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106TH CONGRESS
2D SESSION

H. R. 5291

To amend titles XVIII, XIX, and XXI of the Social Security Act to make additional corrections and refinements in the Medicare, Medicaid, and State children's health insurance programs, as revised by the Balanced Budget Act of 1997.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 26, 2000

Mr. BLILEY (for himself, Mr. DINGELL, Mr. BILIRAKIS, Mr. BROWN of Ohio, Mr. TAUZIN, Mr. OXLEY, Mr. UPTON, Mr. STEARNS, Mr. GILLMOR, Mr. GREENWOOD, Mr. BURR of North Carolina, Mr. NORWOOD, Mr. ROGAN, Mr. SHIMKUS, Mrs. WILSON, Mr. PICKERING, Mr. BRYANT, Mr. BLUNT, Mr. EHRLICH, Ms. MCCARTHY of Missouri, Mr. LUTHER, Mr. ALLEN, Mr. WEYGAND, Mr. WAXMAN, Mr. MARKEY, Mr. HALL of Texas, Mr. BOUCHER, Mr. TOWNS, Mr. PALLONE, Mr. GORDON, Ms. ESHOO, Mr. KLINK, Mr. STUPAK, Mr. ENGEL, Mr. WYNN, Mr. BARRETT of Wisconsin, and Mr. HOEFFEL) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend titles XVIII, XIX, and XXI of the Social Security Act to make additional corrections and refinements in the Medicare, Medicaid, and State children's health insurance programs, as revised by the Balanced Budget Act of 1997.

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 ''Beneficiary Improvement and Protection 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) BALANCED BUDGET ACT OF 1997.—The term ''BBA'' means the Balanced Budget Act of 1997 (Public Law 105–33).

(2) 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, as enacted into law by section 1000(a)(6) of Public Law 106–113 (Appendix F).

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

TITLE I—BENEFICIARY IMPROVEMENTS

SEC. 101. IMPROVING AVAILABILITY OF QMB/SLMB APPLICATION FORMS.

(a) THROUGH LOCAL SOCIAL SECURITY OFFICES.—

(1) IN GENERAL.—Section 1804 (42 U.S.C. 1395b–2) is amended by adding at the end the following new subsection:

''(d) AVAILABILITY OF APPLICATION FORMS FOR MEDICAL ASSISTANCE FOR MEDICARE COST-SHARING.—The Secretary shall make available to the Administrator of the Social Security Administration appropriate forms for applying for medical assistance for medicare cost-sharing under a State plan under title XIX. Such Administrator, through local offices of the Social Security Administration shall—

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

''(2) provide assistance to such individuals in completing such forms and, upon request, in submitting such forms to the appropriate State agency.''.

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

inserting before the semicolon at the end the following: ''and provide application forms for medical assistance for medicare cost-sharing under the plan to the Secretary in order to make them available through Federal offices under section 1804(d) within the State''.

(b) STREAMLINING APPLICATION PROCESS.—

(1) REQUIREMENT.—Section 1902(a)(8) (42 U.S.C. 1396a(a)(8)) is amended by striking '', and that'' and inserting ''permit individuals to apply for and obtain medical assistance for medicare cost-sharing using the simplified uniform application form developed under section 1905(p)(5), make available such forms to such individuals, permit such individuals to apply for such assistance by mail (and, at the State option, by telephone or other electronic means) and not require them to apply in person, and provide that''.

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

''(5)(A) The Secretary shall develop a simplified application form for use by individuals (including both qualified medicare beneficiaries and specified low-income medicare beneficiaries) in applying for medical assistance for

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

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

''(C) The Secretary shall make such application forms available—

''(i) to the Administrator of the Social Security Administration for distribution through local social security offices;

''(ii) at such other sites as the Secretary determines appropriate; and

''(iii) to persons upon request.''.

(c) EFFECTIVE DATES.—

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

(2) EFFECTIVE DATE.—The amendments made by subsection (b) take effect 1 year after the date of the enactment of this Act, regardless of whether regulations have been promulgated to carry out such amendments by such date. Secretary of Health and Human Services shall develop the uniform application form under the amendment made by subsection (b)(2) by not later than 9 months after the date of the enactment of this Act.

SEC. 102. STUDY ON LIMITATION ON STATE PAYMENT FOR MEDICARE COST-SHARING AFFECTING ACCESS TO SERVICES FOR QUALIFIED MEDICARE BENEFICIARIES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine if access to certain services (including mental health services) for qualified medicare beneficiaries has been affected by limitations on a State's payment for medicare cost-sharing for such beneficiaries under section 1902(n) of the Social Security Act (42 U.S.C. 1396a(n)). As part of such study, the Secretary shall analyze the effect of such payment limitation on providers who serve a disproportionate share of such beneficiaries.

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

SEC. 103. ELECTION OF PERIODIC COLONOSCOPY.

(a) COVERAGE.—Section 1861(pp)(1)(C) (42 U.S.C. 1395x(pp)(1)(C)) is amended by inserting ''and in the case of an individual making the election described in section 1834(d)(4)'' after ''high risk for colorectal cancer''.

(b) ELECTION.—Section 1834(d) (42 U.S.C. 1395m(d)) is amended—

(1) in paragraph (2)(E)—

(A) by striking ''or'' at the end of clause (i);

(B) by striking the period at the end of clause (ii) and inserting ''; or''; and

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

''(iii) if the procedure is performed within 119 months after a screening colonoscopy under paragraph (4).'';

(2) in paragraph (3)(A), by inserting ''and for individuals making the election described in paragraph (4)'' after ''1861(pp)(2))'';

(3) in paragraph (3)(E), by adding at the end the following: ''No payment may be made under this part for a colorectal cancer screening test consisting of a screening colonoscopy for individuals making the election described in paragraph (4) if the procedure is performed within the 119 months after a previous screening colonoscopy or within 47 months after a screening flexible sigmoidoscopy.''; and

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

''(4) ELECTION OF SCREENING COLONOSCOPY INSTEAD OF SCREENING SIGMOIDOSCOPY.—An individual may elect, in a manner specified by the Secretary, to receive a screening colonoscopy instead of a screening sigmoidoscopy.''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2001.

SEC. 104. WAIVER OF 24-MONTH WAITING PERIOD FOR MEDICARE COVERAGE OF INDIVIDUALS DISABLED WITH AMYOTROPHIC LATERAL SCLEROSIS (ALS).

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

(1) by redesignating subsection (h) as subsection (j) and by moving such subsection to the end of the section, and

(2) by inserting after subsection (g) the following new subsection:

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

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

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

''(3) Subsection (f) shall not be applied.''.

(b) CONFORMING AMENDMENT.—Section 1837 (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

''(j) In applying this section in the case of an individual who is entitled to benefits under part A pursuant to the operation of section 226(h), the following special rules apply:

''(1) The initial enrollment period under subsection (d) shall begin on the first day of the first month in which the individual satisfies the requirement of section 1836(1).

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

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

SEC. 105. ELIMINATION OF TIME LIMITATION ON MEDICARE BENEFITS FOR IMMUNOSUPPRESSIVE DRUGS.

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

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

SEC. 106. 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 drugs and biologicals which are not usually self-administered by the patient)".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to drugs and biologicals administered on or after October 1, 2000.

SEC. 107. DEMONSTRATION OF MEDICARE COVERAGE OF MEDICAL NUTRITION THERAPY SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project (in

this section referred to as the ''project'') to examine the cost-effectiveness of providing medical nutrition therapy services under the medicare program and the financial impact of providing such services under the program.

(b) SCOPE OF SERVICES.—

(1) TIME PERIOD AND LOCATIONS.—The project shall be conducted—

(A) during a period of 5 fiscal years; and

(B) in the 5 States which have the highest proportion of the population who are 65 years of age or older.

(2) FUNDING.—The total amount of the payments that may be made under this section shall not exceed $60,000,000 for each of the 5 fiscal years of the project. Funding for the project shall be made from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t).

(c) COVERAGE AS MEDICARE PART B SERVICES.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, medical nutrition therapy services furnished under the project shall be considered to be services covered under part B of title XVIII of the Social Security Act.

(2) PAYMENT.—Payment for such services shall be made at a rate of 80 percent of the lesser of the actual charge for the services or 85 percent of the amount determined under the fee schedule established under section 1848(b) of the Social Security Act (42 U.S.C. 1395w–4(b)) for the same services if furnished by a physician.

(3) APPLICATION OF LIMITS ON BILLING.—The provisions of section 1842(b)(18) of the Social Security Act (42 U.S.C. 1395u(b)(18)) shall apply to a registered dietitian or nutrition professional furnishing services under the project in the same manner as they to a practitioner described in subparagraph (C) of such section furnishing services under title XVIII of such Act.

(d) REPORTS.—The Secretary shall submit to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate interim reports on the project and a final report on the project within 6 months after the conclusion of the project. The final report shall include an evaluation of the impact of the use of medical nutrition therapy services on medicare beneficiaries and on the medicare program, including any impact on reduc-

ing costs under the program and improving the health of beneficiaries.

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

(1) MEDICAL NUTRITION THERAPY SERVICES.—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 section 1861(r)(1) of the Social Security Act, 42 U.S.C. 1395x(r)(1)).

(2) REGISTERED DIETITIAN OR NUTRITION PROFESSIONAL.—

(A) IN GENERAL.—Subject to subparagraph (B), the term ''registered dietitian or nutrition professional'' means an individual who—

(i) 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 accredita-

tion organization recognized by the Secretary for this purpose;

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

(iii)(I) is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed, or

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

(B) EXCEPTION.—Clauses (i) and (ii) of subparagraph (A) shall not apply in the case of an individual who as of the date of the enactment of this Act is licensed or certified as a dietitian or nutrition professional by the State in which medical nutrition therapy services are performed.

(3) SECRETARY.—The term ''Secretary'' means Secretary of Health and Human Services.

TITLE II—OTHER MEDICARE PART B PROVISIONS

Subtitle A—Access to Technology

SEC. 201. ANNUAL REPORTS ON NATIONAL COVERAGE DETERMINATIONS.

(a) ANNUAL REPORTS.—Not later than December 1 of each year, beginning in 2001, the Secretary of Health and Human Services shall submit to Congress a report that sets forth a detailed compilation of the actual time periods that were necessary to complete and fully implement any national coverage determinations that were made in the previous fiscal year for items, services, or medical devices not previously covered as a benefit under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including, with respect to each new item, service, or medical device, a statement of the time taken by the Secretary to make the necessary coverage, coding, and payment determinations, including the time taken to complete each significant step in the process of making such determinations.

(b) PUBLICATION OF REPORTS ON THE INTERNET.—The Secretary of Health and Human Services shall publish each report submitted under subsection (a) on the medicare Internet site of the Department of Health and Human Services.

SEC. 202. NATIONAL LIMITATION AMOUNT EQUAL TO 100 PERCENT OF NATIONAL MEDIAN FOR NEW CLINICAL LABORATORY TEST TECHNOLOGIES; FEE SCHEDULE FOR NEW CLINICAL LABORATORY TESTS.

(a) IN GENERAL.—Section 1833(h)(4)(B)(viii) (42 U.S.C. 1395l(h)(4)(B)(viii)) is amended by inserting before the period 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)''.

(b) FEE SCHEDULE FOR NEW CLINICAL LAB TESTS.—

(1) ESTABLISHMENT OF FEE SCHEDULE FOR NEW TESTS.—Section 1833(h)(1) (42 U.S.C. 1395l(h)(1)) is amended—

(A) in subparagraph (B), by striking ''In'' and inserting ''Except for tests described in subparagraph (E), in''; and

(B) by inserting at the end the following new subparagraph:

''(E) In the case of a clinical diagnostic laboratory test which is described by a new code in the Health Care Financing Administration Common Procedure Coding

System (commonly referred to as 'HCPCS'), for which the Secretary is not able to crosswalk with a similar test with an established schedule amount, the Secretary shall establish for purposes of subparagraph (A) a single fee schedule amount for all areas in the following manner:

''(i) By not later than December 1 of each year, beginning with 2001, the Secretary shall cause to have published in the Federal Register (which may include publication on an interim final rule basis with a comment period) an interim fee schedule amount for each such new test which shall apply for such new tests furnished during the following year.

''(ii) The interim fee schedule amount for each such new test shall be subject to a comment period of 60 days. The Secretary shall review comments and data received and make appropriate adjustments to the fee schedule for each test applicable beginning with the following calendar year.

''(iii) For years beginning with 2002, the Secretary shall also cause to have published in the Federal Register by not later than December 1 of the year prior to its application, the adjustments to the interim fee schedule amount described in clause (ii) for each such new test for which an interim fee schedule amount was established for a year, includ-

ing adjustments to such fee schedule amounts in response to comments.''.

(2) CONFORMING AMENDMENT TO UPDATE PROVISION.—Section 1833(h)(2)(A) (42 U.S.C. 1395l(h)(2)(A)) is amended by striking ''July 1, 1984,'' and inserting the following: ''July 1, 1984. The fee schedules established under the previous sentence and paragraph (1)(E)(3) shall be''.

SEC. 203. 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:

''(B) USE OF CATEGORIES IN DETERMINING ELIGIBILITY OF A DEVICE FOR PASS-THROUGH PAYMENTS.—The Secretary shall determine whether a medical device meets the requirements of subparagraph (A)(iv) as follows:

''(i) ESTABLISHMENT OF CATEGORIES.—The Secretary shall establish

categories of medical devices based on type of medical device as follows:

"(I) IN GENERAL.—The Secretary shall establish criteria that will be used for creation of categories through rulemaking (which may include use of an interim final rule with comment period). Such categories shall be established 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, as estimated by the Secretary, is not insignificant as described in paragraph (A)(iv)(II).

"(II) INITIAL CATEGORIES.—The categories to be applied as of the category-based pass-through implementation date specified pursuant to subclause (V) 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 a such a cat-

egory. For purposes of the preceding sentence, whether a medical device meets the requirements of clause (ii) or (iv) of subparagraph (A) as of such date shall be determined without regard to clause (ii) of this subparagraph and on the basis of the program memoranda issued before such date identifying medical devices that meet such requirements.

''(III) 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 (as described in subparagraph (C)(iii)) is appropriate. The Secretary shall only establish a new category for a medical device that is described by a category that was previously in effect if the Secretary determines, in accord with criteria established under subclause

(I) of this clause, that the device represents a significant advance in medical technology that is expected to significantly improve the treatment of Medicare beneficiaries.

(IV) DELETING CATEGORIES.—The Secretary shall delete a category at the close of the period for which the category is in effect (as described in subparagraph (C)(iii)).

''(V) CATEGORY-BASED PASS-THROUGH IMPLEMENTATION DATE.—For purposes of this subparagraph and subparagraph (C), the 'category-based pass-through implementation date' is a date specified by the Secretary as of which the categories established under this clause are first used for purposes of clause (ii)(I). Such date may not be later than July 1, 2000.

''(ii) 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 under clause (i), and

''(II) an application under section 515 of the Federal Food, Drug, and Cosmetic Act has been approved with respect to the device, 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, without an additional requirement for application or prior approval.——

''(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.—Except as provided in clause (iv), 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 under subparagraph (B)(i); 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 cat-

egory is in effect (as described in clause (iii)).

''(iii) PERIOD FOR WHICH CATEGORY IS IN EFFECT.—For purposes of this subparagraph and subparagraph (B), a category of medical devices established under subparagraph (B)(i) 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 subparagraph (B)(i)(II), 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 the category-based pass-through implementation date); and

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

"(iv) PAYMENTS MADE BEFORE CATEGORY-BASED PASS-THROUGH IMPLEMENTATION DATE.—

"(I) in the case of a medical device provided as part of a service (or group of services) paid for under this subsection and provided during the period beginning on the first date on which the system under this subsection is implemented and ending on (and including) the day before the category-based pass-through implementation date specified pursuant to subparagraph (B)(i)(V), payment shall be made in accordance with the provisions of this paragraph as in effect on the day before the date of the enactment of this subparagraph; and

"(II) notwithstanding subclause (I), the Secretary shall make payments under this paragraph during the period beginning one month after the date of enactment of the Beneficiary Improvement and Protection Act of 2000 and ending on the same

ending date in subclause (I) with respect to any medical device that is not included in a program memorandum referred to in subparagraph (B)(i)(II) but that is substantially similar (other than with respect to the restriction in subparagraph (A)(iv)(I)) to devices that are so included and that the Secretary determines is likely to be described by a initial category established under such subparagraph.''.

(b) CONFORMING AMENDMENTS.—Section 1833(t) is further amended—

(1) 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)'';

(2) in paragraph (12)(E), by striking ''paragraph (6)(B)'' and inserting ''paragraph (6)(C)'';

(3) in paragraph (11)(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))''; and

(4) in paragraph (6)(A), 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''.

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

SEC. 204. ACCESS TO NEW TECHNOLOGIES APPLIED TO SCREENING MAMMOGRAPHY TO ENHANCE BREAST CANCER DETECTION.

(a) $15 INITIAL INCREASE IN PAYMENT LIMIT.—Section 1834(c)(3) (42 U.S.C. 1395m(c)(3)) is amended—

(1) in subparagraph (A)—

(A) by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (D)''; and

(B) in clause (ii), by inserting ''(taking into account, if applicable, subparagraph (D))'' after ''for the preceding year''; and

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

''(D) INCREASE IN PAYMENT LIMIT FOR NEW TECHNOLOGIES.—In the case of new technologies applied to screening mammography performed beginning in 2001 and determined

by the Secretary to enhance the detection of breast cancer, the limit applied under this paragraph for 2001 shall be increased by $15.''.

(b) CHANGE IN REVISION OF LIMIT.—Subparagraph (B) of such section is amended—

(1) by striking ''REDUCTION OF'' and inserting ''REVISIONS TO'',

(2) by inserting ''or new technologies described in paragraph (1)(D)'' after ''1992'', and

(3) by inserting ''increase or'' before ''reduce''.

(c) INCLUSION OF NEW TECHNOLOGY.—Section 1861(jj) (42 U.S.C. 1395x(jj)) is amended by inserting before the period at the end the following: '', as well as new technology applied to such a procedure that the Secretary determines enhances the detection of breast cancer''.

(d) EFFECTIVE DATE.—The amendments made by this section apply to mammography performed on or after January 1, 2001.

Subtitle B—Provisions Relating to Physicians Services

SEC. 211. GAO STUDY OF 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 about 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 Medicare were not to cover gastrointestinal endoscopic services in physicians offices. –

(b) REPORT.—The Comptroller General shall submit a report to Congress on such study no later than July 1, 2002 and include such recommendations as the Comptroller General determines to be appropriate.

SEC. 212. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

(a) IN GENERAL.—When an independent laboratory furnishes the technical component of a physician pathology service to a fee-for-service medicare beneficiary who is a patient of a grandfathered hospital, the Secretary of Health and Human Services shall treat such component as a service for which payment shall be made to the laboratory under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) and not as an inpatient hospital service for which payment is made to the hospital under section 1886(d) of such Act (42 U.S.C. 1395ww(d)) or as an outpatient hospital service for which payment is made to the hospital under section 1834(t) of such Act (42 U.S.C. 1395l(t)).

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

(1) GRANDFATHERED HOSPITAL.—The term ''grandfathered hospital'' means a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the technical component of physician pathology services to fee-for-service medicare beneficiaries who were hospital patients and submitted claims for payment for such component to a medicare carrier (and not to the hospital).

(2) FEE-FOR-SERVICE MEDICARE BENEFICIARY.—The term ''fee-for-service medicare beneficiary'' means an individual who—

(A) is entitled to benefits under part A, or enrolled under part B, of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.); and

(B) is not enrolled in (i) a Medicare+Choice plan under part C of such title (42 U.S.C. 1395w–21 et seq.), (ii) a plan offered by an eligible organization under section 1876 of such Act (42 U.S.C. 1395mm), (iii) a program of all-inclusive care for the elderly (PACE) under section 1898 of such Act, or (iv) a social health maintenance organization (SHMO) demonstration project established under section 4018(b) of the Omnibus Budget

Reconciliation Act of 1987 (Public Law 100–203).

(3) MEDICARE CARRIER.—The term ''medicare carrier'' means an organization with a contract under section 1842 of such Act (42 U.S.C. 1395u).

(c) EFFECTIVE DATE.—Subsection (a) applies to services furnished during the 2-year period beginning on January 1, 2001.

(d) GAO REPORT.—

(1) STUDY.—The Comptroller General of the United States shall—

(A) analyze the types of hospitals that are grandfathered under subsection (a); and

(B) study the effects of subsection (a) on hospitals, laboratories, and medicare beneficiaries access to physician pathology services.

(2) REPORT.—The Comptroller General shall submit a report to Congress on such analysis and study no later than July 1, 2002. The report shall include recommendations about whether the provisions of subsection (a) should apply after the 2-year period under subsection (c) for grandfathered hospitals for either (or both) inpatient and outpatient hospital services and whether such subsection should

be extended to apply to other hospitals that have similar characteristics to grandfathered hospitals.

SEC. 213. PHYSICIAN GROUP PRACTICE DEMONSTRATION.

Title XVIII is amended by inserting after section 1866 the following new sections:

''DEMONSTRATION OF APPLICATION OF PHYSICIAN VOLUME INCREASES TO GROUP PRACTICES

''SEC. 1866A. (a) DEMONSTRATION PROGRAM AUTHORIZED.—

''(1) IN GENERAL.—The Secretary shall conduct demonstration projects to test and, if proven effective, expand the use of incentives to health care groups participating in the program under this title that—

''(A) encourage coordination of the care furnished to individuals under the programs under parts A and B by institutional and other providers, practitioners, and suppliers of health care items and services;

''(B) encourage investment in administrative structures and processes to ensure efficient service delivery; and

''(C) reward physicians for improving health outcomes.

''(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may

administer the program under this section in accordance with section 1866B.

''(3) DEFINITIONS.—For purposes of this section, terms have the following meanings:

''(A) PHYSICIAN.—Except as the Secretary may otherwise provide, the term 'physician' means any individual who furnishes services which may be paid for as physicians' services under this title .

''(B) HEALTH CARE GROUP.—The term 'health care group' means a group of physicians (as defined in subparagraph (A)) organized at least in part for the purpose of providing physicians' services under this title. As the Secretary finds appropriate, a health care group may include a hospital and any other individual or entity furnishing items or services for which payment may be made under this title that is affiliated with the health care group under an arrangement structured so that such individual or entity participates in a demonstration under this section and will share in any bonus earned under subsection (d).

''(b) ELIGIBILITY CRITERIA.—

''(1) IN GENERAL.—The Secretary is authorized to establish criteria for health care groups eligible to participate in a demonstration under this section, including criteria relating to numbers of health care professionals in, and of patients served by, the group, scope of services provided, and quality of care.

''(2) PAYMENT METHOD.—A health care group participating in the demonstration under this section shall agree with respect to services furnished to beneficiaries within the scope of the demonstration (as determined under subsection (c))—

''(A) to be paid on a fee-for-service basis; and

''(B) that payment with respect to all such services furnished by members of the health care group to such beneficiaries shall (where determined appropriate by the Secretary) be made to a single entity.

''(3) DATA REPORTING.—A health care group participating in a demonstration under this section shall report to the Secretary such data, at such times and in such format as the Secretary require, for purposes of monitoring and evaluation of the demonstration under this section.

''(c) PATIENTS WITHIN SCOPE OF DEMONSTRATION.—

''(1) IN GENERAL.—The Secretary shall specify, in accordance with this subsection, the criteria for identifying those patients of a health care group who shall be considered within the scope of the demonstration under this section for purposes of application of subsection (d) and for assessment of the effectiveness of the group in achieving the objectives of this section.

''(2) OTHER CRITERIA.—The Secretary may establish additional criteria for inclusion of beneficiaries within a demonstration under this section, which may include frequency of contact with physicians in the group or other factors or criteria that the Secretary finds to be appropriate.

''(3) NOTICE REQUIREMENTS.—In the case of each beneficiary determined to be within the scope of a demonstration under this section with respect to a specific health care group, the Secretary shall ensure that such beneficiary is notified of the incentives, and of any waivers of coverage or payment rules, applicable to such group under such demonstration.

''(d) INCENTIVES.—

''(1) PERFORMANCE TARGET.—The Secretary shall establish for each health care group participating in a demonstration under this section—

''(A) a base expenditure amount, equal to the average total payments under parts A and B for patients served by the health care group on a fee-for-service basis in a base period determined by the Secretary; and

''(B) an annual per capita expenditure target for patients determined to be within the scope of the demonstration, reflecting the base expenditure amount adjusted for risk and expected growth rates.

''(2) INCENTIVE BONUS.—The Secretary shall pay to each participating health care group (subject to paragraph (4)) a bonus for each year under the demonstration equal to a portion of the Medicare savings realized for such year relative to the performance target.

''(3) ADDITIONAL BONUS FOR PROCESS AND OUTCOME IMPROVEMENTS.—At such time as the Secretary has established appropriate criteria based on evidence the Secretary determines to be sufficient, the Secretary shall also pay to a participating health care group (subject to paragraph (4)) an ad-

ditional bonus for a year, equal to such portion as the Secretary may designate of the saving to the program under this title resulting from process improvements made by and patient outcome improvements attributable to activities of the group.

''(4) LIMITATION.—The Secretary shall limit bonus payments under this section as necessary to ensure that the aggregate expenditures under this title (inclusive of bonus payments) with respect to patients within the scope of the demonstration do not exceed the amount which the Secretary estimates would be expended if the demonstration projects under this section were not implemented.

''PROVISIONS FOR ADMINISTRATION OF DEMONSTRATION PROGRAM

''SEC. 1866B. (a) GENERAL ADMINISTRATIVE AUTHORITY.—

''(1) BENEFICIARY ELIGIBILITY.—Except as otherwise provided by the Secretary, an individual shall only be eligible to receive benefits under the program under section 1866A (in this section referred to as the 'demonstration program') if such individual—

''(A) is enrolled in under the program under part B and entitled to benefits under part A; and

"(B) is not enrolled in a Medicare+Choice plan under part C, an eligible organization under a contract under section 1876 (or a similar organization operating under a demonstration project authority), an organization with an agreement under section 1833(a)(1)(A), or a PACE program under section 1894.

"(2) SECRETARY'S DISCRETION AS TO SCOPE OF PROGRAM.—The Secretary may limit the implementation of the demonstration program to—

"(A) a geographic area (or areas) that the Secretary designates for purposes of the program, based upon such criteria as the Secretary finds appropriate;

"(B) a subgroup (or subgroups) of beneficiaries or individuals and entities furnishing items or services (otherwise eligible to participate in the program), selected on the basis of the number of such participants that the Secretary finds consistent with the effective and efficient implementation of the program;

"(C) an element (or elements) of the program that the Secretary determines to be suitable for implementation; or

''(D) any combination of any of the limits described in subparagraphs (A) through (C).

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

''(4) AGREEMENTS.—The Secretary is authorized to enter into agreements with individuals and entities to furnish health care items and services to beneficiaries under the demonstration program.

''(5) PROGRAM STANDARDS AND CRITERIA.—The Secretary shall establish performance standards for the demonstration program including, as applicable, standards for quality of health care items and services, cost-effectiveness, beneficiary satisfaction, and such other factors as the Secretary finds appropriate. The eligibility of individuals or entities for the initial award, continuation, and renewal of agreements to provide health care items and services under the program shall be conditioned, at a minimum, on performance that meets or exceeds such standards.

''(6) ADMINISTRATIVE REVIEW OF DECISIONS AFFECTING INDIVIDUALS AND ENTITIES FURNISHING SERVICES.—An individual or entity fur-

nishing services under the demonstration program shall be entitled to a review by the program administrator (or, if the Secretary has not contracted with a program administrator, by the Secretary) of a decision not to enter into, or to terminate, or not to renew, an agreement with the entity to provide health care items or services under the program.

''(7) SECRETARY'S REVIEW OF MARKETING MATERIALS.—An agreement with an individual or entity furnishing services under the demonstration program shall require the individual or entity to guarantee that it will not distribute materials marketing items or services under the program without the Secretary's prior review and approval;

''(8) PAYMENT IN FULL.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), an individual or entity receiving payment from the Secretary under a contract or agreement under the demonstration program shall agree to accept such payment as payment in full, and such payment shall be in lieu of any payments to which the individual or entity would otherwise be entitled under this title.

''(B) COLLECTION OF DEDUCTIBLES AND COINSURANCE.—Such individual or entity may collect any applicable deductible or coinsurance amount from a beneficiary.

''(b) CONTRACTS FOR PROGRAM ADMINISTRATION.—

''(1) IN GENERAL.—The Secretary may administer the demonstration program through a contract with a program administrator in accordance with the provisions of this subsection.

''(2) SCOPE OF PROGRAM ADMINISTRATOR CONTRACTS.—The Secretary may enter into such contracts for a limited geographic area, or on a regional or national basis.

''(3) ELIGIBLE CONTRACTORS.—The Secretary may contract for the administration of the program with—

''(A) an entity that, under a contract under section 1816 or 1842, determines the amount of and makes payments for health care items and services furnished under this title; or

''(B) any other entity with substantial experience in managing the type of program concerned.

''(4) CONTRACT AWARD, DURATION, AND RENEWAL.—

"(A) IN GENERAL.—A contract under this subsection shall be for an initial term of up to three years, renewable for additional terms of up to three years.

"(B) NONCOMPETITIVE AWARD AND RENEWAL FOR ENTITIES ADMINISTERING PART A OR PART B PAYMENTS.—The Secretary may enter or renew a contract under this subsection with an entity described in paragraph (3)(A) without regard to the requirements of section 5 of title 41, United States Code.

"(5) APPLICABILITY OF FEDERAL ACQUISITION REGULATION.—The Federal Acquisition Regulation shall apply to program administration contracts under this subsection.

"(6) PERFORMANCE STANDARDS.—The Secretary shall establish performance standards for the program administrator including, as applicable, standards for the quality and cost-effectiveness of the program administered, and such other factors as the Secretary finds appropriate. The eligibility of entities for the initial award, continuation, and renewal of program administration contracts shall be conditioned, at a minimum, on performance that meets or exceeds such standards.

"(7) FUNCTIONS OF PROGRAM ADMINISTRATOR.—A program administrator shall perform any or all of the following functions, as specified by the Secretary:

"(A) AGREEMENTS WITH ENTITIES FURNISHING HEALTH CARE ITEMS AND SERVICES.—Determine the qualifications of entities seeking to enter or renew agreements to provide services under the program, and as appropriate enter or renew (or refuse to enter or renew) such agreements on behalf of the Secretary.

"(B) ESTABLISHMENT OF PAYMENT RATES.—Negotiate or otherwise establish, subject to the Secretary's approval, payment rates for covered health care items and services.

"(C) PAYMENT OF CLAIMS OR FEES.—Administer payments for health care items or services furnished under the program.

"(D) PAYMENT OF BONUSES.—Using such guidelines as the Secretary shall establish, and subject to the approval of the Secretary, make bonus payments as described in subsection (c)(2)(A)(ii) to entities furnishing items or services for which payment may be made under the program.

''(E) OVERSIGHT.—Monitor the compliance of individuals and entities with agreements under the program with the conditions of participation.

''(F) ADMINISTRATIVE REVIEW.—Conduct reviews of adverse determinations specified in subsection (a)(6).

''(G) REVIEW OF MARKETING MATERIALS.—Conduct a review of marketing materials proposed by an entity furnishing services under the program.

''(H) ADDITIONAL FUNCTIONS.—Perform such other functions as the Secretary may specify.

''(8) LIMITATION OF LIABILITY.—The provisions of section 1157(b) shall apply with respect to activities of contractors and their officers, employees, and agents under a contract under this subsection.

''(9) INFORMATION SHARING.—Notwithstanding section 1106 and section 552a of title 5, United States Code, the Secretary is authorized to disclose to an entity with a program administration contract under this subsection such information (including medical information) on individuals receiving health

care items and services under the program as the entity may require to carry out its responsibilities under the contract.

''(c) RULES APPLICABLE TO BOTH PROGRAM AGREEMENTS AND PROGRAM ADMINISTRATION CONTRACTS.—

''(1) RECORDS, REPORTS, AND AUDITS.—The Secretary is authorized to require entities with agreements to provide health care items or services under the demonstration program, and entities with program administration contracts under subsection (b), to maintain adequate records, to afford the Secretary access to such records (including for audit purposes), and to furnish such reports and other materials (including audited financial statements and performance data) as the Secretary may require for purposes of implementation, oversight, and evaluation of the program and of individuals' and entities' effectiveness in performance of such agreements or contracts.

''(2) BONUSES.—Notwithstanding any other provision of law, but subject to subparagraph (B)(ii), the Secretary may make bonus payments under the program from the Federal Health Insurance Trust Fund and the Federal Supplementary

Medical Insurance Trust Fund in amounts that do not exceed the amounts authorized under the program in accordance with the following:

"(A) PAYMENTS TO PROGRAM ADMINISTRATORS.—The Secretary may make bonus payments under the program to program administrators.

"(B) PAYMENTS TO ENTITIES FURNISHING SERVICES.—

"(i) IN GENERAL.—Subject to clause (ii), the Secretary may make bonus payments to individuals or entities furnishing items or services for which payment may be made under the program, or may authorize the program administrator to make such bonus payments in accordance with such guidelines as the Secretary shall establish and subject to the Secretary's approval.

"(ii) LIMITATIONS.—The Secretary may condition such payments on the achievement of such standards related to efficiency, improvement in processes or outcomes of care, or such other factors as the Secretary determines to be appropriate.

''(3) ANTIDISCRIMINATION LIMITATION.—The Secretary shall not enter into an agreement with an entity to provide health care items or services under the program, or with an entity to administer the program, unless such entity guarantees that it will not deny, limit, or condition the coverage or provision of benefits under the program, for individuals eligible to be enrolled under such program, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(d) LIMITATIONS ON JUDICIAL REVIEW.—The following actions and determinations with respect to the demonstration program shall not be subject to review by a judicial or administrative tribunal:

''(1) Limiting the implementation of the program under subsection (a)(2).

''(2) Establishment of program participation standards under subsection (a)(5) or the denial or termination of, or refusal to renew, an agreement with an entity to provide health care items and services under the program.

''(3) Establishment of program administration contract performance standards under subsection (b)(6), the refusal to renew a program administration contract, or the noncompetitive award or re-

newal of a program administration contract under subsection (b)(4)(B).

''(4) Establishment of payment rates, through negotiation or otherwise, under a program agreement or a program administration contract.

''(5) A determination with respect to the program (where specifically authorized by the program authority or by subsection (c)(2))—

''(A) as to whether cost savings have been achieved, and the amount of savings; or

''(B) as to whether, to whom, and in what amounts bonuses will be paid.

''(e) APPLICATION LIMITED TO PARTS A AND B.—None of the provisions of this section or of the demonstration program shall apply to the programs under part C.

''(f) REPORTS TO CONGRESS.—Not later than two years after the date of enactment of this section, and biennially thereafter for six years, the Secretary shall report to the Congress on the use of authorities under the demonstration program. Each report shall address the impact of the use of those authorities on expenditures, access, and quality under the programs under this title.''.

SEC. 214. DESIGNATION OF SEPARATE CATEGORY FOR INTERVENTIONAL PAIN MANAGEMENT PHYSICIANS.

With respect to services furnished on or after January 1, 2002, the Secretary of Health and Human Services shall provide for the designation under section 1848(c)(3)(A) of the Social Security Act (42 U.S.C. 1395w–4(c)(3)(A)) of interventional pain management physicians as a separate category of physician specialists.

SEC. 215. EVALUATION OF ENROLLMENT PROCEDURES FOR MEDICAL GROUPS THAT RETAIN INDEPENDENT CONTRACTOR PHYSICIANS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct an evaluation of the current medicare enrollment process for medical groups that retain independent contractor physicians with particular emphasis on hospital-based physicians, such as emergency department staffing groups. In conducting the evaluation, the Secretary shall—

(1) review the increase of individual medicare provider numbers issued and the possible medicare program integrity vulnerabilities of the current process;

(2) assess how program integrity could be enhanced by the enrollment of groups that retain independent contractor hospital-based physicians; and

(3) develop suggested procedures for the enrollment of these groups.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a).

Subtitle C—Other Services

SEC. 221. 3-YEAR MORATORIUM ON SNF PART B CONSOLIDATED BILLING REQUIREMENTS.

(a) MORATORIUM IN APPLICATION OF CONSOLIDATED BILLING TO SNF RESIDENTS IN NON-COVERED STAYS.—Section 1842(b)(6)(E) (42 U.S.C. 1395u(b)(6)(E)) is amended by inserting ''(on or after October 1, 2003)'' after ''furnished to an individual''.

(b) MORATORIUM IN PROVIDER AGREEMENT PROVISION.—Section 1866(a)(1)(H)(ii)(I) (42 U.S.C. 1395cc(a)(1)(H)(ii)(I) is amended by inserting ''in the case of a resident who is in a stay covered under part A, and for services furnished on or after October 1, 2003, in the case of a resident who is not in a stay covered under such part'' before the comma.

(c) MORATORIUM IN REQUIREMENT FOR SNF BILLING OF PART B SERVICES.—Section 1862(a)(18) (42 U.S.C. 1395y(a)(18)) is amended to read as follows:

"(18) which are covered skilled nursing facility services described in section 1888(e)(2)(A)(i) and which are furnished to an individual who is a resident—

"(A) of a skilled nursing facility in the case of a resident who is in a stay covered under part A; or

"(B) of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility (as determined under regulations) for services furnished on or after October 1, 2003, in the case of a resident who is not in a stay covered under such part,

by an entity other than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the skilled nursing facility;".

(d) EFFECTIVE DATE.—The amendments made by subsections (a), (b) and (c) are effective as if included in the enactment of BBA.

(e) REPORT.—Not later than October 1, 2002, the Comptroller General of the United States shall submit to Congress a report that includes an analysis and recommendations on—

(1) alternatives, if any, to consolidated billing for part B items and services described in section 1842(b)(6) of the Social Security Act (42 U.S.C. 1395u(b)(6)) to ensure accountability by skilled nursing facilities and accuracy in claims submitted for all services and items provided to skilled nursing facility residents under part B of the medicare program;

(2) the costs expected to be incurred by skilled nursing facilities under such alternative approaches, compared with the costs associated with the implementation of consolidated billing; and

(3) the costs incurred by the medicare program in implementing such alternative approaches and their effect on utilization review, compared with the costs and effect on utilization review expected with consolidated billing.

SEC. 222. 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 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(c) of BBRA 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. 223. 1-YEAR EXTENSION OF MORATORIUM ON THERAPY CAPS.

(a) IN GENERAL.—Section 1833(g)(4) (42 U.S.C. 1395l(g)), as added by section 221(a) of BBRA, is amended by striking ''and 2001'' and inserting '', 2001, and 2002''.

(b) CONFORMING AMENDMENT TO CONTINUE FOCUSED MEDICAL REVIEWS OF CLAIMS DURING MORATORIUM PERIOD.—Section 221(a)(2) of BBRA is amended by striking ''(under the amendment made by paragraph (1)(B))''.

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

Section 4206 of the Balanced Budget Act of 1997 (42 U.S.C. 1395l note) is amended to read as follows:

''(a) TELEHEALTH SERVICES REIMBURSED.—

''(1) IN GENERAL.—Not later than April 1, 2001, the Secretary of Health and Human Services shall make payments from the Federal Supplementary Medical Insurance Trust Fund in accordance with the methodology described in subsection (b) for services for which payment may be made under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) that are furnished via a telecommunications system by a physician or practitioner to an eligible telehealth beneficiary.

''(2) 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.

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

''(1) IN GENERAL.—The Secretary shall make payment under this section as follows:

''(A) Subject to subparagraph (B), with respect to a physician or practitioner located at a distant site that furnishes a service to an eligible medicare beneficiary under subsection (a), an amount equal to the amount that such physician or practitioner would have been paid had the service been furnished without the use of a telecommunications system.

''(B) With respect to an originating site, a facility fee equal to—

''(i) for 2001 (beginning with April 1, 2001) and 2002, $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.

"(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) APPLICATION OF NONPARTICIPATING PHYSICIAN PAYMENT DIFFERENTIAL AND BALANCE BILLING LIMITS.—The payment differential of section 1848(a)(3) of such Act (42 U.S.C. 1395w–4(a)(3)) shall apply to services furnished by non-participating physicians. The provisions of section 1848(g) of such Act (42 U.S.C. 1395w–4(g)) and section 1842(b)(18) of such Act (42 U.S.C. 1395u(b)(18)) shall apply. Payment for such service shall be increased annually by the update factor for physicians' services determined under section 1848(d) of such Act (42 U.S.C. 1395w–4(d)).

"(c) TELEPRESENTER NOT REQUIRED.—Nothing in this section shall be construed as requiring an eligible tele-

health beneficiary to be presented by a physician or practitioner at the originating site for the furnishing of a service via a telecommunications system, unless it is medically necessary as determined by the physician or practitioner at the distant site.

''(d) COVERAGE OF ADDITIONAL SERVICES.—

''(1) STUDY AND REPORT ON ADDITIONAL SERVICES.—

''(A) STUDY.—The Secretary of Health and Human Services shall conduct a study to identify services in addition to those described in subsection (a)(1) that are appropriate for payment under this section.

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

''(2) IN GENERAL.—The Secretary shall provide for payment under this section for services identified in paragraph (1).

''(e) CONSTRUCTION RELATING TO HOME HEALTH SERVICES.—

''(1) 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 furnishing a home health unit of service for which payment is made under the prospective payment system established in such section for such units of service from furnishing the service.

''(2) LIMITATION.—The Secretary shall not consider a home health service provided in the manner described in paragraph (1) to be a home health visit for purposes of—

''(A) determining the amount of payment to be made under such prospective payment system; or

''(B) 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)).

''(f) COVERAGE OF ITEMS AND SERVICES.—

''(1) IN GENERAL.—Subject to paragraph (2), 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,

90804–90809, and 90862, and any additional item or service specified by the Secretary.

''(2) YEARLY UPDATE.—The Secretary shall provide a process that provides, on at least an annual basis, for the review and revision of services (and HCPCS codes) to those specified in paragraph (1) for authorized payment under subsection (a).

''(g) DEFINITIONS.—In this section:

''(1) ELIGIBLE TELEHEALTH BENEFICIARY.—The term 'eligible telehealth beneficiary' means an individual enrolled under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) that receives a service originating—

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

''(C) effective January 1, 2002, in 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))); or

''(D) in a service which originated in a facility which participates in a Federal telemedicine demonstration project.

''(2) PHYSICIAN.—The term 'physician' has the meaning given that term in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r))

''(3) PRACTITIONER.—The term 'practitioner' means a practitioner described in section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)).

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

''(5) ORIGINATING SITE.—

''(A) IN GENERAL.—The term 'originating site' means any site described in subparagraph (B) at which the eligible telehealth beneficiary is located at the time the service is furnished via a telecommunications system.

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

''(i) On or after April 1, 2001—

''(I) the office of a physician or a practitioner,

"(II) a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act (42 U.S.C. 1395x(mm)(1))),

"(III) a rural health clinic (as defined in section 1861(aa)(2) of such Act (42 U.S.C. 1395x(aa)(2))), and

"(IV) a Federally qualified health center (as defined in section 1861(aa)(4) of such Act (42 U.S.C. 1395x(aa)(4))).

"(ii) On or after January 1, 2002—

"(I) a hospital (as defined in section 1861(e) of such Act (42 U.S.C. 1395x(e))),

"(II) a skilled nursing facility (as defined in section 1861(j) of such Act (42 U.S.C. 1395x(j))),

"(III) a comprehensive outpatient rehabilitation facility (as defined in section 1861(cc)(2) of such Act (42 U.S.C. 1395x(cc)(2))),

"(IV) a renal dialysis facility (described in section 1881(b)(1) of such Act (42 U.S.C. 1395rr(b)(1))),

"(V) an ambulatory surgical center (described in section 1833(i)(1)(A) of such Act (42 U.S.C. 1395l(i)(1)(A))),

"(VI) a hospital or skilled nursing facility of the Indian Health Service (under section 1880 of such Act (42 U.S.C. 1395qq)), and

"(VII) a community mental health center (as defined in section 1861(ff)(3)(B) of such Act (42 U.S.C. 1395x(ff)(3)(B))).

"(6) FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—The term 'Federal Supplementary Medical Insurance Trust Fund' means the trust fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t).".

SEC. 225. PAYMENT FOR AMBULANCE SERVICES.

(a) ELIMINATING BBA REDUCTION.—Section 1834(l)(3) (42 U.S.C. 1395m(l)(3)) is amended, in subparagraphs (A) and (B), by striking " reduced in the case of 2001 and 2002 by 1.0 percentage points" both places it appears.

(b) MILEAGE PAYMENTS.—Section 1834(l)(2)(E) (42 U.S.C. 1395m(l)(2)(E)) is amended by inserting be-

fore the period at the end the following: ‘‘, except that such phase-in shall provide for full payment of any national mileage rate beginning with the effective date of the fee schedule for ambulance services provided by suppliers in any State where payment for such services did not include a separate amount for all mileage prior to the implementation of the fee schedule’’.

(c) GAO STUDY ON COSTS OF AMBULANCE SERVICES.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study of the costs of providing ambulance services covered under the medicare program under title XVIII of the Social Security Act across the range of service levels for which such services are provided.

(2) REPORT.—Not later than 18 months after the date of the 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). Such report shall include recommendations for any changes in methodology or payment levels necessary to fairly compensate suppliers of ambulance services and to ensure the access of medicare beneficiaries to such services under the medicare program.

SEC. 226. 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) CONFORMING AMENDMENT.—Section 1861(t)(1) (42 U.S.C. 1395x(t)(1)) is amended by inserting ''(including contrast agents)'' after ''only such drugs''.

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

SEC. 227. 10-YEAR PHASED IN INCREASE FROM 55 PERCENT TO 80 PERCENT IN THE PROPORTION OF HOSPITAL BAD DEBT RECOGNIZED.

Section 1861(v)(1)(T) (42 U.S.C. 1395x(v)(1)(T)) is amended—

(1) by striking ''and'' at the end of clause (ii);

(2) in clause (iii) by striking ''a subsequent fiscal year'' and inserting ''fiscal year 2000'' and by striking the period at the end and inserting a semicolon; and

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

''(iv) for cost reporting periods beginning during fiscal year 2001 and each subsequent fiscal year (before fiscal year 2011), by the percent specified in clause (iii) or this clause for the preceding fiscal year reduced by 2.5 percentage points, of such amount otherwise allowable; and

''(v) for cost reporting periods beginning during fiscal year 2011 or a subsequent fiscal year, by 20 percent of such amount otherwise allowable.''.

SEC. 228. STATE ACCREDITATION OF DIABETES SELF-MANAGEMENT TRAINING PROGRAMS.

Section 1861(qq)(2) (42 U.S.C. 1395x(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:

''(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. 229. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.

(a) IN GENERAL.—The last sentence of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by striking ''2001, by 1.2 percent'' and inserting ''2001, by 2.4 percent''.

(b) REPORT ON LITERATURE REVIEW.—The Secretary of Health and Human Services shall conduct a literature review of studies on the impact of oral self-administered prescription non-calcium phosphate binding drugs in reducing the incidence of hospitalization under the medicare program for medicare beneficiaries with end stage renal disease. Not later than 6 months after the date of the enactment of this Act, the Secretary shall transmit to the Committees on Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate a summary of the literature review conducted under this subsection.

TITLE III—MEDICARE PART A AND B PROVISIONS

SEC. 301. HOME HEALTH SERVICES.

(a) 1-YEAR DELAY IN 15 PERCENT REDUCTION IN PAYMENT RATES UNDER THE MEDICARE PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES.—Section 1895(b)(3)(A)(i) (42 U.S.C. 1395fff(b)(3)(A)(i)) is amended—

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

(2) in subparagraph (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) 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 shall include forms of technology in determining what constitutes ''supervision'' for purposes of determining a home heath agency's branch office status under paragraph (1).

(c) CLARIFICATION OF THE DEFINITION OF HOMEBOUND.—

(1) IN GENERAL.—The last sentence of sections 1814(a) and 1835(a) (42 U.S.C. 1395f(a); 1395n(a)) are each amended by striking the period and inserting ''including participating in an adult day care program licensed by a State to furnish adult day care services in the State for the purposes of therapeutic treatment for Alzheimer's disease or a related dementia, or for medical treatment furnished in an adult day care program.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) apply to items and services provided on or after October 1, 2001.

(d) 1-YEAR DELAY IN REPORT.—Section 302(c) of the the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–360), as enacted into law by section 1000(a)(6) of Public Law 106–113, is amended by striking ''six months'' and inserting ''18 months''.

SEC. 302. ADVISORY OPINIONS.

(a) MAKING PERMANENT EXISTING ADVISORY OPINION AUTHORITY.—Section 1128D(b)(6) (42 U.S.C. 1320a–7d(b)(6)) is amended by striking ''and before the date which is 4 years after such date of enactment''.

(b) NONDISCLOSURE OF REQUESTS AND SUPPORTING MATERIALS.—

(1) IN GENERAL.—Section 1128D(b) (42 U.S.C. 1320a–7d(b)) is amended by adding at the end the following new paragraph:

''(7) NONDISCLOSURE OF REQUESTS AND SUPPORTING MATERIALS.—A request for an advisory opinion under this subsection and any supporting written materials submitted by the party requesting the opinion shall not be subject to disclosure under section 552 of title 5, United States Code.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) applies to requests made before, on, or after the date of the enactment of this Act.

SEC. 303. HOSPITAL GEOGRAPHIC RECLASSIFICATION FOR LABOR COSTS FOR OTHER PPS SYSTEMS.

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

(1) IN GENERAL.—Notwithstanding the geographic adjustment factor otherwise established under title XVIII of the Social Security Act for items and services paid under a prospective payment system described in paragraph (2), in the case of a hospital with an application that has been approved by the Medicare Geographic Classification Review Board under section 1886(d)(10)(C) of such Act (42 U.S.C. 1395ww(d)(10)(C)) to change the hospital's geographic classification for a fiscal year for purposes of the factor used to adjust the prospective payment rate for area differences in hospital wage levels that applies to such hospital under section 1886(d)(3)(E) of such Act, the Secretary shall substitute such change in the hospital's geographic adjustment that would otherwise be applied to an entity or department of the hospital that is provider based to account for variations in costs which are at-

tributable to wages and wage-related costs for items and services paid under the prospective payment systems described in paragraph (2).

(2) PROSPECTIVE PAYMENT SYSTEMS COVERED.—For purposes of this section, items and services furnished under the following prospective payment systems are covered:

(A) SNF PROSPECTIVE PAYMENT SYSTEM.—The prospective payment system for covered skilled nursing facility services under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)).

(B) HOME HEALTH SERVICES PROSPECTIVE PAYMENT SYSTEM.—The prospective payment system for home health services under section 1895(b) of such Act (42 U.S.C. 1395fff(b)).

(C) INPATIENT REHABILITATION HOSPITAL SERVICES.—The prospective payment system for inpatient rehabilitation services under section 1888(j) of such Act (42 U.S.C. 1395ww(j)).

(D) INPATIENT LONG-TERM CARE HOSPITAL SERVICES.—The prospective payment system for inpatient hospital services of long-

term care hospitals under section 123 of the BBRA.

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

(b) EFFECTIVE DATE.—Subsection (a) applies to fiscal years beginning with fiscal year 2002.

SEC. 304. RECLASSIFICATION OF A METROPOLITAN STATISTICAL AREA FOR PURPOSES OF REIMBURSEMENT UNDER THE MEDICARE PROGRAM.

Notwithstanding any other provision of law, effective for discharges occurring and services furnished during fiscal year 2001 and subsequent fiscal years, for purposes of making payments under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to hospitals in the Mansfield, Ohio Metropolitan Statistical Area, such Metropolitan Statistical Area is deemed to be located in the Cleveland-Loraine-Elyria, Ohio Metropolitan Statistical Area. The reclassification made under the previous sentence shall be treated as a decision of the Medicare Geographic Classification Review Board under section 1886(d)(10) of such Act (42 U.S.C. 1395ww(d)(10)).

SEC. 305. MAKING THE MEDICARE DEPENDENT, SMALL RURAL HOSPITAL PROGRAM PERMANENT.

(a) PAYMENT METHODOLOGY.—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(1) in clause (i), by striking ''and before October 1, 2006,''; and

(2) in clause (ii)(II), by striking ''and before October 1, 2006,''.

(b) CONFORMING AMENDMENTS.—

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

(A) in the matter preceding clause (i), by striking ''and before October 1, 2006,''; and

(B) in clause (iv), by striking ''through fiscal year 2005,'' and inserting ''or any subsequent fiscal year,''.

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note) is amended by striking ''or fiscal year 2000 through fiscal year 2005'' and inserting ''fiscal year 2000, or any subsequent fiscal year,''.

SEC. 306. OPTION TO BASE ELIGIBILITY ON DISCHARGES DURING ANY OF THE 3 MOST RECENT AUDITED COST REPORTING PERIODS.

(a) OPTION TO BASE ELIGIBILITY ON DISCHARGES DURING ANY OF THE 3 MOST RECENT AUDITED COST REPORTING PERIODS.—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 amendments made by this section shall apply with respect to cost reporting periods beginning on or after the date of enactment of this Act.

SEC. 307. IDENTIFICATION AND REDUCTION OF MEDICAL ERRORS BY PEER REVIEW ORGANIZATIONS.

(a) IN GENERAL.—Section 1154(a) (42 U.S.C. 1320c–3(a)) is amended by inserting after paragraph (11) the following new paragraph:

"(12) The organization shall assist providers, practitioners, and Medicare+Choice organizations in identifying and developing strategies to reduce the incidence of actual and potential medical errors and problems related to patient safety affecting individuals entitled to benefits under title XVIII. For the purposes of this part and title XVIII, the functions

described in this paragraph shall be treated as a review function.''.

(b) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2001.

SEC. 308. GAO REPORT ON IMPACT OF THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA) ON HOSPITAL EMERGENCY DEPARTMENTS.

(a) CONGRESSIONAL FINDINGS.—The Congress makes the following findings:

(1) The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that hospitals and the emergency physicians as well as doctors on call at hospital emergency departments screen and stabilize patients who go to emergency departments for treatment.

(2) Physicians who refuse to treat emergency department patients or fail to respond to hospital emergency department requests when on call face significant fines and are exposed to liability under EMTALA.

(3) The Balanced Budget Act of 1997 made many changes in hospital and physician reimbursement that appear to have had unintended consequences that have hampered the ability of hos-

pitals, emergency physicians, and physicians covering emergency department call to comply with the requirements of EMTALA.

(4) Estimates indicate that EMTALA costs emergency department physicians $426,000,000 per year and leads to at least $10,000,000,000 more in uncompensated inpatient services.

(5) Emergency departments, emergency physicians, and physicians covering emergency department call have become the de facto providers of indigent health care in America.

(6) 27 percent of the over 4,300,000 people living in Arizona are uninsured.

(7) Many physicians covering emergency department call in Phoenix, Arizona, are resigning from the medical staff at hospitals due to burdensome on-call requirements and uncompensated care.

(8) Significant concern exists as to whether downtown Phoenix hospitals can keep their emergency departments open.

(9) The cumulative effect of potential hospital closings and staff resignations threatens the quality of health care in Phoenix, Arizona.

(b) REPORT.—The Comptroller General of the United States shall submit a report to the Subcommittee

on Health and Environment of the Committee on Commerce of the House of Representatives by May 1, 2001, on the effect of the Emergency Medical Treatment and Active Labor Act on hospitals, emergency physicians, and physicians covering emergency department call, focusing on those in Arizona (including Phoenix) and California (including Los Angeles).

(c) REPORT REQUIREMENTS.—The report should evaluate—

(1) the extent to which hospitals, emergency physicians, and physicians covering emergency department call provide uncompensated services in relation to the requirements of EMTALA;

(2) the extent to which the requirements of EMTALA are having a deleterious effect on the legislation's original intent;

(3) any possible estimates for the total dollar amount EMTALA-related care costs emergency physicians, physicians covering emergency department call, and hospital emergency departments;

(4) the extent to which different portions of the country may be experiencing similar uncompensated EMTALA-related care;

(5) the extent to which EMTALA would be classified as an unfunded mandate;

(6) the extent to which States have programs to provide financial support for uncompensated care;

(7) the extent to which funds under medicare hospital bad debt accounts are available to underwrite the cost of uncompensated EMTALA-related care; and

(8) the financial strain that illegal immigration populations place on hospital emergency departments.

(d) DEFINITION.—In this section, the terms ''Emergency Medical Treatment and Active Labor Act'' and ''EMTALA'' mean section 1867 of the Social Security Act (42 U.S.C. 1395dd).

TITLE IV—MEDICARE+CHOICE PROGRAM STABILIZATION AND IMPROVEMENTS

Subtitle A—Payment Reforms

SEC. 401. INCREASING 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 a Metropolitan Statistical Area with a population of more than 250,000, $525 (and for any other area, $475).''.

SEC. 402. 3 PERCENT MINIMUM PERCENTAGE UPDATE FOR 2001.

Section 1853(c)(1)(C)(ii) (42 U.S.C. 1395w–23(c)(1)(C)(ii)) is amended by inserting ''(or 103 percent in the case of 2001)'' after ''102 percent''.

SEC. 403. 10-YEAR PHASE IN OF RISK ADJUSTMENT BASED ON DATA FROM ALL SETTINGS.

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

(1) by striking the period at the end of subclause (II) and inserting a semicolon; and

(2) by adding after and below subclause (II) the following:

''and, beginning in 2004, insofar as such risk adjustment is based on data from substantially all settings, the methodology shall be phased in equal increments over a 10-year period, beginning with 2004 or (if later) the first year in which such data are used.''.

SEC. 404. TRANSITION TO REVISED MEDICARE+CHOICE PAYMENT RATES.

(a) ANNOUNCEMENT OF REVISED MEDICARE+CHOICE PAYMENT RATES.—Within 2 weeks after the date of the enactment of this Act, the Secretary of Health and Human Services shall determine, and shall announce (in a manner intended to provide notice to interested parties) Medicare+Choice capitation rates under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for 2001, revised in accordance with the provisions of this Act.

(b) REENTRY INTO PROGRAM PERMITTED FOR MEDICARE+CHOICE PROGRAMS IN 2000.—A Medicare+Choice organization that provided notice to the Secretary of Health and Human Services as of July 3, 2000, that it was terminating its contract under part C of title XVIII of the Social Security Act or was reducing the service area of a Medicare+Choice plan offered under such part shall be permitted to continue participation under such part, or to maintain the service area of such plan, for 2001 if it provides the Secretary with the information described in section 1854(a)(1) of the Social Security Act (42 U.S.C. 1395w–24(a)(1)) within four weeks after the date of the enactment of this Act.

(c) REVISED SUBMISSION OF PROPOSED PREMIUMS AND RELATED INFORMATION.—If—

(1) a Medicare+Choice organization provided notice to the Secretary of Health and Human Services as of July 3, 2000, that it was renewing its contract under part C of title XVIII of the Social Security Act for all or part of the service area or areas served under its current contract, and

(2) any part of the service area or areas addressed in such notice includes a county for which the Medicare+Choice capitation rate under section 1853(c) of such Act (42 U.S.C. 1395w–23(c)) for 2001, as determined under subsection (a), is higher than the rate previously determined for such year,

such organization shall revise its submission of the information described in section 1854(a)(1) of the Social Security Act (42 U.S.C. 1395w–24(a)(1)), and shall submit such revised information to the Secretary, within four weeks after the date of the enactment of this Act.

Subtitle B—Administrative Reforms

SEC. 411. EFFECTIVENESS OF ELECTIONS AND CHANGES OF ELECTIONS.

(a) IN GENERAL.—Section 1851(f)(2) (42 U.S.C. 1395w–21(f)(2)) is amended by striking ''made,'' and all that follows and inserting ''made.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies with respect to years beginning on or after January 1, 2001.

SEC. 412. MEDICARE+CHOICE PROGRAM COMPATIBILITY WITH EMPLOYER OR UNION GROUP HEALTH PLANS.

(a) IN GENERAL.—Section 1857 (42 U.S.C. 1395w–27) is amended by adding at the end the following new subsection:

''(i) M+C PROGRAM COMPATIBILITY WITH EMPLOYER OR UNION GROUP HEALTH PLANS.—To facilitate the offering of Medicare+Choice plans under contracts between Medicare+Choice organizations and employers, labor organizations, or the trustees of a fund established by 1 or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such Medicare+Choice plans.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies with respect to years beginning with 2001.

SEC. 413. UNIFORM PREMIUM AND BENEFITS.

(a) IN GENERAL.—Subsections (c) and (f)(1)(D) of section 1854 (42 U.S.C. 1395w–24) are each amended by inserting before the period at the end the following: ", except across counties as approved by the Secretary".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply with respect to years beginning on or after January 1, 2001.

TITLE V—MEDICAID

SEC. 501. DSH PAYMENTS.

(a) CONTINUATION OF MEDICAID DSH ALLOTMENTS AT FISCAL YEAR 2000 LEVELS FOR FISCAL YEARS 2001 AND 2002.—Section 1923(f) (42 U.S.C. 1396r–4(f)), as amended by section 601 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (as enacted into law by section 1000(a)(6) of Public Law 106–113), is amended—

(1) in paragraph (2)—

(A) in the matter preceding the table, by striking "2002" and inserting "2000";

(B) in the table in such paragraph, by striking the columns labeled "FY 01" and "FY 02" relating to fiscal years 2001 and 2002; and

(2) in paragraph (3)—

(A) by striking "2003" in the heading and inserting "2001"; and

(B) by striking ''2003'' and inserting ''2001''.

(b) HIGHER RATE OF INCREASE IN MEDICAID DSH ALLOTMENT FOR EXTREMELY LOW DSH STATES.—Section 1923(f)(3) (42 U.S.C. 1396r–4(f)(3)) is amended—

(1) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)''; and

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

''(C) HIGHER UPDATE RATE FOR EXTREMELY LOW DSH STATES.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 1999, as reported to the Administrator of the Health Care Financing Administration as of August 31, 2000, is less than 1 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2001 shall be increased to 1 percent of the State's total amount of expenditures under such plan for such assistance during such fiscal year.''.

(c) DISTRICT OF COLUMBIA.—Effective beginning with fiscal year 2001, the item in the table in section 1923(f) (42 U.S.C. 1396r–4(f)) relating to District of Columbia for FY 2000, is amended by striking ''32'' and inserting ''49''.

(d) CONTINGENT ALLOTMENT FOR TENNESSEE.—Section 1923(f) (42 U.S.C. 1396r–4(f)) is amended—

(1) in paragraph (3)(A), by striking ''or this paragraph'' and inserting '', this paragraph, or paragraph (4)''; and

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

''(4) CONTINGENT ALLOTMENT ADJUSTMENT FOR TENNESSEE.—If the State-wide waiver approved under section 1115 for the State of Tennessee with respect to requirements under this title as in effect on the date of the enactment of this subsection is revoked or terminated, the DSH allotment for Tennessee for fiscal year 2001 is deemed to be equal to $286,442,437.''.

(e) ASSURING IDENTIFICATION OF MEDICAID MANAGED CARE PATIENTS.—

(1) IN GENERAL.—Section 1932 (42 U.S.C. 1396u–2) is amended by adding at the end the following:

''(g) IDENTIFICATION OF PATIENTS FOR PURPOSES OF MAKING DSH PAYMENTS.—Each contract with a managed care entity under section 1903(m) or under section 1905(t)(3) shall require the entity either—

''(1) to report to the State information necessary to determine the hospital services provided under the contract (and the identity of hospitals providing such services) for purposes of applying sections 1886(d)(5)(F) and 1923; or

''(2) to include a sponsorship code in the identification card issued to individuals covered under this title in order that a hospital may identify a patient as being entitled to benefits under this title.''.

(2) CLARIFICATION OF COUNTING MANAGED CARE MEDICAID PATIENTS.—Section 1923(a)(2)(D) (42 U.S.C. 1396r–4(a)(2)(D)) is amended—

(A) in subsection (a)(2)(D), by inserting after ''the proportion of low-income and medicaid patients'' the following: ''(including such patients who receive benefits through a managed care entity)'';

(B) in subsection (b)(2), by inserting after ''a State plan approved under this title in a period'' the following: ''(regardless of whether

they receive benefits on a fee-for-service basis or through a managed care entity)''; and

(C) in subsection (b)(3)(A)(i), by inserting after ''under a State plan under this title'' the following: ''(regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity)''.

(3) EFFECTIVE DATE.—The amendments made by paragraph (1) apply to payments made for periods on or after January 1, 2001.

SEC. 502. 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) for payment for services described in clause (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. The payment rate under this subsection shall not vary based upon the site services provided in the case of the same center or clinic entity.

''(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 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 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.—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 (at least quarterly) 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.

''(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 Balanced Budget Act of 1997 (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 the 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. 503. OPTIONAL COVERAGE OF LEGAL IMMIGRANTS UNDER THE MEDICAID PROGRAM.

(a) IN GENERAL.—Section 1903(v) (42 U.S.C. 1396b(v)) is amended—

(1) in paragraph (1), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (4)''; and

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

''(4)(A) A State may elect (in a plan amendment under this title) to provide medical assistance under this title, notwithstanding sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, for aliens who are lawfully residing in the United States (including battered aliens described in section 431(c) of such Act) and who are otherwise eligible for such assistance, within either or both of the following eligibility categories, but only if they have lawfully resided in the United States for 2 years:

''(i) PREGNANT WOMEN.—Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

''(ii) CHILDREN.—Children (as defined under such plan), including optional targeted low-income children described in section 1905(u)(2)(B).

''(B) In the case of a State that has elected to provide medical assistance to a category of aliens under subpara-

graph (A), no action may be brought under an affidavit of support against any sponsor of such an alien who has lawfully resided in the United State for 2 years on the basis of provision of assistance to such category.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on October 1, 2000, and apply to medical assistance and child health assistance furnished on or after such date.

SEC. 504. ADDITIONAL ENTITIES QUALIFIED TO DETERMINE MEDICAID PRESUMPTIVE ELIGIBILITY FOR LOW-INCOME CHILDREN.

(a) IN GENERAL.—Section 1920A(b)(3)(A)(i) (42 U.S.C. 1396r–1a(b)(3)(A)(i)) is amended—

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

(2) by inserting ''eligibility of a child for medical assistance under the State plan under this title, or eligibility of a child for child health assistance under the program funded under title XXI, (III) is an elementary school or secondary school, as such terms are defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801), an elementary or secondary school operated or supported by the Bureau of Indian Affairs, a State or tribal child support enforcement agency,

a child care resource and referral agency, an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act, or a State or tribal office or entity involved in enrollment in the program under this title, under part A of title IV, under title XXI, or that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437 et seq.) or under the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4101 et seq.), or (IV) any other entity the State so deems, as approved by the Secretary'' before the semicolon.

(b) TECHNICAL AMENDMENTS.—Section 1920A (42 U.S.C. 1396r–1a) is amended—

(1) in subsection (b)(3)(A)(ii)—

(A) by striking ''paragraph (1)(A)'' and inserting ''paragraph (2)'', and

(B) by striking ''42 U.S.C. 9821'' and inserting ''42 U.S.C. 9831''; and

(2) in subsection (c)(2), in the matter preceding subparagraph (A), by striking ''subsection (b)(1)(A)'' and inserting ''subsection (b)(2)''.

(c) APPLICATION TO PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN UNDER MEDICAID.—Section 1920(b) (42 U.S.C. 1396r–1(b)) is amended by adding at the end after and below paragraph (2) the following flush sentence:

''The term 'qualified provider' includes a qualified entity as defined in section 1920A(b)(3).''.

(d) APPLICATION UNDER TITLE XXI.—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).''.

SEC. 505. IMPROVING WELFARE-TO-WORK TRANSITION.

(a) 1 YEAR EXTENSION.—Section 1925(f) (42 U.S.C. 1396r–6(f)) is amended by striking ''2001'' and inserting ''2002''.

(b) SIMPLIFICATION OPTIONS.—

(1) REMOVAL OF ADMINISTRATIVE REPORTING REQUIREMENTS FOR ADDITIONAL 6-MONTH EXTENSION.—Section 1925(b)(2) of such Act (42 U.S.C. 1396r–6(b)(2)) is amended by adding at the end the following new subparagraph:

''(C) STATE OPTION TO WAIVE REPORTING REQUIREMENTS.—A State may elect to waive the reporting requirements under subparagraph (B) and, in the case of such a waiver for purposes of notices required under subparagraph (A), to exclude from such notices any reference to any requirement under subparagraph (B).''.

(2) EXEMPTION FOR STATES COVERING NEEDY FAMILIES UP TO 185 PERCENT OF POVERTY.—Section 1925 (42 U.S.C. 1396r–6) is amended—

(A) in each of subsections (a)(1) and (b)(1), by inserting ''but subject to subsection (g),'' after ''Notwithstanding any other provision of this title,''; and

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

''(g) EXEMPTION FOR STATE COVERING NEEDY FAMILIES UP TO 185 PERCENT OF POVERTY.—

''(1) IN GENERAL.—At State option, the provisions of this section shall not apply to a State that uses the authority under section 1931(b)(2)(C) to make medical assistance available under the State plan under this title, at a minimum, to all individuals described in section 1931(b)(1) in families with gross incomes (determined without regard to work-

related child care expenses of such individuals) at or below 185 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(2) APPLICATION TO OTHER PROVISIONS OF THIS TITLE.—The State plan of a State described in paragraph (1) shall be deemed to meet the requirements of sections 1902(a)(10)(A)(i)(I) and 1902(e)(1).''.

(3) EFFECTIVE DATE.—The amendments made by this subsection take effect on October 1, 2000.

SEC. 506. MEDICAID COUNTY-ORGANIZED HEALTH SYSTEMS.

Section 9517(c)(3)(C) of the Comprehensive Omnibus Budget Reconciliation Act of 1985 is amended by striking ''10 percent'' and inserting ''14 percent''.

SEC. 507. MEDICAID RECOGNITION FOR SERVICES OF PHYSICIAN ASSISTANTS.

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

(1) by redesignating paragraphs (22) through (27) as paragraphs (23) through (28), and

(2) by inserting after paragraph (21) the following new paragraph:

''(22) services furnished by an physician assistant (as defined in section 1861(aa)(5)) which the assistant is legally authorized to perform under State law and with the supervision of a physician;''.

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

(2) Section 1929(e)(2)(A) (42 U.S.C. 1396t(e)(2)(A)) is amended by striking ''1905(a)(23)'' and inserting ''1905(a)(24)''.

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

TITLE VI—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

SEC. 601. SPECIAL RULE FOR AVAILABILITY AND REDISTRIBUTION OF UNUSED FISCAL YEAR 1998 AND 1999 SCHIP ALLOTMENTS.

(a) CHANGE IN RULES FOR RETENTION AND REDISTRIBUTION 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 EXTENDED AVAILABILITY AND REDISTRIBUTION OF FISCAL YEARS 1998 AND 1999 ALLOTMENTS.—

''(1) AMOUNT REDISTRIBUTED.—In the case of a State that expends all of its allotment under this section for fiscal year 1998 by the end of fiscal year 2000, and for fiscal year 1999 by the end of fiscal year 2001, the Secretary shall redistribute to the State under subsection (f) (from the unexpended portion of fiscal year 1998 or 1999 allotments of other States (as applicable and determined by the application of paragraph (2) with respect to such fiscal year)) the following amount:

''(A) STATE.—In the case of one of the 50 States or the District of Columbia, the amount of the State's expenditures in excess of the State's allotment for fiscal year 1998 or 1999 (as applicable).

''(B) 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 its fiscal year 1998 or 1999 allotment under subsection (c) (as applicable) bears to the total of all such

allotments for such fiscal year under such subsection.

''(2) EXTENSION OF AVAILABILITY OF PORTION OF FISCAL YEARS 1998 AND 1999 ALLOTMENTS.—

''(A) IN GENERAL.—Notwithstanding subsection (e)—

''(i) 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; and

''(ii) of the amounts allotted to a State pursuant to this section for fiscal year 1999 that were not expended by the State by the end of fiscal year 2001,

the amount specified in subparagraph (B) with respect to fiscal year 1998 or 1999 (as applicable) for such State shall remain available for expenditure by the State through the end of fiscal year 2002.

''(B) AMOUNT REMAINING AVAILABLE FOR EXPENDITURE.—With respect to any State described in subparagraph (A), the amount specified in this subparagraph is equal to—

''(i) the amount by which (I) the total amount available for redistribution under

subsection (f) from the allotments for fiscal year 1998 or 1999 (as applicable and determined without regard to this subsection), exceeds (II) the total amounts redistributed under paragraph (1); multiplied by

"(ii) the ratio of such State's unexpended fiscal year 1998 or 1999 allotment (as applicable) to the total amount described in clause (i)(I) for such 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), the State may use up to 10 percent of the amount specified in subparagraph (B) for fiscal year 1998 for expenditures for outreach activities made consistent with section 2102(c)(1).

"(3) DETERMINATION OF AMOUNTS.—For purposes of calculating the amounts described in paragraphs (1) and (2), the Secretary shall use the amounts reported by the States not later than November 30 of the appropriate year 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. 602. OPTIONAL COVERAGE OF CERTAIN LEGAL IMMIGRANTS UNDER SCHIP.

(a) IN GENERAL.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is amended by adding at the end the following new subparagraph:

''(D) Section 1903(v)(4) (relating to optional coverage of categories of permanent resident alien children), but only if the State has elected to apply such section to the category of children under title XIX.''.

(b) EFFECTIVE DATE.—The amendment made by this section takes effect on October 1, 2000, and applies to medical assistance and child health assistance furnished on or after such date.

TITLE VII—EXTENSION OF SPECIAL DIABETES GRANT PROGRAMS

SEC. 701. EXTENSION OF JUVENILE AND INDIAN DIABETES GRANT PROGRAMS.

(a) JUVENILE DIABETES RESEARCH PROGRAM.—Section 330B of the Public Health Service Act (42 U.S.C. 254c–2) is amended by adding at the end the following new subsection:

''(c) EXTENSION OF FUNDING.—There are hereby appropriated, from any amounts in the Treasury not otherwise appropriated, for each of fiscal years 2003 through 2007, $50,000,000 for grants under this section, to remain available until expended. Nothing in this subsection shall be construed as providing for such amounts to be derived or deducted from appropriations made under section 2104(a) of the Social Security Act.''.

(b) INDIAN DIABETES GRANT PROGRAM.——Section 330C of the Public Health Service Act (42 U.S.C. 254c–3) is amended by adding at the end the following new subsection:

''(d) EXTENSION OF FUNDING.—There are hereby appropriated, from any amounts in the Treasury not otherwise appropriated, for each of fiscal years 2003 through 2007, $50,000,000 for grants under this section, to re-

main available until expended. Nothing in this subsection shall be construed as providing for such amounts to be derived or deducted from appropriations made under section 2104(a) of the Social Security Act.''.

(c) EXTENSION OF REPORTS ON GRANT PROGRAMS.—Section 4923(b) of BBA is amended—

(1) in paragraph (1), by striking ''an interim report'' and inserting ''interim reports'';

(2) in paragraph (1), by striking '', 2000'' and inserting ''in each of 2000, 2002, and 2004''; and

(3) in paragraph (2), by striking ''2002'' and inserting ''2007''.

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