106TH CONGRESS
2D SESSION

S. _____

IN THE SENATE OF THE UNITED STATES

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

A BILL

To amend the Social Security Act to make corrections and refinements in the Medicare, Medicaid, and SCHIP health insurance programs, as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO OTHER ACTS; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 2000''.

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

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

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

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

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

TITLE I—BENEFIT IMPROVEMENTS

Subtitle A—Beneficiary Assistance

SEC. 101. LIMITING COPAYMENT AMOUNT FOR HOSPITAL OUTPATIENT SERVICES.

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

(1) in the heading, by striking ''TO INPATIENT HOSPITAL DEDUCTIBLE AMOUNT''; and

(2) by striking ''exceed the amount'' and all that follows before the period and inserting ''exceed an amount equal to the greater of—

''(i) one-half of the amount of the inpatient hospital deductible established under section 1813(b) for that year; or

''(ii) 20 percent of the payment amount determined under this subsection for the procedure.''.

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

SEC. 102. COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.

(a) ELIMINATION OF TIME LIMITATION FOR COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—

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

''(J) prescription drugs used in immunosuppressive therapy furnished to an individual who—

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

''(B) received an organ transplant during the 36-month period immediately preceding the individual's most recent effective date of coverage of benefits under this part.''.

(2) CONFORMING AMENDMENTS.—

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

(i) by striking subsection (b); and

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

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

(b) CONTINUED ENTITLEMENT FOR IMMUNOSUPPRESSIVE DRUGS FOR CERTAIN INDIVIDUALS AFTER MEDICARE BENEFITS END.—

(1) IN GENERAL.—Section 226A(b)(2) (42 U.S.C. 426–1(b)(2)) is amended by inserting ''(except for the provision of immunosuppressive drugs pursuant to section 1861(s)(2)(J))'' after ''shall end''.

(2) APPLICATION.—In the case of an individual whose eligibility for benefits under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) has ended except for the provision of immunosuppressive drugs pursuant to the amendment made by paragraph (1), such individual shall be deemed to be enrolled in the original medicare fee-for-service program for purposes of receiving coverage of such drugs.

(3) TECHNICAL AMENDMENT.—Subsection (c) of section 226A (42 U.S.C. 426–1), as added by section 201(a)(3)(D)(ii) of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296; 108 Stat. 1497), is redesignated as subsection (d).

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

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

SEC. 103. PRESERVATION OF COVERAGE OF DRUGS AND BIOLOGICALS UNDER PART B OF THE MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended, in each of subparagraphs (A) and (B), by striking ''(including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered)'' and inserting ''(including injectable and infusable drugs and biologicals which are not usually self-administered by the patient)''.

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

(1) REPORT TO CONGRESS REQUIRED BEFORE COVERAGE IS LIMITED OR TERMINATED.—Notwithstanding any other provision of law, beginning on the date of enactment of this Act, the Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') may not limit or terminate coverage (or permit an agency or organization with a contract under section 1816 or 1842 of the Social Security Act (42 U.S.C. 1395h; 42 U.S.C. 1395u) to limit or terminate coverage) of any

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

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

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

(B) the reasons for taking such action.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to drugs and biologicals furnished on or after October 1, 2000.

SEC. 104. MORATORIUM ON REDUCTIONS IN CURRENT REIMBURSEMENT RATES FOR OUTPATIENT DRUGS AND BIOLOGICALS; GAO STUDY AND REPORT AND HHS COMMENTS.

(a) MORATORIUM.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may not implement any reduction in the rate of reimbursement for any outpatient drug or biological under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) during the period that begins on the date of enactment of this Act and ends on September 15, 2001.

(b) GAO STUDY AND REPORT REGARDING REIMBURSEMENT RATES FOR OUTPATIENT DRUGS AND BIOLOGICALS.—

(1) STUDY.—

(A) IN GENERAL.—The Comptroller General of the United States shall conduct a study on the reasonableness of the reimbursement policy for outpatient drugs and biologicals under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) based on the average wholesale price of such drugs.

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

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

(2) REPORT.—Not later than July 1, 2001, the Comptroller General of the United States shall submit to the Secretary of Health and Human Services and Congress a report on the study conducted under paragraph (1) together with recommendations for such legislation and administrative actions as the Comptroller General considers appropriate regarding any adjustment in payment policy necessary to ensure reasonable reimbursement for outpatient drugs and biologicals under the medicare program.

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

Subtitle B—Improved Preventive Benefits

SEC. 111. COVERAGE OF BIANNUAL SCREENING PAP SMEAR AND PELVIC EXAMS.

(a) IN GENERAL.—

(1) BIANNUAL SCREENING PAP SMEAR.—Section 1861(nn)(1) (42 U.S.C. 1395x(nn)(1)) is

amended by striking ''3 years'' and inserting ''2 years''.

(2) BIANNUAL SCREENING PELVIC EXAM.—Section 1861(nn)(2) (42 U.S.C. 1395x(nn)(2)) is amended by striking ''3 years'' and inserting ''2 years''.

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

SEC. 112. COVERAGE OF SCREENING COLONOSCOPY FOR AVERAGE RISK INDIVIDUALS.

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

(1) in paragraph (1)(C), by striking ''In the case of an individual at high risk for colorectal cancer, screening colonoscopy'' and inserting ''Screening colonoscopy''; and

(2) in paragraph (2), by striking ''In paragraph (1)(C), an'' and inserting ''An''.

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

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

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

(2) in paragraph (3)—

(A) in the heading by striking ''FOR INDIVIDUALS AT HIGH RISK FOR COLORECTAL CANCER'';

(B) in subparagraph (A), by striking ''for individuals at high risk for colorectal cancer (as defined in section 1861(pp)(2))'';

(C) in subparagraph (E), by inserting before the period at the end the following: ''or for other individuals if the procedure is performed within the 119 months after a previous screening colonoscopy or within 47 months of a previous screening flexible sigmoidoscopy''.

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

SEC. 113. MEDICAL NUTRITION THERAPY SERVICES FOR BENEFICIARIES WITH DIABETES, A CARDIOVASCULAR DISEASE, OR A RENAL DISEASE.

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

(1) in subparagraph (S), by striking ''and'' at the end;

(2) in subparagraph (T), by adding ''and'' at the end; and

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

''(U) medical nutrition therapy services (as defined in subsection (uu)(1)) in the case of a beneficiary with diabetes, a cardiovascular disease (including congestive heart failure, arteriosclerosis, hyperlipidemia, hypertension, and hypercholesterolemia), or a renal disease;''.

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

''Medical Nutrition Therapy Services; Registered Dietitian or Nutrition Professional

''(uu)(1) The term 'medical nutrition therapy services' means nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional (as defined in paragraph (2)) pursuant to a referral by a physician (as defined in subsection (r)(1)).

''(2) Subject to paragraph (3), the term 'registered dietitian or nutrition professional' means an individual who—

''(A) holds a baccalaureate or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized by the Secretary for this purpose;

''(B) has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional; and

''(C)(i) is licensed or certified as a dietitian or nutrition professional by the State in which the service is performed; or

''(ii) in the case of an individual in a State that does not provide for such licensure or certification, meets such other criteria as the Secretary establishes.

''(3) Subparagraphs (A) and (B) of paragraph (2) shall not apply in the case of an individual who, as of the date of enactment of this subsection, is licensed or certified as a dietitian or nutrition professional by the State in which the medical nutrition therapy service is performed.''.

(c) LIMITATION ON FREQUENCY.—Section 1834 (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(m) FREQUENCY LIMITATION FOR COVERAGE OF MEDICAL NUTRITION THERAPY SERVICES.—Notwithstanding any other provision of this part, no payment may be made under this part for a medical nutrition therapy service (as defined in section 1861(uu)) provided to an individual if such service is provided—

''(1) during the 12-month period beginning on the date that such individual first received a medical nutrition therapy service covered under this part and such individual has previously received 3 medical nutritional therapy services during such period; or

''(2) at any time after such 12-month period if such individual has previously received 3 medical nutritional therapy services covered under this part after such 12-month period.

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

(1) by striking ''and'' before ''(S)''; and

(2) by inserting before the semicolon at the end the following: '', and (T) with respect to medical nutrition therapy services (as defined in section 1861(uu)(1)), the amount paid shall be 85 percent

of the lesser of the actual charge for the services or the amount determined under the fee schedule established under section 1848(b) for the same services if furnished by a physician''.

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

(1) in subparagraph (H), by striking ''and'' at the end;

(2) in subparagraph (I), by striking the semicolon at the end and inserting '', and''; and

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

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

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

SEC. 114. STATE ACCREDITATION OF DIABETES SELF-MANAGEMENT TRAINING PROGRAMS.

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

(1) in the matter preceding subparagraph (A), by striking ''paragraph (1)—'' and inserting ''paragraph (1):'';

(2) in subparagraph (A)—

(A) by striking ''a 'certified provider' '' and inserting ''A 'certified provider' ''; and

(B) by striking ''; and'' and inserting a period; and

(3) in subparagraph (B)—

(A) by striking ''a physician, or such other individual'' and inserting ''(i) A physician, or such other individual'';

(B) by inserting ''(I)'' before ''meets applicable standards'';

(C) by inserting ''(II)'' before ''is recognized'';

(D) by inserting '', or by a program described in clause (ii),'' after ''recognized by an organization that represents individuals (including individuals under this title) with diabetes''; and

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

''(ii) Notwithstanding any reference to 'a national accreditation body' in section 1865(b), for

purposes of clause (i), a program described in this clause is a program operated by a State for the purposes of accrediting diabetes self-management training programs, if the Secretary determines that such State program has established quality standards that meet or exceed the standards established by the Secretary under clause (i) or the standards originally established by the National Diabetes Advisory Board and subsequently revised as described in clause (i).''.

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

(a) STUDIES.—The Secretary of Health and Human Services, acting through the United States Preventive Services Task Force, shall conduct a series of studies designed to identify preventive interventions that can be delivered in the primary care setting and that are most valuable to older Americans.

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

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

port to Congress on the conclusions of the studies conducted under subsection (a), together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

SEC. 116. INSTITUTE OF MEDICINE 3-YEAR MEDICARE PREVENTION BENEFIT STUDY AND REPORT.

(a) STUDY.—

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

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

(B) to submit the report described in subsection (b).

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

(A) whether each covered benefit is—

(i) medically effective; and

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

(B) utilization of covered benefits (including any barriers to or incentives to increase utilization); and

(C) quality of life issues associated with both health promotion and disease prevention benefits covered under the medicare program and those that are not covered under such program that would affect all medicare beneficiaries.

(b) REPORT.—

(1) IN GENERAL.—Not later than 3 years after the date of enactment of this Act, and every third year thereafter, the Institute of Medicine of the National Academy of Sciences shall submit to the Secretary of Health and Human Services and Congress a report that contains a detailed statement of the findings and conclusions of the study conducted under subsection (a) and the recommendations for legislation described in paragraph (2).

(2) RECOMMENDATIONS FOR LEGISLATION.—The Institute of Medicine of the National Academy of Sciences, in consultation with the Partnership for Prevention, shall develop recommendations in legislative form that—

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

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

(3) REQUIREMENTS FOR INITIAL REPORT.—The initial report submitted pursuant to paragraph (1) shall address issues related to the following preventive benefits:

(A) Thyroid screening.

(B) Smoking cessation therapy services.

(C) Glaucoma detection tests.

(D) Appropriate preventive treatments for precancerous skin lesions.

(c) DEFINITIONS.—In this section:

(1) COST-EFFECTIVE BENEFIT.—The term ''cost-effective benefit'' means a benefit or technique that has—

(A) been subject to peer review;

(B) been described in scientific journals; and

(C) demonstrated value as measured by unit costs relative to health outcomes achieved.

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

(A) been subject to peer review;

(B) been described in scientific journals; and

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

(3) MEDICALLY EFFECTIVE.—The term ''medically effective'' means, with respect to a benefit or technique, that the benefit or technique has been—

(A) subject to peer review;

(B) described in scientific journals; and

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

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

SEC. 117. MEDPAC STUDY AND REPORT ON MEDICARE COVERAGE OF CARDIAC AND PULMONARY REHABILITATION THERAPY SERVICES.

(a) STUDY.—

(1) IN GENERAL.—The Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) (in this section referred to as ''MedPAC'') shall conduct a study on coverage of cardiac and pulmonary rehabilitation therapy services under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

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

(A) qualifying diagnoses required for coverage of cardiac and pulmonary rehabilitation therapy services;

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

(C) level of reimbursement for such services.

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

gether with such recommendations for legislation and administrative action as MedPAC determines appropriate.

TITLE II—RURAL HEALTH CARE IMPROVEMENTS

Subtitle A—Critical Access Hospital Provisions

SEC. 201. CLARIFICATION OF NO BENEFICIARY COST-SHARING FOR CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED BY CRITICAL ACCESS HOSPITALS.

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

''(4) NO BENEFICIARY COST-SHARING FOR CLINICAL DIAGNOSTIC LABORATORY SERVICES.—No coinsurance, deductible, copayment, or other cost sharing otherwise applicable under this part shall apply with respect to clinical diagnostic laboratory services furnished as an outpatient critical access hospital service. Nothing in this title shall be construed as providing for payment for clinical diagnostic laboratory services furnished as part of outpatient critical access hospital services, other than on the basis described in this subsection.''.

(b) TECHNICAL AND CONFORMING AMENDMENTS.—

(1) Paragraphs (1)(D)(i) and (2)(D)(i) of section 1833(a) (42 U.S.C. 1395l(a)(1)(D)(i); 1395l(a)(2)(D)(i)) are each amended by striking ''or which are furnished on an outpatient basis by a critical access hospital''.

(2) Section 403(d)(2) of BBRA (113 Stat. 1501A–371) is amended by striking ''The amendment made by subsection (a) shall apply'' and inserting ''Paragraphs (1) through (3) of section 1834(g) of the Social Security Act (as amended by paragraph (1)) apply''.

(c) EFFECTIVE DATES.—The amendment made—

(1) by subsection (a) applies to services furnished on or after the date of the enactment of BBRA;

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

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

SEC. 202. REVISION OF PAYMENT FOR PROFESSIONAL SERVICES PROVIDED BY A CRITICAL ACCESS HOSPITAL.

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

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

SEC. 203. PERMITTING CRITICAL ACCESS HOSPITALS TO OPERATE PPS EXEMPT DISTINCT PART PSYCHIATRIC AND REHABILITATION UNITS.

(a) CRITERIA FOR DESIGNATION AS A CRITICAL ACCESS HOSPITAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395i–4(c)(2)(B)(iii)) is amended by inserting ''excluding any psychiatric or rehabilitation unit of the facility which is a distinct part of the facility,'' before ''provides not''.

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

empt from the prospective payment system under this section.''.

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

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

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

(1) in the heading, by striking ''TRANSITION FOR'' and inserting ''TREATMENT OF'';

(2) in subparagraph (A), by striking ''IN GENERAL.—The'' and inserting ''TRANSITION.—Subject to subparagraph (C), the'';

(3) in subparagraph (A), by inserting ''(other than critical access hospitals)'' after ''facilities described in subparagraph (B)'';

(4) in subparagraph (B), by striking '', for which payment'' and all that follows before the period at the end; and

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

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

established under this subsection shall not apply to services furnished by a critical access hospital pursuant to an agreement under section 1883.''.

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

(1) in paragraph (2)(A), by inserting ''(other than a critical access hospital)'' after ''any hospital''; and

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

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

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

Subtitle B—Other Rural Hospital Provisions

SEC. 211. EQUITABLE TREATMENT FOR RURAL DISPROPORTIONATE SHARE HOSPITALS.

(a) APPLICATION OF UNIFORM THRESHOLD.—Section 1886(d)(5)(F)(v) (42 U.S.C. 1395ww(d)(5)(F)(v)) is amended—

(1) in subclause (II), by inserting ''(or 15 percent, for discharges occurring on or after October 1, 2001)'' after ''30 percent'';

(2) in subclause (III), by inserting ''(or 15 percent, for discharges occurring on or after October 1, 2001)'' after ''40 percent''; and

(3) in subclause (IV), by inserting ''(or 15 percent, for discharges occurring on or after October 1, 2001)'' after ''45 percent''.

(b) ADJUSTMENT OF PAYMENT FORMULAS.—

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

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

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

''(x) For purposes of clause (iv)(VI), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

''(I) is less than 17.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P–15)(.65) + 2.5;

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

''(III) is equal to or exceeds 30, such adjustment percentage is equal to 10 percent,

where 'P' is the hospital's disproportionate patient percentage (as defined in clause (vi)).''.

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

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

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

''(xi) For purposes of clause (iv)(V), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

''(I) is less than 17.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P–15)(.65) + 2.5;

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

''(III) is equal to or exceeds 30, such adjustment percentage is determined in accordance with the following formula: (P–30)(.6) + 4,

where 'P' is the hospital's disproportionate patient percentage (as defined in clause (vi)).''.

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

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

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

''(xii) For purposes of clause (iv)(III), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

''(I) is less than 17.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P–15)(.65) + 2.5;

''(II) is equal to or exceeds 17.3, such adjustment percentage is equal to 4 percent,

where 'P' is the hospital's disproportionate patient percentage (as defined in clause (vi)).''.

(4) HOSPITALS THAT ARE BOTH SOLE COMMUNITY HOSPITALS AND RURAL REFERRAL CENTERS.—Such section is further amended, in clause (iv)(IV), by inserting after ''clause (viii)'' the following: ''or, for discharges occurring on or after October 1, 2001, the greater of the percentages determined under clause (x) or (xi)''.

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

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

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

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

''(xiii) For purposes of clause (iv)(II), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

''(I) is less than 17.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P–15)(.65) + 2.5;

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

''(III) is equal to or exceeds 40, such adjustment percentage is equal to 5 percent,

where 'P' is the hospital's disproportionate patient percentage (as defined in clause (vi)).''.

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

SEC. 212. OPTION TO BASE ELIGIBILITY FOR MEDICARE DEPENDENT, SMALL RURAL HOSPITAL PROGRAM ON DISCHARGES DURING ANY OF THE 3 MOST RECENT AUDITED COST REPORTING PERIODS.

(a) IN GENERAL.—Section 1886(d)(5)(G)(iv)(IV) (42 U.S.C. 1395ww(d)(5)(G)(iv)(IV)) is amended by inserting ", or any of the 3 most recent audited cost reporting periods," after "1987".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to cost reporting periods beginning on or after the date of enactment of this Act.

SEC. 213. EXTENSION OF OPTION TO USE REBASED TARGET AMOUNTS TO ALL SOLE COMMUNITY HOSPITALS.

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

(1) in the matter preceding subclause (I)—

(A) by striking "that for its cost reporting period beginning during 1999 is paid on the basis of the target amount applicable to the hospital under subparagraph (C) and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital"; and

(B) by striking ''substituted for such target amount'' and inserting ''substituted, if such substitution results in a greater payment under this section for such hospital, for the amount otherwise determined under subsection (d)(5)(D)(i)'';

(2) in subclause (I), by striking ''target amount otherwise applicable'' and all that follows through ''target amount')'' and inserting ''the amount otherwise applicable to the hospital under subsection (d)(5)(D)(i) (referred to in this clause as the 'subsection (d)(5)(D)(i) amount')''; and

(3) in each of subclauses (II) and (III), by striking ''subparagraph (C) target amount'' and inserting ''subsection (d)(5)(D)(i) amount''.

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

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

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

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

(2) in its report under subsection (b) of such section a recommendation on whether special treatment for such hospitals may be warranted.

Subtitle C—Other Rural Provisions

SEC. 221. PROVIDER-BASED RURAL HEALTH CLINIC CAP EXEMPTION.

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

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

SEC. 222. PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT SERVICES.

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

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

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

(a) INCREASE FOR 2001 AND 2002.—In the case of a unit of home health service furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) during 2001 or 2002, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such unit of service by 10 percent.

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

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

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

SEC. 224. REFINEMENT OF MEDICARE REIMBURSEMENT FOR TELEHEALTH SERVICES.

(a) REVISION OF TELEHEALTH PAYMENT METHODOLOGY AND ELIMINATION OF FEE-SHARING REQUIREMENT.—Section 4206(b) of the Balanced Budget Act of 1997 (42 U.S.C. 1395l note) is amended to read as follows:

''(b) METHODOLOGY FOR DETERMINING AMOUNT OF PAYMENTS.—

''(1) IN GENERAL.—The Secretary shall pay to—

''(A) the physician or practitioner at a distant site that provides an item or service under subsection (a) an amount equal to the amount that such physician or provider would have been paid had the item or service been provided without the use of a telecommunications system; and

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

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

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

''(3) DEFINITIONS.—In this subsection:

''(A) DISTANT SITE.—The term 'distant site' means the site at which the physician or practitioner is located at the time the item or service is provided via a telecommunications system.

''(B) FACILITY FEE.—The term 'facility fee' means an amount equal to—

''(i) for 2000 and 2001, $20; and

''(ii) for a subsequent year, the facility fee under this subsection for the previous year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for such subsequent year.

''(C) ORIGINATING SITE.—

''(i) IN GENERAL.—The term 'originating site' means the site described in clause (ii) at which the eligible telehealth beneficiary under the medicare program is located at the time the item or service is provided via a telecommunications system.

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

''(I) On or before January 1, 2002, the office of a physician or a practitioner, a critical access hospital, a rural health clinic, and a Federally qualified health center.

''(II) On or before January 1, 2003, a hospital, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a renal dialysis facility, an ambulatory surgical center, an Indian Health Service facility, and a community mental health center.''.

(b) ELIMINATION OF REQUIREMENT FOR TELEPRESENTER.—Section 4206 of the Balanced Budget Act of 1997 (42 U.S.C. 1395l note) is amended—

(1) in subsection (a), by striking '', notwithstanding that the individual physician'' and all that follows before the period at the end; and

(2) by adding at the end the following new subsection:

''(e) TELEPRESENTER NOT REQUIRED.—Nothing in this section shall be construed as requiring an eligible telehealth beneficiary to be presented by a physician or practi-

tioner for the provision of an item or service via a telecommunications system.''.

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

(1) by striking ''IN GENERAL.—Not later than'' and inserting the following: ''TELEHEALTH SERVICES REIMBURSED.—

''(1) IN GENERAL.—Not later than'';

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

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

''(2) ELIGIBLE TELEHEALTH BENEFICIARY DEFINED.—In this section, the term 'eligible telehealth beneficiary' means a beneficiary under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) that resides in—

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

''(B) a county that is not included in a Metropolitan Statistical Area; or

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

(d) TELEHEALTH COVERAGE FOR DIRECT PATIENT CARE.—

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

(A) in subsection (a)(1), by striking ''professional consultation via telecommunications systems with a physician'' and inserting ''items and services for which payment may be made under such part that are furnished via a telecommunications system by a physician''; and

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

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

(2) STUDY AND REPORT REGARDING ADDITIONAL ITEMS AND SERVICES.—

(A) STUDY.—The Secretary of Health and Human Services shall conduct a study to identify items and services in addition to those described in section 4206(f) of the Balanced Budget Act of 1997 (as added by paragraph (1)) that would be appropriate to provide payment under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

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

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

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

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

''(3) PRACTITIONER DEFINED.—For purposes of paragraph (1), the term 'practitioner' includes—

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

''(B) a physical, occupational, or speech therapist.''.

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

''(4) USE OF STORE-AND-FORWARD TECHNOLOGIES.—For purposes of paragraph (1), in the case of any Federal telemedicine demonstration program in Alaska or Hawaii, the term 'telecommunications system' includes store-and-forward technologies that provide for the asynchronous transmission of health care information in single or multimedia formats.''.

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

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

"(5) CONSTRUCTION RELATING TO HOME HEALTH SERVICES.—

"(A) IN GENERAL.—Nothing in this section or in section 1895 of the Social Security Act (42 U.S.C. 1395fff) shall be construed as preventing a home health agency that is receiving payment under the prospective payment system described in such section from furnishing a home health service via a telecommunications system.

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

"(i) determining the amount of payment to be made under the prospective payment system established under section 1895 of the Social Security Act (42 U.S.C. 1395fff); or

"(ii) any requirement relating to the certification of a physician required under section 1814(a)(2)(C) of such Act (42 U.S.C. 1395f(a)(2)(C)).".

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

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

(a) STUDY.—The Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) (in this section referred to as ''MedPAC'') shall conduct a study on the effect of low patient and procedure volume on the financial status of low-volume, isolated rural health care providers participating in the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

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

(1) whether low-volume, isolated rural health care providers are having, or may have, significantly decreased medicare margins or other financial difficulties resulting from any of the payment methodologies described in subsection (c);

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

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

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

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

(1) The prospective payment system for hospital outpatient department services under section 1833(t) of the Social Security Act (42 U.S.C. 1395l).

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

(3) The prospective payment system for inpatient hospital services under section 1886 of such Act (42 U.S.C. 1395ww).

(4) The prospective payment system for routine service costs of skilled nursing facilities under section 1888(e) of such Act (42 U.S.C. 1395yy(e)).

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

TITLE III—PROVISIONS RELATING TO PART A

Subtitle A—PPS Hospitals

SEC. 301. DELAY OF REDUCTION IN PPS HOSPITAL PAYMENT UPDATE.

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

(1) in subclause (XVI), by striking ''minus 1.1 percentage points for hospitals (other than sole community hospitals) in all areas, and the market basket percentage increase for sole community hospitals,'' and inserting ''for hospitals in all areas,'';

(2) in subclause (XVII)—

(A) by striking ''minus 1.1 percentage points''; and

(B) by striking ''and'' at the end;

(3) by redesignating subclause (XVIII) as subclause (XIX);

(4) in subclause (XIX), as so redesignated, by striking ''fiscal year 2003'' and inserting ''fiscal year 2004''; and

(5) by inserting after subclause (XVII) the following new subclause:

''(XVIII) for fiscal year 2003, the market basket percentage increase minus 1 percentage point for hospitals in all areas, and''.

(b) SPECIAL RULE FOR PAYMENT FOR INPATIENT HOSPITAL SERVICES FOR FISCAL YEAR 2001.—Notwithstanding the amendments made by subsection (a), for purposes of making payments for fiscal year 2001 for inpatient hospital services furnished by subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))), the ''applicable percentage increase'' referred to in section 1886(b)(3)(B)(i) of such Act (42 U.S.C. 1395ww(b)(3)(B)(i))—

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

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

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

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

SEC. 302. REVISION OF REDUCTION OF INDIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.

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

(1) in subclause (V)—

(A) by striking ''fiscal year 2001'' and inserting ''each of fiscal years 2001 and 2002''; and

(B) by striking ''equal to 1.54'' and inserting ''equal to 1.6''; and

(2) in subclause (VI), by striking ''2001'' and inserting ''2002''.

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

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

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

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

(c) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended—

(1) by striking ''1997'' and inserting ''1997,''; and

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

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

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

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

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

SEC. 303. DECREASE IN REDUCTIONS FOR DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.

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

(1) in subclause (III), by striking ''each of fiscal years 2000 and 2001'' and inserting ''fiscal year 2000'';

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

(3) in subclause (V), as redesignated, by striking ''4 percent'' and inserting ''3 percent''; and

(4) by inserting after subclause (III) the following new subclause:

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

(b) SPECIAL RULE FOR DSH PAYMENT.—Notwithstanding the amendments made by subsection (a), for purposes of making disproportionate share payments for subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) for fiscal year 2001, the additional payment amount other-

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

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

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

(c) CONFORMING AMENDMENTS RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)), is amended—

(1) by striking ''1989 or'' and inserting ''1989,''; and

(2) by inserting '', or the enactment of section 303 of the Medicare, Medicaid, and SCHIP Balanced Budget Further Refinement Act of 2000'' after ''Omnibus Budget Reconciliation Act of 1990''.

SEC. 304. MODIFICATION OF PAYMENT RATE FOR PUERTO RICO HOSPITALS.

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

(1) in clause (i), by striking ''October 1, 1997, 50 percent ('' and inserting ''October 1, 2000, 25 percent (for discharges between October 1, 1997, and September 30, 2000, 50 percent,''; and

(2) in clause (ii), in the matter preceding subclause (I), by striking ''after October 1, 1997, 50 percent ('' and inserting ''after October 1, 2000, 75 percent (for discharges between October 1, 1997, and September 30, 2000, 50 percent,''.

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

(1) IN GENERAL.—Notwithstanding the amendment made by subsection (a), for purposes of making payments for the operating costs of inpatient hospital services of a section 1886(d) Puerto Rico hospital for fiscal year 2001, the amount referred to in the matter preceding clause (i) of section 1886(d)(9)(A) of the Social Security Act (42 U.S.C. 1395ww(d)(9)(A))—

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

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

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

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

(ii) using 100 percent of the discharge-weighted average referred to in clause (ii) of such section.

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

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

(a) STUDY.—

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

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

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

(A) the appropriate method for determining hospital area wage indexes;

(B) the appropriate portion of hospital payments that should be adjusted by the applicable area wage index;

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

(D) the feasibility and impact of making changes (as determined appropriate by MedPAC) to the methods used to determine such indexes, including the need for a data system required to implement such changes.

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

gether with such recommendations for legislation and administrative action as MedPAC determines appropriate.

SEC. 306. MEDPAC STUDY AND REPORT REGARDING CERTAIN HOSPITAL COSTS.

(a) STUDY.—

(1) IN GENERAL.—The Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) (in this section referred to as ''MedPAC'') shall conduct a study on—

(A) any increased costs incurred by subsection (d) hospitals (as defined in paragraph (1)(B) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d))) in providing inpatient hospital services to medicare beneficiaries under title XVIII of such Act during the period beginning on October 1, 1983, and ending on September 30, 1999, that were attributable to—

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

(ii) providing such services using new technologies;

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

section provides adequate and timely recognition of such increased costs;

(C) the prospects for (and to the extent practicable, the magnitude of) cost increases that hospitals will incur in providing such services that are attributable to complying with new blood safety measure requirements and providing such services using new technologies during the 10 years after the date of enactment of this Act; and

(D) the feasibility and advisability of establishing mechanisms under such payment system to provide for more timely and accurate recognition of such cost increases in the future.

(2) CONSULTATION.—In conducting the study under this section, MedPAC shall consult with representatives of the blood community, including

(A) hospitals;

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

(C) organizations involved in the development of new blood safety technologies.

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

gress on the study conducted under subsection (a) together with such recommendations for legislation and administrative action as MedPAC determines appropriate.

Subtitle B—PPS Exempt Hospitals

SEC. 311. PERMANENT GUARANTEE OF PRE-BBA PAYMENT LEVELS FOR OUTPATIENT SERVICES FURNISHED BY CHILDREN'S HOSPITALS.

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

(1) in the heading of paragraph (7)(D)(ii), by inserting ''AND CHILDREN'S HOSPITALS'' after ''CANCER HOSPITALS''; and

(2) in paragraphs (7)(D)(ii) and (11), by striking ''section 1886(d)(1)(B)(v)'' and inserting ''clause (iii) or (v) of section 1886(d)(1)(B)''.

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

SEC. 312. PAYMENT FOR INPATIENT SERVICES OF REHABILITATION HOSPITALS.

(a) ASSISTANCE WITH ADMINISTRATIVE COSTS ASSOCIATED WITH COMPLETION OF PATIENT ASSESSMENT.—Section 1886(j)(3)(B) (42 U.S.C. 1395ww(j)(3)(B)) is amended by striking ''98 percent''

and inserting ''100 percent for fiscal year 2001 and 98 percent for fiscal year 2002''.

(b) ELECTION TO APPLY FULL PROSPECTIVE PAYMENT RATE WITHOUT PHASE-IN.—

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

(A) in subparagraph (A), by inserting ''other than a facility making an election under subparagraph (F)'' before '', in a cost reporting period'';

(B) in subparagraph (B), by inserting ''or, in the case of a facility making an election under subparagraph (F), for any cost reporting period described in such subparagraph,'' after ''2002,''; and

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

''(F) ELECTION TO APPLY FULL PROSPECTIVE PAYMENT SYSTEM.—A rehabilitation facility may elect, at least 30 days before the first date on which the payment methodology under this subsection applies, to have payment made to the facility under this subsection under the provisions of subparagraph (B) (rather than subparagraph (A)) for each cost reporting pe-

riod to which such payment methodology applies.''.

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

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

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

(a) MODIFICATION OF REQUIREMENT.—In developing the prospective payment system required under section 123 of BBRA (113 Stat. 1501A–331), the Secretary of Health and Human Services shall examine the feasibility and the impact of basing payment under such system on the use of existing (or refined) hospital diagnosis-related groups (DRGs) and the use of the most recently available hospital discharge data.

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

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

Subtitle C—Skilled Nursing Facilities

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

(a) REVISION.—Section 1888(e)(4)(E)(ii)(II) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(E)(ii)(II)) is amended by striking ''minus 1 percentage point'' and inserting ''plus 1 percentage point''.

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

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

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

(2) for the period beginning on April 1, 2001, and ending on September 30, 2001, shall be the rate computed for fiscal year 2000 pursuant to subclause (I) of such paragraph increased by the skilled nursing facility market basket percentage change for fiscal year 2001 plus 3 percentage points.

SEC. 322. APPLICATION OF SNF CONSOLIDATED BILLING REQUIREMENT LIMITED TO PART A COVERED STAYS.

(a) IN GENERAL.—Section 1862(a)(18) (42 U.S.C. 1395y(a)(18)) is amended by inserting after ''(as determined under regulations)'' the following: ''during a period in which the resident is provided covered post-hospital extended care services''.

(b) CONFORMING AMENDMENTS.—(1) Section 1842(b)(6)(E) (42 U.S.C. 1395u(b)(6)(E)) is amended by striking ''in the case of an item or service (other than services described in section 1888(e)(2)(A)(ii))'' and inserting ''in the case of services described in section 1861(s)(2)(D)''.

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

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

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

(d) OVERSIGHT.—The Secretary of Health and Human Services, through the Office of the Inspector General in the Department of Health and Human Services or otherwise, shall monitor payments made under part B of the title XVIII of the Social Security Act for items and services furnished to residents of skilled nursing facilities during a time in which the residents are not being provided medicare covered post-hospital extended care services to ensure that there is not duplicate billing for services or excessive services provided.

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

(a) REEXAMINATION.—

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

Security Act (42 U.S.C. 1395yy(e)) that was used in making the update to the first fiscal year under paragraph (4)(B) of such section under the prospective payment system for skilled nursing facility services.

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

(b) AUTHORITY.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall make adjustments to payments under the prospective payment system under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) for covered skilled nursing facility services furnished in fiscal year 2002 to reflect any necessary adjustments to such payments as is appropriate as a result of the reexamination conducted under subsection (a).

(c) PUBLICATION.—

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

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

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

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

Subtitle D—Hospice Care

SEC. 331. REVISION OF MARKET BASKET INCREASE FOR 2001 AND 2002.

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

(1) by redesignating subclause (VII) as subclause (VIII);

(2) in subclause (VI)—

(A) by striking ''through 2002'' and inserting ''through 2000''; and

(B) by striking ''and'' at the end; and

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

''(VII) for each of fiscal years 2001 and 2002, the market basket percentage increase for the fiscal year plus 1.0 percentage point; and''.

(b) REPEAL OF BBRA TEMPORARY INCREASE.—

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

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

(c) TRANSITION DURING FISCAL YEAR 2001.—Notwithstanding the amendments made by subsection (a), for purposes of making payments for hospice care under section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) for fiscal year 2001, the payment rates referred to in paragraph (1)(C) of such section—

(1) for the period beginning on October 1, 2000, and ending on March 31, 2001, shall be the rate determined in accordance with the law as in effect on the day before the date of enactment of this Act; and

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

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

SEC. 332. STUDY AND REPORT ON PHYSICIAN CERTIFICATION REQUIREMENT FOR HOSPICE BENEFITS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to examine the appropriateness of the certification regarding terminal illness of an individual under section 1814(a)(7) of the Social Security Act (42 U.S.C. 1395f(a)(7)) that is required in order for such individual to receive hospice benefits under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.).

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

SEC. 333. HOSPICE DEMONSTRATION PROGRAM AND HOSPICE EDUCATION GRANTS.

(a) DEFINITIONS.—In this section:

(1) DEMONSTRATION PROGRAM.—The term ''demonstration program'' means the Hospice Demonstration Program established by the Secretary under subsection (b)(1).

(2) HOSPICE CARE; HOSPICE PROGRAM.—Except as otherwise provided, the terms ''hospice care''

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

(3) MEDICARE BENEFICIARY.—The term ''medicare beneficiary'' means any individual who is entitled to benefits under part A or enrolled under part B of the medicare program, including any individual enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization under part C of such program.

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

(5) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services, acting through the Administrator of the Health Care Financing Administration.

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

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

(b) HOSPICE DEMONSTRATION PROGRAM.—

(1) ESTABLISHMENT.—Not later than 2 years after the date of enactment of this Act, the Secretary shall establish a Hospice Demonstration Program in accordance with the provisions of this subsection to increase the utility of hospice care for seriously ill medicare beneficiaries.

(2) PARTICIPATION.—

(A) HOSPICE PROGRAMS.—Except as provided in paragraph (4)(A), only a hospice program with an agreement under section 1866 of the Social Security Act (42 U.S.C. 1395cc), a consortium of such hospice programs, or a State hospice association may participate in the demonstration program.

(B) MEDICARE BENEFICIARIES.—The Secretary shall permit any seriously ill medicare beneficiary residing in the service area of a hospice program participating in the demonstration program to participate in the demonstration program on a voluntary basis.

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

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

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

(B) any licensed nurse practitioner or physician assistant may admit a seriously ill medicare beneficiary as the primary care provider when necessary and within the scope of practice of such practitioner or assistant under State law;

(C) if a community does not have a qualified social worker, any professional (other than a social worker) who has the necessary knowledge, skills, and ability to provide medical social services may provide such services;

(D) the Secretary shall waive any requirement that nursing facilities used for respite care have skilled nurses on the premises 24 hours per day;

(E) the Secretary shall permit respite care to be provided to a seriously ill medicare beneficiary at home; and

(F) the Secretary shall waive reimbursement regulations to provide—

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

(ii) except with respect to the supportive and comfort care benefit under paragraph (4), a minimum payment for hospice care provided under the demonstration program based on the provision of hospice care to a seriously ill medicare beneficiary for a period of 14 days that—

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

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

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

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

(II) the higher costs of providing hospice care in rural areas due to lack of economies of scale or large geographic areas;

(iv) direct payment of any nurse practitioner or physician assistant practicing within the scope of State law in relation to hospice care provided by such practitioner or assistant; and

(v) a per diem rate of payment for in-home care under subparagraph (E) that reflects the range of care needs of the seriously ill medicare beneficiary and that—

(I) in the case of a seriously ill medicare beneficiary that needs routine care, is not less than 150 percent, and not more than 200 percent, of the routine home care rate for hospice care; and

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

(4) SUPPORTIVE AND COMFORT CARE BENEFIT.—

(A) IN GENERAL.—For purposes of the demonstration program, the Secretary shall establish a supportive and comfort care benefit for any seriously ill medicare beneficiary electing hospice care.

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

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

(i) continue to receive benefits for disease and symptom modifying treatment under the medicare program (and the Secretary may not require or prohibit any specific treatment or decision);

(ii) receive case management and hospice care through a hospice program participating in the demonstration program (for which payment shall be made under paragraph (3)(F)(ii)); and

(iii) receive information and experience in order to better understand the utility of hospice care.

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

(5) CONDUCT OF DEMONSTRATION PROGRAM.—

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

(B) SELECTION OF SITES.—

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

demonstration sites, on the basis of proposals submitted under subparagraph (C), that are located in geographic areas that—

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

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

(ii) EXCEPTIONS.—

(I) UNDERSERVED URBAN AREAS.—If a geographic area does not have any rural hospice program available to participate in the demonstration program, such area may substitute an underserved urban area, but the Secretary shall give priority to those proposals that include a rural hospice program.

(II) SPECIFIC SITE.—The Secretary shall select 1 demonstration site in the State in which, according to the Hospital Referral Region of Residence, 1994–1995, as listed in the Dartmouth Atlas of Health Care 1998, the largest metropolitan area of

such State had the lowest percentage of medicare beneficiary deaths in a hospital compared to the largest metropolitan area of each other State and the percentage of enrollees who experienced intensive care during the last 6 months of life was 21.5 percent.

(C) PROPOSALS.—

(i) IN GENERAL.—Under the demonstration program, the Secretary shall accept proposals by any State hospice association, hospice program, or consortium of hospice programs at such time, in such manner, and in such form as the Secretary may reasonably require.

(ii) RESEARCH DESIGNS.—The Secretary shall permit research designs that use time series, sequential implementation of the intervention, randomization by wait list, or any other design that allows the strongest possible implementation of the demonstration program.

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

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

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

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

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

(B) whether any increase in payments for hospice care provided under the medicare program is offset by savings in other parts of the medicare program;

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

(D) in consultation with hospice organizations and hospice programs (including organizations and programs that represent rural areas), whether a payment system based on diagnosis-related groups is useful for administering the

hospice care provided under the medicare program.

(8) REPORTS TO CONGRESS.—

(A) INTERIM REPORT.—Not later than 2 years after the implementation of the demonstration program, the Secretary, in consultation with participants in the program, shall submit to the to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate an interim report on the demonstration program.

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

(9) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of the medicare program to the extent and for the period the Secretary finds necessary for the conduct of the demonstration program.

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

(c) HOSPICE EDUCATION GRANT PROGRAM.—

(1) ESTABLISHMENT.—The Secretary shall establish a Hospice Education Grant Program under which the Secretary awards education grants to hospice programs participating in the demonstration program for the purpose of providing information about—

(A) hospice care under the medicare program; and

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

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

(A) to provide—

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

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

(B) to test strategies to improve the general public knowledge about hospice care under the medicare program and the benefits available to seriously ill medicare beneficiaries under the demonstration program.

(d) FUNDING.—

(1) HOSPICE DEMONSTRATION PROGRAM.—

(A) IN GENERAL.—Except as provided in subparagraph (B), expenditures made for the demonstration program shall be in lieu of the funds that would have been provided to participating hospices under section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)).

(B) SUPPORTIVE AND COMFORT CARE BENEFIT.—The Secretary shall pay any expenses for the supportive and comfort care benefit established under subsection (a)(4) from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Secu-

rity Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines is appropriate.

(2) HOSPICE EDUCATION GRANTS.—The Secretary is authorized to expend such sums as may be necessary for the purposes of carrying out the Hospice Education Grant program established under subsection (c)(1) from the Research and Demonstration Budget of the Health Care Financing Administration.

Subtitle E—Other Provisions

SEC. 341. SIX-MONTH DELAY IN IMPLEMENTATION OF RULE REGARDING PROVIDER-BASED CRITERIA.

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

TITLE IV—PROVISIONS RELATING TO PART B

Subtitle A—Hospital Outpatient Services

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

(a) IN GENERAL.—Section 1833(t)(7)(F)(ii)(I) (42 U.S.C. 1395l(t)(7)(F)(ii)(I)) is amended by inserting ''(or, in the case of a hospital that did not submit a cost report for such period, during the first cost reporting period ending in a year after 1996 and before 2001 for which the hospital submitted a cost report)'' after ''1996''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of section 202 of BBRA.

SEC. 402. CLARIFYING PROCESS AND STANDARDS FOR DETERMINING ELIGIBILITY OF DEVICES FOR PASS-THROUGH PAYMENTS UNDER HOSPITAL OUTPATIENT PPS.

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

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

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

''(B) USE OF CATEGORIES IN DETERMINING ELIGIBILITY OF A DEVICE FOR PASS-THROUGH PAYMENTS.—The following provisions apply for purposes of determining whether a medical device qualifies for additional payments under clause (ii) or (iv) of subparagraph (A):

''(i) ESTABLISHMENT OF INITIAL CATEGORIES.—The Secretary shall initially establish under this clause categories of medical devices based on type of device by April 1, 2001. Such categories shall be established in a manner such that each medical device that meets the requirements of clause (ii) or (iv) of subparagraph (A) as of such date is included in such a category and no such device is included in more than one category. For purposes of the preceding sentence, whether a medical device meets such requirements as of such date shall be determined on the basis of the program memoranda issued before such date or if the Secretary determines

the medical device would have been included in the program memoranda but for the requirement of subparagraph (A)(iv)(I). The categories may be established under this clause by program memorandum or otherwise, after consultation with groups representing hospitals, manufacturers of medical devices, and other affected parties.

''(ii) ESTABLISHING CRITERIA FOR ADDITIONAL CATEGORIES.—

''(I) IN GENERAL.—The Secretary shall establish criteria that will be used for creation of additional categories (other than those established under clause (i)) through rulemaking (which may include use of an interim final rule with comment period).

''(II) STANDARD.—Such categories shall be established under this clause in a manner such that no medical device is described by more than one category. Such criteria shall include a test of whether the average cost of devices that would be included

in a category and are in use at the time the category is established is not insignificant, as described in subparagraph (A)(iv)(II).

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

''(IV) ADDING CATEGORIES.—The Secretary shall promptly establish a new category of medical device under this clause for any medical device that meets the requirements of subparagraph (A)(iv) and for which none of the categories in effect (or that were previously in effect) is appropriate.

''(iii) PERIOD FOR WHICH CATEGORY IS IN EFFECT.—A category of medical devices established under clause (i) or clause (ii) shall be in effect for a period of at least 2 years, but not more than 3 years, that begins—

''(I) in the case of a category established under clause (i), on the first date on which payment was made under this paragraph for any device described by such category (including payments made during the period before April 1, 2001); and

''(II) in the case of any other category, on the first date on which payment is made under this paragraph for any medical device that is described by such category.

''(iv) REQUIREMENTS TREATED AS MET.—A medical device shall be treated as meeting the requirements of subparagraph (A)(iv) if—

''(I) the device is described by a category established and in effect under clause (i); or

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

vice, or the device has been cleared for market under section 510(k) of such Act, or the device is exempt from the requirements of section 510(k) of such Act pursuant to subsection (l) or (m) of section 510 of such Act or section 520(g) of such Act.

Nothing in this clause shall be construed as requiring an application or prior approval (other than that described in subclause (II)) in order for a device to qualify for payment under this paragraph.

''(C) LIMITED PERIOD OF PAYMENT.—

''(i) DRUGS AND BIOLOGICALS.—The payment under this paragraph with respect to a drug or biological shall only apply during a period of at least 2 years, but not more than 3 years, that begins—

''(I) on the first date this subsection is implemented in the case of a drug or biological described in clause (i), (ii), or (iii) of subparagraph (A) and in the case of a drug or biological described in subparagraph (A)(iv) and for which payment under

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

''(II) in the case of a drug or biological described in subparagraph (A)(iv) not described in subclause (I), on the first date on which payment is made under this part for the drug or biological as an outpatient hospital service.

''(ii) MEDICAL DEVICES.—Payment shall be made under this paragraph with respect to a medical device only if such device—

''(I) is described by a category of medical devices established and in effect under subparagraph (B); and

''(II) is provided as part of a service (or group of services) paid for under this subsection and provided during the period for which such category is in effect under such subparagraph.''.

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

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

(2) in paragraph (6)(D) (as redesignated by subsection (a)(1)), by striking ''subparagraph (D)(iii)'' in the matter preceding clause (i) and inserting ''subparagraph (E)(iii)''; and

(3) in paragraph (12)(E), by striking ''additional payments (consistent with paragraph (6)(B))'' and inserting ''additional payments, the determination and deletion of initial and new categories (consistent with subparagraphs (B) and (C) of paragraph (6))''.

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

(d) TRANSITION.—In the case of a medical device provided as part of a service (or group of services) furnished during the period beginning on the date that is 30 days after the date of the enactment of this Act and ending on the day before the initial categories are implemented under subparagraph (B)(i) of section 1833(t)(6) of the Social Security Act (as amended by subsection (a)), payment shall be made for such device under such section

in accordance with the provisions in effect before the date of the enactment of this Act, except that (notwithstanding subparagraph (C)(ii) of such section, as so amended) payment shall also be made for such a device that is not included in a program memorandum described in such subparagraph if the Secretary determines that the device is likely to be described by such an initial category.

SEC. 403. CONTRAST ENHANCED DIAGNOSTIC PROCEDURES UNDER HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

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

(1) by striking ''and'' at the end of subparagraph (E);

(2) by striking the period at the end of subparagraph (F) and inserting ''; and''; and

(3) by inserting after subparagraph (F) the following new subparagraph:

''(G) the Secretary shall create additional groups of covered OPD services that classify separately those procedures that utilize contrast media from those that do not.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of BBA.

SEC. 404. TRANSITIONAL PASS-THROUGH FOR CONTRAST AGENTS.

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

(1) in subparagraph (A)(iv)—

(A) in the heading, by striking ''AND BIOLOGICALS'' and inserting ''BIOLOGICALS, AND CONTRAST AGENTS'';

(B) in the matter preceding subclause (I), by striking ''or biological'' and inserting ''biological, or contrast agent'';

(C) in subclause (I), by striking ''or biological'' and inserting ''biological, or contrast agent''; and

(D) in subclause (II), by striking ''or biological'' and inserting '', biological, or contrast agent'';

(2) in subparagraph (C)—

(A) in the heading, by striking ''AND BIOLOGICALS'' and inserting ''BIOLOGICALS, AND CONTRAST AGENTS''; and

(B) by striking ''or biological'' the first, third, fourth, and fifth place it appears and inserting '', biological, or contrast agent''; and

(3) in subparagraph (D)—

(A) in the matter preceding clause (i), by striking ''or biological'' and inserting ''biological, or contrast agent''; and

(B) in clause (i), by striking ''or biological'' each place it appears and inserting '', biological, or contrast agent''.

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

Subtitle B—Provisions Relating to Physicians

SEC. 411. MEDPAC STUDY ON THE RESOURCE-BASED PRACTICE EXPENSE SYSTEM.

(a) STUDY.—The Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) (in this section referred to as ''MedPAC'') shall conduct a study on the refinements to the practice expense relative value units during the transition to a resource-based practice expense system for physician payments under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (in this section referred to as the ''medicare program'').

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

under subsection (a) together with recommendations regarding—

(1) any change or adjustment that is appropriate to ensure full access to a spectrum of care for beneficiaries under the medicare program; and

(2) the appropriateness of payments to physicians.

SEC. 412. GAO STUDIES AND REPORTS ON MEDICARE PAYMENTS.

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

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

(A) coding and billing;

(B) documentation requirements; and

(C) the calculation of overpayments.

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

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

(b) GAO STUDY ON ADMINISTRATION AND OVERSIGHT.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the aggregate effects of regulatory, audit, oversight, and paperwork burdens on physicians and other health care providers participating in the medicare program.

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

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

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

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

SEC. 413. GAO STUDY ON GASTROINTESTINAL ENDOSCOPIC SERVICES FURNISHED IN PHYSICIANS' OFFICES AND HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the appropriateness of furnishing gastrointestinal endoscopic physicians' services in physicians' offices. In conducting this study, the Comptroller General shall—

(1) review available scientific and clinical evidence regarding the safety of performing procedures in physicians' offices and hospital outpatient departments;

(2) assess whether resource-based practice expense relative values established by the Secretary of Health and Human Services under the medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for gastrointestinal endoscopic services furnished in physicians' offices and hospital outpatient departments create an incentive to furnish such services in physicians' offices instead of hospital outpatient departments; and

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

(b) REPORT.—Not later than July 1, 2002, the Comptroller General of the United States shall submit a report to the Secretary of Health and Human Services and Congress on the study conducted under subsection (a) together with such recommendations for legislation and administrative action as the Comptroller General determines appropriate.

Subtitle C—Ambulance Services

SEC. 421. ELIMINATION OF REDUCTION IN INFLATION ADJUSTMENTS FOR AMBULANCE SERVICES.

Subparagraphs (A) and (B) of section 1834(l)(3) (42 U.S.C. 1395m(l)(3)(A)) are each amended by striking ''reduced in the case of 2001 and 2002 by 1.0 percentage points'' and inserting ''increased in the case of 2001 by 1.0 percentage point''.

SEC. 422. ELECTION TO FOREGO PHASE-IN OF FEE SCHEDULE FOR AMBULANCE SERVICES.

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

''(8) ELECTION TO FOREGO PHASE-IN OF FEE SCHEDULE.—

''(A) IN GENERAL.—If the Secretary provides for a phase-in of the fee schedule established under this subsection, a supplier of ambulance services may make an election to receive payments at any time during such phase-in based only on such fee schedule as in effect after such phase-in, and the Secretary shall begin to make payments to the supplier based only on such fee schedule not later than the date that is 60 days after the date on which the supplier notifies the Secretary of such election.

''(B) WAIVER OF BUDGET NEUTRALITY.—The Secretary shall apply paragraph (3)(A) as if this paragraph had not been enacted.''.

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

(a) STUDY.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), in consultation with the Office of Rural Health Policy, shall conduct a study on the means by which rural areas with low population densities can be identified for the purpose of designating areas in which the cost of providing ambulance services would be expected to be higher than similar services provided in more heavily populated areas because of low usage. Such study shall also include an

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

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

SEC. 424. GAO STUDY AND REPORT ON THE COSTS OF EMERGENCY AND MEDICAL TRANSPORTATION SERVICES.

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

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

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

Subtitle D—Other Services

SEC. 431. REVISION OF MORATORIUM IN CAPS FOR THERAPY SERVICES.

(a) EXTENSION OF MORATORIUM.—Section 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended by striking ''during 2000 and 2001'' and inserting ''during the period beginning on January 1, 2000, and ending on the date that is 18 months after the date on which the Secretary submits the report required under section 4541(d)(2) of the Balanced Budget Act of 1997 to Congress''.

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

SEC. 432. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.

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

and inserting ''for such services furnished on or after January 1, 2001, by 2.4 percent''.

SEC. 433. FULL UPDATE IN 2001 FOR DURABLE MEDICAL EQUIPMENT, OXYGEN, AND OXYGEN EQUIPMENT.

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

(1) by redesignating subparagraph (D) as subparagraph (F);

(2) in subparagraph (C)—

(A) by striking ''through 2002'' and inserting ''through 2000''; and

(B) by striking '' and'' at the end; and

(3) by inserting after subparagraph (C) the following new subparagraphs:

''(D) for 2001, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June 2000;

''(E) for 2002, 0 percentage points; and''.

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

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

(2) in clause (v)—

(A) by striking ''through 2002'' and inserting ''through 2000''; and

(B) by striking '' and'' at the end; and

(3) by inserting after clause (v) the following new clauses:

''(vi) for 2001, the percentage increase in the consumer price index for all urban consumers (United States City average) for the 12-month period ending with June 2000;

''(vi) for 2002, 1 percent; and''.

(c) PARENTERAL AND ENTERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT.—Section 4551(b) of BBA (42 U.S.C. 1395m note) is amended by striking ''through 2002'' and inserting '', 1999, 2000, and 2002''.

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

(1) in clause (v), by striking ''and'' at the end;

(2) in clause (vi)—

(A) by striking ''each subsequent year'' and inserting ''2000''; and

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

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

''(vii) for 2001, the amount determined under this subparagraph for 2000 increased by the covered item update for 2001;

''(viii) for 2002, 70 percent of the amount determined under this subparagraph for 1997; and

''(ix) for 2003 and each subsequent year, the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year.''.

(e) CONFORMING AMENDMENT.—Section 228 of BBRA (113 Stat. 1501A–356) is repealed.

SEC. 434. NATIONAL LIMITATION AMOUNT EQUAL TO 100 PERCENT OF NATIONAL MEDIAN FOR NEW PAP SMEAR TECHNOLOGIES AND OTHER NEW CLINICAL LABORATORY TEST TECHNOLOGIES.

Section 1833(h)(4)(B)(viii) (42 U.S.C. 1395l(h)(4)(B)(viii)) is amended by inserting before the period at the end the following: ''(or 100 percent of such median in the case of a clinical diagnostic laboratory test performed on or after January 1, 2001, that the Secretary determines is a new test for which no limitation amount

has previously been established under this subparagraph)''.

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

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

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

''(1) in the first year of its implementation, only a proportion (specified by the Secretary and not to exceed ¼) of the payment for such services shall be made in accordance with such system and the remainder shall be made in accordance with current regulations; and

''(2) in each of the following 2 years a proportion (specified by the Secretary and not to exceed ½, and ¾, respectively) of the payment for such services shall be made under such system and the

remainder shall be made in accordance with current regulations.''.

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

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

SEC. 436. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

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

''(4) TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.—

''(A) IN GENERAL.—Notwithstanding any other provision of law, when an independent laboratory furnishes the technical component of a physician pathology service with respect to a fee-for-service medicare beneficiary who is a patient of a grandfathered hospital, such component shall be treated as a service for which payment shall be made to the laboratory under this section and not as—

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

''(ii) a hospital outpatient service for which payment is made to the hospital under the prospective payment system under section 1834(t).

''(B) DEFINITIONS.—In this paragraph:

''(i) GRANDFATHERED HOSPITAL.—The term 'grandfathered hospital' means a hospital that had an arrangement with an independent laboratory—

''(I) that was in effect as of July 22, 1999; and

''(II) under which the laboratory furnished the technical component of physician pathology services with respect to patients of the hospital and submitted a claim for payment for such component to a carrier with a contract under section 1842 (and not to the hospital).

''(ii) FEE-FOR-SERVICE MEDICARE BENEFICIARY.—The term 'fee-for-service

medicare beneficiary' means an individual who is not enrolled—

"(I) in a Medicare+Choice plan under part C;

"(II) in a plan offered by an eligible organization under section 1876;

"(III) with a PACE provider under section 1894;

"(IV) in a medicare managed care demonstration project; or

"(V) in the case of a service furnished to an individual on an outpatient basis, in a health care prepayment plan under section 1833(a)(1)(A).".

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

SEC. 437. MODIFICATION OF MEDICARE BILLING REQUIREMENTS FOR CERTAIN INDIAN PROVIDERS.

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

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

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

SEC. 438. REPLACEMENT OF PROSTHETIC DEVICES AND PARTS.

(a) IN GENERAL.—Section 1834(h)(1) of the Social Security Act (42 U.S.C. 1395m(h)(1)) is amended by adding at the end the following new subparagraph:

''(F) REPLACEMENT OF PROSTHETIC DEVICES AND PARTS.—

''(i) IN GENERAL.—Payment shall be made for the replacement of prosthetic devices which are artificial limbs, or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions if an ordering physician determines that the provision of a replacement device, or a replacement part of

such a device, is necessary because of any of the following:

"(I) A change in the physiological condition of the patient.

"(II) An irreparable change in the condition of the device, or in a part of the device.

"(III) The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

"(ii) CONFIRMATION MAY BE REQUIRED IF REPLACEMENT DEVICE OR PART IS LESS THAN 2 YEARS OLD.—If a physician determines that a replacement device, or a replacement part, is necessary pursuant to clause (i)—

"(I) such determination shall be controlling; and

"(II) such replacement device or part shall be deemed to be reasonable

and necessary for purposes of section 1862(a)(1)(A);

except that if the device, or part, being replaced is less than 2 years old (calculated from the date on which the beneficiary began to use the device or part), the Secretary may also require the beneficiary to provide confirmation of necessity of the replacement device, or, as the case may be, the replacement part, by a prosthetist selected by the beneficiary.''.

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

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

SEC. 439. MEDPAC STUDY AND REPORT ON MEDICARE REIMBURSEMENT FOR SERVICES PROVIDED BY CERTAIN PROVIDERS.

(a) STUDY.—The Medicare Payment Advisory Commission (referred to in this section as ''MedPAC'') shall

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

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

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

(3) nurse practitioner (as defined in such subsection); and

(4) clinical nurse specialist (as defined in subsection (aa)(5)(B) of such section).

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

SEC. 440. MEDPAC STUDY AND REPORT ON MEDICARE COVERAGE OF SERVICES PROVIDED BY CERTAIN NON-PHYSICIAN PROVIDERS.

(a) STUDY.—

(1) IN GENERAL.—The Medicare Payment Advisory Commission (referred to in this section as ''MedPAC'') shall conduct a study to determine the appropriateness of providing coverage under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for services provided by a—

(A) certified first nurse assistant;

(B) marriage counselor;

(C) pastoral care counselor; and

(D) licensed professional counselor of mental health.

(2) COSTS TO PROGRAM.—The study shall consider the short-term and long-term benefits, and costs to the medicare program, of providing the coverage described in paragraph (1).

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

TITLE V—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

SEC. 501. 1-YEAR ADDITIONAL DELAY IN APPLICATION OF 15 PERCENT REDUCTION ON PAYMENT LIMITS FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1895(b)(3)(A)(i) (42 U.S.C. 1395fff(b)(3)(A)(i)) is amended—

(1) by redesignating subclause (II) as subclause (III);

(2) in subclause (III), as redesignated, by striking ''described in subclause (I)'' and inserting ''described in subclause (II)''; and

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

''(II) For the 12-month period beginning after the period described in subclause (I), such amount (or amounts) shall be equal to the amount (or amounts) determined under subclause (I), updated under subparagraph (B).''.

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

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

SEC. 502. RESTORATION OF FULL HOME HEALTH MARKET BASKET UPDATE FOR HOME HEALTH SERVICES FOR FISCAL YEAR 2001.

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

(1) by striking ''2001,''; and

(2) by adding at the end the following: ''With respect to cost reporting periods beginning during fiscal year 2001, the update to any limit under this subparagraph shall be the home health market basket index.''.

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

(1) IN GENERAL.—Notwithstanding the amendments made by subsection (a), for purposes of making payments under section 1895(b) of the Social Security Act (42 U.S.C. 1395fff(b)) for home health services for fiscal year 2001, the Secretary of Health and Human Services shall—

(A) with respect to episodes and visits ending on or after October 1, 2000, and before April 1, 2001, use the final standardized and

budget neutral prospective payment amounts for 60 day episodes and standardized average per visit amounts for fiscal year 2001 as published by the Secretary in Federal Register of the July 3, 2000 (65 Federal Register 41128–41214); and

(B) with respect to episodes and visits ending on or after April 1, 2001, and before October 1, 2001, use such amounts increased by an actuarially determined amount that represents the different distributions of episodes and visits in the first and second 6 month periods of fiscal year 2001 due to implementation of the home health prospective payment system under section 1895 of such Act (42 U.S.C. 1395fff).

(2) NO EFFECT ON OTHER PAYMENTS OR DETERMINATIONS.—The Secretary shall not take the provisions of paragraph (1) into account for purposes of payments, determinations, or budget neutrality adjustments under section 1895 of the Social Security Act.

(c) ADJUSTMENT FOR CASE MIX CHANGES.—

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

''(vi) ADJUSTMENT FOR CASE MIX CHANGES.—Insofar as the Secretary determines that the adjustments under paragraph (4)(A)(i) for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in the coding or classification of different units of services that do not reflect real changes in case mix, the Secretary may adjust the standard prospective payment amount (or amounts) under paragraph (3) for subsequent fiscal years so as to eliminate the effect of such coding or classification changes.''.

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

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

(a) EXCLUSION.—

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

''(e) EXCLUSION OF NONROUTINE MEDICAL SUPPLIES.—

''(1) IN GENERAL.—Notwithstanding the preceding provisions of this section, in the case of all nonroutine medical supplies (as defined by the Secretary) furnished by a home health agency during a year (beginning with 2001) for which payment is otherwise made on the basis of the prospective payment amount under this section, payment under this section shall be based instead on the lesser of—

''(A) the actual charge for the nonroutine medical supply; or

''(B) the amount determined under the fee schedule established by the Secretary for purposes of making payment for such items under part B for nonroutine medical supplies furnished during that year.

''(2) BUDGET NEUTRALITY ADJUSTMENT.—The Secretary shall provide for an appropriate proportional reduction in payments under this section so that, beginning with fiscal year 2001, the aggregate amount of such reductions is equal to the aggregate

increase in payments attributable to the exclusion effected under paragraph (1).''.

(2) CONFORMING AMENDMENT.—Section 1895(b)(1) of the Social Security Act (42 U.S.C. 1395fff(b)(1)) is amended by striking ''The Secretary'' and inserting ''Subject to subsection (e), the Secretary''.

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

(b) EXCLUSION FROM CONSOLIDATED BILLING.—

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

(A) section 1842(b)(6)(F) of such Act (42 U.S.C. 1395u(b)(6)(F)) was amended by striking ''(including medical supplies described in section 1861(m)(5), but excluding durable medical equipment to the extent provided for in such section)'' and inserting ''(excluding medical supplies and durable medical equipment described in section 1861(m)(5))''; and

(B) section 1862(a)(21) of such Act (42 U.S.C. 1395y(a)(21)) was amended by striking ''(including medical supplies described in section 1861(m)(5), but excluding durable medical equipment to the extent provided for in such section)'' and inserting ''(excluding medical supplies and durable medical equipment described in section 1861(m)(5))''.

(2) APPLICABLE PERIOD DEFINED.—For purposes of paragraph (1), the term ''applicable period'' means the period beginning on January 1, 2001, and ending on the later of—

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

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

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

(1) STUDY.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall conduct a study to identify any nonroutine medical supply that may be appropriately and cost-effectively excluded from the prospective payment system for home health services

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

(2) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), including a list of any nonroutine medical supplies that should be excluded from the prospective payment system for home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff).

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

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

(a) TREATMENT OF BRANCH OFFICES.—

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

(2) CONSIDERATION OF FORMS OF TECHNOLOGY IN DEFINITION OF SUPERVISION.—The Secretary of Health and Human Services may include forms of technology in determining what constitutes ''supervision'' for purposes of determining a home heath agency's branch office status under paragraph (1).

(b) GAO STUDY.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study of the provision of adequate supervision to maintain quality of home health services delivered under the medicare program in isolated rural areas. The study shall evaluate the methods that home health agency branches and subunits use to maintain adequate supervision in the delivery of services to clients residing in those

areas, how these methods of supervision compare to requirements that subunits independently meet medicare conditions of participation, and the resources utilized by subunits to meet such conditions.

(2) REPORT.—Not later than January 1, 2002, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include recommendations on whether exceptions are needed for subunits and branches of home health agencies under the medicare program to maintain access to the home health benefit or whether alternative policies should be developed to assure adequate supervision and access and recommendations on whether a national standard for supervision is appropriate.

SEC. 505. TEMPORARY ADDITIONAL PAYMENTS FOR HIGH-COST PATIENTS.

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

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

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

(c) WAIVING BUDGET NEUTRALITY.—The Secretary of Health and Human Services shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff), including under subsection (b)(3)(C) of such Act, applicable to units of home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a).

SEC. 506. CLARIFICATION OF THE HOMEBOUND DEFINITION UNDER THE MEDICARE HOME HEALTH BENEFIT.

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

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

(2) by adding at the end the following new sentences: "Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be 'confined to his home'. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or short duration. For purposes of the preceding sentence, any absence for the purpose of visiting a family member who is unable to visit the individual or for the purpose of attending a religious service shall be deemed to be an absence of infrequent and short duration.".

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

Subtitle B—Direct Graduate Medical Education

SEC. 511. AUTHORITY TO INCLUDE COSTS OF TRAINING OF CLINICAL PSYCHOLOGISTS IN PAYMENTS TO HOSPITALS.

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

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

Subtitle A—Medicare+Choice Payment Reforms

SEC. 601. INCREASE IN NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE IN 2001 AND 2002.

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

(1) in clause (iv), by striking ''for 2001, 0.5 percentage points'' and inserting ''for 2001, 0 percentage points''; and

(2) in clause (v), by striking ''for 2002, 0.3 percentage points'' and inserting ''for 2002, 0 percentage points''.

SEC. 602. REMOVING APPLICATION OF BUDGET NEUTRALITY FOR 2002.

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

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

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

SEC. 603. INCREASE IN MINIMUM PAYMENT AMOUNT.

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

(1) by striking ''(ii) For a succeeding year'' and inserting ''(ii)(I) Subject to subclause (II), for a succeeding year''; and

(2) by adding at the end the following new subclause:

''(II) For 2001 for any area in any Metropolitan Statistical Area with a population of more than 250,000, $475 (and for any area outside such an area, $425).''.

SEC. 604. ALLOWING MOVEMENT TO 50:50 PERCENT BLEND IN 2002.

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

(1) by striking the period at the end of subparagraph (F) and inserting a semicolon; and

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

''except that a Medicare+Choice organization may elect to apply subparagraph (F) (rather than subparagraph (E)) for 2002.''.

SEC. 605. INCREASED UPDATE FOR PAYMENT AREAS WITH ONLY ONE OR NO MEDICARE+CHOICE CONTRACTS.

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

(1) by striking ''(ii) For a subsequent year'' and inserting ''(ii)(I) Subject to subclause (II), for a subsequent year''; and

(2) by adding at the end the following new subclause:

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

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

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

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

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

(2) in subclause (II), by striking ''2002.'' and inserting ''2002 and 2003.''; and

(3) by adding at the end the following:

''(IV) 30 percent of such capitation rate in 2004 (in which such methodology should reflect a blend of 20 percent of only data from inpatient settings and 10 percent of data from all settings);

''(V) 40 percent of such amount in 2005 (in which such methodology should reflect a blend of 10 percent of only data from inpatient settings and 30 percent of data from all settings);

''(VI) 50 percent of such amount in 2006 (in which such methodology should reflect data from all settings);

''(VII) 60 percent of such amount in 2007 (in which such meth-

odology should reflect data from all settings);

''(VIII) 70 percent of such amount in 2008 (in which such methodology should reflect data from all settings);

''(IX) 80 percent of such amount in 2009 (in which such methodology should reflect data from all settings);

''(X) 90 percent of such amount in 2010 (in which such methodology should reflect data from all settings); and

''(XI) 100 percent of such amount in any subsequent year (in which such methodology should reflect data from all settings).''.

SEC. 607. PERMITTING PREMIUM REDUCTIONS AS ADDITIONAL BENEFITS UNDER MEDICARE+CHOICE PLANS.

(a) IN GENERAL.—

(1) AUTHORIZATION OF PART B PREMIUM REDUCTIONS.—Section 1854(f)(1) (42 U.S.C. 1395w–24(f)(1)) is amended by adding at the end the following new subparagraph:

"(F) PREMIUM REDUCTIONS.—

"(i) IN GENERAL.—Subject to clause (ii), as part of providing any additional benefits required under subparagraph (A), a Medicare+Choice organization may elect a reduction in its payments under section 1853(a)(1)(A) with respect to a Medicare+Choice plan and the Secretary shall apply such reduction to reduce the premium under section 1839 of each enrollee in such plan as provided in section 1840(i).

"(ii) AMOUNT OF REDUCTION.—The amount of the reduction under clause (i) with respect to any enrollee in a Medicare+Choice plan—

"(I) may not exceed 120 percent of the premium described under section 1839(a)(3); and

"(II) shall apply uniformly to each enrollee of the Medicare+Choice plan to which such reduction applies.".

(2) CONFORMING AMENDMENTS.—

(A) ADJUSTMENT OF PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS.—Section 1853(a)(1)(A) (42 U.S.C. 1395w–23(a)(1)(A)) is amended by inserting ''reduced by the amount of any reduction elected under section 1854(f)(1)(F) and'' after ''for that area,''.

(B) ADJUSTMENT AND PAYMENT OF PART B PREMIUMS.—

(i) ADJUSTMENT OF PREMIUMS.—Section 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is amended by striking ''shall'' and all that follows and inserting the following: ''shall be the amount determined under paragraph (3), adjusted as required in accordance with subsections (b), (c), and (f), and to reflect 80 percent of any reduction elected under section 1854(f)(1)(F).''.

(ii) PAYMENT OF PREMIUMS.—Section 1840 (42 U.S.C. 1395s) is amended by adding at the end the following new subsection:

''(i) In the case of an individual enrolled in a Medicare+Choice plan, the Secretary shall provide for necessary adjustments of the monthly beneficiary pre-

mium to reflect 80 percent of any reduction elected under section 1854(f)(1)(F). This premium adjustment may be provided directly or as an adjustment to any social security, railroad retirement, and civil service retirement benefits, to the extent which the Secretary determines that such an adjustment is appropriate and feasible with the concurrence of the agencies responsible for the administration of such benefits.''.

(C) INFORMATION COMPARING PLAN PREMIUMS UNDER PART C.—Section 1851(d)(4)(B) (42 U.S.C. 1395w–21(d)(4)(B)) is amended—

(i) by striking ''PREMIUMS.—The'' and inserting ''PREMIUMS.—

''(i) IN GENERAL.—The''; and

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

''(ii) REDUCTIONS.—The reduction in premiums, if any.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to years beginning with 2002.

SEC. 608. DELAY FROM JULY TO NOVEMBER 2000, IN DEADLINE FOR OFFERING AND WITHDRAWING MEDICARE+CHOICE PLANS FOR 2001.

Notwithstanding any other provision of law, the deadline for a Medicare+Choice organization to withdraw the

offering of a Medicare+Choice plan under part C of title XVIII of the Social Security Act (or otherwise to submit information required for the offering of such a plan) for 2001 is delayed from July 1, 2000, to November 15, 2000, and any such organization that provided notice of withdrawal of such a plan during 2000 before the date of enactment of this Act may rescind such withdrawal at any time before November 15, 2000.

SEC. 609. REVISION OF PAYMENT RATES FOR ESRD PATIENTS ENROLLED IN MEDICARE+CHOICE PLANS.

(a) IN GENERAL.—Section 1853(a)(1)(B) (42 U.S.C. 1395w–23(a)(1)(B)) is amended by adding at the end the following: ''In establishing such rates the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk-adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease demonstrations established by section 2355 of the Deficit Reduction Act of 1984 (Public Law 98–369; 98 Stat. 1103), as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66; 107 Stat. 608), and shall compute such rates by taking into account such factors as renal treatment modality,

age, and the underlying cause of the end-stage renal disease.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to payments for months beginning with January 2002.

(c) PUBLICATION.—The Secretary of Health and Human Services, not later than 6 months after the date of enactment of this Act, shall publish for public comment a description of the appropriate adjustments described in the last sentence of section 1853(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B)), as added by subsection (a). The Secretary shall publish such adjustments in final form by not later than July 1, 2001, so that the amendment made by subsection (a) is implemented on a timely basis consistent with subsection (b).

SEC. 610. MODIFICATION OF PAYMENT RULES FOR CERTAIN FRAIL ELDERLY MEDICARE BENEFICIARIES.

(a) MODIFICATION OF PAYMENT RULES.—Section 1853 (42 U.S.C. 1395w–23) is amended—

(1) in subsection (a)—

(A) in paragraph (1)(A), by striking ''subsections (e), (g), and (i)'' and inserting ''subsections (e), (g), (i), and (j)'';

(B) in paragraph (3)(D), by inserting ''paragraph (4) and'' after ''Subject to''; and

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

''(4) EXEMPTION FROM RISK-ADJUSTMENT SYSTEM FOR FRAIL ELDERLY BENEFICIARIES ENROLLED IN SPECIALIZED PROGRAMS.—

''(A) IN GENERAL.—In applying the risk-adjustment factors established under paragraph (3) during the period described in subparagraph (B), the limitation under paragraph (3)(C)(ii)(I) shall apply to a frail elderly Medicare+Choice beneficiary (as defined in subsection (j)(3)) who is enrolled in a Medicare+Choice plan under a specialized program for the frail elderly (as defined in subsection (j)(2)) during the entire period.

''(B) PERIOD OF APPLICATION.—The period described in this subparagraph begins with January 2001, and ends with the first month for which the Secretary certifies to Congress that a comprehensive risk adjustment methodology under paragraph (3)(C) that takes into account the factors described in subsection (j)(1)(B) is being fully implemented.''; and

(2) by adding at the end the following new subsection:

''(j) SPECIAL RULES FOR FRAIL ELDERLY ENROLLED IN SPECIALIZED PROGRAMS FOR THE FRAIL ELDERLY.—

''(1) DEVELOPMENT AND IMPLEMENTATION OF NEW PAYMENT SYSTEM.—

''(A) IN GENERAL.—The Secretary shall develop and implement (as soon as possible after the date of enactment of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 2000) a payment methodology for frail elderly Medicare+Choice beneficiaries enrolled in a Medicare+Choice plan under a specialized program for the frail elderly (as defined in paragraph (2)(A)).

''(B) FACTORS DESCRIBED.—The methodology developed and implemented under subparagraph (A) shall take into account the prevalence, mix, and severity of chronic conditions among frail elderly Medicare+Choice beneficiaries and shall include—

''(i) medical diagnostic factors from all provider settings (including hospital and nursing facility settings);

''(ii) functional indicators of health status; and

''(iii) such other factors as may be necessary to achieve appropriate payments for plans serving such beneficiaries.

''(2) SPECIALIZED PROGRAM FOR THE FRAIL ELDERLY DEFINED.—

''(A) IN GENERAL.—In this part, the term 'specialized program for the frail elderly' means a program that the Secretary determines—

''(i) is offered under this part as a distinct part of a Medicare+Choice plan;

''(ii) primarily enrolls frail elderly Medicare+Choice beneficiaries; and

''(iii) has a clinical delivery system that is specifically designed to serve the special needs of such beneficiaries and to coordinate short-term and long-term care for such beneficiaries through the use of a team described in subparagraph (B) and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

''(B) SPECIALIZED TEAM DESCRIBED.—A team described in this subparagraph—

''(i) includes—

''(I) a physician; and

''(II) a nurse practitioner or geriatric care manager; and

''(ii) has as members individuals who—

''(I) have special training in the care and management of the frail elderly beneficiaries; and

''(II) specialize in the care and management of such beneficiaries.

''(3) FRAIL ELDERLY MEDICARE+CHOICE BENEFICIARY DEFINED.—In this part, the term 'frail elderly Medicare+Choice beneficiary' means a Medicare+Choice eligible individual who—

''(A) is residing in a skilled nursing facility (as defined in section 1819(a)) or a nursing facility (as defined in section 1919(a)) for an indefinite period and without any intention of residing outside the facility; and

''(B) has a severity of condition that makes the individual frail (as determined under guidelines approved by the Secretary).''.

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

SEC. 611. FULL IMPLEMENTATION OF RISK ADJUSTMENT FOR CONGESTIVE HEART FAILURE ENROLLEES FOR 2001.

(a) IN GENERAL.—Section 1853(a)(3)(C) (42 U.S.C. 1395w–23(a)(3)(C)) is amended—

(1) in clause (ii), by striking ''Such risk adjustment'' and inserting ''Except as provided in clause (iii), such risk adjustment''; and

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

''(iii) FULL IMPLEMENTATION OF RISK ADJUSTMENT FOR CONGESTIVE HEART FAILURE ENROLLEES FOR 2001.—

''(I) EXEMPTION FROM PHASE-IN.—Subject to subclause (II), the Secretary shall fully implement the risk adjustment methodology described in clause (i) with respect to each individual who has had a qualifying congestive heart failure inpatient diagnosis (as determined by the Secretary under such risk adjustment

methodology) during the period beginning on July 1, 1999, and ending on June 30, 2000, and who is enrolled in a coordinated care plan that is the only coordinated care plan offered on January 1, 2001, in the service area of the individual.

''(II) PERIOD OF APPLICATION.—Subclause (I) shall only apply during the 1-year period beginning on January 1, 2001.''.

(b) EXCLUSION FROM DETERMINATION OF THE BUDGET NEUTRALITY FACTOR.—Section 1853(c)(5) (42 U.S.C. 1395w–23(c)(5)) is amended by striking ''subsection (i)'' and inserting ''subsections (a)(3)(C)(iii) and (i)''.

SEC. 612. INCLUSION OF COSTS OF DOD MILITARY TREATMENT FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES IN CALCULATION OF MEDICARE+CHOICE PAYMENT RATES.

Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)) is amended—

(1) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (E)''; and

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

"(E) INCLUSION OF COSTS OF CERTAIN DOD MILITARY TREATMENT FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—

"(i) IN GENERAL.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2001), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for a Medicare+Choice payment area that is within 1 or more MTF affected areas (as defined in clause (ii)) shall be increased by the sum of the MTF percentages (as described in clause (iii)) for the MTF affected area or areas. The increase under this subparagraph shall not be taken into account in computing the national standardized annual Medicare+Choice capitation rate under paragraph (4)(B).

"(ii) MTF AFFECTED AREA DEFINED.—In this subparagraph, the term 'MTF affected area' means, with respect to a military treatment facility (as defined in

subsection (a)(6) of section 1896), an area that includes the following:

"(I) The Medicare+Choice payment area in which a military treatment facility that was part of the medicare subvention demonstration project under such section as of July 1, 2000, is located.

"(II) Any Medicare+Choice payment area which is contiguous to the area described in subclause (I) and located not farther than 40 miles from the facility.

"(iii) MTF PERCENTAGE.—For purposes of clause (i), the MTF percentage for an MTF affected area is equal to the ratio of—

"(I) the aggregate amount of costs incurred by the Department of Defense in furnishing items and services to individuals entitled to benefits under this title who received services from the military treatment facility described in clause (ii) for that area in 1996 (as determined pursuant to

section 1896(j)(1)(A)), increased by the national per capita Medicare+Choice growth percentage under paragraph (6) for 1997, to

"(II) the average number of individuals residing in such area in 1996 entitled to benefits under part A and enrolled under part B.".

Subtitle B—Other Medicare+Choice Reforms

SEC. 621. AMOUNTS IN MEDICARE TRUST FUNDS AVAILABLE FOR SECRETARY'S SHARE OF MEDICARE+CHOICE EDUCATION AND ENROLLMENT-RELATED COSTS.

(a) RELOCATION OF PROVISIONS.—Section 1857(e)(2) (42 U.S.C. 1395w–27(e)(2)) is amended to read as follows:

"(2) COST-SHARING IN ENROLLMENT-RELATED COSTS.—A Medicare+Choice organization shall pay the fee established by the Secretary under section 1851(j)(3)(A).".

(b) FUNDING FOR EDUCATION AND ENROLLMENT ACTIVITIES.—Section 1851 (42 U.S.C. 1395w–21) is amended by adding at the end the following new subsection:

''(j) FUNDING FOR BENEFICIARY EDUCATION AND ENROLLMENT ACTIVITIES.—

''(1) SECRETARY'S ESTIMATE OF TOTAL COSTS.—The Secretary shall annually estimate the total cost for a fiscal year of carrying out this section, section 4360 of the Omnibus Budget Reconciliation Act of 1990 (relating to the health insurance counseling and assistance program), and related activities.

''(2) TOTAL AMOUNT AVAILABLE.—The total amount available to the Secretary for a fiscal year for the costs of the activities described in paragraph (1) shall be equal to the lesser of—

''(A) the amount estimated for such fiscal year under paragraph (1); or

''(B) for—

''(i) fiscal year 2001, $115,000,000; and

''(ii) fiscal year 2002 and each subsequent fiscal year, the amount for the previous fiscal year, adjusted to account for inflation, any change in the number of beneficiaries under this title, and any other relevant factors.

"(3) COST-SHARING IN ENROLLMENT-RELATED COSTS.—

"(A) AMOUNTS FROM MEDICARE+CHOICE ORGANIZATIONS.—

"(i) IN GENERAL.—The Secretary is authorized to charge a fee to each Medicare+Choice organization with a contract under this part that is equal to the organization's pro rata share (as determined by the Secretary) of the Medicare+Choice portion (as defined in clause (ii)) of the total amount available under paragraph (2) for a fiscal year. Any amounts collected shall be available without further appropriation to the Secretary for the costs of the activities described in paragraph (1).

"(ii) MEDICARE+CHOICE PORTION DEFINED.—For purposes of clause (i), the term 'Medicare+Choice portion' means, for a fiscal year, the ratio, as estimated by the Secretary, of—

"(I) the average number of individuals enrolled in Medicare+Choice plans during the fiscal year; to

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

"(B) SECRETARY'S SHARE.—

"(i) AMOUNTS AVAILABLE FROM TRUST FUNDS.—The Secretary's share of expenses shall be payable from funds in the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, in such proportion as the Secretary shall deem to be fair and equitable after taking into consideration the expenses attributable to the administration of this part with respect to parts A and B. The Secretary shall make such transfers of moneys between such Trust Funds as may be appropriate to settle accounts between the Trust Funds in cases where expenses properly payable from one such Trust Fund have been paid from the other such Trust Fund.

"(ii) SECRETARY'S SHARE OF EXPENSES DEFINED.—For purposes of clause (i), the term 'Secretary's share of ex-

penses' means, for a fiscal year, an amount equal to—

''(I) the total amount available to the Secretary under paragraph (2) for the fiscal year; less

''(II) the amount collected under subparagraph (A) for the fiscal year.''.

SEC. 622. SPECIAL MEDIGAP ENROLLMENT ANTIDISCRIMINATION PROVISION FOR CERTAIN BENEFICIARIES.

(a) DISENROLLMENT WINDOW IN ACCORDANCE WITH BENEFICIARY'S CIRCUMSTANCE.—Section 1882(s)(3) (42 U.S.C. 1395ss(s)(3)) is amended—

(1) in subparagraph (A), in the matter following clause (iii), by striking '', subject to subparagraph (E), seeks to enroll under the policy not later than 63 days after the date of termination of enrollment described in such subparagraph'' and inserting ''seeks to enroll under the policy during the period specified in subparagraph (E)''; and

(2) by striking subparagraph (E) and inserting the following new subparagraph:

''(E) For purposes of subparagraph (A), the time period specified in this subparagraph is—

''(i) in the case of an individual described in subparagraph (B)(i), the period beginning on the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if no such notice is received, notice that a claim has been denied because of such a termination or cessation) and ending on the date that is 63 days after the applicable notice;

''(ii) in the case of an individual described in clause (ii), (iii), (v), or (vi) of subparagraph (B) whose enrollment is terminated involuntarily, the period beginning on the date that the individual receives a notice of termination and ending on the date that is 63 days after the date the applicable coverage is terminated;

''(iii) in the case of an individual described in subparagraph (B)(iv)(I), the period beginning on the earlier of (I) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice, if any, and (II) the date that the applicable coverage is terminated, and ending on the date that is 63 days after the date the coverage is terminated;

''(iv) in the case of an individual described in clause (ii), (iii), (iv)(II), (iv)(III), (v), or (vi) of sub-

paragraph (B) who disenrolls voluntarily, the period beginning on the date that is 60 days before the effective date of the disenrollment and ending on the date that is 63 days after such effective date; and

''(v) in the case of an individual described in subparagraph (B) but not described in the preceding provisions of this subparagraph, the period beginning on the effective date of the disenrollment and ending on the date that is 63 days after such effective date.''.

(b) EXTENDED MEDIGAP ACCESS FOR INTERRUPTED TRIAL PERIODS.—Section 1882(s)(3) (42 U.S.C. 1395ss(s)(3)), as amended by subsection (a), is amended by adding at the end the following new subparagraph:

''(F)(i) Subject to clause (ii), for purposes of this paragraph—

''(I) in the case of an individual described in subparagraph (B)(v) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with an organization or provider described in subclause (II) of such subparagraph is involuntarily terminated within the first 12 months of such enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, such subsequent enrollment shall be deemed to be an

initial enrollment described in such subparagraph; and

''(II) in the case of an individual described in clause (vi) of subparagraph (B) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with a plan or in a program described in such clause is involuntarily terminated within the first 12 months of such enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, such subsequent enrollment shall be deemed to be an initial enrollment described in such clause.

''(ii) For purposes of clauses (v) and (vi) of subparagraph (B), no enrollment of an individual with an organization or provider described in clause (v)(II), or with a plan or in a program described in clause (vi), may be deemed to be an initial enrollment under this clause after the 2-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program.''.

SEC. 623. RESTORING EFFECTIVE DATE OF ELECTIONS AND CHANGES OF ELECTIONS OF MEDICARE+CHOICE PLANS.

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

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

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to elections and changes of coverage made on or after January 1, 2001.

SEC. 624. PERMITTING ESRD BENEFICIARIES TO ENROLL IN ANOTHER MEDICARE+CHOICE PLAN IF THE PLAN IN WHICH THEY ARE ENROLLED IS TERMINATED.

(a) IN GENERAL.—Section 1851(a)(3)(B) (42 U.S.C. 1395w–21(a)(3)(B)) is amended by striking ''except that'' and all that follows and inserting the following: ''except that—

''(i) an individual who develops end-stage renal disease while enrolled in a Medicare+Choice plan may continue to be enrolled in that plan; and

''(ii) in the case of such an individual who is enrolled in a Medicare+Choice plan under clause (i) (or subsequently under this clause), if the enrollment is discontinued under circumstances described in

section 1851(e)(4)(A), then the individual will be treated as a 'Medicare+Choice eligible individual' for purposes of electing to continue enrollment in another Medicare+Choice plan.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall apply to terminations and discontinuations occurring on or after the date of enactment of this Act.

(2) APPLICATION TO PRIOR PLAN TERMINATIONS.—Clause (ii) of section 1851(a)(3)(B) of the Social Security Act (as inserted by subsection (a)) also shall apply to individuals whose enrollment in a Medicare+Choice plan was terminated or discontinued after December 31, 1997, and before the date of enactment of this Act. In applying this paragraph, such an individual shall be treated, for purposes of part C of title XVIII of the Social Security Act, as having discontinued enrollment in such a plan as of the date of enactment of this Act.

SEC. 625. ELECTION OF UNIFORM LOCAL COVERAGE POLICY FOR MEDICARE+CHOICE PLAN COVERING MULTIPLE LOCALITIES.

Section 1852(a)(2) (42 U.S.C. 1395w–22(a)(2)) is amended by adding at the end the following new subparagraph:

''(C) ELECTION OF UNIFORM COVERAGE POLICY.—With respect to each item or service furnished by a Medicare+Choice organization that offers a Medicare+Choice plan in a geographic area that includes at least 15 States and in which more than 1 local coverage policy is applied with respect to different parts of the area, the organization may elect to have the local coverage policy for the part of the area that affords the broadest coverage to Medicare+Choice enrollees (as determined by the Secretary) with respect to such item or service apply with respect to all Medicare+Choice enrollees enrolled in the plan.''.

Subtitle C—Other Managed Care Reforms

SEC. 631. REVISED TERMS AND CONDITIONS FOR EXTENSION OF MEDICARE COMMUNITY NURSING ORGANIZATION (CNO) DEMONSTRATION PROJECT.

(a) IN GENERAL.—Section 532 of BBRA (42 U.S.C. 1395mm note) is amended—

(1) in subsection (a), by striking the second sentence; and

(2) by striking subsection (b) and inserting the following new subsections:

''(b) TERMS AND CONDITIONS.—

''(1) JANUARY THROUGH SEPTEMBER 2000.—For the 9-month period beginning with January 2000, any such demonstration project shall be conducted under the same terms and conditions as applied to such project during 1999.

''(2) OCTOBER 2000 THROUGH DECEMBER 2001.—For the 15-month period beginning with October 2000, any such demonstration project shall be conducted under the same terms and conditions as applied to such project during 1999, except that the following modifications shall apply:

"(A) BASIC CAPITATION RATE.—The basic capitation rate paid for services covered under the project (other than case management services) per enrollee per month shall be the basic capitation rate paid for such services for 1999, reduced by 10 percent in the case of the demonstration sites located in Arizona, Minnesota, and Illinois, and 15 percent for the demonstration site located in New York.

"(B) TARGETED CASE MANAGEMENT FEE.—A case management fee shall be paid only for enrollees who are classified as 'moderate' or 'at risk' through a baseline health assessment (as required for Medicare+Choice plans under section 1852(e) of the Social Security Act (42 U.S.C. 1395ww–22(e)).

"(C) GREATER UNIFORMITY IN CLINICAL FEATURES AMONG SITES.—The project shall implement for each site—

"(i) protocols for periodic telephonic contact with enrollees based on—

"(I) the results of such standardized written health assessment; and

"(II) the application of appropriate care planning approaches;

"(ii) disease management programs for targeted diseases (such as congestive heart failure, arthritis, diabetes, and hypertension) that are highly prevalent in the enrolled populations;

"(iii) systems and protocols to track enrollees through hospitalizations, including preadmission planning, concurrent management during inpatient hospital stays, and post-discharge assessment, planning, and followup; and

"(iv) standardized patient educational materials for specified diseases and health conditions.

"(D) QUALITY IMPROVEMENT.—The project shall implement at each site once during the 15-month period—

"(i) surveys on enrollee satisfaction; and

"(ii) reports on specified quality indicators for the enrolled population.

"(c) EVALUATION.—

"(1) PRELIMINARY REPORT.—Not later than July 1, 2001, the Secretary of Health and Human Services shall submit to the Committees on Ways

and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate a preliminary report that—

"(A) evaluates such demonstration projects for the period beginning July 1, 1997, and ending December 31, 1999, on a site-specific basis with respect to the impact on per beneficiary spending, specific health utilization measures, and enrollee satisfaction; and

"(B) includes a similar evaluation of such projects for the portion of the extension period that occurs after September 30, 2000.

"(2) FINAL REPORT.—The Secretary shall submit a final report to such Committees on such demonstration projects not later than July 1, 2002. Such report shall include the same elements as the preliminary report required by paragraph (1), but for the period after December 31, 1999.

"(3) METHODOLOGY FOR SPENDING COMPARISONS.—Any evaluation of the impact of the demonstration projects on per beneficiary spending included in such reports shall be based on a comparison of—

"(A) data for all individuals who—

"(i) were enrolled in such demonstration projects as of the first day of the period under evaluation; and

"(ii) were enrolled for a minimum of 6 months thereafter; with

"(B) data for a matched sample of individuals who are enrolled under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) and who are not enrolled in such a project, in a Medicare+Choice plan under part C of such title (42 U.S.C. 1395w–21 et seq.), a plan offered by an eligible organization under section 1876 of such Act (42 U.S.C. 1395mm), or a health care prepayment plan under section 1833(a)(1)(A) of such Act (42 U.S.C. 1395l(a)(1)(A)).".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall be effective as if included in the enactment of section 532 of BBRA (42 U.S.C. 1395mm note).

SEC. 632. SERVICE AREA EXPANSION FOR MEDICARE COST CONTRACTS DURING TRANSITION PERIOD.

Section 1876(h)(5) (42 U.S.C. 1395mm(h)(5)) is amended—

(1) by redesignating subparagraph (B) as subparagraph (C); and

(2) by inserting after subparagraph (A), the following new subparagraph:

''(B) Subject to subparagraph (C), the Secretary shall approve an application for a modification to a reasonable cost contract under this section in order to expand the service area of such contract if—

''(i) such application is submitted to the Secretary on or before September 1, 2003; and

''(ii) the Secretary determines that the organization with the contract continues to meet the requirements applicable to such organizations and contracts under this section.''.

TITLE VII—MEDICAID

SEC. 701. NEW PROSPECTIVE PAYMENT SYSTEM FOR FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.

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

(1) in paragraph (13)—

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

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

(C) by striking subparagraph (C); and

(2) by inserting after paragraph (14) the following new paragraph:

''(15) provide for payment for services described in subparagraph (B) or (C) of section 1905(a)(2) under the plan in accordance with subsection (aa);''.

(b) NEW PROSPECTIVE PAYMENT SYSTEM.—Section 1902 (42 U.S.C. 1396a) is amended by adding at the end the following:

''(aa) PAYMENT FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.—

''(1) IN GENERAL.—Beginning with fiscal year 2001 and each succeeding fiscal year, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by a Federally-qualified health center and services described in section 1905(a)(2)(B) furnished by a rural health clinic in accordance with the provisions of this subsection.

''(2) FISCAL YEAR 2001.—Subject to paragraph (4), for services furnished during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such

services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under section 1833(a)(3), adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001.

''(3) FISCAL YEAR 2002 AND SUCCEEDING FISCAL YEARS.—Subject to paragraph (4), for services furnished during fiscal year 2002 or a succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this subsection for the preceding fiscal year—

''(A) increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) for that fiscal year; and

''(B) adjusted to take into account any increase or decrease in the scope of such services

furnished by the center or clinic during that fiscal year.

''(4) ESTABLISHMENT OF INITIAL YEAR PAYMENT AMOUNT FOR NEW CENTERS OR CLINICS.—In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after fiscal year 2000, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by the center or services described in section 1905(a)(2)(B) furnished by the clinic in the first fiscal year in which the center or clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year based on the rates established under this subsection for the fiscal year for other such centers or clinics located in the same or adjacent area with a similar case load or, in the absence of such a center or clinic, in accordance with the regulations and methodology referred to in paragraph (2) or based on such other tests of reasonableness as the Secretary may specify. For each fiscal year following the fiscal year in which the entity first qualifies as a Federally-qualified health center or rural health clinic, the

State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

''(5) ADMINISTRATION IN THE CASE OF MANAGED CARE.—

''(A) IN GENERAL.—In the case of services furnished by a Federally-qualified health center or rural health clinic pursuant to a contract between the center or clinic and a managed care entity (as defined in section 1932(a)(1)(B)), the State plan shall provide for payment to the center or clinic by the State of a supplemental payment equal to the amount (if any) by which the amount determined under paragraphs (2), (3), and (4) of this subsection exceeds the amount of the payments provided under the contract.

''(B) PAYMENT SCHEDULE.—The supplemental payment required under subparagraph (A) shall be made pursuant to a payment schedule agreed to by the State and the Federally-qualified health center or rural health clinic.

''(6) ALTERNATIVE PAYMENT METHODOLOGIES.—Notwithstanding any other provision of this section, the State plan may provide for payment in any fiscal year to a Federally-qualified health center

for services described in section 1905(a)(2)(C) or to a rural health clinic for services described in section 1905(a)(2)(B) in an amount which is determined under an alternative payment methodology that—

''(A) is agreed to by the State and the center or clinic; and

''(B) results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under this section.''.

(c) CONFORMING AMENDMENTS.—

(1) Section 4712 of the BBA (Public Law 105–33; 111 Stat. 508) is amended by striking subsection (c).

(2) Section 1915(b) (42 U.S.C. 1396n(b)) is amended by striking ''1902(a)(13)(E)'' and inserting ''1902(a)(15), 1902(aa),''.

(d) GAO STUDY OF FUTURE REBASING.—The Comptroller General of the United States shall provide for a study on the need for, and how to, rebase or refine costs for making payment under the medicaid program for services provided by Federally-qualified health centers and rural health centers (as provided under the amendments made by this section). The Comptroller General shall provide for submittal of a report on such study to Congress

by not later than 4 years after the date of the enactment of this Act.

(e) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2000, and apply to services furnished on or after such date.

SEC. 702. MEDICAID DSH ALLOTMENTS.

(a) ONE-YEAR FREEZE IN MEDICAID DSH ALLOTMENTS.—Section 1923(f)(2) (42 U.S.C. 1396r–4(f)(2)) is amended—

(1) in the matter preceding the table, by inserting ''(and the DSH allotment for a State for fiscal year 2001 is the same as the DSH allotment for the State for fiscal year 2000, as determined under the following table)'' after ''2002''; and

(2) in the table—

(A) by striking the column in the table relating to FY 01 (fiscal year 2001); and

(B) by striking the heading in such table relating to FY 00 (fiscal year 2000) and inserting ''FYS 00, 01''.

(b) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2000.

SEC. 703. PERMANENT EXTENSION OF PAYMENT OF MEDICARE PART B PREMIUMS FOR QUALIFIED MEDICARE BENEFICIARIES WITH INCOME UP TO 135 PERCENT OF POVERTY.

(a) IN GENERAL.—Section 1902(a)(10)(E)(iv) (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended—

(1) in the matter preceding subclause (I), by striking ''(but only for premiums payable with respect to months during the period beginning with January 1998, and ending with December 2002)'';

(2) in subclause (I), by inserting ''only for premiums payable with respect to months beginning with January 1998,'' after ''(I)''; and

(3) in subclause (II), by inserting ''only for premiums payable with respect to months during the period beginning with January 1998, and ending with December 2002,'' after ''(II)''.

(b) CONFORMING AMENDMENT.—Section 1933(c)(1) (42 U.S.C. 1396u–3(c)(1)) is amended—

(1) in subparagraph (D), by striking ''and'' at the end;

(2) in subparagraph (E), by striking the period and inserting ''; and''; and

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

''(F) fiscal year 2003 and each fiscal year thereafter, the amount specified under this paragraph for the preceding fiscal year increased by the percentage increase (if any) in the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average).''.

SEC. 704. STREAMLINED APPROVAL OF CONTINUED STATEWIDE SECTION 1115 MEDICAID WAIVERS.

(a) IN GENERAL.—Section 1115 (42 U.S.C. 1315) is amended by adding at the end the following new subsection:

''(f) An application by the chief executive officer of a State for an extension of a waiver project the State is operating under an extension under subsection (e) (in this subsection referred to as the 'waiver project') shall be submitted and approved or disapproved in accordance with the following:

''(1) The application for an extension of the waiver project shall be submitted to the Secretary at least 120 days prior to the expiration of the current period of the waiver project.

''(2) Not later than 45 days after the date such application is received by the Secretary, the Secretary shall notify the State if the Secretary intends

to review the existing terms and conditions of the waiver project. A failure to provide such notification shall be deemed to be an approval of the application.

''(3) Not later than 45 days after the date of a notification made in accordance with paragraph (2), the Secretary shall inform the State of proposed changes in the terms and conditions of the waiver project. A failure to provide such information shall be deemed to be an approval of the application.

''(4) During the 30-day period that begins on the date information described in paragraph (3) is provided to a State, the Secretary shall negotiate revised terms and conditions of the waiver project with the State.

''(5)(A) Not later than 120 days after the date an application for an extension of the waiver project is submitted to the Secretary (or such later date agreed to by the chief executive officer of the State), the Secretary shall—

''(i) approve the application subject to such modifications in the terms and conditions—

''(I) as have been agreed to by the Secretary and the State; or

''(II) in the absence of such agreement, as are determined by the Secretary

to be reasonable consistent with the overall objectives of the waiver project; or

''(ii) disapprove the application.

''(B) A failure by the Secretary to approve or disapprove an application submitted under this subsection in accordance with the requirements of subparagraph (A) shall be deemed to be an approval of the application subject to such modifications in the terms and conditions as have been agreed to (if any) by the Secretary and the State.

''(6) An approval of an application for an extension of a waiver project under this subsection shall be for a period requested by the State, not to exceed 3 years.

''(7) An extension of a waiver project under this subsection shall be subject to the final reporting and evaluation requirements of paragraphs (4) and (5) of subsection (e).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to requests for extensions of demonstration projects pending or submitted on or after the date of enactment of this Act.

SEC. 705. ALASKA FMAP.

(a) IN GENERAL.—The first sentence of section 1905(b) (42 U.S.C. 1396d(b)) is amended—

(1) by striking ''and (3)'' and inserting ''(3)''; and

(2) by striking the period and inserting '', and

(4) only with respect to each of fiscal years 2001 through 2005, for purposes of this title and title XXI, the State percentage used to determine the Federal medical assistance percentage for Alaska shall be that percentage which bears the same ratio to 45 percent as the square of the adjusted per capita income of Alaska (determined by dividing the State's 3-year average per capita income by 1.05) bears to the square of the per capita income of the 50 States.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect October 1, 2000.

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

SEC. 801. SPECIAL RULE FOR REDISTRIBUTION AND AVAILABILITY OF UNUSED FISCAL YEAR 1998 AND 1999 SCHIP ALLOTMENTS.

(a) CHANGE IN RULES FOR REDISTRIBUTION AND RETENTION OF UNUSED SCHIP ALLOTMENTS FOR FISCAL YEARS 1998 AND 1999.—Section 2104 (42 U.S.C.

1397dd) is amended by adding at the end the following new subsection:

"(g) RULE FOR REDISTRIBUTION AND EXTENDED AVAILABILITY OF FISCAL YEARS 1998 AND 1999 ALLOTMENTS.—

"(1) AMOUNT REDISTRIBUTED.—

"(A) IN GENERAL.—In the case of a State that expends all of its allotment under subsection (b) or (c) for fiscal year 1998 by the end of fiscal year 2000, or for fiscal year 1999 by the end of fiscal year 2001, the Secretary shall redistribute to the State under subsection (f) (from the fiscal year 1998 or 1999 allotments of other States, respectively, as determined by the application of paragraphs (2) and (3) with respect to the respective fiscal year)) the following amount:

"(i) STATE.—In the case of 1 of the 50 States or the District of Columbia, with respect to—

"(I) the fiscal year 1998 allotment, the amount by which the State's expenditures under this title in fiscal years 1998, 1999, and 2000 ex-

ceed the State's allotment for fiscal year 1998 under subsection (b); or

"(II) the fiscal year 1999 allotment, the amount by which the State's expenditures under this title in fiscal years 1999, 2000, and 2001 exceed the State's allotment for fiscal year 1999 under subsection (b).

"(ii) TERRITORY.—In the case of a commonwealth or territory described in subsection (c)(3), an amount that bears the same ratio to 1.05 percent of the total amount described in paragraph (2)(B)(i)(I) as the ratio of the commonwealth's or territory's fiscal year 1998 or 1999 allotment under subsection (c) (as the case may be) bears to the total of all such allotments for such fiscal year under such subsection.

"(B) EXPENDITURE RULES.—An amount redistributed to a State under this paragraph with respect to fiscal year 1998 or 1999—

"(i) shall not be included in the determination of the State's allotment for any fiscal year under this section;

''(ii) notwithstanding subsection (e), shall remain available for expenditure by the State through the end of fiscal year 2002; and

''(iii) shall be counted as being expended with respect to a fiscal year allotment in accordance with applicable regulations of the Secretary.

''(2) EXTENSION OF AVAILABILITY OF PORTION OF UNEXPENDED FISCAL YEARS 1998 AND 1999 ALLOTMENTS.—

''(A) IN GENERAL.—Notwithstanding subsection (e):

''(i) FISCAL YEAR 1998 ALLOTMENT.—Of the amounts allotted to a State pursuant to this section for fiscal year 1998 that were not expended by the State by the end of fiscal year 2000, the amount specified in subparagraph (B) for fiscal year 1998 for such State shall remain available for expenditure by the State through the end of fiscal year 2002.

''(ii) FISCAL YEAR 1999 ALLOTMENT.—Of the amounts allotted to a State pursuant to this subsection for fiscal year

1999 that were not expended by the State by the end of fiscal year 2001, the amount specified in subparagraph (B) for fiscal year 1999 for such State shall remain available for expenditure by the State through the end of fiscal year 2002.

''(B) AMOUNT REMAINING AVAILABLE FOR EXPENDITURE.—The amount specified in this subparagraph for a State for a fiscal year is equal to—

''(i) the amount by which (I) the total amount available for redistribution under subsection (f) from the allotments for that fiscal year, exceeds (II) the total amounts redistributed under paragraph (1) for that fiscal year; multiplied by

''(ii) the ratio of the amount of such State's unexpended allotment for that fiscal year to the total amount described in clause (i)(I) for that fiscal year.

''(C) USE OF UP TO 10 PERCENT OF RETAINED 1998 ALLOTMENTS FOR OUTREACH ACTIVITIES.—Notwithstanding section 2105(c)(2)(A), with respect to any State described in subparagraph (A)(i), the State may

use up to 10 percent of the amount specified in subparagraph (B) for fiscal year 1998 for expenditures for outreach activities approved by the Secretary.

''(3) DETERMINATION OF AMOUNTS.—For purposes of calculating the amounts described in paragraphs (1) and (2) relating to the allotment for fiscal year 1998 or fiscal year 1999, the Secretary shall use the amounts reported by the States not later than November 30, 2000, or November 30, 2001, respectively, on HCFA Form 64 or HCFA Form 21, as approved by the Secretary.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 4901 of BBA (111 Stat. 552).

SEC. 802. PRESUMPTIVE ELIGIBILITY UNDER SCHIP.

(a) APPLICATION UNDER SCHIP.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is amended by adding at the end the following new subparagraph:

''(D) Section 1920A (relating to presumptive eligibility).''.

(b) TECHNICAL AMENDMENTS.—Section 1920A (42 U.S.C. 1396r–1a) is amended—

(1) in subsection (b)(3)(A)(ii), by striking ''paragraph (1)(A)'' and inserting ''paragraph (2)''; and

(2) in subsection (c)(2), in the matter preceding subparagraph (A), by striking ''subsection (b)(1)(A)'' and inserting ''subsection (b)(2)''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) takes effect October 1, 2000, and applies to allotments under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) for fiscal year 2001 and each succeeding fiscal year thereafter.

(2) TECHNICAL AMENDMENTS.—The amendments made by subsection (b) take effect as if included in the enactment of section 4912 of BBA (111 Stat. 571).

SEC. 803. AUTHORITY TO PAY MEDICAID EXPANSION SCHIP COSTS FROM TITLE XXI APPROPRIATION.

(a) AUTHORITY TO PAY MEDICAID EXPANSION SCHIP COSTS FROM TITLE XXI APPROPRIATION.—Section 2105(a) (42 U.S.C. 1397ee(a)) is amended—

(1) by redesignating subparagraphs (A) through (D) of paragraph (2) as clauses (i) through (iv), respectively, and indenting appropriately;

(2) by redesignating paragraph (1) as subparagraph (B), and indenting appropriately;

(3) by redesignating paragraph (2) as subparagraph (C), and indenting appropriately;

(4) by striking ''(a) IN GENERAL.—'' and the remainder of the text that precedes subparagraph (B), as so redesignated, and inserting the following: ''(a) PAYMENTS.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this section, the Secretary shall pay to each State with a plan approved under this title, from its allotment under section 2104, an amount for each quarter equal to the enhanced FMAP of expenditures in the quarter—

''(A) for child health assistance under the plan for targeted low-income children in the form of providing medical assistance for which payment is made on the basis of an enhanced FMAP under the fourth sentence of section 1905(b);''; and

(5) by adding after subparagraph (C), as so redesignated, the following new paragraph:

''(2) ORDER OF PAYMENTS.—Payments under paragraph (1) from a State's allotment shall be made in the following order:

"(A) First, for expenditures for items described in paragraph (1)(A).

"(B) Second, for expenditures for items described in paragraph (1)(B).

"(C) Third, for expenditures for items described in paragraph (1)(C).".

(b) ELIMINATION OF REQUIREMENT TO REDUCE TITLE XXI ALLOTMENT BY MEDICAID EXPANSION SCHIP COSTS.—Section 2104 (42 U.S.C. 1397dd) is amended by striking subsection (d).

(c) AUTHORITY TO TRANSFER TITLE XXI APPROPRIATIONS TO TITLE XIX APPROPRIATION ACCOUNT AS REIMBURSEMENT FOR MEDICAID EXPENDITURES FOR MEDICAID EXPANSION SCHIP SERVICES.—Notwithstanding any other provision of law, all amounts appropriated under title XXI and allotted to a State pursuant to subsection (b) or (c) of section 2104 of the Social Security Act (42 U.S.C. 1397dd) for fiscal years 1998 through 2000 (including any amounts that, but for this provision, would be considered to have expired) and not expended in providing child health assistance or related services for which payment may be made pursuant to subparagraph (B) or (C) of section 2105(a)(1) of such Act (42 U.S.C. 1397ee(a)(1)) (as amended by subsection (a)), shall be available to reimburse the Grants to States for Medicaid

account in an amount equal to the total payments made to such State under section 1903(a) of such Act (42 U.S.C. 1396b(a)) for expenditures in such years for medical assistance described in subparagraph (A) of section 2105(a)(1) of such Act (42 U.S.C. 1397ee(a)(1)) (as so amended).

(d) CONFORMING AMENDMENTS.—

(1) Section 1905(b) (42 U.S.C. 1396d(b)) is amended in the fourth sentence by striking ''the State's allotment under section 2104 (not taking into account reductions under section 2104(d)(2)) for the fiscal year reduced by the amount of any payments made under section 2105 to the State from such allotment for such fiscal year'' and inserting ''the State's available allotment under section 2104''.

(2) Section 1905(u)(1)(B) (42 U.S.C. 1396d(u)(1)(B)) is amended by striking ''and section 2104(d)''.

(3) Section 2104 (42 U.S.C. 1397dd), as amended by subsection (b), is further amended—

(A) in subsection (b)(1), by striking ''and subsection (d)''; and

(B) in subsection (c)(1), by striking ''subject to subsection (d),''.

(4) Section 2105(c) (42 U.S.C. 1397ee(c)) is amended—

(A) in paragraph (2)(A), by striking all that follows ''Except as provided in this paragraph,'' and inserting ''the amount of payment that may be made under subsection (a) for a fiscal year for expenditures for items described in paragraph (1)(C) of such subsection shall not exceed 10 percent of the total amount of expenditures for which payment is made under subparagraphs (A), (B), and (C) of paragraph (1) of such subsection.'';

(B) in paragraph (2)(B), by striking ''described in subsection (a)(2)'' and inserting ''described in subsection (a)(1)(C)''; and

(C) in paragraph (6)(B), by striking ''Except as otherwise provided by law,'' and inserting ''Except as provided in subsection (a)(1)(A) or any other provision of law,''.

(5) Section 2110(a) (42 U.S.C. 1397jj(a)) is amended by striking ''section 2105(a)(2)(A)'' and inserting ''section 2105(a)(1)(C)(i)''.

(e) TECHNICAL AMENDMENT.—Section 2105(d)(2)(B)(ii) (42 U.S.C. 1397ee(d)(2)(B)(ii)) is amended by striking ''enhanced FMAP under section

1905(u)'' and inserting ''enhanced FMAP under the fourth sentence of section 1905(b)''.

(f) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of section 4901 of the BBA (111 Stat. 552).

TITLE IX—OTHER PROVISIONS

SEC. 901. INCREASE IN AUTHORIZATION OF APPROPRIATIONS FOR THE MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT.

(a) IN GENERAL.—Section 501(a) (42 U.S.C. 701(a)) is amended in the matter preceding paragraph (1) by striking ''$705,000,000 for fiscal year 1994'' and inserting ''$1,000,000,000 for fiscal year 2001''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on October 1, 2000.

SEC. 902. INCREASE IN APPROPRIATIONS FOR SPECIAL DIABETES PROGRAMS FOR CHILDREN WITH TYPE I DIABETES AND INDIANS.

(a) SPECIAL DIABETES PROGRAMS FOR CHILDREN WITH TYPE I DIABETES.—Section 330B(b) of the Public Health Service Act (42 U.S.C. 254c–2(b)) is amended—

(1) by striking ''Notwithstanding'' and inserting the following:

''(1) TRANSFERRED FUNDS.—Notwithstanding''; and

(2) by adding at the end the following:

''(2) APPROPRIATIONS.—For the purpose of making grants under this section, there is appropriated, out of any funds in the Treasury not otherwise appropriated $70,000,000 for each of fiscal years 2001 and 2002 (which shall be combined with amounts transferred under paragraph (1) for each such fiscal years).''.

(b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—Section 330C(c) of the Public Health Service Act (42 U.S.C. 254c–3(c)) is amended—

(1) by striking ''Notwithstanding'' and inserting the following:

''(1) TRANSFERRED FUNDS.—Notwithstanding''; and

(2) by adding at the end the following:

''(2) APPROPRIATIONS.—For the purpose of making grants under this section, there is appropriated, out of any money in the Treasury not otherwise appropriated $70,000,000 for each of fiscal years 2001 and 2002 (which shall be combined with amounts transferred under paragraph (1) for each such fiscal years).''.