP SMEARS.**

4 (a) PAP SMEAR PAYMENT INCREASE.—Section  
5 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at  
6 the end the following new paragraph:

7 “(7) Notwithstanding paragraphs (1) and (4), the  
8 Secretary shall establish a national minimum payment  
9 amount under this subsection for a diagnostic or screening  
10 pap smear laboratory test (including all cervical cancer  
11 screening technologies that have been approved by the  
12 Food and Drug Administration as a primary screening  
13 method for detection of cervical cancer) equal to \$14.60  
14 for tests furnished in 2000. For such tests furnished in  
15 subsequent years, such national minimum payment  
16 amount shall be adjusted annually as provided in para-  
17 graph (2).”.

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

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

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

4 (3) the Health Care Financing Administration  
5 should institute an appropriate increase in the pay-  
6 ment rate for new cervical cancer screening tech-  
7 nologies that have been approved by the Food and  
8 Drug Administration and that are significantly more  
9 effective than a conventional pap smear.

10 **SEC. 225. REFINEMENT OF AMBULANCE SERVICES DEM-**  
11 **ONSTRATION PROJECT.**

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

14 (1) in subsection (a), by adding at the end the  
15 following: “Not later than July 1, 2000, the Sec-  
16 retary shall publish a request for proposals for such  
17 projects.”; and

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

20 “(2) **CAPITATED PAYMENT RATE DEFINED.**—In  
21 this subsection, the term ‘capitated payment rate’  
22 means, with respect to a demonstration project—

23 “(A) in its first year, a rate established for  
24 the project by the Secretary, using the most  
25 current available data, in a manner that en-

1           sures that aggregate payments under the  
2           project will not exceed the aggregate payment  
3           that would have been made for ambulance serv-  
4           ices under part B of title XVIII of the Social  
5           Security Act in the local area of government's  
6           jurisdiction; and

7                   “(B) in a subsequent year, the capitated  
8           payment rate established for the previous year  
9           increased by an appropriate inflation adjust-  
10          ment factor.”.

11 **SEC. 226. PHASE-IN OF PPS FOR AMBULATORY SURGICAL**  
12                   **CENTERS.**

13          If the Secretary of Health and Human Services im-  
14          plements a revised prospective payment system for serv-  
15          ices of ambulatory surgical facilities under section 1833(i)  
16          of the Social Security Act (42 U.S.C. 1395l(i)), prior to  
17          incorporating data from the 1999 Medicare cost survey  
18          or a subsequent cost survey, such system shall be imple-  
19          mented in a manner so that—

20                   (1) in the first year of its implementation, only  
21          a proportion (specified by the Secretary and not to  
22          exceed  $\frac{1}{3}$ ) of the payment for such services shall be  
23          made in accordance with such system and the re-  
24          mainder shall be made in accordance with current  
25          regulations; and

1           (2) in the following year a proportion (specified  
2           by the Secretary and not to exceed  $\frac{2}{3}$ ) of the pay-  
3           ment for such services shall be made under such sys-  
4           tem and the remainder shall be made in accordance  
5           with current regulations.

6 **SEC. 227. EXTENSION OF MEDICARE BENEFITS FOR IM-**  
7 **MUNOSUPPRESSIVE DRUGS.**

8           (a) IN GENERAL.—Section 1861(s)(2)(J)(v) (42  
9 U.S.C. 1395x(s)(2)(J)(v)) is amended by inserting before  
10 the semicolon at the end the following: “plus such addi-  
11 tional number of months (if any) provided under section  
12 1832(b)”.

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

15           (1) by redesignating subsection (b) as sub-  
16           section (c); and

17           (2) by inserting after subsection (a) the fol-  
18           lowing new subsection:

19           “(b) EXTENSION OF COVERAGE OF IMMUNO-  
20 SUPPRESSIVE DRUGS.—

21           “(1) EXTENSION.—

22           “(A) IN GENERAL.—The Secretary shall  
23           specify consistent with this subsection an addi-  
24           tional number of months (which may be por-  
25           tions of months) of coverage of immuno-

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

5 “(i) for 2000 shall be 8 months; and

6 “(ii) for 2001 shall, subject to para-  
7 graph (2)(A)(i), be 8 months.

8 “(B) APPLICATION OF ADDITIONAL  
9 MONTHS IN A YEAR ONLY TO COHORT IN THAT  
10 YEAR.—

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

17 “(ii) CONSTRUCTION.—Nothing in  
18 this subsection shall be construed as pre-  
19 venting additional months of coverage pro-  
20 vided for a cohort for a year from extend-  
21 ing coverage to drugs furnished in months  
22 in the succeeding year.

23 “(C) COHORT DEFINED.—In this sub-  
24 section, the term ‘cohort’ means, with respect to  
25 a year, those individuals who would (but for

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

5           “(2) TIMING OF SPECIFICATION.—Consistent  
6           with paragraphs (3) and (4)—

7                   “(A) MAY 1, 2001.—Not later than May 1,  
8                   2001, the Secretary—

9                           “(i) may increase the number of  
10                           months for the cohort for 2001 above the  
11                           8 months provided under paragraph  
12                           (1)(A)(ii); and

13                           “(ii) shall compute and specify the  
14                           number of additional months of benefits  
15                           that will be available for the cohort for  
16                           2002.

17                   “(B) MAY 1, 2002 AND 2003.—Not later  
18                   than May 1 of 2002 and 2003, the Secretary  
19                   shall compute and specify the number of addi-  
20                   tional months of benefits that will be available  
21                   for the cohort for the following year under this  
22                   subsection. Such number may be more or less  
23                   than 8 months.

24           “(3) BASIS FOR SPECIFICATION.—Using appro-  
25           appropriate actuarial methods, the Secretary shall com-

1       pute the number of additional months for the cohort  
2       for a year under this subsection in a manner so that  
3       the total expenditures under this part attributable to  
4       this subsection, as computed based upon the best  
5       available data at the time additional months are  
6       specified under this subsection, do not exceed  
7       \$150,000,000. Subject to paragraph (4), the Sec-  
8       retary shall seek to compute such months in a man-  
9       ner that provides for a level number of months for  
10      each cohort in each year in the last 4 years of the  
11      5-year period described in paragraph (1)(A).

12           “(4) ANNUAL ADJUSTMENT TO MAINTAIN AG-  
13      GREGATE EXPENDITURES WITHIN LIMITS.—In com-  
14      puting and specifying the number of additional  
15      months under paragraph (2), the Secretary shall ad-  
16      just the number of additional months under this  
17      subsection for a cohort for a year from that provided  
18      in the previous year within such 5-year period to the  
19      extent necessary to take into account, based upon  
20      the best available data, differences between actual  
21      and estimated expenditures under this part attrib-  
22      utable to this subsection for previous years and to  
23      comply with the limitation on total expenditures  
24      under paragraph (3).”.

1 (c) TRANSITIONAL PASS-THROUGH OF ADDITIONAL  
2 COSTS UNDER MEDICARE+ CHOICE PROGRAM FOR  
3 2000.—The provisions of subparagraphs (A) and (B) of  
4 section 1852(a)(5) of the Social Security Act (42 U.S.C.  
5 1395w-22(a)(5)) shall apply with respect to the coverage  
6 of additional benefits for immunosuppressive drugs under  
7 the amendments made by this section for drugs furnished  
8 in 2000 in the same manner as if such amendments con-  
9 stituted a national coverage determination described in the  
10 matter in such section before subparagraph (A).

11 (d) REPORT ON IMMUNOSUPPRESSIVE DRUG BEN-  
12 EFIT.—

13 (1) IN GENERAL.—Not later than March 1,  
14 2003, the Secretary of Health and Human Services  
15 shall submit to Congress a report on the operation  
16 of this section and the amendments made by this  
17 section. The report shall include—

18 (A) an analysis of the impact of this sec-  
19 tion; and

20 (B) recommendations regarding an appro-  
21 priate cost-effective method for providing cov-  
22 erage of immunosuppressive drugs under the  
23 medicare program on a permanent basis.

24 (2) CONSIDERATIONS.—In making rec-  
25 ommendations under paragraph (1)(B), the Sec-

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

4               (A) improving health outcomes (by de-  
5       creasing transplant rejection rates that are at-  
6       tributable to failure to comply with immuno-  
7       suppressive drug regimens);

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

12              (C) meeting the needs of those medicare  
13      beneficiaries who, because of income or other  
14      factors, would be less likely to maintain an im-  
15      munosuppressive drug regimen in the absence  
16      of such modifications.

17   **SEC. 228. TEMPORARY INCREASE IN PAYMENT RATES FOR**  
18                   **DURABLE MEDICAL EQUIPMENT AND OXY-**  
19                   **GEN.**

20       (a) **IN GENERAL.**—For purposes of payments under  
21      section 1834(a) of the Social Security Act (42 U.S.C.  
22      1395m(a)) for covered items (as defined in paragraph (13)  
23      of that section) furnished during 2001 and 2002, the Sec-  
24      retary of Health and Human Services shall increase the

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

3 (1) 2001 by 0.3 percent, and

4 (2) 2002 by 0.6 percent.

5 (b) LIMITING APPLICATION TO SPECIFIED YEARS.—

6 The payment amount increase—

7 (1) under subsection (a)(1) shall not apply after  
8 2001 and shall not be taken into account in calcu-  
9 lating the payment amounts applicable for covered  
10 items furnished after such year; and

11 (2) under subsection (a)(2) shall not apply after  
12 2002 and shall not be taken into account in calcu-  
13 lating the payment amounts applicable for covered  
14 items furnished after such year.

15 **SEC. 229. STUDIES AND REPORTS.**

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

18 (1) IN GENERAL.—The Medicare Payment Ad-  
19 visory Commission shall conduct a study on the cost-  
20 effectiveness and efficacy of covering under the  
21 medicare program under title XVIII of the Social  
22 Security Act services of a post-surgical recovery care  
23 center (that provides an intermediate level of recov-  
24 ery care following surgery). In conducting such

1 study, the Commission shall consider data on these  
2 centers gathered in demonstration projects.

3 (2) REPORT.—Not later than 1 year after the  
4 date of the enactment of this Act, the Commission  
5 shall submit to Congress a report on such study and  
6 shall include in the report recommendations on the  
7 feasibility, costs, and savings of covering such serv-  
8 ices under the medicare program.

9 (b) AHCPR STUDY ON EFFECT OF CREDENTIALING  
10 OF TECHNOLOGISTS AND SONOGRAPHERS ON QUALITY OF  
11 ULTRASOUND.—

12 (1) STUDY.—The Administrator for Health  
13 Care Policy and Research shall provide for a study  
14 that, with respect to the provision of ultrasound  
15 under the medicare and medicaid programs under ti-  
16 tles XVIII and XIX of the Social Security Act, com-  
17 pares differences in quality between ultrasound fur-  
18 nished by individuals who are credentialed by private  
19 entities or organizations and ultrasound furnished  
20 by those who are not so credentialed. Such study  
21 shall examine and evaluate differences in error rates,  
22 resulting complications, and patient outcomes as a  
23 result of the differences in credentialing. In design-  
24 ing the study, the Administrator shall consult with

1 organizations nationally recognized for their exper-  
2 tise in ultrasound.

3 (2) REPORT.—Not later than two years after  
4 the date of the enactment of this Act, the Adminis-  
5 trator shall submit a report to Congress on the  
6 study conducted under paragraph (1).

7 (c) MEDPAC STUDY ON THE COMPLEXITY OF THE  
8 MEDICARE PROGRAM AND THE LEVELS OF BURDENS  
9 PLACED ON PROVIDERS THROUGH FEDERAL REGULA-  
10 TIONS.—

11 (1) STUDY.—The Medicare Payment Advisory  
12 Commission shall undertake a comprehensive study  
13 to review the regulatory burdens placed on all class-  
14 es of health care providers under parts A and B of  
15 the medicare program under title XVIII of the So-  
16 cial Security Act and to determine the costs these  
17 burdens impose on the nation's health care system.  
18 The study shall also examine the complexity of the  
19 current regulatory system and its impact on pro-  
20 viders.

21 (2) REPORT.—Not later than December 31,  
22 2001, the Commission shall submit to Congress one  
23 or more reports on the study conducted under para-  
24 graph (1). The report shall include recommendations  
25 regarding—

1 (A) how the Health Care Financing Ad-  
2 ministration can reduce the regulatory burdens  
3 placed on patients and providers; and

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

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

12 (1) continue the monitoring, begun under sec-  
13 tion 118 of the Department of Justice Appropria-  
14 tions Act, 1999 (included in Public Law 105-277)  
15 of the compliance of the Department of Justice and  
16 all United States Attorneys with the “Guidance on  
17 the Use of the False Claims Act in Civil Health  
18 Care Matters” issued by the Department of Justice  
19 on June 3, 1998, including any revisions to that  
20 guidance; and

21 (2) not later than April 1, 2000, and of each  
22 of the two succeeding years, submit a report on such  
23 compliance to the appropriate Committees of Con-  
24 gress.

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

4   **SEC. 301. ADJUSTMENT TO REFLECT ADMINISTRATIVE**  
5                   **COSTS NOT INCLUDED IN THE INTERIM PAY-**  
6                   **MENT SYSTEM; GAO REPORT ON COSTS OF**  
7                   **COMPLIANCE WITH OASIS DATA COLLECTION**  
8                   **REQUIREMENTS.**

9           (a) ADJUSTMENT TO REFLECT ADMINISTRATIVE  
10   Costs.—

11           (1) IN GENERAL.—In the case of a home health  
12           agency that furnishes home health services to a  
13           medicare beneficiary, for each such beneficiary to  
14           whom the agency furnished such services during the  
15           agency's cost reporting period beginning in fiscal  
16           year 2000, the Secretary of Health and Human  
17           Services shall pay the agency, in addition to any  
18           amount of payment made under section  
19           1861(v)(1)(L) of the Social Security Act (42 U.S.C.  
20           1395x(v)(1)(L)) for the beneficiary and only for  
21           such cost reporting period, an aggregate amount of  
22           \$10 to defray costs incurred by the agency attrib-  
23           utable to data collection and reporting requirements  
24           under the Outcome and Assessment Information Set

1 (OASIS) required by reason of section 4602(e) of  
2 BBA (42 U.S.C. 1395fff note).

3 (2) PAYMENT SCHEDULE.—

4 (A) MIDYEAR PAYMENT.—Not later than  
5 April 1, 2000, the Secretary shall pay to a  
6 home health agency an amount that the Sec-  
7 retary estimates to be 50 percent of the aggre-  
8 gate amount payable to the agency by reason of  
9 this subsection.

10 (B) UPON SETTLED COST REPORT.—The  
11 Secretary shall pay the balance of amounts pay-  
12 able to an agency under this subsection on the  
13 date that the cost report submitted by the agen-  
14 cy for the cost reporting period beginning in fis-  
15 cal year 2000 is settled.

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

21 (4) DEFINITIONS.—In this subsection:

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

1 (B) HOME HEALTH SERVICES.—The term  
2 “home health services” has the meaning given  
3 that term under section 1861(m) of such Act  
4 (42 U.S.C. 1395x(m)).

5 (C) MEDICARE BENEFICIARY.—The term  
6 “medicare beneficiary” means a beneficiary de-  
7 scribed in section 1861(v)(1)(L)(vi)(II) of the  
8 Social Security Act (42 U.S.C.  
9 1395x(v)(1)(L)(vi)(II)).

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

12 (1) REPORT TO CONGRESS.—

13 (A) IN GENERAL.—Not later than 180  
14 days after the date of the enactment of this  
15 Act, the Comptroller General of the United  
16 States shall submit to Congress a report on the  
17 matters described in subparagraph (B) with re-  
18 spect to the data collection requirement of pa-  
19 tients of such agencies under the Outcome and  
20 Assessment Information Set (OASIS) standard  
21 as part of the comprehensive assessment of pa-  
22 tients.

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

1 (i) An assessment of the costs in-  
2 curred by medicare home health agencies  
3 in complying with such data collection re-  
4 quirement.

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

9 (C) AUDIT.—The Comptroller General  
10 shall conduct an independent audit of the costs  
11 described in subparagraph (B)(i). Not later  
12 than 180 days after receipt of the report under  
13 subparagraph (A), the Comptroller General  
14 shall submit to Congress a report describing the  
15 Comptroller General's findings with respect to  
16 such audit, and shall include comments on the  
17 report submitted to Congress by the Secretary  
18 of Health and Human Services under subpara-  
19 graph (A).

20 (2) DEFINITIONS.—In this subsection:

21 (A) COMPREHENSIVE ASSESSMENT OF PA-  
22 TIENTS.—The term “comprehensive assessment  
23 of patients” means the rule published by the  
24 Health Care Financing Administration that re-  
25 quires, as a condition of participation in the

1 medicare program, a home health agency to  
2 provide a patient-specific comprehensive assess-  
3 ment that accurately reflects the patient's cur-  
4 rent status and that incorporates the Outcome  
5 and Assessment Information Set (OASIS).

6 (B) OUTCOME AND ASSESSMENT INFORMA-  
7 TION SET.—The term “Outcome and Assess-  
8 ment Information Set” means the standard pro-  
9 vided under the rule relating to data items that  
10 must be used in conducting a comprehensive as-  
11 sessment of patients.

12 **SEC. 302. DELAY IN APPLICATION OF 15 PERCENT REDUC-**  
13 **TION IN PAYMENT RATES FOR HOME HEALTH**  
14 **SERVICES UNTIL ONE YEAR AFTER IMPLE-**  
15 **MENTATION OF PROSPECTIVE PAYMENT SYS-**  
16 **TEM.**

17 (a) CONTINGENCY REDUCTION.—Section 4603 of  
18 BBA (42 U.S.C. 1395fff note) (as amended by section  
19 5101(c)(3) of the Tax and Trade Relief Extension Act of  
20 1998 (contained in division J of Public Law 105–277))  
21 is amended by striking subsection (e).

22 (b) PROSPECTIVE PAYMENT SYSTEM.—Section  
23 1895(b)(3)(A)(i) (42 U.S.C. 1395fff(b)(3)(A)(i)) (as  
24 amended by section 5101 of the Tax and Trade Relief Ex-

1 tension Act of 1998 (contained in division J of Public Law  
2 105-277)) is amended to read as follows:

3 “(i) IN GENERAL.—Under such sys-  
4 tem the Secretary shall provide for com-  
5 putation of a standard prospective pay-  
6 ment amount (or amounts) as follows:

7 “(I) Such amount (or amounts)  
8 shall initially be based on the most  
9 current audited cost report data avail-  
10 able to the Secretary and shall be  
11 computed in a manner so that the  
12 total amounts payable under the sys-  
13 tem for the 12-month period begin-  
14 ning on the date the Secretary imple-  
15 ments the system shall be equal to the  
16 total amount that would have been  
17 made if the system had not been in ef-  
18 fect.

19 “(II) For periods beginning after  
20 the period described in subclause (I),  
21 such amount (or amounts) shall be  
22 equal to the amount (or amounts)  
23 that would have been determined  
24 under subclause (I) that would have  
25 been made for fiscal year 2001 if the

1 system had not been in effect but if  
2 the reduction in limits described in  
3 clause (ii) had been in effect, updated  
4 under subparagraph (B).

5 Each such amount shall be standardized in  
6 a manner that eliminates the effect of vari-  
7 ations in relative case mix and area wage  
8 adjustments among different home health  
9 agencies in a budget neutral manner con-  
10 sistent with the case mix and wage level  
11 adjustments provided under paragraph  
12 (4)(A). Under the system, the Secretary  
13 may recognize regional differences or dif-  
14 ferences based upon whether or not the  
15 services or agency are in an urbanized  
16 area.”.

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

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

3 **SEC. 303. INCREASE IN PER BENEFICIARY LIMITS.**

4 (a) INCREASE IN PER BENEFICIARY LIMITS.—Sec-  
5 tion 1861(v)(1)(L) of the Social Security Act (42 U.S.C.  
6 1395x(v)(1)(L)), as amended by section 5101 of the Tax  
7 and Trade Relief Extension Act of 1998 (contained in Di-  
8 vision J of Public Law 105–277), is amended—

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

10 and

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

13 “(ix) Notwithstanding the per beneficiary limit under  
14 clause (viii), if the limit imposed under clause (v) (deter-  
15 mined without regard to this clause) for a cost reporting  
16 period beginning during or after fiscal year 2000 is less  
17 than the median described in clause (vi)(I) (but deter-  
18 mined as if any reference in clause (v) to ‘98 percent’ were  
19 a reference to ‘100 percent’), the limit otherwise imposed  
20 under clause (v) for such provider and period shall be in-  
21 creased by 2 percent.”.

22 (b) INCREASE NOT INCLUDED IN PPS BASE.—The  
23 second sentence of section 1895(b)(3)(A)(i) (42 U.S.C.  
24 1395fff(b)(3)(A)(i)), as amended by section 302(b), is fur-  
25 ther amended—

1 (1) in subclause (I), by inserting “and if section  
2 1861(v)(1)(L)(ix) had not been enacted” before the  
3 semicolon; and

4 (2) in subclause (II), by inserting “and if sec-  
5 tion 1861(v)(1)(L)(ix) had not been enacted” after  
6 “if the system had not been in effect”.

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

11 **SEC. 304. CLARIFICATION OF SURETY BOND REQUIRE-**  
12 **MENTS.**

13 (a) HOME HEALTH AGENCIES.—Section 1861(o)(7)  
14 (42 U.S.C. 1395x(o)(7)) is amended to read as follows:

15 “(7) provides the Secretary with a surety  
16 bond—

17 “(A) effective for a period of 4 years (as  
18 specified by the Secretary) or in the case of a  
19 change in the ownership or control of the agen-  
20 cy (as determined by the Secretary) during or  
21 after such 4-year period, an additional period of  
22 time that the Secretary determines appropriate,  
23 such additional period not to exceed 4 years  
24 from the date of such change in ownership or  
25 control;



1 home health agency had a surety bond in effect under such  
2 section before such date.

3 **SEC. 305. REFINEMENT OF HOME HEALTH AGENCY CON-**  
4 **SOLIDATED BILLING.**

5 (a) IN GENERAL.—Section 1842(b)(6)(F) (42 U.S.C.  
6 1395u(b)(6)(F)) is amended by inserting “(including med-  
7 ical supplies described in section 1861(m)(5), but exclud-  
8 ing durable medical equipment to the extent provided for  
9 in such section)” after “home health services”.

10 (b) CONFORMING AMENDMENT.—Section  
11 1862(a)(21) (42 U.S.C. 1395y(a)(21)) is amended by in-  
12 serting “(including medical supplies described in section  
13 1861(m)(5), but excluding durable medical equipment to  
14 the extent provided for in such section)” after “home  
15 health services”.

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

19 **SEC. 306. TECHNICAL AMENDMENT CLARIFYING APPLICA-**  
20 **BLE MARKET BASKET INCREASE FOR PPS.**

21 Section 1895(b)(3)(B)(ii)(I) (42 U.S.C.  
22 1395fff(b)(3)(B)(ii)(I)) is amended by striking “fiscal  
23 year 2002 or 2003” and inserting “each of fiscal years  
24 2002 and 2003”.

1 **SEC. 307. STUDY AND REPORT TO CONGRESS REGARDING**  
2 **THE EXEMPTION OF RURAL AGENCIES AND**  
3 **POPULATIONS FROM INCLUSION IN THE**  
4 **HOME HEALTH PROSPECTIVE PAYMENT SYS-**  
5 **TEM.**

6 (a) **STUDY.**—The Medicare Payment Advisory Com-  
7 mission (referred to in this section as “MedPAC”) shall  
8 conduct a study to determine the feasibility and advis-  
9 ability of exempting home health services provided by a  
10 home health agency (or by others under arrangements  
11 with such agency) located in a rural area, or to an indi-  
12 vidual residing in a rural area, from payment under the  
13 prospective payment system for such services established  
14 by the Secretary of Health and Human Services in accord-  
15 ance with section 1895 of the Social Security Act (42  
16 U.S.C. 1395fff).

17 (b) **REPORT.**—Not later than 2 years after the date  
18 of the enactment of this Act, MedPAC shall submit a re-  
19 port to Congress on the study conducted under subsection  
20 (a), together with any recommendations for legislation  
21 that MedPAC determines to be appropriate as a result of  
22 such study.

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

3   **SEC. 311. USE OF NATIONAL AVERAGE PAYMENT METHOD-**  
4                   **LOGY IN COMPUTING DIRECT GRADUATE**  
5                   **MEDICAL EDUCATION (DGME) PAYMENTS.**

6           (a) IN GENERAL.—Section 1886(h)(2) (42 U.S.C.  
7 1395ww(h)(2)) is amended—

8                   (1) in subparagraph (D)(i), by striking “clause  
9           (ii)” and inserting “a subsequent clause”;

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

12                           “(iii) FLOOR IN FISCAL YEAR 2001 AT  
13                           70 PERCENT OF LOCALITY ADJUSTED NA-  
14                           TIONAL AVERAGE PER RESIDENT  
15                           AMOUNT.—The approved FTE resident  
16                           amount for a hospital for the cost report-  
17                           ing period beginning during fiscal year  
18                           2001 shall not be less than 70 percent of  
19                           the locality adjusted national average per  
20                           resident amount computed under subpara-  
21                           graph (E) for the hospital and period.

22                           “(iv) ADJUSTMENT IN RATE OF IN-  
23                           CREASE FOR HOSPITALS WITH FTE AP-  
24                           PROVED AMOUNT ABOVE 140 PERCENT OF

1 LOCALITY ADJUSTED NATIONAL AVERAGE  
2 PER RESIDENT AMOUNT.—

3 “(I) FREEZE FOR FISCAL YEARS  
4 2001 AND 2002.—For a cost reporting  
5 period beginning during fiscal year  
6 2001 or fiscal year 2002, if the ap-  
7 proved FTE resident amount for a  
8 hospital for the preceding cost report-  
9 ing period exceeds 140 percent of the  
10 locality adjusted national average per  
11 resident amount computed under sub-  
12 paragraph (E) for that hospital and  
13 period, subject to subclause (III), the  
14 approved FTE resident amount for  
15 the period involved shall be the same  
16 as the approved FTE resident amount  
17 for the hospital for such preceding  
18 cost reporting period.

19 “(II) 2 PERCENT DECREASE IN  
20 UPDATE FOR FISCAL YEARS 2003, 2004,  
21 AND 2005.—For a cost reporting pe-  
22 riod beginning during fiscal year  
23 2003, fiscal year 2004, or fiscal year  
24 2005, if the approved FTE resident  
25 amount for a hospital for the pre-

1 ceding cost reporting period exceeds  
2 140 percent of the locality adjusted  
3 national average per resident amount  
4 computed under subparagraph (E) for  
5 that hospital and preceding period,  
6 the approved FTE resident amount  
7 for the period involved shall be up-  
8 dated in the manner described in sub-  
9 paragraph (D)(i) except that, subject  
10 to subclause (III), the consumer price  
11 index applied for a 12-month period  
12 shall be reduced (but not below zero)  
13 by 2 percentage points.

14 “(III) NO ADJUSTMENT BELOW  
15 140 PERCENT.—In no case shall sub-  
16 clause (I) or (II) reduce an approved  
17 FTE resident amount for a hospital  
18 for a cost reporting period below 140  
19 percent of the locality adjusted na-  
20 tional average per resident amount  
21 computed under subparagraph (E) for  
22 such hospital and period.”;

23 (3) by redesignating subparagraph (E) as sub-  
24 paragraph (F); and

1           (4) by inserting after subparagraph (D) the fol-  
2           lowing new subparagraph:

3           “(E) DETERMINATION OF LOCALITY AD-  
4           JUSTED NATIONAL AVERAGE PER RESIDENT  
5           AMOUNT.—The Secretary shall determine a lo-  
6           cality adjusted national average per resident  
7           amount with respect to a cost reporting period  
8           of a hospital beginning during a fiscal year as  
9           follows:

10           “(i) DETERMINING HOSPITAL SINGLE  
11           PER RESIDENT AMOUNT.—The Secretary  
12           shall compute for each hospital operating  
13           an approved graduate medical education  
14           program a single per resident amount  
15           equal to the average (weighted by number  
16           of full-time equivalent residents, as deter-  
17           mined under paragraph (4)) of the primary  
18           care per resident amount and the non-pri-  
19           mary care per resident amount computed  
20           under paragraph (2) for cost reporting pe-  
21           riods ending during fiscal year 1997.

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

1 resident amount computed under clause (i)  
2 by an average of the 3 geographic index  
3 values (weighted by the national average  
4 weight for each of the work, practice ex-  
5 pense, and malpractice components) as ap-  
6 plied under section 1848(e) for 1999 for  
7 the fee schedule area in which the hospital  
8 is located.

9 “(iii) COMPUTING OF WEIGHTED AV-  
10 ERAGE.—The Secretary shall compute the  
11 average of the standardized per resident  
12 amounts computed under clause (ii) for  
13 such hospitals, with the amount for each  
14 hospital weighted by the average number  
15 of full-time equivalent residents at such  
16 hospital (as determined under paragraph  
17 (4)).

18 “(iv) COMPUTING NATIONAL AVERAGE  
19 PER RESIDENT AMOUNT.—The Secretary  
20 shall compute the national average per  
21 resident amount, for a hospital’s cost re-  
22 porting period that begins during fiscal  
23 year 2001, equal to the weighted average  
24 computed under clause (iii) increased by  
25 the estimated percentage increase in the

1 consumer price index for all urban con-  
2 sumers during the period beginning with  
3 the month that represents the midpoint of  
4 the cost reporting periods described in  
5 clause (i) and ending with the midpoint of  
6 the hospital's cost reporting period that be-  
7 gins during fiscal year 2001.

8 “(v) ADJUSTING FOR LOCALITY.—The  
9 Secretary shall compute the product of—

10 “(I) the national average per  
11 resident amount computed under  
12 clause (iv) for the hospital, and

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

17 “(vi) COMPUTING LOCALITY AD-  
18 JUSTED AMOUNT.—The locality adjusted  
19 national per resident amount for a hospital  
20 for—

21 “(I) the cost reporting period be-  
22 ginning during fiscal year 2001 is the  
23 product computed under clause (v); or

24 “(II) each subsequent cost re-  
25 porting period is equal to the locality

1 adjusted national per resident amount  
2 for the hospital for the previous cost  
3 reporting period (as determined under  
4 this clause) updated, through the mid-  
5 point of the period, by projecting the  
6 estimated percentage change in the  
7 consumer price index for all urban  
8 consumers during the 12-month pe-  
9 riod ending at that midpoint.”.

10 (b) CONFORMING AMENDMENTS.—Section  
11 1886(h)(2)(D) (42 U.S.C. 1395ww(h)(2)(D)) is further  
12 amended—

13 (1) in clause (i)—

14 (A) by striking “PERIODS.—(i)” and in-  
15 serting the following (and conforming the in-  
16 dentation of the succeeding matter accordingly):

17 “PERIODS.—

18 “(i) IN GENERAL.—”; and

19 (B) by striking “the amount determined”  
20 and inserting “the approved FTE resident  
21 amount determined”; and

22 (2) in clause (ii)—

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

1 (B) by inserting “FREEZE IN UPDATE FOR  
2 FISCAL YEARS 1994 AND 1995.—” after “(ii)”.

3 **SEC. 312. INITIAL RESIDENCY PERIOD FOR CHILD NEU-**  
4 **ROLOGY RESIDENCY TRAINING PROGRAMS.**

5 (a) IN GENERAL.—Section 1886(h)(5) (42 U.S.C.  
6 1395ww(h)(5)) is amended—

7 (1) in the last sentence of subparagraph (F), by  
8 striking “The initial residency period” and inserting  
9 “Subject to subparagraph (G)(v), the initial resi-  
10 dency period”; and

11 (2) in subparagraph (G)—

12 (A) in clause (i) by striking “and (iv)” and  
13 inserting “(iv), and (v)”; and

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

16 “(v) CHILD NEUROLOGY TRAINING  
17 PROGRAMS.—In the case of a resident en-  
18 rolled in a child neurology residency train-  
19 ing program, the period of board eligibility  
20 and the initial residency period shall be the  
21 period of board eligibility for pediatrics  
22 plus 2 years.”.

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

1 dency programs that began before, on, or after the date  
2 of the enactment of this Act.

3 (c) MEDPAC REPORT.—The Medicare Payment Ad-  
4 visory Commission shall include in its report submitted to  
5 Congress in March of 2001 recommendations regarding  
6 the appropriateness of the initial residency period used  
7 under section 1886(h)(5)(F) of the Social Security Act  
8 (42 U.S.C. 1395ww(h)(5)(F)) for other residency training  
9 programs in a specialty that require preliminary years of  
10 study in another specialty.

## 11 **Subtitle C—Technical Corrections**

### 12 **SEC. 321. BBA TECHNICAL CORRECTIONS.**

13 (a) SECTION 4201.—Section 1820(c)(2)(B)(i) (42  
14 U.S.C. 1395i-4(c)(2)(B)(i)) is amended by striking “and  
15 is located in a county (or equivalent unit of local govern-  
16 ment) in a rural area (as defined in section  
17 1886(d)(2)(D)) that” and inserting “that is located in a  
18 county (or equivalent unit of local government) in a rural  
19 area (as defined in section 1886(d)(2)(D)), and that”.

20 (b) SECTION 4204.—(1) Section 1886(d)(5)(G) (42  
21 U.S.C. 1395ww(d)(5)(G)) is amended—

22 (A) in clause (i), by striking “or beginning on  
23 or after October 1, 1997, and before October 1,  
24 2001,” and inserting “or discharges occurring on or

1 after October 1, 1997, and before October 1,  
2 2001.”; and

3 (B) in clause (ii)(II), by striking “or beginning  
4 on or after October 1, 1997, and before October 1,  
5 2001,” and inserting “or discharges occurring on or  
6 after October 1, 1997, and before October 1,  
7 2001.”.

8 (2) Section 1886(b)(3)(D) (42 U.S.C.  
9 1395ww(b)(3)(D)) is amended in the matter preceding  
10 clause (i) by striking “and for cost reporting periods be-  
11 ginning on or after October 1, 1997, and before October  
12 1, 2001,” and inserting “and for discharges beginning on  
13 or after October 1, 1997, and before October 1, 2001.”.

14 (c) SECTION 4319.—Section 1847(b)(2) (42 U.S.C.  
15 1395w-3(b)(2)) is amended by inserting “and” after  
16 “specified by the Secretary”.

17 (d) SECTION 4401.—Section 4401(b)(1)(B) of BBA  
18 (42 U.S.C. 1395ww note) is amended by striking “section  
19 1886(b)(3)(B)(i)(XIII) of the Social Security Act (42  
20 U.S.C. 1395ww(b)(3)(B)(i)(XIII))” and inserting “sec-  
21 tion 1886(b)(3)(B)(i)(XIV) of the Social Security Act (42  
22 U.S.C. 1395ww(b)(3)(B)(i)(XIV))”.

23 (e) SECTION 4402.—The last sentence of section  
24 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended

1 by striking “September 30, 2002,” and inserting “October  
2 1, 2002,”.

3 (f) SECTION 4419.—The first sentence of section  
4 1886(b)(4)(A)(i) (42 U.S.C. 1395ww(b)(4)(A)(i)) is  
5 amended by striking “or unit”.

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

9 (2) Section 1833(h)(5)(A)(iii) (42 U.S.C.  
10 1395l(h)(5)(A)(iii)) is amended—

11 (A) by striking “or critical access hospital,” and  
12 inserting “, critical access hospital, or skilled nurs-  
13 ing facility,”; and

14 (B) by inserting “or skilled nursing facility” be-  
15 fore the period.

16 (h) SECTION 4416.—Section 1886(b)(7)(A)(i)(II)  
17 (42 U.S.C. 1395ww(b)(7)(A)(i)(II)) is amended by insert-  
18 ing “(as estimated by the Secretary)” after “median”.

19 (i) SECTION 4442.—Section 4442(b) of BBA (42  
20 U.S.C. 1395f note) is amended by striking “applies to cost  
21 reporting periods beginning” and inserting “applies to  
22 items and services furnished”.

23 (j) HIPAA SECTION 201.—

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

1 “section 982(a)(6)(B)” and inserting “section  
2 24(a)”.

3 (2) EFFECTIVE DATE.—The amendment made  
4 by this subsection shall take effect as if included in  
5 the amendment made by section 201 of the Health  
6 Insurance Portability and Accountability Act of  
7 1996 (Public Law 104–191; 110 Stat. 1992).

8 (k) OTHER TECHNICAL AMENDMENTS.—

9 (1) SECTION 4611.—Section 1812(b) (42 U.S.C.  
10 1395d(b)) is amended in the matter following para-  
11 graph (3) by inserting “during” after “100 visits”.

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

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

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

19 (B) in clause (v), by striking “, and” and  
20 inserting “; and”.

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

24 (5) SECTIONS 4103, 4104, AND 4106.—

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

4 (B) SECTION 4104.—Such section is fur-  
5 ther amended by striking “(B),” and inserting  
6 “(B),”.

7 (C) SECTION 4106.—Such section is further  
8 amended by striking “and (15)” and inserting  
9 “, and (15)”.

10 (6) SECTION 4001.—(A) Section 1851(i)(2) (42  
11 U.S.C. 1395w-21(i)(2)) is amended by striking  
12 “and” after “1857(f)(2),”.

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

15 (i) in subsection (a)(3)(A)—

16 (I) by striking the comma after “MSA  
17 plan”; and

18 (II) by inserting a comma after “the  
19 coverage”;

20 (ii) in subsection (g)—

21 (I) in paragraph (1)(B), by inserting  
22 “or” after “in whole”; and

23 (II) in paragraph (3)(B)(ii), by insert-  
24 ing a period at the end;

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

3 (iv) in subsection (k)(2)(C)(ii), by striking  
4 “balancing” and inserting “balance”.

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

7 (i) in paragraph (2)—

8 (I) in subparagraph (A), in the matter  
9 preceding clause (i), by inserting “section”  
10 before “1852(a)(1)(A)”; and

11 (II) in subparagraph (B), in the mat-  
12 ter preceding clause (i), by inserting “sec-  
13 tion” after “described in”;

14 (ii) in paragraph (3)—

15 (I) in subparagraph (A), by inserting  
16 “section” after “described in”; and

17 (II) in subparagraph (B), by inserting  
18 “section” after “described in”; and

19 (iii) in paragraph (4)—

20 (I) in the matter preceding subpara-  
21 graph (A), by inserting “section” after  
22 “described in”;

23 (II) in subparagraph (A), in the mat-  
24 ter preceding clause (i), by inserting “sec-  
25 tion” after “described in”; and

1 (III) in subparagraph (B), by insert-  
2 ing “section” after “described in”.

3 (7) SECTION 4557.—Section 1861(s)(2)(T)(ii)  
4 (42 U.S.C. 1395x(s)(2)(T)(ii)) is amended by strik-  
5 ing the period and inserting a semicolon.

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

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

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

14 (9) SECTION 4454.—Section 1861(ss)(1)(G)(i)  
15 (42 U.S.C. 1395x(ss)(1)(G)(i)) is amended—

16 (A) by striking “owed” and inserting  
17 “owned”; and

18 (B) by striking “of” and inserting “or”.

19 (10) SECTION 4103.—Section 1862(a)(7) (42  
20 U.S.C. 1395y(a)(7)) is amended by striking “sub-  
21 paragraphs” and inserting “subparagraph”.

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

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

1 (B) in subparagraph (N)(iv), by striking  
2 “and” at the end; and

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

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

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

10 (B) in subparagraph (R), by inserting “,  
11 and” at the end.

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

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

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

21 (A) in paragraph (1), in the matter fol-  
22 lowing subparagraph (C), by inserting a comma  
23 after “paragraph (2)”; and

24 (B) in paragraph (3)(B)(ii)—

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

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

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

8 (17) SECTION 4406.—Section 1886(d)(9)(A)(ii)  
9 (42 U.S.C. 1395ww(d)(9)(A)(ii)) is amended by in-  
10 sserting a comma after “1987”.

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

13 (A) in clause (i), by striking “federal” and  
14 inserting “Federal”; and

15 (B) in clause (ii), in the matter preceding  
16 subclause (I), by striking “federal” each place  
17 it appears and inserting “Federal”.

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

21 (I) SECTION 1135 OF THE SOCIAL SECURITY ACT.—  
22 Effective on the date of the enactment of this Act, section  
23 1135 (42 U.S.C. 1320b–5) is repealed.

1 (m) EFFECTIVE DATE.—Except as otherwise pro-  
2 vided, the amendments made by this section shall take ef-  
3 fect as if included in the enactment of BBA.

4 **TITLE IV—RURAL PROVIDER**  
5 **PROVISIONS**

6 **Subtitle A—Rural Hospitals**

7 **SEC. 401. PERMITTING RECLASSIFICATION OF CERTAIN**  
8 **URBAN HOSPITALS AS RURAL HOSPITALS.**

9 (a) IN GENERAL.—Section 1886(d)(8) (42 U.S.C.  
10 1395ww(d)(8)) is amended by adding at the end the fol-  
11 lowing new subparagraph:

12 “(E)(i) For purposes of this subsection, not later  
13 than 60 days after the receipt of an application (in a form  
14 and manner determined by the Secretary) from a sub-  
15 section (d) hospital described in clause (ii), the Secretary  
16 shall treat the hospital as being located in the rural area  
17 (as defined in paragraph (2)(D)) of the State in which  
18 the hospital is located.

19 “(ii) For purposes of clause (i), a subsection (d) hos-  
20 pital described in this clause is a subsection (d) hospital  
21 that is located in an urban area (as defined in paragraph  
22 (2)(D)) and satisfies any of the following criteria:

23 “(I) The hospital is located in a rural census  
24 tract of a metropolitan statistical area (as deter-  
25 mined under the most recent modification of the

1 Goldsmith Modification, originally published in the  
2 Federal Register on February 27, 1992 (57 Fed.  
3 Reg. 6725)).

4 “(II) The hospital is located in an area des-  
5 ignated by any law or regulation of such State as a  
6 rural area (or is designated by such State as a rural  
7 hospital).

8 “(III) The hospital would qualify as a rural, re-  
9 gional, or national referral center under paragraph  
10 (5)(C) or as a sole community hospital under para-  
11 graph (5)(D) if the hospital were located in a rural  
12 area.

13 “(IV) The hospital meets such other criteria as  
14 the Secretary may specify.”.

15 (b) CONFORMING CHANGES.—(1) Section 1833(t)  
16 (42 U.S.C. 1395l(t)), as amended by sections 201 and  
17 202, is further amended by adding at the end the following  
18 new paragraph:

19 “(13) MISCELLANEOUS PROVISIONS.—

20 “(A) APPLICATION OF RECLASSIFICATION  
21 OF CERTAIN HOSPITALS.—If a hospital is being  
22 treated as being located in a rural area under  
23 section 1886(d)(8)(E), that hospital shall be  
24 treated under this subsection as being located  
25 in that rural area.”.

1           (2) Section 1820(c)(2)(B)(i) (42 U.S.C. 1395i-  
2 4(c)(2)(B)(i)) is amended, in the matter preceding sub-  
3 clause (I), by inserting “or is treated as being located in  
4 a rural area pursuant to section 1886(d)(8)(E)” after  
5 “section 1886(d)(2)(D)”.

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

8 **SEC. 402. UPDATE OF STANDARDS APPLIED FOR GEO-**  
9 **GRAPHIC RECLASSIFICATION FOR CERTAIN**  
10 **HOSPITALS.**

11           (a) IN GENERAL.—Section 1886(d)(8)(B) (42 U.S.C.  
12 1395ww(d)(8)(B)) is amended—

13                 (1) by inserting “(i)” after “(B)”;

14                 (2) by striking “published in the Federal Reg-  
15 ister on January 3, 1980” and inserting “described  
16 in clause (ii)”;

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

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

21                 “(I) before fiscal year 2003, are the standards  
22 published in the Federal Register on January 3,  
23 1980, or, at the election of the hospital with respect  
24 to fiscal years 2001 and 2002, standards so pub-  
25 lished on March 30, 1990; and



1 PITAL.—Section 1820(c)(2)(B)(i) (42 U.S.C. 1395i–  
2 4(c)(2)(B)(i)) is amended in the matter preceding sub-  
3 clause (I), by striking “nonprofit or public hospital” and  
4 inserting “hospital”.

5 (c) ALLOWING CLOSED OR DOWNSIZED HOSPITALS  
6 TO CONVERT TO CRITICAL ACCESS HOSPITALS.—Section  
7 1820(c)(2) (42 U.S.C. 1395i–4(c)(2)) is amended—

8 (1) in subparagraph (A), by striking “subpara-  
9 graph (B)” and inserting “subparagraphs (B), (C),  
10 and (D)”; and

11 (2) by adding at the end the following new sub-  
12 paragraphs:

13 “(C) RECENTLY CLOSED FACILITIES.—A  
14 State may designate a facility as a critical ac-  
15 cess hospital if the facility—

16 “(i) was a hospital that ceased oper-  
17 ations on or after the date that is 10 years  
18 before the date of the enactment of this  
19 subparagraph; and

20 “(ii) as of the effective date of such  
21 designation, meets the criteria for designa-  
22 tion under subparagraph (B).

23 “(D) DOWNSIZED FACILITIES.—A State  
24 may designate a health clinic or a health center

1 (as defined by the State) as a critical access  
2 hospital if such clinic or center—

3 “(i) is licensed by the State as a  
4 health clinic or a health center;

5 “(ii) was a hospital that was  
6 downsized to a health clinic or health cen-  
7 ter; and

8 “(iii) as of the effective date of such  
9 designation, meets the criteria for designa-  
10 tion under subparagraph (B).”.

11 (d) ELECTION OF COST-BASED PAYMENT OPTION  
12 FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERV-  
13 ICES.—

14 (1) IN GENERAL.—Section 1834(g) (42 U.S.C.  
15 1395m(g)) is amended to read as follows:

16 “(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS  
17 HOSPITAL SERVICES.—

18 “(1) IN GENERAL.—The amount of payment  
19 for outpatient critical access hospital services of a  
20 critical access hospital is the reasonable costs of the  
21 hospital in providing such services, unless the hos-  
22 pital makes the election under paragraph (2).

23 “(2) ELECTION OF COST-BASED HOSPITAL OUT-  
24 PATIENT SERVICE PAYMENT PLUS FEE SCHEDULE  
25 FOR PROFESSIONAL SERVICES.—A critical access

1 hospital may elect to be paid for outpatient critical  
2 access hospital services amounts equal to the sum of  
3 the following, less the amount that such hospital  
4 may charge as described in section 1866(a)(2)(A):

5 “(A) FACILITY FEE.—With respect to fa-  
6 cility services, not including any services for  
7 which payment may be made under subpara-  
8 graph (B), the reasonable costs of the critical  
9 access hospital in providing such services.

10 “(B) FEE SCHEDULE FOR PROFESSIONAL  
11 SERVICES.—With respect to professional serv-  
12 ices otherwise included within outpatient critical  
13 access hospital services, such amounts as would  
14 otherwise be paid under this part if such serv-  
15 ices were not included in outpatient critical ac-  
16 cess hospital services.

17 “(3) DISREGARDING CHARGES.—The payment  
18 amounts under this subsection shall be determined  
19 without regard to the amount of the customary or  
20 other charge.”.

21 (2) EFFECTIVE DATE.—The amendment made  
22 by subsection (a) shall apply for cost reporting peri-  
23 ods beginning on or after October 1, 2000.

1 (e) ELIMINATION OF COINSURANCE FOR CLINICAL  
2 DIAGNOSTIC LABORATORY TESTS FURNISHED BY A CRIT-  
3 ICAL ACCESS HOSPITAL ON AN OUTPATIENT BASIS.—

4 (1) IN GENERAL.—Paragraphs (1)(D)(i) and  
5 (2)(D)(i) of section 1833(a) (42 U.S.C. 1395l(a))  
6 are each amended by inserting “or which are fur-  
7 nished on an outpatient basis by a critical access  
8 hospital” after “on an assignment-related basis”.

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

12 (f) PARTICIPATION IN SWING BED PROGRAM.—Sec-  
13 tion 1883 (42 U.S.C. 1395tt) is amended—

14 (1) in subsection (a)(1), by striking “(other  
15 than a hospital which has in effect a waiver under  
16 subparagraph (A) of the last sentence of section  
17 1861(e))”; and

18 (2) in subsection (c), by striking “, or during  
19 which there is in effect for the hospital a waiver  
20 under subparagraph (A) of the last sentence of sec-  
21 tion 1861(e)”.

1 **SEC. 404. 5-YEAR EXTENSION OF MEDICARE DEPENDENT**  
2 **HOSPITAL (MDH) PROGRAM.**

3 (a) EXTENSION OF PAYMENT METHODOLOGY.—Sec-  
4 tion 1886(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(G)) is  
5 amended—

6 (1) in clause (i), by striking “and before Octo-  
7 ber 1, 2001,” and inserting “and before October 1,  
8 2006,”; and

9 (2) in clause (ii)(II), by striking “and before  
10 October 1, 2001,” and inserting “and before Octo-  
11 ber 1, 2006,”.

12 (b) CONFORMING AMENDMENTS.—

13 (1) EXTENSION OF TARGET AMOUNT.—Section  
14 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)) is  
15 amended—

16 (A) in the matter preceding clause (i), by  
17 striking “and before October 1, 2001,” and in-  
18 serting “and before October 1, 2006,”; and

19 (B) in clause (iv), by striking “during fis-  
20 cal year 1998 through fiscal year 2000” and in-  
21 serting “during fiscal year 1998 through fiscal  
22 year 2005”.

23 (2) PERMITTING HOSPITALS TO DECLINE RE-  
24 CLASSIFICATION.—Section 13501(e)(2) of Omnibus  
25 Budget Reconciliation Act of 1993 (42 U.S.C.  
26 1395ww note), as amended by section 4204(a)(3) of

1 BBA, is amended by striking “or fiscal year 2000”  
2 and inserting “or fiscal year 2000 through fiscal  
3 year 2005”.

4 **SEC. 405. REBASING FOR CERTAIN SOLE COMMUNITY HOS-**  
5 **PITALS.**

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

8 (1) in subparagraph (C), by inserting “subject  
9 to subparagraph (I),” before “the term ‘target  
10 amount’ means”; and

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

13 “(I)(i) For cost reporting periods beginning on or  
14 after October 1, 2000, in the case of a sole community  
15 hospital that for its cost reporting period beginning during  
16 1999 is paid on the basis of the target amount applicable  
17 to the hospital under subparagraph (C) and that elects  
18 (in a form and manner determined by the Secretary) this  
19 subparagraph to apply to the hospital, there shall be sub-  
20 stituted for such target amount—

21 “(I) with respect to discharges occurring in fis-  
22 cal year 2001, 75 percent of the target amount oth-  
23 erwise applicable to the hospital under subparagraph  
24 (C) (referred to in this clause as the ‘subparagraph

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

3 “(II) with respect to discharges occurring in fis-  
4 cal year 2002, 50 percent of the subparagraph (C)  
5 target amount and 50 percent of the rebased target  
6 amount;

7 “(III) with respect to discharges occurring in  
8 fiscal year 2003, 25 percent of the subparagraph (C)  
9 target amount and 75 percent of the rebased target  
10 amount; and

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

14 “(ii) For purposes of this subparagraph, the ‘rebased  
15 target amount’ has the meaning given the term ‘target  
16 amount’ in subparagraph (C) except that—

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

20 “(II) any reference in subparagraph (C)(i) to  
21 the ‘first cost reporting period’ described in such  
22 subparagraph is deemed a reference to the first cost  
23 reporting period beginning on or after October 1,  
24 2000; and

1           “(III) applicable increase percentage shall only  
2           be applied under subparagraph (C)(iv) for dis-  
3           charges occurring in fiscal years beginning with fis-  
4           cal year 2002.”.

5   **SEC. 406. ONE YEAR SOLE COMMUNITY HOSPITAL PAY-**  
6                           **MENT INCREASE.**

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

9           (1) by redesignating subclause (XVII) as sub-  
10          clause (XVIII);

11          (2) by striking subclause (XVI); and

12          (3) by inserting after subclause (XV) the fol-  
13          lowing new subclauses:

14               “(XVI) for fiscal year 2001, the market basket  
15               percentage increase minus 1.1 percentage points for  
16               hospitals (other than sole community hospitals) in  
17               all areas, and the market basket percentage increase  
18               for sole community hospitals,

19               “(XVII) for fiscal year 2002, the market basket  
20               percentage increase minus 1.1 percentage points for  
21               hospitals in all areas, and”.

1 **SEC. 407. INCREASED FLEXIBILITY IN PROVIDING GRAD-**  
2 **UATE PHYSICIAN TRAINING IN RURAL AND**  
3 **OTHER AREAS.**

4 (a) COUNTING PRIMARY CARE RESIDENTS ON CER-  
5 TAIN APPROVED LEAVES OF ABSENCE IN BASE YEAR  
6 FTE COUNT.—

7 (1) PAYMENT FOR DIRECT GRADUATE MEDICAL  
8 EDUCATION.—Section 1886(h)(4)(F) (42 U.S.C.  
9 1395ww(h)(4)(F)) is amended—

10 (A) by redesignating the first sentence as  
11 clause (i) with the heading “IN GENERAL.—”  
12 and appropriate indentation; and

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

15 “(ii) COUNTING PRIMARY CARE RESI-  
16 DENTS ON CERTAIN APPROVED LEAVES OF  
17 ABSENCE IN BASE YEAR FTE COUNT.—

18 “(I) IN GENERAL.—In deter-  
19 mining the number of such full-time  
20 equivalent residents for a hospital’s  
21 most recent cost reporting period end-  
22 ing on or before December 31, 1996,  
23 for purposes of clause (i), the Sec-  
24 retary shall count an individual to the  
25 extent that the individual would have  
26 been counted as a primary care resi-

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

6                           “(II) LIMITATION TO 3 FTE RESI-  
7           DENTS FOR ANY HOSPITAL.—The  
8           total number of individuals counted  
9           under subclause (I) for a hospital may  
10          not exceed 3 full-time equivalent resi-  
11          dents.”.

12                   (2) PAYMENT FOR INDIRECT MEDICAL EDU-  
13          CATION.—Section 1886(d)(5)(B)(v) (42 U.S.C.  
14          1395ww(d)(5)(B)(v)) is amended by adding at the  
15          end the following: “Rules similar to the rules of sub-  
16          section (h)(4)(F)(ii) shall apply for purposes of this  
17          clause.”.

18                   (3) EFFECTIVE DATE.—

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

23                           (B) IME.—The amendment made by para-  
24          graph (2) applies to discharges occurring in

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

3 (b) PERMITTING 30 PERCENT EXPANSION IN CUR-  
4 RENT GME TRAINING PROGRAMS FOR HOSPITALS LO-  
5 CATED IN RURAL AREAS.—

6 (1) PAYMENT FOR DIRECT GRADUATE MEDICAL  
7 EDUCATION.—Section 1886(h)(4)(F)(i) (42 U.S.C.  
8 1395ww(h)(4)(F)(i)), as amended by subsection  
9 (a)(1), is amended by inserting “(or, 130 percent of  
10 such number in the case of a hospital located in a  
11 rural area)” after “may not exceed the number”.

12 (2) PAYMENT FOR INDIRECT MEDICAL EDU-  
13 CATION.—Section 1886(d)(5)(B)(v) (42 U.S.C.  
14 1395ww(d)(5)(B)(v)) is amended by inserting “(or,  
15 130 percent of such number in the case of a hospital  
16 located in a rural area)” after “may not exceed the  
17 number”.

18 (3) EFFECTIVE DATES.—

19 (A) DGME.—The amendment made by  
20 paragraph (1) applies to cost reporting periods  
21 beginning on or after April 1, 2000.

22 (B) IME.—The amendment made by para-  
23 graph (2) applies to discharges occurring on or  
24 after April 1, 2000.

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

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

6 “(iv) NONRURAL HOSPITALS OPER-  
7 ATING TRAINING PROGRAMS IN RURAL  
8 AREAS.—In the case of a hospital that is  
9 not located in a rural area but establishes  
10 separately accredited approved medical  
11 residency training programs (or rural  
12 tracks) in an rural area or has an accred-  
13 ited training program with an integrated  
14 rural track, the Secretary shall adjust the  
15 limitation under subparagraph (F) in an  
16 appropriate manner insofar as it applies to  
17 such programs in such rural areas in order  
18 to encourage the training of physicians in  
19 rural areas.”.

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

22 (A) payments to hospitals under section  
23 1886(h) of the Social Security Act (42 U.S.C.  
24 1395ww(h)) for cost reporting periods begin-  
25 ning on or after April 1, 2000; and

1 (B) payments to hospitals under section  
2 1886(d)(5)(B)(v) of such Act (42 U.S.C.  
3 1395ww(d)(5)(B)(v)) for discharges occurring  
4 on or after April 1, 2000.

5 (d) NOT COUNTING AGAINST NUMERICAL LIMITA-  
6 TION CERTAIN INTERNS AND RESIDENTS TRANSFERRED  
7 FROM A VA RESIDENCY PROGRAM THAT LOSES ACCREDI-  
8 TATION.—

9 (1) IN GENERAL.—Any applicable resident de-  
10 scribed in paragraph (2) shall not be taken into ac-  
11 count in applying any limitation regarding the num-  
12 ber of residents or interns for which payment may  
13 be made under section 1886 of the Social Security  
14 Act (42 U.S.C. 1395ww).

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

18 (A) participated in graduate medical edu-  
19 cation at a facility of the Department of Vet-  
20 erans Affairs;

21 (B) was subsequently transferred on or  
22 after January 1, 1997, and before July 31,  
23 1998, to a hospital that was not a Department  
24 of Veterans Affairs facility; and

1 (C) was transferred because the approved  
2 medical residency program in which the resi-  
3 dent or intern participated would lose accredita-  
4 tion by the Accreditation Council on Graduate  
5 Medical Education if such program continued  
6 to train residents at the Department of Vet-  
7 erans Affairs facility.

8 (3) EFFECTIVE DATE.—

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

11 (B) RETROACTIVE PAYMENTS.—If the Sec-  
12 retary of Health and Human Services deter-  
13 mines that a hospital operating an approved  
14 medical residency program is owed payments as  
15 a result of enactment of this subsection, the  
16 Secretary shall make such payments not later  
17 than 60 days after the date of the enactment of  
18 this Act.

19 **SEC. 408. ELIMINATION OF CERTAIN RESTRICTIONS WITH**  
20 **RESPECT TO HOSPITAL SWING BED PRO-**  
21 **GRAM.**

22 (a) ELIMINATION OF REQUIREMENT FOR STATE  
23 CERTIFICATE OF NEED.—Section 1883(b) (42 U.S.C.  
24 1395tt(b)) is amended to read as follows:



1 systems required to meet requirements estab-  
2 lished under the medicare program pursuant to  
3 amendments made by the Balanced Budget Act  
4 of 1997.

5 “(B) ELIGIBLE SMALL RURAL HOSPITAL  
6 DEFINED.—For purposes of this paragraph, the  
7 term ‘eligible small rural hospital’ means a non-  
8 Federal, short-term general acute care hospital  
9 that—

10 “(i) is located in a rural area (as de-  
11 fined for purposes of section 1886(d)); and

12 “(ii) has less than 50 beds.

13 “(C) APPLICATION.—A hospital seeking a  
14 grant under this paragraph shall submit an ap-  
15 plication to the Secretary on or before such  
16 date and in such form and manner as the Sec-  
17 retary specifies.

18 “(D) AMOUNT OF GRANT.—A grant to a  
19 hospital under this paragraph may not exceed  
20 \$50,000.

21 “(E) USE OF FUNDS.—A hospital receiving  
22 a grant under this paragraph may use the  
23 funds for the purchase of computer software  
24 and hardware, the education and training of  
25 hospital staff on computer information systems,

1           and to offset costs related to the implementa-  
2           tion of prospective payment systems.

3           “(F) REPORTS.—

4                   “(i) INFORMATION.—A hospital re-  
5                   ceiving a grant under this section shall fur-  
6                   nish the Secretary with such information  
7                   as the Secretary may require to evaluate  
8                   the project for which the grant is made  
9                   and to ensure that the grant is expended  
10                  for the purposes for which it is made.

11                  “(ii) TIMING OF SUBMISSION.—

12                   “(I) INTERIM REPORTS.—The  
13                   Secretary shall report to the Com-  
14                   mittee on Ways and Means of the  
15                   House of Representatives and the  
16                   Committee on Finance of the Senate  
17                   at least annually on the grant pro-  
18                   gram established under this section,  
19                   including in such report information  
20                   on the number of grants made, the  
21                   nature of the projects involved, the ge-  
22                   ographic distribution of grant recipi-  
23                   ents, and such other matters as the  
24                   Secretary deems appropriate.

1                   “(II) FINAL REPORT.—The Sec-  
2                   retary shall submit a final report to  
3                   such committees not later than 180  
4                   days after the completion of all of the  
5                   projects for which a grant is made  
6                   under this section.”.

7 **SEC. 410. GAO STUDY ON GEOGRAPHIC RECLASSIFICATION.**

8           (a) IN GENERAL.—The Comptroller General of the  
9           United States shall conduct a study of the current laws  
10           and regulations for geographic reclassification of hospitals  
11           to determine whether such reclassification is appropriate  
12           for purposes of applying wage indices under the medicare  
13           program and whether such reclassification results in more  
14           accurate payments for all hospitals. Such study shall ex-  
15           amine data on the number of hospitals that are reclassi-  
16           fied and their reclassified status in determining payments  
17           under the medicare program. The study shall evaluate—

18                   (1) the magnitude of the effect of geographic  
19                   reclassification on rural hospitals that are not reclassi-  
20                   fied;

21                   (2) whether the current thresholds used in geo-  
22                   graphic reclassification reclassify hospitals to the ap-  
23                   propriate labor markets;

24                   (3) the effect of eliminating geographic reclassi-  
25                   fication through use of the occupational mix data;

- 1 (4) the group reclassification policy;
- 2 (5) changes in the number of reclassifications
- 3 and the compositions of the groups;
- 4 (6) the effect of State-specific budget neutrality
- 5 compared to national budget neutrality; and
- 6 (7) whether there are sufficient controls over
- 7 the intermediary evaluation of the wage data re-
- 8 ported by hospitals.

9 (b) REPORT.—Not later than 18 months after the

10 date of the enactment of this Act, the Comptroller General

11 of the United States shall submit to Congress a report

12 on the study conducted under subsection (a).

### 13 **Subtitle B—Other Rural Provisions**

#### 14 **SEC. 411. MEDPAC STUDY OF RURAL PROVIDERS.**

15 (a) STUDY.—The Medicare Payment Advisory Com-

16 mission shall conduct a study of rural providers furnishing

17 items and services for which payment is made under title

18 XVIII of the Social Security Act. Such study shall exam-

19 ine and evaluate the adequacy and appropriateness of the

20 categories of special payments (and payment methodolo-

21 gies) established for rural hospitals under the medicare

22 program, and the impact of such categories on beneficiary

23 access and quality of health care services.

24 (b) REPORT.—Not later than 18 months after the

25 date of the enactment of this Act, the Medicare Payment

1 Advisory Commission shall submit to Congress a report  
2 on the study conducted under subsection (a).

3 **SEC. 412. EXPANSION OF ACCESS TO PARAMEDIC INTER-**  
4 **CEPT SERVICES IN RURAL AREAS.**

5 (a) EXPANSION OF PAYMENT AREAS.—Section  
6 4531(c) of BBA (42 U.S.C. 1395x note) is amended by  
7 adding at the end the following flush sentence:  
8 “For purposes of this subsection, an area shall be treated  
9 as a rural area if it is designated as a rural area by any  
10 law or regulation of the State or if it is located in a rural  
11 census tract of a metropolitan statistical area (as deter-  
12 mined under the most recent Goldsmith Modification,  
13 originally published in the Federal Register on February  
14 27, 1992 (57 Fed. Reg. 6725)).”.

15 (b) EFFECTIVE DATE.—The amendment made by  
16 subsection (a) takes effect on January 1, 2000, and ap-  
17 plies to ALS intercept services furnished on or after such  
18 date.

19 **SEC. 413. PROMOTING PROMPT IMPLEMENTATION OF**  
20 **INFORMATICS, TELEMEDICINE, AND EDU-**  
21 **CATION DEMONSTRATION PROJECT.**

22 Section 4207 of BBA (42 U.S.C. 1395b-1 note) is  
23 amended—

24 (1) in subsection (a)(1), by adding at the end  
25 the following: “The Secretary shall make an award

1 for such project not later than 3 months after the  
2 date of the enactment of the Medicare, Medicaid,  
3 and SCHIP Balanced Budget Refinement Act of  
4 1999. The Secretary shall accept the proposal ad-  
5 judged to be the best technical proposal as of such  
6 date of enactment without the need for additional  
7 review or resubmission of proposals.”;

8 (2) in subsection (a)(2)(A), by inserting before  
9 the period at the end the following: “that qualify as  
10 Federally designated medically underserved areas or  
11 health professional shortage areas at the time of en-  
12 rollment of beneficiaries under the project”;

13 (3) in subsection (c)(2), by striking “and the  
14 source and amount of non-Federal funds used in the  
15 project”;

16 (4) in subsection (d)(2)(A), by striking “at a  
17 rate of 50 percent of the costs that are reasonable  
18 and” and inserting “for the costs that are”;

19 (5) in subsection (d)(2)(B)(i), by striking “(but  
20 only in the case of patients located in medically un-  
21 derserved areas)” and inserting “or at sites pro-  
22 viding health care to patients located in medically  
23 underserved areas”;

1 (6) in subsection (d)(2)(C)(i), by striking “to  
2 deliver medical informatics services under” and in-  
3 sserting “for activities related to”; and

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

6 “(4) COST-SHARING.—The project may not im-  
7 pose cost-sharing on a medicare beneficiary for the  
8 receipt of services under the project. Project costs  
9 will cover all costs to medicare beneficiaries and pro-  
10 viders related to participation in the project.”.

11 **TITLE V—PROVISIONS RELAT-**  
12 **ING TO PART C**  
13 **(MEDICARE+CHOICE PRO-**  
14 **GRAM) AND OTHER MEDI-**  
15 **CARE MANAGED CARE PROVI-**  
16 **SIONS**

17 **Subtitle A—Provisions To Accom-**  
18 **modate and Protect Medicare**  
19 **Beneficiaries**

20 **SEC. 501. CHANGES IN MEDICARE+CHOICE ENROLLMENT**  
21 **RULES.**

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

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

4           “(A)(i) the certification of the organization  
5 or plan under this part has been terminated, or  
6 the organization or plan has notified the indi-  
7 vidual of an impending termination of such cer-  
8 tification; or

9           “(ii) the organization has terminated or  
10 otherwise discontinued providing the plan in the  
11 area in which the individual resides, or has no-  
12 tified the individual of an impending termi-  
13 nation or discontinuation of such plan;”.

14           (2) CONFORMING MEDIGAP AMENDMENT.—Sec-  
15 tion 1882(s)(3) (42 U.S.C. 1395ss(s)(3)) is  
16 amended—

17           (A) in subparagraph (A) in the matter fol-  
18 lowing clause (iii), by inserting “, subject to  
19 subparagraph (E),” after “in the case of an in-  
20 dividual described in subparagraph (B) who”;  
21 and

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

24           “(E)(i) An individual described in subparagraph  
25 (B)(ii) may elect to apply subparagraph (A) by sub-

1 stituting, for the date of termination of enrollment, the  
2 date on which the individual was notified by the  
3 Medicare+ Choice organization of the impending termi-  
4 nation or discontinuance of the Medicare+ Choice plan it  
5 offers in the area in which the individual resides, but only  
6 if the individual disenrolls from the plan as a result of  
7 such notification.

8 “(ii) In the case of an individual making such an elec-  
9 tion, the issuer involved shall accept the application of the  
10 individual submitted before the date of termination of en-  
11 rollment, but the coverage under subparagraph (A) shall  
12 only become effective upon termination of coverage under  
13 the Medicare+ Choice plan involved.”.

14 (b) CONTINUOUS OPEN ENROLLMENT FOR INSTITU-  
15 TIONALIZED INDIVIDUALS.—Section 1851(e)(2) (42  
16 U.S.C. 1395w-21(e)(2)) is amended—

17 (1) in subparagraph (B)(i), by inserting “and  
18 subparagraph (D)” after “clause (ii)”;

19 (2) in subparagraph (C)(i), by inserting “and  
20 subparagraph (D)” after “clause (ii)”;

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

23 “(D) CONTINUOUS OPEN ENROLLMENT  
24 FOR INSTITUTIONALIZED INDIVIDUALS.—At  
25 any time after 2001 in the case of a

1 Medicare+ Choice eligible individual who is in-  
2 stitutionalized (as defined by the Secretary),  
3 the individual may elect under subsection  
4 (a)(1)—

5 “(i) to enroll in a Medicare+ Choice  
6 plan; or

7 “(ii) to change the Medicare+ Choice  
8 plan in which the individual is enrolled.”.

9 (c) CONTINUING ENROLLMENT FOR CERTAIN EN-  
10 ROLLEES.—Section 1851(b)(1) (42 U.S.C. 1395w-  
11 21(b)(1)) is amended—

12 (1) in subparagraph (A), by inserting “and ex-  
13 cept as provided in subparagraph (C)” after “may  
14 otherwise provide”; and

15 (2) by adding at the end the following new sub-  
16 paragraph:

17 “(C) CONTINUATION OF ENROLLMENT  
18 PERMITTED WHERE SERVICE CHANGED.—Not-  
19 withstanding subparagraph (A) and in addition  
20 to subparagraph (B), if a Medicare+ Choice or-  
21 ganization eliminates from its service area a  
22 Medicare+ Choice payment area that was pre-  
23 viously within its service area, the organization  
24 may elect to offer individuals residing in all or  
25 portions of the affected area who would other-

1 wise be ineligible to continue enrollment the op-  
2 tion to continue enrollment in a  
3 Medicare+ Choice plan it offers so long as—

4 “(i) the enrollee agrees to receive the  
5 full range of basic benefits (excluding  
6 emergency and urgently needed care) ex-  
7 clusively at facilities designated by the or-  
8 ganization within the plan service area;  
9 and

10 “(ii) there is no other  
11 Medicare+ Choice plan offered in the area  
12 in which the enrollee resides at the time of  
13 the organization’s election.”.

14 (d) EFFECTIVE DATES.—

15 (1) The amendments made by subsection (a)  
16 apply to notices of impending terminations or  
17 discontinuances made on or after the date of the en-  
18 actment of this Act.

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

1 **SEC. 502. CHANGE IN EFFECTIVE DATE OF ELECTIONS AND**  
2 **CHANGES OF ELECTIONS OF**  
3 **MEDICARE+CHOICE PLANS.**

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

6 (1) by inserting “or change” before “is made”;

7 and

8 (2) by inserting “, except that if such election  
9 or change is made after the 10th day of any cal-  
10 endar month, then the election or change shall not  
11 take effect until the first day of the second calendar  
12 month following the date on which the election or  
13 change is made” before the period.

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

17 **SEC. 503. 2-YEAR EXTENSION OF MEDICARE COST CON-**  
18 **TRACTS.**

19 Section 1876(h)(5)(B) (42 U.S.C.  
20 1395mm(h)(5)(B)) is amended by striking “2002” and in-  
21 serting “2004”.



1           (1) STUDY.—The Medicare Payment Advisory  
2 Commission shall conduct a study that evaluates the  
3 methodology used by the Secretary of Health and  
4 Human Services in developing the risk factors used  
5 in adjusting the Medicare+ Choice capitation rate  
6 paid to Medicare+ Choice organizations under sec-  
7 tion 1853 of the Social Security Act (42 U.S.C.  
8 1395w-23) and includes the issues described in  
9 paragraph (2).

10           (2) ISSUES TO BE STUDIED.—The issues de-  
11 scribed in this paragraph are the following:

12           (A) The ability of the average risk adjust-  
13 ment factor applied to a Medicare+ Choice plan  
14 to explain variations in plans' average per cap-  
15 ita medicare costs, as reported by  
16 Medicare+ Choice plans in the plans' adjusted  
17 community rate filings.

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

22           (C) For medicare beneficiaries newly en-  
23 rolled in Medicare+ Choice plans in a given  
24 year, the correspondence between the average  
25 risk factor calculated from medicare fee-for-

1 service data for those individuals from the pe-  
2 riod prior to their enrollment in a  
3 Medicare+ Choice plan and the average risk fac-  
4 tor calculated for such individuals during their  
5 initial year of enrollment in a Medicare+ Choice  
6 plan.

7 (D) For medicare beneficiaries disenrolling  
8 from or switching among Medicare+ Choice  
9 plans in a given year, the correspondence be-  
10 tween the average risk factor calculated from  
11 data pertaining to the period prior to their  
12 disenrollment from a Medicare+ Choice plan  
13 and the average risk factor calculated from  
14 data pertaining to the period after  
15 disenrollment.

16 (E) An evaluation of the exclusion of “dis-  
17 cretionary” hospitalizations from consideration  
18 in the risk adjustment methodology.

19 (F) Suggestions for changes or improve-  
20 ments in the risk adjustment methodology.

21 (3) REPORT.—Not later than December 1,  
22 2000, the Commission shall submit a report to Con-  
23 gress on the study conducted under paragraph (1),  
24 together with any recommendations for legislation

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

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

5 (1) STUDY.—The Secretary of Health and  
6 Human Services shall conduct a study on how to re-  
7 duce the costs and burdens on Medicare+ Choice or-  
8 ganizations of their complying with reporting re-  
9 quirements for encounter data imposed by the Sec-  
10 retary in establishing and implementing a risk ad-  
11 justment methodology used in making payments to  
12 such organizations under section 1853 of the Social  
13 Security Act (42 U.S.C. 1395w-23). The Secretary  
14 shall consult with representatives of  
15 Medicare+ Choice organizations in conducting the  
16 study. The study shall address the following issues:

17 (A) Limiting the number and types of sites  
18 of services (that are in addition to inpatient  
19 sites) for which encounter data must be re-  
20 ported.

21 (B) Establishing alternative risk adjust-  
22 ment methods that would require submission of  
23 less data.

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

1 report prevalence of diagnoses in outpatient  
2 sites of care, the potential for increases in pay-  
3 ments to Medicare+ Choice organizations from  
4 changes in Medicare+ Choice plan coding prac-  
5 tices (commonly known as “coding creep”) and  
6 proposed methods for detecting and adjusting  
7 for such variations in diagnosis coding as part  
8 of the risk adjustment methodology using en-  
9 counter data from multiple sites of care.

10 (D) The impact of such requirements on  
11 the willingness of insurers to offer  
12 Medicare+ Choice MSA plans and options for  
13 modifying encounter data reporting require-  
14 ments to accommodate such plans.

15 (E) Differences in the ability of  
16 Medicare+ Choice organizations to report en-  
17 counter data, and the potential for adverse com-  
18 petitive impacts on group and staff model  
19 health maintenance organizations or other inte-  
20 grated providers of care based on data report-  
21 ing capabilities.

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

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

3 **SEC. 512. ENCOURAGING OFFERING OF MEDICARE+CHOICE**  
4 **PLANS IN AREAS WITHOUT PLANS.**

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

6 (1) in subsection (a)(1), by striking “sub-  
7 sections (e) and (f)” and inserting “subsections (e),  
8 (g), and (i)”;

9 (2) in subsection (c)(5), by inserting “(other  
10 than those attributable to subsection (i))” after  
11 “payments under this part”; and

12 (3) by adding at the end the following new sub-  
13 section:

14 “(i) NEW ENTRY BONUS.—

15 “(1) IN GENERAL.—Subject to paragraphs (2)  
16 and (3), in the case of Medicare+ Choice payment  
17 area in which a Medicare+ Choice plan has not been  
18 offered since 1997 (or in which all organizations  
19 that offered a plan since such date have filed notice  
20 with the Secretary, as of October 13, 1999, that  
21 they will not be offering such a plan as of January  
22 1, 2000), the amount of the monthly payment other-  
23 wise made under this section shall be increased—

24 “(A) only for the first 12 months in which  
25 any Medicare+ Choice plan is offered in the

1 area, by 5 percent of the total monthly payment  
2 otherwise computed for such payment area; and

3 “(B) only for the subsequent 12 months,  
4 by 3 percent of the total monthly payment oth-  
5 erwise computed for such payment area.

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

11 “(3) LIMITATION TO ORGANIZATION OFFERING  
12 FIRST PLAN IN AN AREA.—Paragraph (1) shall only  
13 apply to payment to the first Medicare+ Choice orga-  
14 nization that offers a Medicare+ Choice plan in each  
15 Medicare+ Choice payment area, except that if more  
16 than one such organization first offers such a plan  
17 in an area on the same date, paragraph (1) shall  
18 apply to payment for such organizations.

19 “(4) CONSTRUCTION.—Nothing in paragraph  
20 (1) shall be construed as affecting the calculation of  
21 the annual Medicare+ Choice capitation rate under  
22 subsection (c) for any payment area or as applying  
23 to payment for any period not described in such  
24 paragraph and paragraph (2).

1           “(5) OFFERED DEFINED.—In this subsection,  
2           the term ‘offered’ means, with respect to a  
3           Medicare+ Choice plan as of a date, that a  
4           Medicare+ Choice eligible individual may enroll with  
5           the plan on that date, regardless of when the enroll-  
6           ment takes effect or when the individual obtains  
7           benefits under the plan.”.

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

10           (a) REDUCTION OF GENERAL EXCLUSION PERIOD  
11 TO 2 YEARS.—Section 1857(c)(4) (42 U.S.C. 1395w-  
12 27(c)(4)) is amended by striking “5-year period” and in-  
13 sserting “2-year period”.

14           (b) SPECIFIC EXCEPTION WHERE CHANGE IN PAY-  
15 MENT POLICY.—

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

18                                   (A) by striking “except in circumstances”  
19                                   and inserting “except as provided in subpara-  
20                                   graph (B) and except in such other cir-  
21                                   cumstances”;

22                                   (B) by redesignating the sentence following  
23                                   “(4)” as a subparagraph (A) with an appro-  
24                                   priate indentation and the heading “IN GEN-  
25                                   ERAL.—”; and

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

3 “(B) EARLIER RE-ENTRY PERMITTED  
4 WHERE CHANGE IN PAYMENT POLICY.—Sub-  
5 paragraph (A) shall not apply with respect to  
6 the offering by a Medicare+ Choice organization  
7 of a Medicare+ Choice plan in a  
8 Medicare+ Choice payment area if during the 6-  
9 month period beginning on the date the organi-  
10 zation notified the Secretary of the intention to  
11 terminate the most recent previous contract,  
12 there was a legislative change enacted (or a reg-  
13 ulatory change adopted) that has the effect of  
14 increasing payment amounts under section  
15 1853 for that Medicare+ Choice payment  
16 area.”.

17 (2) CONSTRUCTION RELATING TO ADDITIONAL  
18 EXCEPTIONS.—Nothing in the amendment made by  
19 paragraph (1)(C) shall be construed to affect the au-  
20 thority of the Secretary of Health and Human Serv-  
21 ices to provide for exceptions in addition to the ex-  
22 ception provided in such amendment, including ex-  
23 ceptions provided under Operational Policy Letter  
24 #103 (OPL99.103).

1 (c) EFFECTIVE DATE.—The amendments made by  
2 this section apply to contract terminations occurring be-  
3 fore, on, or after the date of the enactment of this Act.

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

8 (a) IN GENERAL.—Section 1853(b) (42 U.S.C.  
9 1395w-23(b)) is amended by adding at the end the fol-  
10 lowing new paragraph:

11 “(4) CONTINUED COMPUTATION AND PUBLICA-  
12 TION OF COUNTY-SPECIFIC PER CAPITA FEE-FOR-  
13 SERVICE EXPENDITURE INFORMATION.—The Sec-  
14 retary, through the Chief Actuary of the Health  
15 Care Financing Administration, shall provide for the  
16 computation and publication, on an annual basis be-  
17 ginning with 2001 at the time of publication of the  
18 annual Medicare+Choice capitation rates under  
19 paragraph (1), of the following information for the  
20 original medicare fee-for-service program under  
21 parts A and B (exclusive of individuals eligible for  
22 coverage under section 226A) for each  
23 Medicare+Choice payment area for the second cal-  
24 endar year ending before the date of publication:

1           “(A) Total expenditures per capita per  
2           month, computed separately for part A and for  
3           part B.

4           “(B) The expenditures described in sub-  
5           paragraph (A) reduced by the best estimate of  
6           the expenditures (such as graduate medical  
7           education and disproportionate share hospital  
8           payments) not related to the payment of claims.

9           “(C) The average risk factor for the cov-  
10          ered population based on diagnoses reported for  
11          medicare inpatient services, using the same  
12          methodology as is expected to be applied in  
13          making payments under subsection (a).

14          “(D) Such average risk factor based on di-  
15          agnoses for inpatient and other sites of service,  
16          using the same methodology as is expected to  
17          be applied in making payments under sub-  
18          section (a).”.

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

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

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

5 (1) in subsection (a)(1), by inserting “(or seg-  
6 ment of such an area if permitted under subsection  
7 (h))” after “service area” in the matter preceding  
8 subparagraph (A); and

9 (2) by adding at the end the following:

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

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

20 **SEC. 516. DELAY IN DEADLINE FOR SUBMISSION OF AD-**  
21 **JUSTED COMMUNITY RATES.**

22 (a) DELAY IN DEADLINE FOR SUBMISSION OF AD-  
23 JUSTED COMMUNITY RATES.—Section 1854(a)(1) (42  
24 U.S.C. 1395w–24(a)(1)) is amended by striking “May 1”  
25 and inserting “July 1” in the matter preceding subpara-  
26 graph (A).

1 (b) EFFECTIVE DATE.—The amendment made by  
2 subsection (a) applies to information submitted by  
3 Medicare+ Choice organizations for years beginning with  
4 1999.

5 **SEC. 517. REDUCTION IN ADJUSTMENT IN NATIONAL PER**  
6 **CAPITA MEDICARE+CHOICE GROWTH PER-**  
7 **CENTAGE FOR 2002.**

8 Section 1853(c)(6)(B)(v) (42 U.S.C. 1395w-  
9 23(c)(6)(B)(v)) is amended by striking “0.5 percentage  
10 points” and inserting “0.3 percentage points”.

11 **SEC. 518. DEEMING OF MEDICARE+CHOICE ORGANIZATION**  
12 **TO MEET REQUIREMENTS.**

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

15 “(4) TREATMENT OF ACCREDITATION.—

16 “(A) IN GENERAL.—The Secretary shall  
17 provide that a Medicare+ Choice organization is  
18 deemed to meet all the requirements described  
19 in any specific clause of subparagraph (B) if  
20 the organization is accredited (and periodically  
21 reaccredited) by a private accrediting organiza-  
22 tion under a process that the Secretary has de-  
23 termined assures that the accrediting organiza-  
24 tion applies and enforces standards that meet  
25 or exceed the standards established under sec-

1           tion 1856 to carry out the requirements in such  
2           clause.

3           “(B) REQUIREMENTS DESCRIBED.—The  
4           provisions described in this subparagraph are  
5           the following:

6                   “(i) Paragraphs (1) and (2) of this  
7                   subsection (relating to quality assurance  
8                   programs).

9                   “(ii) Subsection (b) (relating to anti-  
10                   discrimination).

11                   “(iii) Subsection (d) (relating to ac-  
12                   cess to services).

13                   “(iv) Subsection (h) (relating to con-  
14                   fidentiality and accuracy of enrollee  
15                   records).

16                   “(v) Subsection (i) (relating to infor-  
17                   mation on advance directives).

18                   “(vi) Subsection (j) (relating to pro-  
19                   vider participation rules).

20           “(C) TIMELY ACTION ON APPLICATIONS.—  
21           The Secretary shall determine, within 210 days  
22           after the date the Secretary receives an applica-  
23           tion by a private accrediting organization and  
24           using the criteria specified in section  
25           1865(b)(2), whether the process of the private

1           accrediting organization meets the requirements  
2           with respect to any specific clause in subpara-  
3           graph (B) with respect to which the application  
4           is made. The Secretary may not deny such an  
5           application on the basis that it seeks to meet  
6           the requirements with respect to only one, or  
7           more than one, such specific clause.

8           “(D) CONSTRUCTION.—Nothing in this  
9           paragraph shall be construed as limiting the au-  
10          thority of the Secretary under section 1857, in-  
11          cluding the authority to terminate contracts  
12          with Medicare+ Choice organizations under sub-  
13          section (c)(2) of such section.”.

14 **SEC. 519. TIMING OF MEDICARE+CHOICE HEALTH INFOR-**  
15 **MATION FAIRS.**

16          (a) IN GENERAL.—Section 1851(e)(3)(C) (42 U.S.C.  
17 1395w-21(e)(3)(C)) is amended by striking “In the month  
18 of November” and inserting “During the fall season”.

19          (b) EFFECTIVE DATE.—The amendment made by  
20 subsection (a) first applies to campaigns conducted begin-  
21 ning in 2000.

22 **SEC. 520. QUALITY ASSURANCE REQUIREMENTS FOR PRE-**  
23 **FERRED PROVIDER ORGANIZATION PLANS.**

24          (a) IN GENERAL.—Section 1852(e)(2) (42 U.S.C.  
25 1395w-22(e)(2)) is amended—

1 (1) in subparagraph (A), by striking “or a non-  
2 network MSA plan” and inserting “, a non-network  
3 MSA plan, or a preferred provider organization  
4 plan”;

5 (2) in subparagraph (B)—

6 (A) in the heading, by striking “AND NON-  
7 NETWORK MSA PLANS” and inserting “, NON-  
8 NETWORK MSA PLANS, AND PREFERRED PRO-  
9 VIDER ORGANIZATION PLANS”; and

10 (B) by striking “or a non-network MSA  
11 plan” and inserting “, a non-network MSA  
12 plan, or a preferred provider organization  
13 plan”;

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

15 “(D) DEFINITION OF PREFERRED PRO-  
16 VIDER ORGANIZATION PLAN.—In this para-  
17 graph, the term ‘preferred provider organization  
18 plan’ means a Medicare+ Choice plan that—

19 “(i) has a network of providers that  
20 have agreed to a contractually specified re-  
21 imbursement for covered benefits with the  
22 organization offering the plan;

23 “(ii) provides for reimbursement for  
24 all covered benefits regardless of whether

1           such benefits are provided within such net-  
2           work of providers; and

3           “(iii) is offered by an organization  
4           that is not licensed or organized under  
5           State law as a health maintenance organi-  
6           zation.”.

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

10          (c) QUALITY IMPROVEMENT STANDARDS.—

11           (1) STUDY.—The Medicare Payment Advisory  
12           Commission shall conduct a study on the appro-  
13           priate quality improvement standards that should  
14           apply to—

15           (A) each type of Medicare+ Choice plan de-  
16           scribed in section 1851(a)(2) of the Social Se-  
17           curity Act (42 U.S.C. 1395w-21(a)(2)), includ-  
18           ing each type of Medicare+ Choice plan that is  
19           a coordinated care plan (as described in sub-  
20           paragraph (A) of such section); and

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

24           (2) CONSIDERATIONS.—Such study shall spe-  
25           cifically examine the effects, costs, and feasibility of

1 requiring entities, physicians, and other health care  
2 providers that provide items and services under the  
3 original medicare fee-for-service program to comply  
4 with quality standards and related reporting require-  
5 ments that are comparable to the quality standards  
6 and related reporting requirements that are applica-  
7 ble to Medicare+ Choice organizations.

8 (3) REPORT.—Not later than 2 years after the  
9 date of the enactment of this Act, such Commission  
10 shall submit a report to Congress on the study con-  
11 ducted under this subsection, together with any rec-  
12 ommendations for legislation that it determines to be  
13 appropriate as a result of such study.

14 **SEC. 521. CLARIFICATION OF NONAPPLICABILITY OF CER-**  
15 **TAIN PROVISIONS OF DISCHARGE PLANNING**  
16 **PROCESS TO MEDICARE+CHOICE PLANS.**

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

19 “(3) With respect to a discharge plan for an indi-  
20 vidual who is enrolled with a Medicare+ Choice organiza-  
21 tion under a Medicare+ Choice plan and is furnished inpa-  
22 tient hospital services by a hospital under a contract with  
23 the organization—

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

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

4               “(B) notwithstanding subparagraph (H)(i), the  
5       plan may specify or limit the provider (or providers)  
6       of post-hospital home health services or other post-  
7       hospital services under the plan.”.

8   **SEC. 522. USER FEE FOR MEDICARE+CHOICE ORGANIZA-**  
9                   **TIONS BASED ON NUMBER OF ENROLLED**  
10                  **BENEFICIARIES.**

11       (a) IN GENERAL.—Section 1857(e)(2) (42 U.S.C.  
12 1395w-27(e)(2)) is amended—

13           (1) in subparagraph (B), by striking “Any  
14       amounts collected are authorized to be appropriated  
15       only for” and inserting “Any amounts collected shall  
16       be available without further appropriation to the  
17       Secretary for”;

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

20               “(C) AUTHORIZATION OF APPROPRIA-  
21       TIONS.—There are authorized to be appro-  
22       priated for the purposes described in subpara-  
23       graph (B) for each fiscal year beginning with  
24       fiscal year 2001 an amount equal to  
25       \$100,000,000, reduced by the amount of fees

1 authorized to be collected under this paragraph  
2 for the fiscal year.”;

3 (3) in subparagraph (D)(ii)—

4 (A) in subclause (II), by striking “and”;

5 (B) in subclause (III), by striking “ and  
6 each subsequent fiscal year.” and inserting “;  
7 and”; and

8 (C) by adding at the end the following:

9 “(IV) the Medicare+ Choice portion  
10 (as defined in subparagraph (E)) of  
11 \$100,000,000 in fiscal year 2001 and each  
12 succeeding fiscal year.”; and

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

14 “(E) MEDICARE+ CHOICE PORTION DE-  
15 FINED.—In this paragraph, the term  
16 ‘Medicare+ Choice portion’ means, for a fiscal  
17 year, the ratio, as estimated by the Secretary,  
18 of—

19 “(i) the average number of individuals  
20 enrolled in Medicare+ Choice plans during  
21 the fiscal year, to

22 “(ii) the average number of individ-  
23 uals entitled to benefits under part A, and  
24 enrolled under part B, during the fiscal  
25 year.”.

1 (b) EFFECTIVE DATE.—The amendments made by  
2 subsection (a) apply to fees charged on or after January  
3 1, 2001. The Secretary of Health and Human Services  
4 may not increase the fees charged under section  
5 1857(e)(2) of the Social Security Act (42 U.S.C. 1395w–  
6 27(e)(2)) for the 3-month period beginning with October  
7 2000 above the level in effect during the previous 9-month  
8 period.

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

12 Section 1859(e)(2) (42 U.S.C. 1395w–29(e)(2)) is  
13 amended in the matter preceding subparagraph (A) by  
14 striking “section 1851(a)(2)(A)” and inserting “section  
15 1851(a)(2)”.

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

18 (a) IN GENERAL.—Section 1877(b)(3) (42 U.S.C.  
19 1395nn(b)(3)) is amended—

20 (1) in subparagraph (C), by striking “or” at  
21 the end;

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

23 (2) in subparagraph (D), by striking the period  
24 at the end and inserting “, or”; and



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

3               (3) by adding at the end of paragraph (4) the  
4       following: “Not later than 6 months after the date  
5       the Secretary submits such final report, the Medi-  
6       care Payment Advisory Commission shall submit to  
7       Congress a report containing recommendations re-  
8       garding such project.”.

9       (b) SUBSTITUTION OF AGGREGATE CAP.—Section  
10   13567(c) of the Omnibus Budget Reconciliation Act of  
11   1993 (Public Law 103–66) is amended to read as follows:

12       “(c) AGGREGATE LIMIT ON NUMBER OF MEM-  
13   BERS.—The Secretary of Health and Human Services  
14   may not impose a limit on the number of individuals that  
15   may participate in a project conducted under section 2355  
16   of the Deficit Reduction Act of 1984, other than an aggre-  
17   gate limit of not less than 324,000 for all sites.”.

18   **SEC. 532. EXTENSION OF MEDICARE COMMUNITY NURSING**

19                               **ORGANIZATION DEMONSTRATION PROJECT.**

20       (a) EXTENSION.—Notwithstanding any other provi-  
21   sion of law, any demonstration project conducted under  
22   section 4079 of the Omnibus Budget Reconciliation Act  
23   of 1987 (Public Law 100–123; 42 U.S.C. 1395mm note)  
24   and conducted for the additional period of 2 years as pro-  
25   vided for under section 4019 of BBA, shall be conducted

1 for an additional period of 2 years. The Secretary of  
2 Health and Human Services shall provide for such reduc-  
3 tion in payments under such project in the extension pe-  
4 riod provided under the previous sentence as the Secretary  
5 determines is necessary to ensure that total Federal ex-  
6 penditures during the extension period under the project  
7 do not exceed the total Federal expenditures that would  
8 have been made under title XVIII of the Social Security  
9 Act if such project had not been so extended.

10 (b) REPORT.—Not later than July 1, 2001, the Sec-  
11 retary of Health and Human Services shall submit to Con-  
12 gress a report describing the results of any demonstration  
13 project conducted under section 4079 of the Omnibus  
14 Budget Reconciliation Act of 1987, and describing the  
15 data collected by the Secretary relevant to the analysis of  
16 the results of such project, including the most recently  
17 available data through the end of 2000.

18 **SEC. 533. MEDICARE+CHOICE COMPETITIVE BIDDING DEM-**  
19 **ONSTRATION PROJECT.**

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

22 (1) in subsection (a)—

23 (A) by striking “The Secretary” and in-  
24 serting the following (and conforming the in-

1           dentation for the remainder of the subsection  
2           accordingly):

3           “(1) IN GENERAL.—Subject to the succeeding  
4           provisions of this subsection, the Secretary”; and

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

6           “(2) DELAY IN IMPLEMENTATION.—The Sec-  
7           retary shall not implement the project until January  
8           1, 2002, or, if later, 6 months after the date the  
9           Competitive Pricing Advisory Committee has sub-  
10          mitted to Congress a report on each of the following  
11          topics:

12                 “(A) INCORPORATION OF ORIGINAL MEDI-  
13                 CARE FEE-FOR-SERVICE PROGRAM INTO  
14                 PROJECT.—What changes would be required in  
15                 the project to feasibly incorporate the original  
16                 medicare fee-for-service program into the  
17                 project in the areas in which the project is oper-  
18                 ational.

19                 “(B) QUALITY ACTIVITIES.—The nature  
20                 and extent of the quality reporting and moni-  
21                 toring activities that should be required of plans  
22                 participating in the project, the estimated costs  
23                 that plans will incur as a result of these re-  
24                 quirements, and the current ability of the  
25                 Health Care Financing Administration to col-

1 lect and report comparable data, sufficient to  
2 support comparable quality reporting and moni-  
3 toring activities with respect to beneficiaries en-  
4 rolled in the original medicare fee-for-service  
5 program generally.

6 “(C) RURAL PROJECT.—The current via-  
7 bility of initiating a project site in a rural area,  
8 given the site specific budget neutrality require-  
9 ments of the project under subsection (g), and  
10 insofar as the Committee decides that the addi-  
11 tion of such a site is not viable, recommenda-  
12 tions on how the project might best be changed  
13 so that such a site is viable.

14 “(D) BENEFIT STRUCTURE.—The nature  
15 and extent of the benefit structure that should  
16 be required of plans participating in the project,  
17 the rationale for such benefit structure, the po-  
18 tential implications that any benefit standard-  
19 ization requirement may have on the number of  
20 plan choices available to a beneficiary in an  
21 area designated under the project, the potential  
22 implications of requiring participating plans to  
23 offer variations on any standardized benefit  
24 package the committee might recommend, such  
25 that a beneficiary could elect to pay a higher

1 percentage of out-of-pocket costs in exchange  
2 for a lower premium (or premium rebate as the  
3 case may be), and the potential implications of  
4 expanding the project (in conjunction with the  
5 potential inclusion of the original medicare fee-  
6 for-service program) to require medicare supple-  
7 mental insurance plans operating in an area  
8 designated under the project to offer a coordi-  
9 nated and comparable standardized benefit  
10 package.

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

16 (2) in subsection (c)(1)(A)—

17 (A) by striking “and” at the end of clause  
18 (i); and

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

21 “(iii) establish beneficiary premiums  
22 for plans offered in such area in a manner  
23 such that a beneficiary who enrolls in an  
24 offered plan the per capita bid for which is  
25 less than the standard per capita govern-

1           ment contribution (as established by the  
2           competitive pricing methodology estab-  
3           lished for such area) may, at the plan's  
4           election, be offered a rebate of some or all  
5           of the medicare part B premium that such  
6           individual must otherwise pay in order to  
7           participate in a Medicare+Choice plan  
8           under the Medicare+Choice program;  
9           and”.

10 **SEC. 534. EXTENSION OF MEDICARE MUNICIPAL HEALTH**  
11 **SERVICES DEMONSTRATION PROJECTS.**

12           Section 9215(a) of the Consolidated Omnibus Budget  
13 Reconciliation Act of 1985, as amended by section 6135  
14 of the Omnibus Budget Reconciliation Act of 1989, section  
15 13557 of the Omnibus Budget Reconciliation Act of 1993,  
16 and section 4017 of BBA, is amended by striking “Decem-  
17 ber 31, 2000” and inserting “December 31, 2002”.

18 **SEC. 535. MEDICARE COORDINATED CARE DEMONSTRATION**  
19 **PROJECT.**

20           Section 4016(e)(1)(A)(ii) of BBA (42 U.S.C. 1395b-  
21 1 note) is amended to read as follows:

22                           “(ii) CANCER HOSPITAL.—In the case  
23                           of the project described in subsection  
24                           (b)(2)(C), the Secretary shall provide for  
25                           the transfer from the Federal Hospital In-

1 insurance Trust Fund and the Federal Sup-  
2 plementary Insurance Trust Fund under  
3 title XVIII of the Social Security Act (42  
4 U.S.C. 1395i, 1395t), in such proportions  
5 as the Secretary determines to be appro-  
6 priate, of such funds as are necessary to  
7 cover costs of the project, including costs  
8 for information infrastructure and recur-  
9 ring costs of case management services,  
10 flexible benefits, and program manage-  
11 ment.”.

12 **SEC. 536. MEDIGAP PROTECTIONS FOR PACE PROGRAM EN-**  
13 **ROLLEES.**

14 (a) IN GENERAL.—Section 1882(s)(3)(B) (42 U.S.C.  
15 1395ss(s)(3)(B)) is amended—

16 (1) in clause (ii), by inserting “or the individual  
17 is 65 years of age or older and is enrolled with a  
18 PACE provider under section 1894, and there are  
19 circumstances that would permit the discontinuance  
20 of the individual’s enrollment with such provider  
21 under circumstances that are similar to the cir-  
22 cumstances that would permit discontinuance of the  
23 individual’s election under the first sentence of such  
24 section if such individual were enrolled in a  
25 Medicare+ Choice plan” before the period;

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

4 (3) in clause (vi)—

5 (A) by inserting “or in a PACE program  
6 under section 1894” after “part C”; and

7 (B) by striking “such plan” and inserting  
8 “such plan or such program”.

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

12 **Subtitle D—Medicare+Choice Nurs-**  
13 **ing and Allied Health Profes-**  
14 **sional Education Payments**

15 **SEC. 541. MEDICARE+CHOICE NURSING AND ALLIED**  
16 **HEALTH PROFESSIONAL EDUCATION PAY-**  
17 **MENTS.**

18 (a) ADDITIONAL PAYMENTS FOR NURSING AND AL-  
19 LIED HEALTH EDUCATION.—Section 1886 (42 U.S.C.  
20 1395ww) is amended by adding at the end the following  
21 new subsection:

22 “(I) PAYMENT FOR NURSING AND ALLIED HEALTH  
23 EDUCATION FOR MANAGED CARE ENROLLEES.—

24 “(1) IN GENERAL.—For portions of cost report-  
25 ing periods occurring in a year (beginning with

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

6               “(2) PAYMENT AMOUNT.—The additional pay-  
7       ment amount under this subsection for each hospital  
8       for portions of cost reporting periods occurring in a  
9       year shall be an amount specified by the Secretary  
10      in a manner consistent with the following:

11               “(A) DETERMINATION OF MANAGED CARE  
12      ENROLLEE PAYMENT RATIO FOR GRADUATE  
13      MEDICAL EDUCATION PAYMENTS.—The Sec-  
14      retary shall estimate the ratio of payments for  
15      all hospitals for portions of cost reporting peri-  
16      ods occurring in the year under subsection  
17      (h)(3)(D) to total direct graduate medical edu-  
18      cation payments estimated for such portions of  
19      periods under subsection (h)(3).

20               “(B) APPLICATION TO FEE-FOR-SERVICE  
21      NURSING AND ALLIED HEALTH EDUCATION  
22      PAYMENTS.—Such ratio shall be applied to the  
23      Secretary’s estimate of total payments for nurs-  
24      ing and allied health education determined  
25      under section 1861(v) for portions of cost re-

1           porting periods occurring in the year to deter-  
2           mine a total amount of additional payments for  
3           nursing and allied health education to be dis-  
4           tributed to hospitals under this subsection for  
5           portions of cost reporting periods occurring in  
6           the year; except that in no case shall such total  
7           amount exceed \$60,000,000 in any year.

8           “(C) APPLICATION TO HOSPITAL.—The  
9           amount of payment under this subsection to a  
10          hospital for portions of cost reporting periods  
11          occurring in a year is equal to the total amount  
12          of payments determined under subparagraph  
13          (B) for the year multiplied by the Secretary’s  
14          estimate of the ratio of the amount of payments  
15          made under section 1861(v) to the hospital for  
16          nursing and allied health education activities  
17          for the hospital’s cost reporting period ending  
18          in the second preceding fiscal year to the total  
19          of such amounts for all hospitals for such cost  
20          reporting periods.”.

21          (b) ADJUSTMENTS IN PAYMENTS FOR DIRECT GRAD-  
22          UATE MEDICAL EDUCATION.—Section 1886(h)(3)(D) (42  
23          U.S.C. 1395ww(h)(3)(D)) is amended—

24                 (1) in clause (i), by inserting “, subject to  
25                 clause (iii),” after “shall equal”;

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

2 and

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

4 new clause:

5 “(iii) PROPORTIONAL REDUCTION FOR  
6 NURSING AND ALLIED HEALTH EDU-  
7 CATION.—The Secretary shall estimate a  
8 proportional adjustment in payments to all  
9 hospitals determined under clauses (i) and  
10 (ii) for portions of cost reporting periods  
11 beginning in a year (beginning with 2000)  
12 such that the proportional adjustment re-  
13 duces payments in an amount for such  
14 year equal to the total additional payment  
15 amounts for nursing and allied health edu-  
16 cation determined under subsection (l) for  
17 portions of cost reporting periods occurring  
18 in that year.”.

## 19 **Subtitle E—Studies and Reports**

### 20 **SEC. 551. REPORT ON ACCOUNTING FOR VA AND DOD EX-** 21 **PENDITURES FOR MEDICARE BENE-** 22 **FICIARIES.**

23 Not later April 1, 2001, the Secretary of Health and  
24 Human Services, jointly with the Secretaries of Defense  
25 and of Veterans Affairs, shall submit to Congress a report

1 on the estimated use of health care services furnished by  
2 the Departments of Defense and of Veterans Affairs to  
3 medicare beneficiaries, including both beneficiaries under  
4 the original medicare fee-for-service program and under  
5 the Medicare+ Choice program. The report shall include  
6 an analysis of how best to properly account for expendi-  
7 tures for such services in the computation of  
8 Medicare+ Choice capitation rates.

9 **SEC. 552. MEDICARE PAYMENT ADVISORY COMMISSION**  
10 **STUDIES AND REPORTS.**

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

14 (1) STUDY.—The Medicare Payment Advisory  
15 Commission shall conduct a study on the develop-  
16 ment of a payment methodology under the  
17 Medicare+ Choice program for frail elderly  
18 Medicare+ Choice beneficiaries enrolled in a  
19 Medicare+ Choice plan under a specialized program  
20 for the frail elderly that—

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

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

4 (C) includes functional indicators of health  
5 status and such other factors as may be nec-  
6 essary to achieve appropriate payments for  
7 plans serving such beneficiaries.

8 (2) REPORT.—Not later than 1 year after the  
9 date of the enactment of this Act, the Commission  
10 shall submit a report to Congress on the study con-  
11 ducted under paragraph (1), together with any rec-  
12 ommendations for legislation that the Commission  
13 determines to be appropriate as a result of such  
14 study.

15 (b) REPORT ON MEDICARE MSA (MEDICAL SAVINGS  
16 ACCOUNT) PLANS.—Not later than 1 year after the date  
17 of the enactment of this Act, the Medicare Payment As-  
18 sessment Commission shall submit to Congress a report  
19 on specific legislative changes that should be made to  
20 make MSA plans (as defined in section 1859(b)(3) of the  
21 Social Security Act, 42 U.S.C. 1395w-29(b)(3)) a viable  
22 option under the Medicare+ Choice program.

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

24 (a) STUDY OF MEDIGAP POLICIES.—

1           (1) IN GENERAL.—The Comptroller General of  
2           the United States (in this section referred to as the  
3           “Comptroller General”) shall conduct a study of the  
4           issues described in paragraph (2) regarding medi-  
5           care supplemental policies described in section  
6           1882(g)(1) of the Social Security Act (42 U.S.C.  
7           1395ss(g)(1)).

8           (2) ISSUES TO BE STUDIED.—The issues de-  
9           scribed in this paragraph are the following:

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

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

14                   (C) The availability of each type of medi-  
15                   care supplemental policy to medicare bene-  
16                   ficiaries over age 65½.

17                   (D) The number and type of medicare sup-  
18                   plemental policies offered in each State.

19                   (E) The average out-of-pocket costs (in-  
20                   cluding premiums) per beneficiary under each  
21                   type of medicare supplemental policy.

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

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

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

7           (1) IN GENERAL.—Beginning in 2000, the  
8       Comptroller General shall conduct an annual audit  
9       of the expenditures by the Secretary of Health and  
10      Human Services during the preceding year in pro-  
11      viding information regarding the Medicare+ Choice  
12      program under part C of title XVIII of the Social  
13      Security Act (42 U.S.C. 1395w-21 et seq.) to eligi-  
14      ble medicare beneficiaries.

15          (3) REPORTS.—Not later than March 31 of  
16      2001, 2004, 2007, and 2010, the Comptroller Gen-  
17      eral shall submit a report to Congress on the results  
18      of the audit of the expenditures of the preceding 3  
19      years conducted pursuant to subsection (a), together  
20      with an evaluation of the effectiveness of the means  
21      used by the Secretary of Health and Human Serv-  
22      ices in providing information regarding the  
23      Medicare+ Choice program under part C of title  
24      XVIII of the Social Security Act (42 U.S.C. 1395w-  
25      21 et seq.) to eligible medicare beneficiaries.

1                   **TITLE VI—MEDICAID**

2   **SEC. 601. INCREASE IN DSH ALLOTMENT FOR CERTAIN**  
3                   **STATES AND THE DISTRICT OF COLUMBIA.**

4           (a) IN GENERAL.—The table in section 1923(f)(2)  
5 (42 U.S.C. 1396r-4(f)(2)) is amended under each of the  
6 columns for FY 00, FY 01, and FY 02—

7               (1) in the entry for the District of Columbia, by  
8               striking “23” and inserting “32”;

9               (2) in the entry for Minnesota, by striking “16”  
10              and inserting “33”;

11              (3) in the entry for New Mexico, by striking  
12              “5” and inserting “9”; and

13              (4) in the entry for Wyoming, by striking “0”  
14              and inserting “0.1”.

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

18   **SEC. 602. REMOVAL OF FISCAL YEAR LIMITATION ON CER-**  
19                   **TAIN TRANSITIONAL ADMINISTRATIVE COSTS**  
20                   **ASSISTANCE.**

21           (a) IN GENERAL.—Section 1931(h) (42 U.S.C.  
22 1396u-1(h)) is amended—

23               (1) in paragraph (3), by striking “and ending  
24               with fiscal year 2000”; and

25               (2) by striking paragraph (4).

1 (b) EFFECTIVE DATE.—The amendments made by  
2 this section shall take effect as if included in the enact-  
3 ment of section 114 of the Personal Responsibility and  
4 Work Opportunity Reconciliation Act of 1996 (Public Law  
5 104–193; 110 Stat. 2177).

6 **SEC. 603. MODIFICATION OF THE PHASE-OUT OF PAYMENT**  
7 **FOR FEDERALLY-QUALIFIED HEALTH CEN-**  
8 **TER SERVICES AND RURAL HEALTH CLINIC**  
9 **SERVICES BASED ON REASONABLE COSTS.**

10 (a) MODIFICATION OF PHASE-OUT.—

11 (1) IN GENERAL.—Section 1902(a)(13)(C)(i)  
12 (42 U.S.C. 1396a(a)(13)(C)(i)) is amended by strik-  
13 ing “90 percent for services furnished during fiscal  
14 year 2001, 85 percent for services furnished during  
15 fiscal year 2002, or 70 percent for services furnished  
16 during fiscal year 2003” and inserting “fiscal year  
17 2001, or fiscal year 2002, 90 percent for services  
18 furnished during fiscal year 2003, or 85 percent for  
19 services furnished during fiscal year 2004”.

20 (2) CONFORMING AMENDMENT TO END OF  
21 TRANSITIONAL PAYMENT RULES.—Section 4712(c)  
22 of BBA (111 Stat. 509) is amended by striking  
23 “2003” and inserting “2004”.

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

1 the enactment of section 4712 of BBA (111 Stat.  
2 508).

3 (b) GAO STUDY AND REPORT.—Not later than 1  
4 year after the date of the enactment of this Act, the Comp-  
5 troller General of the United States shall submit a report  
6 to Congress that evaluates the effect on Federally-quali-  
7 fied health centers and rural health clinics and on the pop-  
8 ulations served by such centers and clinics of the phase-  
9 out and elimination of the reasonable cost basis for pay-  
10 ment for Federally-qualified health center services and  
11 rural health clinic services provided under section  
12 1902(a)(13)(C)(i) of the Social Security Act (42 U.S.C.  
13 1396a(a)(13)(C)(i)), as amended by section 4712 of BBA  
14 (111 Stat. 508) and subsection (a) of this section. Such  
15 report shall include an analysis of the amount, method,  
16 and impact of payments made by States that have pro-  
17 vided for payment under title XIX of such Act for such  
18 services on a basis other than payment of costs which are  
19 reasonable and related to the cost of furnishing such serv-  
20 ices, together with any recommendations for legislation,  
21 including whether a new payment system is needed, that  
22 the Comptroller General determines to be appropriate as  
23 a result of the study.

1 **SEC. 604. PARITY IN REIMBURSEMENT FOR CERTAIN UTILI-**  
2 **ZATION AND QUALITY CONTROL SERVICES;**  
3 **ELIMINATION OF DUPLICATIVE REQUIRE-**  
4 **MENTS FOR EXTERNAL QUALITY REVIEW OF**  
5 **MEDICAID MANAGED CARE ORGANIZATIONS.**

6 (a) PARITY IN REIMBURSEMENT FOR CERTAIN UTI-  
7 LIZATION AND QUALITY CONTROL SERVICES.—

8 (1) INTERIM AMENDMENT TO REMOVE REF-  
9 ERENCES TO QUALITY REVIEW.—Section 1902(d)  
10 (42 U.S.C. 1396a(d)) is amended by striking “for  
11 the performance of the quality review functions de-  
12 scribed in subsection (a)(30)(C),”.

13 (2) FINAL AMENDMENTS TO REMOVE REF-  
14 ERENCES TO QUALITY REVIEW.—

15 (A) SECTION 1902.—Section 1902(d) (42  
16 U.S.C. 1396a(d)) is amended by striking “(in-  
17 cluding quality review functions described in  
18 subsection (a)(30)(C))”.

19 (B) SECTION 1903.—Section  
20 1903(a)(3)(C)(i) (42 U.S.C. 1396b(a)(3)(C)(i))  
21 is amended by striking “or quality review”.

22 (b) ELIMINATION OF DUPLICATIVE REQUIREMENTS  
23 FOR EXTERNAL QUALITY REVIEW OF MEDICAID MAN-  
24 AGED CARE ORGANIZATIONS.—

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

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

3 (B) in subparagraph (B)(ii), by striking  
4 “and” at the end; and

5 (C) by striking subparagraph (C).

6 (2) CONFORMING AMENDMENT.—Section  
7 1903(m)(6)(B) (42 U.S.C. 1396b(m)(6)(B)) is  
8 amended—

9 (A) in clause (ii), by adding “and” at the  
10 end;

11 (B) in clause (iii), by striking “; and” and  
12 inserting a period; and

13 (C) by striking clause (iv).

14 (c) EFFECTIVE DATES.—

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

18 (2) The amendments made by subsections  
19 (a)(2) and (b) apply as of such date as the Secretary  
20 of Health and Human Services certifies to Congress  
21 that the Secretary is fully implementing section  
22 1932(c)(2) of the Social Security Act (42 U.S.C.  
23 1396u-2(c)(2)).

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

4 (a) IN GENERAL.—The last sentence of section  
5 1905(b) (42 U.S.C. 1396d(b)) is amended by inserting  
6 “(other than expenditures under section 1923)” after  
7 “with respect to expenditures”.

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

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

13 (a) IN GENERAL.—Section 1927(a)(1) (42 U.S.C.  
14 1396r-8(a)(1)) is amended by striking “shall not be effec-  
15 tive until” and inserting “shall become effective as of the  
16 date on which the agreement is entered into or, at State  
17 option, on any date thereafter on or before”.

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

21 **SEC. 607. MAKING MEDICAID DSH TRANSITION RULE PER-**  
22 **MANENT.**

23 (a) IN GENERAL.—Section 4721(e) of BBA (42  
24 U.S.C. 1396r-4 note) is amended—

25 (1) in the matter before paragraph (1), by  
26 striking “1923(g)(2)(A)” and “1396r-4(g)(2)(A)”

1 and inserting “1923(g)(2)” and “1396r-4(g)(2)”,  
2 respectively;

3 (2) in paragraphs (1) and (2)—

4 (A) by striking “, and before July 1,  
5 1999”; and

6 (B) by striking “in such section” and in-  
7 serting “in subparagraph (A) of such section”;  
8 and

9 (3) by striking “and” at the end of paragraph  
10 (1), by striking the period at the end of paragraph  
11 (2) and inserting “; and”, and by adding at the end  
12 the following new paragraph:

13 “(3) effective for State fiscal years that begin  
14 on or after July 1, 1999, ‘or (b)(1)(B)’ were in-  
15 serted in section 1923(g)(2)(B)(ii)(I) after  
16 ‘(b)(1)(A)’.”.

17 (b) EFFECTIVE DATE.—The amendments made by  
18 subsection (a) shall take effect as if included in the enact-  
19 ment of section 4721(e) of BBA.

20 **SEC. 608. MEDICAID TECHNICAL CORRECTIONS.**

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

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

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

3 (1) in paragraph (1)(C), by striking “children  
4 children” and inserting “children”;

5 (2) in paragraph (3), in the matter preceding  
6 subparagraph (A), by striking the first comma after  
7 “(a)(10)(A)(i)(VII)”;

8 (3) in paragraph (4)(B), by inserting a comma  
9 after “(a)(10)(A)(i)(IV)”.

10 (d) Section 1902(v) (42 U.S.C. 1396a(v)) is amended  
11 by striking “(1)”.

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

15 (f) The left margins of clauses (i) and (ii) of section  
16 1903(d)(3)(B) (42 U.S.C. 1396b(d)(3)(B)) are each re-  
17 aligned so as to align with the left margin of section  
18 1903(d)(3)(A).

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

21 (h) Section 1903(i)(14) (1396b(i)(14)) is amended by  
22 adding “or” after the semicolon.

23 (i) Section 1903(m)(2)(A) (42 U.S.C.  
24 1396b(m)(2)(A)) is amended—

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

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

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

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

10 (1) in paragraph (1)(B), by striking “puroses”  
11 and inserting “purposes”;

12 (2) in paragraph (3)(B), by inserting a comma  
13 after “(D)”;

14 (3) by realigning the left margin of clause (viii)  
15 in paragraph (7)(A) so as to align with the left mar-  
16 gin of clause (vii) of that paragraph.

17 (l) Section 1905(b)(1) (42 U.S.C. 1396d(b)(1)) is  
18 amended by striking “per centum,,” and inserting “per  
19 centum,”.

20 (m) Section 1905(l)(2)(B) (42 U.S.C.  
21 1936d(l)(2)(B)) is amended by striking “a entity” and in-  
22 serting “an entity”.

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

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

1 (1) in subsection (b), by striking  
2 “1902(a)(13)(E)” and inserting “1902(a)(13)(C)”;

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

6 (3) in subsection (h), by striking “90 day” and  
7 inserting “90 days”.

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

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

11 (2) in subsection (d)(4)(A), by striking “1124”  
12 and inserting “1124”).

13 (q) Section 1920(b)(2)(D)(i)(I) (42 U.S.C. 1396r–  
14 1(b)(2)(D)(i)(I)) is amended by striking “329, 330, or  
15 340” and inserting “330 or 330A”.

16 (r) Section 1920A(d)(1)(B) (42 U.S.C. 1396r–  
17 1a(d)(1)(B)) is amended by striking “a entity” and insert-  
18 ing “an entity”.

19 (s) Section 1923(c)(3)(B) (42 U.S.C. 1396r–  
20 4(c)(3)(B)) is amended by striking “patients.” and insert-  
21 ing “patients,”.

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

23 (1) in subsection (a)(3)(C), by striking “(i)(VI)  
24 (i)(VII),” and inserting “(i)(VI), (i)(VII),”; and

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

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

5           (1) in subsection (g)(2)(A)(ii)(II)(cc), by strik-  
6           ing “individuals” and inserting “individual’s”;

7           (2) in subsection (i)(1), by striking “the the”  
8           and inserting “the”; and

9           (3) in subsection (k)(7)—

10           (A) in subparagraph (A)(iv), by striking  
11           “distributers” and inserting “distributors”; and

12           (B) in subparagraph (C)(i), by striking  
13           “pharmaceutically” and inserting “pharma-  
14           ceutically”.

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

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

20           (2) in subsection (k)(1)(A)(i), by striking “set-  
21           tings,” and inserting “settings),”; and

22           (3) in subsection (l), by striking “State wide-  
23           ness” and inserting “Statewideness”.

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

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

3 (2) in subsection (d)—

4 (A) in paragraph (1)(C)(ii), by striking  
5 “Act” and inserting “Regulation”; and

6 (B) in paragraph (2)(B), by striking  
7 “1903(t)(3)” and inserting “1905(t)(3)”.

8 (x) Section 1933(b)(4) (42 U.S.C. 1396u-3(b)(4)) is  
9 amended by inserting “a” after “for a month in”.

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

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

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

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

21 (1) section 1902(a)(10)(A)(ii)(XIV) (42 U.S.C.  
22 1396a(a)(10)(A)(ii)(XIV)) is amended by striking  
23 “1905(u)(2)(C)” and inserting “1905(u)(2)(B)”;

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

1 (A), by striking “1905(p)(1), or 1905(u)” and in-  
2 serting “1902(a)(10)(A)(ii)(XIII),  
3 1902(a)(10)(A)(ii)(XIV), or 1905(p)(1)”; and  
4 (3) section 1905(a)(15) (42 U.S.C.  
5 1396d(a)(15)) is amended by striking  
6 “1902(a)(31)(A)” and inserting “1902(a)(31)”.

7 (bb) Except as otherwise provided, the amendments  
8 made by this section shall take effect on the date of enact-  
9 ment of this Act.

10 **TITLE VII—STATE CHILDREN’S**  
11 **HEALTH INSURANCE PRO-**  
12 **GRAM (SCHIP)**

13 **SEC. 701. STABILIZING THE STATE CHILDREN’S HEALTH IN-**  
14 **SURANCE PROGRAM ALLOTMENT FORMULA.**

15 (a) IN GENERAL.—Section 2104(b) (42 U.S.C.  
16 1397dd(b)) is amended—

17 (1) in paragraph (2)(A)—

18 (A) in clause (i), by striking “through  
19 2000” and inserting “and 1999”; and

20 (B) in clause (ii), by striking “2001” and  
21 inserting “2000”;

22 (2) by amending paragraph (4) to read as fol-  
23 lows:

24 “(4) FLOORS AND CEILINGS IN STATE ALLOT-  
25 MENTS.—

1           “(A) IN GENERAL.—The proportion of the  
2 allotment under this subsection for a subsection  
3 (b) State (as defined in subparagraph (D)) for  
4 fiscal year 2000 and each fiscal year thereafter  
5 shall be subject to the following floors and ceil-  
6 ings:

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

11           “(ii) ANNUAL FLOOR OF 10 PERCENT  
12 BELOW PRECEDING FISCAL YEAR’S PRO-  
13 PORTION.—A floor of 90 percent of the  
14 proportion for the State for the preceding  
15 fiscal year.

16           “(iii) CUMULATIVE FLOOR OF 30 PER-  
17 CENT BELOW THE FY 1999 PROPORTION.—  
18 A floor of 70 percent of the proportion for  
19 the State for fiscal year 1999.

20           “(iv) CUMULATIVE CEILING OF 45  
21 PERCENT ABOVE FY 1999 PROPORTION.—A  
22 ceiling of 145 percent of the proportion for  
23 the State for fiscal year 1999.

24           “(B) RECONCILIATION.—

1                   “(i) ELIMINATION OF ANY DEFICIT BY  
2                   ESTABLISHING A PERCENTAGE INCREASE  
3                   CEILING FOR STATES WITH HIGHEST AN-  
4                   NUAL PERCENTAGE INCREASES.—To the  
5                   extent that the application of subpara-  
6                   graph (A) would result in the sum of the  
7                   proportions of the allotments for all sub-  
8                   section (b) States exceeding 1.0, the Sec-  
9                   retary shall establish a maximum percent-  
10                  age increase in such proportions for all  
11                  subsection (b) States for the fiscal year in  
12                  a manner so that such sum equals 1.0.

13                  “(ii) ALLOCATION OF SURPLUS  
14                  THROUGH PRO RATA INCREASE.—To the  
15                  extent that the application of subpara-  
16                  graph (A) would result in the sum of the  
17                  proportions of the allotments for all sub-  
18                  section (b) States being less than 1.0, the  
19                  proportions of such allotments (as com-  
20                  puted before the application of floors under  
21                  clauses (i), (ii), and (iii) of subparagraph  
22                  (A)) for all subsection (b) States shall be  
23                  increased in a pro rata manner (but not to  
24                  exceed the ceiling established under sub-  
25                  paragraph (A)(iv)) so that (after the appli-

1 cation of such floors and ceiling) such sum  
2 equals 1.0.

3 “(C) CONSTRUCTION.—This paragraph  
4 shall not be construed as applying to (or taking  
5 into account) amounts of allotments redistrib-  
6 uted under subsection (f).

7 “(D) DEFINITIONS.—In this paragraph:

8 “(i) PROPORTION OF ALLOTMENT.—  
9 The term ‘proportion’ means, with respect  
10 to the allotment of a subsection (b) State  
11 for a fiscal year, the amount of the allot-  
12 ment of such State under this subsection  
13 for the fiscal year divided by the total of  
14 the amount available under this subsection  
15 for all such allotments for the fiscal year.

16 “(ii) SUBSECTION (b) STATE.—The  
17 term ‘subsection (b) State’ means one of  
18 the 50 States or the District of Colum-  
19 bia.”;

20 (3) in paragraph (2)(B), by striking “the fiscal  
21 year” and inserting “the calendar year in which  
22 such fiscal year begins”; and

23 (4) in paragraph (3)(B), by striking “the fiscal  
24 year involved” and inserting “the calendar year in  
25 which such fiscal year begins”.

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

5 **SEC. 702. INCREASED ALLOTMENTS FOR TERRITORIES**  
6 **UNDER THE STATE CHILDREN'S HEALTH IN-**  
7 **SURANCE PROGRAM.**

8 Section 2104(c)(4)(B) (42 U.S.C. 1397dd(c)(4)(B))  
9 is amended by inserting “, \$34,200,000 for each of fiscal  
10 years 2000 and 2001, \$25,200,000 for each of fiscal years  
11 2002 through 2004, \$32,400,000 for each of fiscal years  
12 2005 and 2006, and \$40,000,000 for fiscal year 2007”  
13 before the period.

14 **SEC. 703. IMPROVED DATA COLLECTION AND EVALUA-**  
15 **TIONS OF THE STATE CHILDREN'S HEALTH**  
16 **INSURANCE PROGRAM.**

17 (a) FUNDING FOR RELIABLE ANNUAL STATE-BY-  
18 STATE ESTIMATES ON THE NUMBER OF CHILDREN WHO  
19 DO NOT HAVE HEALTH INSURANCE COVERAGE.—Section  
20 2109 (42 U.S.C. 1397ii) is amended by adding at the end  
21 the following:

22 “(b) ADJUSTMENT TO CURRENT POPULATION SUR-  
23 VEY TO INCLUDE STATE-BY-STATE DATA RELATING TO  
24 CHILDREN WITHOUT HEALTH INSURANCE COVERAGE.—

1           “(1) IN GENERAL.—The Secretary of Com-  
2           merce shall make appropriate adjustments to the an-  
3           nual Current Population Survey conducted by the  
4           Bureau of the Census in order to produce statis-  
5           tically reliable annual State data on the number of  
6           low-income children who do not have health insur-  
7           ance coverage, so that real changes in the  
8           uninsurance rates of children can reasonably be de-  
9           tected. The Current Population Survey should  
10          produce data under this subsection that categorizes  
11          such children by family income, age, and race or eth-  
12          nicity. The adjustments made to produce such data  
13          shall include, where appropriate, expanding the sam-  
14          ple size used in the State sampling units, expanding  
15          the number of sampling units in a State, and an ap-  
16          propriate verification element.

17          “(2) APPROPRIATION.—Out of any money in  
18          the Treasury of the United States not otherwise ap-  
19          propriated, there are appropriated \$10,000,000 for  
20          fiscal year 2000 and each fiscal year thereafter for  
21          the purpose of carrying out this subsection.”.

22          (b) FEDERAL EVALUATION OF STATE CHILDREN’S  
23          HEALTH INSURANCE PROGRAMS.—Section 2108 (42  
24          U.S.C. 1397hh) is amended by adding at the end the fol-  
25          lowing:

1 “(c) FEDERAL EVALUATION.—

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

6 “(2) SELECTION OF STATES.—In selecting  
7 States for the evaluation conducted under this sub-  
8 section, the Secretary shall choose 10 States that  
9 utilize diverse approaches to providing child health  
10 assistance, represent various geographic areas (in-  
11 cluding a mix of rural and urban areas), and contain  
12 a significant portion of uncovered children.

13 “(3) MATTERS INCLUDED.—In addition to the  
14 elements described in subsection (b)(1), the evalua-  
15 tion conducted under this subsection shall include  
16 each of the following:

17 “(A) Surveys of the target population (en-  
18 rollees, disenrollees, and individuals eligible for  
19 but not enrolled in the program under this  
20 title).

21 “(B) Evaluation of effective and ineffective  
22 outreach and enrollment practices with respect  
23 to children (for both the program under this  
24 title and the medicaid program under title  
25 XIX), and identification of enrollment barriers

1 and key elements of effective outreach and en-  
2 rollment practices, including practices that have  
3 successfully enrolled hard-to-reach populations  
4 such as children who are eligible for medical as-  
5 sistance under title XIX but have not been en-  
6 rolled previously in the medicaid program under  
7 that title.

8 “(C) Evaluation of the extent to which  
9 State medicaid eligibility practices and proce-  
10 dures under the medicaid program under title  
11 XIX are a barrier to the enrollment of children  
12 under that program, and the extent to which  
13 coordination (or lack of coordination) between  
14 that program and the program under this title  
15 affects the enrollment of children under both  
16 programs.

17 “(D) An assessment of the effect of cost-  
18 sharing on utilization, enrollment, and coverage  
19 retention.

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

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

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

3 “(5) FUNDING.—Out of any money in the  
4 Treasury of the United States not otherwise appro-  
5 priated, there are appropriated \$10,000,000 for fis-  
6 cal year 2000 for the purpose of conducting the eval-  
7 uation authorized under this subsection. Amounts  
8 appropriated under this paragraph shall remain  
9 available for expenditure through fiscal year 2002.”.

10 (c) INSPECTOR GENERAL AUDIT AND GAO REPORT  
11 ON ENROLLEES ELIGIBLE FOR MEDICAID.—Section 2108  
12 (42 U.S.C. 1397hh), as amended by subsection (b), is  
13 amended by adding at the end the following:

14 “(d) INSPECTOR GENERAL AUDIT AND GAO RE-  
15 PORT.—

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

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

1           come           children           under           section  
2           1902(a)(10)(A)(ii)(XIV)); and

3                   “(B) assess the progress made in reducing  
4           the number of uncovered low-income children,  
5           including the progress made to achieve the stra-  
6           tegic objectives and performance goals included  
7           in the State child health plan under section  
8           2107(a).

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

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

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



1           (2) the term “State children’s health insurance  
2           program” instead of the term “children’s health in-  
3           surance program”.

4 **SEC. 705. SCHIP TECHNICAL CORRECTIONS.**

5           (a) Section 2104(b)(3)(B) (42 U.S.C.  
6 1397dd(b)(3)(B)) is amended by striking “States.” and  
7 inserting “States,”.

8           (b) Section 2105(d)(2)(B)(iii) (42 U.S.C.  
9 1397ee(d)(2)(B)(iii)) is amended by inserting “in” after  
10 “described”.

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

13           (1) in paragraph (1), by striking “title II” and  
14           inserting “title I”; and

15           (2) in paragraph (2), by inserting “)” before  
16           the period.