for Members of Congress, the Vice President, certain senior executive officers, and Federal judges, and for other purposes; to the Committee on Governmental Affairs.

By Mr. LUGAR (for himself, Mr. SCHUMER, Ms. COLLINS, and Mr. FEINGOLD):

S. 3076. A bill to establish an undergraduate grant program of the Department of State to assist students of limited financial means from the United States to pursue studies abroad; to the Committee on Foreign Relations.

By Mr. MOYNIHAN (for himself, Mr. DASCHLE, Mr. ROCKEFELLER, Mr. BREAUX, Mr. GRAHAM, Mr. KERREY, Mr. ROBB, Mr. KENNEDY, Mr. AKAKA, Mr. BINGAMAN, Mrs. BOXER, Mr. CLELAND, Mr. DODD, Mr. DORGAN, Mr. EDWARDS, Mr. HOLLINGS, Mr. INOUYE, Mr. JOHNSON, Mr. KERRY, Ms. LANDRIEU, Mr. LEAHY, Mr. LEVIN, Mrs. LINCOLN, Ms. MIKULSKI, Mr. MILLER, Mrs. MURRAY, Mr. REED, Mr. SARBANES, Mr. SCHUMER, Mr. TORRICELLI, and Mr. WELLSTONE):

S. 3077. A bill to amend the Social Security Act to make corrections and refinements in the Medicare, Medicaid, and SCHIP health insurance programs, as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes; to the Committee on Finance.

By Mr. DOMENICI:

S. 3078. A bill to amend the Reclamation Wastewater and Groundwater Study and Facilities Act to authorize the Secretary of the Interior to participate in the Santa Fe Regional Water Management and River Restoration Project; to the Committee on Energy and Natural Resources.

By Mr. HATCH:

S. 3079. A bill to amend the Public Health Services Act to provide for suicide prevention activities with respect to children and adolescents; to the Committee on Health, Education, Labor, and Pensions.

By Mr. HATCH:

S. 3080. A bill to amend the Public Health Services Act to provide for the establishment of a coordinated program to improve preschool oral health; to the Committee on Health, Education, Labor, and Pensions.

By Mr. HATCH:

S. 3081. A bill to amend the Public Health Services Act to provide for the conduct of studies and the establishment of innovative programs with respect to traumatic brain surgery; to the Committee on Health, Education, Labor, and Pensions.

By Mr. HATCH:

S. 3082. A bill to amend title XVIII of the Social Security Act to improve the manner in which new medical technologies are made available to Medicare beneficiaries under the Medicare Program, and for other purposes; to the Committee on Finance.

By Mr. LEAHY:

S. 3083. A bill to enhance privacy and the protection of the public in the use of computers and the Internet, and for other purposes; to the Committee on the Judiciary.

By Mr. HATCH:

S. 3084. A bill to amend title XVIII of the Social Security Act to provide for State accreditation of diabetes self-management training programs under the Medicare Program; to the Committee on Finance.

By Mr. JEFFORDS (for himself, Mr. KENNEDY, Mr. CLELAND, and Mrs. MURRAY):

S. 3085. A bill to provide assistance to mobilize and support United States communities in carrying out youth development programs that assure that all youth have access to programs and services that build the competencies and character development needed to fully prepare the youth to become adults and effective citizens; to the Committee on Health, Education, Labor, and Pensions.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

Mr. FEINGOLD:

S. 3075. A bill to repeal the provisions of law that provide automatic pay adjustments for Members of Congress, the Vice President, certain senior executive officers, and Federal judges, and for other purposes; to the Committee on Governmental Affairs.

CONGRESSIONAL PAY ADJUSTMENT LEGISLATION

Mr. FEINGOLD. Mr. President, I rise to introduce a bill that would put an end to automatic cost-of-living adjustments for Congressional pay.

As my Colleagues are aware, it is an unusual thing to have the power to raise our own pay. Few people have that ability. Most of our constituents do not have that power. And that this power is so unusual is good reason for the Congress to exercise that power openly, and to exercise it subject to regular procedures that include debate, amendment, and a vote on the RECORD.

Earlier today, the Senate voted down the conference report on the Legislative Branch appropriations bill. As I noted during the debate on that bill, by considering the Treasury-Postal appropriations bill as part of that conference report, shielded as it was from amendment, the Senate blocked any opportunity to force an open debate of a $3,800 pay raise next year for every Member of the Senate and the House of Representatives. This process of pay raises without accountability must end.

The stealth pay raise technique being employed this year began with a change Congress enacted in the Ethics Reform Act of 1989. In section 704 of that Act, Members of Congress voted to make themselves entitled to an annual raise equal to half a percentage point less than the employment cost index, one measure of inflation. Many times, Congress has voted to deny itself the raise, and Congress traditionally does that on the Treasury-Postal appropriations bill.

And by bringing the Treasury-Postal Appropriations bill to the Senate floor for the first time this week in a conference report, without Senate floor consideration, the majority leadership prevented anyone from offering an amendment on that bill to block the pay raise. The majority leadership tried to make it impossible even to put Senators on record in an up-or-down vote directly for or against the pay raise. The majority nearly perfected the technique of the stealth pay raise.

And the majority also made it impossible to link this Congressional pay raise directly to other pay issues of importance to the American people. The majority made it impossible to consider, among other things, an amendment that would have delayed the Congressional pay raise until working Americans get a much-needed raise in the minimum wage.

The majority leadership thus appears to believe that cost-of-living adjustments make sense for Senators and Congressmen, but that cost-of-living adjustments do not make sense for working people making the minimum wage.

The process that gives Senators and Congressmen an automatic cost-of-living adjustment makes it easier for the majority leadership to block the Senate from rectifying this injustice. If the Senate had to debate and vote on a bill to raise its pay, a Senator could offer an amendment that would point out inequities like this.

The question of how and whether Members of Congress can raise their own pay was one that our Founders considered from the beginning of our Nation. In August of 1789, as part of the package of 12 amendments advocated by James Madison that included what has become our Bill of Rights, the House of Representatives passed an amendment to the Constitution providing that Congress could not raise its pay without an intervening election. Almost exactly 211 years ago, on September 9, 1789, the Senate passed that amendment. In late September of 1789, Congress submitted the amendments to the states.

Although the amendment on pay raises languished for two centuries, in the 1980s, a campaign began to ratify it. While I was a member of the Wisconsin state Senate, I was proud to help ratify the amendment. Its approval by the Michigan legislature on May 7, 1992, gave it the needed approval by three-fourths of the states.

The 27th Amendment to the Constitution now states: ''No law, varying the compensation for the services of the senators and representatives, shall take effect, until an election of representatives shall have intervened.''

I try to honor that limitation in my own practices. In my own case, throughout my 6-year term, I accept only the rate of pay that Senators receive on the date on which I was sworn in as a Senator. And I return to the Treasury any additional income Senators get, whether from a cost-of-living adjustment or a pay raise we vote for ourselves. I don't take a raise until my boss, the people of Wisconsin, give me one at the ballot box. That is the spirit of the 27th Amendment.

Now, this year's procedural device allowing another pay raise to go into effect without a recorded vote does not violate the letter of the Constitution. But stealth pay raises like the one that the Senate allowed this year certainly violate the spirit of that amendment.

Mr. President, this practice must end. To address it, I am introducing this bill to end the automatic cost-of-living adjustment for Congressional pay. Senators and Congressmen should have to vote up-or-down to raise Congressional pay.

The majority has sought to prevent votes on pay raises. My bill would simply require us to vote in the open. We owe our constituents no less.

I urge my Colleagues to support this bill.

Mr. President, I ask unanimous consent to print the bill in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 3075

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

SECTION 1. ELIMINATION OF AUTOMATIC PAY ADJUSTMENTS FOR FEDERAL OFFICIALS.

(a) MEMBERS OF CONGRESS.—

(1) IN GENERAL.—Paragraph (2) of section 601(a) of the Legislative Reorganization Act of 1946 (2 U.S.C. 31) is repealed.

(2) TECHNICAL AND CONFORMING AMENDMENTS.—Section 601(a)(1) of such Act is amended—

(A) by striking ''(a)(1)'' and inserting ''(a)'';

(B) by redesignating subparagraphs (A), (B), and (C) as paragraphs (1), (2), and (3), respectively; and

(C) by striking ''as adjusted by paragraph (2) of this subsection'' and inserting ''adjusted as provided by law''.

(b) VICE PRESIDENT.—Section 104 of title 3, United States Code, is amended—

(1) in subsection (a)—

(A) by striking ''(a)'';

(B) in the first sentence by striking ''as adjusted under this section'' and inserting ''adjusted as provided by law''; and

(C) by striking the second and third sentences; and

(2) by striking subsection (b).

(c) EXECUTIVE SCHEDULE POSITIONS.—

(1) IN GENERAL.—Section 5318 of title 5, United States Code, is repealed.

(2) TECHNICAL AND CONFORMING AMENDMENTS.—

(A) The table of sections for chapter 53 of title 5, United States Code, is amended by striking the item relating to section 5318.

(B) Sections 5312, 5313, 5314, 5315, and 5316 of title 5, United States Code, are each amended by striking ''as adjusted by section 5318 of this title'' and inserting ''adjusted as provided by law''.

(d) JUSTICES AND JUDGES.—

(1) IN GENERAL.—Section 461 of title 28, United States Code, is repealed.

(2) TECHNICAL AND CONFORMING AMENDMENTS.—

(A) The table of sections for chapter 21 of title 28, United States Code, is amended by striking the item relating to section 461.

(B) Sections 5, 44(d), 135, and 252 of title 28, United States Code, are each amended by striking ''as adjusted by section 461 of this title'' and inserting ''adjusted as provided by law''.

(C) Section 371(b)(2) of title 28, United States Code, is amended in the second sentence by striking ''under section 461 of this title'' and inserting ''as provided by law''.

(e) EFFECTIVE DATES.—This section shall take effect on February 1, 2001.

Mr. LUGAR (for himself, Mr. SCHUMER, Ms. COLLINS, and Mr. FEINGOLD):

S. 3076. A bill to establish an undergraduate grant program of the Department of State to assist students of limited financial means from the United States to pursue studies abroad; to the Committee on Foreign Relations.

INTERNATIONAL ACADEMIC OPPORTUNITY ACT OF 2000

Mr. LUGAR. Mr. President, I rise to introduce the International Academic Opportunity Act of 2000. I'm pleased to be joined by Senators SCHUMER, COLLINS, and FEINGOLD in introducing this important piece of legislation.

Our bill attempts to address a gap in U.S. institutions of higher education among undergraduate students who wish to study abroad but who lack the financial means to do so. Specifically, our bill would establish an undergraduate grant program in the Department of State for the purpose of assisting American students with limited financial means to pursue studies abroad. It would provide grants for eligible students of up to $5,000 toward the cost of studying overseas for up to one academic year. These grants would be made available from existing appropriations, so we are not requesting any new funds to administer the program.

The program would be administered by the Department of State and funded through the 150 International Affairs budget. Global education is a foreign policy and national security issue, not only an education matter. During the cold war period and now, international education is part of the glue that helps to hold alliances together, that promotes cooperative bilateral relationships, that enhances international trade and business and narrows the psychological distance between counties and cultures. Our target population are the many students who wish to study abroad but who are unable to do so because of financial limitations. Our bill attempts to remedy this gap in American higher education.

To qualify for these grants, an individual must be a student in good standing at a United States institution of higher education, must have been accepted for up to one academic year of study at an institution of higher education outside the United States or be in a study program abroad approved by the student's home institution, and must be a citizen or national of the United States. Priority would be given to those who have a demonstrated financial need and who meet these other eligibility requirements.

It is my understanding that this proposal has been endorsed by the American Council on Education, the Association of State College and Universities, the Alliance for International Education and Cultural Exchange, NAFSA (Association of International Educators), the Institute of International Education, the American Councils for International Education: ACTR/ACCELS, and other educational associations and organizations involved in promoting and implementing international exchanges and higher education.

Mr. President, there are roughly five foreign students studying in the United States for every one U.S. student studying abroad. Only one percent of our total university population in the United States—about 15 million—studies abroad. This imbalance is troubling and should be rectified. 95 percent of the world's population—and all potential trading partners and customers for U.S. exports—live outside the United States. We need to improve the availability and the means for more students, scholars and practitioners to study abroad—in institutions of higher learning, to engage in language studies, to conduct field research, and to participate in international exchanges.

There is extensive research which indicates that experience in study abroad programs produces significant measurable language improvement, typically raising students from survival level skills to real fluency. Research also shows that alumni of study abroad programs view that experience as critical to their career choices and to the performances of their jobs.

In a globalized economy, our ability to understand, communicate, and conduct international commerce and other forms of cross-national and cross-cultural interactions hinge on our ability to understand and work effectively with other societies. Globalization makes the imperative of knowing and understanding the rest of the world more compelling than ever. The global economic and technology revolutions have helped redefine our nation's economic security. The opening of markets, the expansion of international trade, the extraordinary effects of Internet technology, and the need for American business to compete around the world require a larger global vision that can be advanced through expanded contacts and international education.

In order to make our program successful, other countries need to improve their exchange programs to attract American students by making more classroom space available, more and better housing, and improved language capabilities. For our part, we need to do more to encourage undergraduate students to explore the challenges and opportunities of living abroad in another culture, of being exposed to different values and different mores.

I believe this bill merits special attention. The costs are minimal, it adds no new funding to the already-strained appropriations for international affairs and it addresses the needs of those undergraduate American students who wish to study abroad but cannot ordinarily do so because they lack the financial means.

I hope my colleagues will support this initiative.

I ask that the full text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 3076

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''International Academic Opportunity Act of 2000''.

SEC. 2. STATEMENT OF PURPOSE.

It is the purpose of this Act to establish an undergraduate grant program for students of limited financial means from the United States to enable such students to study abroad. Such foreign study is intended to broaden the outlook and better prepare such students of demonstrated financial need to assume significant roles in the increasingly global economy.

SEC. 3. ESTABLISHMENT OF GRANT PROGRAM FOR FOREIGN STUDY BY AMERICAN COLLEGE STUDENTS OF LIMITED FINANCIAL MEANS.

(a) ESTABLISHMENT.—Subject to the availability of appropriations and under the authorities of the Mutual Educational and Cultural Exchange Act of 1961, the Secretary of State shall establish and carry out a program in each fiscal year to award grants of up to $5,000, to individuals who meet the requirements of subsection (b), toward the cost of up to one academic year of undergraduate study abroad. Grants under this Act shall be known as the ''Benjamin A. Gilman International Scholarships''.

(b) ELIGIBILITY.—An individual referred to in subsection (a) is an individual who—

(1) is a student in good standing at an institution of higher education in the United States (as defined in section 101(a) of the Higher Education Act of 1965);

(2) has been accepted for up to one academic year of study—

(A) at an institution of higher education outside the United States (as defined by section 102(b) of the Higher Education Act of 1965); or

(B) on a program of study abroad approved for credit by the student's home institution;

(3) is receiving any need-based student assistance under title IV of the Higher Education Act of 1965; and

(4) is a citizen or national of the United States.

(c) APPLICATION AND SELECTION.—

(1) Grant application and selection shall be carried out through accredited institutions of higher education in the United States or a combination of such institutions under such procedures as are established by the Secretary of State.

(2) In considering applications for grants under this section—

(A) consideration of financial need shall include the increased costs of study abroad; and

(B) priority consideration shall be given to applicants who are receiving Federal Pell Grants under title IV of the Higher Education Act of 1965.

SEC. 4. REPORT TO CONGRESS.

The Secretary of State shall report annually to the Congress concerning the grant program established under this Act. Each such report shall include the following information for the preceding year:

(1) The number of participants.

(2) The institutions of higher education in the United States that participants attended.

(3) The institutions of higher education outside the United States participants attended during their year of study abroad.

(4) The areas of study of participants.

SEC. 5. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated $1,500,000 for each fiscal year to carry out this Act.

SEC. 6. EFFECTIVE DATE.

This Act shall take effect October 1, 2000.

By Mr. MOYNIHAN (for himself, Mr. DASCHLE, Mr. ROCKEFELLER, Mr. BREAUX, Mr. GRAHAM, Mr. KERREY, Mr. ROBB, Mr. KENNEDY, Mr. AKAKA, Mr. BINGAMAN, Mrs. BOXER, Mr. CLELAND, Mr. DODD, Mr. DORGAN, Mr. EDWARDS, Mr. HOLLINGS, Mr. INOUYE, Mr. JOHNSON, Mr. KERRY, Ms. LANDRIEU, Mr. LEAHY, Mr. LEVIN, Mrs. LINCOLN, Ms. MIKULSKI, Mr. MILLER, Mrs. MURRAY, Mr. REED, Mr. SARBANES, Mr. SCHUMER, Mr. TORRICELLI, and Mr. WELLSTONE):

S. 3077. A bill to amend the Social Security Act to make corrections and refinements in the Medicare, Medicaid, and SCHIP health insurance programs, as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes; to the Committee on Finance.

BALANCED BUDGET REFINEMENT ACT OF 2000

Mr. MOYNIHAN. Mr. President, I am pleased to join with Senator DASCHLE and many of my Democratic colleagues in sponsoring the Balanced Budget Refinement Act of 2000 (BBRA–2000). First, a few words on the genesis of this bill.

As part of the effort to balance the Federal Budget, the Balanced Budget Act of 1997 (BBA) provided for reduction in Medicare payments for medical services. At the time of enactment, the Congressional Budget Office (CBO) estimated that these provisions would reduce Medicare outlays by $112 billion over 5 years. We now know that these BBA cuts have been much larger than originally anticipated.

Hospital industry representatives and other providers of health care services have asserted that the magnitude of the reductions are having unintended consequences which are seriously impacting the quantity and quality of health care services available to our citizens.

Last year, the Congress address some of those unintended consequences, by enacting the Balanced Budget Refinement Act (BBRA), which added back $16 billion over 5 years in payments to various Medicare providers, including: Teaching Hospitals; Hospital Outpatient Departments; Medicare HMOs (Health Maintenance Organizations); Skilled Nursing Facilities; Rural Health Providers; and Home Health Agencies.

However, Members of Congress are continuing to hear from providers who argue that the 1997 reductions are still having serious unanticipated consequences.

To respond to these continuing problems, the President last June proposed additional BBA relief in the amount of $21 billion over the next 5 years. On July 27, Senator DASCHLE and I announced the outlines of a similar, but more substantial, Senate Democratic BBA relief package that would provide about $40 billion over 5 years in relief to health care providers and beneficiaries. Today, along with many of our colleagues, Senator DASCHLE and I are introducing this package as the Balanced Budget Refinement Act of 2000 (BBRA–2000).

Before I submit for the record a summary of this legislation, I want, in particular, to highlight that our legislation would prevent further reductions in payments to our Nation's teaching hospitals. The BBA, unwisely in my view, enacted a multi-year schedule of cuts in payments by Medicare to academic medical centers. These cuts would seriously impair the cutting edge research conducted by teaching hospitals, as well as impair their ability to train doctors and to serve so many of our nation's indigent.

Last year, in the BBRA, we mitigated the scheduled reductions in fiscal years 2000 and 2001. The package we are introducing today, would cancel any further reductions in what we call ''Indirect Medical Education payments,'' thereby restoring nearly $2.7 billion over 5 years ($6.9 billion over 10 years) to our Nation's teaching hospitals.

I have stood before my colleagues on countless occasions to bring attention to the financial plight of medical schools and teaching hospitals. Yet, I regret that the fate of the 144 accredited medical schools and 1416 graduate medical education teaching institutions still remains uncertain. The proposals in our Democratic BBRA–2000 package will provide critically needed financing in the short-run.

In the long-run, however, we need to restructure the financing of graduate medical education along the lines I have proposed in the Graduate Medical Education Trust Fund Act (S. 210). What is needed is explicit and dedicated funding for these institutions, which will ensure that the United States continues to lead the world in this era of medical discovery. The Graduate Medical Education Trust Fund Act would require that the public sector, through the Medicare and Medicaid programs, and the private sector through an assessment on health insurance premiums, provide broad-based financial support for graduate medical education. S. 210 would roughly double current funding levels for Graduate Medical Education and would establish a Medical Education Advisory Commission to make recommendations on the operation of the Medical Education Trust Fund, on alternative payment sources for funding graduate medical education and teaching hospitals, and on policies designed to maintain superior research and educational capacities.

In addition to restoring much needed funding to our Nation's teaching hospitals, BBRA–2000 would add back funding in many vital areas of health care. Key provisions of the bill we are introducing today would: provide full market basket (inflation) adjustments to hospitals for 2001 and 2002; prevent further reductions in Indirect Medical Education (IME) payments to teaching hospitals; target additional relief to rural hospitals; eliminate cuts in payments to hospitals for handling large numbers of low-income patients (referred to as ''disproportionate share

(DSH) hospital payments''); repeal the scheduled 15 percent cut in payments to home health agencies; provide a full market basket (inflation) adjustment to skilled nursing facilities; assist beneficiaries through preventive benefits and smaller coinsurance payments; provide increased payments to Medicare manager care plans (HMOs); and improve eligibility and enrollment processes in Medicaid and the State Children's Health Insurance Program (SCHIP).

Mr. President, I ask unanimous consent that the bill language, a summary of the bill, and several letters of support which I send to the desk, be placed in the RECORD at the conclusion of my statement. I would like to thank Kyle Kinner and Kirsten Beronio of the minority health staff of the Finance Committee for their efforts in assembling this legislation.

S. 3077

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

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

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

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

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

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

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

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

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

TITLE I—PROVISIONS RELATING TO PART A

Subtitle A—Skilled Nursing Facilities

Sec. 101. Eliminating reduction in skilled nursing facility (SNF) market basket update.
Sec. 102. Revision of BBRA increase for skilled nursing facilities in fiscal years 2001 and 2002.
Sec. 103. MedPAC study on payment updates for skilled nursing facilities; authority of Secretary to make adjustments.

Subtitle B—PPS Hospitals

Sec. 111. Revision of reduction of indirect graduate medical education payments.
Sec. 112. Eliminating reduction in PPS hospital payment update.
Sec. 113. Eliminating reduction in disproportionate share hospital (DSH) payments.
Sec. 114. Equalizing the threshold and updating payment formulas for disproportionate share hospitals.
Sec. 115. Care for low-income patients.
Sec. 116. Modification of payment rate for Puerto Rico hospitals.
Sec. 117. MedPAC study on hospital area wage indexes.

Subtitle C—PPS Exempt Hospitals

Sec. 121. Treatment of certain cancer hospitals.
Sec. 122. Payment adjustment for inpatient services in rehabilitation hospitals.

Subtitle D—Hospice Care

Sec. 131. Revision in payments for hospice care.

Subtitle E—Other Provisions

Sec. 141. Hospitals required to comply with bloodborne pathogens standard.
Sec. 142. Informatics and data systems grant program.
Sec. 143. Relief from medicare part A late enrollment penalty for group buy-in for State and local retirees.

Subtitle F—Transitional Provisions

Sec. 151. Reclassification of certain counties and areas for purposes of reimbursement under the medicare program.
Sec. 152. Calculation and application of wage index floor for a certain area.

TITLE II—PROVISIONS RELATING TO PART B

Subtitle A—Hospital Outpatient Services

Sec. 201. Reduction of effective HOPD coinsurance rate to 20 percent by 2014.
Sec. 202. Application of transitional corridor to certain hospitals that did not submit a 1996 cost report.
Sec. 203. Permanent guarantee of pre-BBA payment levels for outpatient services furnished by children's hospitals.

Subtitle B—Provisions Relating to Physicians

Sec. 211. Loan deferment for residents.
Sec. 212. GAO studies and reports on medicare payments.
Sec. 213. MedPAC study on the resource-based practice expense system.

Subtitle C—Ambulance Services

Sec. 221. Election to forego phase-in of fee schedule for ambulance services.
Sec. 222. Prudent layperson standard for emergency ambulance services.
Sec. 223. Elimination of reduction in inflation adjustments for ambulance services.
Sec. 224. Study and report on the costs of rural ambulance services.
Sec. 225. Interim payments for rural ground ambulance services until regulation implemented.
Sec. 226. GAO study and report on the costs of emergency and medical transportation services.

Subtitle D—Preventive Services

Sec. 231. Elimination of deductibles and coinsurance for preventive benefits.
Sec. 232. Counseling for cessation of tobacco use.
Sec. 233. Coverage of glaucoma detection tests.
Sec. 234. Medical nutrition therapy services for beneficiaries with diabetes, a cardiovascular disease, or a renal disease.
Sec. 235. Studies on preventive interventions in primary care for older Americans.
Sec. 236. Institute of Medicine 5-year medicare prevention benefit study and report.
Sec. 237. Fast-track consideration of prevention benefit legislation.

Subtitle E—Other Services

Sec. 241. Revision of moratorium in caps for therapy services.
Sec. 242. Revision of coverage of immunosuppressive drugs.
Sec. 243. State accreditation of diabetes self-management training programs.
Sec. 244. Elimination of reduction in payment amounts for durable medical equipment and oxygen and oxygen equipment.
Sec. 245. Standards regarding payment for certain orthotics and prosthetics.
Sec. 246. National limitation amount equal to 100 percent of national median for new pap smear technologies and other new clinical laboratory test technologies.
Sec. 247. Increased medicare payments for certified nurse-midwife services.
Sec. 248. Payment for administration of drugs.
Sec. 249. MedPAC study on in-home infusion therapy nursing services.

TITLE III—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

Sec. 301. Elimination of 15 percent reduction in payment rates under the prospective payment system for home health services.
Sec. 302. Exclusion of certain nonroutine medical supplies under the PPS for home health services.
Sec. 303. Permitting home health patients with Alzheimer's disease or a related dementia to attend adult day-care.
Sec. 304. Standards for home health branch offices.
Sec. 305. Treatment of home health services provided in certain counties.

Subtitle B—Direct Graduate Medical Education

Sec. 311. Not counting certain geriatric residents against graduate medical education limitations.
Sec. 312. Program of payments to children's hospitals that operate graduate medical education programs.
Sec. 313. Authority to include costs of training of clinical psychologists in payments to hospitals.
Sec. 314. Treatment of certain newly established residency programs in computing medicare payments for the costs of medical education.

Subtitle C—Miscellaneous Provisions

Sec. 321. Waiver of 24-month waiting period for medicare coverage of individuals disabled with amyotrophic lateral sclerosis (ALS).

TITLE IV—RURAL PROVIDER PROVISIONS

Subtitle A—Critical Access Hospitals

Sec. 401. Payments to critical access hospitals for clinical diagnostic laboratory tests.
Sec. 402. Revision of payment for professional services provided by a critical access hospital.
Sec. 403. Permitting critical access hospitals to operate PPS exempt distinct part psychiatric and rehabilitation units.

Subtitle B—Medicare Dependent, Small Rural Hospital Program

Sec. 411. Making the medicare dependent, small rural hospital program permanent.

Sec. 412. Option to base eligibility for medicare dependent, small rural hospital program on discharges during any of the 3 most recent audited cost reporting periods.

Subtitle C—Sole Community Hospitals

Sec. 421. Extension of option to use rebased target amounts to all sole community hospitals.

Sec. 422. Deeming a certain hospital as a sole community hospital.

Subtitle D—Other Rural Hospital Provisions

Sec. 431. Exemption of hospital swing-bed program from the PPS for skilled nursing facilities.

Sec. 432. Permanent guarantee of pre-BBA payment levels for outpatient services furnished by rural hospitals.

Sec. 433. Treatment of certain physician pathology services.

Subtitle E—Other Rural Provisions

Sec. 441. Revision of bonus payments for services furnished in health professional shortage areas.

Sec. 442. Provider-based rural health clinic cap exemption.

Sec. 443. Payment for certain physician assistant services.

Sec. 444. Bonus payments for rural home health agencies in 2001 and 2002.

Sec. 445. Exclusion of clinical social worker services and services performed under a contract with a rural health clinic or federally qualified health center from the PPS for SNFs.

Sec. 446. Coverage of marriage and family therapist services provided in rural health clinics.

Sec. 447. Capital infrastructure revolving loan program.

Sec. 448. Grants for upgrading data systems.

Sec. 449. Relief for financially distressed rural hospitals.

Sec. 450. Refinement of medicare reimbursement for telehealth services.

Sec. 451. MedPAC study on low-volume, isolated rural health care providers.

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

Sec. 501. Restoring effective date of elections and changes of elections of Medicare+Choice plans.

Sec. 502. Special Medigap enrollment anti-discrimination provision for certain beneficiaries.

Sec. 503. Increase in national per capita Medicare+Choice growth percentage in 2001 and 2002.

Sec. 504. Allowing movement to 50:50 percent blend in 2002.

Sec. 505. Delay from July to November 2000, in deadline for offering and withdrawing Medicare+Choice plans for 2001.

Sec. 506. Amounts in medicare trust funds available for Secretary's share of Medicare+Choice education and enrollment-related costs.

Sec. 507. Revised terms and conditions for extension of medicare community nursing organization (CNO) demonstration project.

Sec. 508. Modification of payment rules for certain frail elderly medicare beneficiaries.

TITLE VI—PROVISIONS RELATING TO INDIVIDUALS WITH END-STAGE RENAL DISEASE

Sec. 601. Update in renal dialysis composite rate.

Sec. 602. Revision of payment rates for ESRD patients enrolled in Medicare+Choice plans.

Sec. 603. Permitting ESRD beneficiaries to enroll in another Medicare+Choice plan if the plan in which they are enrolled is terminated.

Sec. 604. Coverage of certain vascular access services for ESRD beneficiaries provided by ambulatory surgical centers.

Sec. 605. Collection and analysis of information on the satisfaction of ESRD beneficiaries with the quality of and access to health care under the medicare program.

TITLE VII—ACCESS TO CARE IMPROVEMENTS THROUGH MEDICAID AND SCHIP

Sec. 701. New prospective payment system for Federally-qualified health centers and rural health clinics.

Sec. 702. Transitional medical assistance.

Sec. 703. Application of simplified SCHIP procedures under the medicaid program.

Sec. 704. Presumptive eligibility.

Sec. 705. Improvements to the maternal and child health services block grant.

Sec. 706. Improving access to medicare cost-sharing assistance for low-income beneficiaries.

Sec. 707. Breast and cervical cancer prevention and treatment.

TITLE VIII—OTHER PROVISIONS

Sec. 801. Appropriations for Ricky Ray Hemophilia Relief Fund.

Sec. 802. Increase in appropriations for special diabetes programs for children with type I diabetes and Indians.

Sec. 803. Demonstration grants to improve outreach, enrollment, and coordination of programs and services to homeless individuals and families.

Sec. 804. Protection of an HMO enrollee to receive continuing care at a facility selected by the enrollee.

Sec. 805. Grants to develop and establish real choice systems change initiatives.

TITLE I—PROVISIONS RELATING TO PART A

Subtitle A—Skilled Nursing Facilities

SEC. 101. ELIMINATING REDUCTION IN SKILLED NURSING FACILITY (SNF) MARKET BASKET UPDATE.

(a) ELIMINATION OF REDUCTION.—Section 1888(e)(4)(E)(ii) (42 U.S.C. 1395yy(e)(4)(E)(ii)) is amended—

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

(2) by striking subclause (II); and

(3) by redesignating subclause (III) as subclause (II).

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

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

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

SEC. 102. REVISION OF BBRA INCREASE FOR SKILLED NURSING FACILITIES IN FISCAL YEARS 2001 AND 2002.

(a) REVISION.—Section 101(d) of BBRA (113 Stat. 1501A–325) is amended—

(1) in paragraph (1)—

(A) by striking ''4.0 percent for each such fiscal year'' and inserting ''the applicable percent (as defined in paragraph (3)) for each such fiscal year (or portion of such year)''; and

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

''(3) APPLICABLE PERCENT DEFINED.—For purposes of this subsection, the term 'applicable percent' means, with respect to services provided during—

''(A) the period beginning on October 1, 2000, and ending on March 31, 2001, 4.0 percent;

''(B) the period beginning on April 1, 2001, and ending on September 30, 2001, 8.0 percent; and

''(C) fiscal year 2002, 6.0 percent.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in the enactment of section 101 of BBRA (113 Stat. 1501A–324).

SEC. 103. MEDPAC STUDY ON PAYMENT UPDATES FOR SKILLED NURSING FACILITIES; AUTHORITY OF SECRETARY TO MAKE ADJUSTMENTS.

(a) STUDY.—The Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) (in this section referred to as ''MedPAC'') shall conduct a study of nursing home costs to determine the adequacy of payment rates (including updates to such rates) under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.) (in this section referred to as the ''medicare program'') for items and services furnished by skilled nursing facilities. In conducting such study, MedPAC shall use data on actual costs and cost increases.

(b) REPORT.—Not later than 12 months after the date of enactment of this Act, MedPAC shall submit a report to the Secretary of Health and Human Services and Congress on the study conducted under subsection (a), including a description of the methodology and calculations used by the Health Care Financing Administration to establish the original payment level under the prospective payment system for skilled nursing facility services under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) and to annually update payments under the medicare program for items and services furnished by skilled nursing facilities, together with recommendations regarding methods to ensure that all input variables, including the labor costs, the intensity of services, and the changes in science and technology that are specific to such facilities, are adequately accounted for.

(c) AUTHORITY OF SECRETARY TO MAKE ADJUSTMENTS.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may make adjustments to payments under the prospective payment system under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) for covered skilled nursing facility services to reflect any necessary adjustments to such payments as is appropriate as a result of the study conducted under subsection (a).

(d) PUBLICATION.—

(1) IN GENERAL.—Not later than April 1, 2002, the Secretary of Health and Human Services shall publish for public comment a description of—

(A) whether the Secretary will make any adjustments pursuant to subsection (c); and

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

(2) FINAL FORM.—Not later than August 1, 2002, the Secretary of Health and Human Services shall publish the description described in paragraph (1) in final form.

Subtitle B—PPS Hospitals

SEC. 111. REVISION OF REDUCTION OF INDIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.

(a) REVISION.—

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

(A) in subclause (IV), by adding ''and'' at the end; and

(B) by striking subclauses (V) and (VI) and inserting the following new subclause:

''(V) on or after October 1, 2000, 'c' is equal to 1.6.''.

(2) TECHNICAL AMENDMENTS.—Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)), as amended by paragraph (1), is amended—

(A) by realigning the left margins of clauses (ii) and (v) so as to align with the left margin of clause (i); and

(B) by realigning the left margins of subclauses (I) through (V) of clause (ii) appropriately.

(b) SPECIAL ADJUSTMENT FOR PURPOSES OF MAINTAINING 6.5 PERCENT IME PAYMENT FOR FISCAL YEAR 2001.—Notwithstanding paragraph (5)(B)(ii)(V) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(ii)(V)), as amended by subsection (a), for purposes of making payments for subsection (d) hospitals (as defined in paragraph (1)(B) of such section) with indirect costs of medical education, the indirect teaching adjustment factor referred to in paragraph (5)(B)(ii) of such section shall be determined—

(1) for discharges occurring on or after October 1, 2000, and before April 1, 2001, pursuant to such paragraph as in effect on the day before the date of enactment of this Act; and

(2) for discharges occurring on or after April 1, 2001, and before October 1, 2001, by substituting ''1.66'' for ''1.6'' in subclause (V) of such paragraph (as so amended).

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

(1) by inserting a comma after ''Balanced Budget Act of 1997''; and

(2) by inserting '', or any payment under such paragraph resulting from the application of section 111(b) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 2000'' after ''Balanced Budget Refinement Act of 1999''.

SEC. 112. ELIMINATING REDUCTION IN PPS HOSPITAL PAYMENT UPDATE.

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

(1) in subclause (XV), by adding ''and'' at the end;

(2) by striking subclauses (XVI) and (XVII);

(3) by redesignating subclause (XVIII) as subclause (XVI); and

(4) in subclause (XVI), as so redesignated, by striking ''fiscal year 2003'' and inserting ''fiscal year 2001''.

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

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

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

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

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

SEC. 113. ELIMINATING REDUCTION IN DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

(a) ELIMINATION OF REDUCTION.—

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

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

(B) by striking subclause (IV);

(C) by redesignating subclause (V) as subclause (IV); and

(D) in subclause (IV), as so redesignated, by striking ''during fiscal year 2003'' and inserting ''during fiscal year 2001''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to discharges occurring on or after October 1, 2000.

(b) SPECIAL RULE FOR DSH PAYMENT FOR FISCAL YEAR 2001.—Notwithstanding the amendments made by subsection (a)(1), for purposes of making disproportionate share payments for subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) for fiscal year 2001, the additional payment amount otherwise determined under clause (ii) of section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F))—

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

(2) for discharges occurring on or after April 1, 2001, and before October 1, 2001, shall be increased by 3 percent.

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

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

(2) by inserting '', or the enactment of section 113(b) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 2000'' after ''Omnibus Budget Reconciliation Act of 1990''.

SEC. 114. EQUALIZING THE THRESHOLD AND UPDATING PAYMENT FORMULAS FOR DISPROPORTIONATE SHARE HOSPITALS.

(a) APPLICATION OF UNIFORM 15 PERCENT THRESHOLD.—Section 1886(d)(5)(F)(v) (42 U.S.C. 1395ww(d)(5)(F)(v)) is amended by striking ''exceeds—'' and all that follows and inserting ''exceeds 15 percent.''.

(b) CHANGE IN PAYMENT PERCENTAGE FORMULAS.—Section 1886(d)(5)(F)(viii) (42 U.S.C. 1395ww(d)(5)(F)(viii)) is amended to read as follows:

''(viii) The formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in subclause (II), (III), or (IV) of clause (iv) is—

''(I) in the case of such a hospital with a disproportionate patient percentage (as defined in clause (vi)) that does not exceed 20.2, (P–15)(.65) + 2.5;

''(II) in the case of such a hospital with a disproportionate patient percentage (as so defined) that exceeds 20.2 but does not exceed 25.2, (P–20.2)(.825) + 5.88;

''(III) except as provided in subclause (IV), in the case of such a hospital with a disproportionate patient percentage (as so defined) that exceeds 25.2, the disproportionate share adjustment percentage = 10; and

''(IV) in the case of such a hospital with a disproportionate patient percentage (as so defined) that exceeds 30.0 and that is described in clause (iv)(III), (P–30)(.6) + 10;

where 'P' is the hospital's disproportionate patient percentage (as so defined).''.

(c) CONFORMING AMENDMENTS.—Section 1886(d)(5)(F)(iv) (42 U.S.C. 1395ww(d)(5)(F)(iv)) is amended—

(1) in subclause (I), by striking ''is described in the second sentence of clause (v)'' and inserting ''is located in a rural area and has 500 or more beds'';

(2) by amending subclause (II) to read as follows:

''(II) is located in an urban area and has less than 100 beds, or is located in a rural area and has less than 500 beds and is not described in subclause (III) or (IV), is equal to the percent determined in accordance with the applicable formula described in clause (viii);'';

(3) by striking subclauses (III) and (IV);

(4) by redesignating subclauses (V) and (VI) as subclauses (III) and (IV), respectively;

(5) in subclause (III) (as so redesignated), by striking ''and is not classified as a sole community hospital under subparagraph (D),''; and

(6) in subclause (IV) (as so redesignated), by striking ''10 percent'' and inserting ''equal to the percent determined in accordance with the applicable formula described in clause (viii)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after April 1, 2001.

SEC. 115. CARE FOR LOW-INCOME PATIENTS.

(a) FREEZE IN MEDICAID DSH ALLOTMENTS.—

(1) IN GENERAL.—Section 1923(f) (42 U.S.C. 1396r–4(f)) is amended—

(A) by redesignating paragraph (4) as paragraph (5); and

(B) by inserting after paragraph (3), the following new paragraph:

''(4) SPECIAL RULE FOR FISCAL YEARS 2001 THROUGH 2008.—With respect to each of fiscal years 2001 through 2008—

''(A) paragraph (2) shall be applied—

''(i) by substituting—

''(I) in the heading, '2001' for '2002';

''(II) in the matter preceding the table, '2001 (and the DSH allotment for a State for fiscal year 2001 is the same as the DSH allotment for the State for fiscal year 2000, as determined under the following table)' for '2002'; and

''(ii) without regard to the columns in the table relating to FY 01 and FY 02 (fiscal years 2001 and 2002); and

''(B) paragraph (3) shall be applied by substituting—

''(i) in the heading, '2002' for '2003';

''(ii) in subparagraph (A), '2002' for '2003'.''.

(2) REPEAL; APPLICABILITY.—Effective October 1, 2008, the amendments made by paragraph (1) are repealed and section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) shall be applied and administered as if such amendments had not been enacted.

(b) INCREASE IN DSH ALLOTMENTS FOR THE DISTRICT OF COLUMBIA.—

(1) IN GENERAL.—Each of the entries in the table in section 1923(f)(2) (42 U.S.C. 1396r–4(f)(2)) relating to the District of Columbia for FY 98 (fiscal year 1998), for FY 99 (fiscal year 1999), for FY 00 (fiscal year 2000), for FY

01 (fiscal year 2001), and for FY 02 (fiscal year 2002) are amended by striking the amount otherwise specified and inserting ''43.4''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect as if included in the enactment of section 4721(a) of BBA (111 Stat. 511).

(c) OPTIONAL ELIGIBILITY OF CERTAIN ALIEN PREGNANT WOMEN AND CHILDREN FOR MEDICAID AND SCHIP.—

(1) MEDICAID.—Section 1903(v) (42 U.S.C. 1396b(v)) is amended—

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

(B) 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 any of the following eligibility categories:

''(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 subparagraph (A), no action may be brought under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such category.''.

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

''(D) Section 1903(v)(4)(A)(ii) (relating to optional coverage of permanent resident alien children), but only if the State has in effect an election under that same eligibility category for purposes of title XIX.''.

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

SEC. 116. MODIFICATION OF PAYMENT RATE FOR PUERTO RICO HOSPITALS.

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

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

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

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

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

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

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

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

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

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

SEC. 117. MEDPAC STUDY ON HOSPITAL AREA WAGE INDEXES.

(a) STUDY.—

(1) IN GENERAL.—The Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) (in this section referred to as ''MedPAC'') shall conduct a study on the hospital area wage indexes used in making payments to hospitals under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), including an assessment of the accuracy of those indexes in reflecting geographic differences in wage and wage-related costs of hospitals.

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

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

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

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

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

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

Subtitle C—PPS Exempt Hospitals

SEC. 121. TREATMENT OF CERTAIN CANCER HOSPITALS.

(a) IN GENERAL.—Section 1886(d)(1)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(v)) is amended—

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

(2) in subclause (II), by striking the semicolon at the end and inserting '', or''; and

(3) by adding at the end the following:

''(III) a hospital that was recognized as a clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of February 18, 1998, that has never been reimbursed for inpatient hospital services pursuant to a reimbursement system under a demonstration project under section 1814(b), that is a freestanding facility organized primarily for treatment of and research on cancer and is not a unit of another hospital, that as of the date of enactment of this subclause, is licensed for 162 acute care beds, and that demonstrates for the 4-year period ending on June 30, 1999, that at least 50 percent of its total discharges have a principal finding of neoplastic disease, as defined in subparagraph (E);''.

(b) CONFORMING AMENDMENT.—Section 1886(d)(1)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(E)) is amended by striking ''For purposes of subparagraph (B)(v)(II)'' and inserting ''For purposes of subclauses (II) and (III) of subparagraph (B)(v)''.

(c) PAYMENT.—

(1) APPLICATION TO COST REPORTING PERIODS.—Any classification by reason of section 1886(d)(1)(B)(v)(III) of the Social Security Act (as added by subsection (a)) shall apply to 12-month cost reporting periods beginning on or after July 1, 1999.

(2) BASE YEAR.—Notwithstanding the provisions of section 1886(b)(3)(E) of such Act (42 U.S.C. 1395ww(b)(3)(E)) or other provisions to the contrary, the base cost reporting period for purposes of determining the target amount for any hospital classified by reason of section 1886(d)(1)(B)(v)(III) of such Act (as added by subsection (a)) shall be the 12-month cost reporting period beginning on July 1, 1995.

(3) DEADLINE FOR PAYMENTS.—Any payments owed to a hospital by reason of this subsection shall be made expeditiously, but in no event later than 1 year after the date of enactment of this Act.

SEC. 122. PAYMENT ADJUSTMENT FOR INPATIENT SERVICES IN REHABILITATION HOSPITALS.

(a) OPTION TO APPLY PROSPECTIVE PAYMENT SYSTEM DURING TRANSITION PERIOD.—Section 1886(j)(1)(A) (42 U.S.C. 1395ww(j)(1)(A)) is amended in the matter preceding subclause (i) by inserting ''the greater of the prospective payment rate determined in paragraph (3)(A) or'' after ''is equal to''.

(b) INCREASE IN PROSPECTIVE PAYMENT PERCENTAGE DURING TRANSITION PERIOD.—Section 1886(j)(1)(A)(ii)(I) (42 U.S.C. 1395ww(j)(1)(A)(ii)(I)) is amended by inserting ''102 percent of'' before ''the per unit''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 4421 of BBA (111 Stat. 410).

Subtitle D—Hospice Care

SEC. 131. REVISION IN PAYMENTS FOR HOSPICE CARE.

(a) INCREASE.—Section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)) is amended—

(1) in clause (i), by adding at the end the following new sentence: ''With respect to routine home care and other services included in hospice care furnished during fiscal year 2001, the payment rates for such care and services for such fiscal year shall be 110 percent of such rates as would otherwise be in effect for such fiscal year (taking into account the increase under clause (ii) but not taking into account the increase under section 131 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999), and such payment rates shall be used in determining payments for such care and services furnished in a subsequent fiscal year under clause (ii).''; and

(2) in clause (ii), by striking ''during a subsequent fiscal year'' and inserting ''during a fiscal year beginning after September 30, 1990''.

(b) ELIMINATING REDUCTION IN UPDATE.—Section 1814(i)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)(ii)) is amended—

(1) in subclause (VI), by striking ''through 2002'' and inserting ''through 2000''; and

(2) in subclause (VII), by striking ''for a subsequent fiscal year'' and inserting ''for fiscal year 2001 and each subsequent fiscal year''.

(c) SPECIAL RULE FOR PAYMENT FOR HOSPICE CARE FOR FISCAL YEAR 2001.—Notwithstanding the amendments made by subsections (a) and (b), for purposes of making payments under section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)) for routine home care and other services included in hospice care furnished during fiscal year 2001, such payment rates shall be determined—

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

(2) for the period beginning on April 1, 2001, and ending on September 30, 2001—

(A) by substituting ''120 percent'' for ''110 percent'' in the second sentence of clause (i) of such section (as added by subsection (a)(1)); and

(B) as if the increase under subclause (ii)(VII) (as amended by subsection (b)) for fiscal year 2001 was equal to the market basket increase for the fiscal year plus 1.0 percentage point.

Subtitle E—Other Provisions

SEC. 141. HOSPITALS REQUIRED TO COMPLY WITH BLOODBORNE PATHOGENS STANDARD.

(a) AGREEMENTS WITH HOSPITALS.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

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

(2) in subparagraph (S), by striking the period at the end and inserting '', and''; and

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

''(T) in the case of hospitals that are not otherwise subject to regulation by the Occupational Safety and Health Administration, to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to agreements in effect on or after the date that is 1 year after the date of enactment of this Act.

SEC. 142. INFORMATICS AND DATA SYSTEMS GRANT PROGRAM.

(a) GRANTS TO HOSPITALS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a program to make grants to hospitals that have submitted applications in accordance with subsection (c) to assist such hospitals in offsetting the costs related to—

(A) developing and implementing standardized clinical health care informatics systems designed to improve medical care and reduce adverse events and health care complications resulting from medication errors; and

(B) establishing data systems to comply with the administrative simplification requirements under part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.).

(2) COSTS.—For purposes of paragraph (1), the term ''costs'' shall include costs associated with—

(A) purchasing computer software and hardware; and

(B) providing education and training to hospital staff on computer information systems.

(3) DURATION.—The authority of the Secretary to make grants under this section shall terminate on September 30, 2011.

(4) LIMITATION.—A hospital that has received a grant under section 1611 of the Public Health Service Act (as added by section 447 of this Act) is not eligible to receive a grant under this section.

(b) SPECIAL CONSIDERATION FOR LARGE URBAN HOSPITALS.—In awarding grants under this section, the Secretary shall give special consideration to hospitals located in large urban areas (as defined for purposes of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)).

(c) APPLICATION.—A hospital seeking a grant under this section shall submit an application to the Secretary at such time and in such form and manner as the Secretary specifies.

(d) REPORTS.—

(1) INFORMATION.—A hospital receiving a grant under this section shall furnish the Secretary with such information as the Secretary may require to—

(A) evaluate the project for which the grant is made; and

(B) ensure that the grant is expended for the purposes for which it is made.

(2) TIMING OF SUBMISSION.—

(A) INTERIM REPORTS.—The Secretary shall report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate at least annually on the grant program established under this section, including in such report information on the number of grants made, the nature of the projects involved, the geographic distribution of grant recipients, and such other matters as the Secretary deems appropriate.

(B) FINAL REPORT.—The Secretary shall submit a final report to such committees not later than 180 days after the completion of all of the projects for which a grant is made under this section.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) $25,000,000 for each of the fiscal years 2001 through 2011 for the purposes of making grants under this section.

SEC. 143. RELIEF FROM MEDICARE PART A LATE ENROLLMENT PENALTY FOR GROUP BUY-IN FOR STATE AND LOCAL RETIREES.

Section 1818(d) (42 U.S.C. 1395i–2(d)) is amended by adding at the end the following new paragraph:

''(6)(A) In the case where a State, a political subdivision of a State, or an agency or instrumentality of a State or political subdivision thereof determines to pay, for the life of each individual, the monthly premiums due under paragraph (1) on behalf of each of the individuals in a qualified State or local government retiree group who meets the conditions of subsection (a), the amount of any increase otherwise applicable under section 1839(b) (as modified by subsection (c)(6) of this section) with respect to the monthly premium for benefits under this part for an individual who is a member of such group shall be reduced by the total amount of taxes paid under section 3101(b) of the Internal Revenue Code of 1986 by such individual and under section 3111(b) by the employers of such individual on behalf of such individual with respect to employment (as defined in section 3121(b) of such Code).

''(B) For purposes of this paragraph, the term 'qualified State or local government retiree group' means all of the individuals who retire prior to a specified date that is before January 1, 2002, from employment in 1 or more occupations or other broad classes of employees of—

''(i) the State;

''(ii) a political subdivision of the State; or

''(iii) an agency or instrumentality of the State or political subdivision of the State.''.

Subtitle F—Transitional Provisions

SEC. 151. RECLASSIFICATION OF CERTAIN COUNTIES AND AREAS FOR PURPOSES OF REIMBURSEMENT UNDER THE MEDICARE PROGRAM.

(a) FISCAL YEARS 2002 THROUGH 2004.—Notwithstanding any other provision of law, effective for discharges occurring during fiscal years 2002, 2003, and 2004, for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d))—

(1) Iredell County, North Carolina is deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina-South Carolina Metropolitan Statistical Area; and

(2) the large urban area of New York, New York is deemed to include Orange County, New York (including hospitals that have been reclassified into such county).

For purposes of that section, any reclassification under this subsection shall be treated as a decision of the Medicare Geographic Classification Review Board under paragraph (10) of that section.

(b) FISCAL YEARS 2001 THROUGH 2003.—Notwithstanding any other provision of law, effective for discharges occurring during fiscal years 2001, 2002, and 2003, for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d))—

(1) the Jackson, Michigan Metropolitan Statistical Area is deemed to be located in the Ann Arbor, Michigan Metropolitan Statistical Area;

(2) Tangipahoa Parish, Louisiana is deemed to be located in the New Orleans, Louisiana Metropolitan Statistical Area; and

(3) the large urban area of New York, New York is deemed to include Duchess County, New York.

For purposes of that section, any reclassification under this subsection shall be treated as a decision of the Medicare Geographic Classification Review Board under paragraph (10) of that section.

(c) TECHNICAL CORRECTION TO BBRA.—

(1) IN GENERAL.—Section 152 of BBRA (113 Stat. 1501A–334) is amended—

(A) in subsection (a)(2), by inserting ''(including hospitals that have been reclassified into such county)'' after ''such county''; and

(B) in subsection (b)(2), by inserting ''(including hospitals that have been reclassified into such county)'' after ''Orange County, New York''; and

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect as if included in the enactment of section 152 of BBRA (113 Stat. 1501A–334).

SEC. 152. CALCULATION AND APPLICATION OF WAGE INDEX FLOOR FOR A CERTAIN AREA.

Notwithstanding any other provision of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), for discharges occurring during fiscal year 2000, the Secretary of Health and Human Services shall calculate and apply the wage index for the Barnstable-Yarmouth Metropolitan Statistical Area under that section as if the Jordan Hospital were classified in such area for purposes of payment under that section for such fiscal year. Such recalculation shall not affect the wage index for any other area.

TITLE II—PROVISIONS RELATING TO PART B

Subtitle A—Hospital Outpatient Services

SEC. 201. REDUCTION OF EFFECTIVE HOPD COINSURANCE RATE TO 20 PERCENT BY 2019.

Section 1833(t)(3)(B)(ii) (42 U.S.C. 1395l(t)(3)(B)(ii)) is amended—

(1) by striking ''If the'' and inserting:

''(I) IN GENERAL.—If the''; and

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

''(II) ACCELERATED PHASE-IN.—The Secretary shall estimate, prior to January 1, 2002, the unadjusted copayment amount for each such service (or groups of such services). If the Secretary estimates such unadjusted copayment amount to be greater than 20 percent for any such service (or group of such services) on or after January 1, 2019, the Secretary shall, for services furnished beginning on or after January 1, 2002, reduce the unadjusted copayment amount for such service (or group of such services) in equal increments each year, from the amount applicable in 2001, by an amount estimated by the Secretary such that the unadjusted copayment amount shall equal 20 percent beginning on or after January 1, 2019.''.

SEC. 202. APPLICATION OF TRANSITIONAL CORRIDOR TO CERTAIN HOSPITALS THAT DID NOT SUBMIT A 1996 COST REPORT.

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

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

SEC. 203. PERMANENT GUARANTEE OF PRE-BBA PAYMENT LEVELS FOR OUTPATIENT SERVICES FURNISHED BY CHILDREN'S HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D) (42 U.S.C. 1395l(t)(7)(D)), as amended by section 432, is amended—

(1) in the heading, by inserting '', CHILDREN'S,'' after ''SMALL RURAL''; and

(2) by striking ''section 1886(d)(1)(B)(v)'' and inserting ''clause (iii) or (v) of section 1886(d)(1)(B)''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services provided on or after the date that is 1 year after the date of enactment of this Act.

Subtitle B—Provisions Relating to Physicians

SEC. 211. LOAN DEFERMENT FOR RESIDENTS.

(a) FAIRNESS IN MEDICAL STUDENT LOAN FINANCING.—

(1) ELIGIBILITY REQUIREMENTS.—Section 427(a)(2)(C)(iii) of the Higher Education Act of 1965 (20 U.S.C. 1077(a)(2)(C)(iii)) is amended by inserting before the semicolon the following: '', except that for a medical student such period shall not exceed the full initial residency period''.

(2) INSURANCE PROGRAM AGREEMENTS.—Section 428(b)(1)(M)(iii) of the Higher Education Act of 1965 (20 U.S.C. 1078(b)(1)(M)(iii)) is amended by inserting before the semicolon the following: '', except that for a medical student such period shall not exceed the full initial residency period''.

(3) DEFERMENT ELIGIBILITY.—Section 455(f)(2)(C) of the Higher Education Act of 1965 (20 U.S.C. 1087e(f)(2)(C)) is amended by inserting before the period the following: '', except that for a medical student such period shall not exceed the full initial residency period''.

(4) CONTENTS OF LOAN AGREEMENT.—Section 464(c)(2)(A)(iii) of the Higher Education Act of 1965 (20 U.S.C. 1087dd(c)(2)(A)(iii)) is amended by inserting before the semicolon the following: '', except that for a medical student such period shall not exceed the full initial residency period''.

(b) FAIRNESS IN ECONOMIC HARDSHIP DETERMINATION.—Section 435(o)(1)(B) of the Higher Education Act of 1965 (20 U.S.C. 1085(o)(1)(B)) is amended to read as follows:

''(B) such borrower is working full time and has a Federal educational debt burden that equals or exceeds 20 percent of such borrower's adjusted gross income, and the difference between such borrower's adjusted gross income minus such burden is less than 250 percent of the greater of—

''(i) the annual earnings of an individual earning the minimum wage under section 6 of the Fair Labor Standards Act of 1938; or

''(ii) 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 Community Service Block Grant Act) applicable to a family of 2; or''.

SEC. 212. GAO STUDIES AND REPORTS ON MEDICARE PAYMENTS.

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

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

(A) coding and billing;

(B) documentation requirements; and

(C) the calculation of overpayments.

(2) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General shall submit a report to the Secretary of Health and Human Services and Congress on the study conducted under paragraph (1) together with specific recommendations for changes or improvements in the post-payment audit process described in such paragraph.

(b) GAO STUDY ON ADMINISTRATION AND OVERSIGHT.—

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

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

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

(B) additional payments or education are needed to assist physicians and other health care providers in understanding and complying with any legal or regulatory requirements.

SEC. 213. MEDPAC STUDY ON THE RESOURCE-BASED PRACTICE EXPENSE SYSTEM.

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

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

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

(2) the appropriateness of payments to physicians.

Subtitle C—Ambulance Services

SEC. 221. ELECTION TO FOREGO PHASE-IN OF FEE SCHEDULE FOR AMBULANCE SERVICES.

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

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

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

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

SEC. 222. PRUDENT LAYPERSON STANDARD FOR EMERGENCY AMBULANCE SERVICES.

(a) IN GENERAL.—Section 1861(s)(7) (42 U.S.C. 1395x(s)(7)) is amended by inserting before the semicolon at the end the following: '', except that such regulations shall not fail to treat ambulance services as medical and other health services solely because the ultimate diagnosis of the individual receiving the ambulance services results in a conclusion that ambulance services were not necessary, as long as the request for ambulance services is made after the sudden onset of a medical condition that would be classified as an emergency medical condition (as defined in section 1852(d)(3)(B)).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to ambulance services provided on or after October 1, 2000.

SEC. 223. ELIMINATION OF REDUCTION IN INFLATION ADJUSTMENTS FOR AMBULANCE SERVICES.

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

SEC. 224. STUDY AND REPORT ON THE COSTS OF RURAL AMBULANCE SERVICES.

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

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

SEC. 225. INTERIM PAYMENTS FOR RURAL GROUND AMBULANCE SERVICES UNTIL REGULATION IMPLEMENTED.

(a) INTERIM PAYMENTS.—Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 221, is amended by adding at the end the following new paragraph:

''(9) INTERIM PAYMENTS FOR RURAL GROUND AMBULANCE SERVICES.—Until such time as the fee schedule established under this subsection is modified by the regulation described in section 224(b) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 2000, the amount of payment under this subsection for ground ambulance services provided in a rural area (as defined in section 1886(d)(2)(D)) shall be the greater of—

''(A) the amount determined under the fee schedule established under this subsection (without regard to any phase-in established pursuant to paragraph (2)(E)); or

''(B) the amount that would have been paid for such services if the amendments made by

section 4531(b) of the Balanced Budget Act of 1997 had not been enacted;

as adjusted for inflation in the manner described in paragraph (3)(B). For purposes of this paragraph, an ambulance trip shall be considered to have been provided in a rural area only if the transportation of the patient originated in a rural area.''.

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

(1) in subparagraph (R)—

(A) by inserting ''except as provided in subparagraph (T),'' before ''with respect''; and

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

(2) in subparagraph (S), by striking the semicolon at the end and inserting '', and (T) with respect to ambulance services described in section 1834(l)(9), the amount paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined under such section;''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services provided on and after January 1, 2001.

SEC. 226. GAO STUDY AND REPORT ON THE COSTS OF EMERGENCY AND MEDICAL TRANSPORTATION SERVICES.

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

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General shall submit a report to the Secretary of Health and Human Services and Congress on the study conducted under subsection (a), together with recommendations for any changes in methodology or payment level necessary to fairly compensate suppliers of emergency and medical transportation services and to ensure the access of beneficiaries under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such services.

Subtitle D—Preventive Services

SEC. 231. ELIMINATION OF DEDUCTIBLES AND COINSURANCE FOR PREVENTIVE BENEFITS.

(a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l) is amended by inserting after subsection (o) the following new subsection:

''(p) DEDUCTIBLES AND COINSURANCE WAIVED FOR PREVENTIVE BENEFITS.—The Secretary may not require the payment of any deductible or coinsurance under subsection (a) or (b) of any individual enrolled for coverage under this part for any of the following preventive health care items and services:

''(1) Blood-testing strips, lancets, and blood glucose monitors for individuals with diabetes described in section 1861(n).

''(2) Diabetes outpatient self-management training services (as defined in section 1861(qq)(1)).

''(3) Pneumococcal, influenza, and hepatitis B vaccines and administration described in section 1861(s)(10).

''(4) Screening mammography (as defined in section 1861(jj)).

''(5) Screening pap smear and screening pelvic exam (as defined in paragraphs (1) and (2) of section 1861(nn), respectively).

''(6) Bone mass measurement (as defined in section 1861(rr)(1)).

''(7) Prostate cancer screening test (as defined in section 1861(oo)(1)).

''(8) Colorectal cancer screening test (as defined in section 1861(pp)(1)).''.

(b) WAIVER OF COINSURANCE.—Section 1833(a)(1)(B) (42 U.S.C. 1395l(a)(1)(B)) is amended to read as follows: ''(B) with respect to preventive health care items and services described in subsection (p), the amounts paid shall be 100 percent of the fee schedule or other basis of payment under this title,''.

(c) WAIVER OF DEDUCTIBLE.—Section 1833(b)(1) (42 U.S.C. 1395l(b)(1)) is amended to read as follows: ''(1) such deductible shall not apply with respect to preventive health care items and services described in subsection (p),''.

(d) ADDING ''LANCET'' TO DEFINITION OF DME.—Section 1861(n) (42 U.S.C. 1395x(n)) is amended by striking ''blood-testing strips and blood glucose monitors'' and inserting ''blood-testing strips, lancets, and blood glucose monitors''.

(e) CONFORMING AMENDMENTS.—

(1) ELIMINATION OF COINSURANCE FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.—Paragraphs (1)(D)(i) and (2)(D)(i) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended—

(A) by striking ''basis or which'' and inserting ''basis, which''; and

(B) by inserting '', or which are described in subsection (p)'' after ''critical access hospital''.

(2) ELIMINATION OF COINSURANCE FOR CERTAIN DME.—Section 1834(a)(1)(A) (42 U.S.C. 1395m(a)(1)(A)) is amended by inserting ''(or 100 percent, in the case of such an item described in section 1833(p))'' after ''80 percent''.

(3) ELIMINATION OF COINSURANCE FOR SCREENING MAMMOGRAPHY.—Section 1834(c)(1)(C) (42 U.S.C. 1395m(c)(1)(C)) is amended by striking ''80 percent'' and inserting ''100 percent''.

(4) ELIMINATION OF DEDUCTIBLES AND COINSURANCE FOR COLORECTAL CANCER SCREENING TESTS.—Section 1834(d) (42 U.S.C. 1395m(d)) is amended—

(A) in paragraph (2)(C)—

(i) by striking clause (ii);

(ii) by striking ''FACILITY PAYMENT LIMIT.—'' and all that follows through ''Notwithstanding'' and inserting ''FACILITY PAYMENT LIMIT.—Notwithstanding''; and

(iii) by redesignating subclauses (I) and (II) as clauses (i) and (ii), respectively; and

(B) in paragraph (3)(C)—

(i) by striking clause (ii); and

(ii) by striking ''FACILITY PAYMENT LIMIT.—'' and all that follows through ''Notwithstanding'' and inserting ''FACILITY PAYMENT LIMIT.—Notwithstanding''.

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

SEC. 232. COUNSELING FOR CESSATION OF TOBACCO USE.

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

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

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

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

''(U) counseling for cessation of tobacco use (as defined in subsection (uu)) for individuals who have a history of tobacco use;''.

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

''Counseling for Cessation of Tobacco Use

''(uu)(1) Except as provided in paragraph (2), the term 'counseling for cessation of tobacco use' means diagnostic, therapy, and counseling services for cessation of tobacco use which are furnished—

''(A) by or under the supervision of a physician; or

''(B) by any other health care professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.

''(2) The term 'counseling for cessation of tobacco use' does not include coverage for drugs or biologicals that are not otherwise covered under this title.''.

(c) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)), as amended by section 225(b), is amended—

(A) by striking ''and'' before ''(T)''; and

(B) by inserting before the semicolon at the end the following: '', and (U) with respect to counseling for cessation of tobacco use (as defined in section 1861(uu)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended—

(A) by striking ''and'' before ''(6)''; and

(B) by inserting before the period the following: '', and (7) such deductible shall not apply with respect to counseling for cessation of tobacco use (as defined in section 1861(uu))''.

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

SEC. 233. COVERAGE OF GLAUCOMA DETECTION TESTS.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by section 232, is amended—

(1) in subsection (s)(2)—

(A) in subparagraph (T), by striking ''and'' at the end;

(B) in subparagraph (U), by inserting ''and'' at the end; and

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

''(V) glaucoma detection tests (as defined in subsection (vv));''; and

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

''Glaucoma Detection Tests

''(vv) The term 'glaucoma detection test' means all of the following conducted for the purpose of early detection of glaucoma:

''(1) A dilated eye examination with an intraocular pressure measurement.

''(2) Direct ophthalmoscopy or slit-lamp biomicroscopic examination.''.

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

''(m) LIMITATION ON COVERAGE OF GLAUCOMA DETECTION TESTS.—

''(1) IN GENERAL.—Notwithstanding any other provision of this part, with respect to expenses incurred for glaucoma detection tests (as defined in section 1861(vv)), payment may be made only for glaucoma detection tests conducted—

''(A) for individuals described in paragraph (2); and

''(B) consistent with the frequency permitted under paragraph (3).

''(2) INDIVIDUALS ELIGIBLE FOR BENEFIT.—Individuals described in this paragraph are as follows:

''(A) Individuals who are 60 years of age or older and who have a family history of glaucoma.

''(B) Other individuals who are at high risk (as determined by the Secretary) of developing glaucoma.

''(3) FREQUENCY LIMIT.—

''(A) IN GENERAL.—Subject to subparagraph (B), payment may not be made under this part for a glaucoma detection test performed for an individual within 23 months following the month in which a glaucoma detection test was performed under this part for the individual.

''(B) EXCEPTION.—The Secretary may permit a glaucoma detection test to be covered on a more frequent basis than that provided under subparagraph (A) under such circumstances as the Secretary determines to be appropriate.''.

(c) NO APPLICATION OF DEDUCTIBLE.—Section 1833(b)(5) (42 U.S.C. 1395l(b)(5)) is amended by inserting ''or with respect to glaucoma detection tests (as defined in section 1861(vv))'' after ''1861(jj))''.

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

(1) in paragraph (1)—

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

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

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

''(J) in the case of glaucoma detection tests (as defined in section 1861(vv)), which are furnished to an individual not described in paragraph (2) of section 1834(m) or which are performed more frequently than is covered under paragraph (3) of such section;''; and

(2) in paragraph (7), by striking ''or (H)'' and inserting ''(H), or (I)''.

(e) EFFECTIVE DATE.—The amendments made by this section apply to tests provided on or after July 1, 2001.

SEC. 234. MEDICAL NUTRITION THERAPY SERVICES FOR BENEFICIARIES WITH DIABETES, A CARDIOVASCULAR DISEASE, OR A RENAL DISEASE.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by section 233(a), is amended—

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

(2) in subparagraph (V) by inserting ''and'' at the end; and

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

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

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x), as amended by section 233(a), is amended by adding at the end the following new subsection:

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

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

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

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

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

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

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

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

(c) PAYMENT.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)), as amended by section 232(c)(1), is amended—

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

(2) by inserting before the semicolon at the end the following: '', and (V) with respect to medical nutrition therapy services (as defined in section 1861(ww)), the amount paid shall be 85 percent of the lesser of the actual charge for the services or the amount determined under the fee schedule established under section 1848(b) for the same services if furnished by a physician''.

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

SEC. 235. STUDIES ON PREVENTIVE INTERVENTIONS IN PRIMARY CARE FOR OLDER AMERICANS.

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

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

(c) REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Secretary of Health and Human Services shall submit a report to Congress on the conclusions of the studies conducted under subsection (a), together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

SEC. 236. INSTITUTE OF MEDICINE 5-YEAR MEDICARE PREVENTION BENEFIT STUDY AND REPORT.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall contract with the Institute of Medicine of the National Academy of Sciences to conduct a comprehensive study of current literature and best practices in the field of health promotion and disease prevention among medicare beneficiaries including the issues described in paragraph (2) and to submit the report described in subsection (b).

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

(A) whether each covered benefit is—

(i) medically effective; and

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

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

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

(b) REPORT.—

(1) IN GENERAL.—Not later than 5 years after the date of enactment of this section, and every fifth year thereafter, the Institute of Medicine of the National Academy of Sciences shall submit to the President a report that contains a detailed statement of the findings and conclusions of the study conducted under subsection (a) and the recommendations for legislation described in paragraph (2).

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

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

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

(c) TRANSMISSION TO CONGRESS.—

(1) IN GENERAL.—On the day on which the report described in subsection (b) is submitted to the President, the President shall transmit the report and recommendations in legislative form described in subsection (b)(2) to Congress.

(2) DELIVERY.—Copies of the report and recommendations in legislative form required to be transmitted to Congress under paragraph (1) shall be delivered—

(A) to both Houses of Congress on the same day;

(B) to the Clerk of the House of Representatives if the House is not in session; and

(C) to the Secretary of the Senate if the Senate is not in session.

(d) DEFINITIONS.—In this section:

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

(A) been subject to peer review;

(B) been described in scientific journals; and

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

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

(A) been subject to peer review;

(B) been described in scientific journals; and

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

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

(A) subject to peer review;

(B) described in scientific journals; and

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

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

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

SEC. 237. FAST-TRACK CONSIDERATION OF PREVENTION BENEFIT LEGISLATION.

(a) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This section is enacted by Congress—

(1) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and is deemed a part of the rules of each House of Congress, but—

(A) is applicable only with respect to the procedure to be followed in that House of Congress in the case of an implementing bill (as defined in subsection (d)); and

(B) supersedes other rules only to the extent that such rules are inconsistent with this section; and

(2) with full recognition of the constitutional right of either House of Congress to change the rules (so far as relating to the procedure of that House of Congress) at any time, in the same manner and to the same

extent as in the case of any other rule of that House of Congress.

(b) INTRODUCTION AND REFERRAL.—

(1) INTRODUCTION.—

(A) IN GENERAL.—Subject to paragraph (2), on the day on which the President transmits the report pursuant to section 236(c) to the House of Representatives and the Senate, the recommendations in legislative form transmitted by the President with respect to such report shall be introduced as a bill (by request) in the following manner:

(i) HOUSE OF REPRESENTATIVES.—In the House of Representatives, by the Majority Leader, for himself and the Minority Leader, or by Members of the House of Representatives designated by the Majority Leader and Minority Leader.

(ii) SENATE.—In the Senate, by the Majority Leader, for himself and the Minority Leader, or by Members of the Senate designated by the Majority Leader and Minority Leader.

(B) SPECIAL RULE.—If either House of Congress is not in session on the day on which such recommendations in legislative form are transmitted, the recommendations in legislative form shall be introduced as a bill in that House of Congress, as provided in subparagraph (A), on the first day thereafter on which that House of Congress is in session.

(2) REFERRAL.—Such bills shall be referred by the presiding officers of the respective Houses to the appropriate committee, or, in the case of a bill containing provisions within the jurisdiction of 2 or more committees, jointly to such committees for consideration of those provisions within their respective jurisdictions.

(c) CONSIDERATION.—After the recommendations in legislative form have been introduced as a bill and referred under subsection (b), such implementing bill shall be considered in the same manner as an implementing bill is considered under subsections (d), (e), (f), and (g) of section 151 of the Trade Act of 1974 (19 U.S.C. 2191).

(d) IMPLEMENTING BILL DEFINED.—In this section, the term ''implementing bill'' means only the recommendations in legislative form of the Institute of Medicine of the National Academy of Sciences described in section 236(b)(2), transmitted by the President to the House of Representatives and the Senate under section 236(c), and introduced and referred as provided in subsection (b) as a bill of either House of Congress.

(e) COUNTING OF DAYS.—For purposes of this section, any period of days referred to in section 151 of the Trade Act of 1974 shall be computed by excluding—

(1) the days on which either House of Congress is not in session because of an adjournment of more than 3 days to a day certain or an adjournment of Congress sine die; and

(2) any Saturday and Sunday, not excluded under paragraph (1), when either House is not in session.

Subtitle E—Other Services

SEC. 241. REVISION OF MORATORIUM IN CAPS FOR THERAPY SERVICES.

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

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

SEC. 242. REVISION OF COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.

(a) REVISION.—

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

''(J) prescription drugs used in immunosuppressive therapy furnished—

''(i) on or after the date of enactment of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 2000 and before January 1, 2004, to an individual who has received an organ transplant; and

''(ii) on or after January 1, 2004, to an individual who receives an organ transplant for which payment is made under this title, but only in the case of drugs furnished within 36 months after the date of the transplant procedure.''.

(2) CONFORMING AMENDMENTS.—

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

(i) by striking subsection (b); and

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

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

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

(b) EXTENSION OF CERTAIN SECONDARY PAYER REQUIREMENTS.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended by adding at the end the following: ''With regard to immunosuppressive drugs furnished on or after the date of enactment of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 2000 and before January 1, 2004, this subparagraph shall be applied without regard to any time limitation.''.

SEC. 243. STATE ACCREDITATION OF DIABETES SELF-MANAGEMENT TRAINING PROGRAMS.

Section 1861(qq)(2) of the Social Security Act (42 U.S.C. 1395xx(qq)(2)) is amended—

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

(2) in subparagraph (A)—

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

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

(3) in subparagraph (B)—

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

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

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

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

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

''(ii) Notwithstanding any reference to 'a national accreditation body' in section 1865(b), for purposes of clause (i), a program described in this clause is a program operated by a State for the purposes of accrediting diabetes self-management training programs, if the Secretary determines that such State program has established quality standards that meet or exceed the standards established by the Secretary under clause (i) or the standards originally established by the National Diabetes Advisory Board and subsequently revised as described in clause (i).''.

SEC. 244. ELIMINATION OF REDUCTION IN PAYMENT AMOUNTS FOR DURABLE MEDICAL EQUIPMENT AND OXYGEN AND OXYGEN EQUIPMENT.

(a) UPDATE FOR COVERED ITEMS.—Section 1834(a)(14)(C) (42 U.S.C. 1395m(a)(14)(C)) is amended by striking ''through 2002'' and inserting ''through 2000''.

(b) ORTHOTICS AND PROSTHETICS.—Section 1834(h)(4)(A)(v) (42 U.S.C. 1395m(h)(4)(A)(v)) is amended by striking ''through 2002'' and inserting ''through 2000''.

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

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

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

(2) in clause (vi)—

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

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

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

''(vii) for 2001 and each subsequent year, the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year.''.

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

SEC. 245. STANDARDS REGARDING PAYMENT FOR CERTAIN ORTHOTICS AND PROSTHETICS.

(a) STANDARDS.—

(1) IN GENERAL.—Section 1834(h)(1) (42 U.S.C. 1395m(h)(1)) is amended by adding at the end the following:

''(F) ESTABLISHMENT OF STANDARDS FOR CERTAIN ITEMS.—

''(i) IN GENERAL.—No payment shall be made for an applicable item unless such item is provided by a qualified practitioner or a qualified supplier under the system established by the Secretary under clause (iii). For purposes of the preceding sentence, if a qualified practitioner or a qualified supplier contracts with an entity to provide an applicable item, then no payment shall be made for such item unless the entity is also a qualified supplier.

''(ii) DEFINITIONS.—In this subparagraph—

''(I) APPLICABLE ITEM.—The term 'applicable item' means orthotics and prosthetics that require education, training, and experience to custom fabricate such item. Such term does not include shoes and shoe inserts.

''(II) QUALIFIED PRACTITIONER.—The term 'qualified practitioner' means a physician or health professional who meets any of the following requirements:

''(aa) The physician or health professional is specifically trained and educated to provide or manage the provision of custom-designed, fabricated, modified, and fitted orthotics and prosthetics, and is either certified by the American Board for Certification in Orthotics and Prosthetics, Inc., certified by the Board for Orthotist/Prosthetist Certification, or credentialed and approved by a program that the Secretary determines, in consultation with appropriate experts in orthotics and prosthetics, has training and education standards that are necessary to provide applicable items.

''(bb) The physician or health professional is licensed in orthotics or prosthetics by the State in which the applicable item is supplied, but only if the Secretary determines that the mechanisms used by the State to provide such licensure meet standards determined appropriate by the Secretary.

''(cc) The physician or health professional has completed at least 10 years practice in the provision of applicable items. A physician or health professional may not qualify as a qualified practitioner under the preceding sentence with respect to an applicable item if the item was provided on or after January 1, 2005.

''(III) QUALIFIED SUPPLIER.—The term 'qualified supplier' means any entity that is—

''(aa) accredited by the American Board for Certification in Orthotics and Prosthetics, Inc. or the Board for Orthotist/Prosthetist Certification; or

''(bb) accredited and approved by a program that the Secretary determines has accreditation and approval standards that are essentially equivalent to those of such Board.

''(iii) SYSTEM.—The Secretary, in consultation with appropriate experts in orthotics and prosthetics, shall establish a system under which the Secretary shall—

''(I) determine which items are applicable items and formulate a list of such items;

''(II) review the applicable items billed under the coding system established under this title; and

''(III) limit payment for applicable items pursuant to clause (i).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items provided on or after January 1, 2003.

(b) REVISION OF DEFINITION OF ORTHOTICS.—

(1) IN GENERAL.—Section 1861(s)(9) (42 U.S.C. 1395x(s)(9)) is amended by inserting ''(including such braces that are used in conjunction with, or as components of, other medical or non-medical equipment when provided by a qualified practitioner (as defined in subclause (II) of section 1834(h)(1)(F))) or a qualified supplier (as defined in subclause (III) of such section)'' after ''braces''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items provided on or after January 1, 2003.

SEC. 246. NATIONAL LIMITATION AMOUNT EQUAL TO 100 PERCENT OF NATIONAL MEDIAN FOR NEW PAP SMEAR TECHNOLOGIES AND OTHER NEW CLINICAL LABORATORY TEST TECHNOLOGIES.

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

SEC. 247. INCREASED MEDICARE PAYMENTS FOR CERTIFIED NURSE-MIDWIFE SERVICES.

(a) AMOUNT OF PAYMENT.—Section 1833(a)(1)(K) (42 U.S.C. 1395l(a)(1)(K)) is amended by striking ''65 percent of the prevailing charge that would be allowed for the same service performed by a physician, or, for services furnished on or after January 1, 1992, 65 percent'' and inserting ''85 percent''.

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

SEC. 248. PAYMENT FOR ADMINISTRATION OF DRUGS.

(a) REVIEW OF CHEMOTHERAPY ADMINISTRATION PRACTICE EXPENSES RVUS.—The Secretary of Health and Human Services shall review the resource-based practice expense component of relative value units under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for chemotherapy administration services to determine if such units should be increased.

(b) MORE ACCURATE CHEMOTHERAPY DRUG PAYMENTS TIED TO INCREASES IN CHEMOTHERAPY ADMINISTRATION PAYMENTS.—If the Secretary of Health and Human Services determines, as a result of the review under subsection (a), that the resource-based practice expense relative value units for chemotherapy administration services should be increased, the Secretary—

(1) may implement such increases for such services, but only if the Secretary simultaneously implements more accurate average wholesale prices for chemotherapy drugs (but in no case shall such simultaneous implementation occur prior to January 1, 2002); and

(2) if the Secretary implements such increases for such services, shall do so without taking into account the requirement under the physician fee schedule under section 1848(c)(2)(B)(ii)(II) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)(ii)(II)).

(c) BLOOD CLOTTING DRUG-RELATED ACTIVITIES.—

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

(A) by striking ''and'' after ''supervision,''; and

(B) by inserting the following before the semicolon: '', and the costs (pursuant to section 1834(n)) incurred by suppliers of such factors''.

(2) PAYMENTS.—Section 1834 (42 U.S.C. 1395m), as amended by section 233(b), is amended by adding at the end the following new subsection:

''(n) PAYMENT FOR BLOOD CLOTTING DRUG-RELATED ACTIVITIES.—

''(1) IN GENERAL.—The Secretary shall make payments in accordance with paragraph (2) to suppliers of blood clotting factors (as described in section 1861(s)(2)(I)) to cover the costs (such as shipping, storage, inventory control, or other costs specified by the Secretary) incurred by such suppliers in furnishing such factors to individuals enrolled under this part.

''(2) PAYMENT AMOUNT.—The amount of payment for furnishing such blood clotting factors (as so described) shall be an amount equal to 80 percent of the lesser of—

''(A) the actual charge for the furnishing of such factors; or

''(B) an amount equal to 10 cents (or such other amount determined appropriate by the Secretary) per unit of such factor furnished.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to blood clotting factors (as described in section 1861(s)(2)(I) of the Social Security Act (42 U.S.C. 1395x(s)(2)(I))) furnished on or after the date that the Secretary of Health and Human Services implements more accurate average wholesale prices for such factors.

SEC. 249. MEDPAC STUDY ON IN-HOME INFUSION THERAPY NURSING SERVICES.

(a) STUDY.—The Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) (in this section referred to as ''MedPAC'') shall conduct a study on the provision of in-home infusion therapy nursing services, including a review of any documentation of clinical efficacy for those services and any costs associated with providing those services.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, MedPAC shall submit a report to the Secretary of Health and Human Services and Congress on the study and review conducted under subsection (a) together with recommendations regarding the establishment of a payment methodology for in-home infusion therapy nursing services that ensures the continuing access of beneficiaries under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to those services.

TITLE III—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

SEC. 301. ELIMINATION OF 15 PERCENT REDUCTION IN PAYMENT RATES UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1895(b)(3)(A) (42 U.S.C. 1395fff(b)(3)(A)) is amended to read as follows:

''(A) INITIAL BASIS.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts). Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for the 12-month period beginning on the date the Secretary implements the system shall be equal to the total amount that would have been made if the system had not been in effect and if section 1861(v)(1)(L)(ix) had not been enacted. Each such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and area wage adjustments among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.''.

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

SEC. 302. EXCLUSION OF CERTAIN NONROUTINE MEDICAL SUPPLIES UNDER THE PPS FOR HOME HEALTH SERVICES.

(a) EXCLUSION.—

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

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

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

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

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

''(2) BUDGET NEUTRALITY ADJUSTMENT.—The Secretary shall provide for an appropriate proportional reduction in payments under this section so that beginning with fiscal year 2001, the aggregate amount of such reductions is equal to the aggregate increase in payments attributable to the exclusion effected under paragraph (1).''.

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

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

(b) EXCLUSION FROM CONSOLIDATED BILLING.—

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

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

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

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

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

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

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

(1) STUDY.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall conduct a study to identify any nonroutine medical supply that may be appropriately and cost-effectively excluded from the prospective payment system for home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff). Specifically, the Secretary shall consider whether wound care and ostomy supplies should be excluded from such prospective payment system.

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

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

SEC. 303. PERMITTING HOME HEALTH PATIENTS WITH ALZHEIMER'S DISEASE OR A RELATED DEMENTIA TO ATTEND ADULT DAY-CARE.

(a) IN GENERAL.—Sections 1814(a) and 1835(a) of the Social Security Act (42 U.S.C. 1395f(a); 1395n(a)) are each amended in the last sentence by inserting ''(including regularly participating, for the purpose of therapeutic treatment for Alzheimer's disease or a related dementia, in an adult day-care program that is licensed, certified, or accredited by a State to furnish adult day-care services in the State)'' before the period.

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

SEC. 304. STANDARDS FOR HOME HEALTH BRANCH OFFICES.

(a) IN GENERAL.—Section 1861(o) (42 U.S.C. 1395x(o)) is amended by adding at the end the following new sentences: ''For purposes of this subsection, a home health agency may provide services through a single site or through a branch office. For purposes of the preceding sentence, the term 'branch office' means a service site for home health services that is controlled and supervised by a home health agency.''.

(b) ESTABLISHMENT OF STANDARDS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall establish, using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code, standards for the operation of a branch office (as defined in the last sentence of section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)), as added by subsection (a)).

(2) REQUIREMENTS.—In establishing standards under paragraph (1), the Secretary shall—

(A) provide for the special treatment of any home health agency or branch office—

(i) that is located in a frontier area; or

(ii) with any other special circumstance that the Secretary determines is appropriate; and

(B) allow the use of technology used by the home health agency to supervise the branch office.

(3) CONSULTATION.—The Secretary shall establish the regulations under this subsection in consultation with representatives of the home health industry.

SEC. 305. TREATMENT OF HOME HEALTH SERVICES PROVIDED IN CERTAIN COUNTIES.

(a) IN GENERAL.—Notwithstanding any other provision of law, effective for home health services provided under the prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff) during fiscal year 2001 in an applicable county, the geographic adjustment factors applicable in such year to hospitals physically located in such county under section 1886(d) of such Act (42 U.S.C. 1395ww(d)) (including the factors applicable to such hospitals by reason of any reclassification or deemed reclassification) shall be deemed to apply to such services instead of the area wage adjustment factors that would otherwise be applicable to such services under section 1895(b)(4)(C) of such Act (42 U.S.C. 1395fff(b)(4)(C)).

(b) APPLICABLE COUNTY DEFINED.—For purposes of subsection (a), the term ''applicable county'' means any of the following counties:

(1) Duchess County, New York.
(2) Orange County, New York.
(3) Clinton County, New York.
(4) Ulster County, New York.
(5) Otsego County, New York.
(6) Cayuga County, New York.
(7) St. Jefferson County, New York.

Subtitle B—Direct Graduate Medical Education

SEC. 311. NOT COUNTING CERTAIN GERIATRIC RESIDENTS AGAINST GRADUATE MEDICAL EDUCATION LIMITATIONS.

For cost reporting periods beginning on or after October 1, 2000, and before October 1, 2005, in applying the limitations regarding the total number of full-time equivalent interns and residents in the field of allopathic or osteopathic medicine under subsections (d)(5)(B)(v) and (h)(4)(F) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) for a hospital, the Secretary of Health and Human Services shall not take into account a maximum of 3 interns or residents in the field of geriatric medicine to the extent the hospital increases the number of geriatric interns or residents above the number of such interns or residents for the hospital's most recent cost reporting period ending before October 1, 2000.

SEC. 312. PROGRAM OF PAYMENTS TO CHILDREN'S HOSPITALS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.

Part A of title XI (42 U.S.C. 1301 et seq.) is amended by adding after section 1150 the following new section:

''PROGRAM OF PAYMENTS TO CHILDREN'S HOSPITALS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS

''SEC. 1150A. (a) PAYMENTS.—The Secretary shall make 2 payments under this section to each children's hospital for each of fiscal years 2002 through 2005, 1 for the direct expenses and the other for the indirect expenses associated with operating approved graduate medical residency training programs.

''(b) AMOUNT OF PAYMENTS.—

''(1) IN GENERAL.—Subject to paragraph (2), the amounts payable under this section to a children's hospital for an approved graduate medical residency training program for a fiscal year are each of the following amounts:

''(A) DIRECT EXPENSE AMOUNT.—The amount determined under subsection (c) for direct expenses associated with operating approved graduate medical residency training programs.

''(B) INDIRECT EXPENSE AMOUNT.—The amount determined under subsection (d) for indirect expenses associated with the treatment of more severely ill patients and the additional costs relating to teaching residents in such programs.

''(2) CAPPED AMOUNT.—

''(A) IN GENERAL.—The total of the payments made to children's hospitals under subparagraph (A) or (B) of paragraph (1) in a fiscal year shall not exceed the funds appropriated under paragraph (1) or (2), respectively, of subsection (f) for such payments for that fiscal year.

''(B) PRO RATA REDUCTIONS OF PAYMENTS FOR DIRECT EXPENSES.—If the Secretary determines that the amount of funds appropriated under subsection (f)(1) for a fiscal year is insufficient to provide the total amount of payments otherwise due for such periods under paragraph (1)(A), the Secretary shall reduce the amounts so payable on a pro rata basis to reflect such shortfall.

''(c) AMOUNT OF PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION.—

''(1) IN GENERAL.—The amount determined under this subsection for payments to a children's hospital for direct graduate expenses relating to approved graduate medical residency training programs for a fiscal year is equal to the product of—

''(A) the updated per resident amount for direct graduate medical education, as determined under paragraph (2); and

''(B) the average number of full-time equivalent residents in the hospital's graduate approved medical residency training programs (as determined under section 1886(h)(4)) during the fiscal year.

''(2) UPDATED PER RESIDENT AMOUNT FOR DIRECT GRADUATE MEDICAL EDUCATION.—The updated per resident amount for direct graduate medical education for a hospital for a fiscal year is an amount determined as follows:

''(A) DETERMINATION OF HOSPITAL SINGLE PER RESIDENT AMOUNT.—The Secretary shall compute for each hospital operating an approved graduate medical education program (regardless of whether or not it is a children's hospital) a single per resident amount equal to the average (weighted by number of full-time equivalent residents) of the primary care per resident amount and the nonprimary care per resident amount computed under section 1886(h)(2) for cost reporting periods ending during fiscal year 1997.

''(B) DETERMINATION OF WAGE AND NONWAGE-RELATED PROPORTION OF THE SINGLE PER RESIDENT AMOUNT.—The Secretary shall estimate the average proportion of the single per resident amounts computed under subparagraph (A) that is attributable to wages and wage-related costs.

''(C) STANDARDIZING PER RESIDENT AMOUNTS.—The Secretary shall establish a

standardized per resident amount for each such hospital—

''(i) by dividing the single per resident amount computed under subparagraph (A) into a wage-related portion and a non-wage-related portion by applying the proportion determined under subparagraph (B);

''(ii) by dividing the wage-related portion by the factor applied under section 1886(d)(3)(E) for discharges occurring during fiscal year 1999 for the hospital's area; and

''(iii) by adding the non-wage-related portion to the amount computed under clause (ii).

''(D) DETERMINATION OF NATIONAL AVERAGE.—The Secretary shall compute a national average per resident amount equal to the average of the standardized per resident amounts computed under subparagraph (C) for such hospitals, with the amount for each hospital weighted by the average number of full-time equivalent residents at such hospital.

''(E) APPLICATION TO INDIVIDUAL HOSPITALS.—The Secretary shall compute for each such hospital that is a children's hospital a per resident amount—

''(i) by dividing the national average per resident amount computed under subparagraph (D) into a wage-related portion and a non-wage-related portion by applying the proportion determined under subparagraph (B);

''(ii) by multiplying the wage-related portion by the factor described in subparagraph (C)(ii) for the hospital's area; and

''(iii) by adding the non-wage-related portion to the amount computed under clause (ii).

''(F) UPDATING RATE.—The Secretary shall update such per resident amount for each such children's hospital by the estimated percentage increase in the Consumer Price Index for all urban consumers (U.S. city average) during the period beginning October 1997, and ending with the midpoint of the Federal fiscal year for which payments are made.

''(d) AMOUNT OF PAYMENT FOR INDIRECT MEDICAL EDUCATION.—

''(1) IN GENERAL.—The amount determined under this subsection for payments to a children's hospital for indirect expenses associated with the treatment of more severely ill patients and the additional costs related to the teaching of residents for a fiscal year is equal to an amount determined appropriate by the Secretary.

''(2) FACTORS.—In determining the amount under paragraph (1), the Secretary shall—

''(A) take into account variations in case mix and regional wage levels among children's hospitals and the number of full-time equivalent residents in the hospitals' approved graduate medical residency training programs; and

''(B) assure that the aggregate of the payments for indirect expenses associated with the treatment of more severely ill patients and the additional costs related to the teaching of residents under this section in a fiscal year are equal to the amount appropriated for such expenses for the fiscal year involved under subsection (f)(2).

''(e) MAKING OF PAYMENTS.—

''(1) INTERIM PAYMENTS.—The Secretary shall determine, before the beginning of each fiscal year involved for which payments may be made for a hospital under this section, the amounts of the payments for direct graduate medical education and indirect medical education for such fiscal year and shall (subject to paragraph (2)) make the payments of such amounts in 26 equal interim installments during such period. Such interim payments to each individual hospital shall be based on the number of residents reported in the hospital's most recently filed medicare cost report prior to the application date for the Federal fiscal year for which the interim payment amounts are established.

''(2) WITHHOLDING.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall withhold 25 percent from each interim installment for direct and indirect graduate medical education paid under paragraph (1).

''(B) REDUCTION OF WITHHOLDING.—The Secretary shall reduce the percent withheld from each installment pursuant to subparagraph (A) if the Secretary determines that such reduced percent will provide the Secretary with a reasonable level of assurance that most hospitals will not be overpaid on an interim basis.

''(3) RECONCILIATION.—Prior to the end of each fiscal year, the Secretary shall determine any changes to the number of residents reported by a hospital and shall use that number of residents to determine the final amount payable to the hospital for the current fiscal year for both direct expense and indirect expense amounts. Based on such determination, the Secretary shall recoup any overpayments made or pay any balance due to the extent possible. In the event that a hospital's interim payments were greater than the final amount to which it is entitled, the Secretary shall have the option of recouping that excess amount in determining the amount to be paid in the subsequent year to that hospital. The final amount so determined shall be considered a final intermediary determination for purposes of applying section 1878 and shall be subject to review under that section in the same manner as the amount of payment under section 1886(d) is subject to review under such section.

''(f) AUTHORIZATION OF APPROPRIATIONS.—

''(1) DIRECT GRADUATE MEDICAL EDUCATION.—

''(A) IN GENERAL.—There are appropriated, out of any money in the Treasury not otherwise appropriated, for payments under subsection (b)(1)(A) for each of fiscal years 2002 through 2005, $95,000,000.

''(B) CARRYOVER OF EXCESS.—The amounts appropriated under subparagraph (A) for each fiscal year shall remain available for obligation through the end of the subsequent fiscal year.

''(2) INDIRECT MEDICAL EDUCATION.—There are appropriated, out of any money in the Treasury not otherwise appropriated, for payments under subsection (b)(1)(A) for each of fiscal years 2002 through 2005, $190,000,000.

''(g) DEFINITIONS.—In this section:

''(1) APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAM.—The term 'approved graduate medical residency training program' has the meaning given the term 'approved medical residency training program' in section 1886(h)(5)(A).

''(2) CHILDREN'S HOSPITAL.—The term 'children's hospital' means a hospital with a medicare payment agreement and which is excluded from the medicare inpatient prospective payment system pursuant to section 1886(d)(1)(B)(iii) and its accompanying regulations.

''(3) DIRECT GRADUATE MEDICAL EDUCATION COSTS.—The term 'direct graduate medical education costs' has the meaning given such term in section 1886(h)(5)(C).''.

SEC. 313. AUTHORITY TO INCLUDE COSTS OF TRAINING OF CLINICAL PSYCHOLOGISTS IN PAYMENTS TO HOSPITALS.

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

SEC. 314. TREATMENT OF CERTAIN NEWLY ESTABLISHED RESIDENCY PROGRAMS IN COMPUTING MEDICARE PAYMENTS FOR THE COSTS OF MEDICAL EDUCATION.

(a) IN GENERAL.—Section 1886(h)(4)(H) (42 U.S.C. 1395ww(h)(4)(H)) is amended by adding at the end the following new clause:

''(v) TREATMENT OF CERTAIN NEWLY ESTABLISHED PROGRAMS.—Any hospital that has received payments under this subsection for a cost reporting period ending before January 1, 1995, and that operates an approved medical residency training program established on or after August 5, 1997, shall be treated as meeting the requirements for an adjustment under the rules prescribed pursuant to clause (i) with respect to such program if—

''(I) such program received accreditation from the American Council of Graduate Medical Education not later than August 5, 1998;

''(II) such program was in operation (with 1 or more residents in training) as of January 1, 2000;

''(III) such hospital is located in an area that is contiguous to a rural area and serves individuals from such rural area; and

''(IV) such hospital serves a medical service area with a population that is less than 500,000.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of section 4623 of BBA (111 Stat. 477).

Subtitle C—Miscellaneous Provisions

SEC. 321. 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 shall apply to benefits for months beginning after the date of enactment of this Act.

TITLE IV—RURAL PROVIDER PROVISIONS

Subtitle A—Critical Access Hospitals

SEC. 401. PAYMENTS TO CRITICAL ACCESS HOSPITALS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) PAYMENT ON COST BASIS WITHOUT BENEFICIARY COST-SHARING.—

(1) IN GENERAL.—Section 1833(a)(6) (42 U.S.C. 1395l(a)(6)) is amended by inserting ''(including clinical diagnostic laboratory services furnished by a critical access hospital)'' after ''outpatient critical access hospital services''.

(2) NO BENEFICIARY COST-SHARING.—

(A) IN GENERAL.—Section 1834(g) (42 U.S.C. 1395m(g)) is amended by inserting ''(except that in the case of clinical diagnostic laboratory services furnished by a critical access hospital the amount of payment shall be equal to 100 percent of the reasonable costs of the critical access hospital in providing such services)'' before the period at the end.

(B) BBRA AMENDMENT.—Section 1834(g) (42 U.S.C. 1395m(g)), as amended by section 403(d) of BBRA (113 Stat. 1501A–371), is amended—

(i) in paragraph (1), by inserting ''(except that in the case of clinical diagnostic laboratory services furnished by a critical access hospital the amount of payment shall be equal to 100 percent of the reasonable costs of the critical access hospital in providing such services)'' after ''such services''; and

(ii) in paragraph (2)(A), by inserting ''(except that in the case of clinical diagnostic laboratory services furnished by a critical access hospital the amount of payment shall be equal to 100 percent of the reasonable costs of the critical access hospital in providing such services)'' before the period at the end.

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

(c) TECHNICAL AMENDMENT.—Section 403(d)(2) of BBRA (113 Stat. 1501A–371) is amended by striking ''subsection (a)'' and inserting ''paragraph (1)''.

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to services furnished on or after November 29, 1999.

(2) BBRA AND TECHNICAL AMENDMENTS.—The amendments made by subsections (a)(2)(B) and (c) shall take effect as if included in the enactment of section 403(d) of BBRA (113 Stat. 1501A–371).

SEC. 402. REVISION OF PAYMENT FOR PROFESSIONAL SERVICES PROVIDED BY A CRITICAL ACCESS HOSPITAL.

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

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

SEC. 403. PERMITTING CRITICAL ACCESS HOSPITALS TO OPERATE PPS EXEMPT DISTINCT PART PSYCHIATRIC AND REHABILITATION UNITS.

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

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

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

Subtitle B—Medicare Dependent, Small Rural Hospital Program

SEC. 411. MAKING THE MEDICARE DEPENDENT, SMALL RURAL HOSPITAL PROGRAM PERMANENT.

(a) PAYMENT METHODOLOGY.—Section 1886(d)(5)(G) (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), as amended by section 404(b)(2) of BBRA (113 Stat. 1501A–372), is amended by striking ''or fiscal year 2000 through fiscal year 2005'' and inserting ''fiscal year 2000, or any subsequent fiscal year,''.

SEC. 412. OPTION TO BASE ELIGIBILITY FOR MEDICARE DEPENDENT, SMALL RURAL HOSPITAL PROGRAM ON DISCHARGES DURING ANY OF THE 3 MOST RECENT AUDITED COST REPORTING PERIODS.

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

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

Subtitle C—Sole Community Hospitals

SEC. 421. EXTENSION OF OPTION TO USE REBASED TARGET AMOUNTS TO ALL SOLE COMMUNITY HOSPITALS.

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

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

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

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

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

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

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

SEC. 422. DEEMING A CERTAIN HOSPITAL AS A SOLE COMMUNITY HOSPITAL.

Notwithstanding any other provision of law, for purposes of discharges occurring on or after October 1, 2000, the Greensville Memorial Hospital located in Emporia, Virginia shall be deemed to have satisfied the travel and time criteria under section 1886(d)(5)(D)(iii)(II) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(D)(iii)(II)) for classification as a sole community hospital.

Subtitle D—Other Rural Hospital Provisions

SEC. 431. EXEMPTION OF HOSPITAL SWING-BED PROGRAM FROM THE PPS FOR SKILLED NURSING FACILITIES.

(a) EXEMPTION FOR MEDICARE SWING-BED HOSPITALS.—

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

(A) in the heading, by striking ''TRANSITION'' and inserting ''EXEMPTION'';

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

''(A) IN GENERAL.—The prospective payment system under this subsection shall not apply to items and services provided by a facility described in subparagraph (B).''; and

(C) in subparagraph (B), by striking '', for which payment'' and all that follows before the period.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect as if included in the enactment of section 4432 of BBA (111 Stat. 414).

(b) CHANGE IN EFFECTIVE DATE OF BBRA AMENDMENTS.—

(1) IN GENERAL.—Section 408(c) of BBRA (113 Stat. 1501A–375) is amended by striking ''the date that is'' and all that follows and inserting ''January 1, 2001.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect as if included in the enactment of section 408 of BBRA (113 Stat. 1501A–375).

SEC. 432. PERMANENT GUARANTEE OF PRE-BBA PAYMENT LEVELS FOR OUTPATIENT SERVICES FURNISHED BY RURAL HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D), as amended by section 203, is amended to read as follows:

''(D) HOLD HARMLESS PROVISIONS FOR SMALL RURAL AND CANCER HOSPITALS.—In the case of a hospital located in a rural area and that has not more than 100 beds or a hospital described in section 1886(d)(1)(B)(v), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of section 202 of BBRA (111 Stat. 1501A–342).

SEC. 433. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

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

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

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

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

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

''(B) DEFINITIONS.—In this paragraph:

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

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

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

''(ii) FEE-FOR-SERVICE MEDICARE BENEFICIARY.—The term 'fee-for-service medicare beneficiary' means an individual who is not enrolled—

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

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

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

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

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

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

Subtitle E—Other Rural Provisions

SEC. 441. REVISION OF BONUS PAYMENTS FOR SERVICES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.

(a) EXPANSION OF BONUS PAYMENTS TO INCLUDE PHYSICIAN ASSISTANT AND NURSE PRACTITIONER SERVICES.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended—

(1) by inserting ''(or services furnished by a physician assistant or nurse practitioner that would be physicians' services if furnished by a physician)'' after ''physicians' services'';

(2) by inserting '', physician assistant (in the case of a physician assistant described in subparagraph (C)(ii) of section 1842(b)(6)), or nurse practitioner'' after ''physician''; and

(3) by striking ''clause (A) of section 1842(b)(6)'' and inserting ''subparagraphs (A) and (C)(i) of such section''.

(b) ELIMINATION OF REQUIREMENT TO MAKE BONUS PAYMENTS ON MONTHLY OR QUARTERLY BASIS.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended by striking ''(on a monthly or quarterly basis)''.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by subsection (a) shall apply to services furnished on or after July 1, 2001.

(2) MONTHLY OR QUARTERLY PAYMENTS.—The amendment made by subsection (b) shall apply to services furnished on or after the first day of the first calendar quarter beginning at least 240 days after the date of enactment of this Act.

SEC. 442. PROVIDER-BASED RURAL HEALTH CLINIC CAP EXEMPTION.

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

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

SEC. 443. PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT SERVICES.

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

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

SEC. 444. BONUS PAYMENTS FOR RURAL HOME HEALTH AGENCIES IN 2001 AND 2002.

(a) INCREASE IN PAYMENT RATES FOR RURAL AGENCIES IN 2001 AND 2002.—Section 1895(b) (42 U.S.C. 1395fff(b)) is amended by adding at the end the following new paragraph:

''(7) ADDITIONAL PAYMENT AMOUNT FOR SERVICES FURNISHED IN RURAL AREAS IN 2001 AND 2002.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D)) during 2001 or 2002, the Secretary shall provide for an addition or adjustment to the payment amount otherwise made under this section for services furnished in a rural area in an amount equal to 10 percent of the amount otherwise determined under this subsection.''.

(b) WAIVING BUDGET NEUTRALITY.—Section 1895(b)(3) (42 U.S.C. 1395fff(b)(3)) is amended by adding at the end the following new subparagraph:

''(D) NO ADJUSTMENT FOR ADDITIONAL PAYMENTS FOR RURAL SERVICES.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under this paragraph applicable to home health services furnished during a period to offset the increase in payments resulting from the application of paragraph (7) (relating to services furnished in rural areas).''.

SEC. 445. EXCLUSION OF CLINICAL SOCIAL WORKER SERVICES AND SERVICES PERFORMED UNDER A CONTRACT WITH A RURAL HEALTH CLINIC OR FEDERALLY QUALIFIED HEALTH CENTER FROM THE PPS FOR SNFs.

(a) IN GENERAL.—Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended—

(1) in the first sentence, by inserting ''clinical social worker services,'' after ''qualified psychologist services,''; and

(2) by inserting after the first sentence the following: ''Services described in this clause also include services that are provided by a physician, a physician assistant, a nurse practitioner, a certified nurse midwife, a qualified psychologist, or a clinical social worker who is employed, or otherwise under contract, with a rural health clinic or a Federally qualified health center.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided on or after the date which is 60 days after the date of enactment of this Act.

SEC. 446. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES PROVIDED IN RURAL HEALTH CLINICS.

(a) COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES.—

(1) PROVISION OF SERVICES IN RURAL HEALTH CLINICS.—Section 1861(aa)(1)(B) (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking ''Secretary)'' and inserting ''Secretary), by a marriage and family therapist (as defined in subsection (xx)(2)),''.

(2) MARRIAGE AND FAMILY THERAPIST SERVICES DEFINED.—Section 1861 (42 U.S.C. 1395x), as amended by section 234(b), is amended by adding at the end the following new subsection:

''Marriage and Family Therapist Services

''(xx)(1) The term 'marriage and family therapist services' means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(2) The term 'marriage and family therapist' means an individual who—

''(A) possesses a master's or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law;

''(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

''(C)(i) is licensed or certified as a marriage and family therapist in the State in which marriage and family therapist services are performed; or

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

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished on or after January 1, 2002.

SEC. 447. CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM.

(a) IN GENERAL.—Part A of title XVI of the Public Health Service Act (42 U.S.C. 300q et seq.) is amended by adding at the end the following new section:

''CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM

''SEC. 1603. (a) AUTHORITY TO MAKE AND GUARANTEE LOANS.—

''(1) AUTHORITY TO MAKE LOANS.—The Secretary may make loans from the fund established under section 1602(d) to any rural entity for projects for capital improvements, including—

''(A) the acquisition of land necessary for the capital improvements;

''(B) the renovation or modernization of any building;

''(C) the acquisition or repair of fixed or major movable equipment; and

''(D) such other project expenses as the Secretary determines appropriate.

''(2) AUTHORITY TO GUARANTEE LOANS.—

''(A) IN GENERAL.—The Secretary may guarantee the payment of principal and interest for loans to rural entities for projects for capital improvements described in paragraph (1) to non-Federal lenders.

''(B) INTEREST SUBSIDIES.—In the case of a guarantee of any loan to a rural entity under subparagraph (A)(i), the Secretary may pay to the holder of such loan and for and on behalf of the project for which the loan was made, amounts sufficient to reduce by not more than 3 percentage points of the net effective interest rate otherwise payable on such loan.

''(b) AMOUNT OF LOAN.—The principal amount of a loan directly made or guaranteed under subsection (a) for a project for capital improvement may not exceed $5,000,000.

''(c) FUNDING LIMITATIONS.—

''(1) GOVERNMENT CREDIT SUBSIDY EXPOSURE.—The total of the Government credit subsidy exposure under the Credit Reform Act of 1990 scoring protocol with respect to the loans outstanding at any time with respect to which guarantees have been issued, or which have been directly made, under subsection (a) may not exceed $50,000,000 per year.

''(2) TOTAL AMOUNTS.—Subject to paragraph (1), the total of the principal amount of all loans directly made or guaranteed under subsection (a) may not exceed $250,000,000 per year.

''(d) ADDITIONAL ASSISTANCE.—

''(1) NONREPAYABLE GRANTS.—Subject to paragraph (2), the Secretary may make a

grant to a rural entity, in an amount not to exceed $50,000, for purposes of capital assessment and business planning.

''(2) LIMITATION.—The cumulative total of grants awarded under this subsection may not exceed $2,500,000 per year.

''(e) TERMINATION OF AUTHORITY.—The Secretary may not directly make or guarantee any loan under subsection (a) or make a grant under subsection (d) after September 30, 2005.''.

(b) RURAL ENTITY DEFINED.—Section 1624 of the Public Health Service Act (42 U.S.C. 300s–3) is amended by adding at the end the following new paragraph:

''(15)(A) The term 'rural entity' includes—

''(i) a rural health clinic, as defined in section 1861(aa)(2) of the Social Security Act;

''(ii) any medical facility with at least 1, but less than 50, beds that is located in—

''(I) a county that is not part of a metropolitan statistical area; or

''(II) a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725));

''(iii) a hospital that is classified as a rural, regional, or national referral center under section 1886(d)(5)(C) of the Social Security Act; and

''(iv) a hospital that is a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of the Social Security Act).

''(B) For purposes of subparagraph (A), the fact that a clinic, facility, or hospital has been geographically reclassified under the medicare program under title XVIII of the Social Security Act shall not preclude a hospital from being considered a rural entity under clause (i) or (ii) of subparagraph (A).''.

(c) CONFORMING AMENDMENTS.—Section 1602 of the Public Health Service Act (42 U.S.C. 300q–2) is amended—

(1) in subsection (b)(2)(D), by inserting ''or 1603(a)(2)(B)'' after ''1601(a)(2)(B)''; and

(2) in subsection (d)—

(A) in paragraph (1)(C), by striking ''section 1601(a)(2)(B)'' and inserting ''sections 1601(a)(2)(B) and 1603(a)(2)(B)''; and

(B) in paragraph (2)(A), by inserting ''or 1603(a)(2)(B)'' after ''1601(a)(2)(B)''.

SEC. 448. GRANTS FOR UPGRADING DATA SYSTEMS.

(a) IN GENERAL.—Part B of title XVI of the Public Health Service Act (42 U.S.C. 300r et seq.) is amended by adding at the end the following new section:

''GRANTS FOR UPGRADING DATA SYSTEMS

''SEC. 1611. (a) GRANTS TO HOSPITALS.—

''(1) IN GENERAL.—The Secretary shall establish a program to make grants to hospitals that have submitted applications in accordance with subsection (c) to assist eligible small rural hospitals in offsetting the costs of establishing data systems—

''(A) required to—

''(i) implement prospective payment systems under title XVIII of the Social Security Act; and

''(ii) comply with the administrative simplification requirements under part C of title XI of such Act; or

''(B) to reduce medication errors.

''(2) COSTS.—For purposes of paragraph (1), the term 'costs' shall include costs associated with—

''(A) purchasing computer software and hardware; and

''(B) providing education and training to hospital staff on computer information systems.

''(3) LIMITATION.—A hospital that has received a grant under section 142 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 2000 is not eligible to receive a grant under this section.

''(b) ELIGIBLE SMALL RURAL HOSPITAL DEFINED.—For purposes of this section, the term 'eligible small rural hospital' means a non-Federal, short-term general acute care hospital that—

''(1) is located in a rural area, as defined for purposes of section 1886(d) of the Social Security Act; and

''(2) has less than 50 beds.

''(c) APPLICATION.—A hospital seeking a grant under this section shall submit an application to the Secretary at such time and in such form and manner as the Secretary specifies.

''(d) AMOUNT OF GRANT.—A grant to a hospital under this section may not exceed $100,000.

''(e) REPORTS.—

''(1) INFORMATION.—A hospital receiving a grant under this section shall furnish the Secretary with such information as the Secretary may require to—

''(A) evaluate the project for which the grant is made; and

''(B) ensure that the grant is expended for the purposes for which it is made.

''(2) TIMING OF SUBMISSION.—

''(A) INTERIM REPORTS.—The Secretary shall report to the Committee on Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate at least annually on the grant program established under this section, including in such report information on the number of grants made, the nature of the projects involved, the geographic distribution of grant recipients, and such other matters as the Secretary deems appropriate.

''(B) FINAL REPORT.—The Secretary shall submit a final report to such committees not later than 180 days after the completion of all of the projects for which a grant is made under this section.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for grants under this section.''.

(b) CONFORMING AMENDMENT.—Section 1820(g)(3) (42 U.S.C. 1395i–4(g)(3)) is repealed.

SEC. 449. RELIEF FOR FINANCIALLY DISTRESSED RURAL HOSPITALS.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by inserting after section 330D the following new section:

''SEC. 330E. RELIEF FOR FINANCIALLY DISTRESSED RURAL HOSPITALS.

''(a) GRANTS TO SMALL RURAL HOSPITALS.—The Secretary, acting through the Health Resources and Services Administration, may award grants to eligible small rural hospitals that have submitted applications in accordance with subsection (c) to provide relief for financial distress that has a negative impact on access to care for beneficiaries under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) that reside in a rural area.

''(b) ELIGIBLE SMALL RURAL HOSPITAL DEFINED.—For purposes of this paragraph, the term 'eligible small rural hospital' means a non-Federal, short-term general acute care hospital that—

''(1) is located in a rural area (as defined for purposes of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d))); and

''(2) has less than 50 beds.

''(c) APPLICATION AND APPROVAL.—

''(1) APPLICATION.—Each eligible small rural hospital that desires to receive a grant under this paragraph shall submit an application to the Secretary, at such time, in such form and manner, and accompanied by such additional information as the Secretary may reasonably require.

''(2) APPROVAL.—The Secretary shall approve applications submitted under paragraph (1) based on a methodology developed by the Secretary in consultation with the Office of Rural Health Policy.

''(d) AMOUNT OF GRANT.—A grant to an eligible small rural hospital under this paragraph may not exceed $250,000.

''(e) USE OF FUNDS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), an eligible small rural hospital may use amounts received under a grant under this section to temporarily offset financial operating losses, with emphasis on those losses attributable to reimbursement formula changes that resulted from the Balanced Budget Act of 1997, in order to ensure continued operation and short-term sustainability or to address emergency physical capital needs that might otherwise result in closure.

''(2) PROHIBITED USES.—A hospital may not use funds received under a grant under this section for new construction, the purchase of medical equipment, or for computer software or hardware.

''(f) REPORT.—

''(1) INFORMATION.—A hospital receiving a grant under this section shall furnish the Secretary with such information as the Secretary may require to evaluate the project for which the grant is made and to ensure that the grant is expended for the purposes for which it is made.

''(2) REPORTING.—

''(A) ANNUAL REPORTS.—

''(i) IN GENERAL.—Not later than December 31 of each year (beginning with 2001), the Secretary shall submit a report to the committees of jurisdiction of the House of Representatives and the Senate on the grant program established under this section.

''(ii) INFORMATION INCLUDED.—The report submitted under clause (i) shall include information on the number of grants made, the nature of the projects involved, the geographic distribution of grant recipients, and such other information as the Secretary determines is appropriate.

''(B) FINAL REPORT.—Not later than 180 days after the completion of all of the projects for which a grant is made under this section, the Secretary shall submit a final report on the grant program established under this section to the committees described in subparagraph (A).

''(g) APPROPRIATIONS.—There are appropriated, out of any money in the Treasury not otherwise appropriated, for making grants under this section $25,000,000 for each of the fiscal years 2001 through 2005.''.

SEC. 450. REFINEMENT OF MEDICARE REIMBURSEMENT FOR TELEHEALTH SERVICES.

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

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

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

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

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

''(2) APPLICATION OF PART B COINSURANCE AND DEDUCTIBLE.—Any payment made under this section shall be subject to the coinsurance and deductible requirements under subsections (a)(1) and (b) of section 1833 of the Social Security Act (42 U.S.C. 1395l).

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

''(A) DISTANT SITE.—The term 'distant site' means the site at which the physician or

practitioner is located at the time the item or service is provided via a telecommunications system.

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

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

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

''(C) ORIGINATING SITE.—

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

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

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

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

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

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

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

''(e) TELEPRESENTER NOT REQUIRED.—Nothing in this section shall be construed as requiring an eligible telehealth beneficiary to be presented by a physician or practitioner for the provision of an item or service via a telecommunications system.''.

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

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

''(1) IN GENERAL.—Not later than'';

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

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

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

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

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

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

(d) TELEHEALTH COVERAGE FOR DIRECT PATIENT CARE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) CONSTRUCTION RELATING TO HOME HEALTH SERVICES.—Section 4206(a) of the Balanced Budget Act of 1997 (42 U.S.C. 1395l note), as amended by subsection (f), is amended by adding at the end the following new paragraph:

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

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

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

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

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

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

SEC. 451. MEDPAC STUDY ON LOW-VOLUME, ISOLATED RURAL HEALTH CARE PROVIDERS.

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 501. RESTORING EFFECTIVE DATE OF ELECTIONS AND CHANGES OF ELECTIONS OF MEDICARE+CHOICE PLANS.

(a) OPEN ENROLLMENT.—Section 1851(f)(2) (42 U.S.C. 1395w–21(f)(2)) is amended by striking '', except that if such election or change is made after the 10th day of any calendar month, then the election or change shall not take effect until the first day of the second calendar month following the date on which the election or change is made''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to elections and changes of coverage made on or after January 1, 2001.

SEC. 502. SPECIAL MEDIGAP ENROLLMENT ANTI-DISCRIMINATION PROVISION FOR CERTAIN BENEFICIARIES.

(a) DISENROLLMENT WINDOW IN ACCORDANCE WITH BENEFICIARY'S CIRCUMSTANCE.—Section 1882(s)(3) (42 U.S.C. 1395ss(s)(3)) is amended—

(1) in subparagraph (A), in the matter following clause (iii), by striking '', subject to subparagraph (E), seeks to enroll under the policy not later than 63 days after the date of termination of enrollment described in such subparagraph'' and inserting ''seeks to enroll under the policy during the period specified in subparagraph (E)''; and

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

''(E) For purposes of subparagraph (A), the time period specified in this subparagraph is—

''(i) in the case of an individual described in subparagraph (B)(i), the period beginning on the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if no such notice is received, notice that a claim has been denied because of such a termination or cessation) and ending on the date that is 63 days after the applicable notice;

''(ii) in the case of an individual described in clause (ii), (iii), (v), or (vi) of subparagraph (B) whose enrollment is terminated involuntarily, the period beginning on the date that the individual receives a notice of termination and ending on the date that is 63 days after the date the applicable coverage is terminated;

''(iii) in the case of an individual described in subparagraph (B)(iv)(I), the period beginning on the earlier of (I) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice, if any, and (II) the date that the applicable coverage is terminated, and ending on the date that is 63 days after the date the coverage is terminated;

''(iv) in the case of an individual described in clause (ii), (iii), (iv)(II), (iv)(III), (v), or (vi) of subparagraph (B) who disenrolls voluntarily, the period beginning on the date that is 60 days before the effective date of the disenrollment and ending on the date that is 63 days after such effective date; and

''(v) in the case of an individual described in subparagraph (B) but not described in the preceding provisions of this subparagraph, the period beginning on the effective date of the disenrollment and ending on the date that is 63 days after such effective date.''.

(b) EXTENDED MEDIGAP ACCESS FOR INTERRUPTED TRIAL PERIODS.—Section 1882(s)(3) (42 U.S.C. 1395ss(s)(3)), as amended by subsection (a), is amended by adding at the end the following new subparagraph:

''(F) For purposes of this paragraph—

''(i) in the case of an individual described in subparagraph (B)(v) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with an organization or provider described in subclause (II) of such subparagraph is involuntarily terminated within the first 12 months of such enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, such subsequent enrollment shall be deemed to be an initial enrollment described in such subparagraph; and

''(ii) in the case of an individual described in clause (vi) of subparagraph (B) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with a plan or in a program described in clause (v)(II) of such subparagraph is involuntarily terminated within the first 12 months of such enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, such subsequent enrollment shall be deemed to be an initial enrollment described in clause (vi) of such subparagraph.''.

SEC. 503. INCREASE IN NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE IN 2001 AND 2002.

Section 1853(c)(6)(B) of the Social Security Act (42 U.S.C. 1395w–23(c)(6)(B)) is amended—

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

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

SEC. 504. ALLOWING MOVEMENT TO 50:50 PERCENT BLEND IN 2002.

Section 1853(c)(2) of the Social Security Act (42 U.S.C. 1395w–23(c)(2)) is amended—

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

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

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

SEC. 505. DELAY FROM JULY TO NOVEMBER 2000, IN DEADLINE FOR OFFERING AND WITHDRAWING MEDICARE+CHOICE PLANS FOR 2001.

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

SEC. 506. AMOUNTS IN MEDICARE TRUST FUNDS AVAILABLE FOR SECRETARY'S SHARE OF MEDICARE+CHOICE EDUCATION AND ENROLLMENT-RELATED COSTS.

(a) RELOCATION OF PROVISIONS.—Section 1857(e)(2) (42 U.S.C. 1395w–27(e)(2)) is amended to read as follows:

''(2) COST-SHARING IN ENROLLMENT-RELATED COSTS.—A Medicare+Choice organization shall pay the fee established by the Secretary under section 1851(j)(3)(A).''.

(b) FUNDING FOR EDUCATION AND ENROLLMENT ACTIVITIES.—Section 1851 (42 U.S.C. 1395w–21) is amended by adding at the end the following new subsection:

''(j) FUNDING FOR BENEFICIARY EDUCATION AND ENROLLMENT ACTIVITIES.—

''(1) SECRETARY'S ESTIMATE OF TOTAL COSTS.—The Secretary shall annually estimate the total cost for a fiscal year of carrying out this section, section 4360 of the Omnibus Budget Reconciliation Act of 1990 (relating to the health insurance counseling and assistance program), and related activities.

''(2) TOTAL AMOUNT AVAILABLE.—The total amount available to the Secretary for a fiscal year for the costs of the activities described in paragraph (1) shall be equal to the lesser of—

''(A) the amount estimated for such fiscal year under paragraph (1); or

''(B) for—

''(i) fiscal year 2001, $130,000,000; and

''(ii) fiscal year 2002 and each subsequent fiscal year, the amount for the previous fiscal year, adjusted to account for inflation, any change in the number of beneficiaries under this title, and any other relevant factors.

''(3) COST-SHARING IN ENROLLMENT-RELATED COSTS.—

''(A) AMOUNTS FROM MEDICARE+CHOICE ORGANIZATIONS.—

''(i) IN GENERAL.—The Secretary is authorized to charge a fee to each Medicare+Choice organization with a contract under this part that is equal to the organization's pro rata share (as determined by the Secretary) of the Medicare+Choice portion (as defined in clause (ii)) of the total amount available under paragraph (2) for a fiscal year. Any amounts collected shall be available without further appropriation to the Secretary for the costs of the activities described in paragraph (1).

''(ii) MEDICARE+CHOICE PORTION DEFINED.—For purposes of clause (i), the term 'Medicare+Choice portion' means, for a fiscal year, the ratio, as estimated by the Secretary, of—

''(I) the average number of individuals enrolled in Medicare+Choice plans during the fiscal year; to

''(II) the average number of individuals entitled to benefits under parts A, and enrolled under part B, during the fiscal year.

''(B) SECRETARY'S SHARE.—

''(i) AMOUNTS AVAILABLE FROM TRUST FUNDS.—The Secretary's share of expenses shall be payable from funds in the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, in such proportion as the Secretary shall deem to be fair and equitable after taking into consideration the expenses attributable to the administration of this part with respect to part A and B. The Secretary shall make such transfers of moneys between such Trust Funds as may be appropriate to settle accounts between the Trust Funds in cases where expenses properly payable from one such Trust Fund have been paid from the other such Trust Fund.

''(ii) SECRETARY'S SHARE OF EXPENSES DEFINED.—For purposes of clause (i), the term 'Secretary's share of expenses' means, for a fiscal year, an amount equal to—

''(I) the total amount available to the Secretary under paragraph (2) for the fiscal year; less

''(II) the amount collected under subparagraph (A) for the fiscal year.''.

SEC. 507. REVISED TERMS AND CONDITIONS FOR EXTENSION OF MEDICARE COMMUNITY NURSING ORGANIZATION (CNO) DEMONSTRATION PROJECT.

(a) IN GENERAL.—Section 532 of BBRA (42 U.S.C. 1395mm note) is amended—

(1) in subsection (a), by striking the second sentence; and

(2) by striking subsection (b) and inserting the following new subsections:

''(b) TERMS AND CONDITIONS.—

''(1) JANUARY THROUGH SEPTEMBER 2000.—For the 9-month period beginning with January 2000, any such demonstration project shall be conducted under the same terms and conditions as applied to such demonstration during 1999.

''(2) OCTOBER 2000 THROUGH DECEMBER 2001.—For the 15-month period beginning with October 2000, any such demonstration project shall be conducted under the same terms and conditions as applied to such demonstration during 1999, except that the following modifications shall apply:

''(A) BASIC CAPITATION RATE.—The basic capitation rate paid for services covered under the project (other than case management services) per enrollee per month shall be basic capitation rate paid for such services for 1999, reduced by 10 percent in the case of the demonstration sites located in Arizona, Minnesota, and Illinois, and 15 percent for the demonstration site located in New York.

''(B) TARGETED CASE MANAGEMENT FEE.—A case management fee shall be paid only for enrollees who are classified as 'moderate' or 'at risk' through a baseline health assessment (as required for Medicare+Choice plans under section 1852(e) of the Social Security Act (42 U.S.C. 1395ww–22(e)).

''(C) GREATER UNIFORMITY IN CLINICAL FEATURES AMONG SITES.—Each project shall implement for each site—

''(i) protocols for periodic telephonic contact with enrollees based on—

''(I) the results of such standardized written health assessment; and

''(II) the application of appropriate care planning approaches;

''(ii) disease management programs for targeted diseases (such as congestive heart failure, arthritis, diabetes, and hypertension) that are highly prevalent in the enrolled populations;

''(iii) systems and protocols to track enrollees through hospitalizations, including pre-admission planning, concurrent management during inpatient hospital stays, and post-discharge assessment, planning, and follow-up; and

''(iv) standardized patient educational materials for specified diseases and health conditions.

''(D) QUALITY IMPROVEMENT.—Each project shall implement at each site once during the 15-month period—

''(i) enrollee satisfaction surveys; and

''(ii) reporting on specified quality indicators for the enrolled population.

''(c) EVALUATION.—

''(1) PRELIMINARY REPORT.—Not later than July 1, 2001, the Secretary of Health and Human Services shall submit to the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate a preliminary report that—

''(A) evaluates such demonstration projects for the period beginning July 1, 1997, and ending December 31, 1999, on a site-specific basis with respect to the impact on per beneficiary spending, specific health utilization measures, and enrollee satisfaction; and

''(B) includes a similar evaluation of such projects for the portion of the extension period that occurs after September 30, 2000.

''(2) FINAL REPORT.—Not later than July 1, 2002, the Secretary shall submit a final report to such Committees on such demonstration projects. Such report shall include the same elements as the preliminary report required by paragraph (1), but for the period after December 31, 1999.

''(3) METHODOLOGY FOR SPENDING COMPARISONS.—Any evaluation of the impact of the demonstration projects on per beneficiary spending included in such reports shall be based on a comparison of—

''(A) data for all individuals who—

''(i) were enrolled in such demonstration projects as of the first day of the period under evaluation; and

''(ii) were enrolled for a minimum of 6 months thereafter; with

''(B) data for a matched sample of individuals who are enrolled under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) and who are not enrolled in such a project, in a Medicare+Choice plan under part C of such title (42 U.S.C. 1395w–21 et seq.), a plan offered by an eligible organization under section 1876 of such Act (42 U.S.C. 1395mm), or a health care prepayment plan under section 1833(a)(1)(A) of such Act (42 U.S.C. 1395l(a)(1)(A)).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall be effective as if included in the enactment of section 532 of BBRA (42 U.S.C. 1395mm note).

SEC. 508. MODIFICATION OF PAYMENT RULES FOR CERTAIN FRAIL ELDERLY MEDICARE BENEFICIARIES.

(a) MODIFICATION OF PAYMENT RULES.—Section 1853 (42 U.S.C. 1395w–23) is amended—

(1) in subsection (a)—

(A) in paragraph (1)(A), by striking ''subsections (e), (g), and (i)'' and inserting ''subsections (e), (g), (i), and (j)'';

(B) in paragraph (3)(D), by inserting ''paragraph (4) and'' after ''Subject to''; and

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

''(4) EXEMPTION FROM RISK-ADJUSTMENT SYSTEM FOR FRAIL ELDERLY BENEFICIARIES ENROLLED IN SPECIALIZED PROGRAMS.—

''(A) IN GENERAL.—In applying the risk-adjustment factors established under paragraph (3) during the period described in subparagraph (B), the limitation under paragraph (3)(C)(ii)(I) shall apply to a frail elderly Medicare+Choice beneficiary (as defined in subsection (j)(3)) who is enrolled in a Medicare+Choice plan under a specialized program for the frail elderly (as defined in subsection (j)(2)) during the entire period.

''(B) PERIOD OF APPLICATION.—The period described in this subparagraph begins with January 2001, and ends with the first month for which the Secretary certifies to Congress that a comprehensive risk adjustment methodology under paragraph (3)(C) that takes into account the factors described in subsection (j)(1)(B) is being fully implemented.''; and

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

''(j) SPECIAL RULES FOR FRAIL ELDERLY ENROLLED IN SPECIALIZED PROGRAMS FOR THE FRAIL ELDERLY.—

''(1) DEVELOPMENT AND IMPLEMENTATION OF NEW PAYMENT SYSTEM.—

''(A) IN GENERAL.—The Secretary shall develop and implement (as soon as possible after the date of enactment of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 2000), during the period described in subsection (a)(4)(B), a payment methodology for frail elderly Medicare+Choice beneficiaries enrolled in a Medicare+Choice plan under a specialized program for the frail elderly (as defined in paragraph (2)(A)).

''(B) FACTORS DESCRIBED.—The methodology developed and implemented under subparagraph (A) shall take into account the prevalence, mix, and severity of chronic conditions among frail elderly Medicare+Choice beneficiaries and shall include—

''(i) medical diagnostic factors from all provider settings (including hospital and nursing facility settings);

''(ii) functional indicators of health status; and

''(iii) such other factors as may be necessary to achieve appropriate payments for plans serving such beneficiaries.

''(2) SPECIALIZED PROGRAM FOR THE FRAIL ELDERLY DEFINED.—

''(A) IN GENERAL.—In this part, the term 'specialized program for the frail elderly' means a program that the Secretary determines—

''(i) is offered under this part as a distinct part of a Medicare+Choice plan;

''(ii) primarily enrolls frail elderly Medicare+Choice beneficiaries; and

''(iii) has a clinical delivery system that is specifically designed to serve the special needs of such beneficiaries and to coordinate short-term and long-term care for such beneficiaries through the use of a team described in subparagraph (B) and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

''(B) SPECIALIZED TEAM DESCRIBED.—A team described in this subparagraph—

''(i) includes—

''(I) a physician; and

''(II) a nurse practitioner or geriatric care manager; and

''(ii) has as members individuals who—

''(I) have special training in the care and management of the frail elderly beneficiaries; and

''(II) specialize in the care and management of such beneficiaries.

''(3) FRAIL ELDERLY MEDICARE+CHOICE BENEFICIARY DEFINED.—In this part, the term 'frail elderly Medicare+Choice beneficiary' means a Medicare+Choice eligible individual who—

''(A) is residing in a skilled nursing facility (as defined in section 1819(a)) or a nursing facility (as defined in section 1919(a)) for an indefinite period and without any intention of residing outside the facility; and

''(B) has a severity of condition that makes the individual frail (as determined under guidelines approved by the Secretary).''.

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

TITLE VI—PROVISIONS RELATING TO INDIVIDUALS WITH END-STAGE RENAL DISEASE

SEC. 601. 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 '', and for such services'' and all that follows before the period at the end and inserting the following: '', for such services furnished during 2001, by 2.4 percent above such composite rate payment amounts for such services furnished on December 31, 2000, for such services furnished during 2002 and 2003, by the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year above such composite rate payment amounts for such services furnished on December 31 of the previous year, and for such services furnished during a subsequent year, by the ESRD market basket percentage increase above such composite rate payment amounts for such services furnished on December 31 of the previous year''.

(b) ESRD MARKET BASKET PERCENTAGE INCREASE DEFINED.—Section 1881(b) (42 U.S.C. 1395rr(b)) is amended by adding at the end the following new paragraph:

''(12)(A) For purposes of this title, the term 'ESRD market basket percentage increase' means, with respect to a calendar year, the percentage (estimated by the Secretary before the beginning of such year) by which—

''(i) the cost of the mix of goods and services included in the provision of dialysis services (which may include the costs described in subparagraph (D) as determined appropriate by the Secretary) that is determined based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such dialysis services for the calendar year; exceeds

''(ii) the cost of such mix of goods and services for the preceding calendar year.

''(B) In determining the percentage under subparagraph (A), the Secretary may take into account any increase in the costs of furnishing the mix of goods and services described in such subparagraph resulting from—

''(i) the adoption of scientific and technological innovations used to provide dialysis services; and

''(ii) changes in the manner or method of delivering dialysis services.

''(C) The Secretary shall periodically review and update (as necessary) the items and services included in the mix of goods and services used to determine the percentage under subparagraph (A).

''(D) The costs described in this subparagraph include—

''(i) labor, including direct patient care costs and administrative labor costs, vacation and holiday pay, payroll taxes, and employee benefits;

''(ii) other direct costs, including drugs, supplies, and laboratory fees;

''(iii) overhead, including medical director fees, temporary services, general and administrative costs, interest expenses, and bad debt;

''(iv) capital, including rent, real estate taxes, depreciation, utilities, repairs, and maintenance; and

''(v) such other allowable costs as the Secretary may specify.''.

SEC. 602. REVISION OF PAYMENT RATES FOR ESRD PATIENTS ENROLLED IN MEDICARE+CHOICE PLANS.

(a) IN GENERAL.—Section 1853(a)(1)(B) (42 U.S.C. 1395w–23(a)(1)(B)) is amended by adding at the end the following: ''In establishing such rates the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including any risk-adjustment associated with such rate) of the social health maintenance organization end-stage renal disease demonstrations established by section 2355 of the Deficit Reduction Act of 1984 (Public Law 98–369; 98 Stat. 1103), as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66; 107 Stat. 608), and shall compute such rates by not taking into account individuals with kidney transplants and individuals in which the program under this title is a secondary payer to another payer (or payers) pursuant to section 1862(b).''.

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

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

SEC. 603. PERMITTING ESRD BENEFICIARIES TO ENROLL IN ANOTHER MEDICARE+CHOICE PLAN IF THE PLAN IN WHICH THEY ARE ENROLLED IS TERMINATED.

(a) IN GENERAL.—Section 1851(a)(3)(B) (42 U.S.C. 1395w–21(a)(3)(B)) is amended by striking ''except that'' and all that follows and inserting the following: ''except that—

''(i) an individual who develops end-stage renal disease while enrolled in a Medicare+Choice plan may continue to be enrolled in that plan; and

''(ii) in the case of such an individual who is enrolled in a Medicare+Choice plan under clause (i) (or subsequently under this clause), if the enrollment is discontinued under circumstances described in section 1851(e)(4)(A) then the individual will be treated as a 'Medicare+Choice eligible individual' for purposes of electing to continue enrollment in another Medicare+Choice plan.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall apply to terminations and discontinuations occurring on or after the date of enactment of this Act.

(2) APPLICATION TO PRIOR PLAN TERMINATIONS.—Clause (ii) of section 1851(a)(3)(B) of the Social Security Act (as inserted by subsection (a)) also shall apply to individuals whose enrollment in a Medicare+Choice plan was terminated or discontinued after December 31, 1997, and before the date of enactment of this Act. In applying this paragraph, such an individual shall be treated, for purposes of part C of title XVIII of the Social Security Act, as having discontinued enrollment in such a plan as of the date of enactment of this Act.

SEC. 604. COVERAGE OF CERTAIN VASCULAR ACCESS SERVICES FOR ESRD BENEFICIARIES PROVIDED BY AMBULATORY SURGICAL CENTERS.

(a) IN GENERAL.—The matter following subparagraph (B) of section 1833(i)(1) (42 U.S.C. 1395l(i)(1)) is amended by adding at the end the following new sentence: ''Such lists shall include the procedures identified as of July 30, 1999, by vascular access codes 34101, 34111, 34490, 35190, 35458, 35460, 35475, 35476, 35903, 36005, 36010, 36011, 36120, 36140, 36145, 36215–36218, 36831–36834, 37201, 37204–37208, 37250, 37251, and 49423.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to vascular access services furnished on or after January 1, 2000.

SEC. 605. COLLECTION AND ANALYSIS OF INFORMATION ON THE SATISFACTION OF ESRD BENEFICIARIES WITH THE QUALITY OF AND ACCESS TO HEALTH CARE UNDER THE MEDICARE PROGRAM.

(a) COLLECTION OF INFORMATION.—The Secretary shall collect information on the satisfaction of each ESRD medicare beneficiary with the quality of health care under the original fee-for-service medicare program and the Medicare+Choice program, and the access of each beneficiary to that care.

(b) ANALYSIS OF COLLECTED INFORMATION.—

(1) IN GENERAL.—The Secretary shall conduct an analysis of the information collected under subsection (a) to determine—

(A) the kinds of health care that each non-dialysis health care provider provides to each ESRD medicare beneficiary for the treatment of end-stage renal disease and each comorbidity;

(B) the effect of the availability of supplemental insurance on the use by beneficiary of health care;

(C) the perceptions of each beneficiary regarding the access of that beneficiary to health care; and

(D) the quality of health care provided to each ESRD medicare beneficiary enrolled under the Medicare+Choice program compared to each beneficiary enrolled under the original fee-for-service medicare program.

(2) CONSIDERATIONS.—In conducting the analysis under paragraph (1), the Secretary shall consider—

(A) the feasibility of routinely collecting information on the satisfaction of each ESRD medicare beneficiary with dialysis and non-dialysis health care;

(B) whether to collect information using disease specific questions or generic questions (similar to those used in conducting the Medicare Current Beneficiary Survey);

(C) how well collected information detects access problems within each specific group of ESRD medicare beneficiaries, including beneficiaries without supplemental insurance and beneficiaries that reside in a rural area; and

(D) each obstacle that a health care provider may face in offering each type of dialysis service.

(c) AVAILABILITY OF INFORMATION AND ANALYSIS.—Not later than January 1 of each year (beginning in 2002) the Secretary shall make the information collected under subsection (a) and the analysis conducted under subsection (b) available to the public.

(d) DEFINITIONS.—In this section:

(1) ESRD MEDICARE BENEFICIARY.—The term ''ESRD medicare beneficiary'' means an individual eligible for benefits under the medicare program that has end-stage renal disease (including an individual enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization under the Medicare+Choice program).

(2) MEDICARE+CHOICE PROGRAM.—The term ''Medicare+Choice program'' means the program established under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.).

(3) ORIGINAL FEE-FOR-SERVICE MEDICARE PROGRAM.—The term ''original fee-for-service medicare program'' means the health benefits program under parts A and B title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

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

TITLE VII—ACCESS TO CARE IMPROVEMENTS THROUGH MEDICAID AND SCHIP

SEC. 701. NEW PROSPECTIVE PAYMENT SYSTEM FOR FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.

(a) IN GENERAL.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (13)—

(A) in subparagraph (A), by adding ''and'' at the end;

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

(C) by striking subparagraph (C); and

(2) by inserting after paragraph (14) the following new paragraph:

''(15) for payment for services described in subparagraph (B) or (C) of section 1905(a)(2) under the plan in accordance with subsection (aa);''.

(b) NEW PROSPECTIVE PAYMENT SYSTEM.—Section 1902 (42 U.S.C. 1396a) is amended by adding at the end the following:

''(aa) PAYMENT FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.—

''(1) IN GENERAL.—Beginning with fiscal year 2001 and each succeeding fiscal year, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by a Federally-qualified health center and services described in section 1905(a)(2)(B) furnished by a rural health clinic in accordance with the provisions of this subsection.

''(2) FISCAL YEAR 2001.—Subject to paragraph (4), for services furnished during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of the center or clinic of furnishing such services during fiscal year 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 in accordance with the regulations and methodology referred to in paragraph (2). 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 BBA (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) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2000, and apply to services furnished on or after such date.

SEC. 702. TRANSITIONAL MEDICAL ASSISTANCE.

(a) MAKING PROVISION PERMANENT.—

(1) IN GENERAL.—Subsection (f) of section 1925 (42 U.S.C. 1396r–6) is repealed.

(2) CONFORMING AMENDMENT.—Section 1902(e)(1) (42 U.S.C. 1396a(e)(1)) is repealed.

(b) STATE OPTION OF INITIAL 12-MONTH ELIGIBILITY.—Section 1925 (42 U.S.C. 1396r–6) is amended—

(1) in subsection (a), by adding at the end the following new paragraph:

''(5) OPTION OF 12-MONTH INITIAL ELIGIBILITY PERIOD.—A State may elect to treat any reference in this subsection to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months). In the case of such an election, subsection (b) shall not apply.''; and

(2) in subsection (b)(1), by inserting ''and subsection (a)(5)'' after ''paragraph (3)''.

(c) SIMPLIFICATION OPTIONS.—

(1) REMOVAL OF ADMINISTRATIVE REPORTING REQUIREMENTS FOR ADDITIONAL 6-MONTH EXTENSION.—Section 1925(b) (42 U.S.C. 1396r–6(b)) is amended—

(A) in paragraph (2)—

(i) in the heading, by striking ''AND REPORTING'';

(ii) by striking subparagraph (B);

(iii) in subparagraph (A)(i)—

(I) by striking ''(I)'' and all that follows through ''(II)'' and inserting ''(i)'';

(II) by striking '', and (III)'' and inserting ''and (ii)''; and

(III) by redesignating such subparagraph as subparagraph (A) (with appropriate indentation); and

(iv) in subparagraph (A)(ii)—

(I) by striking ''notify the family of the reporting requirement under subparagraph (B)(ii) and a statement of'' and inserting ''provide the family with notification of''; and

(II) by redesignating such subparagraph as subparagraph (B) (with appropriate indentation);

(B) in paragraph (3)(A)—

(i) in clause (iii)—

(I) in the heading, by striking ''REPORTING AND TEST'';

(II) by striking subclause (I); and

(III) by redesignating subclauses (II) and (III) as subclauses (I) and (II), respectively; and

(ii) by striking the last 3 sentences; and

(C) in paragraph (3)(B), by striking ''subparagraph (A)(iii)(II)'' and inserting ''subparagraph (A)(iii)(I)''.

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

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

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

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

(3) STATE OPTION TO ELECT SHORTER PERIOD FOR REQUIREMENT FOR RECEIPT OF MEDICAL ASSISTANCE AS A CONDITION OF ELIGIBILITY FOR TRANSITIONAL MEDICAL ASSISTANCE.—Section 1925(a)(1) (42 U.S.C. 1396r–6(a)(1)) is amended by inserting ''(or such shorter period as the State may elect)'' after ''3''.

(d) APPLICATION OF NOTICE OF ELIGIBILITY TO ALL FAMILIES LEAVING WELFARE.—Section 1925(a) (42 U.S.C. 1396r–6(a)), as amended by subsection (b)(1), is amended by adding at the end the following new paragraph:

''(6) NOTICE OF ELIGIBILITY FOR MEDICAL ASSISTANCE TO ALL FAMILIES LEAVING TANF.—Each State shall notify each family which was receiving assistance under the State program funded under part A of title IV and which is no longer eligible for such assistance, of the potential eligibility of the family and any individual members of such family for medical assistance under this title or child health assistance under title XXI. Such notice shall include a statement that the family does not have to be receiving assistance under the State program funded under part A of title IV in order to be eligible for such medical assistance or child health assistance.''.

(e) ENROLLMENT DATA.—Section 1925 (42 U.S.C. 1396r–6), as amended by subsection (c)(2)(B), is amended by adding at the end the following new subsection:

''(g) ENROLLMENT DATA.—The Secretary annually shall obtain from each State with a State plan approved under this title enrollment data regarding—

''(1) the number of adults and children who—

''(A) receive medical assistance under this title based on eligibility under section 1931;

''(B) at the time they were first determined to be eligible for such medical assistance, also received cash assistance under the State program funded under part A of title IV; and

''(C) subsequently ceased to receive assistance under such State program due to increased earnings or increased child support income;

''(2) the percentage of the adults and children described in paragraph (1) who receive transitional medical assistance under this section or otherwise remain enrolled in the program under this title; and

''(3) the percentage of such adults and children that receive such transitional medical assistance for more than 6 months or that remain enrolled in the program under this title for more than 6 months after such adults or children ceased to receive assistance under the State program funded under part A of title IV.''.

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

SEC. 703. APPLICATION OF SIMPLIFIED SCHIP PROCEDURES UNDER THE MEDICAID PROGRAM.

(a) COORDINATION WITH MEDICAID.—

(1) IN GENERAL.—Section 1902(l) (42 U.S.C. 1396a(l)) is amended—

(A) in paragraph (3), by inserting ''subject to paragraph (5)'', after ''Notwithstanding subsection (a)(17),''; and

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

''(5) With respect to determining the eligibility of individuals under 19 years of age for medical assistance under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), (a)(10)(A)(ii)(IX), or (a)(10)(A)(ii)(XIV), notwithstanding any other provision of this title, if the State has established a State child health plan under title XXI, or expanded coverage beyond the income eligibility standards required for such individuals under this title under a waiver granted under section 1115—

''(A) the State may not apply a resource standard if the State does not apply such a standard under such child health plan or section 1115 waiver with respect to such individuals;

''(B) the State shall use the same simplified eligibility form (including, if applicable, permitting application other than in person) as the State uses under such State child health plan or section 1115 waiver with respect to such individuals;

''(C) the State shall provide for initial eligibility determinations and redeterminations of eligibility using the same verification policies, forms, and frequency as the State uses for such purposes under such State child health plan or section 1115 waiver with respect to such individuals; and

''(D) the State shall not require a face-to-face interview for purposes of initial eligibility determinations and redeterminations unless the State required such an interview for such purposes under such child health plan or section 1115 waiver with respect to such individuals.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) take effect on October 1, 2000, and apply to eligibility determinations and redeterminations made on or after such date.

(b) AUTOMATIC REASSESSMENT OF ELIGIBILITY FOR TITLE XXI AND MEDICAID BENEFITS FOR CHILDREN LOSING MEDICAID OR TITLE XXI ELIGIBILITY.—

(1) LOSS OF MEDICAID ELIGIBILITY.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(A) by striking the period at the end of paragraph (65) and inserting ''; and'', and

(B) by inserting after paragraph (65) the following new paragraph:

''(66) provide, by not later than the first day of the first month that begins more than 1 year after the date of the enactment of this paragraph and in the case of a State with a State child health plan under title XXI, that before medical assistance to a child (or a parent of a child) is discontinued under this title, a determination of whether the child (or parent) is eligible for benefits under title XXI shall be made and, if determined to be so eligible, the child (or parent) shall be automatically enrolled in the program under such title without the need for a new application and without being asked to provide any information that is already available to the State.''.

(2) LOSS OF TITLE XXI ELIGIBILITY.—Section 2102(b)(3) (42 U.S.C. 1397bb(b)(3)) is amended by redesignating subparagraphs (D) and (E) as subparagraphs (E) and (F), respectively, and by inserting after subparagraph (C) the following new subparagraph:

''(D) that before health assistance to a child (or a parent of a child) is discontinued under this title, a determination of whether the child (or parent) is eligible for benefits under title XIX is made and, if determined to be so eligible, the child (or parent) is automatically enrolled in the program under such title without the need for a new application and without being asked to provide any information that is already available to the State;''.

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) apply to individuals who lose eligibility under the medicaid program under title XIX, or under a State child health insurance plan under title XXI, respectively, of the Social Security Act (42 U.S.C. 1396 et seq.; 1397aa et seq.) on or after the date that is 60 days after the date of the enactment of this Act.

SEC. 704. PRESUMPTIVE ELIGIBILITY.

(a) ADDITIONAL ENTITIES QUALIFIED TO DETERMINE PRESUMPTIVE ELIGIBILITY FOR LOW-INCOME CHILDREN.—

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

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

(B) 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 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 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 (IV) any other entity the State so deems, as approved by the Secretary'' before the semicolon.

(2) APPLICATION 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 1920A (relating to presumptive eligibility).''.

(B) EXCEPTION FROM LIMITATION ON ADMINISTRATIVE EXPENSES.—Section 2105(c)(2) (42 U.S.C. 1397ee(c)(2)) is amended by adding at the end the following new subparagraph:

''(C) EXCEPTION FOR PRESUMPTIVE ELIGIBILITY EXPENDITURES.—The limitation under subparagraph (A) on expenditures shall not apply to expenditures attributable to the application of section 1920A (pursuant to section 2107(e)(1)(D)), regardless of whether the child is determined to be ineligible for the program under this title or title XIX.''.

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

(A) in subsection (b)(3)(A)(ii), by striking ''paragraph (1)(A)'' and inserting ''paragraph (2)(A)''; and

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

(b) ELIMINATION OF SCHIP FUNDING OFFSET FOR EXERCISE OF PRESUMPTIVE ELIGIBILITY OPTION.—

(1) IN GENERAL.—Section 2104(d) (42 U.S.C. 1397dd(d)) is amended by striking ''the sum of—'' and all that follows through ''(2)'' and conforming the margins of all that remains accordingly.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect October 1, 2000, and applies to allotments under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) for fiscal year 2001 and each succeeding fiscal year thereafter.

SEC. 705. IMPROVEMENTS TO THE MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT.

(a) INCREASE IN AUTHORIZATION OF APPROPRIATIONS.—Section 501(a) (42 U.S.C. 701(a)) is amended in the matter preceding paragraph (1) by striking ''$705,000,000 for fiscal year 1994'' and inserting ''$1,000,000,000 for fiscal year 2001''.

(b) COORDINATION WITH MEDICAID AND SCHIP.—

(1) SCHIP.—Section 505(a)(5)(F) (42 U.S.C. 705(a)(5)(F)) is amended—

(A) in clause (ii), by inserting ''and in the coordination of the administration of the State program under title XXI with the care and services available under this title, as required under subsections (b)(3)(G) and (c)(2) of section 2102'' before the comma; and

(B) in clause (iv), by striking ''and infants who are eligible for medical assistance under subparagraph (A) or (B) of section 1902(l)(1)'' and inserting '', infants, and children who are eligible for medical assistance under section 1902(l)(1), and children who are eligible for child health assistance under the State program under title XXI''.

(2) CONFORMING AMENDMENTS TO SCHIP.—Section 2102(b)(3) (42 U.S.C. 1397bb(b)(3)), as amended by section 703(b)(2), is amended—

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

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

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

''(G) that operations and activities under this title are developed and implemented in consultation and coordination with the program operated by the State under title V with respect to outreach and enrollment, benefits and services, service delivery standards, public health and social service agency relationships, and quality assurance and data reporting.''.

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

SEC. 706. IMPROVING ACCESS TO MEDICARE COST-SHARING ASSISTANCE FOR LOW-INCOME BENEFICIARIES.

(a) INCREASE IN SLMB ELIGIBILITY.—

(1) IN GENERAL.—Section 1902(a)(10)(E) (42 U.S.C. 1396a(a)(10)(E)) is amended—

(A) in clause (iii), by striking ''and 120 percent in 1995'' and inserting '', 120 percent in 1995 through 2000, and 135 percent in 2001''; and

(B) in clause (iv), by striking ''2002)—'' and all that follows through ''(II) for'' and inserting ''2002) for''.

(2) CONFORMING AMENDMENT.—Section 1933(c)(2)(A) (42 U.S.C. 1396u–3(c)(2)(A)) is amended by striking ''sum of—'' and all that follows through ''(ii) the'''''.

(3) EFFECTIVE DATE.—The amendments made by this subsection take effect on January 1, 2001, and with respect to the amendment made by paragraph (2), applies to allocations determined under section 1933(c) of the Social Security Act (42 U.S.C. 1396u–3(c)) for the last 3 quarters of fiscal year 2001 and all of fiscal year 2002.

(b) INDEX OF ASSETS TEST TO INFLATION.—Section 1905(p)(1)(C) (42 U.S.C. 1396d(p)(1)(C)) is amended by inserting '', increased (beginning with 2001 and each year thereafter) by the percentage increase (if any) in the Consumer Price Index for All Urban Consumers (United States city average)'' before the period.

(c) INCREASED EFFORT TO PROVIDE MEDICARE BENEFICIARIES WITH MEDICARE COST-SHARING UNDER THE MEDICAID PROGRAM.—

(1) IN GENERAL.—Section 1902(a) (42 U.S.C. 1396a(a)), as amended by section 703(b)(1)(A), is amended—

(A) in paragraph (65), by striking ''and'' at the end;

(B) in paragraph (66), by striking the period and inserting ''; and''; and

(C) by inserting after paragraph (66) the following new paragraph:

''(67) provide for the determination of eligibility for medicare cost-sharing (as defined in section 1905(p)(3)) for individuals described in paragraph (10)(E) and, if eligible for such medicare cost-sharing, for the enrollment of such individuals at any hospital, clinic, or similar entity at which State or local agency personnel are stationed for the purpose of determining the eligibility of individuals for medical assistance under the State plan or providing outreach services to eligible or potentially eligible individuals.''.

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

(d) PRESUMPTIVE ELIGIBILITY OF CERTAIN LOW-INCOME INDIVIDUALS FOR MEDICARE COST-SHARING UNDER THE QMB OR SLMB PROGRAM.—Title XIX (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920A the following new section:

''PRESUMPTIVE ELIGIBILITY OF CERTAIN LOW-INCOME INDIVIDUALS

''SEC. 1920B. (a) A State plan approved under section 1902 shall provide for making medical assistance with respect to medicare cost-sharing covered under the State plan available to a low-income individual on the date the low-income individual becomes entitled to benefits under part A of title XVIII during a presumptive eligibility period.

''(b) For purposes of this section:

''(1) The term 'low-income individual' means an individual who at the age of 65 years is described—

''(A) in section 1902(a)(10)(E)(i), or

''(B) in section 1902(a)(10)(E)(iii).

''(2) The term 'medicare cost-sharing'—

''(A) with respect to an individual described in paragraph (1)(A), has the meaning given such term in section 1905(p)(3); and

''(B) with respect to an individual described in paragraph (1)(B), has the meaning given such term in section 1905(p)(3)(A).

''(3) The term 'presumptive eligibility period' means, with respect to a low-income individual, the period that—

''(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the income and resources of the individual do not exceed the applicable income and resource level of eligibility under the State plan, and

''(B) ends with (and includes) the earlier of—

''(i) the day on which a determination is made with respect to the eligibility of the low-income individual for medical assistance for medical cost-sharing under the State plan, or

''(ii) in the case of a low-income individual on whose behalf an application is not filed by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

''(4)(A) Subject to subparagraph (B), the term 'qualified entity' means any of the following:

''(i) Qualified individuals within the Social Security Administration.

''(ii) An entity determined by the State agency to be capable of making determinations of the type described in paragraph (3).

''(B) The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

''(c)(1) The State agency, after consultation with the Secretary, shall provide qualified entities with—

''(A) such forms as are necessary for an application to be made on behalf of a low-income individual for medical assistance for medical cost-sharing under the State plan, and

''(B) information on how to assist low-income individuals and other persons in completing and filing such forms.

''(2) A qualified entity that determines under subsection (b)(2)(A) that a low-income individual is presumptively eligible for medical assistance for medical cost-sharing under a State plan shall—

''(A) notify the State agency of the determination within 5 working days after the date on which the determination is made, and

''(B) inform the low-income individual at the time the determination is made that an application for medical assistance for medical cost-sharing under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

''(3) In the case of a low-income individual who is determined by a qualified entity to be presumptively eligible for medical assistance for medical cost-sharing under a State plan, the low-income individual shall make application for medical assistance for medical cost-sharing under such plan by not later than the last day of the month following the month during which the determination is made.

''(d) Notwithstanding any other provision of this title, medical assistance for medicare cost-sharing that—

''(1) is furnished to a low-income individual during a presumptive eligibility period under the State plan; and

''(2) is included in the services covered by a State plan;

shall be treated as medical assistance provided by such plan for purposes of section 1903.''.

SEC. 707. BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(A) in subclause (XVI), by striking ''or'' at the end;

(B) in subclause (XVII), by adding ''or'' at the end; and

(C) by adding at the end the following:

''(XVIII) who are described in subsection (aa) (relating to certain breast or cervical cancer patients);''.

(2) GROUP DESCRIBED.—Section 1902 (42 U.S.C. 1396a) is amended by adding at the end the following:

''(aa) Individuals described in this subsection are individuals who—

''(1) are not described in subsection (a)(10)(A)(i);

''(2) have not attained age 65;

''(3) have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention breast and cervical cancer early detection program established under title XV of the Public Health Service Act (42 U.S.C. 300k et seq.) in accordance with the requirements of section 1504 of that Act (42 U.S.C. 300n) and need treatment for breast or cervical cancer; and

''(4) are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)).''.

(3) LIMITATION ON BENEFITS.—Section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G)—

(A) by striking ''and (XIII)'' and inserting ''(XIII)''; and

(B) by inserting '', and (XIV) the medical assistance made available to an individual described in subsection (aa) who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer'' before the semicolon.

(4) CONFORMING AMENDMENTS.—Section 1905(a) (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(A) in clause (xi), by striking ''or'' at the end;

(B) in clause (xii), by adding ''or'' at the end; and

(C) by inserting after clause (xii) the following:

''(xiii) individuals described in section 1902(aa),''.

(b) PRESUMPTIVE ELIGIBILITY.—

(1) IN GENERAL.—Title XIX (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920A the following:

''PRESUMPTIVE ELIGIBILITY FOR CERTAIN BREAST OR CERVICAL CANCER PATIENTS

''SEC. 1920B. (a) STATE OPTION.—A State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(aa) (relating to certain breast or cervical cancer patients) during a presumptive eligibility period.

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

''(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The term 'presumptive eligibility period' means, with respect to an individual described in subsection (a), the period that—

''(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(aa); and

''(B) ends with (and includes) the earlier of—

''(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

''(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

''(2) QUALIFIED ENTITY.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'qualified entity' means any entity that—

''(i) is eligible for payments under a State plan approved under this title; and

''(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

''(B) REGULATIONS.—The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

''(C) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed under subparagraph (B).

''(c) ADMINISTRATION.—

''(1) IN GENERAL.—The State agency shall provide qualified entities with—

''(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

''(B) information on how to assist such individuals in completing and filing such forms.

''(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

''(A) notify the State agency of the determination within 5 working days after the date on which the determination is made; and

''(B) inform such individual at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

''(3) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made.

''(d) PAYMENT.—Notwithstanding any other provision of this title, medical assistance that—

''(1) is furnished to an individual described in subsection (a)—

''(A) during a presumptive eligibility period; and

''(B) by a entity that is eligible for payments under the State plan; and

''(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(47) (42 U.S.C. 1396a(a)(47)) is amended by inserting before the semicolon at the end the following: ''and provide for making medical assistance available to individuals described in subsection (a) of section 1920B during a presumptive eligibility period in accordance with such section''.

(B) Section 1903(u)(1)(D)(v) (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

(i) by striking ''or for'' and inserting '', for''; and

(ii) by inserting before the period the following: ''; or for medical assistance provided to an individual described in subsection (a) of section 1920B during a presumptive eligibility period under such section''.

(c) ENHANCED MATCH.—The first sentence of section 1905(b) (42 U.S.C. 1396d(b)) is amended—

(1) by striking ''and'' before ''(3)''; and

(2) by inserting before the period at the end the following: '', and (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 2105(b) with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XVIII)''.

(d) EFFECTIVE DATE.—The amendments made by this section apply to medical assistance for items and services furnished on or after October 1, 2000, without regard to whether final regulations to carry out such amendments have been promulgated by such date.

TITLE VIII—OTHER PROVISIONS

SEC. 801. APPROPRIATIONS FOR RICKY RAY HEMOPHILIA RELIEF FUND.

Section 101(e) of the Ricky Ray Hemophilia Relief Fund Act of 1998 (42 U.S.C. 300c–22 note) is amended by adding at the end the following: ''There is appropriated to the Fund $475,000,000 for fiscal year 2001, to remain available until expended.''.

SEC. 802. INCREASE IN APPROPRIATIONS FOR SPECIAL DIABETES PROGRAMS FOR CHILDREN WITH TYPE I DIABETES AND INDIANS.

(a) SPECIAL DIABETES PROGRAMS FOR CHILDREN WITH TYPE I DIABETES.—Section 330B(b) of the Public Health Service Act (42 U.S.C. 254c–2(b)) is amended—

(1) by striking ''Notwithstanding'' and inserting the following:

''(1) TRANSFERRED FUNDS.—Notwithstanding''; and

(2) by adding at the end the following:

''(2) APPROPRIATIONS.—For the purpose of making grants under this section, there are appropriated, out of any money in the Treasury not otherwise appropriated—

''(A) $70,000,000 for each of fiscal years 2001 and 2002 (which shall be combined with amounts transferred under paragraph (1) for each such fiscal years); and

''(B) $100,000,000 for each of fiscal years 2003 through 2005.''.

(b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—Section 330C(c) of the Public Health Service Act (42 U.S.C. 254c–3(c)) is amended—

(1) by striking ''Notwithstanding'' and inserting the following:

''(1) TRANSFERRED FUNDS.—Notwithstanding'';

(2) by adding at the end the following:

''(2) APPROPRIATIONS.—For the purpose of making grants under this section, there are appropriated, out of any money in the Treasury not otherwise appropriated—

''(A) $70,000,000 for each of fiscal years 2001 and 2002 (which shall be combined with amounts transferred under paragraph (1) for each such fiscal years); and

''(B) $100,000,000 for each of fiscal years 2003 through 2005.''.

SEC. 803. DEMONSTRATION GRANTS TO IMPROVE OUTREACH, ENROLLMENT, AND COORDINATION OF PROGRAMS AND SERVICES TO HOMELESS INDIVIDUALS AND FAMILIES.

(a) AUTHORITY.—The Secretary of Health and Human Services may award demonstration grants to not more than 7 States (or other qualified entities) to conduct innovative programs that are designed to improve outreach to homeless individuals and families under the programs described in subsection (b) with respect to enrollment of such individuals and families under such programs and the provision of services (and coordinating the provision of such services) under such programs.

(b) PROGRAMS FOR HOMELESS DESCRIBED.—The programs described in this subsection are as follows:

(1) MEDICAID.—The program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(2) SCHIP.—The program under title XXI of such Act (42 U.S.C. 1397aa et seq.).

(3) TANF.—The program under part of A of title IV of such Act (42 U.S.C. 601 et seq.).

(4) MATERNAL AND CHILD HEALTH BLOCK GRANTS.—The program under title V of the Social Security Act (42 U.S.C. 701 et seq.).

(5) MENTAL HEALTH AND SUBSTANCE ABUSE BLOCK GRANTS.—The program under part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–1 et seq.).

(6) HIV/AIDS CARE GRANTS.—The program under part B of title XXVI of the Public Health Service Act (42 U.S.C. 300ff–21 et seq.).

(7) FOOD STAMP PROGRAM.—The program under the Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.).

(8) WORKFORCE INVESTMENT ACT.—The program under the Workforce Investment Act of 1999 (29 U.S.C. 2801 et seq.).

(9) WELFARE-TO-WORK.—The welfare-to-work program under section 403(a)(5) of the Social Security Act (42 U.S.C. 603(a)(5)).

(10) OTHER PROGRAMS.—Other public and private benefit programs that serve low-income individuals.

(c) APPROPRIATIONS.—For the purposes of carrying out this section, there are appropriated, out of any funds in the Treasury not otherwise appropriated, $10,000,000, to remain available until expended.

SEC. 804. PROTECTION OF AN HMO ENROLLEE TO RECEIVE CONTINUING CARE AT A FACILITY SELECTED BY THE ENROLLEE.

(a) AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following new section:

''SEC. 714. ENSURING CHOICE FOR CONTINUING CARE.

''(a) IN GENERAL.—With respect to health insurance coverage provided to participants or beneficiaries through a managed care organization under a group health plan, or through a health insurance issuer providing health insurance coverage in connection with a group health plan, such plan or issuer may not deny coverage for services provided to such participant or beneficiary by a continuing care retirement community, skilled nursing facility, or other qualified facility in which the participant or beneficiary resided prior to a hospitalization, regardless of whether such organization is under contract with such community or facility if the requirements described in subsection (b) are met.

''(b) REQUIREMENTS.—The requirements of this subsection are that—

''(1) the service involved is a service for which the managed care organization involved would be required to provide or pay for under its contract with the participant or beneficiary if the continuing care retirement community, skilled nursing facility, or other qualified facility were under contract with the organization;

''(2) the participant or beneficiary involved—

''(A) resided in the continuing care retirement community, skilled nursing facility, or other qualified facility prior to being hospitalized;

''(B) had a contractual or other right to return to the facility after hospitalization; and

''(C) elects to return to the facility after hospitalization, whether or not the residence of the participant or beneficiary after returning from the hospital is the same part of the facility in which the beneficiary resided prior to hospitalization;

''(3) the continuing care retirement community, skilled nursing facility, or other qualified facility has the capacity to provide the services the participant or beneficiary needs; and

''(4) the continuing care retirement community, skilled nursing facility, or other qualified facility is willing to accept substantially similar payment under the same terms and conditions that apply to similarly situated health care facility providers under contract with the organization involved.

''(c) SERVICES TO PREVENT HOSPITALIZATION.—A group health plan or health insurance issuer to which this section applies may not deny payment for a skilled nursing service provided to a participant or beneficiary by a continuing care retirement community, skilled nursing facility, or other qualified facility in which the participant or beneficiary resides, without a preceding hospital stay, regardless of whether the organization is under contract with such community or facility, if—

''(1) the plan or issuer has determined that the service is necessary to prevent the hospitalization of the participant or beneficiary; and

''(2) the service to prevent hospitalization is provided as an additional benefit as described in section 417.594 of title 42, Code of Federal Regulations, and would otherwise be covered as provided for in subsection (b)(1).

''(d) RIGHTS OF SPOUSES.—A group health plan or health insurance issuer to which this section applies shall not deny payment for services provided by a skilled nursing facility for the care of a participant or beneficiary, regardless of whether the plan or issuer is under contract with such facility, if the spouse of the participant or beneficiary is already a resident of such facility and the requirements described in subsection (b) are met.

''(e) EXCEPTIONS.—Subsection (a) shall not apply—

''(1) where the attending acute care provider and the participant or beneficiary (or a designated representative of the participant or beneficiary where the participant or beneficiary is physically or mentally incapable of making an election under this paragraph) do not elect to pursue a course of treatment necessitating continuing care; or

''(2) unless the community or facility involved—

''(A) meets all applicable licensing and certification requirements of the State in which it is located; and

''(B) agrees to reimbursement for the care of the participant or beneficiary at a rate similar to the rate negotiated by the managed care organization with similar providers of care for similar services.

''(f) PROHIBITIONS.—A group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan may not—

''(1) deny to an individual eligibility, or continued eligibility, to enroll or to renew coverage with a managed care organization under the plan, solely for the purpose of avoiding the requirements of this section;

''(2) provide monetary payments or rebates to enrollees to encourage such enrollees to accept less than the minimum protections available under this section;

''(3) penalize or otherwise reduce or limit the reimbursement of an attending physician because such physician provided care to a participant or beneficiary in accordance with this section; or

''(4) provide incentives (monetary or otherwise) to an attending physician to induce such physician to provide care to a participant or beneficiary in a manner inconsistent with this section.

''(g) RULES OF CONSTRUCTION.—

''(1) HMO NOT OFFERING BENEFITS.—This section shall not apply with respect to any managed care organization under a group health plan, or through a health insurance issuer providing health insurance coverage in connection with a group health plan, that does not provide benefits for stays in a continuing care retirement community, skilled nursing facility, or other qualified facility.

''(2) COST-SHARING.—Nothing in this section shall be construed as preventing a managed care organization under a group health plan, or through a health insurance issuer providing health insurance coverage in connection with a group health plan, from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for care in a continuing care facility.

''(h) PREEMPTION; EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

''(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage to the extent that a State law (as defined in section 2723(d)(1) of the Public Health Service Act) applies to such coverage and is described in any of the following subparagraphs:

''(A) Such State law requires such coverage to provide for referral to a continuing care retirement community, skilled nursing facility, or other qualified facility in a manner that is more protective of participants or beneficiaries than the provisions of this section.

''(B) Such State law expands the range of services or facilities covered under this section and is otherwise more protective of the rights of participants or beneficiaries than the provisions of this section.

''(2) CONSTRUCTION.—Section 731(a)(1) shall not be construed to provide that any requirement of this section applies with respect to health insurance coverage, to the extent that a State law described in paragraph (1) applies to such coverage.

''(i) PENALTIES.—A participant or beneficiary may enforce the provisions of this section in an appropriate Federal district court. An action for injunctive relief or damages may be commenced on behalf of the participant or beneficiary by the participant's or beneficiary's legal representative. The court may award reasonable attorneys' fees to the prevailing party. If a beneficiary dies before conclusion of an action under this section, the action may be maintained by a representative of the participant's or beneficiary's estate.

''(j) DEFINITIONS.—In this section:

''(1) ATTENDING ACUTE CARE PROVIDER.—The term 'attending acute care provider' means anyone licensed or certified under State law to provide health care services who is operating within the scope of such license and who is primarily responsible for the care of the enrollee.

''(2) CONTINUING CARE RETIREMENT COMMUNITY.—The term 'continuing care retirement community' means an organization that provides or arranges for the provision of housing and health-related services to an older person under an agreement effective for the life of the person or for a specified period greater than 1 year.

''(3) MANAGED CARE ORGANIZATION.—The term 'managed care organization' means an organization that provides comprehensive health services to participants or beneficiaries, directly or under contract or other agreement, on a prepayment basis to such individuals. For purposes of this section, the following shall be considered as managed care organizations:

''(A) A Medicare+Choice plan authorized under section 1851(a) of the Social Security Act (42 U.S.C. 1395w–21(a)).

''(B) Any other entity that manages the cost, utilization, and delivery of health care through the use of predetermined periodic payments to health care providers employed by or under contract or other agreement, directly or indirectly, with the entity.

''(4) OTHER QUALIFIED FACILITY.—The term 'other qualified facility' means any facility that can provide the services required by the participant or beneficiary consistent with State and Federal law.

''(5) SKILLED NURSING FACILITY.—The term 'skilled nursing facility' means a facility that meets the requirements of section 1819 of the Social Security Act (42 U.S.C. 1395i–3).''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the items relating to subpart B of part 7 of subtitle B of title I the following new item:

''Sec. 714. Ensuring choice for continuing care.''.

(3) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2001.

(b) AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.—

(1) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–4 et seq.) is amended by adding at the end the following new section:

''SEC. 2707. ENSURING CHOICE FOR CONTINUING CARE.

''(a) IN GENERAL.—With respect to health insurance coverage provided to enrollees through a managed care organization under a group health plan, or through a health insurance issuer providing health insurance coverage in connection with a group health plan, such plan or issuer may not deny coverage for services provided to such enrollee by a continuing care retirement community, skilled nursing facility, or other qualified facility in which the enrollee resided prior to a hospitalization, regardless of whether such organization is under contract with such community or facility if the requirements described in subsection (b) are met.

''(b) REQUIREMENTS.—The requirements of this subsection are that—

''(1) the service involved is a service for which the managed care organization involved would be required to provide or pay for under its contract with the enrollee if the continuing care retirement community, skilled nursing facility, or other qualified facility were under contract with the organization;

''(2) the enrollee involved—

''(A) resided in the continuing care retirement community, skilled nursing facility, or other qualified facility prior to being hospitalized;

''(B) had a contractual or other right to return to the facility after hospitalization; and

''(C) elects to return to the facility after hospitalization, whether or not the residence of the enrollee after returning from the hospital is the same part of the facility in which the beneficiary resided prior to hospitalization;

''(3) the continuing care retirement community, skilled nursing facility, or other qualified facility has the capacity to provide the services the enrollee needs; and

''(4) the continuing care retirement community, skilled nursing facility, or other qualified facility is willing to accept substantially similar payment under the same terms and conditions that apply to similarly situated health care facility providers under contract with the organization involved.

''(c) SERVICES TO PREVENT HOSPITALIZATION.—A group health plan or health insurance issuer to which this section applies may not deny payment for a skilled nursing service provided to an enrollee by a continuing care retirement community, skilled nursing facility, or other qualified facility in which the enrollee resides, without a preceding hospital stay, regardless of whether the plan or issuer is under contract with such community or facility, if—

''(1) the plan or issuer has determined that the service is necessary to prevent the hospitalization of the enrollee; and

''(2) the service to prevent hospitalization is provided as an additional benefit as described in section 417.594 of title 42, Code of Federal Regulations, and would be covered as provided for in subsection (b)(1).

''(d) RIGHTS OF SPOUSES.—A group health plan or health insurance issuer to which this section applies shall not deny payment for services provided by a skilled nursing facility for the care of an enrollee, regardless of whether the plan or issuer is under contract with such facility, if the spouse of the enrollee is already a resident of such facility and the requirements described in subsection (b) are met.

''(e) EXCEPTIONS.—Subsection (a) shall not apply—

''(1) where the attending acute care provider and the enrollee (or a designated representative of the enrollee where the enrollee is physically or mentally incapable of making an election under this paragraph) do not elect to pursue a course of treatment necessitating continuing care; or

''(2) unless the community or facility involved—

''(A) meets all applicable licensing and certification requirements of the State in which it is located; and

''(B) agrees to reimbursement for the care of the enrollee at a rate similar to the rate negotiated by the managed care organization with similar providers of care for similar services.

''(f) PROHIBITIONS.—A group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan may not—

''(1) deny to an individual eligibility, or continued eligibility, to enroll or to renew coverage with a managed care organization under the plan, solely for the purpose of avoiding the requirements of this section;

''(2) provide monetary payments or rebates to enrollees to encourage such enrollees to accept less than the minimum protections available under this section;

''(3) penalize or otherwise reduce or limit the reimbursement of an attending physician because such physician provided care to an enrollee in accordance with this section; or

''(4) provide incentives (monetary or otherwise) to an attending physician to induce such physician to provide care to an enrollee in a manner inconsistent with this section.

''(g) RULES OF CONSTRUCTION.—

''(1) HMO NOT OFFERING BENEFITS.—This section shall not apply with respect to any managed care organization under a group health plan, or through a health insurance issuer providing health insurance coverage in connection with a group health plan, that does not provide benefits for stays in a continuing care retirement community, skilled nursing facility, or other qualified facility.

''(2) COST-SHARING.—Nothing in this section shall be construed as preventing a managed care organization under a group health plan, or through a health insurance issuer

providing health insurance coverage in connection with a group health plan, from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for care in a continuing care facility.

''(h) PREEMPTION; EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

''(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage to the extent that a State law (as defined in section 2723(d)(1)) applies to such coverage and is described in any of the following subparagraphs:

''(A) Such State law requires such coverage to provide for referral to a continuing care retirement community, skilled nursing facility, or other qualified facility in a manner that is more protective of the enrollee than the provisions of this section.

''(B) Such State law expands the range of services or facilities covered under this section and is otherwise more protective of enrollee rights than the provisions of this section.

''(2) CONSTRUCTION.—Section 2723(a)(1) shall not be construed to provide that any requirement of this section applies with respect to health insurance coverage, to the extent that a State law described in paragraph (1) applies to such coverage.

''(i) PENALTIES.—An enrollee may enforce the provisions of this section in an appropriate Federal district court. An action for injunctive relief or damages may be commenced on behalf of the enrollee by the enrollee's legal representative. The court may award reasonable attorneys' fees to the prevailing party. If a beneficiary dies before conclusion of an action under this section, the action may be maintained by a representative of the enrollee's estate.

''(j) DEFINITIONS.—In this section:

''(1) ATTENDING ACUTE CARE PROVIDER.—The term 'attending acute care provider' means anyone licensed or certified under State law to provide health care services who is operating within the scope of such license and who is primarily responsible for the care of the enrollee.

''(2) CONTINUING CARE RETIREMENT COMMUNITY.—The term 'continuing care retirement community' means an organization that provides or arranges for the provision of housing and health-related services to an older person under an agreement effective for the life of the person or for a specified period greater than 1 year.

''(3) MANAGED CARE ORGANIZATION.—The term 'managed care organization' means an organization that provides comprehensive health services to enrollees, directly or under contract or other agreement, on a prepayment basis to such individuals. For purposes of this section, the following shall be considered as managed care organizations:

''(A) A Medicare+Choice plan authorized under section 1851(a) of the Social Security Act (42 U.S.C. 1395w–21(a)).

''(B) Any other entity that manages the cost, utilization, and delivery of health care through the use of predetermined periodic payments to health care providers employed by or under contract or other agreement, directly or indirectly, with the entity.

''(4) OTHER QUALIFIED FACILITY.—The term 'other qualified facility' means any facility that can provide the services required by the enrollee consistent with State and Federal law.

''(5) SKILLED NURSING FACILITY.—The term 'skilled nursing facility' means a facility that meets the requirements of section 1819 of the Social Security Act (42 U.S.C. 1395i–3).''.

(2) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 2001.

(c) AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE INDIVIDUAL MARKET.—

(1) IN GENERAL.—The first subpart 3 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–51 et seq.) (relating to other requirements) is amended—

(A) by redesignating such subpart as subpart 2; and

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

''SEC. 2753. ENSURING CHOICE FOR CONTINUING CARE.

''The provisions of section 2707 shall apply to health maintenance organization coverage offered by a health insurance issuer in the individual market in the same manner as they apply to such coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.''.

(2) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 2001.

SEC. 805. GRANTS TO DEVELOP AND ESTABLISH REAL CHOICE SYSTEMS CHANGE INITIATIVES.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall award grants described in subsection (b) to States to support real choice systems change initiatives that establish specific action steps and specific timetables to achieve enduring system improvements and to provide consumer-responsive long-term services and supports to eligible individuals in the most integrated setting appropriate based on the unique strengths and needs of the individual, the priorities and concerns of the individual (or, as appropriate, the individual's representative), and the individual's desires with regard to participation in community life.

(2) ELIGIBILITY.—To be eligible for a grant under this section, a State shall—

(A) establish a Consumer Task Force in accordance with subsection (d); and

(B) submit an application at such time, in such manner, and containing such information as the Secretary may determine. The application shall be jointly developed and signed by the designated State official and the chairperson of such Task Force, acting on behalf of and at the direction of the Task Force.

(3) DEFINITION OF STATE.—In this section, the term ''State'' means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the United States Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(b) GRANTS FOR REAL CHOICE SYSTEMS CHANGE INITIATIVES.—

(1) IN GENERAL.—From funds appropriated under subsection (f), the Secretary shall award grants to States to—

(A) support the establishment, implementation, and operation of the State real choice systems change initiatives described in subsection (a); and

(B) conduct outreach campaigns regarding the existence of such initiatives.

(2) DETERMINATION OF AWARDS; STATE ALLOTMENTS.—The Secretary shall develop a formula for the distribution of funds to States for each fiscal year under subsection (a). Such formula shall give preference to States that have a higher need for assistance, as determined by the Secretary, based on indicators such as a relatively higher proportion of long-term services and supports furnished to individuals in an institutional setting but who have a plan described in an application submitted under subsection (a)(2).

(c) AUTHORIZED ACTIVITIES.—A State that receives a grant under this section shall use the funds made available through the grant to accomplish the purposes described in subsection (a) and, in accomplishing such purposes, may carry out any of the following systems change activities:

(1) NEEDS ASSESSMENT AND DATA GATHERING.—The State may use funds to conduct a statewide needs assessment that may be based on data in existence on the date on which the assessment is initiated and may include information about the number of individuals within the State who are receiving long-term services and supports in unnecessarily segregated settings, the nature and extent to which current programs respond to the preferences of individuals with disabilities to receive services in home and community-based settings as well as in institutional settings, and the expected change in demand for services provided in home and community settings as well as institutional settings.

(2) INSTITUTIONAL BIAS: REMEDIES AND PROMOTION OF COMMUNITY PARTICIPATION.—The State may use funds to identify, develop, and implement strategies for modifying policies, practices, and procedures that unnecessarily bias the provision of long-term services and supports toward institutional settings and away from home and community-based settings, including policies, practices, and procedures governing statewideness, comparability in amount, duration, and scope of services, financial eligibility, individualized functional assessments and screenings (including individual and family involvement), knowledge about service options, and promotion of self-direction of services and community-integrated living and service arrangements that facilitate participation in community life to the fullest extent possible and desired by the individual.

(3) OVER MEDICALIZATION OF SERVICES.—The State may use funds to identify, develop, and implement strategies for modifying policies, practices, and procedures that unnecessarily bias the provision of long-term services and supports by health care professionals to the extent that quality services and supports can be provided by other qualified individuals, including policies, practices, and procedures governing service authorization, case management, and service coordination, service delivery options, quality controls, and supervision and training.

(4) INTERAGENCY COORDINATION; SINGLE POINT OF ENTRY.—The State may support activities to identify and coordinate Federal and State policies, resources, and services, relating to the provision of long-term services and supports, including the convening of interagency work groups and the entering into of interagency agreements that provide for a single point of entry with one-stop access for long-term support services and the design and implementation of a coordinated screening and assessment system for all persons eligible for long-term services and supports.

(5) TRAINING AND TECHNICAL ASSISTANCE.—The State may carry out directly, or may provide support to a public or private entity to carry out training and technical assistance activities that are provided for individuals with disabilities, and, as appropriate, their representatives, attendants, and other personnel (including professionals, paraprofessionals, volunteers, and other members of the community).

(6) PUBLIC AWARENESS.—The State may support a public awareness program that is designed to provide information relating to the availability of choices available to individuals with disabilities for receiving long-

term services and support in the most integrated setting appropriate.

(7) TRANSITIONAL COSTS.—The State may use funds to provide transitional costs such as rent and utility deposits, first months's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from an institutional facility to a community-based home setting where the individual resides.

(8) TASK FORCE.—The State may use funds to support the operation of the Consumer Task Force established under subsection (d).

(9) DEMONSTRATIONS OF NEW APPROACHES.—The State may use funds to conduct, on a time-limited basis, the demonstration of new approaches to accomplishing the purposes described in subsection (a)(1).

(10) IMPROVEMENT IN THE QUALITY OF SERVICES AND SUPPORTS.—The State may use funds to improve the quality of services and supports provided to individuals with disabilities and their families.

(11) OTHER ACTIVITIES.—The State may use funds for any systems change activities that are not described in any of the preceding paragraphs of this subsection and that are necessary for developing, implementing, or evaluating the comprehensive statewide system of community-integrated long-term services and supports.

(d) CONSUMER TASK FORCE.—

(1) ESTABLISHMENT AND DUTIES.—To be eligible to receive a grant under this section, each State shall establish a Consumer Task Force (referred to in this section as the ''Task Force'') to assist the State in the development, implementation, and evaluation of real choice systems change initiatives.

(2) APPOINTMENT.—Members of the Task Force shall be appointed by the Chief Executive Officer of the State in accordance with the requirements of paragraph (3), after the solicitation of recommendations from representatives of organizations representing a broad range of individuals with disabilities and organizations interested in individuals with disabilities.

(3) COMPOSITION.—

(A) IN GENERAL.—The Task Force shall represent a broad range of individuals with disabilities from diverse backgrounds and shall include representatives from Developmental Disabilities Councils, Mental Health Councils, State Independent Living Centers and Councils, Commissions on Aging, organizations that provide services to individuals with disabilities and consumers of long-term services and supports.

(B) INDIVIDUALS WITH DISABILITIES.—A majority of the members of the Task Force shall be individuals with disabilities or the representatives of such individuals.

(C) LIMITATION.—The Task Force shall not include employees of any State agency providing services to individuals with disabilities other than employees of agencies described in the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6000 et seq.) or the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10801 et seq.).

(e) AVAILABILITY OF FUNDS.—

(1) FUNDS ALLOTTED TO STATES.—Funds allotted to a State under a grant made under this section for a fiscal year shall remain available until expended.

(2) FUNDS NOT ALLOTTED TO STATES.—Funds not allotted to States in the fiscal year for which they are appropriated shall remain available in succeeding fiscal years for allotment by the Secretary using the allotment formula established by the Secretary under subsection (b)(2).

(f) ANNUAL REPORT.—A State that receives a grant under this section shall submit an annual report to the Secretary on the use of funds provided under the grant. Each report shall include the number and percentage increase in the number of eligible individuals in the State who receive long-term services and supports in the most integrated setting appropriate, including through community attendant services and supports and other community-based settings.

(g) FUNDING.—

(1) FISCAL YEAR 2001.—For the purpose of making grants under this section, there are appropriated, out of any funds in the Treasury not otherwise appropriated, $50,000,000 for fiscal year 2001.

(2) FISCAL YEAR 2002 AND THEREAFTER.—There is authorized to be appropriated such sums as may be necessary to carry out this section for fiscal year 2002 and each fiscal year thereafter.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

BALANCED BUDGET REFINEMENT ACT OF 2000—SUMMARY

The Balanced Budget Act (BBA) of 1997 made some important changes in Medicare payment policy and contributed to our current period of budget surpluses through significant cost savings in Medicare. CBO originally estimated the Medicare spending cuts at $112 billion over 5 years. Some of the policies enacted in the BBA, however, cut payments to providers more significantly than expected—in some cases more than double the expected amount—and threaten the survival of institutions and services vital to seniors and their communities throughout the country.

The Congress addressed some of those unintended consequences last year, by enacting the Balanced Budget Refinement Act (BBRA), which added back $16 billion over 5 years in payments to various Medicare providers.

However, Congress is continuing to hear serious concerns from health care providers and beneficiaries in our States—particularly teaching hospitals and hospitals serving people who are uninsured or underinsured, as well as concerns from skilled nursing facilities, rural health providers, home health agencies, and Medicare managed care providers.

In light of the projected $700 billion on-budget surplus over the next 5 years and the problems facing vital health care services, the Congress should enact an additional, significant package of BBA adjustments and beneficiary protections. Senate Democrats are therefore today introducing the Balanced Budget Refinement Act of 2000 (BBRA–2000), which is a package of payment adjustments and access to care provisions amounting to about $40 billion over 5 years.

Hospitals. A significant portion of the BBA spending reductions have impacted hospitals. According to the Medicare Payment Advisory Commission (MedPAC), ''Hospitals' financial status deteriorated significantly in 1998 and 1999,'' the years following enactment of BBA. BBRA–2000 would address the most pressing problems facing hospitals by:

Fully restoring, for fiscal years '01 and '02, inpatient market basket payments to keep up with increases in hospital costs, an improvement that will help all hospitals.

Preventing implementation of further reductions in (IME) payment rates for vital teaching hospitals—which are on the cutting edge of medical research and provide essential care to a large proportion of indigent patients. Support for medical training and research at independent children's hospitals is also included in the Democratic proposal.

Targeting additional relief to rural hospitals (Critical Access Hospitals, Medicare Dependent Hospitals, and Sole Community Hospitals) and making it easier for them to qualify for disproportionate share payments under Medicare.

Providing additional support for hospitals with a disproportionate share of indigent patients, including elimination of scheduled reductions in Medicare and Medicaid disproportionate share (DSH) payments, and extending Medicaid to legal immigrant children and pregnant women, as well as providing State Children's Health Insurance Program (SCHIP) coverage to these children.

Establishing a grant program to assist hospitals in their transition to a more data intensive care-delivery model.

Providing Puerto Rico hospitals with a more favorable payment rate (specifically, the inpatient operating blend rate) as MedPAC data suggests is warranted.

Home Health. The BBA hit home agencies particularly hard. Home health spending dropped 45 percent between 1997 and 1999, while the number of home health declined by more than 2000 over that period. MedPAC has cautioned against implementing next year the scheduled 15 percent reduction in payments. BBRA–2000 would:

Repeal the scheduled 15 percent cut in home health payments, delay for at least two years the inclusion of medical supplies in the home health prospective payment system (PPS), and provide a 10-percent upward adjustment in rural home health payments for two years to address the special needs of rural home health agencies in the transition to PPS. BBRA-2000 would also provide an exception for ''very rural'' home health agencies under the branch office definition.

Provide full update payments (inflation) for medical equipment, oxygen, and other suppliers.

Skilled Nursing Facilities (SNFs). The BBA was expected to reduce payments to skilled nursing facilities by about $9.5 billion. The actual reduction in payments to SNFs over the period is estimated to be significantly larger. BBRA–2000 would:

Allow nursing home payments to keep up with increases in costs through a full market basket update for SNFs for FY 2001 and FY 2002, and market basket plus two percent for additional payments.

Further delay caps on the amount of physical/speech therapy and occupational therapy a patient can receive while the Secretary completes a scheduled study on this issue.

Rural. Rural providers typically serve a larger proportion of Medicare beneficiaries and are more adversely affected by reductions in Medicare payments. In addition to the rural relief measures noted above (under ''hospitals''), BBRA–2000 addresses the unique situation faced in rural areas through a number of measures, including: a permanent ''hold-harmless'' exemption for small rural hospitals from the Medicare Outpatient PPS; assistance for rural home health agencies; a capital loan fund to improve infrastructure of small rural facilities; assistance to develop technology related to new prospective payment systems; bonus payments for providers who serve independent hospitals; ensuring rural facilities can continue to offer quality lab services to beneficiaries; and specific provisions to assist Rural Health Clinics.

Hospice. Payments to hospices have not kept up with the cost of providing care because of the cost of prescription drugs, the therapies now used in end-of-life care, as well as decreasing lengths of stay. Hospice base rates have not been increased since 1989. BBRA–220 would provide significant additional funding for hospice services to account for their increasing costs, including full market basket updates for fiscal years '01 and '02 and a 10-percent upward adjustment in the underlying hospice rates.

Medicare+Choice. This legislation would ensure that appropriate payments are made to Medicare+Choice (M+C) plans. Expenditures by Medicare for its fee-for-service providers included in BBRA–2000 indirectly benefit M+C plans to a significant extent. Moreover, the legislation includes an increase in the M+C growth percentage for fiscal years '01 and '02, permitting plans to move to the 50:50 blended payment one year earlier, and allowing plans which have decided to withdraw to reconsider by November 2000.

Physicians. Congress understands the pressures that physicians face to deliver high-quality care while still complying with payment and other regulatory obligations. BBRA–2000 provides for comprehensive studies of issues important to physicians, including: the practice expense component of the Resource-Based Relative Value Scale (RBRVS) physician payment system, post-payment audits, and regulatory burdens. BBRA–2000 would provide relief to physicians in training, whose debt can often be crushing, by lowering the threshold for loan deferment from $72,000 to $48,000.

Beneficiary Improvements. Senate Democrats continue to believe that passage of a universal, affordable, voluntary, and meaningful Medicare prescription drug benefit is the highest priority for beneficiaries. In addition, BBRA–2000 would directly assist beneficiaries in the following ways:

Coinsurance: BBRA–2000 would lower beneficiary coinsurance to achieve a true 20 percent beneficiary copayment for all hospital outpatient services within 20 years.

Preventive Benefits: The bill would provide for significant advances in preventive medicine for Medicare beneficiaries, including waiver of deductibles and cost-sharing, glaucoma screening, counseling for smoking cessation, and nutrition therapy.

Immunosuppressive Drugs: The bill would remove current restrictions on payment for immunosuppressive drugs for organ transplant patients.

ALS: The bill would waive the 24-month waiting period for Medicare disability coverage for individuals diagnosed with amyotrophic lateral sclerosis (ALS).

M+C Transition: For beneficiaries who have lost Medicare+Choice plans in their area, BBRA–2000 includes provisions that would strengthen fee-for-service Medicare and assist beneficiaries in the period immediately following loss of service.

Return-to-home: The bill would allow beneficiaries to return to the same nursing home or other appropriate site-of-care after a hospital stay.

Other Provisions. BBRA–2000 would address other high priority issues, including: improved payment for dialysis in fee-for-service and M+C to assure access to quality care for end stage renal disease (ESRD) patients; increased market basket updates for ambulance providers in fiscal years '01 and '02; an immediate opt-in to the new ambulance fee schedule for affected providers; and enhanced training opportunities for geriatricians and clinical psychologists. BBRA–2000 also includes important modifications to the Community Nursing Organization (CNO) demonstration project, and additional funding for the Ricky Ray Hemophilia program

Medicaid and SCHIP. The growing number of uninsured individuals and declining enrollment in the Medicaid program are issues which also must be addressed. To improve access to health care for the uninsured and ensure that services available through the Medicaid and SCHIP programs are reaching those eligible for assistance, BBRA–2000 includes the following provisions:

Improve eligibility and enrollment processes in SCHIP and Medicaid.

Extend and improve the Transitional Medical Assistance program for people who leave welfare for work.

Improve access to Medicare cost-sharing assistance for low-income beneficiaries.

Give states grants to develop home and community based services for beneficiaries who would otherwise be in nursing homes.

Create a new prospective payment system (PPS) for Community Health Centers to ensure they remain a strong, viable component of our health care safety net.

Extend Medicaid coverage of breast and cervical cancer treatment to women diagnosed through the federally-funded early detection program.

NATIONAL IMMIGRATION LAW CENTER,
Washington, DC, September 20, 2000.

Hon. DANIEL PATRICK MOYNIHAN,
464 Senate Russell Office Building,
Washington, DC.

DEAR SENATOR MOYNIHAN: We strongly applaud your decision to include important health care restorations for low-income immigrant children and pregnant women in the Senate Democrat's Balanced Budget Act Refinement and Access to Care proposal. The provisions would permit federal reimbursement to states that choose to cover lawfully present children and pregnant women under their Medicaid and State Children's Health Insurance Programs.

As you know, legislation passed in 1996, at a time of very tight budgets, left the safety net for legal immigrants in tatters. As a result, health dare coverage for low-income lawfully present immigrant children and pregnant women has become a state-by-state patchwork, with tragic results. In many states, there is no coverage at all for large numbers of these children and pregnant women.

The policy of denying federal health care to lawfully present immigrants is unfair and unwise. It is unfair because immigrants pay the same taxes as all others, and deserve the same access to health care that those taxes buy. In fact, immigrant taxes are more than sufficient to pay for the health care needs and all other expenses associated with immigration. The average immigrant contributes $1,800 more each year in taxes than the government pays out for her, including the costs of roads, infrastructure, and education, as well as all government services.

The policy is unwise because we are counting on these immigrant children to join with all other children in contributing to the American dream. They cannot do so if they are hindered in their early years because they could not obtain health care. And it is unwise because it shifts the responsibility for immigrant health care from the federal to the state governments, rather than maintain a shared federal-state responsibility.

The Balanced Budget Act Refinement and Access to Care proposal recognizes that some of the cuts to health care providers made in the name of balancing the budget went too far. In this time of surpluses, as Congress considers proposals to eliminate the excesses of those budget cuts on behalf of health care providers, Congress should also restore services to lawfully present immigrant children and pregnant women who sacrificed as much as anyone under the budget balancing legislation of the 1990's.

Sincerely,

Asian Pacific American Labor Alliance, Alliance for Children and Families, American College Obstetricians and Gynecologists, Center for Public Policy Priorities, Children's Defense Fund, Coalition for Humane Immigrant Rights of Los Angeles, Council of Great City Schools, Families USA, Florida Immigrant Advocacy Center, Inc., Florida Legal Services, Inc., Hebrew Immigrant Aid Society, Immigrant Legal Resource Center, Immigration and Refugee Services of America, Jewish Federation of Metro Chicago, Jewish Council for Public Affairs, March of Dimes, Migrant Legal Action Program, National Asian Pacific American Legal Consortium, National Association of Public Hospitals and Health Systems, National Council of La Raza, National Head Start Association, National Health Law Program, National Korean American Service & Education Consortium (NAKASEC), National Immigration Law Center, New Jersey Immigration Policy Network, Inc., New York Immigration Coalition, Massachusetts Immigrant and Refugee Advocacy Coalition, Southeast Asia Resource Action Center, Texas Appleseed, Texas Immigrant and Refugee Coalition, and United Jewish Communities.

NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS,
Washington DC, September 20, 2000.

DEAR SENATOR MOYNIHAN: I am writing on behalf of the National Association of Public Hospitals & Health Systems (NAPH) to express our strong support for the ''Medicare, Medicaid, and SCHIP Balanced Budget Further Refinement Act of 2000.'' NAPH represents more than 100 metropolitan area safety net hospitals and health systems. As safety net institutions, our members are essential providers of care to uninsured and vulnerable populations whose access would otherwise be severely limited. More than 65 percent of the patients served by these systems are either Medicaid recipients or Medicare beneficiaries; another 25 percent are uninsured.

NAPH is pleased that this legislation includes a number of provisions that will assist low-income Medicaid beneficiaries and the providers that serve them. In particular, we are pleased that the legislation would avert Medicaid DSH allotment reductions after fiscal year 2000 otherwise required by the BBA. Medicaid DSH is our nation's primary source of support for safety net hospitals that serve the most vulnerable Medicaid, uninsured and underinsured patients.

NAPH has long been supportive of efforts to expand access to health insurance coverage and is pleased that the legislation includes a number of these provisions. In particular, the proposed legislation would allow states the option to provide coverage under Medicaid and/or SCHIP for legal immigrants, which will reduce confusion regarding eligibility in the immigrant community, allow legal immigrants to receive more appropriate care, and improve public health in general. The legislation also includes a state option to provide Medicaid coverage for certain women diagnosed with breast or cervical cancer and provides requirements designed to simplify Medicaid eligibility. We are grateful for your efforts to expand Medicaid and SCHIP to ensure that all low-income Americans have access to appropriate health coverage.

NAPH is also pleased that the legislation addresses many of the severe payment reductions in many areas (in addition to Medicaid DSH) imposed by the BBA on providers. In particular, NAPH is pleased that the legislation eliminates further Medicare DSH reductions, freezes IME adjustments, and restores the full market basket index update to hospital PPS rates beginning April, 2001.

We thank you for your ongoing leadership in developing legislation to assure the maintenance of the health care safety net and we look forward to working with you further to develop solutions to the problems of our nation's poor and uninsured. If you have any

questions about this letter, please contact Charles Luband at (202) 624–7215.

Sincerely,

LARRY S. GAGE,
President.

FAMILIES USA, THE VOICE FOR HEALTH CARE CONSUMERS,
September 20, 2000.

Senator PATRICK MOYNIHAN,
464 Russell Senate Office Building,
Washington, DC.

DEAR SENATOR MOYNIHAN: As you introduce the Medicare, Medicaid and SCHIP Balanced Budget Further Refinement Act of 2000, we want to support a number of provisions that will improve low-income people's access to health care coverage. In particular, we support the expansion of Medicaid to certain immigrant children and pregnant women, the improvements for Medicaid adults and children, the changes which will ease enrollment for children who may be eligible for Medicaid and the State Child Health Insurance Program and the changes which will help low-income seniors who may be eligible for the Qualified Medicare Beneficiary (QMB) Program and the Specified Low-Income Medicare Beneficiary (SLMB) Program receive assistance in getting help with Medicare premiums and cost-sharing.

As you well know, despite the concerted efforts of many people, the number of uninsured Americans has continued to grow. Recent studies have shown that uninsured Americans are less likely to have a usual source of care, are more likely to delay seeking care, and are less likely to use preventive services. In addition, uninsured Americans are four times more likely than insured patients to require both avoidable hospitalizations and emergency hospital care.

These provisions will help more people get access to public health insurance programs. Please let us know if we can be of assistance in getting these provisions enacted into law.

Sincerely,

RONALD F. POLLACK,
Executive Director.

ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAMS,
September 20, 2000.

Hon. DANIEL PATRICK MOYNIHAN,
U.S. Senate,
Washington, DC.

DEAR SENATOR MOYNIHAN: The Association of Maternal and Child Health Programs (AMCHP) strongly supports your efforts to further refine the Balanced Budget Act of 1997 (BBA) and increase access to health care. In particular, we commend your leadership over the years in improving our nation's fiscal health. Through this visionary leadership, the nation now has a projected $2.2 trillion on-budget surplus over the next 10 years. It is both appropriate and fair that a portion of this surplus should help offset severe problems facing our health care services.

AMCHP strongly supports efforts included in your legislation to improve access to health care for many uninsured people including legal immigrant children and pregnant women. In addition, we applaud efforts to improve eligibility and enrollment processes in SCHIP and Medicaid. AMCHP and its members want to particularly thank you for your support of enhanced coordination and cooperation among the various health care programs aimed at improving maternal and child health and for your efforts to increase the authorization level for Title V.

The Association of Maternal and Child Health Programs is an organization dedicated to providing leadership in assuring the health and well being of all women of reproductive age, children and youth, including those with special health care needs and their families. The state directors of Title V and related programs formed the association in 1944 to share information and collaborate with each other and others concerned with the health of mothers and children.

In closing, thank you for your most recent efforts on behalf of maternal and child health through the introduction of legislation intended to further refine the BBA and improve access to health care.

Very truly yours,

DEBORAH F. DIETRICH,
Director of Legislative Affairs.

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC.,
September 20, 2000.

Hon. TOM DASCHLE,
Democratic Leader, U.S. Senate,
Washington, DC.

Hon. DANIEL PATRICK MOYNIHAN,
Ranking Member, Senate Finance Committee,
Washington, DC.

DEAR SENATORS DASCHLE AND MOYNIHAN: On behalf of the National Association of Community Health Centers (NACHC), the nationwide network of 3,000 health centers, and the more than 11 million patients they serve, I am writing to express our extreme gratitude for your inclusion of the text of S. 1277, the Safety Net Preservation act, in your legislation to provide relief from the Balanced Budget Act of 1997 (BBA).

As you know, the BBA eliminated a fundamental underpinning of America's health center safety net by phasing-out and eventually terminating the Medicaid cost-based reimbursement system for Federally qualified health centers. Because health centers are required by Federal law to provide access to care to anyone, regardless of ability to pay, centers cannot afford to be underpaid for services provided to Medicaid patients. In other words, without this payment system, health centers will be forced to subsidize low Medicaid payments with grant dollars intended to care for the uninsured—thereby forcing them to reduce the health care services they provide in their communities.

In an effort to protect health centers from the loss of this system, the Safety Net Preservation Act has been introduced in the House and Senate to ensure that health centers receive adequate Medicaid payments. This legislation, which has the bipartisan support of 54 members of the Senate and 243 members of the House of Representatives, has been endorsed by NACHC, the National Association of Rural Health Clinics, the National Rural Health Association, the United States Conference of Mayors, and the National Association of Counties.

Health centers believe that this legislation is essential to their continued survival and will ensure that they remain a viable part of America's health care safety net. Thank you again for your commitment to protecting health centers through your BBA relief legislation. It is our sincerest hope that the Safety Net Preservation Act will be included in any BBA relief package and signed into law by the time the 106th Congress adjourns.

Please feel free to contact me if there is anything that I can do for you.

Sincerely,

THOMAS J. VAN COVERDEN,
President and CEO.

CENTER ON BUDGET AND POLICY PRIORITIES,
September 20, 2000.

Hon. DANIEL PATRICK MOYNIHAN,
Senate Russell Building,
Washington, DC.

DEAR SENATOR MOYNIHAN: We write to applaud your efforts to help low-income families and children access much-needed health care coverage. In particular, the Center on Budget and Policy Priorities strongly supports provisions in your ''Medicare, Medicaid, and S–CHIP Balanced Budget Refinement Act of 2000'' aimed at reversing a trend of declining access to health coverage by low-income families and immigrant children. These provisions are important because families with children have been losing out on health care coverage as a result of unanticipated consequences of recent federal and state actions.

A growing body of evidence indicates that a significant number of low-income families with children have been inadvertently harmed by federal and state laws enacted in recent years to promote welfare reform. Despite the best intentions of many policymakers, disturbing numbers of families leaving welfare for work have lost out on health care coverage. Indeed, a recent Center analysis found that roughly half of parents and nearly one out of three children leaving welfare lost Medicaid and were at high risk of being uninsured even though the vast majority of them remained eligible for Medicaid or SCHIP. Similarly, studies indicate that the Medicaid participation of children in legal immigrant families has dropped in recent years. The largest group of such children consists of those who remain eligible for Medicaid because they are citizens of the United States. These children were not the intended targets of immigration-based restrictions on Medicaid coverage included in the 1996 welfare law, but they nevertheless have been adversely affected by the confusion and fear generated by the immigration-based restrictions on health care coverage included in the 1996 welfare law and modified in the Balanced Budget Act of 1997.

For these reasons, we strongly applaud the provisions in your legislation that would undue many of the unintended consequences on health care coverage for low-income families of recent state and federal actions, as well as restore health care coverage to all legal immigrant children. In particular, we strongly support the provisions designed to promote the simplification, coordination, and streamlining of states' application and re-enrollment procedures; to expand state flexibility to allow schools and other organizations that work with families to enroll children in health care coverage under the ''presumptive eligibility'' option; to give states more flexibility to provide transitional Medicaid coverage to families leaving welfare for work; and to restore state flexibility to cover legal immigrant children and pregnant women who arrived in the United States after August 22, 1996. In combination, these provisions would represent a very significant step forward.

Sincerely,

ROBERT GREENSTEIN,
Executive Director.

THE NATIONAL COUNCIL ON THE AGING,
Washington, DC, September 20, 2000.

Hon. DANIEL PATRICK MOYNIHAN,
464 Russell Senate Office Building,
Washington, DC.

DEAR SENATOR MOYNIHAN: On behalf of the National Council on the Aging (NCOA)—the nation's first organization formed to represent older Americans and those who serve them—I write to express our sincere gratitude and support for the numerous provisions in your Medicare Balanced Budget Act (BBA) refinement bill that would directly help Medicare beneficiaries.

In particular, we strongly support provisions to: (1) clarify the Medicare home health ''homebound'' problem; (2) improve Medicare low-income protections; (3) improve Medicare coverage and utilization of preventive services; (4) remove the arbitrary

cap on immunosuppressive drug coverage; (5) provide grants to states for home and community-based care; and (6) accelerate the phase-in period for reducing hospital outpatient coinsurance.

First, under current law, in order for Medicare beneficiaries to receive coverage for home health services they must be ''confined to home.'' Current irrational and inconsistent interpretations of this homebound requirement are causing substantial harm to Medicare beneficiaries by effectively forcing home health users to be imprisoned within their own homes. We deeply appreciate the provision to permit beneficiaries with Alzheimer's disease or related dementia to receive therapeutic treatment in adult day centers without losing home health coverage. We urge that you consider going further by including Senator JEFFORDS' S. 2298, which is endorsed by 46 national organizations and would provide relief for all beneficiaries suffering under the homebound problem.

Second, our current methods for protecting low-income Medicare beneficiaries against increasing out-of-pocket costs are simply abysmal. A shocking number of those eligible for protection simply do not receive it. Current Medicare low-income protections are a national embarrassment. NCOA strongly supports provisions in your bill to: provide for presumptive eligibility for low-income protections; significantly improve the QI–1 program for beneficiaries with incomes between 120% and 135% of poverty; index the asset test to inflation, which is long overdue; and improve outreach for Qualified Medicare Beneficiaries.

Third, NCOA strongly supports the provisions to improve preventive care for Medicare beneficiaries. It is often easier and less expensive to prevent disease than to cure it. Disease prevention must be an essential component of Medicare beneficiaries' continuum of care. Medicare, however, still fails to cover a number of important preventive services, and those that are covered are underutilized. We support provisions to extend Medicare coverage to tobacco cessation counseling, glaucoma screening and medical nutrition therapy. The addition of these new benefits will accelerate the critical shift in Medicare from a sickness program to a wellness program. We also support the provision to eliminate all coinsurance and deductibles for preventive services. Utilization of these critical services has been surprisingly low. By encouraging greater utilization of these services, beneficiaries' quality of life will be greatly enhanced and Medicare expenditures will decline over the long run.

Fourth, NCOA supports the provision to eliminate the arbitrary and costly cap on benefits for immunosuppressive drug coverage under Medicare. The Institute of Medicine recently recommended eliminating the time limitation, noting the positive economic, clinical and social implications. It makes no sense for Medicare to pay for the more expensive consequences of organ rejection, such as dialysis or a second transplant, but refuse to pay for the drugs to prevent the rejection of the initial transplanted organ beyond 44 months. This coverage can mean the difference between life and death for some and, for others, the difference between a transplant recipient having to experience the pain of an organ rejection, a return to dialysis—for kidney recipients—and the return to a long waiting list for another organ.

Fifth, we strongly support providing grants to states for home and community-based care and to assist in implementing the Supreme Court's Olmstead decision. These services are grossly underfunded, resulting in unreasonable and costly burdens on caregivers and premature placement in institutions. Funding for home and community-based care promotes dignity and independence and helps keep families together. America's long-term care crisis will only grow worse as our population ages. The proposed grants are a good start in addressing the serious institutional bias that exists for persons with disabilities needing long-term services and supports.

Sixth, we support accelerating the phase-in period for reducing hospital outpatient coinsurance. Coinsurance for these services now averages almost 50 percent of costs. Although current law provides that coinsurance amounts will remain fixed at their current dollar level until they are reduced to 20 percent of Medicare-approved payment amounts, the process will take up to 40 years for some services. By comparison, the most gradual phase-in Medicare has used to date for any payment system change is 10 years. The current phase-in schedule is simply far too long.

NCOA commends and thanks you for your strong leadership on these important issues for America's seniors. Please let us know if there is anything we can do to assist you in enacting these provisions into law this year.

Sincerely,

HOWARD BEDLIN,
Vice President, Public Policy and Advocacy.

GREATER NEW YORK
HOSPITAL ASSOCIATION,
New York, NY, September 20, 2000.

Hon. DANIEL PATRICK MOYNIHAN,
464 Russell Senate Office Building,
Washington, DC.

DEAR SENATOR MOYNIHAN, The Greater New York Hospital Association (GNYHA) is extremely pleased to express its strong and unqualified support for your bill, ''The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 2000,'' co-sponsored by your colleagues, Senator Charles E. Schumer and Senator Tom Daschle. This bill, if enacted, would greatly improve the Medicare program for all of its beneficiaries as well as provide critical, permanent relief for America's hospitals, skilled nursing facilities, and home health agencies from Medicare reductions contained in the Balanced Budget Act of 1997 (BBA).

For beneficiaries, your legislation makes a number of important improvements in the Medicare program including new coverage for many critical preventive health care benefits. In addition, you provide an option for states to provide Medicaid and SCHIP coverage for pregnant women and children who, because they are immigrants, have been denied health care coverage due to the restrictions contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. The bill also simplifies the SCHIP enrollment process and improves SCHIP and Medicaid in a variety of other ways. GNYHA strongly supports these provisions.

Your bill also recognizes that Medicare and Medicaid beneficiaries cannot receive quality health care services unless the health care providers they rely upon have the resources to provide the best care possible. To that end, GNYHA strongly supports the following provisions.

The bill halts further Medicare reductions to teaching hospitals by maintaining the indirect medical education (IME) payment adjustment at 6.5 percent permanently, incorporating the provisions of your Teaching Hospital Preservation Act (S. 2394). As you know, the BBA called for a 29 percent reduction in Medicare payments to teaching hospitals for the indirect costs of medical education. The BBRA postponed the cuts by one year; however, under current law, the IME adjustment would be reduced to 6.25 percent in FY 2001 and 5.5 percent in FY 2002 and years thereafter. The Further Refinement Act freezes IME adjustments at 6.5 percent, saving America's teaching hospitals from over $2 billion in additional Medicare cuts. The bill also provides greater flexibility to allow hospitals to increase the number of residents training in geriatrics and allows hospitals to be reimbursed by Medicare for the costs of training clinical psychologists.

The bill provides a full market basket update for prospective payment system hospitals, nursing homes, and home health agencies for the next two years. Under the BBA, hospitals would have received market basket minus 1.1 percent in FY 2001 and FY 2002, and nursing homes and home health agencies would have received market basket minus 1 percent. The BBA reduced inflation updates so substantially that the market basket update reductions constituted the largest single cuts suffered by hospitals and continuing care providers under the BBA. This bill ensures Medicare payments will keep pace with the increased costs of caring for Medicare beneficiaries by providing full market basket updates.

This bill restores Medicare funding for disproportionate share hospitals (DSH) by eliminating cuts in DSH payments, thus strengthening the safety net DSH hospitals provide for low-income patients.

The bill eliminates further reductions in Medicare DSH payments to states, thus enabling states to provide critical support for hospitals that serve a disproportionate share of low-income and uninsured patients.

The bill creates a grant program to help hospitals obtain advanced information systems to improve quality and efficiency.

The bill eliminates the 15 percent reduction for home health reimbursement rates, which under current law would take affect in 2002.

The bill extends the ''prudent layperson'' standard to ambulance services, so that ambulance providers are not unfairly denied payment by HMOs for services legitimately provided to Medicare beneficiaries.

The Medicare, Medicaid, and SCHIP Balanced Budget Further Refinement Act of 2000 recognizes the need to improve the Medicare program by providing much-needed coverage for Medicare beneficiaries, the need to improve the Medicaid and SCHIP programs for low-income Americans, and the need to repair the damage to hospitals and continuing care providers as a result of the BBA. Without your efforts, hospitals and continuing care providers will continue to struggle to provide quality care and will be forced to close down services essential to the health care needs of their communities.

GNYHA will work diligently with members of Congress to ensure passage of this very important legislation. GNYHA would like to thank you for once again providing the strong leadership necessary to improve the health care of all New Yorkers.

My best.

Sincerely,

KENNETH E. RASKE,
President.

Mr. DASCHLE. Mr. President, I join today with Senator MOYNIHAN and many of our colleagues in introducing the Balanced Budget Refinement Act of 2000 (BBRA–2000).

The Balanced Budget Act of 1997 (BBA) made some justified changes in Medicare payment policy and contributed to our current budget surpluses. It also included important provisions to improve seniors' access to preventive benefits, and it created the Children's

Health Insurance Program. These are important accomplishments.

But some of the policies enacted in the BBA cut providers significantly more than expected. This has created severe problems for health care providers all over the country. Last year, we took steps to correct these problems. But we did not go far enough.

When I met with hospital administrators in South Dakota earlier this summer, one told me that since the cuts from the BBA were implemented, his hospital has been just barely breaking even. Usually, that alone would be cause for concern. But then other hospital administrators told me they were jealous, because they are far from breaking even. In my state, the operating margins for hospitals with 50 or fewer beds were a relatively healthy 2 percent before the BBA. Last year, these small hospitals—which are so vital to their communities—had negative margins of 6 percent.

Hospitals are not the only health care providers facing this problem. Home health agencies, nursing homes, hospices, and many other providers are all struggling to make ends meet in the face of deeper-than-expected cuts.

The package of payment adjustments that Senate Democrats are introducing today will provide a much-needed boost to these providers—totaling $80 billion over 10 years. This will ensure that Medicare beneficiaries continue to have access to the care that we have promised them.

The bill has many provisions, but I would like to highlight a few.

For hospitals, BBRA–2000 would restore the full inflation update. It would also improve payments for Disproportionate Share Hospitals (DSH) and teaching hospitals, who provide essential care for some of the neediest patients.

Our bill repeals the 15 percent cut in home health, and delays adding medical supplies to the home health prospective payment system (PPS). These fixes are essential to an industry that has seen an unprecedented drop in spending.

For skilled nursing facilities we would restore the full inflation update, with an additional two percent increase in fiscal years 2001 and 2002. We would also delay therapy caps for two additional years so that beneficiaries do not face an arbitrary limit on the amount of care they can receive.

Although the cost of providing care at the end of life has risen dramatically, the base for hospice payments has not been changed since 1989. The bill restores the full inflation update for hospice providers, and provides a ten percent upward adjustment in hospice base rates.

We are committed to ensuring that appropriate payments are made to Medicare+Choice plans. BBRA–2000 increases the growth rate in payments to these plans and allows plans to move to a 50–50 national blend one year earlier.

The bill also improves payment for ambulance providers, medical equipment suppliers, and dialysis facilities, who all provide important services to Medicare beneficiaries.

We recognize the special circumstances of rural health care providers in our bill. The rural health provisions include increasing payments for small rural hospitals, rural home health agencies, and rural ambulance providers.

There are other steps we need to take to improve beneficiaries' access to care. The bill we are introducing today includes a package of refinements to Medicare that directly help beneficiaries. For example, the bill will build on provisions in the BBA to lower beneficiary copayments and expand preventive benefits in Medicare.

We also provide for increased access to health care through improvements to Medicaid and the Children's Health Insurance Program. These include changes to the BBA, such as improving state processes for enrolling people who are eligible for Medicaid and CHIP. We also make changes to the health-related provisions of immigration and welfare reform legislation that passed in 1996. For example, the bill would extend assistance to people who leave welfare for work.

Senate Democrats continue to believe that passage of an affordable, voluntary, meaningful Medicare prescription drug benefit is of highest priority. This bill, the Balanced Budget Refinement Act of 2000, is the next step in ensuring that beneficiaries have access to the care they need.

I want to thank Senator MOYNIHAN and his staff for their hard work putting this bill together. They have spent the last two months listening to health care providers, beneficiaries, community leaders, and members of our caucus. Through that listening process they have drafted a bill that addresses the needs of the many communities that are struggling to deal with the impact of the Balanced Budget Act.

We know the problems providers are facing in health care. And we know how to fix many of them. The bill we are introducing today is a comprehensive plan to ensure the stability that health care providers need and that beneficiaries depend on. We must take this opportunity to act, before it is too late to save some of the providers who are so close to closing their doors.

Mr. KENNEDY. Mr. President, it is a privilege to join Senator DASCHLE, Senator MOYNIHAN, and other colleagues in introducing the Balanced Budget Refinement Act of 2000. This bill takes the next step in our continued effort to restore the excessive Medicare cuts in the Balanced Budget Act of 1997. This legislation also includes several proposals to ease the financial burden and improve care for all beneficiaries. It also includes important proposals to increase the effectiveness of Medicaid and the children's Health Insurance Program, and to improve access to care for vulnerable populations, including legal immigrant children and pregnant women. Our goal is to pass this legislation before the end of the year.

The cost-saving measures enacted by Congress as part of the Balanced Budget Act of 1997 have turned out to be far deeper than the estimates at that time, and these excessive cuts have put countless outstanding health care institutions across the country at risk.

In Massachusetts, 25 percent of home health agencies no longer serve Medicare patients. Forty-three nursing homes have closed in the state since 1998, and another 20 percent are in bankruptcy. Two out of every three hospitals in Massachusetts are losing money on patient care.

The record surpluses we currently enjoy and anticipate in the years ahead are partly due to the savings achieved by cutting Medicare in the BBA. Most of these savings came from policy and payment reforms, including actual cuts in payments for various services. While some changes were clearly justified, the overall cuts were much deeper than intended and are too severe to sustain.

Last year, in passing the Balanced Budget Refinement Act of 1999, we made a good start. It gave needed relief to Medicare providers. But when we enacted that bill last year, we also knew that it was only a down-payment, and that additional relief would be needed.

The bill we are introducing today follows through on that commitment. It would invest $80 billion over 10 years to restore payments to Medicare and Medicaid providers, improve benefits, and increase access to health care under Medicaid and CHIP. It provides the funding needed to allow these essential health professionals and institutions to do what they do best—provide the best health care possible for elderly and disabled Americans on Medicare. It will ensure that the nation's health care system is able to care responsibly for today's senior citizens, and is adequately prepared to take care of those who will be retiring in the future.

No senior citizen should be forced to enter a hospital or a nursing home because Medicare can't afford to pay for the services that will keep her in her own home and in her own community.

No person with a disability should be told that occupational therapy services are no longer available. Because legislation to balance the budget reduced the rehabilitation services they need.

No community should be told that their number one employer and provider of health care will be closing its doors or engaging in massive layoffs, because Medicare can no longer pay its fair share of health costs.

No freestanding children's hospital should wonder whether it can continue to train providers to care for children, because of uncertain federal support for its teaching activities.

Yet these scenes and many others are playing out in towns and cities across the country today, in large part due to the excessive cuts required by the Balanced Budget Act three years ago.

With the retirement of the baby boom generation, the last thing we

should do is jeopardize the viability and commitment of the essential institutions that care for Medicare beneficiaries. Yet that is now happening in cities and towns across the nation. In the vast majority of cases, the providers who care for Medicare patients are the same providers who care for working families and everyone else in their community. When hospitals who serve Medicare beneficiaries are threatened, health care for the entire community is threatened too.

This legislation is an important step to maintain excellence throughout our health care system. I commend Senator DASCHLE and Senator MOYNIHAN for their leadership on this vital issue. It deserves prompt consideration by the Finance Committee and the entire Senate, and it should be enacted into law before we adjourn.

Mr. DORGAN. Mr. President, I am joining with my colleagues Senator MOYNIHAN, Senator DASCHLE, and others today to introduce the Balanced Budget Refinement Act of 2000. This legislation seeks to address some of the unintended consequences the Balanced Budget Act, BBA, of 1997 is having on access to Medicare services vital to older Americans. The BBA has had a particularly serious impact on rural health care providers, and I am pleased that the legislation we are introducing today acknowledges the special needs of rural America.

Like many of my colleagues, I supported the Balanced Budget Act when it was enacted by Congress in 1997 with strong bipartisan support. Prior to the passage of this law, Medicare was projected to be insolvent within two years (by 2001), so it was imperative that we took action to extend Medicare's financial health and to constrain its rate of growth to a more sustainable level. Thanks in part to this law, we have a flourishing economy in most parts of the country and the Medicare trust fund is projected to be solvent until 2025.

But in some respects, the Balanced Budget Act was successful beyond our wildest expectations in reducing Medicare program costs. The Congressional Budget Office originally estimated that Medicare spending would be reduced by $112 billion over five years, but instead, the reduction in spending growth has been nearly double that amount. This unexpected result is having real consequences for Medicare beneficiaries and health care providers, and Congress simply must take action to address these problems before adjourning this year.

Congress took a step in the right direction towards addressing the problems facing Medicare providers by enacting the Balanced Budget Refinement Act, BBRA, of 1999. Unfortunately, however, there is growing evidence that the negative changes resulting from the BBA have not been adequately addressed by the BBRA. Moreover, the impacts continue to disproportionately affect rural health care providers and the quality of care rural Medicare beneficiaries receive.

Part of the problem facing rural providers is simply demographics: My home state of North Dakota is the second oldest in the nation, and our overall population is shrinking. In fact, in six of North Dakota's ''frontier'' counties, there were 20 or fewer births for the entire county for the entire year of 1997. Admissions to rural hospitals have dropped by a drastic 60 percent in the last two decades, and those patients who do remain tend to be older and sicker. This means that rural hospitals tend to be disproportionately dependent upon Medicare reimbursement, to the extent that Medicare accounts for 85 percent of their revenue. Obviously, given this reality, changes in Medicare reimbursement have a tremendous impact on the financial health of rural hospitals.

Another part of the problem is that Medicare has historically reimbursed urban health care providers at a higher rate than their rural counterparts. Of course, some of this difference can be explained by regional differences in the cost of health care and variations in the health status of older Americans. But this isn't the whole explanation. Even after adjusting for these factors, a report by health care economists found that, for example, Medicare's per beneficiary spending was about $8,000 in Miami, but only $3,500 in Minneapolis. When average Medicare payments for the same procedure are compared, the disparities in payment in different areas of the country are dramatic. For example, Medicare pays $6,588 for the treatment of simple pneumonia in the District of Columbia, but only $3,383 in North Dakota. In my opinion, this difference is largely explained by a Medicare reimbursement system that is skewed in favor of urban areas. For the most part, the BBA further perpetuates this inequity, despite efforts by some of us to address this concern.

There are a few areas of the Balanced Budget Act and BBRA that I think warrant further scrutiny and action, and these areas are addressed in the legislation being introduced today. The first is hospital payments, particularly for outpatient services. A recent analysis by a health policy research firm estimates that the BBA would reduce Medicare payments to North Dakota hospitals by $163.8 million between FY 1998 and FY2002. The BBRA passed last year restores only $16 million of those reductions. So even with BBRA refinements, North Dakota hospitals face a loss of $147.8 million in revenues. Outpatient services are a particularly critical component of care in many North Dakota hospitals: 40 percent of the hospitals in my state get more than half of their revenues from outpatient services. Senator DASCHLE and MOYNIHAN's legislation will address the problems faced by rural hospitals by, among other things, providing a full inflation increase in Medicare payments to all hospitals in 2001 and 2002 and holding rural hospitals permanently harmless from the outpatient prospective payment system.

This legislation also addresses the issue of home health reimbursement. Nearly 70 percent of the home health agencies in my home state are hospital-based, so the changes in home-health reimbursement are having a domino effect on North Dakota's hospitals. I am concerned that the Health Care Financing Administration's, HCFA, proposed rule for the new home health Prospective Payment System, PPS, does not take account of the smaller size of rural home health agencies and the higher fixed costs per visit. And, HCFA did not take sufficient account of the greater travel cost per visit in rural areas, and the higher incidence of chronic illness in rural communities. Today's legislation would address this concern by providing a 10 percent increase in rural home health payments for the next two years and repealing the 15 percent cut in home health reimbursement scheduled to take place on October 1, 2001.

This legislation also proposes other changes I think are worth further mention, including a further delay in the arbitrary caps on the amount of physical, speech, and occupational therapy Medicare beneficiaries can receive, and a 10 percent increase in the base payment rate for hospice care, which hasn't been increased in over a decade.

Finally, while all of the provisions of this bill will together help to ensure that Medicare beneficiaries can continue to rely on the quality care they need and expect, this legislation includes a number of changes that will also make Medicare an even better deal. In particular, this bill will expand Medicare's emphasis on preventive medicine by adding such benefits as coverage for glaucoma screening, counseling for smoking cessation, and nutrition therapy. The bill will also eliminate the current three-year time limit on Medicare's coverage of immunosuppressive drugs, the expensive medicines that transplant recipients need to keep their bodies from rejecting their new organs or tissue.

In short, the Balanced Budget Refinement Act of 2000 addresses many of the needs and concerns of Medicare beneficiaries and health care providers. I hope this legislation will help lay the framework for the enactment of bipartisan legislation to address these issues before the 106th Congress goes home.

Mr. JOHNSON. Mr. President, I am pleased to cosponsor the Balanced Budget Refinement Act introduced today that works to correct the inequities of Medicare reforms included in the Balanced Budget Act (BBA) of 1997.

I would like to commend Senator DASCHLE for his tremendous efforts on this issue and for his leadership with the introduction of this bill. As well, I

congratulate a number of my other colleagues who have contributed immensely to the crafting of this critically important piece of legislation, including Senators MOYNIHAN, ROCKEFELLER, CONRAD, GRAHAM, KERREY, ROBB, BAUCUS, BREAUX and others.

By way of background, as part of the effort to balance the federal budget, the BBA of 1997 provided for major reforms in the way Medicare pays for medical services. The BBA made some important changes in Medicare payment policy and contributed to our current period of budget surpluses through significant cost savings in Medicare. These changes were originally expected to cut Medicare spending by about $112 billion over five years, according to the Congressional Budget Office (CBO).

However, projections showed spending falling nearly twice that much, and as a result, unintended payment cuts to providers had deepened more significantly than expected. In the face of these profound cuts, health care providers began to struggle, and beneficiary access to care became threatened, due to forced reductions in services especially in rural parts of the country such as South Dakota. As a result, Congress addressed some of these unintended consequences of the BBA by enacting the Balanced Budget Refinement Act (BBRA) last year which provided $16 billion over 5 years in payments to various Medicare providers, including; Hospital Outpatient Departments; Skilled Nursing Facilities; Rural Health Providers; Home Health Agencies; Medicare HMOs; and Teaching Hospitals. The impact in South Dakota indicated that approximately 9% of Medicare funding reductions imposed by the BBA of 1997 were returned as a result of the BBRA passed last year, resulting in approximately $15.3 million being restored to South Dakota Medicare providers.

While this was certainly a step in the right direction, the BBRA of 1999 did not do enough as concerns from hospital and nursing home administrators, home health facilities, rural health providers, ambulance services and Medicare beneficiaries continued to be heard across the country.

Not surprising, I continue to hear from many South Dakota safety net providers about the devastating effects such reductions in Medicare reimbursements are having throughout the health care industry in my home state. Consumers are also feeling the pain, as many individuals are being turned away from hospitals and nursing homes who cannot afford to accept new patients because of the lower reimbursement rates included in BBA of 1997. The undesirable and unintended cuts are devastating and feared to have severe implications on the quality and access of health care throughout our nation, including South Dakota, unless Congress acts immediately to further correct these problems. In South Dakota, and other rural parts of the country, hospitals and other health care providers have an extremely high percentage of Medicare beneficiaries making these cuts in reimbursement even more devastating. If Congress does not act in a timely fashion many of these providers may be forced to close their doors.

Nowhere can we see the impact of closures more evident than within the nursing home industry. Nursing homes are experiencing closures at record rates across the country. In South Dakota, just last month we endured our first nursing home closure in Parker, South Dakota. Not only was this devastating for residents and workers, but the domino economic impact that goes hand in hand with such a facility closure is enormous for small communities to absorb.

As well, one does not have to look far in my home state of South Dakota to see the impact many other health care providers and facilities are experiencing. Furthermore, the consequences are being felt across the board, from larger health systems in South Dakota communities such as Sioux Falls, Rapid City and Aberdeen, to medium centers in Brookings, Watertown, Pierre and Yankton, to the smaller rural facilities in places like Martin, Edgemont, Gregory, Miller, Hot Springs and Redfield, just to name a few. The situation is arduous for many of these facilities, who often carry the immense task of being the sole health care provider in the entire county. By way of example, Gregory Healthcare Center is a 26 bed rural hospital serving approximately 9,000 people. Not surprising, Gregory is the only local provider to offer a range of services including surgery, obstetrics, and various therapies, and also operates the only home health agency in the area. The facility in Gregory was forced to cut back its' home health services as a result of the BBA Medicare reductions. Many individuals once benefiting from specialized medication oversight and condition management services through Gregory's home health agency were now at home performing these services on their own, resulting in some cases to unnecessary hospitalizations. The situation in Gregory is by far not an isolated situation and facilities nationwide are being forced to cut services just to survive. Whether it be Gregory, South Dakota, or one of far too many other facilities in this country with similar issues, these are direct examples of the intense real life situations that facilities, providers and beneficiaries are experiencing every day as a result of inadequate BBA adjustments, payment updates and beneficiary protections.

Therefore, I stand in strong support of the BBRA legislation being introduced today which will address problems facing vital health care services. I look forward to working with my colleagues on passage of the BBRA of 2000 which develops a creative, cost-effective approach to address the unintended, long-term consequences of the BBA. The proposed budget surplus provides Congress the unique opportunity to address many of the deficiencies in our nation's health care system. We need to address the valid concerns of teaching hospitals, skilled nursing facilities, home health providers, rural and community hospitals, and other health care providers who require relief from the consequences of the BBA.

Mr. DOMENICI:

S. 3078. A bill to amend the Reclamation Wastewater and Groundwater Study and Facilities Act to authorize the Secretary of the Interior to participate in the Santa Fe Regional Water Management and River Restoration Project; to the Committee on Energy and Natural Resources.

RECLAMATION WASTEWATER AND GROUNDWATER STUDY AND FACILITIES ACT

Mr. DOMENICI. Mr. President, I am pleased today to be introducing a bill authorizing the next logical step in the City of Santa Fe's Regional Water Management and River Restoration Strategy. This bill allows the Secretary of Interior to participate in the design, planning and construction of the Santa Fe, New Mexico, regional water management and river restoration project, consisting of the diversion and reuse of water, the conversion of irrigation uses from potable water to reclaimed water, and the use of reclaimed water to restore Santa Fe River flows.

Limited water resources in the Santa Fe region and increased demands threaten the sustainability of surface and groundwater supplies. The Regional Water Management and River Restoration Strategy is a comprehensive, collaborative plan to responsibly and sustainability address the region's water supply needs. The full program goals are to return flow to the river, protect riparian habitat and the traditional, cultural and religious uses of the water.

The Santa Fe area has been working overtime to determine how best to improve its water supply. I have been proud to help fund its efforts. The FY99 Energy and Water Appropriations Act provided $450,000 and the FY 2000 Energy and Water Appropriations Act included $750,000 to support the Santa Fe Regional Water Management and River Restoration initiative to address long-term water supplies in the greater Santa Fe area. That funding allowed the Bureau of Reclamation to continue and complete environmental studies required under the National Environmental Policy Act for the comprehensive plan to improve Santa Fe's regional water supplies through a reuse program and restoration of the Santa Fe River watershed.

I was also pleased to gain approval for $750,000 to support the project in the Senate FY01 VA/HUD bill to assist in the planning, coordination and development of restoration projects for the Santa Fe River under a comprehensive, watershed-based implementation

program. The funding, provided through EPA's Environmental Programs and Management program, would help the WMRRS reuse treated effluent to augment streamflow, recharge the regional aquifer, and enhance the riparian habitat and recreational uses within the Santa Fe River corridor.

The Santa Fe Water Management and River Restoration Strategy is a cooperative partnership among Santa Fe County, the city of Santa Fe, and the San Ildefonso Pueblo. The city of Espanola, the Eldorado Water and Sanitation District, and the Northern Pueblos Tributary Water Rights Association (representing San Ildefonso, Nambe, Pojoaque and Tesuque pueblos) are also involved.

In June of this year, a $601,000 grant was awarded to the project following my request in the FY 2000 Veterans' Affairs, Housing and Urban Development and Independent Agencies (VA-HUD) Appropriations Bill. The funding was awarded through the Department of Housing and Urban Development's Economic Development Initiative (EDI) program.

This funding represents federal support for the effort to rehabilitate the Santa Fe River, a project that is one aspect of an overall initiative to address the future of water in the Santa Fe area. Those funds will be used for urban river restoration planning, source water protection planning, and development of a comprehensive trails and open space plan.

This authorizing legislation takes the water management strategy to the next phase. The plan has already been backed by a local and regional commitment of at least $2.7 million for the multi-year program. The sponsors of the program have requested this authorization to provide additional financial support for this project. This legislative authority will make the project eligible for future funding as the project is developed, as well as federal cooperation with the surrounding pueblos. I hope that this body can take swift action on the worthy legislation.

By Mr. HATCH:

S. 3082. A bill to amend title XVIII of the Social Security Act to improve the manner in which new medical technologies are made available to Medicare beneficiaries under the Medicare Program, and for other purposes; to the Committee on Finance.

MEDICARE PATIENT ACCESS TO TECHNOLOGY ACT 20000

Mr. HATCH. Mr. President, when I first introduced this legislation over one year ago, Medicare beneficiaries with advanced heart disease could not gain access to ventriculaassist devices. Medicare patients who could have benefitted from cochlear implants did not receive them.

It is now over a year later. Unfortunately, these problems still persist. Medicare beneficiaries still have trouble gaining access to many technologies that are covered under private plans. And while the Omnibus Budget legislation for FY 2001 addressed the overall problem and by addressing access concerns for Medicare beneficiaries, there is still plenty of work that needs to be done. That is why I am introducing the Medicare Patient Access to Technology Act 2000 today.

We must eliminate the delays and barriers to access that have arisen in the way Medicare decides to cover, code and pay for new devices and diagnostics. The measure I am introducing today is identical to legislation introduced by Congressman JIM RAMSTAD and Congresswoman KAREN THURMAN earlier this year. It seeks to build off of the success we had last year in the Balanced Budget Refinement Act. The BBRA represented an important first step in creating a Medicare program that provides timely access to needed treatments.

The BBRA, which was signed into law as part of last year's omnibus budget legislation made significant changes. We crafted special temporary payments for new breakthrough technologies to ensure they are provided to Medicare beneficiaries in a timely manner. We also established payment categories that better reflect advances in clinical practice and technology.

The Medicare Patient Access to Technology Act 2000 recognizes that all Medicare beneficiaries, not just those in the outpatient setting, should be able to benefit from these kinds of improvements.

The bill would require: annual updates of Medicare's payment programs; temporary procedure codes to be issued by Medicare for new technologies at the time of FDA review; quarterly updates of Medicare's payment codes; external data to be used to improve the timeliness and appropriateness of reimbursement decisions; and annual reports be made on the timeliness of its coverage, coding and payment decisions.

There are some notable changes in this new version of the bill:

A provision to extend the issuance of temporary codes and quarterly coding updates to inpatient, or ICD–9, codes as well as outpatient (HCPCS) codes.

A provision to require HCFA to create open, timely procedures and sound methods for making coding and payment decisions for new diagnostic tests. It would also give stakeholders the ability to appeal a coding or payment decision for a diagnostic test.

This legislation will provide assistance to Medicare beneficiaries who currently face almost insurmountable barriers to advanced technologies.

Without this bill, Medicare will continue to fall far short of making the latest technologies and procedures available to beneficiaries in a timely manner.

I will fight for enactment of this bill in an effort to make sure that our seniors have access to the advanced treatments that can save and improve their lives.

By Mr. LEAHY:

S. 3083. A bill to enhance privacy and the protection of the public in the use of computers and the Internet, and for other purposes; to the Committee on the Judiciary.

ENHANCEMENT OF PRIVACY AND PUBLIC SAFETY IN CYBERSPACE ACT

Mr. LEAHY. Mr. President, at the end of July, the administration transmitted to the Senate and the House of Representatives legislation intended to increase privacy and security in cyberspace. Today, at the request and on behalf of the Administration, I introduce this legislation, the Enhancement of Privacy and Public Safety in Cyberspace Act.

The White House Chief of Staff, John Podesta, announced the administration's cyber-security proposal in an important speech at the National Press Club on Monday, July 17, 2000. This is a complex area that requires close attention to get the balance among law enforcement, business and civil liberties interests just right. I welcome the Administration's participation in this debate on the privacy implications of government surveillance, which certainly deserves just as much attention as the issue of the collection and dissemination of personally-identifiable information by the private-sector.

The means by which law enforcement authorities may gain access to a person's private ''effects'' is no longer limited by physical proximity, as it was at the time the Framers crafted our Constitution's Fourth Amendment right of the American people to be secure in their persons, houses, papers and effects, against unreasonable searches and seizures. New communications methods and surveillance devices have dramatically expanded the opportunities for surreptitious law enforcement access to private messages and records from remote locations.

One example of these devices is the Federal Bureau of Investigation's Carnivore software program, which screens Internet traffic and captures information targeted by court orders. The Senate and House Judiciary Committees have both conducted hearings on Carnivore to discuss how the software works and whether it minimizes intrusion or maximizes the potential for government abuse. The Attorney General is arranging for an independent technical review of Carnivore, and I look forward to reviewing the results.

In short, new communications technologies pose both benefits and challenges to privacy and law enforcement. The Congress has worked successfully in the past to mediate this tension with a combination of stringent procedures for law enforcement access to our communications and legal protections to maintain their privacy and confidentiality, whether they occur in person or over the telephone, fax machine or computer. In 1968, the Congress passed comprehensive legislation authorizing government interception, under carefully defined circumstances, of voice

communications over telephones or in person in Title III of the Omnibus Crime Control and Safe Streets Act.

We returned to this important area in 1986, when we passed the Electronic Communications Privacy Act (ECPA), which I was proud to sponsor, that outlined procedures for law enforcement access to electronic mail systems and remote data processing systems, and that provided important privacy safeguards for computer users.

The Administration's legislation is an important contribution to the ongoing debate over the sufficiency of our current laws in the face of the exponential growth of computer and communications networks. In fact, this legislation contains some proposals which I support. For example, the bill would allow judicial review of pen register orders so the judge is not just a rubber stamp, and would update the wiretap laws to apply the same procedural rules to e-mail intercepts as to phone intercepts.

Nevertheless, the merits of other provisions in this legislation would benefit from additional scrutiny and debate. For example, the legislation proposes elimination of the current $5,000 threshold for large categories of federal computer crimes. This would lower the bar for federal investigative and prosecutorial attention with the result that lesser computer abuses could be converted into federal crimes.

Specifically, federal jurisdiction currently exists for a variety of computer crimes if, and only if, such criminal offenses result in at least $5,000 of aggregate damage or cause another specified injury, such as the impairment of medical treatment, physical injury to a person or a threat to public safety. Elimination of the $5,000 threshold would criminalize a variety of minor computer abuses, regardless of whether any significant harm results. Our federal laws do not need to reach each and every minor, inadvertent and harmless hacking offense—after all, each of the 50 states has its own computer crime laws. Rather, our federal laws need to reach those offenses for which federal jurisdiction is appropriate. This can be accomplished, as I have done in the Internet Security Act, S. 2430, which I introduced earlier this year, by simply adding an appropriate definition of ''loss'' to the statute.

Prior Congresses have declined to over-federalize computer offenses and sensibly determined that not all computer abuses warrant federal criminal sanctions. When the computer crime law was first enacted in 1984, the House Judiciary Committee reporting the bill stated:

> The Federal jurisdictional threshold is that there must be $5,000 worth of benefit to the defendant or loss to another in order to concentrate Federal resources on the more substantial computer offenses that affect interstate or foreign commerce. (H.Rep. 98–894, at p. 22, July 24, 1984).

Similarly, the Senate Judiciary Committee under the chairmanship of Senator THURMOND, rejected suggestions in 1986 that ''the Congress should enact as sweeping a Federal statute as possible so that no computer crime is potentially uncovered.'' (S. Rep. 99–432, at p. 4, September 3, 1986).

For example, if an overly-curious college sophomore checks a professor's unattended computer to see what grade he is going to get and accidentally deletes a file or a message, current Federal law does not make that conduct a crime. That conduct may be cause for discipline at the college, but not for the FBI to swoop in and investigate. Yet, under the Administration's legislation, this unauthorized access to the professor's computer would constitute a federal offense.

As the Congress considers changes in our current laws with a view to updating our current privacy safeguards from unreasonable government surveillance, I commend the administration for focusing attention on this important issue by transmitting its legislative proposal.

I ask unanimous consent that the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 3083

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Enhancement of Privacy and Public Safety in Cyberspace Act''.

SEC. 2. COMPUTER CRIME.

(a) FRAUD AND RELATED ACTIVITY IN CONNECTION WITH COMPUTERS.—

(1) OFFENSES.—Subsection (a) of section 1030 of title 18, United States Code, is amended—

(A) in paragraph (3), by striking ''accesses such a computer'' and inserting ''or in excess of authorization to access any nonpublic computer of a department or agency of the United States, accesses a computer''; and

(B) in paragraph (7), by striking '', firm, association, educational institution, financial institution, government entity, or other legal entity,''.

(2) ATTEMPTED OFFENSES.—Subsection (b) of that section is amended by inserting before the period the following: ''as if such person had committed the completed offense''.

(3) PUNISHMENT.—Subsection (c) of that section is amended—

(A) in paragraph (1), by striking '', or an attempt to commit an offense punishable under this subparagraph'' each place it appears in subparagraphs (A) and (B);

(B) in paragraph (2)—

(i) by striking subparagraph (A) and inserting the following new subparagraph (A):

''(A) except as provided in subparagraphs (B) and (C) of this subparagraph, a fine under this title or imprisonment for not more than one year, or both, in the case of an offense under subsection (a)(2), (a)(3), (a)(5), or (a)(6) of this section which does not occur after a conviction for another offense under this section;'';

(ii) in subparagraph (B), by adding ''and'' at the end; and

(iii) by striking subparagraph (C) and inserting the following new subparagraph (C):

''(C) a fine under this title or imprisonment for not more than ten years, or both, in the case of an offense under subsection (a)(5)(A) or (a)(5)(B) if the offense caused (or, in the case of an attempted offense, would, if completed, have caused)—

''(i) loss to one or more persons during any one year period (including loss resulting from a related course of conduct affecting one or more other protected computers) aggregating at least $5,000;

''(ii) the modification or impairment, or potential modification or impairment, of the medical examination, diagnosis, treatment, or care of one or more individuals;

''(iii) physical injury to any individual;

''(iv) a threat to public health or safety; or

''(v) damage affecting a computer system used by or for a government entity in furtherance of the administration of justice, national defense, or national security;'';

(C) in paragraph (3)—

(i) by striking ''(3)(A)'' and inserting ''(3)'';

(ii) by striking '', (a)(5)(A), (a)(5)(B),'';

(iii) by striking '', or an attempt to commit an offense punishable under this subparagraph;''; and

(iv) by striking subparagraph (B); and

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

''(4) a fine under this title or imprisonment for not more than ten years, or both, in the case of an offense under subsection (a)(2), (a)(3), (a)(4), (a)(5), (a)(6), or (a)(7) of this section which occurs after a conviction for another offense under this section.''.

(4) INVESTIGATIVE AUTHORITY OF UNITED STATES SECRET SERVICE.—Subsection (d) of that section is amended—

(A) in the first sentence, by striking ''subsections (a)(2)(A), (a)(2)(B), (a)(3), (a)(4), (a)(5), and (a)(6) of''; and

(B) in the second sentence, by striking ''which shall be entered into by'' and inserting ''between''.

(5) DEFINITIONS.—Subsection (e) of that section is amended—

(A) in paragraph (2)(B), by inserting before the semicolon the following: '', including a computer located outside the United States'';

(B) in paragraph (7), by striking ''and'' at the end;

(C) in paragraph (8), by striking ''or information,'' and all that follows through the end of the paragraph and inserting ''or information;'';

(D) in paragraph (9), by striking the period at the end and inserting a semicolon; and

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

''(10) the term 'conviction for another offense under this section' includes—

''(A) an adjudication of juvenile delinquency for a violation of this section; and

''(B) a conviction under State law for a crime punishable by imprisonment for more than one year, an element of which is unauthorized access, or exceeding authorized access, to a computer;

''(11) the term 'loss' means any reasonable cost to any victim, including responding to the offense, conducting a damage assessment, restoring any data, program, system, or information to its condition before the offense, and any revenue lost or costs incurred because of interruption of service; and

''(12) the term 'person' includes any individual, firm, association, educational institution, financial institution, corporation, company, partnership, society, government entity, or other legal entity.''.

(6) CIVIL ACTIONS.—Subsection (g) of that section is amended to read as follows:

''(g) Any person who suffers damage or loss by reason of a violation of this section may maintain a civil action against the violator to obtain compensatory damages and injunctive or other equitable relief. An action

under this subsection for a violation of subsection (a)(5) may be brought only if the conduct involves one or more of the factors set forth in subsection (c)(2)(C). No action may be brought under this subsection unless such action is begun within 2 years of the date of the act complained of or the date of the discovery of the damage.''.

(7) FORFEITURE.—That section is further amended—

(A) by redesignating subsection (h) as subsection (j); and

(B) by inserting after subsection (g), as amended by paragraph (6) of this subsection, the following new subsections (h) and (i):

''(h)(1) The court, in imposing sentence on any person convicted of a violation of this section, shall order, in addition to any other sentence imposed and irrespective of any provision of State law, that such person forfeit to the United States—

''(A) such person's interest in any property, whether real or personal, that was used or intended to be used to commit or to facilitate the commission of such violation; and

''(B) any property, whether real or personal, constituting or derived from, any proceeds that such person obtained, whether directly or indirectly, as a result of such violation.

''(2) The criminal forfeiture of property under this subsection, any seizure and disposition thereof, and any administrative or judicial proceeding in relation thereto, shall be governed by the provisions of section 413 of the Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. 853), except subsection (d) of that section.

''(i)(1) The following shall be subject to forfeiture to the United States, and no property right shall exist in them:

''(A) Any property, whether real or personal, used or intended to be used to commit or to facilitate the commission of any violation of this section.

''(B) Any property, whether real or personal, which constitutes or is derived from proceeds traceable to any violation of this section.

''(2) The provisions of chapter 46 of this title relating to civil forfeiture shall apply to any seizure or civil forfeiture under this subsection.''.

(b) AMENDMENTS TO SENTENCING GUIDELINES.—Pursuant to its authority under section 994(p) of title 28, United States Code, the United States Sentencing Commission shall amend the sentencing guidelines to ensure any individual convicted of a violation of paragraph (4) or a felony violation of paragraph (5)(A), but not a felony violation of paragraph (5)(B) or (5)(C), of section 1030(a) of title 18, United States Code, is imprisoned for not less than 6 months.

(c) COMMUNICATIONS MATTERS.—

(1) IN GENERAL.—Section 223(a)(1) of the Communications Act of 1934 (47 U.S.C. 223(a)(1)) is amended—

(A) in subparagraphs (C) and (E), by inserting ''or interactive computer service'' after ''telecommunications device'';

(B) in subparagraph (D), by striking ''or'' at the end; and

(C) by adding after subparagraph (E) the following new subparagraph:

''(F) with the intent to cause the unavailability of a telecommunications device or interactive computer service, or to cause damage to a protected computer (as those terms are defined in section 1030 of title 18, United States Code), causes or attempts to cause one or more other persons to initiate communication with such telecommunications device, interactive computer service, or protected computer; or''.

(2) CONFORMING AMENDMENT.—The section heading of that section is amended by striking ''**TELEPHONE CALLS**'' and inserting ''**COMMUNICATIONS**''.

SEC. 3. INTERCEPTION OF WIRE, ORAL, AND ELECTRONIC COMMUNICATIONS.

(a) DEFINITIONS.—Section 2510 of title 18, United States Code, is amended—

(1) in paragraph (1), by striking ''electronic storage'' and inserting ''interim storage'';

(2) in paragraph (10), by striking ''section 153(h) of title 47 of the United States Code'' and inserting ''section 3(10) of the Communications Act of 1934 (47 U.S.C. 153(10))'';

(3) in paragraph (14)—

(A) by striking ''of electronic'' and inserting ''of wire or electronic''; and

(B) by striking ''electronic storage'' and inserting ''interim storage''; and

(4) in paragraph (17)—

(A) by striking '''electronic storage''' and inserting '''interim storage'''; and

(B) in subparagraph (A), by inserting ''by an electronic communication service'' after ''intermediate storage''.

(b) PROHIBITION ON INTERCEPTION AND DISCLOSURE OF COMMUNICATIONS.—Section 2511 of that title is amended—

(1) in subsection (2)—

(A) in paragraph (a)(i), by striking ''on officer'' and inserting ''an officer'';

(B) in paragraph (f)—

(i) by inserting ''or 206'' after ''chapter 121''; and

(ii) by striking ''wire and oral'' and inserting ''wire, oral, and electronic''; and

(C) in paragraph (g), by striking clause (i) and inserting the following new clause (i):

''(i) to intercept or access a wire or electronic communication (other than a radio communication) made through an electronic communications system that is configured so that such communication is readily accessible to the general public;''; and

(2) in subsection (4)—

(A) in paragraph (a), by striking ''in paragraph (b) of this subsection or'';

(B) by striking paragraph (b); and

(C) by redesignating paragraph (c) as paragraph (b).

(c) PROHIBITION ON USE OF EVIDENCE OF INTERCEPTED COMMUNICATIONS.—Section 2515 of that title is amended—

(1) by striking ''Whenever any wire or oral communication'' and inserting ''(a) Except as provided in subsection (b), whenever any wire, oral, or electronic communication''; and

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

''(b) Subsection (a) shall not apply to the disclosure, before a grand jury or in a criminal trial, hearing, or other criminal proceeding, of the contents of a communication, or evidence derived therefrom, against a person alleged to have intercepted, used, or disclosed the communication in violation of this chapter, or participated in such violation.''.

(d) AUTHORIZATION FOR INTERCEPTION OF COMMUNICATIONS.—Section 2516 of that title is amended—

(1) in subsection (1)—

(A) by striking ''wire or oral'' in the matter preceding paragraph (a) and inserting ''wire, oral, or electronic'';

(B) in paragraph (b), by inserting ''threat,'' after ''robbery,'';

(C) by striking the first paragraph (p) and inserting the following new paragraph (p):

''(p) a felony violation of section 1030 of this title (relating to computer fraud and abuse), a felony violation of section 223 of the Communications Act of 1934 (47 U.S.C. 223) (relating to abusive communications in interstate or foreign commerce), or a violation of section 1362 of this title (relating to destruction of government communications facilities); or''; and

(D) by redesignating the second paragraph (p) as paragraph (q); and

(2) in subsection (3), by striking ''electronic communications'' and inserting ''one-way pager communications''.

(e) AUTHORIZATION FOR DISCLOSURE OR USE OF INTERCEPTED COMMUNICATIONS.—Section 2517 of that title is amended in subsections (1) and (2) by inserting ''or under the circumstances described in section 2515(b) of this title'' after ''by any means authorized by this chapter''.

(f) PROCEDURE FOR INTERCEPTION.—Section 2518 of that title is amended—

(1) in subsection (7), by striking ''subsection (d)'' and inserting ''subsection (8)(d)''; and

(2) in subsection (10)—

(A) in paragraph (a)—

(i) in the matter preceding subparagraph (i), by striking ''wire or oral'' and inserting ''wire, oral, or electronic''; and

(ii) in the flush matter following subparagraph (iii)—

(I) by striking ''intercepted wire or oral communication'' and inserting ''intercepted communication''; and

(II) by adding at the end the following new sentence: ''No suppression may be ordered under this paragraph under the circumstances described in section 2515(b) of this title.''; and

(B) by striking paragraph (c).

(g) CIVIL DAMAGES.—Section 2520(c)(2) of that title is amended—

(1) in the matter preceding subparagraph (A)—

(A) by striking ''court may'' and inserting ''court shall''; and

(B) by striking ''greater'' and inserting ''greatest'';

(2) in subparagraph (A), by striking ''or'' at the end;

(3) in subparagraph (B), by striking ''whichever is the greater of $100 a day for each day of violation or $10,000.'' and inserting ''$500 a day for each day of violation; or''; and

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

''(C) statutory damages of $10,000.''.

(h) CONFORMING AND CLERICAL AMENDMENTS.—

(1) CONFORMING AMENDMENT.—The section heading of section 2515 of that title is amended to read as follows:

''§ 2515. Prohibition on use as evidence of intercepted wire, oral, or electronic communications''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 119 of that title is amended by striking the item relating to section 2515 and inserting the following new item:

''2515. Prohibition on use as evidence of intercepted wire, oral, or electronic communications.''.

SEC. 4. ELECTRONIC COMMUNICATIONS PRIVACY.

(a) UNLAWFUL ACCESS TO STORED COMMUNICATIONS.—Section 2701 of title 18, United States Code, is amended—

(1) in subsection (a) by striking ''electronic storage'' and inserting ''interim storage'';

(2) in subsection (b)—

(A) in paragraph (1)—

(i) by striking ''purposes of'' in the matter preceding subparagraph (A) and inserting ''a tortious or illegal purpose,'';

(ii) in subparagraph (A) by striking ''one year'' and inserting ''five years''; and

(iii) in subparagraph (B) by striking ''two years'' and inserting ''ten years''; and

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

''(2) in any other case—

''(A) a fine under this title or imprisonment for not more than one year, or both, in the case of a first offense under this subparagraph; and

''(B) a fine under this title or imprisonment for not more than five years, or both, for any subsequent offense under this subparagraph.''.

(b) DISCLOSURE OF CONTENTS.—Section 2702 of that title is amended—

(1) in subsection (a)—

(A) in paragraph (1)—

(i) by striking ''person or entity providing an'' and inserting ''provider of'';

(ii) by striking ''electronic storage'' and inserting ''interim storage''; and

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

(B) in paragraph (2)—

(i) by striking ''person or entity providing'' and inserting ''provider of''; and

(ii) striking the period at the end and inserting ''; and''; and

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

''(3) a provider of remote computing service or electronic communication service to the public shall not knowingly divulge a record or other information pertaining to a subscriber to or customer of such service (not including the contents of communications covered by paragraph (1) or (2) of this subsection) to any governmental entity.'';

(2) in subsection (b)—

(A) in the subsection caption, by inserting ''FOR DISCLOSURE OF COMMUNICATIONS'' after ''EXCEPTIONS'';

(B) in the matter preceding paragraph (1), by striking ''person or entity'' and inserting ''provider described in subsection (a)'';

(C) in paragraph (6)—

(i) in subparagraph (A)(ii), by striking ''or'' at the end;

(ii) in subparagraph (B), by striking the period at the end and inserting ''; or''; and

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

''(C) if the provider reasonably believes that an emergency involving immediate danger of death or serious physical injury to any person justifies disclosure of the information.''; and

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

''(c) EXCEPTIONS FOR DISCLOSURE OF CUSTOMER RECORDS.—A provider described in subsection (a) may divulge a record or other information pertaining to a subscriber to or customer of such service (not including the contents of communications covered by paragraph (1) or (2) of subsection (a))—

''(1) as otherwise authorized in section 2703 of this title;

''(2) with the lawful consent of the customer or subscriber;

''(3) as may be necessarily incident to the rendition of the service or to the protection of the rights or property of the provider of that service;

''(4) to a governmental entity, if the provider reasonably believes that an emergency involving immediate danger of death or serious physical injury to any person justifies disclosure of the information; or

''(5) to any person other than a governmental entity if not otherwise prohibited by law.''.

(c) REQUIREMENTS FOR GOVERNMENTAL ACCESS.—Section 2703 of that title is amended—

(1) in subsection (a), by striking ''electronic storage'' each place it appears and inserting ''interim storage'';

(2) in subsection (b)(1)(B), by striking clause (i) and inserting the following new clause (i):

''(i) uses a Federal or State grand jury or trial subpoena, or a subpoena or equivalent process authorized by a Federal or State statute; or'';

(3) in subsection (c)—

(A) by redesignating paragraph (2) as paragraph (3);

(B) by redesignating subparagraph (C) of paragraph (1) as paragraph (2);

(C) in paragraph (2), as so redesignated—

(i) by striking ''an administrative subpoena authorized by a Federal or State statute or a Federal or State grand jury or trial subpoena'' and inserting ''a Federal or State grand jury or trial subpoena, or a subpoena or equivalent process authorized by a Federal or State statute,''; and

(ii) by striking ''subparagraph (B).'' and inserting ''paragraph (1).''; and

(D) in paragraph (1)—

(i) by striking ''(A) Except as provided in subparagraph (B),'' and inserting ''A governmental entity may require'';

(ii) by striking ''may disclose'' and inserting ''to disclose'';

(iii) by striking ''to any person other than a governmental entity.'';

(iv) by striking ''(B) A provider of'' through ''to a governmental entity'';

(v) by redesignating clauses (i) through (iv) as subparagraphs (A) through (D);

(vi) by striking ''or'' at the end of subparagraph (C), as so redesignated;

(vii) by striking the period at the end of subparagraph (D), as so redesignated, and inserting ''; or''; and

(viii) by adding after subparagraph (D), as so redesignated, the following new subparagraph:

''(E) seeks information pursuant to paragraph (2).''; and

(4) in subsection (d)—

(A) by striking ''subsection (c)'' and inserting ''subsection (c)(1)''; and

(B) by striking ''section 3127(2)(A)'' and inserting ''section 3127(2)''.

(d) DELAYED NOTICE.—Section 2705(a) of that title is amended—

(1) in paragraph (1)(B), by striking ''an administrative subpoena authorized by a Federal or State statute or a Federal or State grand jury subpoena'' and inserting ''a Federal or State grand jury or trial subpoena, or a subpoena or equivalent process authorized by a Federal or State statute,''; and

(2) in paragraph (4), by striking ''by the court'' and all that follows through the end of the paragraph and inserting '', upon application, if the court determines that there is reason to believe that notification of the existence of the court order or subpoena may have an adverse result described in paragraph (2) of this subsection.''.

(e) CIVIL ACTION.—Section 2707(e)(1) of that title is amended by inserting ''a request of a governmental entity under section 2703(f) of this title,'' after ''subpoena,''.

(f) CONFORMING AND CLERICAL AMENDMENTS.—

(1) CONFORMING AMENDMENTS.—(A) The section heading of section 2702 of that title is amended to read as follows:

''§ 2702. Voluntary disclosure of customer communications or records''.

(B) The section heading of section 2703 of that title is amended to read as follows:

''§ 2703. Required disclosure of customer communications or records''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 121 of that title is amended by striking the items relating to sections 2702 and 2703 and inserting the following new items:

''2702. Voluntary disclosure of customer communications or records.''.

''2703. Required disclosure of customer communications or records.''.

SEC. 5. PEN REGISTERS AND TRAP AND TRACE DEVICES.

(a) GENERAL PROHIBITION ON USE.—Section 3121(c) of title 18, United States Code, is amended—

(1) by inserting ''or trap and trace device'' after ''pen register'';

(2) by inserting '', routing, addressing,'' after ''dialing''; and

(3) by striking ''call processing'' and inserting ''the processing and transmitting of wire and electronic communications''.

(b) APPLICATION FOR ORDER.—Section 3122(b)(2) of that title is amended by striking ''certification by the applicant'' and inserting ''statement of facts showing''.

(c) ISSUANCE OF ORDER.—Section 3123 of that title is amended—

(1) by striking subsection (a) and inserting the following new subsection (a):

''(a) IN GENERAL.—(1) Upon an application made under section 3122(a)(1) of this title, the court shall enter an ex parte order authorizing the installation and use of a pen register or a trap and trace device if the court finds, based on facts contained in the application, that the information likely to be obtained by such installation and use is relevant to an ongoing criminal investigation. Such order shall, upon service of such order, apply to any entity providing wire or electronic communication service in the United States whose assistance may facilitate the execution of the order.

''(2) Upon an application made under section 3122(a)(2) of this title, the court shall enter an ex parte order authorizing the installation and use of a pen register or a trap and trace device within the jurisdiction of the court if the court finds, based on facts contained in the application, that the information likely to be obtained by such installation and use is relevant to an ongoing criminal investigation.'';

(2) in subsection (b)(1)—

(A) in subparagraph (A)—

(i) by inserting ''or other facility'' after ''line''; and

(ii) by inserting ''or applied'' after ''attached''; and

(B) in subparagraph (C)—

(i) by striking ''the number'' and inserting ''the attributes of the communications to which the order applies, such as the number or other identifier,'';

(ii) by striking ''physical'';

(iii) by inserting ''or other facility'' after ''line'';

(iv) by inserting ''or applied'' after ''attached''; and

(v) by inserting ''authorized under subsection (a)(2) of this section'' after ''device'' the second place it appears; and

(4) in subsection (d)(2)—

(A) by inserting ''or other facility'' after ''line'';

(B) by inserting ''or applied'' after ''attached''; and

(C) by striking ''has been ordered by the court'' and inserting ''is obligated by the order''.

(d) EMERGENCY INSTALLATION.—Section 3125(a)(1) of that title is amended—

(1) in subparagraph (A), by striking ''or'' at the end;

(2) in subparagraph (B), by striking the comma at the end and inserting a semicolon; and

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

''(C) an immediate threat to a national security interest; or

''(D) an ongoing attack on the integrity or availability of a protected computer punishable pursuant to section 1030(c)(2)(C) of this title,''.

(e) DEFINITIONS.—Section 3127 of that title is amended—

(1) in paragraph (2), by striking subparagraph (A) and inserting the following new subparagraph (A):

''(A) any district court of the United States (including a magistrate judge of such a court) or United States Court of Appeals having jurisdiction over the offense being investigated; or'';

(2) in paragraph (3)—

(A) by striking ''electronic or other impulses which identify the numbers dialed or otherwise transmitted on the telephone line to which such device is attached'' and inserting ''dialing, routing, addressing, and signaling information transmitted by an instrument or facility from which a wire or electronic communication is transmitted''; and

(B) by inserting ''or process'' after ''device'' each place it appears;

(3) in paragraph (4)—

(A) by inserting ''or process'' after ''a device''; and

(B) by striking ''of an instrument or device from which a wire or electronic communication was transmitted'' and inserting ''or other dialing, routing, addressing, and signaling information relevant to identifying the source of a wire or electronic communication'';

(4) in paragraph (5), by striking ''and'' at the end;

(5) in paragraph (6), by striking the period at the end and inserting ''; and''; and

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

''(7) the term 'protected computer' has the meaning given that term in section 1030(e) of this title.''.

SEC. 6. JUVENILE MATTERS.

Section 5032 of title 18, United States Code, is amended in the first undesignated paragraph by inserting after ''section 924(b), (g), or (h) of this title,'' the following: ''or is a violation of section 1030(a)(1), section 1030(a)(2)(B), section 1030(a)(3), or a felony violation of section 1030(a)(5) where such felony violation of section 1030(a)(5) is eligible for punishment under section 1030(c)(2)(C)(ii) through (v) of this title,''.

SEC. 7. PROTECTION OF CABLE SERVICE SUBSCRIBER PRIVACY.

Section 631 of the Communications Act of 1934 (47 U.S.C. 551) is amended—

(1) in subsection (c)(2)—

(A) in subparagraph (B), by striking ''or'' at the end;

(B) in subparagraph (C), by striking the period at the end and inserting ''; or''; and

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

''(D) required under chapter 119, 121, or 206 of title 18, United States Code, except that disclosure under this subparagraph shall not include records revealing customer cable television viewing activity.''; and

(2) in subsection (h), by striking ''A governmental entity'' and inserting ''Except as provided in subsection (c)(2)(D), a governmental entity''.

Mr. HATCH:

S. 3084. A bill to amend title XVIII of the Social Security Act to provide for State accreditation of diabetes self-management training programs under the Medicare Program; to the Committee on Finance.

STATE ACCREDITATION OF DIABETES SELF-MANAGEMENT TRAINING PROGRAMS UNDER THE MEDICARE PROGRAM

Mr. HATCH. Mr. President, today, I am introducing legislation that will allow all state diabetes education programs to be reimbursed by the Medicare program. Currently, state diabetes education programs that only have state certification are not able to receive Medicare reimbursement for the fine work that they do as far as educating diabetics in the communities. As a result, these individuals have less access to the education that they need to control their diabetes.

This issue was brought to my attention by the Program Director of the Utah Diabetes Control Program. There are 32 diabetes education programs in Utah that are either Utah certified or recognized by the American Diabetes Association. Eighteen of those programs have only state certification and seven of those are located in rural communities of Utah, including Moab, Price, Roosevelt, Gunnison, Payson, and Tooele.

Without this legislation, these 18 programs cannot be reimbursed by Medicare unless they are certified by the American Diabetes Association. In Utah, our state certification program exceeds national standards. In addition to submitting an application and documentation that the education programs meet the national standards, Utah Diabetes Control Program staff conduct site visits with all applying programs. The staff also collects data through annual reports to assess continued quality and outcomes.

One of the biggest concerns that has been brought to my attention by the Utah Department of Health is that the American Diabetes Association charges $850 for state programs to apply for ADA certification. The smaller state diabetes education programs have indicated that the ADA fee is cost-prohibitive for them, especially in the more rural areas. On the other hand, state certification is free to all applicants.

I understand that this problem not only exists in Utah, but across the country. I believe that this matter needs to be addressed by Congress so that all Medicare beneficiaries, regardless of where they live, will have access to diabetes education programs.

By Mr. JEFFORDS (for himself, Mr. KENNEDY, Mr. CLELAND, and Mrs. MURRAY):

S. 3085. A bill to provide assistance to mobilize and support United States communities in carrying out youth development programs that assure that all youth have access to programs and services that build the competencies and character development needed to fully prepare the youth to become adults and effective citizens; to the Committee on Health, Education, Labor, and Pensions.

THE YOUNGER AMERICANS ACT

Mr. JEFFORDS. Mr. President, I rise today to introduce the Younger American's Act with Senators KENNEDY, CLELAND, and MURRAY. This legislation embraces the belief that youth are not only our nation's most valuable resource, they also are our most important responsibility. The needs of youth must be moved to a higher priority on our nation's agenda.

It is not enough that government responds to youth when they get into trouble with drugs, teen pregnancy, and violence. We need to strengthen the positive rather than simply respond to the negative. Positive youth development, the framework for the Younger American's Act, is not just about preventing bad things from happening, but giving a nudge to help good things happen. And we know that it works.

Evaluations of Big Brothers/Big Sisters, Boys and Girls Clubs, and other youth development programs have demonstrated significant increases in parental involvement, youth participation in constructive education, social and recreation activities, enrollment in post-secondary education, and community involvement. Just as important, youth actively participating in youth development programs show decreased rates of school failure and absenteeism, teen pregnancy, delinquency, substance abuse, and violent behavior.

We also know that risk taking behavior increases with age. One third of the high school juniors and seniors participate in two or more health risk behaviors. That is why it is important to build a youth development infrastructure that engages youth as they enter pre-adolescence and keeps them engaged throughout their teen years. The Younger American's Act is targeted to youth aged ten to nineteen. This encompasses both the critical middle-school years, as well as the increasingly risky high school years.

The Younger American's Act is about framing a national policy on youth. Up until now, government has responded to kids after they have gotten into trouble. We must take a new tack. Instead of just treating problems, we have to promote healthy development. We have to remember that just because a kid stays out of trouble, it doesn't mean that he or she is ready to handle the responsibilities of adulthood. Research has shown that kids want direction, they want close bonds with parents and other adult mentors. And I believe we owe them that. Ideally, this comes from strong families, but communities and government can help.

In order to keep kids engaged in positive activities, youth must be viewed as resources; as active participants in finding solutions to their own problems. Parents also must be part of those solutions. This legislation requires that youth and parents be part of the decision-making process on the federal and local levels.

The United States does not have a cohesive federal policy on youth. Creating an Office on National Youth Policy within the White House not only raises the priority of youth on the federal agenda, but provides an opportunity to more effectively coordinate existing federal youth programs to increase their impact on the lives of young Americans. The efforts of the Office of National Youth Policy in advocating for the needs of youth, and the Department of Health and Human Service in implementing the Younger American's Act will be helped by the Council on National Youth Policy. This Council, comprised of youth, parents,

experts in youth development, and representatives from the business community, will help ensure that this initiative continually responds to the changing needs of youth and their communities. It will bring a ''real world'' perspective to the efforts of the Office and HHS.

The Younger American's Act provides communities with the funding necessary to adequately ensure that youth have access to five core resources:

Ongoing relationships with caring adults;

Safe places with structured activities in which to grow and learn;

Services that promote healthy lifestyles, including those designed to improve physical and mental health;

Opportunities to acquire marketable skills and competencies; and

Opportunities for community service and civic participation.

Block grant funds will be used to expand existing resources, create new ones where none existed before, overcome barriers to accessing those resources, and fill gaps to create a cohesive network for youth. The funds will be funneled through states, based on an allocation formula that equally weighs population and poverty measures, to communities where the primary decisions regarding the use of the funds will take place. Thirty percent of the local funds are set aside for to address the needs of youth who are particularly vulnerable, such as those who are in out-of home placements, abused or neglected, living in high poverty areas, or living in rural areas where there are usually fewer resources. Dividing the state into regions, or ''planning and mobilization areas,'' ensures that funds will be equitably distributed throughout a state. Empowering community boards, comprised of youth, parents, and other members of the community, to supervise decisions regarding the use of the block grant funds ensures that the programs, services, and activities supported by the Act will be responsive to local needs.

Accountability is integral to any effective federal program. The Younger American's Act provides the Department of Health and Human Services with the responsibility and funding to conduct research and evaluate the effectiveness of funded initiatives. States and the Department are charged with monitoring the use of funds by grantees, and empowered to withhold or reduce funds if problems arise.

The Younger Americans Act will help kids gain the skills and experience they need to successfully navigate the rough waters of adolescence. My twenty-first century community learning centers initiative supports the efforts of schools to operate after-school programs that emphasize academic enrichment. It's time to get the rest of the community involved. It's time to give the same level of support to the thousands of youth development and youth-serving organizations that struggle to keep their doors open every day.

I remember a young man, Brad Luck, who testified before the H.E.L.P. Committee several years ago. As a 14-year-old, Brad embarked on a two-year mission to open a teen center in his home town of Essex Junction, Vermont. He formed a student board of directors, sought 501(c)(3) status and gave over 25 community presentations to convince the town to back the program. Demonstrating the tenacity of youth, he then spear-headed a successful drive to raise $30,000 in 30 days to fund the start-up of the center. Today, the center is thriving in its town-donated space. This is an example of the type of community asset building supported by the Younger Americans Act. The Younger Americans Act is about an investment in our youth, our communities, and our future. I want to thank America's Promise, the United Way, and the National Collaboration for Youth for their work in providing the original framework for the legislation. I am proud and excited to be part of this important initiative.

I ask unanimous consent that a summary of the legislation be printed in the RECORD.

There being no objection, the summary was ordered to be printed in the RECORD, as follows:

YOUNGER AMERICANS ACT—SUMMARY

The Younger Americans Act provides a framework for a cohesive national policy on youth. Loosely based on the Older Americans Act, this legislation is an opportunity to better coordinate the services, activities and programs that help our young people make a successful transition from childhood to adulthood. The bill includes a block grant program to support local communities in their efforts to strengthen the resources that are available to youth. But perhaps most importantly, The Younger Americans Act is about forging partnerships between parents, youth, government, and youth serving organizations.

The Younger Americans Act begins with a statement of national youth policy that youth need to have access five core resources:

Ongoing relationships with caring adults;

Safe places with structured activities;

Services that promote healthy lifestyles, including those designed to improve physical and mental health;

Opportunities to acquire marketable skills and competencies; and

Opportunities for community service and civic participation.

Reflecting the high priority which youth need to occupy on the national agenda, the legislation establishes an Office of National Youth Policy within the White House. This office will serve as an effective advocate for youth within the federal government and assist in resolving administrative and programmatic conflicts between federal programs that are barriers to parents, youth, communities, and service providers in accessing the full array of core resources for youth. Funds for this Office are authorized for $500,000 a year.

The Younger Americans Act creates a Council on National Youth Policy to advise the President, the Director of the Office of National Youth Policy and the Department of Health and Human Services on the developmental needs of youth, youth participation, and federal youth policies. The membership of the Council ensures that youth are active participants in the finding solutions to many of their own problems. The Council is authorized to conduct public forums for discussion and serve as an information conduit between policy makers, youth, and others involved in the provision of youth services. It is authorized for $250,000 per year.

The Younger Americans Act creates a formula-based state block grant to support community-based youth development programs, activities and services. Ninety-seven percent of the funds will be distributed to states, Native American tribes and organizations, and outlying territories. The Department of Health and Human Services is authorized to use the remainder of the funds to conduct demonstration program for youth populations that are particularly vulnerable. Funds are distributed to states based on the population of youth aged 10–19, and the number of children and youth receiving free- or reduced priced lunches. There is a small state minimum of .4 percent.

To implement the block grant, states are required to divide the state into geographical regions called planning and mobilization areas. States are encouraged to utilize existing state administrative or programmatic regions. States may use up to 4 percent of the funds for program review, monitoring, and technical assistance; and no more than 3 percent of the funds to address the needs of particularly vulnerable youth populations, including youth in out-of-home residential settings, such as foster care, communities with high concentrations of poverty, rural areas, and youth that have been abused or neglected. The remaining 93 percent of the funds allotted to the states must be equitably distributed among the planning and mobilization areas, based on the same population and school lunch program participation formula used for the distribution of the federal funds.

An ''area agency for youth'' will be designated to administer the funds, under the direction of a community board. States are encouraged to build on existing community resources and systems. After assessing the available assets for youth, as well as gaps in and barriers to services in the community, a plan to address the needs of local youth in the five core resources is developed for each region of the state. At least 30 percent of the funds provided to the area agency for youth must be used to address the needs of the most vulnerable youth populations in the region. As part of the planning process, area agencies for youth and community boards must identify measures of program effectiveness upon which future progress will be evaluated.

Funds are distributed, on a competitive basis, to community-based youth serving organizations and agencies in such a manner as to build a cohesive network of programs, services and activities for local youth. Provisions in the legislation ensure the participation of youth and their families in decisions about how best to meet the needs of local youth. There is a state or local match requirement of 20 percent for the first two years, increasing to 50 percent by the fifth and subsequent years. The match can meet through cash or in-kind contributions, fairly evaluated. The legislation contains an illustrative list of youth development activities, programs and services that may receive funds from the Younger American's Act. That list includes a broad variety of effective youth development activities such as youth mentoring, community youth centers and clubs, character development, non-school hours programs, sports and recreation activities, academic and cultural enrichment, workforce preparation, community service, and referrals to health and mental health services. The block grant is authorized for $500 million the first year, ramping

up to $2 billion in the fifth year of the legislation, for a total of $5.75 billion over five years.

Although research has demonstrated the effectiveness of positive youth development programs, accountability and evaluation must be part of any significant investment of federal funds. The legislation requires the Department of Health and Human Service to conduct extensive research and evaluation of the programs, services and activities funded under the Act. The Department also has responsibility for funding professional development activities for youth workers and other training and education initiatives to increase the capacity of local boards, agencies and organizations to implement the block grant. These efforts are authorized for $7 million per year.

Mr. KENNEDY. Mr. President, I commend Senator JEFFORDS for his leadership on this important legislation and it is a privilege to join him as a cosponsor on this legislation. I also commend the thirty-four youth organizations that comprise the National Collaboration for Youth and the more than 200 young people who have worked on this bill. They have been skillful and tireless in their efforts to focus on the need for a positive national strategy for youth.

Our goal in introducing the Younger Americans Act is to establish a national policy for youth which focuses on young people, not as problems, but as problem solvers. The Younger Americans Act is intended to create a local and nation-wide collaborative movement to provide programs that offer greater support for youth in the years of adolescence. This bill, modeled on the very successful Older Americans Act of 1965, will help youths between the ages of 10 and 19. It will provide assistance to communities for youths development programs that assure that all youth have access to the skills and character development needed to become good citizens.

In other successful bipartisan measures over the years, such as Head Start, child care, and the 21st century learning communities, we have created a support system for parents of preschool and younger school-age children. These programs reduce the risk that children will grow up to become juvenile delinquents by giving them a healthy and safe start. It's time to do the same thing for adolescents.

Americans overwhelmingly believe that government should invest in initiatives like this. Many studies detail the effectiveness of youth development programs. Beginning with the Carnegie Corporation Report in 1992, ''A Matter of Time—Risk and Opportunity in the Nonschool Hours,'' a series of studies have shown repeatedly that youth development programs at the community level produce powerful and positive results.

In this report this last March, ''Community Counts: How Youth Organizations Matter for Youth Development,'' Milbrey McLaughlin, professor of education at Stanford University, calls for communities to rethink how they design and deliver services for youths, particularly during non-school hours. The report confirms that community involvement is essential in creating and supporting effective programs that meet the needs of today's youth.

Effective community-based youth development programs build on five core resources that all youths need to be successful. These same core resources are the basis for the Younger Americans Act. Youths need ongoing relationships with caring adults, safe places with structured activities, access to services that promote healthy lifestyles, opportunities to acquire marketable skills, and opportunities for community service and community participation.

The Younger Americans Act will establish a way for communities to give thought and planning on the issues at the local level, and to involve both youths and parents in the process. The Act will provide $5.76 billion over the next five years for communities to conduct youth development programs that recognize the primary role of the family, promote the involvement of youth, coordinate services in the community, and eliminate barriers which prevent youth from obtaining the guidance and support they need to become successful adults. The Act also creates a national youth policy office and a national youth council to advise the President and Congress and help focus the country more effectively on the needs of young people.

Too often, the focus on youth has emphasized their problems, not their successes and their potential. This emphasis has sent a negative message to youth that needs to be reversed. We need to deal with negative behaviors, but we also need a broader strategy that provides a positive approach to youth. The Younger Americans Act will accomplish this goal in three ways, by focusing national attention on the strengths and contributions of youths, by providing funds to develop positive and cooperative youth development programs at the state and community levels, and by promoting the involvement of parents and youths in developing positive programs that strengthen families.

The time of adolescence is a complex transitional period of growth and change. We know what works. The challenge we face is to provide the resources to implement positive and practical programs effectively. Investing in youth in ways like that will pay enormous dividends for communities and our country. I urge all members of Congress to join in supporting this important legislation.

ADDITIONAL SPONSORS

S. 61

At the request of Mr. DEWINE, the name of the Senator from Montana (Mr. BAUCUS) was added as a cosponsor of S. 61, a bill to amend the Tariff Act of 1930 to eliminate disincentives to fair trade conditions.

S. 63

At the request of Mr. KOHL, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 63, a bill to amend the Internal Revenue Code of 1986 to provide a credit against tax for employers who provide child care assistance for dependents of their employees, and for other purposes.

S. 1185

At the request of Mr. ABRAHAM, the name of the Senator from Rhode Island (Mr. L. CHAFEE) was added as a cosponsor of S. 1185, a bill to provide small business certain protections from litigation excesses and to limit the product liability of non-manufacturer product sellers.

S. 1446

At the request of Mr. LOTT, the name of the Senator from Arkansas (Mr. HUTCHINSON) was added as a cosponsor of S. 1446, a bill to amend the Internal Revenue Code of 1986 to allow an additional advance refunding of bonds originally issued to finance governmental facilities used for essential governmental functions.

S. 1536

At the request of Mr. DEWINE, the name of the Senator from Washington (Mr. GORTON) was added as a cosponsor of S. 1536, a bill to amend the Older Americans Act of 1965 to extend authorizations of appropriations for programs under the Act, to modernize programs and services for older individuals, and for other purposes.

S. 1810

At the request of Mrs. MURRAY, the name of the Senator from New Jersey (Mr. TORRICELLI) was added as a cosponsor of S. 1810, a bill to amend title 38, United States Code, to clarify and improve veterans' claims and appellate procedures.

S. 2070

At the request of Mr. FITZGERALD, the name of the Senator from Texas (Mrs. HUTCHISON) was added as a cosponsor of S. 2070, a bill to improve safety standards for child restraints in motor vehicles.

S. 2163

At the request of Mrs. MURRAY, her name was added as a cosponsor of S. 2163, a bill to provide for a study of the engineering feasibility of a water exchange in lieu of electrification of the Chandler Pumping Plant at Prosser Diversion Dam, Washington.

S. 2700

At the request of Mr. L. CHAFEE, the name of the Senator from West Virginia (Mr. BYRD) was added as a cosponsor of S. 2700, a bill to amend the Comprehensive Environmental Response, Compensation and Liability Act of 1980 to promote the cleanup and reuse of brownfields, to provide financial assistance for brownfields revitalization, to enhance State response programs, and for other purposes.

S. 2764

At the request of Mr. KENNEDY, the names of the Senators from South Dakota (Mr. DASCHLE) and the Senator