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Part 1

BENEFICIARY IMPROVEMENT AND PROTECTION ACT OF 2000

OCTOBER 30, 2000.—Ordered to be printed

Mr. BLILEY, from the Committee on Commerce, submitted the following

R E P O R T

[To accompany H.R. 5291]

[Including cost estimate of the Congressional Budget Office]

The Committee on Commerce, to whom was referred the bill (H.R. 5291) to amend titles XVIII, XIX, and XXI of the Social Security Act to make additional corrections and refinements in the Medicare, Medicaid, and State children's health insurance programs, as revised by the Balanced Budget Act of 1997, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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AMENDMENT

The amendment is as follows:

Strike all after the enacting clause and insert the following:

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

(a) SHORT TITLE.—This Act may be cited as the "Beneficiary Improvement and Protection Act of 2000".

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

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

(1) BALANCED BUDGET ACT OF 1997.—The term "BBA" means the Balanced Budget Act of 1997 (Public Law 105–33).

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

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

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

TITLE I—BENEFICIARY IMPROVEMENTS

Sec. 101. Improving availability of QMB/SLMB application forms.
Sec. 102. Study on limitation on State payment for medicare cost-sharing affecting access to services for qualified medicare beneficiaries.
Sec. 103. Election of periodic colonoscopy.
Sec. 104. Waiver of 24-month waiting period for medicare coverage of individuals disabled with amyotrophic lateral sclerosis (ALS).
Sec. 105. Elimination of time limitation on medicare benefits for immunosuppressive drugs.
Sec. 106. Preservation of coverage of drugs and biologicals under part B of the medicare program.
Sec. 107. Demonstration of medicare coverage of medical nutrition therapy services.

TITLE II—OTHER MEDICARE PART B PROVISIONS

Subtitle A—Access to Technology

Sec. 201. Annual reports on national coverage determinations.
Sec. 202. National limitation amount equal to 100 percent of national median for new clinical laboratory test technologies; fee schedule for new clinical laboratory tests.
Sec. 203. Clarifying process and standards for determining eligibility of devices for pass-through payments under hospital outpatient PPS.
Sec. 204. Access to new technologies applied to screening mammography to enhance breast cancer detection.

Subtitle B—Provisions Relating to Physicians Services

Sec. 211. GAO study of gastrointestinal endoscopic services furnished in physicians offices and hospital outpatient department services.
Sec. 212. Treatment of certain physician pathology services.
Sec. 213. Physician group practice demonstration.
Sec. 214. Designation of separate category for interventional pain management physicians.
Sec. 215. Evaluation of enrollment procedures for medical groups that retain independent contractor physicians.

Subtitle C—Other Services

Sec. 221. 3-year moratorium on SNF part B consolidated billing requirements.
Sec. 222. Ambulatory surgical centers.
Sec. 223. 1-year extension of moratorium on therapy caps.
Sec. 224. Revision of medicare reimbursement for telehealth services.
Sec. 225. Payment for ambulance services.
Sec. 226. Contrast enhanced diagnostic procedures under hospital prospective payment system.
Sec. 227. 10-Year phased-in increase from 55 percent to 80 percent in the proportion of hospital bad debt recognized.
Sec. 228. State accreditation of diabetes self-management training programs.
Sec. 229. Update in renal dialysis composite rate.

TITLE III—MEDICARE PART A AND B PROVISIONS

Sec. 301. Home health services.
Sec. 302. Advisory opinions.
Sec. 303. Hospital geographic reclassification for labor costs for other PPS systems.
Sec. 304. Reclassification of a metropolitan statistical area for purposes of reimbursement under the medicare program.
Sec. 305. Making the medicare dependent, small rural hospital program permanent.
Sec. 306. Option to base eligibility on discharges during any of the 3 most recent audited cost reporting periods.
Sec. 307. Identification and reduction of medical errors by peer review organizations.
Sec. 308. GAO report on impact of the emergency medical treatment and active labor act (EMTALA) on hospital emergency departments.

TITLE IV—MEDICARE+CHOICE PROGRAM STABILIZATION AND IMPROVEMENTS

Subtitle A—Payment Reforms

Sec. 401. Increasing minimum payment amount.
Sec. 402. 3 percent minimum percentage update in 2001.
Sec. 403. 10-year phase in of risk adjustment based on data from substantially all settings.
Sec. 404. Transition to revised Medicare+Choice payment rates.

Subtitle B—Administrative Reforms

Sec. 411. Effectiveness of elections and changes of elections.

Sec. 412. Medicare+Choice program compatibility with employer or union group health plans.
Sec. 413. Uniform premium and benefits.

TITLE V—MEDICAID

Sec. 501. DSH payments.
Sec. 502. New prospective payment system for Federally-qualified health centers and rural health clinics.
Sec. 503. Optional coverage of legal immigrants under the medicaid program.
Sec. 504. Additional entities qualified to determine medicaid presumptive eligibility for low-income children.
Sec. 505. Improving welfare-to-work transition.
Sec. 506. Medicaid county-organized health systems.
Sec. 507. Medicaid recognition for services of physician assistants.

TITLE VI—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Sec. 601. Special rule for availability and redistribution of unused fiscal year 1998 and 1999 SCHIP allotments.
Sec. 602. Optional coverage of certain legal immigrants under SCHIP.

TITLE VII—EXTENSION OF SPECIAL DIABETES GRANT PROGRAMS

Sec. 701. Extension of juvenile and Indian diabetes grant programs.

TITLE I—BENEFICIARY IMPROVEMENTS

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

(a) THROUGH LOCAL SOCIAL SECURITY OFFICES.—

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

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

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

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

(2) CONFORMING AMENDMENT.—Section 1902(a)(8) (42 U.S.C. 1396a(a)(8)) is amended by inserting before the semicolon at the end the following: "and provide application forms for medical assistance for medicare cost-sharing under the plan to the Secretary in order to make them available through Federal offices under section 1804(d) within the State".

(b) STREAMLINING APPLICATION PROCESS.—

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

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

"(5)(A) The Secretary shall develop a simplified application form for use by individuals (including both qualified medicare beneficiaries and specified low-income medicare beneficiaries) in applying for medical assistance for medicare cost-sharing under this title. Such form shall be easily readable by applicants and uniform nationally.

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

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

"(i) to the Commissioner of Social Security for distribution through local social security offices;

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

"(iii) to persons upon request.".

(c) EFFECTIVE DATES.—

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

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

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

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

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

SEC. 103. ELECTION OF PERIODIC COLONOSCOPY.

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

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

(1) in paragraph (2)(E)—

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

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

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

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

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

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

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

"(4) ELECTION OF SCREENING COLONOSCOPY FOR INDIVIDUALS NOT AT HIGH RISK OF COLORECTAL CANCER INSTEAD OF SCREENING SIGMOIDOSCOPY.—An individual who is not at high risk of colorectal cancer may elect to receive a screening colonoscopy instead of a screening sigmoidoscopy.".

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 106. PRESERVATION OF COVERAGE OF DRUGS AND BIOLOGICALS UNDER PART B OF THE MEDICARE PROGRAM.

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

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

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

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project (in this section referred to as the "project") to examine the cost-effectiveness of providing medical nutrition therapy services under the medicare program and the financial impact of providing such services under the program.

(b) SCOPE OF SERVICES.—

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

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

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

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

(c) COVERAGE AS MEDICARE PART B SERVICES.—

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

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

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

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

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

(1) MEDICAL NUTRITION THERAPY SERVICES.—The term "medical nutrition therapy services" means nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional (as defined in paragraph (2)) pursuant to a referral by a physician (as defined in section 1861(r)(1) of the Social Security Act, 42 U.S.C. 1395x(r)(1)).

(2) REGISTERED DIETITIAN OR NUTRITION PROFESSIONAL.—

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

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

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

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

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

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

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

TITLE II—OTHER MEDICARE PART B PROVISIONS

Subtitle A—Access to Technology

SEC. 201. ANNUAL REPORTS ON NATIONAL COVERAGE DETERMINATIONS.

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

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

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

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

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

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

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

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

"(E) In the case of a clinical diagnostic laboratory test which is described by a new code in the Health Care Financing Administration Common Procedure Coding System (commonly referred to as 'HCPCS'), for which the Secretary is not able to crosswalk with a similar test with an established schedule amount, the Secretary shall establish for purposes of subparagraph (A) a single fee schedule amount for all areas in the following manner:

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

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

"(iii) For years beginning with 2002, the Secretary shall also cause to have published in the Federal Register by not later than December 1 of the year prior to its application, the adjustments to the interim fee schedule amount de-

scribed in clause (ii) for each such new test for which an interim fee schedule amount was established for a year, including adjustments to such fee schedule amounts in response to comments.".

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

SEC. 203. CLARIFYING PROCESS AND STANDARDS FOR DETERMINING ELIGIBILITY OF DEVICES FOR PASS-THROUGH PAYMENTS UNDER HOSPITAL OUTPATIENT PPS.

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

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

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

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

"(i) ESTABLISHMENT OF CATEGORIES.—The Secretary shall establish categories of medical devices based on type of medical device as follows:

"(I) IN GENERAL.—The Secretary shall establish criteria that will be used for creation of categories through rulemaking (which may include use of an interim final rule with comment period). Such categories shall be established in a manner such that no medical device is described by more than one category. Such criteria shall include a test of whether the average cost of devices that would be included in a category, as estimated by the Secretary, is not insignificant as described in paragraph (A)(iv)(II).

"(II) INITIAL CATEGORIES.—The categories to be applied as of the category-based pass-through implementation date specified pursuant to subclause (V) shall be established in a manner such that each medical device that meets the requirements of clause (ii) or (iv) of subparagraph (A) as of such date is included in a such a category. For purposes of the preceding sentence, whether a medical device meets the requirements of clause (ii) or (iv) of subparagraph (A) as of such date shall be determined without regard to clause (ii) of this subparagraph and on the basis of the program memoranda issued before such date identifying medical devices that meet such requirements.

"(III) ADDING CATEGORIES.—The Secretary shall promptly establish a new category of medical device under this clause for any medical device that meets the requirements of subparagraph (A)(iv) and for which none of the categories in effect or that were previously in effect (as described in subparagraph (C)(iii)) is appropriate. The Secretary shall only establish a new category for a medical device that is described by a category that was previously in effect if the Secretary determines, in accord with criteria established under subclause (I) of this clause, that the device represents a significant advance in medical technology that is expected to significantly improve the treatment of Medicare beneficiaries.

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

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

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

"(I) the device is described by a category established under clause (i), and

"(II) an application under section 515 of the Federal Food, Drug, and Cosmetic Act has been approved with respect to the device, or the device has been cleared for market under section 510(k) of such Act, or the device is exempt from the requirements of section 510(k) of such Act pursuant to subsection (l) or (m) of section 510 of such Act or section 520(g) of such Act, without an additional requirement for application or prior approval.

"(C) LIMITED PERIOD OF PAYMENT.—

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

"(I) on the first date this subsection is implemented in the case of a drug or biological described in clause (i), (ii), or (iii) of subparagraph (A) and in the case of a drug or biological described in subparagraph (A)(iv) and for which payment under this part is made as an outpatient hospital service before such first date; or

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

"(ii) MEDICAL DEVICES.—Except as provided in clause (iv), payment shall be made under this paragraph with respect to a medical device only if such device—

"(I) is described by a category of medical devices established under subparagraph (B)(i); and

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

"(iii) PERIOD FOR WHICH CATEGORY IS IN EFFECT.—For purposes of this subparagraph and subparagraph (B), a category of medical devices established under subparagraph (B)(i) shall be in effect for a period of at least 2 years, but not more than 3 years, that begins—

"(I) in the case of a category established under subparagraph (B)(i)(II), on the first date on which payment was made under this paragraph for any device described by such category (including payments made during the period before the category-based pass-through implementation date); and

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

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

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

"(II) notwithstanding subclause (I), the Secretary shall make payments under this paragraph during the period beginning one month after the date of enactment of the Beneficiary Improvement and Protection Act of 2000 and ending on the same ending date in subclause (I) with respect to any medical device that is not included in a program memorandum referred to in subparagraph (B)(i)(II) but that is substantially similar (other than with respect to the restriction in subparagraph (A)(iv)(I)) to devices that are so included and that the Secretary determines is likely to be described by a initial category established under such subparagraph.".

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

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

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

(3) in paragraph (6)(A), by striking "the cost of the device, drug, or biological" and inserting "the cost of the drug or biological or the average cost of the category of devices".

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

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

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

(1) in subparagraph (A)—

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

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

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

"(D) INCREASE IN PAYMENT LIMIT FOR NEW TECHNOLOGIES.—In the case of new technologies applied to screening mammography performed beginning in 2001 and determined by the Secretary to enhance the detection of breast cancer, the limit applied under this paragraph for 2001 shall be increased by $15.".

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

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

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

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

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

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

Subtitle B—Provisions Relating to Physicians Services

SEC. 211. GAO STUDY OF GASTROINTESTINAL ENDOSCOPIC SERVICES FURNISHED IN PHYSICIANS OFFICES AND HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

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

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

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

(3) assess the implications for access to care for Medicare beneficiaries if Medicare were not to cover gastrointestinal endoscopic services in physicians offices.

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

SEC. 212. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

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

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

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

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

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

(B) is not enrolled in (i) a Medicare+Choice plan under part C of such title (42 U.S.C. 1395w–21 et seq.), (ii) a plan offered by an eligible organization under section 1876 of such Act (42 U.S.C. 1395mm), (iii) a program of all-inclusive care for the elderly (PACE) under section 1898 of such Act, or (iv) a social health maintenance organization (SHMO) demonstration project established under section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203).

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

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

(d) GAO REPORT.—

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

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

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

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

SEC. 213. PHYSICIAN GROUP PRACTICE DEMONSTRATION.

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

"DEMONSTRATION OF APPLICATION OF PHYSICIAN VOLUME INCREASES TO GROUP PRACTICES

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

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

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

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

"(C) reward physicians for improving health outcomes.

"(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1866B.

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

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

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

"(b) ELIGIBILITY CRITERIA.—

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

"(2) PAYMENT METHOD.—A health care group participating in the demonstration under this section shall agree with respect to services furnished to bene-

ficiaries within the scope of the demonstration (as determined under subsection (c))—

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

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

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

"(c) PATIENTS WITHIN SCOPE OF DEMONSTRATION.—

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

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

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

"(d) INCENTIVES.—

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

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

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

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

"(3) ADDITIONAL BONUS FOR PROCESS AND OUTCOME IMPROVEMENTS.—At such time as the Secretary has established appropriate criteria based on evidence the Secretary determines to be sufficient, the Secretary shall also pay to a participating health care group (subject to paragraph (4)) an additional bonus for a year, equal to such portion as the Secretary may designate of the saving to the program under this title resulting from process improvements made by and patient outcome improvements attributable to activities of the group.

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

"PROVISIONS FOR ADMINISTRATION OF DEMONSTRATION PROGRAM

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

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

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

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

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

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

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

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

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

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

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

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

"(6) ADMINISTRATIVE REVIEW OF DECISIONS AFFECTING INDIVIDUALS AND ENTITIES FURNISHING SERVICES.—An individual or entity furnishing services under the demonstration program shall be entitled to a review by the program administrator (or, if the Secretary has not contracted with a program administrator, by the Secretary) of a decision not to enter into, or to terminate, or not to renew, an agreement with the entity to provide health care items or services under the program.

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

"(8) PAYMENT IN FULL.—

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

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

"(b) CONTRACTS FOR PROGRAM ADMINISTRATION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(9) INFORMATION SHARING.—Notwithstanding section 1106 and section 552a of title 5, United States Code, the Secretary is authorized to disclose to an entity with a program administration contract under this subsection such information (including medical information) on individuals receiving health care items and services under the program as the entity may require to carry out its responsibilities under the contract.

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

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

"(2) BONUSES.—Notwithstanding any other provision of law, but subject to subparagraph (B)(ii), the Secretary may make bonus payments under the program from the Federal Health Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in amounts that do not exceed the amounts authorized under the program in accordance with the following:

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

"(B) PAYMENTS TO ENTITIES FURNISHING SERVICES.—

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

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

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

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

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

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

"(3) Establishment of program administration contract performance standards under subsection (b)(6), the refusal to renew a program administration contract, or the noncompetitive award or renewal of a program administration contract under subsection (b)(4)(B).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subtitle C—Other Services

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

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

(b) MORATORIUM IN PROVIDER AGREEMENT PROVISION.—Section 1866(a)(1)(H)(ii)(I) (42 U.S.C. 1395cc(a)(1)(H)(ii)(I) is amended by inserting "in the case of a resident

who is in a stay covered under part A, and for services furnished on or after October 1, 2003, in the case of a resident who is not in a stay covered under such part" before the comma.

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

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

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

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

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

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

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

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

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

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

SEC. 222. AMBULATORY SURGICAL CENTERS.

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

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

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

"(2) in each of the following 2 years a proportion (specified by the Secretary and not to exceed ½, and ¾, respectively) of the payment for such services shall be made under such system and the remainder shall be made in accordance with current regulations.".

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

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

SEC. 223. 1-YEAR EXTENSION OF MORATORIUM ON THERAPY CAPS.

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

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

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

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

"(a) TELEHEALTH SERVICES REIMBURSED.—

"(1) IN GENERAL.—Not later than April 1, 2001, the Secretary of Health and Human Services shall make payments from the Federal Supplementary Medical Insurance Trust Fund in accordance with the methodology described in subsection (b) for services for which payment may be made under part B of title

XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) that are furnished via a telecommunications system by a physician or practitioner to an eligible telehealth beneficiary.

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

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

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

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

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

"(i) for 2001 (beginning with April 1, 2001) and 2002, $20; and

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

"(2) APPLICATION OF PART B COINSURANCE AND DEDUCTIBLE.—Any payment made under this section shall be subject to the coinsurance and deductible requirements under subsections (a)(1) and (b) of section 1833 of the Social Security Act (42 U.S.C. 1395l).

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

"(c) TELEPRESENTER NOT REQUIRED.—Nothing in this section shall be construed as requiring an eligible telehealth beneficiary to be presented by a physician or practitioner at the originating site for the furnishing of a service via a telecommunications system, unless it is medically necessary as determined by the physician or practitioner at the distant site.

"(d) COVERAGE OF ADDITIONAL SERVICES.—

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

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

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

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

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

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

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

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

"(B) any requirement relating to the certification of a physician required under section 1814(a)(2)(C) or section 1835(a)(2)(A) of such Act (42 U.S.C. 1395f(a)(2)(C), 1395n(a)(2)(A)).

"(3) CONSTRUCTION.—Nothing in this section shall be construed as waiving the requirement for a physician certification under section 1814(a)(2)(C) or section 1835(a)(2)(A) of such Act (42 U.S.C. 1395f(a)(2)(C), 1395n(a)(2)(A)) for the payment for home health services, whether or not furnished via a telecommunications system.

"(f) COVERAGE OF ITEMS AND SERVICES.—

"(1) IN GENERAL.—Subject to paragraph (2), payment for items and services provided pursuant to subsection (a) shall include payment for professional consultations, office visits, office psychiatry services, including any service identified as of July 1, 2000, by HCPCS codes 99241–99275, 99201–99215, 90804–90809, and 90862, and any additional item or service specified by the Secretary.

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

"(g) DEFINITIONS.—In this section:

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

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

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

"(C) effective January 1, 2002, in an inner-city area that is medically underserved (as defined in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3))); or

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

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

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

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

"(5) ORIGINATING SITE.—

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

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

"(i) On or after April 1, 2001—

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

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

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

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

"(ii) On or after January 1, 2002—

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

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

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

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

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

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

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

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

SEC. 225. PAYMENT FOR AMBULANCE SERVICES.

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

(b) MILEAGE PAYMENTS.—Section 1834(l)(2)(E) (42 U.S.C. 1395m(l)(2)(E)) is amended by inserting before the period at the end the following: ", except that such phase-in shall provide for full payment of any national mileage rate beginning with

the effective date of the fee schedule for ambulance services provided by suppliers in any State where payment for such services did not include a separate amount for all mileage prior to the implementation of the fee schedule".

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

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

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit a report to the Secretary of Health and Human Services and Congress on the study conducted under paragraph (1). Such report shall include recommendations for any changes in methodology or payment levels necessary to fairly compensate suppliers of ambulance services and to ensure the access of medicare beneficiaries to such services under the medicare program.

SEC. 226. CONTRAST ENHANCED DIAGNOSTIC PROCEDURES UNDER HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

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

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

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

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

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

(b) CONFORMING AMENDMENT.—Section 1861(t)(1) (42 U.S.C. 1395x(t)(1)) is amended by inserting "(including contrast agents)" after "only such drugs".

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

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

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

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

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

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

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

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

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

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

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

(2) in subparagraph (A)—

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

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

(3) in subparagraph (B)—

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

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

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

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

(E) by adding at the end the following:

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

lished by the National Diabetes Advisory Board and subsequently revised as described in clause (i).".

SEC. 229. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.

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

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

TITLE III—MEDICARE PART A AND B PROVISIONS

SEC. 301. HOME HEALTH SERVICES.

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

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

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

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

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

(b) TREATMENT OF BRANCH OFFICES.—

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

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

(c) CLARIFICATION OF THE DEFINITION OF HOMEBOUND.—

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

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

(d) 1-YEAR DELAY IN REPORT.—Section 302(c) of the BBRA is amended by striking "six months" and inserting "18 months".

SEC. 302. ADVISORY OPINIONS.

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

(b) NONDISCLOSURE OF REQUESTS AND SUPPORTING MATERIALS.—

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

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

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

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

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

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

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

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

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

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

(D) INPATIENT LONG-TERM CARE HOSPITAL SERVICES.—The prospective payment system for inpatient hospital services of long-term care hospitals under section 123 of the BBRA.

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

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

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

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

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

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

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

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

(b) CONFORMING AMENDMENTS.—

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

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

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

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

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

(a) OPTION TO BASE ELIGIBILITY ON DISCHARGES DURING ANY OF THE 3 MOST RECENT AUDITED COST REPORTING PERIODS.—Section 1886(d)(5)(G)(iv)(IV) (42 U.S.C. 1395ww(d)(5)(G)(iv)(IV)) is amended by inserting ", or any of the 3 most recent audited cost reporting periods," after "1987".

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

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

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

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

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

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

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

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

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

(3) The Balanced Budget Act of 1997 made many changes in hospital and physician reimbursement that appear to have had unintended consequences that have hampered the ability of hospitals, emergency physicians, and physicians covering emergency department call to comply with the requirements of EMTALA.

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

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

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

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

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

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

(b) REPORT.—The Comptroller General of the United States shall submit a report to the Subcommittee on Health and Environment of the Committee on Commerce of the House of Representatives by May 1, 2001, on the effect of the Emergency Medical Treatment and Active Labor Act on hospitals, emergency physicians, and physicians covering emergency department call throughout the United States, focusing on those in Arizona (including Phoenix) and California (including Los Angeles).

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

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

(2) the extent to which the regulatory requirements and enforcement of EMTALA have expanded beyond the legislation's original intent;

(3) estimates for the total dollar amount of EMTALA-related care uncompensated costs to emergency physicians, physicians covering emergency department call, hospital emergency departments;

(4) the extent to which different portions of the United States may be experiencing different levels of uncompensated EMTALA-related care;

(5) the extent to which EMTALA would be classified as an unfunded mandate if it were enacted today;

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

(7) possible sources of funds, including medicare hospital bad debt accounts, that are available to hospitals to assist with the cost of such uncompensated care; and

(8) the financial strain that illegal immigration populations, the uninsured, and the underinsured place on hospital emergency departments, emergency physicians, and physicians covering emergency department call.

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

TITLE IV—MEDICARE+CHOICE PROGRAM STABILIZATION AND IMPROVEMENTS

Subtitle A—Payment Reforms

SEC. 401. INCREASING MINIMUM PAYMENT AMOUNT.

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

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

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

"(II) For 2001 for any area in a Metropolitan Statistical Area with a population of more than 250,000, $525 (and for any other area, $475).".

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

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

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

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

(1) by striking "and" at the end of subclause (I);

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

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

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

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

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

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

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

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

(2) any part of the service area or areas addressed in such notice includes a county for which the Medicare+Choice capitation rate under section 1853(c) of

such Act (42 U.S.C. 1395w–23(c)) for 2001, as determined under subsection (a), is higher than the rate previously determined for such year,

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

Subtitle B—Administrative Reforms

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

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

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

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

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

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

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

SEC. 413. UNIFORM PREMIUM AND BENEFITS.

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

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

TITLE V—MEDICAID

SEC. 501. DSH PAYMENTS.

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

(1) in paragraph (2)—

(A) by striking "2002" in the heading and inserting "2000";

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

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

(2) in paragraph (3)—

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

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

(b) SPECIAL RULE FOR MEDICAID DSH ALLOTMENT FOR EXTREMELY LOW DSH STATES.—Section 1923(f)(3) (42 U.S.C. 1396r–4(f)(3)) is amended—

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

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

"(C) SPECIAL RULE FOR EXTREMELY LOW DSH STATES.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 1999, as reported to the Administrator of the Health Care Financing Administration as of August 31, 2000, is greater than 0 but less than 1 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2001 shall be increased to 1 percent of the State's

total amount of expenditures under such plan for such assistance during such fiscal year. In subsequent fiscal years, such increased allotment is subject to an increase for inflation as provided in subparagraph (A).".

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

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

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

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

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

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

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

"(g) IDENTIFICATION OF PATIENTS FOR PURPOSES OF MAKING DSH PAYMENTS.—Each contract with a managed care entity under section 1903(m) or under section 1905(t)(3) shall require the entity either—

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

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

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

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

(B) in subsection (b)(2), by inserting after "a State plan approved under this title in a period" the following: "(regardless of whether they receive benefits on a fee-for-service basis or through a managed care entity)"; and

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

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

SEC. 502. NEW PROSPECTIVE PAYMENT SYSTEM FOR FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.

(a) IN GENERAL.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (13)—

(A) in subparagraph (A), by adding "and" at the end;

(B) in subparagraph (B), by striking "and" at the end; and

(C) by striking subparagraph (C); and

(2) by inserting after paragraph (14) the following new paragraph:

"(15) provide for payment for services described in clause (B) or (C) of section 1905(a)(2) under the plan in accordance with subsection (aa);".

(b) NEW PROSPECTIVE PAYMENT SYSTEM.—Section 1902 (42 U.S.C. 1396a) is amended by adding at the end the following:

"(aa) PAYMENT FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.—

"(1) IN GENERAL.—Beginning with fiscal year 2001 and each succeeding fiscal year, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by a Federally-qualified health center and services described in section 1905(a)(2)(B) furnished by a rural health clinic in accordance with the provisions of this subsection. The payment rate under this subsection shall not vary based upon the site services are provided in the case of the same center or clinic entity.

"(2) FISCAL YEAR 2001.—Subject to paragraph (4), for services furnished during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of serv-

ices to which such regulations do not apply, the same methodology used under section 1833(a)(3), adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001.

"(3) FISCAL YEAR 2002 AND SUCCEEDING FISCAL YEARS.—Subject to paragraph (4), for services furnished during fiscal year 2002 or a succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this subsection for the preceding fiscal year—

"(A) increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) for that fiscal year; and

"(B) adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during that fiscal year.

"(4) ESTABLISHMENT OF INITIAL YEAR PAYMENT AMOUNT FOR NEW CENTERS OR CLINICS.—In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after fiscal year 2000, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by the center or services described in section 1905(a)(2)(B) furnished by the clinic in the first fiscal year in which the center or clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year based on the rates established under this subsection for the fiscal year for other such centers or clinics located in the same or adjacent area with a similar case load, service package, and case mix or, in the absence of such a center or clinic, in accordance with the regulations and methodology referred to in paragraph (2) or based on such other tests of reasonableness as the Secretary may specify. For each fiscal year following the fiscal year in which the entity first qualifies as a Federally-qualified health center or rural health clinic, the State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

"(5) ADMINISTRATION IN THE CASE OF MANAGED CARE.—In the case of services furnished by a Federally-qualified health center or rural health clinic pursuant to a contract between the center or clinic and a managed care entity (as defined in section 1932(a)(1)(B)), the State plan shall provide for payment to the center or clinic (at least quarterly) by the State of a supplemental payment equal to the amount (if any) by which the amount determined under paragraphs (2), (3), and (4) of this subsection exceeds the amount of the payments provided under the contract.

"(6) ALTERNATIVE PAYMENT METHODOLOGIES.—Notwithstanding any other provision of this section, the State plan may provide for payment in any fiscal year to a Federally-qualified health center for services described in section 1905(a)(2)(C) or to a rural health clinic for services described in section 1905(a)(2)(B) in an amount which is determined under an alternative payment methodology that—

"(A) is agreed to by the State and the center or clinic; and

"(B) results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under this section.".

(c) CONFORMING AMENDMENTS.—

(1) Section 4712 of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 508) is amended by striking subsection (c).

(2) Section 1915(b) (42 U.S.C. 1396n(b)) is amended by striking "1902(a)(13)(C)" and inserting "1902(a)(15), 1902(aa),".

(d) GAO STUDY OF FUTURE REBASING.—The Comptroller General of the United States shall provide for a study on the need for, and how to, rebase or refine costs for making payment under the medicaid program for services provided by Federally-qualified health centers and rural health clinics (as provided under the amendments made by this section). The Comptroller General shall provide for submittal of a report on such study to the Congress by not later than 4 years after the date of the enactment of this Act.

(e) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2000, and apply to services furnished on or after such date.

SEC. 503. OPTIONAL COVERAGE OF LEGAL IMMIGRANTS UNDER THE MEDICAID PROGRAM.

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

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

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

"(4)(A) A State may elect (in a plan amendment under this title) to provide medical assistance under this title, notwithstanding sections 401(a), 402(b), 403, and 421

of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, for aliens who are lawfully residing in the United States (including battered aliens described in section 431(c) of such Act) and who are otherwise eligible for such assistance, within either or both of the following eligibility categories, but only if they have lawfully resided in the United States for 2 years:

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

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

"(B) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien who has lawfully resided in the United State for 2 years on the basis of provision of assistance to such category.".

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

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

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

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

(2) by inserting "eligibility of a child for medical assistance under the State plan under this title, or eligibility of a child for child health assistance under the program funded under title XXI, (III) is an elementary school or secondary school, as such terms are defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801), an elementary or secondary school operated or supported by the Bureau of Indian Affairs, a State or tribal child support enforcement agency, a child care resource and referral agency, an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act, or a State or tribal office or entity involved in enrollment in the program under this title, under part A of title IV, under title XXI, or that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437 et seq.) or under the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4101 et seq.), or (IV) any other entity the State so deems, as approved by the Secretary" before the semicolon.

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

(1) in subsection (b)(3)(A)(i), by striking "42 U.S.C. 9821" and inserting "42 U.S.C. 9831";

(2) in subsection (b)(3)(A)(ii), by striking "paragraph (1)(A)" and inserting "paragraph (2)"; and

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

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

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

(d) APPLICATION UNDER TITLE XXI.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is amended by adding at the end the following new subparagraph:

"(D) Section 1920A (relating to presumptive eligibility).".

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

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

(b) SIMPLIFICATION OPTIONS.—

(1) STATE OPTION TO WAIVE REPORTING REQUIREMENTS.—Section 1925(b)(2) of such Act (42 U.S.C. 1396r–6(b)(2)) is amended by adding at the end the following new subparagraph:

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

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

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

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

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

"(1) IN GENERAL.—At State option, the provisions of this section shall not apply to a State that uses the authority under section 1931(b)(2)(C) to make medical assistance available under the State plan under this title, at a minimum, to all individuals described in section 1931(b)(1) in families with gross incomes (determined without regard to work-related child care expenses of such individuals) at or below 185 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

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

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

SEC. 506. MEDICAID COUNTY-ORGANIZED HEALTH SYSTEMS.

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

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

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

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

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

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

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

(2) Section 1929(e)(2)(A) (42 U.S.C. 1396t(e)(2)(A)) is amended by striking "1905(a)(23)" and inserting "1905(a)(24)".

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

TITLE VI—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

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

(a) CHANGE IN RULES FOR REDISTRIBUTION AND RETENTION OF UNUSED SCHIP ALLOTMENTS FOR FISCAL YEARS 1998 AND 1999.—Section 2104 (42 U.S.C. 1397dd) is amended by adding at the end the following new subsection:

"(g) RULE FOR REDISTRIBUTION AND EXTENDED AVAILABILITY OF FISCAL YEARS 1998 AND 1999 ALLOTMENTS.—

"(1) AMOUNT REDISTRIBUTED.—

"(A) IN GENERAL.—In the case of a State that expends all of its allotment under subsection (b) or (c) for fiscal year 1998 by the end of fiscal year 2000, or for fiscal year 1999 by the end of fiscal year 2001, the Secretary shall redistribute to the State under subsection (f) (from the fiscal year 1998 or 1999 allotments of other States, respectively, as determined by the application of paragraphs (2) and (3) with respect to the respective fiscal year)) the following amount:

"(i) STATE.—In the case of 1 of the 50 States or the District of Columbia, with respect to—

"(I) the fiscal year 1998 allotment, the amount by which the State's expenditures under this title in fiscal years 1998, 1999, and 2000 exceed the State's allotment for fiscal year 1998 under subsection (b); or

"(II) the fiscal year 1999 allotment, the amount by which the State's expenditures under this title in fiscal years 1999, 2000, and 2001 exceed the State's allotment for fiscal year 1999 under subsection (b).

"(ii) TERRITORY.—In the case of a commonwealth or territory described in subsection (c)(3), an amount that bears the same ratio to 1.05 percent of the total amount described in paragraph (2)(B)(i)(I) as the ratio of the commonwealth's or territory's fiscal year 1998 or 1999 allotment under subsection (c) (as the case may be) bears to the total of all such allotments for such fiscal year under such subsection.

"(B) EXPENDITURE RULES.—An amount redistributed to a State under this paragraph with respect to fiscal year 1998 or 1999—

"(i) shall not be included in the determination of the State's allotment for any fiscal year under this section;

"(ii) notwithstanding subsection (e), shall remain available for expenditure by the State through the end of fiscal year 2002; and

"(iii) shall be counted as being expended with respect to a fiscal year allotment in accordance with applicable regulations of the Secretary.

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

"(A) IN GENERAL.—Notwithstanding subsection (e):

"(i) FISCAL YEAR 1998 ALLOTMENT.—Of the amounts allotted to a State pursuant to this section for fiscal year 1998 that were not expended by the State by the end of fiscal year 2000, the amount specified in subparagraph (B) for fiscal year 1998 for such State shall remain available for expenditure by the State through the end of fiscal year 2002.

"(ii) FISCAL YEAR 1999 ALLOTMENT.—Of the amounts allotted to a State pursuant to this subsection for fiscal year 1999 that were not expended by the State by the end of fiscal year 2001, the amount specified in subparagraph (B) for fiscal year 1999 for such State shall remain available for expenditure by the State through the end of fiscal year 2002.

"(B) AMOUNT REMAINING AVAILABLE FOR EXPENDITURE.—The amount specified in this subparagraph for a State for a fiscal year is equal to—

"(i) the amount by which (I) the total amount available for redistribution under subsection (f) from the allotments for that fiscal year, exceeds (II) the total amounts redistributed under paragraph (1) for that fiscal year; multiplied by

"(ii) the ratio of the amount of such State's unexpended allotment for that fiscal year to the total amount described in clause (i)(I) for that fiscal year.

"(C) USE OF UP TO 10 PERCENT OF RETAINED 1998 ALLOTMENTS FOR OUTREACH ACTIVITIES.—Notwithstanding section 2105(c)(2)(A), with respect to any State described in subparagraph (A)(i), the State may use up to 10 percent of the amount specified in subparagraph (B) for fiscal year 1998 for expenditures for outreach activities approved by the Secretary.

"(3) DETERMINATION OF AMOUNTS.—For purposes of calculating the amounts described in paragraphs (1) and (2) relating to the allotment for fiscal year 1998 or fiscal year 1999, the Secretary shall use the amounts reported by the States not later than November 30, 2000, or November 30, 2001, respectively, on HCFA Form 64 or HCFA Form 21, as approved by the Secretary.".

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 4901 of BBA (111 Stat. 552).

SEC. 602. OPTIONAL COVERAGE OF CERTAIN LEGAL IMMIGRANTS UNDER SCHIP.

(a) IN GENERAL.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)), as amended by section 504, is amended by adding at the end the following new subparagraph:

"(E) Section 1903(v)(4) (relating to optional coverage of categories of lawfully residing alien children), but only if the State has elected to apply such section to the category of children under title XIX.".

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

TITLE VII—EXTENSION OF SPECIAL DIABETES GRANT PROGRAMS

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

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

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

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

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

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

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

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

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

PURPOSE AND SUMMARY

The purpose of this legislation is to improve and protect patient access to Federal health care programs. The savings achieved through changes to the Medicare and Medicaid programs enacted as part of the Balanced Budget Act of 1997 were integral to balancing the budget. Since passage of that legislation, the Congressional Budget Office has estimated that the savings from the Medicare and Medicaid programs has exceeded the original targets, and there is concern that beneficiaries in these programs may experience difficulty in accessing health services. This legislation seeks to address many of these access concerns.

H. R. 5291 increases payments to providers under the Medicare and Medicaid programs, improves the quality of benefits for beneficiaries, and adjusts the allocation formula under the State Children Health Insurance Program (SCHIP).

BACKGROUND AND NEED FOR LEGISLATION

In the Balanced Budget Act of 1997 (BBA '97), the Committee made difficult decisions in how best to address the concern of the Nation that the Medicare program was facing financial ruin, and changes needed to be made. Moving to a prospective payment system for hospital outpatient department services, skilled nursing facility services and home health services were just some of the changes the Congressional Budget Office (CBO) projected would reduce Federal spending by $103 billion over 5 years, and create new efficiencies within the Medicare program.

CBO continues to revise their estimates of spending in the Medicare program. Every revision they have released since passage of BBA '97 shows that spending is less than originally anticipated. In addition, spending in fiscal year 1999 was actually less than it was in fiscal year 1998.

BBA '97 also made changes to reduce Federal spending in Medicaid. Last November, Congress responded to the low spending in Medicare and Medicaid by refining the BBA '97 and restoring nearly $16 billion over 5 years to the Medicare, Medicaid, and SCHIP programs.

There are concerns that those changes were not enough. Given the record surpluses realized in recent years, and based on testimony provided to the Committee on this issue, this legislation responds to those concerns.

HEARINGS

The Subcommittee on Health and Environment held a hearing on July 19, 2000 entitled "BBA '97: A Look at the Current Impact on Patients and Providers," which laid the foundation for the development of H.R. 5291, the Beneficiary Improvement and Protection Act of 2000. The Subcommittee received testimony from: Dr. Gail Wilensky of the Medicare Payment Advisory Commission (MedPAC) and Dr. Bill Scanlon of the General Accounting Office on work they have done analyzing the impact BBA '97 has had on Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP).

The Subcommittee also received testimony from patient and provider groups who discussed the impact the changes have had on their ability to receive or deliver quality health care. Witnesses consisted of Dr. Rowen K. Zetterman, American College of Gastroenterology; Ms. Marilyn Tavenner, HCA-The HealthCare Company; Mr. Max Richtman, The National Committee to Preserve Social Security and Medicare; Ms. Karen Coughlin, Physicians Health Services, Inc.; Ms. Mary Lou Connolly, UCSD HomeCare; Mr. Daniel R. Hawkins, Jr., National Association of Community Health Centers, Inc.; and Ms. Juliet Hancock, The National Association for the Support of Long Term Care.

COMMITTEE CONSIDERATION

On September 26, 2000 Full Committee met in open markup session and ordered H.R. 5291 reported to the House, as amended, by a voice vote.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. There were no record votes taken in connection with ordering H.R. 5291 reported. A motion by Mr. Bliley to order H.R. 5291 reported to the House, with an amendment, was agreed to by a voice vote.

The following amendment was agreed to by a voice vote—

> An amendment in the nature of a substitute by Mr. Bilirakis, No. 1, improving beneficiary access to Federal health care benefits through changes to the Medicare, Medicaid and SCHIP programs.

The following amendments were withdrawn—

> An amendment to the amendment in the nature of a substitute by Mrs. Wilson, No. 1a, giving States greater flexibility to use SCHIP funds to cover children currently not eligible and allowing States to expand some services.
>
> An amendment to the amendment in the nature of a substitute by Mr. Barton, No. 1b, requiring community mental health centers to meet State licensing and certifi-

cation requirements as well as ensuring that such facilities provide certain core services.

An amendment to the amendment in the nature of a substitute by Mr. Strickland, No. 1c, allowing the clinical training portion of clinical psychology graduate medical education programs to be reimbursed under Medicare.

An amendment to the amendment in the nature of a substitute by Mr. Engel, No. 1d, prohibiting HCFA from issuing any new regulations that would modify the upper limits test applied to Medicaid spending for plans approved before October 2, 2000.

An amendment to the amendment in the nature of a substitute, by Mrs. Wilson, No. 1e, making improvements to the Medicare+Choice program.

An amendment to the amendment in the nature of a substitute, by Mr. Greenwood, No. 1f, placing a moratorium on any proposed or final regulation relating to the Medicare upper payment limit test applied to State Medicaid spending for any approved State plan in place as of the date of enactment and requiring the Secretary of Health and Human Services to work with States to develop methods to ensure that Federal Medicaid funds are spent on Medicaid eligible services for Medicaid eligible beneficiaries.

An amendment to the amendment in the nature of a substitute, by Mr. Rush, No. 1g, setting the formula for the Medicaid upper payment limits for each class of facility in a State.

An amendment to the amendment in the nature of a substitute, by Mr. Stearns, No. 1h, making various changes to how the Health Care Financing Administration audits physician payments and other issues affecting physicians.

An amendment to the amendment in the nature of a substitute, by Mr. Deutsch, No. 1i, providing for a Medicare+Choice demonstration project to allow Medicare+Choice plans to purchase home care services from a caregiver through a home health referral agency.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee held a legislative hearing and made findings that are reflected in this report.

COMMITTEE ON GOVERNMENT REFORM OVERSIGHT FINDINGS

Pursuant to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Reform.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 5291, the Beneficiary Improvement and Protection Act of 2000, would result

in new or increased budget authority, entitlement authority, or tax expenditures or revenues consistent with the estimate submitted by the Congressional Budget Office.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 2, 2000.

Hon. TOM BLILEY,
Chairman, Committee on Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: At your request, the Congressional Budget Office has prepared the attached table showing our preliminary estimate of the changes in direct spending that would result from enacting H.R. 5291, the Beneficiary Health Improvement Act, as ordered reported by the House Committee on Commerce on September 27, 2000. This estimate is based on draft legislative language and modifications discussed with staff.

CBO estimates that enacting the bill would increase direct spending by $1.7 billion in 2001, $18 billion over the 2001–2005 period, and $55 billion over the 2001–2010 period. Because the bill would affect direct spending, pay-as-you-go procedures would apply.

I hope this information is helpful to you. The CBO staff contact is Tom Bradley.

Sincerely,

STEVEN LIEBERMAN
(For Dan L. Crippen, Director).

Attachment.

CBO ESTIMATE OF DIRECT SPENDING IN H.R. 5291, THE BENEFICIARY HEALTH IMPROVEMENT ACT, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON COMMERCE ON SEPTEMBER 27, 2000 (BASED ON DRAFT LEGISLATIVE LANGUAGE AND MODIFICATIONS DISCUSSED WITH STAFF)

	Outlays by fiscal year in billions of dollars—											
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2001–05	2001–10
Title I: Beneficiary Improvements	0.3	0.4	0.5	0.7	0.9	1.2	1.3	1.5	1.7	2.0	2.8	10.4
Title II: Other Medicare Part B Provisions	0.2	0.5	0.4	0.4	0.6	0.7	0.8	1.0	1.2	1.3	2.1	7.1
Title III: Medicare Part A and B Provisions	0.1	0.7	0.3	0.1	0.2	0.2	0.2	0.3	0.3	0.3	1.3	2.6
Title IV: Medicare+Choice Program Stabilization and Improvements	0.8	1.0	1.2	1.5	1.8	1.5	2.2	2.5	2.8	3.2	6.2	18.4
Interaction: effect of fee-for-service provisions on Medicare+Choice payments	0	0.3	0.3	0.3	0.5	0.6	0.8	1.0	1.2	1.5	1.4	6.5
Subtotal, Gross Medicare Spending	1.3	2.9	2.7	3.1	3.9	4.1	5.3	6.2	7.2	8.4	13.9	45.1
Part B Premiums	−0.2.	−0.4	−0.3	−0.4	−0.5	−0.5	−0.7	−0.8	−0.9	−1.1	−1.7	−5.8
Subtotal, Net Medicare Spending	1.2	2.5	2.3	2.7	3.4	3.6	4.6	5.4	6.3	7.3	12.1	39.3
Title V: Medicaid	0.5	1.3	1.3	1.2	1.3	1.5	1.5	1.6	1.8	1.8	5.7	13.9
Interaction: effect of Medicare provisions on federal Medicaid spending	[1]	[1]	[1]	[1]	0.1	0.2	0.2	0.2	0.2	0.3	[1]	1.2
Subtotal, federal Medicaid	0.5	1.2	1.2	1.3	1.4	1.6	1.8	1.9	2.0	2.1	5.7	15.1
Title VI: State Children's Health Insurance Program	[1]	[1]	[1]	[1]	[1]	0.1	[1]	0.1	0.1	[1]	0.2	0.3
Title VII: Extension of Special Diabetes Grant Programs	0	0	[1]	0.1	0.1	0.1	0.1	0.1	[1]	[1]	0.2	0.5
Total, Changes in Direct Spending	1.7	3.8	3.6	4.0	5.0	5.2	6.5	7.4	8.4	9.4	18.2	55.2

[1] Costs or savings less than $50 million.

FEDERAL MANDATES STATEMENT

The estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act was not timely submitted to the Committee. The Committee will forward such estimate to the House when it is submitted to the Committee.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for this legislation is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian tribes.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

TITLE I—BENEFICIARY IMPROVEMENTS

Section 101. Improving availability of QMB/SLMB application forms

Under current law, State Medicaid programs are required to pay Medicare premiums and cost-sharing charges for Qualified Medicare Beneficiaries (QMBs). These are persons whose incomes are below 100% of the poverty line and whose resources are below $4,000 for an individual and $6,000 for a couple. State Medicaid programs are also required to pay Part B premiums for Specified Low-Income Medicare Beneficiaries (SLMBs). These are persons otherwise meeting the QMB criteria except that their income is above the QMB level. The SLMB level is 120% of poverty. Currently, Medicare beneficiaries must apply for QMB/SLMB benefits at their local welfare/Medicaid office.

This section requires the Secretary of HHS to consult with States and beneficiary groups within nine months of enactment to develop a simplified application form for use in applying for assistance under the QMB/SLMB programs. The form would be easily readable and uniform nationally. Beginning one year after enactment, the Secretary would make the application forms available to the Social Security Administrator for distribution through local Social Security offices as well as to other new and existing sites as the Secretary determined appropriate. Forms would be available to individuals upon request. Individuals would be permitted to apply for assistance through QMB/SLMB programs using this simplified application form and would not be required to apply in person for such assistance.

Beginning on January 1, 2004, individuals could go to local Social Security Offices to receive information about the QMB/SLMB programs. These offices would notify persons who present themselves of the availability of QMB/SLMB application forms, make forms available on request, assist individuals in filling out forms, and upon request, submit them to the appropriate State agency for processing.

The provision providing for the availability of applications in Social Security offices would be effective January 1, 2004. The provision requiring the streamlined application form and process would take effect 1 year after the date of enactment, regardless of whether regulations had been issued. The Secretary would be required to develop the application form not later than 9 months after enactment.

Section 102. Study on limitation on State payment for Medicare cost-sharing affecting access to services for qualified Medicare beneficiaries

Under current law, State Medicaid programs are required to pay Medicare premiums and cost-sharing charges for QMBs. Medicaid's payment rates are frequently below those applicable under Medicare. In the 1997 BBA, Congress specified that a State Medicaid program would not be required to pay any cost-sharing amounts for QMBs to the extent such payment would result in a total payment for the service in excess of the Medicaid level.

The provision requires the Secretary of HHS to conduct a study to determine whether access to certain services (including mental health services) has been affected by the payment limitation. The Secretary is required to submit a report on the study to Congress within one year of enactment. The report must include any recommendations for change in payment limits to assure appropriate access to services.

This section is effective upon enactment.

Section 103. Election of periodic colonoscopy

BBA '97 authorized coverage of, and established frequency limits for, colorectal cancer screening tests. A covered test is any of the following procedures furnished for the purpose of early detection of colorectal cancer: (1) screening fecal-occult blood test (for persons over 50, no more than annually); (2) screening flexible sigmoidoscopy (for persons over 50, no more than one every 4 years); (3) screening colonoscopy for high-risk individuals (limited to one every 2 years); and (4) other procedures as the Secretary finds appropriate for the purpose of early detection of colorectal cancer. The Secretary was required to publish, within 90 days of enactment, a determination on the coverage of screening barium enema. Under the regulation, barium enemas, as an alternative to either a screening flexible sigmoidoscopy or a screening colonoscopy, are covered in accordance with the same screening parameters established for those tests.

The provision permits an individual who is not at high risk to elect to receive a screening colonoscopy instead of a screening sigmoidoscopy. Payments could not be made for such procedures if performed within 10 years of a previous screening colonoscopy or within 4 years of a screening flexible sigmoidoscopy. This change

comports with the new American Cancer Society guidelines which now include this option for average risk individuals. Further, the New England Journal of Medicine recently reported that flexible sigmoidoscopies are likely to miss diseased growths as much as one-third of the time, so allowing beneficiaries the option of the more thorough colonoscopy provides a more effective benefit.

This section is effective January 1, 2001.

Section 104. Waiver of 24-month waiting period for Medicare coverage of individuals disabled with amyotrophic lateral sclerosis (ALS)

Currently, Medicare covers, after a 24-month waiting period, people under age 65 who are either receiving monthly Social Security benefits on the basis of disability or receiving payments as disabled Railroad Retirement System annuitants. Coverage begins with the 25th month of entitlement for disability cash benefits.

The provision waives the 24-month waiting period for an individual medically determined to have amyotrophic lateral sclerosis (ALS). ALS often progresses at a rate that would make Medicare coverage ineffective for this population if individuals were forced to wait 24 months. This provision would ensure individuals with ALS would be able to access medical treatment through Medicare immediately.

The waiver of the waiting period applies to benefits for months beginning after the date of enactment.

Section 105. Elimination of time limitation on Medicare benefits for immunosuppresive drugs

Under current law, Medicare will pay for drugs used in immunosuppressive therapy during the first 36 months following a Medicare-covered organ transplant. The Balanced Budget Refinement Act of 1999 (BBRA '99) provided for a temporary extension of the current 36–month limit on immunosuppressive drugs for Medicare beneficiaries otherwise exhausting their coverage in 2000–2004. In each calendar year, there is to be an extension specified by the Secretary (as the number of months or partial months), applicable to persons who exhaust their benefits in that calendar year. The increase for persons exhausting their benefits in 2000 is 8 months. The minimum increase for persons exhausting their benefits in 2001 is 8 months. Total expenditures over the 5-year period are limited to $150 million. The Secretary, in making the specification of the number of additional months for 2002–2004 is required to make the computation so that expenditures do not exceed this limit.

The provision eliminates the time limitation on coverage of immunosuppressive drugs for Medicare beneficiaries and allows for all Medicare beneficiaries to receive coverage for drugs to prevent rejection of the donor organ following a Medicare-covered organ transplant.

This provision applies to drugs furnished on or after enactment.

Section 106. Preservation of coverage of drugs and biologicals under Part B of the Medicare program

Medicare law defines covered "medical and other health services" for purposes of coverage under Medicare Part B. Included in the

definition are "services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self- administered) furnished as incident to a physician's professional service * * *." The Medicare Carrier's Manual states that whether a drug or biological is of a type which cannot be self-administered is based on the usual method of administration of the form of that drug or biological as furnished by the physician.

Individual Medicare carriers apply different policies when considering whether a drug or biological can or can not be self- administered. Some carriers base the determination on the typical means of administration while others assess the individual patient's ability to administer the drug. On August 13, 1997, the Health Care Financing Administration (HCFA) issued a memorandum to Medicare carriers which was intended to clarify program policy. The memorandum stated that the inability to self-administer was to be based on the typical means of administration of the drug, not on the individual patient's ability to administer the drug.

As a result of this memorandum, certain patients, for example patients with multiple sclerosis, no longer had Medicare coverage for certain drugs. However, implementation of this policy directive was halted for FY2000 by a provision in the Consolidated Appropriations Act (P.L. 106–113). The provision prohibits the use of any funds to carry out the August 13, 1997 transmittal or to promulgate any regulation or other transmittal or policy directive that has the effect of imposing (or clarifying the imposition of) a restriction on the coverage of injectable drugs beyond those applied on the day before issuance of the transmittal. HCFA issued a Program Memorandum in April 2000 which suspended application of the August 13, 1997 memorandum. It noted that each carrier or intermediary must establish its own policies individually and can not establish model policies as a group.

This section clarifies that carriers are to reimburse for self-injectable drugs according to pre-August 1997 policy. This section replaces the current phrase in section 1861(s)(2) relating to certain drugs and biologicals administered incident to a physician's professional service. The new language requires coverage of "drugs and biologicals which are not usually self-administered by the patient." The Committee intends that in determining whether a drug or biological is usually self-administered by the patient, HCFA should only consider whether a majority of Medicare patients with the disease or condition actually administer the drug to themselves. In carrying out this intent, HCFA should assume, as it did for many years, that Medicare patients do not usually self-administer injections or infusions to themselves, while oral medications usually are self-administered. HCFA should also continue to take into account the circumstances under which the drug or biological is being administered and continue to cover products that are administered in emergencies, for example, during which self-administered is not the usual method of administration.

The Committee anticipates that HCFA will instruct its contractors not to rely on this section to exclude a drug or biological without making an explicit finding supported by evidence that it is usually administered to themselves by a majority of Medicare patients who use it for the condition to which the exclusion relates.

This section applies to drugs and biologicals administered on or after October 1, 2000.

Section 107. Demonstration of Medicare coverage of medical nutrition therapy

BBA '97 required the Secretary of HHS to request that the National Academy of Sciences analyze the expansion or modification of preventive and other benefits provided to Medicare beneficiaries. The Secretary was required to submit a report to Congress on specific findings related to several benefit categories. One category included in the required study was "nutrition therapy services, including parenteral and enteral nutrition and including the provision of such services by a registered dietitian." The Academy's Committee on Nutrition Services for Medicare Beneficiaries, Food and Nutrition Board, transmitted a report on nutrition therapy early this year.

The report contained several key recommendations. The Committee recommended that nutrition therapy, upon referral from a physician, should be a reimbursable Medicare benefit. It noted that current evidence suggests that nutrition therapy is effective as part of a comprehensive approach to the management and treatment of many conditions affecting the Medicare population including dyslipidemia, hypertension, heart failure, diabetes, and kidney failure. The Committee also noted that the registered dietician is currently the single identifiable group of health care professionals with standardized education, clinical training, continuing education, and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy.

The provision establishes a demonstration program for Medicare coverage of medical nutrition therapy services for beneficiaries in the five States with the highest proportion of population who are 65 years of age or older.

Under the demonstration program, medical nutrition therapy services are defined as nutritional diagnostic, therapy and counseling services for the purpose of disease management which are furnished by a registered dietician or nutrition professional, pursuant to a referral by a physician. The term registered dietician or nutrition professional means an individual who (1) has completed a baccalaureate or higher degree with completion of academic requirements of a program in nutrition or dietetics; (2) has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional; and, (3) is either licensed or certified as a dietician or nutrition professional by the State in which the services are performed, or, in a State which does not provide for such licensure or certification, meets criteria established by the Secretary. Persons licensed or certified as dieticians or nutrition specialists on the date of enactment would not be required to meet the training requirements under 1 and 2.

Under the demonstration, the provision specifies that the amount paid for medical nutrition therapy services would equal 80% of the lesser of the actual charge for the service or 85% of the amount that would be paid under the physician fee schedule if such services were provided by a physician. Assignment would be required for all claims. The Secretary is required to submit to Congress in-

terim reports on the demonstration project and a final report within six months of the conclusion of the project.

This section applies to services furnished on or after January 1, 2002.

TITLE II—OTHER MEDICARE PART B PROVISIONS

Subtitle A—Access to Technology

Section 201. Annual reports on national coverage determinations

The Medicare statute specifies the broad service categories paid for under the program; these include inpatient and outpatient hospital services, physicians services, and other types of medical care. In general, the law does not specify the types of medical treatments, procedures, or technologies covered. However, the law does specifically exclude coverage for any items or services which "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." HCFA has generally interpreted the statute to preclude payment for services that have not been proven safe and effective by acceptable clinical evidence or that have not been generally accepted in the medical community. Experimental items are generally excluded.

Coverage decisions are made at both the national level by the Health Care Financing Administration and at the local level by Medicare intermediaries and carriers. Currently the majority of determinations are made at the local level. HCFA is currently in the process of revising the process for making national coverage determinations.

The provision requires the Secretary of HHS to annually submit to the Congress a report about national coverage decisions. The report sets forth a detailed compilation of the actual time periods that were necessary to complete and fully implement any national coverage determinations that were made the previous fiscal year for items, services, or medical devices not previously covered under Medicare. The report is to include (for each such item, device, or service) a statement of the time taken by the Secretary to make the necessary coverage, coding, and payment determinations, including the time taken to complete each significant step in the process of making such determinations. The report will be due by December 1 of each year (beginning in 2001). The report would be published on the Medicare Internet site.

This section is made effective upon enactment.

Section 202. National limitation amount equal to 100 percent of national median for new clinical laboratory test technologies; fee schedule for new clinical laboratory tests

Medicare currently pays for clinical laboratory services on the basis of areawide fee schedules. The law sets a cap on the payment amount for a test. BBA '97 froze the fee schedule for the 1998–2002 period. It also lowered the cap from 76% of the median to 74% of the median of all fee schedules for the test.

Under this section, the national limitation amount is set at 100% of the median in the case of a test, performed after January 1,

2001, that the Secretary determined was a new test for which no limitation amount had been previously established.

The Secretary also is required to establish a national uniform fee schedule amount for new tests which are unique and unable to be crosswalked with existing tests. By December 1 of each year (beginning in 2001), the Secretary is to publish in the Federal Register an interim fee schedule amount for each new test which would apply for the following year. The interim fee schedule amount for each test is subject to a 60 day comment period. The Secretary would review the comments and make appropriate adjustments. By December 1 of each year (beginning in 2002), the Secretary must publish in the Federal Register a fee schedule amount for each such new test for which an interim amount was established; the amount applies for the following year.

This section is effective upon enactment.

Section 203. Clarifying process and standards for determining eligibility of devices for pass-through payments under hospital outpatient PPS

BBRA '99 provided that, for 2 to 3 years after the introduction of a new device, the Secretary of HHS is required to provide additional payments for costs of certain "current innovative" devices, drugs, and biologicals, and certain "new" high cost devices, drugs, and biologicals used in hospital outpatient department care. These payments are referred to as "pass-through payments" because they would pass through the hospital outpatient PPS and be paid over and above PPS payments. "Current" is defined as something for which Medicare is paying under outpatient services on the first day of the PPS; "new" is defined as something for which Medicare was not paying on an outpatient basis on December 31, 1996.

A pass-through for the cost of current innovative products apply to (1) orphan drugs; (2) certain cancer therapy drugs, biologicals, and brachytherapy; and (3) radiopharmaceutical drugs and biological products.

A pass-through of costs for "new" medical devices, drugs, and biologicals is required if the costs of those items is "not insignificant" in relation to the fee schedule amount payable for the service.

Pass-through payments are currently made on the basis of a product's brand-name.

This provision requires the Secretary, through public rulemaking procedures, to establish criteria for defining special payment categories under the hospital outpatient PPS for new and certain current medical devices and to establish new categories for such medical devices. These payments are designated as "category-based pass-through payments" as opposed to the current system based on brand. In general, the payment period begins when the first such payment is made for a device after implementation of category-based pass-through payments.

This section is effective upon enactment.

Section 204. Access to new technologies applied to screening mammography to enhance breast cancer detection

Medicare currently limits payment for screening mammography to $67.81 irrespective of what type of technology is used.

This provision allows the Secretary to increase the Medicare payment limit for screening mammographies by $15, if the Secretary determines a new technology that enhances the detection of breast cancer is being used.

Subtitle B—Provisions Relating to Physicians Services

Section 211. GAO study of gastrointestinal endoscopic services furnished in physicians' offices and hospital outpatient department services

Payments for physicians services are made on the basis of a fee schedule which is intended to relate payments for a given service to actual resources used. The fee schedule assigns relative values to services; these values are the sum of three components—a physician work component, a practice expense component, and a malpractice expense component. Each component is adjusted for geographic variations in costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor.

BBA '97 established a process for the development of new relative values for practice expenses. The new resource-based system is being phased-in over 4 years beginning in 1999. For many services, there is a differential between the value assigned to practice expenses for a service provided in a physicians office and that assigned when the service is provided in an institutional setting.

The provision requires the GAO to conduct a study on the appropriateness of furnishing gastrointestinal endoscopic services in physicians offices. The GAO is also required to review available scientific and clinical evidence about the safety of performing procedures in physicians offices and hospital outpatient departments. The GAO is also required to assess whether the assigned practice expense relative value units assigned for these services create an incentive to furnish services in doctors offices, rather than in hospital outpatient departments. The GAO is further required to report on the implications for beneficiary access if Medicare did not cover such services in physicians offices.

The GAO is required to submit the report to Congress, together with any recommendations, by July 1, 2002.

This section is effective upon enactment.

Section 212. Treatment of certain physician pathology services

The final rule for the Medicare physician fee schedule issued November 2, 1999 required hospitals to bill for the technical component of pathology services furnished to its inpatients. Based on comments received, HCFA decided to delay implementation of this rebundling requirement until January 1, 2001, to allow hospitals and independent laboratories sufficient time to negotiate arrangements.

Regulations implementing the hospital outpatient prospective payment system require hospitals to provide directly or under arrangements all services furnished to hospital outpatients. If a specimen (e.g., tissue, blood, urine) is taken from a hospital outpatient, the facility or technical component of the diagnostic test must be billed by the hospital. Thus, independent laboratories cannot bill for the technical component of pathology services furnished to outpatients. On August 11, 2000, HCFA issued a program memo-

randum (Transmittal No. AB–00–73) which delayed implementation of the rebundling requirement until January 1, 2001.

The provision grandfathers hospitals that have an arrangement with an independent lab in effect as of July 22, 1999 under which the lab was furnishing and directly billing the carrier (not the hospital) for a 2 year period. Labs working with these hospitals could continue direct billing for the technical component of pathology services provided to hospital inpatients and hospital outpatients. The provision does not apply to services furnished to Medicare+Choice enrollees.

The GAO will be required to analyze the types of hospitals that are grandfathered under the provision and study the effects of the direct billing provision on hospitals, laboratories, and Medicare beneficiaries access to physician pathology services. The report is due to Congress by July 1, 2002. It would include recommendations on whether the grandfather provision should continue after the 2–year period for either (or both) inpatient and outpatient hospital services and whether the provision should be extended to other hospitals with similar characteristics.

The direct billing provision would apply to services furnished during the 2–year period beginning January 1, 2001. The report requirement is effective on enactment.

Section 213. Physician group practice demonstration

The provision requires the Secretary to conduct demonstration projects to test, and if proven effective, expand the use of incentives to health care groups participating under Medicare. These incentives include encouraging coordination of care furnished under Medicare Parts A and B by institutional and other providers and practitioners; encouraging investment in administrative structures and processes encouraging efficient service delivery; and rewarding physicians for improving health outcomes. For purposes of the demonstration, a health care group is a group of physicians organized, at least in part, for the purpose of providing physicians services under Medicare. As the Secretary finds appropriate, the group could include a hospital or other entity that was affiliated with the group and which would share in any bonus earned under the demonstration.

Groups participating in the demonstration agree to be paid on a fee-for-service basis. They also agree that payment for all services furnished to beneficiaries would be made to a single agency.

The Secretary specifies those patients to be considered within the scope of the demonstration. The Secretary ensures that each beneficiary in a demonstration program would be notified of the incentives and of any waivers of coverage or payment rules under the demonstration program.

The Secretary establishes for each group participating in a demonstration, a base expenditure amount and an expenditure target (reflecting base expenditures adjusted for risk and expected growth rates). The Secretary pays each group a bonus for each year equal to a portion of the savings for the year relative to the target. In addition, at such time as the Secretary had developed appropriate criteria, the Secretary pays an additional bonus related to process and outcome improvements. Total payments under demonstrations

could not exceed what the Secretary estimates would be paid in the absence of the demonstration program.

The provision also specifies requirements for administration of the demonstration program. These include: limiting beneficiary eligibility to fee-for-service enrollees; permitting the Secretary to limit the scope of the program including limitation to a geographic area (or areas) or to subgroup (or subgroups) of beneficiaries or entities; voluntary receipt of services by beneficiaries; permitting the Secretary to enter into agreements with individuals and entities; establishment of performance standards by the Secretary; administrative review of decisions affecting individuals and entities furnishing services; and, Secretarial review of marketing material. Individuals or entities receiving payment under the program would agree to accept such payment as payment in full, except for any deductible and coinsurance amount.

The Secretary is permitted to administer the demonstration program through a contract with a program administrator which could be a Medicare intermediary or carrier or other entity with substantial experience in managing this type of program. Contracts are for an initial term of 3 years and could be awarded noncompetitively. The Secretary could make bonus payments to program administrators; the Secretary could also condition such payments on the achievement of standards related to efficiency, improvement in processes or outcomes of care, or other factors.

Entities with agreements to provide health services under the demonstration and entities with program administration contracts would be required to maintain adequate records and furnish such reports as the Secretary may require. The provision places certain limitations on judicial and administrative review of certain actions and determinations relating to the demonstration. The provision further requires periodic reports to Congress on the use of authorities under the demonstration program.

This section is effective upon enactment.

Section 214. Designation of separate category for interventional pain management services

Payments for physicians services are made on the basis of a fee schedule which is intended to relate payments for a given service to actual resources used. The fee schedule assigns relative values to services; these values are the sum of three components—a physician work component, a practice expense component, and a malpractice expense component. In making these calculations, the Secretary is required to determine, for each physicians service or class of services, the percentage that is performed nationwide by physician in different specialties.

The provision specifies that for services provided on or after January 1, 2002, the Secretary will specify interventional pain management physicians as a separate category of physician specialists.

This section is effective upon enactment.

Section 215. Evaluation of enrollment procedures for medical groups that retain independent contractor physicians

Medicare generally prohibits payments for services to be made to anyone other than the person providing a service. One exception is

if the physician or other practitioner, as a condition of his or her employment, is required to turn over the fee to his or her employer.

This section directs the Secretary of Health and Human Services to evaluate the current Medicare enrollment process for medical groups that retain independent contractor physicians with particular emphasis on hospital-based physicians, such as emergency department staffing groups. The Secretary must review the increase of individual Medicare provider numbers issued and the possible Medicare program integrity vulnerabilities of the current process; assess how program integrity could be enhanced by the enrollment of groups that retain independent contractor hospital-based physicians; and develop suggested procedures for the enrollment of these groups.

The Secretary will submit the report to Congress one year after the date of enactment.

This section is effective upon enactment.

Subtitle C—Other Services

Section 221. 3-year moratorium on SNF Part B consolidated billing requirements

Under the consolidated billing requirement of BBA '97, skilled nursing facilities (SNFs) and all nursing homes that include a Medicare-certified SNF component must submit to Medicare all claims for all the services provided to their residents who are enrolled in traditional fee-for-service Medicare. Thus, the requirement applies to claims on behalf of beneficiaries who are long-term care residents of a nursing home that has a SNF component as well as those who are residents in the SNF. This requirement is referred to as "consolidated billing." (The law includes a list of services that are excluded from the consolidated billing requirement; excluded providers may bill Medicare directly.) The consolidated billing requirement also pertains to Medicare covered services regardless of whether the resident does or does not qualify for SNF care under Medicare Part A. The requirement means that non-excluded service or care providers who furnish covered services to SNF residents may not bill Medicare directly, but must submit their claim to the SNF for payment. If the item or service is covered by Medicare but is not included in the SNF PPS, Medicare makes the payment to the SNF, and the SNF is responsible for paying the provider.

The consolidated billing requirement went into effect in July 1998 (implementation of the SNF PPS) for some, but not all, SNF patients. Consolidated billing has been implemented only for services to those SNF residents who are in a Medicare Part A covered stay, and has not been implemented for Medicare Part B covered services for beneficiaries who are SNF residents whose stay is not covered under Medicare (which includes those who are long-term care residents of the non-SNF component of the facility). When HCFA is ready to expand implementation of consolidated billing it will publish a notice in the Federal Register 90 days prior to implementation.

Under this provision, implementation of consolidated billing is delayed until October 1, 2003, for Part B-covered services to SNF residents who are not in a SNF stay that is covered by Medicare Part A. The Comptroller General is required to submit a report to

Congress by October 1, 2002, regarding alternatives, if any, to consolidated billing for Part B items and services to ensure accountability by SNFs and accuracy in claims submitted for all services and items provided to SNF residents under Part B.

Delay of consolidated billing is effective as if included with enactment of BBA '97.

Section 222. Ambulatory Surgical Centers (ASCs)

Delay in Implementation of Prospective Payment System. From the start of Medicare coverage of ASC services in 1982, Medicare based payments to ASCs on a fee schedule. Starting January 1, 1995, the Secretary of HHS has been required to update ASC rates every 5 years based on a survey of the actual audited costs incurred by a representative sample of ASCs for a representative sample of procedures, and to increase annual payments in the intervening years by the CPI–U. (BBA '97 modified the annual update amounts.)

On June 12, 1998, HCFA issued proposed rules which would make major changes in Medicare payments to ASCs. The major changes include replacing eight payment groupings with an ambulatory payment classification (APC) system comprised of 105 payment groups; updating underlying cost data using 1994 survey data updated to the present; and making additions to and deletions from the list of Medicare covered ASC procedures. Payments would range from $53 to $2,107 and would be updated by the CPI–U annually on a calendar year basis. Final rules are scheduled for publication in November 2000 for implementation in April 2001. BBRA '99 delayed the implementation by requiring a 3 year phase-in.

The Secretary would be prohibited from implementing the changes to the APC system published on June 12, 1998 before January 1, 2002.

This section is effective upon enactment.

Extending Phase-In to 4 Years. BBRA '99 requires that, if the Secretary implements new ASC rates based on the 1994 data (or any rates based on pre-1999 Medicare cost survey data), those new rates must be phased-in by basing payments one-third on the new rates in the first year, two-thirds in the second year, and fully in the third year.

This provision extends the phase-in of new ASC payment rates based on pre-1999 survey data is extended to occur over 4 years (one- fourth per year).

This section is effective upon enactment.

Deadline for Use of 1999 or Later Cost Surveys. This provision requires the Secretary by January 1, 2003, to incorporate data from a 1999 Medicare cost survey or a subsequent cost survey for purposes of revising the ASC payment system.

This section is effective upon enactment.

Section 223. One-year extension of moratorium on therapy caps

BBA '97 established annual payment limits for all outpatient therapy services provided by non-hospital providers. The limits applied to services provided by independent therapists as well as to those provided by comprehensive outpatient rehabilitation facilities (CORFs) and other rehabilitation agencies. The limits did not apply to outpatient services provided by hospitals.

There were two per beneficiary limits. The first was a $1,500 per beneficiary annual cap for all outpatient physical therapy services and speech language pathology services. The second was a $1,500 per beneficiary annual cap for all outpatient occupational therapy services. Beginning in 2002, the amount would increase by the Medicare Economic Index (MEI).

BBRA '99 suspended application of the therapy limits in 2000 and 2001. (In the absence of additional legislation, the caps would be imposed again beginning in 2002.) During this time, the Secretary is required to conduct focused medical reviews of therapy claims with emphasis on claims for services provided to residents of SNFs. The Secretary is also required to study utilization patterns in 2000 compared to those in 1998 and 1999. The study (which must be based on a statistically significant number of claims) will look at nationwide patterns as well as patterns by region, types of setting, and diagnosis or condition. The Secretary is required to report the results of this study to Congress by June 30, 2001, together with any legislative recommendations deemed appropriate.

The provision extends the moratorium on implementation of the therapy cap, and the focused reviews, for 1 year.

This section is effective upon enactment.

Section 224. Revision of Medicare reimbursement for telehealth services

BBA '97 provided for reimbursement from Medicare Part B for professional consultation via telecommunications systems with physicians and practitioners for beneficiaries residing in rural areas.

The provision requires payments to be made no later than April 1, 2001, in accordance with revised payment procedures, for services that are provided on a telecommunications system by a practitioner or provider to an eligible beneficiary. Services covered under the provision will include payments for professional consultations, office visits, office psychiatry visits, including any service identified, as of July 1, 2000, by the following HCPCS codes: 99241–99275, 99201–99215, 90804–90809, and 90862. The Secretary must develop a process to determine what other services would be appropriate to be provided under telehealth and shall annually update covered services through this process.

An eligible beneficiary would be a person residing in a designated health professional shortage area, a county that is not in a metropolitan statistical area (MSA), an inner city area that is medically underserved (effective January 1, 2002), or an area in which there is a Federal telemedicine demonstration program. In the case of any Federal telemedicine demonstration program in Alaska or Hawaii, the term telecommunications system would include store-and-forward technologies that provide for asynchronous transmission of health care information in single or multi-media formats.

The provision requires the Secretary to make payments for telemedicine services in an amount equal to the amount that would have been paid to the physician or practitioner if the service had been furnished to the beneficiary without the use of a telecommunications system. It also eliminates the 75/25 percent fee splitting requirement.

A facility fee would be paid to the originating site. This fee would equal $20 in 2001 and 2002, increased by the percentage increase in the Medicare Economic Index (MEI) in future years. Payments would be subject to beneficiary cost-sharing, however balance billing protections apply. Beginning April 1, 2001, an originating site would be defined as: the physician's or practitioner's office, a critical access hospital, rural health clinic, or Federally qualified health center. Beginning in January 1, 2002, the definition would be expanded to include a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, renal dialysis facility, ambulatory surgical center, hospital or skilled nursing facility of the Indian Health Service, or a community mental health center.

The provision specifies that nothing would be construed as requiring an eligible telehealth beneficiary to be presented by the physician or practitioner at the originating site for the furnishing of a service, unless it was determined medically necessary by the physician or practitioner at the distant site.

The provision requires the Secretary to conduct a study to identify additional services that are appropriate for reimbursement. The report, together with recommendations, would be transmitted to Congress within 2 years of enactment.

The provision clarifies that the telecommunications provisions should not be construed as preventing a home health agency from providing a service, for which payment is made under the prospective payment system, via a telecommunications system.

This section is effective upon enactment.

Section 225. Payment for ambulance services

Payment for ambulance services provided by freestanding suppliers is currently based on reasonable charge screens. Hospital or other provider-based ambulance services are paid on a reasonable cost basis. Payment cannot exceed what would be paid to a freestanding supplier. The reasonable costs or charges cannot exceed costs or charges recognized in a prior year, increased by the CPI–U minus one percentage point.

BBA '97 provided for the implementation of a fee schedule, effective January 1, 2000. The aggregate amount of payments in 2000 could not exceed what would otherwise be paid under the prior system. Increases in subsequent years are to equal the CPI increase, except that there is a one percentage point reduction in 2001 and 2002.

Implementation of the fee schedule has been delayed until at least January 1, 2001.

The provision eliminates the 1.0 percentage point reduction for 2001 and 2002 so that ambulance services will receive a full update for CPI. The provision also specifies that any phase-in of the ambulance fee schedule shall provide, in any State in which suppliers had not been paid a separate amount for all mileage, for full payment of the national mileage rate beginning with the effective date of the fee schedule.

The provision requires the GAO to conduct a study of the costs of providing ambulance services across the range of service levels. Within 18 months of enactment, GAO is required to report to Congress on the study. The report includes any recommendations for

changes in methodology or payment levels necessary to fairly compensate suppliers and to ensure access for Medicare beneficiaries.

This section is effective upon enactment.

Section 226. Contrast enhanced diagnostic procedures under hospital prospective payment system

Currently, Medicare covers diagnostic scanning procedures used in hospital outpatient departments, including procedures that require injection of agents that enhance the visibility of organs showing greater contrast among organs and organ parts. Under the outpatient PPS, coverage of certain agents used for contrasting is generally included in the PPS amount for the procedure for which contrast agents are used.

The Secretary is required to create under the hospital outpatient department PPS additional groups of covered services that classify separately those procedures that utilize contrast media from those that do not. The provision is retroactive to the implementation of the hospital outpatient department PPS (August 1, 2000). The provision also amends the definition of a drug to include contrast agents.

This section is effective as if enacted as part of BBA '97.

Section. 227. Increase from 55 percent to 80 percent the proportion of hospital bad debt recognized

Currently, hospitals receive compensation from Medicare for certain portions of amounts they are unable to collect from beneficiaries for deductibles and coinsurance (applicable to both inpatient and outpatient department care). BBA '97 established a schedule under which the amount of a hospital's bad debt Medicare would recognize as an allowable cost would decline from 75% for cost reporting periods beginning in FY1998 to 55% for cost reporting periods beginning in FY2000 and thereafter. Prior to BBA '97, hospitals received compensation for 100% of bad debt incurred.

This provision would reinstate the ability of hospitals to receive compensation for bad debt. The provision would phase-in Medicare payment for up to 80% of a hospital's allowable costs in equal increments beginning in FY 2000 over 10 years.

Section 228. State accreditation of diabetes outpatient self-management training programs

BBA '97 authorized coverage, effective July 1, 1998, for diabetes outpatient self-management training services. These services are defined as including educational and training services furnished to an individual with diabetes by a certified provider in an outpatient setting. Certified providers for these purposes are defined as physicians or other individuals or entities that, in addition to providing diabetes self-management training services, provide other items or services reimbursed by Medicare. Providers must meet quality standards established by the Secretary. They are deemed to meet the Secretary's standards if they meet standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards of the Board, or if they are recognized by an organization representing persons with diabetes, as meeting standards for furnishing such services.

The provision authorizes State accreditation of diabetes self-management training programs, provided that the Secretary determined that the State program had established quality standards that meet or exceed the national standards or the standards originally established by the National Diabetes Advisory Board, and subsequently revised.

This section is effective upon enactment.

TITLE III—MEDICARE PART A AND B PROVISIONS

Section 301. Home health services

One-Year Delay in 15 Percent Reduction in Payment Rates under the Medicare Prospective Payment System for Home Health Services. BBA '97 required implementation of a home health care prospective payment system and specified that the prospective payment system (PPS) be designed so that in the first 12 months of operation the aggregate amount of Medicare PPS payments would equal the total payments that would have been paid under the interim payment system had it remained in effect that year but with a 15% across-the-board reduction in Medicare payments to home health agencies. The home health PPS was originally scheduled for implementation in FY 1999 but was delayed until October 1, 2000 (FY 2001). BBRA '99 delayed the 15% reduction until 12 months after October 1, 2000 (thus the reduction would go into effect on October 1, 2001), but it required the Secretary to report on the need for a 15% or other reduction 6 months after implementation of the PPS. (This report would be due by March 1, 2001.)

The provision requires that the aggregate amount of Medicare payments to home health agencies in the second year of the PPS (FY2002) must equal the aggregate payments in the first year of the PPS, updated by the Market Basket Increase minus 1.1 percentage points. The 15% reduction to aggregate PPS amounts would be delayed until October 1, 2002.

This section is effective upon enactment.

Treatment of Branch Offices of Home Health Agencies. Prior to BBA '97, home health agency (HHA) payments were based on the HHA's billing location. Thus, an agency headquartered in an urban area would be paid according to rates for urban areas, even though that agency had provided some of its billable visits through branch offices serving rural communities. BBA '97 required HHAs to submit payment claims on the basis of the location in which the service was provided. The home health PPS payments are based on the location in which the care is furnished.

A home health agency may have both branch offices and subunits. Subunits must meet the same conditions of participation as the parent home health agency. These conditions of participation include staffing and supervision standards. Branch offices do not have to meet the conditions of participation independently of the home health agency, and thus are not subject to the same staffing and supervision requirements. For this reason, in order to ensure that branch offices of HHAs are adequately supervised, HCFA regional offices have established "time and distance" restrictions on how far a branch office may be from an agency's main office. Typically, these restrictions specify that a branch office may be no farther than 60 miles or 60 minutes from the main office for that

HHA, although they vary in different areas. The branch office must be easily accessible from the parent office in case of an emergency as the branch office does not have the same skilled staff on site.

Under this provision, use of time and distance as the sole determinant of a home health agency's branch office status is prohibited.

This section is effective upon enactment.

Consideration of Forms of Technology in Definition of Supervision. One component of the definition of a home health agency is that it has policies governing the services it furnishes and provides for supervision of such services by a physician or registered professional nurse.

This section requires the Secretary to include various forms of technology in determining what constitutes "supervision" for purposes of an agency's meeting the definition of a home health agency.

This section is effective upon enactment.

Clarification of the Definition of Homebound. To qualify for home health care under Medicare an individual must be homebound or "confined to home." A homebound individual is defined as one who cannot leave home without a considerable and taxing effort and only with the aid of devices such as a wheelchair, a walker, or through use of special transportation. Absences from home may occur infrequently for short periods of time for such purposes as to receive medical treatment. Medicare law requires that a physician certify that an individual's medical condition confines him or her to home. Currently, some regional home health intermediaries exclude individuals with Alzheimer's from home care if they leave the home for medical or therapeutic treatment at an adult day care center.

This provision clarifies that approved absences from home include participation in an adult day care program licensed or certified by a State to furnish such services for therapeutic treatment for Alzheimer's disease or a related dementia. This would not change the requirement the home health services must be provided by a Medicare home health agency.

This provision is effective October 1, 2001.

One-Year Delay in Report. BBRA '99 required the Secretary to submit, within 6 months of implementation of the home health PPS, a report to Congress on the need for a 15% or other reduction in Medicare payments to home health agencies.

This section requires the Secretary to submit a report to Congress on the need for the 15% or other reduction no later than 18 months after implementation of the home health PPS.

This section is effective upon enactment.

Section 302. Advisory opinions

The Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104–91) required the Department of Health and Human Services, through the Office of the Inspector General (OIG) in consultation with the Department of Justice, to issue advisory opinions to outside parties who request guidance on the applicability of the anti-kickback statute, safe harbor provisions and other OIG health care fraud and abuse sanctions. The authority to issue this guidance expired on August 21, 2000. The OIG protects sub-

missions of proprietary information to the extent possible under the Freedom of Information Act (FOIA; 5 U.S.C § 552).

This section makes permanent the OIG's authority to issue guidance. Any supporting documentation submitted as part of a request for an advisory opinion will not be subject to FOIA.

Section 303. Hospital geographic reclassification for labor costs for other PPS systems opinions

As part of Medicare's prospective payment system for acute hospitals, a hospital may apply to the Medicare Geographic Classification Review Board (MGCRB) to be reclassified to a different area for the purposes of using its wage index, its standardized amount, or both. Although some of Medicare's payment systems for other provider types use the hospital wage index, reclassification decisions made by the MGCRB only apply to inpatient and outpatient hospital PPS payments.

Under this section, MGCRB reclassification decisions to adjust the hospital's wage index in a fiscal year will apply to provider-based entities or distinct part units of that particular hospital paid under the following payment systems: home health PPS, skilled nursing facility PPS, inpatient rehabilitation hospital PPS, inpatient long term care hospital PPS, inpatient psychiatric hospital PPS.

Section 304. Reclassification of a metropolitan statistical area for the purposes of reimbursement under the Medicare program

As part of Medicare's prospective payment system for acute hospitals, hospitals may apply to the Medicare Geographic Classification Review Board to be reclassified to a different area for the purposes of using its wage index, its standardized amount, or both. Hospitals that are in or that are reclassified to metropolitan areas (MSAs) with population of one million or more are considered to be in large urban areas and receive payment based on a higher standardized amount. The labor-related amount of the standardized amount is adjusted by the wage index value of the area the hospital is in or the area to which the hospital has been reclassified. With respect to MGCRB wage index reclassifications, if the wage data for the redesignated hospitals reduces the wage index value of the area to which the hospitals are redesignated by 1 percentage point or less, the original wage index value for the area (exclusive of the wage data for the redesignated hospitals) applies to the redesignated hospitals. However, if the wage data for the redesignated hospitals reduced the wage index value of the area to which the hospitals are redesignated by more than 1 percentage point, the redesignated hospitals are subject to that combined wage index value.

This provision establishes, for FY2001 and subsequently, hospitals in the Mansfield Ohio MSA are deemed to be located in the Cleveland-Loraine-Elyria Ohio MSA, a large urban area. The reclassification made under the previous sentence is to be treated as a MGCRB decision.

This section is effective beginning in fiscal year 2001.

Section 305. Making the Medicare dependent, small rural hospital program permanent

Medicare dependent hospitals (MDHs) are small rural hospitals that treat a relatively high proportion of Medicare patients. MDH's special payment status was phased out as of September 30, 1994 and then reinstated, on a modified basis by BBA '97, starting on October 1, 1997 through October 1, 2001. MDH classification was extended to October 1, 2006 by BBRA '99.

This provision makes the MDH program permanent. Conforming amendments would permit hospitals to decline reclassification by the Medicare Geographic Classification Review Board from a rural to an urban area in order to maintain its MDH status.

This section is effective upon enactment.

Section 306. Option to base eligibility on discharges during any of the 3 most recent audited cost reporting periods

Medicare dependent hospitals are small rural hospitals that treat a relatively high proportion of Medicare patients. Generally, a MDH is located in a rural area, has 100 beds or less, is not classified as a sole community hospital, and had a least 60% of its days or discharges during FY 1987 attributable to Medicare Part A beneficiaries.

This provision updates the MDH criteria to permit an otherwise qualifying small rural hospital to be classified as an MDH if at least 60% of its days or discharges were attributable to Medicare Part A beneficiaries in any of the 3 most recently audited cost reporting periods.

This section is effective upon enactment.

Section 307. Identification and reduction of medical errors by peer review organizations

Peer review organizations (PROs) now have certain statutory responsibilities to work with hospitals and other providers to improve clinical outcomes through data collection and analysis. PROs also address certain beneficiary complaints and work to prevent Medicare payment errors.

This provision gives PROs the authority to work with providers, practitioner, and Medicare+Choice organizations to identify and reduce the incidence of medical errors and problems affecting patient safety.

This section is effective January 1, 2001.

Section 308. GAO Report on Impact of the Emergency Medical Treatment and Active Labor Act (EMTALA) on hospital emergency departments

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that doctors on call at hospital emergency departments screen and stabilize patients who go to emergency departments for treatment. Physicians who refuse to treat emergency department patients or fail to respond to hospital emergency department requests when on call face significant fines and are exposed to liability under EMTALA. There are concerns that the impact of EMTALA, as well as provisions in the Balanced Budget Act of 1997, has led to many physicians covering emergency department calls in Phoenix, Arizona to resign from various hospitals'

medical staffs, thus raising concerns as to whether downtown Phoenix hospitals can keep their emergency departments open.

This provision would require the General Accounting Office to report to the Subcommittee on Health and Environment of the Committee on Commerce of the House of Representatives by May 1, 2001, on the effect of EMTALA on hospitals, emergency physicians, and physicians covering emergency department calls, focusing on those in Arizona and California.

TITLE IV—MEDICARE+CHOICE PROGRAM STABILIZATION AND IMPROVEMENTS

Subtitle A—Payment Reforms

Section 401. Increasing minimum payment amount

Under current law, each county is subject to a floor amount, designed to raise payments in certain counties more quickly than would otherwise occur. The minimum payment amount for aged Medicare+Choice (M+C) enrollees is $401.61 for 2000 and will be $415.01 for 2001. As required by law, each year this payment amount is increased by a measure of the national growth percentage. In 2001, payments for M+C organizations will be set at the floor amount in about one-third of all counties.

This section sets the minimum payment amount or floor payment for aged enrollees in a Metropolitan Statistical Area with a population of more than 250,000 at $525 in 2001. For all other areas, the minimum would be $475. This provision would not apply to M+C private fee-for service plans.

Section 402. 3 Percent minimum percentage update in 2001

The minimum increase rule under current law protects counties that would otherwise receive only a small (if any) increase. In 1998, the minimum rate for any payment area was 102% of its 1997 AAPCC. For each subsequent year, it will be 102% of its annual M+C per capita rate for the previous year. All plans are subject to the same minimum increase.

This section allows plans to receive a 3.0% minimum update, rather than the 2% minimum update for 2001.

Section 403. 10-year phase in of risk adjustment based on data from all settings

M+C payments are risk adjusted to reflect variations in the cost of providing health care among Medicare beneficiaries. For example, if sicker and older patients all sign up for one M+C plan, risk adjustment is designed to compensate the plan for their above average health expenses.

BBA '97 required the Secretary of HHS to develop a risk adjustment mechanism that uses variations in health status as well as demographic factors to account for variations in costs. Beginning in January 2000, the Health Care Financing Administration implemented a new risk adjustment mechanism built on 15 principal inpatient diagnostic cost groups (PIP–DCGs). Payments are adjusted based on inpatient data using the PIP–DCG adjuster and demographic factors, so that this system accounts for both demographic and health-status variations. Under this mechanism, the per capita

payment made to a plan for an enrollee is adjusted if that enrollee had an inpatient stay during the previous year. Separate demographically-based payments are used for enrollees without a prior hospitalization, newly eligible aged persons, newly eligible disabled Medicare enrollees, and others without a medical history.

BBRA '99 slowed down the implementation of the Secretary's proposed phase-in schedule of this system, through 2002. In 2000 and 2001, 10% of payments will include risk adjustment using the PIP–DCG method and 90% will be based solely on the older demographic method. In 2002, up to 20% of the payments will be adjusted under the new system, with the remainder of the payment based on adjustments under the old method. After 2002, the splits are not set in law, although the Secretary originally planned to: (1) base 80% of payments on the PIP–DCG system in 2003; and (2) develop a new risk adjustment system for 2004 and beyond that would incorporate both inpatient and outpatient diagnoses.

This provision phases in a new risk adjustment method based on data from substantially all settings gradually over 10 years, in one-tenth increments, starting in 2004, or, if later, the first year in which such data are used.

Section 404. Transition to revised Medicare+Choice payment rates

Under current law, M+C organizations which choose not to renew their contract with HCFA or to reduce their service area must notify HCFA in writing by July 1 of the year in which the contract would end. (For example notification was due by July 3, 2000 (because July 1 fell on a Saturday) for contracts ending December 31, 2000.)

Under this section, within 2 weeks after the date of enactment of the bill, the Secretary of Health and Human Services must announce revised M+C capitation rates for 2001, due to changes from this legislation. Plans that previously provided notice of their intention to terminate contracts or reduce their service area for 2001 would have 4 weeks after enactment of this Act to rescind their notice and submit an ACR. Further, any M+C organization that would receive higher capitation payments as a result of this bill must submit revised ACR information within four weeks after the date of enactment.

Subtitle B—Administrative Reforms

Section 411. Effectiveness of elections and changes of elections

The Balanced Budget Refinement Act changed BBA '97 to specify that any request to enroll in or disenroll from a M+C plan made after the 10th of the month will not be effective until the first day of the second calendar month thereafter.

This provision reverses that policy and returns to the policy in effect with the BBA '97, allowing individuals who enroll in an M+C plan after the 10th day of the month to receive coverage beginning on the first day of the next calendar month, effective January 1, 2001.

Section 412. Medicare+Choice Program compatibility with employer or union group health plans

This section grants the Secretary authority to waive certain rules that hinder the design of or offering of Medicare+Choice plans to employers and labor organizations, thereby enabling employers and their retirees to take advantage of the Medicare+Choice program.

Over the past few years, employers have increasingly relied on health plans that participate in Medicare to meet their retirees' health care needs. The growing participation in Medicare health plans among employers and retirees reflects the attractiveness over the fee-for-service Medicare program and traditional indemnity retiree health benefits.

Many employers have turned to Medicare+Choice as a way to continue offering coverage to their retirees. Certain BBA rules related to enrollment effective dates and beneficiary information (e.g., all beneficiaries receive the same information), among others, have made it more difficult for employers to offer Medicare+Choice plans to their retirees.

Section 413. Uniform premium and benefit

This section allows the Secretary to waive the BBA '97 rule that Medicare+Choice organizations offer uniform benefits and premiums across a service area without regard to different payment levels in the service area. BBA '97 limited plans' ability to continue or begin serving lower-payment counties, just the opposite of the BBA '97 goal of expanded choice.

The Balanced Budget Act of 1997 required Medicare+Choice plans to have a uniform benefit package and premium across a service area. The Balanced Budget Act of 1999 modified this requirement and allowed plans to break their ACR into service areas which could be as small as a county. Under current law, there is no requirement that you provide the same premium and benefit level in two different counties in your service area. However, plans must submit a separate ACR for each segment. This provision would allow plans to vary benefits across counties without submitting a separate ACR for each county. We note, however, that the Health Care Financing Administration still has the the ability to audit and monitor these situations to ensure that plans continue to be accountable to the Medicare program and its beneficiaries.

This provision is effective upon enactment.

TITLE V—MEDICAID

Subtitle A—General Provisions

Section 501. DSH allotments

Continuation of Medicaid DSH Allotments at Fiscal Year 2000 Levels. Medicaid requires States to make disproportionate share (DSH) payments to certain hospitals treating large numbers of low-income and Medicaid patients. Within broad Federal guidelines, States determine the formulas used to make payments to individual hospitals and to designate which hospitals qualify for payments. Those payments are matched by the Federal government at the Federal medical assistance percentage (FMAP), the same percentage that applies to most other Medicaid payments for benefits.

Provisions were included in the Balanced Budget Act of 1997 that made graduated reductions in DSH spending over time. The formula-based DSH allotments were replaced with specific DSH allotments for each State for FY1998 through 2002, with some high DSH States (above 12%) taking reductions. After 2002, each State's allotment will be equal to its allotment for the previous year increased by the percentage change in the consumer price index for the previous year. Each State's DSH payments for FY2003 and beyond are limited to no more than 12% of spending for medical assistance for that year.

The Committee's provision stops the reduction in allotments to the high DSH States by freezing State-specific DSH allotments for FY2001 at the FY2000 levels, and allow these allotments to grow for inflation. For FY2001 and beyond, each State's DSH allotment would be equal to its allotment for the previous year increased by the percentage change in the consumer price index for the previous year, subject to a ceiling equal to 12% of that State's total medical assistance payments in that year.

Special Rule For Medicaid DSH Allotment for Extremely Low DSH States. The Committee's provision rebases Medicaid DSH allotments for extremely low DSH States.

In the case of a State where the total FY1999 Federal and State DSH expenditures (as reported to HCFA on August 31, 2000) is less than one percent of the State's total medical assistance expenditures during that fiscal year, the DSH allotment for FY2001 must be increased to 1 percent of the State's total amount of expenditures under their plan for such assistance during that fiscal year. This new allotment becomes the State's base allotment for the purposes of applying section 501(a) in future years, and these States would be allowed to grow at CPI–U with the rest of the States. This provision does not apply to Hawaii and Tennessee, which do not have DSH programs.

District of Columbia. The DSH allotment for the District of Colombia is set at $32 million for FY2000.

For the purpose of calculating the FY2001 allotment, the Committee's provision would increase the FY2000 DSH allotment for the District of Columbia to $49 million. This change is intended to compensate for a technical error in calculating the District's 1995 DSH allotment.

Contingent Allotment for Tennessee. Some States in the past obtained waivers of certain Medicaid provisions for a number of purposes including requiring Medicaid beneficiaries to enroll in managed care organizations (MCOs), or limiting MCO services to a specific population or geographic area or to expand the program to individuals who would not otherwise be eligible for Medicaid. These renewable waivers are authorized under sections 1915(b), 1915(c), or 1115 of the Medicaid law. These waivers are required to be budget neutral so oftentimes, the States discontinued their regular DSH programs and used Federal share DSH allotments to help offset the costs of the program expansions.

If Tennessee's State-wide section 1115 Medicaid waiver program is revoked or terminated, the Committee's provision sets Tennessee's FY2001 DSH allotment equal to $286,442,437 so that it could re-institute a regular DSH program and resume DSH payments to hospitals.

Assuring Identification of Medicaid Managed Care Patients. Medicaid requires States to make disproportionate share (DSH) payments to certain hospitals treating large numbers of low-income and Medicaid patients. Within broad Federal guidelines, States determine the formulas used to make payments to individual hospitals and to designate which hospitals qualify for payments. Those payments are matched by the Federal government at the Federal medical assistance percentage (FMAP), the same percentage that applies to most other Medicaid payments for benefits.

States may provide disproportionate share payments to those hospitals whose Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals receiving Medicaid payments in the State, and must provide payments to those with a low-income utilization rate above 25 percent. The Medicaid inpatient utilization rate is in part based on the number of inpatient days attributable to Medicaid beneficiaries. The low-income utilization rate includes the total revenues paid on behalf of Medicaid beneficiaries.

The Committee's provision clarifies that Medicaid enrollees of managed care organizations and primary care case management organizations are to be included for the purposes of calculating the Medicaid inpatient utilization rate and the low-income utilization rate. With the move to managed care, the fee-for-service number by itself is no longer an accurate representation of Medicaid utilization. The State must include in their MCO contracts information that allows the State to determine which hospital services are provided to Medicaid beneficiaries through managed care. The Committee's provision would also requires States to include a sponsorship code for the managed care entity on the Medicaid beneficiary's identification card.

This section is effective January 1, 2001.

Section 502. New prospective payment system for federally-qualified health centers and rural health clinics

Under the Balanced Budget Act of 1997, Congress repealed the requirement that States pay Federally Qualified Health Centers (FQHCs) based on costs incurred in providing care (cost-based reimbursement). States now pay Federally Qualified Health Centers and Rural Health Clinics (RHCs) a percentage of the facilities' reasonable costs for providing services. This percentage decreases for specified fiscal years—100% of costs for services furnished during FY1998 and FY1999; 95% for FY2001 and FY2002; 90% for FY2003; 85% for FY2004; and cost-based reimbursement will expire in 2005. Two special payment rules are applicable during FY1998–FY2002. In the case of a contract between an FQHC or RHC and a managed care organization (MCO), the MCO must pay the FQHC or RHC at least as much as it would pay any other provider for similar services. States are required to make supplemental payments to the FQHCs and RHCs, equal to the difference between the contracted amounts and the cost-based amounts.

The Committee's provision creates a new Medicaid prospective payment system for FQHCs and RHCs beginning in FY2001. An average of the reasonable costs incurred in FY 1999 and 2000 will form the base for prospective payments beginning in FY 2001 to FQHCs and RHCs. This amount will take into account any increase

or decrease in the scope of services furnished. For entities first qualifying as FQHCs or RHCs after 2000, the per visit payments will begin in the first year that the center or clinic attains such qualification and are to be based on 100% of the costs incurred during that year based on the rates established for similar centers or clinics with similar caseloads in the same adjacent geographic area. In the absence of such similar centers or clinics, the methodology would be based on that used for developing rates for established FQHCs or RHCs or a methodology established by the Secretary.

For subsequent fiscal years, per visit payments for all FQHCs and RHCs are equal to amounts for the preceding fiscal year increased by the percentage increase or decrease in the Medicare Economic Index applicable to primary care services for that fiscal year, and adjusted for any increase in the scope of services furnished during that fiscal year. In managed care contracts, States must make supplemental payments to the center or clinic equal to the difference between contracted amounts and the prospective payment system amounts. Those payments are to be paid on a schedule mutually agreed to by the State and the FQHC or RHC. Alternative payment methods are permitted only when payments are at least equal to amounts otherwise provided.

The Committee's provision also directs the Comptroller General to provide for a study on how to rebase or refine cost payment methods for the services of FQHCs and RHCs. The report is due to Congress no later than 4 years after the date of enactment.

This section is effective October 1, 2000.

Section 503. Optional coverage of legal immigrants under the Medicaid program

For the purposes of determining alien eligibility for Federal benefits, the law recognizes two general categories of aliens: qualified and non-qualified aliens. Qualified aliens include legal permanent residents, refugees, aliens paroled into the United States for at least 1 year, aliens granted asylum or related relief, certain abused spouses and children and Cuban-Haitian entrants. Non-qualified aliens are other non-citizens, including illegal aliens, aliens admitted for a temporary purpose, such as tourists and foreign students, short-term parolees, asylum applicants, and various classes or aliens granted temporary permission to remain.

In general, non-qualified aliens are not eligible for Federal medical assistance under title XIX except in the case of medical emergency.

In addition, States are required to cover certain categories of aliens provided they meet the State's financial and other eligibility criteria. These groups include: (1) veterans or persons on active military duty; (2) refugees, asylees, and Cuban and Haitian entrants for seven years after entry, and Amerasians for five years after entry; (3) lawful permanent residents who can be credited with 40 quarters of Social Security coverage; and (4) Canadian- and Mexican-born immigrants of at least 50% North American Native heritage. Legal immigrants who were receiving SSI (and related Medicaid) as of August 22, 1996 continue to be eligible. In addition, those who were here by August 22, 1996, and subsequently became disabled are also eligible for SSI and related Medicaid.

Other lawfully residing aliens may become eligible for Medicaid at State option subject to their State's financial and other criteria, for example, aliens residing in the United States before August 22, 1996. Those entering the United States after August 22, 1996 are barred for 5 years from all but emergency medical assistance. After 5 years, they may become eligible for full Medicaid at State option.

Aliens entering with sponsors after December 19, 1997 are subject to the "deeming rule," under which the sponsors' income and resources are deemed to be available to the immigrant in determining the immigrant's financial eligibility for benefits until the immigrant becomes a citizen or meets the 10-year work requirement or is credited with 40 quarters of work by SSA.

The Committee's provision amends title XIX to allow States the option of extending Medicaid coverage to pregnant women (during pregnancy and for 60 days following birth) or children who would not otherwise qualify under the 1996 welfare reform law provisions pertaining to eligibility for lawfully residing illegal immigrants. To qualify, the pregnant woman or children must meet all other Medicaid eligibility requirements and must have been lawfully residing in the United States for at least 2 years. States could elect to apply the new option to immigrant pregnant women, immigrant children, or both.

In a State that elects to provide Medical assistance to pregnant women and children under this provision, action may not be brought under an affidavit of support against the sponsor of such an alien on the basis of the medical care received. In a State that elects this option, the provisions of the law that might restrict participation in Medicaid of immigrants who have lawfully resided in the country for at least two years would cease to apply. Additionally, if a State chooses to cover these immigrants, sponsors would not incur a debt for the cost of Medicaid benefits provided to immigrants under the election and sponsors would not be asked to repay the value of the medical care received after the two year period had been met. Under section 602, States electing to apply the new option to immigrant children in Medicaid would also be permitted to extend coverage to them in SCHIP under the same terms.

This section is effective October 1, 2000.

Section 504. Additional entities qualified to determine Medicaid presumptive eligibility for low-income children

Qualified Entities to Determine Presumptive Eligibility for Low-Income Children. Currently, States have the option of extending what is known as "presumptive eligibility" to two categories of Medicaid beneficiaries—pregnant women and children under 19 years of age. Presumptive eligibility allows such individuals whose family income appears to be below the State's Medicaid income standards to enroll temporarily in Medicaid, until a final formal determination of eligibility is made. The primary purpose of this option is to make needed services immediately available to these specified groups. Presumptive eligibility has been permitted for pregnant women since 1986, and for children under 19 since 1997.

The law defines the entities permitted to make presumptive eligibility determinations. For children, qualified entities include Medicaid providers, or agencies authorized to determine eligibility for Head Start programs, subsidized child care (under the Child Care

and Development Block Grant), or the Special Supplemental Food Program for Women, Infants and Children (WIC).

For pregnant women, a qualified entity is a provider that: (1) is eligible to receive payments under Medicaid, and provides services of the types delivered by outpatient hospitals, Rural Health Clinics, Federally Qualified Health Centers, or other clinics, and has been designated by the State as being capable of making presumptive eligibility determinations, and receives funds under the Consolidated Health Centers program or the Rural Health Outreach, Network Development and Telemedicine Grant, or the Maternal and Child Health Services Block Grant Program, or the Health Services for Urban Indians program; (2) participates in a program established under the Special Supplemental Food Program for Women, Infants and Children (WIC) or the Commodity Supplemental Food Program; (3) participates in a State perinatal program; or (4) is the Indian Health Service or a health program or facility operated by the tribe or tribal organization under the Indian Self Determination Act.

The Committee's provision adds several new entities to the list of those qualified to make Medicaid presumptive eligibility determinations for low-income children and pregnant women, including (1) those authorized to determine eligibility for children under Medicaid (title XIX) or the State Children's Health Insurance Program (title XXI); (2) elementary or secondary schools as defined in the Elementary and Secondary Education Act of 1965; (3) elementary or secondary schools operated or supported by the Bureau of Indian Affairs; (4) State or tribal child support enforcement agencies; (5) child care resource and referral agencies; (6) organizations providing emergency food and shelter under a grant through the Stewart B. McKinney Homeless Assistance Act; (7) State or tribal offices or entities involved in enrollment under Medicaid, the Temporary Assistance for Needy Families program (part A of title IV), the State Children Health Insurance Program, or that determines eligibility for 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 or under the Native American Housing Assistance and Self-Determination Act of 1996; or (8) any other entity deemed by a State, as approved by the Secretary of Health and Human Services (HHS).

The entities included in this provision are all locations that interact with individuals who may be potentially eligible for health insurance through Medicaid or SCHIP. These entities may have access to the family's income information and could cross reference State Medicaid and SCHIP income eligibility guidelines to determine whether or not the children or pregnant women would qualify for health insurance based on income. This provision does not change current law that requires the State to make the ultimate eligibility determination.

This section is effective October 1, 2000.

Application of Presumptive Eligibility Provisions to the State Children's Health Insurance Program. States' allotments under the State Children's Health Insurance Program (SCHIP; title XXI of the Social Security Act) are made available to pay only the Federal share of costs associated with separate (non-Medicaid) SCHIP pro-

grams. The Federal share of costs associated with Medicaid expansions under SCHIP are paid for under Medicaid. State SCHIP allotments are reduced by the amounts paid under Medicaid for SCHIP Medicaid expansion costs.

Medicaid's presumptive eligibility option allows States to enroll temporarily children whose family income appears to be below the State's applicable income standards, until a final formal determination of eligibility is made. Benefits provided during periods of presumptive eligibility to Medicaid children, both those presumed to be eligible under regular Medicaid and those presumed to be eligible under SCHIP Medicaid expansions, are paid out of title XIX and are counted against a State's SCHIP allotment.

There is no express provision for the treatment of presumptive eligibility under separate (non-Medicaid) SCHIP programs. However, the Secretary of Health and Human Services permits States to develop an equivalent procedure for separate (non-Medicaid) SCHIP programs. Expenditures associated with presumptive eligibility for children who are eventually determined to be ineligible for Medicaid (under title XIX or under a Medicaid expansion under SCHIP) or for a separate (non-Medicaid) SCHIP program are counted against title XXI allotments under the health service initiatives option. Health service initiatives, direct purchase of services to provide child health assistance, outreach activities and other reasonable costs to administer the program are treated as administrative expenses. All administrative expenses are subject to an overall limit of 10% of total program spending per fiscal year.

The Committee's provision would clarify States' authority to conduct presumptive eligibility, as defined in title XIX and amended by the previous provision, under separate (non-Medicaid) SCHIP programs.

This section is effective October 1, 2000.

Section 505. Improving welfare-to-work transition under the Medicaid program

Eligibility for Temporary Assistance for Needy Families (TANF) does not confer automatic Medicaid eligibility. Nonetheless, current law preserves Medicaid entitlement for individuals who meet the requirements for the former Aid to Families with Dependent Children (AFDC) programs that were in effect in States on July 16, 1996, even if they do not qualify for assistance under TANF. This group was created to ensure that certain low-income families do not lose their Medicaid eligibility as a result of welfare reform. States are required to use the eligibility determination processes that were already in place for AFDC and Medicaid, including the same income and resource standards and other rules formerly used to determine if a family's income and composition made it eligible for AFDC and Medicaid. States may modify their "pre-reform" AFDC income and resource standards as follows: (1) States may lower their income eligibility standards, but not below those used on May 1, 1988, (2) States may increase their income and resource standards up to the percentage increase in the Consumer Price Index (CPI), and (3) States may use less restrictive income and resource methodologies than those in effect on July 16, 1996.

Transitional medical assistance (TMA) under Medicaid was created to address the concern that the loss of Medicaid for individ-

uals who successfully obtain employment would be a disincentive to seeking and keeping jobs. States are required to continue Medicaid for 6 months for families included in the group (described above) who received Medicaid in at least 3 of the last 6 months preceding the month in which the family lost Medicaid coverage due to increased hours of employment, increased earnings of the caretaker relative, or the family member's loss of one of the time limited earned income disregards. States must extend Medicaid coverage for an additional 6 months for families that were covered during the entire first 6-month period, and are earning below 185% of the Federal poverty line. The TMA provision will sunset at the end of fiscal year 2001.

States must adhere to certain notification requirements for TMA. During the initial 6-month extension period, at specified intervals, States must notify qualifying families about: (1) their option for an additional 6 months of Medicaid coverage, (2) the reporting requirements applicable to the initial extension period and the additional extension period, (3) whether premiums are required for extended assistance, including premiums required in the first 3 months of the additional 6-month extension, and (4) other out-of-pocket expenses, benefits, reporting and payment procedures and any preexisting condition limitations, waiting periods, or other coverage limitations imposed under any alternative coverage options offered. During the additional 6-month extension period, States must notify qualifying families about the reporting requirements applicable to this period of extension and the amount of any premium required for such extended assistance for the final 3 months of coverage.

To qualify for TMA, families must meet certain reporting requirements. Families receiving the initial 6 months of TMA must report gross monthly earnings and the monthly costs of employment-related child care for months 1 through 3 of this period. Such reporting is a condition for eligibility for the additional 6 months of TMA. During the second 6 months of TMA, families must report the same financial information for months 4 through 9. Thus, families who qualify for the full 12 months of TMA must report gross earnings and employment-related child care costs for each of months 1 through 9.

The Committee's provision extends the sunset on the TMA provision by one year to fiscal year 2002. It also gives States the option to waive reporting requirements for families qualifying for up to 12 months of TMA (and the corresponding obligation of States to notify families of these reporting requirements).

Individuals who are eligible for TMA are automatically eligible for the first six months. The only requirement that beneficiaries must meet during this period is to have a dependent child living in the home. This provision would allow States the option to eliminate this reporting requirement during the first six months.

The provision gives States the option to eliminate the reporting requirements laid out in the statute for the second six months as well. The provision does not in any way alter the requirement that families' incomes do not exceed 185% of poverty. States must continue to ensure that families meet the income requirements to continue to be eligible. The provision in the Committee's bill would allow States the flexibility to look to the regular eligibility redetermination rules and procedures (rather than mandate that they fol-

low the statutory requirements) to ensure that families continue to meet the requirements for eligibility. For example, the Health Care Financing Administration recently notified States of States' ability to do ex parte determinations using existing current information that beneficiaries have filed for other programs to determine and redetermine eligibility, rather than requiring individuals to present in the State office at each interval. This provision will give States more flexibility in managing their programs and alleviate burden on beneficiaries as well.

Finally, the Committee's provision makes TMA an option, rather than a requirement, for the subset of States that already cover individuals in this group at or above 185% of poverty. States that are already covering these individuals in their Medicaid program and are meeting Medicaid eligibility requirements will be deemed to have met the TMA requirements. The Committee believes this option is in keeping with its desire to reduce burdensome or overly prescriptive requirements on States and beneficiaries without decreasing accountability or access.

This section is effective October 1, 2000.

Section 506. Medicaid county-organized health systems

Health insuring organizations (HIOs) are county-sponsored health maintenance organizations which are currently providing care to a limited number of beneficiaries in the California Medicaid program. Currently, five HIOs operate in seven California counties. These entities are exempt from certain Federal statutory requirements for Medicaid HMO contracts if the HIOs enroll no more than 10 percent of all Medicaid beneficiaries in these California counties (not counting qualified Medicare beneficiaries.)

The committee's provision allows the current exemption from Medicaid HMO contracting requirements to continue to apply as long as no more than 14% of all Medicaid beneficiaries in these California counties are enrolled in those HIOs.

This provision is effective upon enactment of this legislation.

Section 507. Medicaid recognition for services of physician assistants

The Federal Medicaid statute lists services that qualify as Medicaid benefits. Federal matching payments are available toward the cost of items on the list, if covered by State Medicaid programs. States are required to cover certain of those listed items and may choose to cover other items on the list. Congress recognized the services of physician assistants for Medicare in the Balanced Budget Act of 1997. However, a parallel change was not made in Medicaid. Currently, all but three States cover the services of physician assistants under Medicaid.

The Committee's provision includes services provided by physician assistants as Medicaid recognized benefits as long as the services are provided under the supervision of a physician and are authorized under State law. The services of physician assistants would be an optional Medicaid benefit.

This section is effective upon enactment.

TITLE VI—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Section 601. Special rule for availability and redistribution of unused fiscal year 1998 and 1999 SCHIP allotments

Title XXI of the Social Security Act, the State Children's Health Insurance Program, authorizes and appropriates funds for SCHIP for FY1998 through FY2007. To receive Federal funds, States must submit a plan describing their program to the Health Care Financing Administration for approval. In order to access FY1998 allotments, States must have had such approval prior to October 1, 1999. Allotment of funds among the States is determined by a formula set in law. This formula is based on a combination of the number of low-income children and low-income uninsured children in the State, and includes a cost factor that represents the average wages in the State compared to the national average.

SCHIP funds not drawn down from a State's Federal allotment by the end of each fiscal year continue to be available for 2 additional fiscal years, giving each State a total of 3 years to draw down its allotment of Federal matching funds from a given year.

FY1998 allotments not spent by the end of FY2000 (as of September 30, 2000) and FY1999 funds not spent by the end of FY2001 (as of September 30, 2001) will be redistributed by a method to be determined by the Secretary of Health and Human Services (HHS) to States that have fully expended their existing FY1998 or FY1999 allotments respectively and are able to provide required matching funds. Redistributed funds not spent by the end of the fiscal year in which they are reallocated will officially expire and return to the Federal Treasury.

Health service initiatives, direct purchase of services to provide child health assistance, outreach activities and other reasonable costs to administer the program are treated as administrative expenses. All administrative expenses are subject to an overall limit of 10% of total program spending per fiscal year.

The Committee's provision establishes a new method for distributing unspent FY1998 and FY1999 allotments to States and territories.

For FY1998, each State (and the District of Columbia) that uses all its SCHIP allotment would receive from the pool of unspent 1998 funds, the amount of its expenditures in excess of its original exhausted allotment. For FY1998, each territory (and commonwealth) that expends all its 1998 SCHIP allotment would receive an amount that bears the same ratio to 1.05 percent of the total amount available for redistribution (across all States and territories) as the ratio of its original allotment to the total FY1998 allotment for all territories. For such States and territories, the same redistribution methods apply with respect to FY1999 funds. The States which have exhausted their 1998 and/or 1999 allotments would have two years to expend the funds which they receive through this process.

For FY1998, each State that did not use all its SCHIP allotment would receive an amount equal to the total amount of unspent 1998 funds, less the amounts distributed to States that fully exhausted their original allotments (described in the paragraph above), multiplied by the ratio of its unspent original 1998 allot-

ment to the total amount of unspent 1998 funds. For such States, the same redistribution methods apply with respect to FY1999 funds. The amount of unspent FY1998 and FY1999 funds provided to these States that had not fully spent their allotments for these years would remain available to them through the end of FY2002. These States may use up to 10% of the retained FY1998 funds for outreach activities, in addition to amounts spent under the 10% administration cap under current law. However, the States which have already exhausted their 1998 and/or 1999 allotments will not be able use 10% of this additional allotment for outreach.

To calculate the amounts available for redistribution in each formula described above, the Secretary will use amounts reported by States not later than November 30 of the relevant fiscal year on HCFA Form 64 or HCFA Form 21, as approved by the Secretary.

This section is effective upon enactment.

Section 602. Optional coverage of legal immigrants under SCHIP

For States choosing to provide health insurance coverage through a Medicaid expansion under SCHIP, legal immigrant children are subject to the same Medicaid restrictions as other legal immigrants. States that operate a separate State (non-Medicaid) SCHIP program must cover those legal immigrant children who meet the Federal definition of qualified alien and who are otherwise eligible. These include: (1) all qualified alien children who were in the United States before August 22, 1996; (2) refugees, asylees, and certain Cuban, Haitian and Amerasian immigrants; (3) unmarried, dependent children of veterans and active duty service members of the Armed Forces; and (4) qualified alien children who enter the United States on or after August 22, 1996 as lawful permanent residents and who are in continuous residence for 5 years—before 5 years of continuous residence, qualified alien children are barred from participation in SCHIP. States that operate separate State programs also may cover battered immigrants as determined by INS provided the qualified alien child is otherwise eligible for the program.

In the case of qualified alien children entering with sponsors after December 19, 1997, SCHIP coverage is subject to the "deeming rule," under which the sponsors' income and resources are deemed to be available to the qualified alien child in determining their eligibility for benefits until the child becomes a citizen or meets the 10-year work requirement.

The Committee's provision adds a new State option to SCHIP that would allow States to expand health insurance coverage to lawfully residing alien children who are otherwise eligible for SCHIP and who have been lawfully residing in the United States for 2 years. In a State that elects this option, the provisions of the 1996 welfare reform law that might restrict the participation in SCHIP of immigrants who have lawfully resided in the country for at least two years would cease to apply. In addition, if a State chooses to cover these immigrants, sponsors would not incur a debt for the cost of SCHIP benefits provided to immigrants under the election and sponsors would not be asked to repay the value of the medical care received after the two year period had been met. The option to expand coverage to this group under SCHIP would only

be available to States that have opted to expand coverage to this category of children under their Medicaid State plan.

This section is effective October 1, 2000.

TITLE VII—EXTENSION OF SPECIAL DIABETES GRANT PROGRAMS

Section 701. Extension of juvenile and Indian diabetes grant programs

Juvenile Diabetes Research Program. The Balanced Budget Act of 1997 amended title III of the Public Health Service Act to create a grant program under which the Secretary could make grants to support prevention and treatment services of, and research relating to, type 1 diabetes in children. Congress committed $150 million, ($30 million each year over 5 years FY1998 through FY2002), for this program, with the funds being transferred from title XXI of the Social Security Act (State Children's Health Insurance Program) for these grants. This commitment was in addition to the annual appropriations for NIH.

The Committee's provision extends appropriated funds from the Treasury to be made available for diabetes grants, bringing the total to $50 million each for FY2003 and FY2007. The funds will remain available until expended. The funds may not be derived or deducted from the State Children's Health Insurance Program.

This section is effective upon enactment.

Indian Diabetes Grant Program. The Balanced Budget Act of 1997 amended title III of the Public Health Service Act to create a grant program under which the Secretary could make grants to support prevention and treatment services of diabetes in Indians. These grants were to purchase services provided through one or more of the following entities: the Indian Health Service, a tribal Indian health program, and an urban Indian health program. Congress committed $150 million, ($30 million each year over 5 years FY1998 through FY2002), for this program, with the funds being transferred from Title XXI of the Social Security Act (State Children's Health Insurance Program) for these grants.

The Committee's provision extends appropriated funds available from the Treasury for diabetes prevention and treatment programs for Indians, bringing the total to $50 million each for FY2003 and FY2007. The funds will remain available until expended. The funds may not be derived or deducted from the State Children's Health Insurance Program.

This section is effective upon enactment.

Extension of Reports on Grant Programs. The Balanced Budget Act of 1997 required that the Secretary conduct an evaluation of the diabetes grant programs established under this section and report to the appropriate committees of Congress an interim report on January 1, 2000, and a final report on January 1, 2002.

The Committee's provision extends the interim report requirements to every two years, 2000, 2002, 2004, with a final report due on January 1, 2007.

This section is effective upon enactment.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

* * * * * * *

ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS

SEC. 226. (a) * * *

* * * * * * *

(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.

* * * * * * *

[(h)**]** *(j)* For entitlement to hospital insurance benefits in the case of certain uninsured individuals, see section 103 of the Social Security Amendments of 1965.

* * * * * * *

TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

* * * * * * *

GUIDANCE REGARDING APPLICATION OF HEALTH CARE FRAUD AND ABUSE SANCTIONS

SEC. 1128D. (a) * * *

* * * * * * *

(b) ADVISORY OPINIONS.—

(1) * * *

* * * * * * *

(6) APPLICATION OF SUBSECTION.—This subsection shall apply to requests for advisory opinions made on or after the date which is 6 months after the date of enactment of this section **[**and before the date which is 4 years after such date of enactment**]**.

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

* * * * * * *

FUNCTIONS OF PEER REVIEW ORGANIZATIONS

SEC. 1154. (a) Any utilization and quality control peer review organization entering into a contract with the Secretary under this part must perform the following functions:

(1) * * *

* * * * * * *

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

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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NOTICE OF MEDICARE BENEFITS; MEDICARE AND MEDIGAP INFORMATION

SEC. 1804. (a) * * *

* * * * * * *

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

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

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

* * * * * * *

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

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CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of Requests and Certifications

SEC. 1814. (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

(1) * * *

* * * * * * *

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician, nurse practitioner, or clinical nurse specialist (as the case may be) makes certification of the kind provided in subparagraph (A), (B), (C), or (D) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. For purposes of paragraph (2)(C), an individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, and that absences of the individual from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment**[**.**]**, *including participating in an adult day care program licensed or certified by a State, or accredited, to furnish adult day care services in the State for the purposes of therapeutic treatment for Alzheimer's disease or a related dementia.*

* * * * * * *

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) * * *

* * * * * * *

(g)(1) * * *

* * * * * * *

(4) This subsection shall not apply to expenses incurred with respect to services furnished during 2000 [and 2001]*, 2001, and 2002*.

(h)(1)(A) * * *

(B) [In] *Except for tests described in subparagraph (E), in* the case of clinical diagnostic laboratory tests performed by a physician or by a laboratory (other than tests performed by a qualified hospital laboratory (as defined in subparagraph (D)) for outpatients of such hospital), the fee schedules established under subparagraph (A) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished on or after July 1, 1984.

* * * * * * *

(E) In the case of a clinical diagnostic laboratory test which is described by a new code in the Health Care Financing Administration Common Procedure Coding System (commonly referred to as "HCPCS"), for which the Secretary is not able to crosswalk with a similar test with an established schedule amount, the Secretary shall establish for purposes of subparagraph (A) a single fee schedule amount for all areas in the following manner:

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

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

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

(2)(A)(i) Except as provided in paragraph (4), the Secretary shall set the fee schedules at 60 percent (or, in the case of a test performed by a qualified hospital laboratory (as defined in paragraph (1)(D)) for outpatients of such hospital, 62 percent) of the prevailing charge level determined pursuant to the third and fourth sentences of section 1842(b)(3) for similar clinical diagnostic laboratory tests

for the applicable region, State, or area for the 12-month period beginning [July 1, 1984,] *July 1, 1984. The fee schedules established under the previous sentence and paragraph (1)(E)(3) shall be* adjusted annually (to become effective on January 1 of each year) by a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index for All Urban Consumers (United States city average), and subject to such other adjustments as the Secretary determines are justified by technological changes.

* * * * * * *

(4)(A) * * *

(B) For purposes of subsections (a)(1)(D)(i) and (a)(2)(D)(i), the limitation amount for a clinical diagnostic laboratory test performed—

(i) * * *

* * * * * * *

(viii) after December 31, 1997, is equal to 74 percent of such median *(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)*.

* * * * * * *

(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

(1) * * *

* * * * * * *

(2) SYSTEM REQUIREMENTS.—Under the payment system—

(A) * * *

* * * * * * *

(E) the Secretary shall establish, in a budget neutral manner, outlier adjustments under paragraph (5) and transitional pass-through payments under paragraph (6) and other adjustments as determined to be necessary to ensure equitable payments, such as adjustments for certain classes of hospitals; [and]

(F) the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services[.]*; and*

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

* * * * * * *

(6) TRANSITIONAL PASS-THROUGH FOR ADDITIONAL COSTS OF INNOVATIVE MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—

(A) IN GENERAL.—The Secretary shall provide for an additional payment under this paragraph for any of the following that are provided as part of a covered OPD service (or group of services):

(i) * * *

* * * * * * *

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

(I) * * *

(II) [the cost of the device, drug, or biological] *the cost of the drug or biological or the average cost of the category of devices* is not insignificant in relation to the OPD fee schedule amount (as calculated under paragraph (3)(D)) payable for the service (or group of services) involved.

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

[(i) on the first date this subsection is implemented in the case of a drug, biological, or device described in clause (i), (ii), or (iii) of subparagraph (A) and in the case of a device, drug, or biological described in subparagraph (A)(iv) and for which payment under this part is made as an outpatient hospital service before such first date; or

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

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

(i) ESTABLISHMENT OF CATEGORIES.—The Secretary shall establish categories of medical devices based on type of medical device as follows:

(I) IN GENERAL.—The Secretary shall establish criteria that will be used for creation of categories through rulemaking (which may include use of an interim final rule with comment period). Such categories shall be established in a manner such that no medical device is described by more than one category. Such criteria shall include a test of whether the average cost of devices that would be included in a category, as estimated by the Secretary, is not insignificant as described in paragraph (A)(iv)(II).

(II) INITIAL CATEGORIES.—The categories to be applied as of the category-based pass-through implementation date specified pursuant to subclause (V) shall be established in a manner such that each medical device that meets the requirements of clause (ii) or (iv) of subparagraph (A) as of such date is included in a such a category. For purposes of the preceding sentence, whether a medical device meets the requirements of clause (ii) or (iv) of subparagraph (A) as of such date shall be determined without regard to clause (ii) of this subparagraph

and on the basis of the program memoranda issued before such date identifying medical devices that meet such requirements.

(III) ADDING CATEGORIES.—The Secretary shall promptly establish a new category of medical device under this clause for any medical device that meets the requirements of subparagraph (A)(iv) and for which none of the categories in effect or that were previously in effect (as described in subparagraph (C)(iii)) is appropriate. The Secretary shall only establish a new category for a medical device that is described by a category that was previously in effect if the Secretary determines, in accord with criteria established under subclause (I) of this clause, that the device represents a significant advance in medical technology that is expected to significantly improve the treatment of Medicare beneficiaries.

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

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

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

(I) the device is described by a category established under clause (i), and

(II) an application under section 515 of the Federal Food, Drug, and Cosmetic Act has been approved with respect to the device, or the device has been cleared for market under section 510(k) of such Act, or the device is exempt from the requirements of section 510(k) of such Act pursuant to subsection (l) or (m) of section 510 of such Act or section 520(g) of such Act, without an additional requirement for application or prior approval.——

(C) LIMITED PERIOD OF PAYMENT.—

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

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

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

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

(ii) MEDICAL DEVICES.—Except as provided in clause (iv), payment shall be made under this paragraph with respect to a medical device only if such device—

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

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

(iii) PERIOD FOR WHICH CATEGORY IS IN EFFECT.—For purposes of this subparagraph and subparagraph (B), a category of medical devices established under subparagraph (B)(i) shall be in effect for a period of at least 2 years, but not more than 3 years, that begins—

(I) in the case of a category established under subparagraph (B)(i)(II), on the first date on which payment was made under this paragraph for any device described by such category (including payments made during the period before the category-based pass-through implementation date); and

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

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

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

(II) notwithstanding subclause (I), the Secretary shall make payments under this paragraph during the period beginning one month after the date of enactment of the Beneficiary Improvement and Protection Act of 2000 and ending on the same ending date in subclause (I) with respect to any medical device that is not included in a program memorandum referred to in subparagraph (B)(i)(II) but that is substantially similar (other than with respect to the restriction in subparagraph (A)(iv)(I)) to devices that are so included

and that the Secretary determines is likely to be described by a initial category established under such subparagraph.

[(C)] *(D)* AMOUNT OF ADDITIONAL PAYMENT.—Subject to [subparagraph (D)(iii)] *subparagraph (E)(iii)*, the amount of the payment under this paragraph with respect to a device, drug, or biological provided as part of a covered OPD service is—

(i) * * *

* * * * * * *

[(D)] *(E)* LIMIT ON AGGREGATE ANNUAL ADJUSTMENT.—

(i) IN GENERAL.—The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied to less than a full year, the previous sentence shall apply only to the portion of such year.

* * * * * * *

(12) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

(A) * * *

* * * * * * *

(E) the determination of the fixed multiple, or a fixed dollar cutoff amount, the marginal cost of care, or applicable percentage under paragraph (5) or the determination of insignificance of cost, the duration of the [additional payments (consistent with paragraph (6)(B))] *additional payments, the determination and deletion of initial and new categories (consistent with subparagraphs (B) and (C) of paragraph (6))*, the portion of the medicare OPD fee schedule amount associated with particular devices, drugs, or biologicals, and the application of any pro rata reduction under paragraph (6).

* * * * * * *

SPECIAL PAYMENT RULES FOR PARTICULAR ITEMS AND SERVICES

SEC. 1834. (a) * * *

* * * * * * *

(c) PAYMENTS AND STANDARDS FOR SCREENING MAMMOGRAPHY.—

(1) * * *

* * * * * * *

(3) LIMIT.—

(A) $55, INDEXED.—Except as provided by the Secretary under [subparagraph (B)] *subparagraphs (B) and (D)*, the limit established under this paragraph—

(i) * * *

(ii) for screening mammography performed in a subsequent year is the limit established under this paragraph for the preceding year *(taking into account, if applicable, subparagraph (D))* increased by the percentage increase in the MEI for that subsequent year.

(B) [REDUCTION OF] *REVISIONS TO* LIMIT.—The Secretary shall review from time to time the appropriateness of the amount of the limit established under this paragraph. The Secretary may, with respect to screening mammography performed in a year after 1992 *or new technologies described in paragraph (1)(D), increase or* reduce the amount of such limit as it applies nationally or in any area to the amount that the Secretary estimates is required to assure that screening mammography of an appropriate quality is readily and conveniently available during the year.

* * * * * * *

(D) INCREASE IN PAYMENT LIMIT FOR NEW TECHNOLOGIES.—In the case of new technologies applied to screening mammography performed beginning in 2001 and determined by the Secretary to enhance the detection of breast cancer, the limit applied under this paragraph for 2001 shall be increased by $15.

* * * * * * *

(d) FREQUENCY LIMITS AND PAYMENT FOR COLORECTAL CANCER SCREENING TESTS.—

(1) * * *

* * * * * * *

(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

(A) * * *

* * * * * * *

(E) FREQUENCY LIMIT.—No payment may be made under this part for a colorectal cancer screening test consisting of a screening flexible sigmoidoscopy—

(i) if the individual is under 50 years of age; [or]

(ii) if the procedure is performed within the 47 months after a previous screening flexible sigmoidoscopy[.]*; or*

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

(3) SCREENING COLONOSCOPY FOR INDIVIDUALS AT HIGH RISK FOR COLORECTAL CANCER.—

(A) FEE SCHEDULE.—With respect to colorectal cancer screening test consisting of a screening colonoscopy for individuals at high risk for colorectal cancer (as defined in section 1861(pp)(2)) *and for individuals making the election described in paragraph (4)*, payment under section 1848 shall be consistent with payment amounts under such section for similar or related services.

* * * * * * *

(E) FREQUENCY LIMIT.—No payment may be made under this part for a colorectal cancer screening test consisting of

a screening colonoscopy for individuals at high risk for colorectal cancer if the procedure is performed within the 23 months after a previous screening colonoscopy. *No payment may be made under this part for a colorectal cancer screening test consisting of a screening colonoscopy for individuals making the election described in paragraph (4) if the procedure is performed within the 119 months after a previous screening colonoscopy or within 47 months after a screening flexible sigmoidoscopy.*

(4) ELECTION OF SCREENING COLONOSCOPY FOR INDIVIDUALS NOT AT HIGH RISK OF COLORECTAL CANCER INSTEAD OF SCREENING SIGMOIDOSCOPY.—An individual who is not at high risk of colorectal cancer may elect to receive a screening colonoscopy instead of a screening sigmoidoscopy.

* * * * * * *

(l) ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.—

(1) * * *

(2) CONSIDERATIONS.—In establishing such fee schedule, the Secretary shall—

(A) * * *

* * * * * * *

(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner*, except that such phase-in shall provide for full payment of any national mileage rate beginning with the effective date of the fee schedule for ambulance services provided by suppliers in any State who were not paid a separate amount for all mileage prior to the implementation of the fee schedule*.

(3) SAVINGS.—In establishing such fee schedule, the Secretary shall—

(A) ensure that the aggregate amount of payments made for ambulance services under this part during 2000 does not exceed the aggregate amount of payments which would have been made for such services under this part during such year if the amendments made by section 4531(a) of the Balanced Budget Act of 1997 continued in effect, except that in making such determination the Secretary shall assume an update in such payments for 2002 equal to 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 **[**reduced in the case of 2001 and 2002 by 1.0 percentage points**]**; and

(B) set the payment amounts provided under the fee schedule for services furnished in 2001 and each subsequent year at amounts equal to the payment amounts under the fee schedule for services furnished during the previous year, increased 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 [reduced in the case of 2001 and 2002 by 1.0 percentage points].

* * * * * * *

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

SEC. 1835. (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

(1) * * *

* * * * * * *

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes a certification of the kind provided in subparagraph (A) or (B) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. For purposes of paragraph (2)(A), an individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, and that absences of the individual from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment[.], *including participating in an adult day care program licensed or certified by a State, or accredited to furnish adult day care services in the State, to furnish adult day care services in the State for the purposes of therapeutic treatment for Alzheimer's disease or a related dementia.*

* * * * * * *

ENROLLMENT PERIODS

SEC. 1837. (a) * * *

* * * * * * *

(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.

* * * * * * *

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *

* * * * * * *

(b)(1) * * *

* * * * * * *

(6) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that (A) payment may be made (i) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (ii) (where the service was provided in a hospital, critical access hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service, (B) payment may be made to an entity (i) which provides coverage of the services under a health benefits plan, but only to the extent that payment is not made under this part, (ii) which has paid the person who provided the service an amount (including the amount payable under this part) which that person has accepted as payment in full for the service, and (iii) to which the individual has agreed in writing that payment may be made under this part, (C) in the case of services described in clause (i) of section 1861(s)(2)(K), payment shall be made to either (i) the employer of the physician assistant involved, or (ii) with respect to a physician assistant who was the owner of a rural health clinic (as described in section 1861(aa)(2)) for a continuous period beginning prior to the date of the enactment of the Balanced Budget Act of 1997 and ending on the date that the Secretary determines such rural health clinic no longer meets the requirements of section 1861(aa)(2), for such services provided before January 1, 2003, payment may be made directly to the physician assistant; (D) payment may be made to a physician for physicians' services (and services furnished incident to such services) furnished by a second physician to patients of the first physician if (i) the first physician is unavailable to provide the services; (ii) the services are furnished

pursuant to an arrangement between the two physicians that (I) is informal and reciprocal, or (II) involves per diem or other fee-for-time compensation for such services; (iii) the services are not provided by the second physician over a continuous period of more than 60 days; and (iv) the claim form submitted to the carrier for such services includes the second physician's unique identifier (provided under the system established under subsection (r)) and indicates that the claim meets the requirements of this subparagraph for payment to the first physician, (E) in the case of an item or service (other than services described in section 1888(e)(2)(A)(ii)) furnished to an individual *(on or after October 1, 2003)* who (at the time the item or service is furnished) is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility (as determined under regulations), payment shall be made to the facility (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise), and (F) in the case of home health services (including medical supplies described in section 1861(m)(5), but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or when any other contracting or consulting arrangement, or otherwise). No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment. For purposes of subparagraph (C) of the first sentence of this paragraph, an employment relationship may include any independent contractor arrangement, and employer status shall be determined in accordance with the law of the State in which the services described in such clause are performed.

* * * * * * *

PART C—MEDICARE+CHOICE PROGRAM

ELIGIBILITY, ELECTION, AND ENROLLMENT

SEC. 1851. (a) * * *

* * * * * * *

(f) EFFECTIVENESS OF ELECTIONS AND CHANGES OF ELECTIONS.—
(1) * * *
(2) DURING CONTINUOUS OPEN ENROLLMENT PERIODS.—An election or change of coverage made under subsection (e)(2) shall take effect with the first day of the first calendar month following the date on which the election or change is **[**made, 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.**]** *made.*

* * * * * * *

PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS

SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—
(1) * * *

* * * * * * *

(3) ESTABLISHMENT OF RISK ADJUSTMENT FACTORS.—
(A) * * *

* * * * * * *

(C) INITIAL IMPLEMENTATION.—
(i) * * *
(ii) PHASE-IN.—Such risk adjustment methodology shall be implemented in a phased-in manner so that the methodology insofar as it makes adjustments to capitation rates for health status applies to—
(I) 10 percent of 1/12 of the annual Medicare+Choice capitation rate in 2000 and 2001; **[**and**]**
(II) not more than 20 percent of such capitation rate in 2002**[**.**]***;*
and, beginning in 2004, insofar as such risk adjustment is based on data from substantially all settings, the methodology shall be phased in equal increments over a 10-year period, beginning with 2004 or (if later) the first year in which such data are used.

* * * * * * *

(c) CALCULATION OF ANNUAL MEDICARE+CHOICE CAPITATION RATES.—
(1) IN GENERAL.—For purposes of this part, subject to paragraphs (6)(C) and (7), each annual Medicare+Choice capitation rate, for a Medicare+Choice payment area for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraph (A), (B), or (C):

(A) * * *

* * * * * * *

(B) MINIMUM AMOUNT.—12 multiplied by the following amount:

(i) For 1998, $367 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area).

[(ii) For a succeeding year**]** *(ii)(I) Subject to subclause (II), for a succeeding year*, the minimum amount specified in this clause (or clause (i)) for the preceding year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (6)(A) for that succeeding year.

(II) For 2001 for any area in a Metropolitan Statistical Area with a population of more than 250,000, $525 (and for any other area, $475).

(C) MINIMUM PERCENTAGE INCREASE.—

(i) * * *

(ii) For a subsequent year, 102 percent *(or 103 percent in the case of 2001)* of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

* * * * * * *

PREMIUMS

SEC. 1854. (a) * * *

* * * * * * *

(c) UNIFORM PREMIUM.—The Medicare+Choice monthly basic and supplemental beneficiary premium, the Medicare+Choice monthly MSA premium charged under subsection (b) of a Medicare+Choice organization under this part may not vary among individuals enrolled in the plan*, except across counties as approved by the Secretary*.

* * * * * * *

(f) REQUIREMENT FOR ADDITIONAL BENEFITS.—

(1) REQUIREMENT.—

(A) * * *

* * * * * * *

(D) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a plan*, except across counties as approved by the Secretary*.

* * * * * * *

CONTRACTS WITH MEDICARE+CHOICE ORGANIZATIONS

SEC. 1857. (a) * * *

* * * * * * *

(i) M+C PROGRAM COMPATIBILITY WITH EMPLOYER OR UNION GROUP HEALTH PLANS.—To facilitate the offering of Medicare+Choice plans under contracts between Medicare+Choice

organizations and employers, labor organizations, or the trustees of a fund established by 1 or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such Medicare+Choice plans.

* * * * * * *

PART D—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * * * *

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) services and supplies **[**(including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered)**]** *(including drugs and biologicals which are not usually self-administered by the patient)* furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills;

(B) hospital services **[**(including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered)**]** *(including drugs and biologicals which are not usually self-administered by the patient)* incident to physicians' services rendered to outpatients and partial hospitalization services incident to such services;

* * * * * * *

(J) prescription drugs used in immunosuppressive therapy furnished, to an individual who receives an organ transplant for which payment is made under this title**[**, but only in the case of drugs furnished—

[(i) before 1995, within 12 months after the date of the transplant procedure,

[(ii) during 1995, within 18 months after the date of the transplant procedure,

[(iii) during 1996, within 24 months after the date of the transplant procedure,

[(iv) during 1997, within 30 months after the date of the transplant procedure, and

[(v) during any year after 1997, within 36 months after the date of the transplant procedureplus such additional

number of months (if any) provided under section 1832(b)**]**;

* * * * * * *

Drugs and Biologicals

(t)(1) The term "drugs" and the term "biologicals", except for purposes of subsection (m)(5) and paragraph (2), include only such drugs *(including contrast agents)* and biologicals, respectively, as are included (or approved for inclusion) in the United States Pharmacopoeia, the National Formulary, or the United States Homeopathic Pharmacopoeia, or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals for use in such hospital.

* * * * * * *

Reasonable Cost

(v)(1)(A) * * *

* * * * * * *

(T) In determining such reasonable costs for hospitals, no reduction in copayments under section 1833(t)(5)(B) shall be treated as a bad debt and the amount of bad debts otherwise treated as allowable costs which are attributable to the deductibles and coinsurance amounts under this title shall be reduced—

(i) * * *

(ii) for cost reporting periods beginning during fiscal year 1999, by 40 percent of such amount otherwise allowable, **[**and**]**

(iii) for cost reporting periods beginning during **[**a subsequent fiscal year**]** *fiscal year 2000*, by 45 percent of such amount otherwise allowable**[**.**]***;*

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

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

* * * * * * *

Screening Mammography

(jj) The term "screening mammography" means a radiologic procedure provided to a woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure*, as well as new technology applied to such a procedure that the Secretary determines enhances the detection of breast cancer*.

* * * * * * *

Colorectal Cancer Screening Tests

(pp)(1) The term "colorectal cancer screening test" means any of the following procedures furnished to an individual for the purpose of early detection of colorectal cancer:

(A) * * *

* * * * * * *

(C) In the case of an individual at high risk for colorectal cancer *and in the case of an individual making the election described in section 1834(d)(4)*, screening colonoscopy.

* * * * * * *

Diabetes Outpatient Self-Management Training Services

(qq)(1) * * *

(2) In **[**paragraph (1)—**]** *paragraph (1):*

(A) **[**a "certified provider"**]** *A "certified provider"* is a physician, or other individual or entity designated by the Secretary, that, in addition to providing diabetes outpatient self-management training services, provides other items or services for which payment may be made under this title**[**; and**]**.

(B) **[**a physician, or such other individual**]** *(i) A physician, or such other individual* or entity, meets the quality standards described in this paragraph if the physician, or individual or entity, meets quality standards established by the Secretary, except that the physician or other individual or entity shall be deemed to have met such standards if the physician or other individual or entity *(I)* meets applicable standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards by such Board, or *(II)* is recognized by an organization that represents individuals (including individuals under this title) with diabetes*, or by a program described in clause (ii),* as meeting standards for furnishing the services.

(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).

* * * * * * *

EXCLUSIONS FROM COVERAGE AND MEDICARE AS SECONDARY PAYER

SEC. 1862. (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1) * * *

* * * * * * *

[(18) which are covered skilled nursing facility services described in section 1888(e)(2)(A)(i) and which are furnished to

an individual who is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility (as determined under regulations), by an entity other than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the skilled nursing facility;]

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

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

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

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

* * * * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) * * *

* * * * * * *

(H)(i) * * *

(ii) in the case of skilled nursing facilities which provide covered skilled nursing facility services—

(I) that are furnished to an individual who is a resident of the skilled nursing facility *in the case of a resident who is in a stay covered under part A, and for services furnished on or after October 1, 2003, in the case of a resident who is not in a stay covered under such part*, and

* * * * * * *

DEMONSTRATION OF APPLICATION OF PHYSICIAN VOLUME INCREASES TO GROUP PRACTICES

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

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

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

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

(C) reward physicians for improving health outcomes.

(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1866B.

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

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

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

(b) ELIGIBILITY CRITERIA.—

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

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

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

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

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

(c) PATIENTS WITHIN SCOPE OF DEMONSTRATION.—

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

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

(3) NOTICE REQUIREMENTS.—In the case of each beneficiary determined to be within the scope of a demonstration under this section with respect to a specific health care group, the Sec-

retary shall ensure that such beneficiary is notified of the incentives, and of any waivers of coverage or payment rules, applicable to such group under such demonstration.

(d) INCENTIVES.—

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

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

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

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

(3) ADDITIONAL BONUS FOR PROCESS AND OUTCOME IMPROVEMENTS.—At such time as the Secretary has established appropriate criteria based on evidence the Secretary determines to be sufficient, the Secretary shall also pay to a participating health care group (subject to paragraph (4)) an additional bonus for a year, equal to such portion as the Secretary may designate of the saving to the program under this title resulting from process improvements made by and patient outcome improvements attributable to activities of the group.

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

PROVISIONS FOR ADMINISTRATION OF DEMONSTRATION PROGRAM

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

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

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

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

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

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

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

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

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

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

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

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

(6) ADMINISTRATIVE REVIEW OF DECISIONS AFFECTING INDIVIDUALS AND ENTITIES FURNISHING SERVICES.—An individual or entity furnishing services under the demonstration program shall be entitled to a review by the program administrator (or, if the Secretary has not contracted with a program administrator, by the Secretary) of a decision not to enter into, or to terminate, or not to renew, an agreement with the entity to provide health care items or services under the program.

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

(8) PAYMENT IN FULL.—

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

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

(b) CONTRACTS FOR PROGRAM ADMINISTRATION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(9) INFORMATION SHARING.—Notwithstanding section 1106 and section 552a of title 5, United States Code, the Secretary is authorized to disclose to an entity with a program administration contract under this subsection such information (including medical information) on individuals receiving health care items and services under the program as the entity may require to carry out its responsibilities under the contract.

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

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

(2) BONUSES.—Notwithstanding any other provision of law, but subject to subparagraph (B)(ii), the Secretary may make bonus payments under the program from the Federal Health Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in amounts that do not exceed the amounts authorized under the program in accordance with the following:

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

(B) PAYMENTS TO ENTITIES FURNISHING SERVICES.—

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

(ii) LIMITATIONS.—The Secretary may condition such payments on the achievement of such standards related to efficiency, improvement in processes or outcomes of

care, or such other factors as the Secretary determines to be appropriate.

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

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

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

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

(3) Establishment of program administration contract performance standards under subsection (b)(6), the refusal to renew a program administration contract, or the noncompetitive award or renewal of a program administration contract under subsection (b)(4)(B).

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

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

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

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

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

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

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MEDICARE COVERAGE FOR END STAGE RENAL DISEASE PATIENTS

SEC. 1881. (a) * * *

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(b)(1) * * *

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(7) The Secretary shall provide by regulation for a method (or methods) for determining prospectively the amounts of payments to

be made for dialysis services furnished by providers of services and renal dialysis facilities to individuals in a facility and to such individuals at home. Such method (or methods) shall provide for the prospective determination of a rate (or rates) for each mode of care based on a single composite weighted formula (which takes into account the mix of patients who receive dialysis services at a facility or at home and the relative costs of providing such services in such settings) for hospital-based facilities and such a single composite weighted formula for other renal dialysis facilities, or based on such other method or combination of methods which differentiate between hospital-based facilities and other renal dialysis facilities and which the Secretary determines, after detailed analysis, will more effectively encourage the more efficient delivery of dialysis services and will provide greater incentives for increased use of home dialysis than through the single composite weighted formulas. The amount of a payment made under any method other than a method based on a single composite weighted formula may not exceed the amount (or, in the case of continuous cycling peritoneal dialysis, 130 percent of the amount) of the median payment that would have been made under the formula for hospital-based facilities. The Secretary shall provide for such exceptions to such methods as may be warranted by unusual circumstances (including the special circumstances of sole facilities located in isolated, rural areas and of pediatric facilities). Each application for such an exception shall be deemed to be approved unless the Secretary disapproves it by not later than 60 working days after the date the application is filed. The Secretary may provide that such method will serve in lieu of any target reimbursement rate that would otherwise be established under paragraph (6). The Secretary shall reduce the amount of each composite rate payment under this paragraph for each treatment by 50 cents (subject to such adjustments as may be required to reflect modes of dialysis other than hemodialysis) and provide for payment of such amount to the organizations (designated under subsection (c)(1)(A)) for such organizations' necessary and proper administrative costs incurred in carrying out the responsibilities described in subsection (c)(2). The Secretary shall provide that amounts paid under the previous sentence shall be distributed to the organizations described in subsection (c)(1)(A) to ensure equitable treatment of all such network organizations. The Secretary in distributing any such payments to network organizations shall take into account—

(A) * * *

* * * * * * *

The Secretary shall increase the amount of each composite rate payment for dialysis services furnished during 2000 by 1.2 percent above such composite rate payment amounts for such services furnished on December 31, 1999, and for such services furnished on or after January 1, [2001, by 1.2 percent] *2000, by 2.4 percent* above such composite rate payment amounts for such services furnished on December 31, 2000.

* * * * * * *

PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. (a) * * *

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(b)(1) * * *

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(3)(A) * * *

* * * * * * *

(D) For cost reporting periods ending on or before September 30, 1994, and for cost reporting periods beginning on or after October 1, 1997, [and before October 1, 2006,] in the case of a hospital that is a medicare-dependent, small rural hospital (as defined in subsection (d)(5)(G)), the term "target amount" means—

(i) * * *

* * * * * * *

(iv) with respect to discharges occurring during fiscal year 1998 [through fiscal year 2005,] *or any subsequent fiscal year,* the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).

* * * * * * *

(d)(1) * * *

* * * * * * *

(5)(A) * * *

* * * * * * *

(G)(i) For any cost reporting period beginning on or after April 1, 1990, and before October 1, 1994, or discharges occurring on or after October 1, 1997, [and before October 1, 2006,] in the case of a subsection (d) hospital which is a medicare-dependent, small rural hospital, payment under paragraph (1)(A) shall be equal to the sum of the amount determined under clause (ii) and the amount determined under paragraph (1)(A)(iii).

(ii) The amount determined under this clause is—

(I) * * *

(II) for discharges occurring during any subsequent cost reporting period (or portion thereof) and before October 1, 1994, or discharges occurring on or after October 1, 1997, [and before October 1, 2006,] 50 percent of the amount by which the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(D)) exceeds the amount determined under paragraph (1)(A)(iii).

* * * * * * *

(iv) The term "medicare-dependent, small rural hospital" means, with respect to any cost reporting period to which clause (i) applies, any hospital—

(I) * * *

* * * * * * *

(IV) for which not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987*, or any of the 3 most recent audited cost reporting*

periods, were attributable to inpatients entitled to benefits under part A.

* * * * * * *

PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

SEC. 1895. (a) * * *

(b) SYSTEM OF PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.—

(1) * * *

* * * * * * *

(3) PAYMENT BASIS.—

(A) INITIAL BASIS.—

(i) IN GENERAL.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts) as follows:

(I) 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.

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

[(II)**]** *(III)* For periods beginning after the period described in subclause **[**(I)**]** *(II)*, such amount (or amounts) shall be equal to the amount (or amounts) that would have been determined under subclause (I) that would have been made for fiscal year 2001 if the system had not been in effect and if section 1861(v)(1)(L)(ix) had not been enacted but if the reduction in limits described in clause (ii) had been in effect, updated under subparagraph (B).

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TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * * * *

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so**[**, and that**]** *permit individuals to apply for and obtain*

medical assistance for medicare cost-sharing using the simplified uniform application form developed under section 1905(p)(5), make available such forms to such individuals, permit such individuals to apply for such assistance by mail (and, at the State option, by telephone or other electronic means) and not require them to apply in person, and provide that such assistance shall be furnished with reasonable promptness to all eligible individuals *and provide application forms for medical assistance for medicare cost-sharing under the plan to the Secretary in order to make them available through Federal offices under section 1804(d) within the State*;

* * * * * * *

(10) provide—

(A) * * *

* * * * * * *

(C) that if medical assistance is included for any group of individuals described in section 1905(a) who are not described in subparagraph (A) or (E), then—

(i) * * *

* * * * * * *

(iv) if such medical assistance includes services in institutions for mental diseases or in an intermediate care facility for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a) or the care and services listed in any 7 of the paragraphs numbered (1) through **[**(24)**]** *(25)* of such section;

* * * * * * *

(13) provide—

(A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which—

(i) * * *

* * * * * * *

(iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs; *and*

(B) for payment for hospice care in amounts no lower than the amounts, using the same methodology, used under part A of title XVIII and for payment of amounts under section 1905(o)(3); except that in the case of hospice care which is furnished to an individual who is a resident of a nursing facility or intermediate care facility for the mentally retarded, and who would be eligible under the plan for nursing facility services or services in an intermediate care facility for the mentally retarded if he had not elected to receive hospice care, there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent

of the rate that would have been paid by the State under the plan for facility services in that facility for that individual; [and]

[(C)(i) for payment for services described in clause (B) or (C) of section 1905(a)(2) under the plan, of 100 percent (or 95 percent for services furnished during fiscal year 2000, fiscal year 2001, or fiscal year 2002, 90 percent for services furnished during fiscal year 2003, or 85 percent for services furnished during fiscal year 2004) of costs 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 those regulations do not apply, on the same methodology used under section 1833(a)(3) and (ii) in carrying out clause (i) in the case of services furnished by a Federally-qualified health center or a rural health clinic pursuant to a contract between the center and an organization under section 1903(m), 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 clause (i) exceeds the amount of the payments provided under such contract;]

* * * * * * *

(15) provide for payment for services described in clause (B) or (C) of section 1905(a)(2) under the plan in accordance with subsection (aa);

* * * * * * *

(aa) PAYMENT FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.—

(1) IN GENERAL.—Beginning with fiscal year 2001 and each succeeding fiscal year, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by a Federally-qualified health center and services described in section 1905(a)(2)(B) furnished by a rural health clinic in accordance with the provisions of this subsection. The payment rate under this subsection shall not vary based upon the site services are provided in the case of the same center or clinic entity.

(2) FISCAL YEAR 2001.—Subject to paragraph (4), for services furnished during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under section 1833(a)(3), adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001.

(3) FISCAL YEAR 2002 AND SUCCEEDING FISCAL YEARS.—Subject to paragraph (4), for services furnished during fiscal year 2002 or a succeeding fiscal year, the State plan shall provide

for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this subsection for the preceding fiscal year—

(A) increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) for that fiscal year; and

(B) adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during that fiscal year.

(4) ESTABLISHMENT OF INITIAL YEAR PAYMENT AMOUNT FOR NEW CENTERS OR CLINICS.—In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after fiscal year 2000, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by the center or services described in section 1905(a)(2)(B) furnished by the clinic in the first fiscal year in which the center or clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year based on the rates established under this subsection for the fiscal year for other such centers or clinics located in the same or adjacent area with a similar case load, service package, and case mix or, in the absence of such a center or clinic, in accordance with the regulations and methodology referred to in paragraph (2) or based on such other tests of reasonableness as the Secretary may specify. For each fiscal year following the fiscal year in which the entity first qualifies as a Federally-qualified health center or rural health clinic, the State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

(5) ADMINISTRATION IN THE CASE OF MANAGED CARE.—In the case of services furnished by a Federally-qualified health center or rural health clinic pursuant to a contract between the center or clinic and a managed care entity (as defined in section 1932(a)(1)(B)), the State plan shall provide for payment to the center or clinic (at least quarterly) by the State of a supplemental payment equal to the amount (if any) by which the amount determined under paragraphs (2), (3), and (4) of this subsection exceeds the amount of the payments provided under the contract.

(6) ALTERNATIVE PAYMENT METHODOLOGIES.—Notwithstanding any other provision of this section, the State plan may provide for payment in any fiscal year to a Federally-qualified health center for services described in section 1905(a)(2)(C) or to a rural health clinic for services described in section 1905(a)(2)(B) in an amount which is determined under an alternative payment methodology that—

(A) is agreed to by the State and the center or clinic; and

(B) results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under this section.

* * * * * * *

PAYMENT TO STATES

SEC. 1903. (a) * * *

* * * * * * *

(v)(1) Notwithstanding the preceding provisions of this section, except as provided in [paragraph (2)] *paragraphs (2) and (4)*, no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

* * * * * * *

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

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

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

(B) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien who has lawfully resided in the United States for 2 years on the basis of provision of assistance to such category.

* * * * * * *

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are—

(i) * * *

* * * * * * *

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for mental diseases);

* * * * * * *

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

[(22)**]** *(23)* home and community care (to the extent allowed and as defined in section 1929) for functionally disabled elderly individuals;

[(23)**]** *(24)* community supported living arrangements services (to the extent allowed and as defined in section 1930);

[(24)**]** *(25)* personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or other location;

[(25)**]** *(26)* primary care case management services (as defined in subsection (t));

[(26)**]** *(27)* services furnished under a PACE program under section 1934 to PACE program eligible individuals enrolled under the program under such section; and

[(27)**]** *(28)* any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary,

* * * * * * *

(p)(1) * * *

* * * * * * *

(5)(A) The Secretary shall develop a simplified application form for use by individuals (including both qualified medicare beneficiaries and specified low-income medicare beneficiaries) in applying for medical assistance for medicare cost-sharing under this title. Such form shall be easily readable by applicants and uniform nationally.

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

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

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

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

(iii) to persons upon request.

* * * * * * *

PROVISIONS RESPECTING INAPPLICABILITY AND WAIVER OF CERTAIN REQUIREMENTS OF THIS TITLE

SEC. 1915. (a) * * *

* * * * * * *

(b) The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this title, may waive such requirements of section 1902 (other than subsection (s)) (other than sections [1902(a)(13)(C)] *1902(a)(15), 1902(aa),* and 1902(a)(10)(A) insofar as it requires provision of the care and services described in section 1905(a)(2)(C)) as may be necessary for a State—

(1) * * *

* * * * * * *

LIENS, ADJUSTMENTS AND RECOVERIES, AND TRANSFERS OF ASSETS

SEC. 1917. (a) * * *

* * * * * * *

(c)(1)(A) * * *

* * * * * * *

(C)(i) * * *

* * * * * * *

(ii) The services described in this subparagraph with respect to a noninstitutionalized individual are services (not including any services described in clause (i)) that are described in paragraph (7), [(22), or (24)] *(23), or (25)* of section 1905(a), and, at the option of a State, other long-term care services for which medical assistance is otherwise available under the State plan to individuals requiring long-term care.

* * * * * * *

PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN

SEC. 1920. (a) * * *

(b) For purposes of this section—

(1) * * *

* * * * * * *

(2) the term "qualified provider" means any provider that—

(A) * * *

* * * * * * *

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

* * * * * * *

PRESUMPTIVE ELIGIBILITY FOR CHILDREN

SEC. 1920A. (a) * * *

(b) For purposes of this section:

(1) * * *

* * * * * * *

(3)(A) Subject to subparagraph (B), the term "qualified entity" means any entity that—

(i)(I) is eligible for payments under a State plan approved under this title and provides items and services described in subsection (a) [or (II)], *(II)* is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act ([42 U.S.C. 9821] *42 U.S.C. 9831* et seq.), eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.), eligibility of an infant or child to receive assistance under the special supplemental nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786) *eligibility of a child for medical assistance under the State plan under this title, or eligibility of a child for child health assistance under the program funded under title XXI, (III) is an elementary school or secondary school, as such terms are defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801), an elementary or secondary school operated or supported by the Bureau of Indian Affairs, a State or tribal child support enforcement agency, a child care resource and referral agency, an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act, or a State or tribal office or entity involved in enrollment in the program under this title, under part A of title IV, under title XXI, or that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437 et seq.) or under the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4101 et seq.), or (IV) any other entity the State so deems, as approved by the Secretary*; and

(ii) is determined by the State agency to be capable of making determinations of the type described in [paragraph (1)(A)] *paragraph (2)*.

* * * * * * *

ADJUSTMENT IN PAYMENT FOR INPATIENT HOSPITAL SERVICES FURNISHED BY DISPROPORTIONATE SHARE HOSPITALS

SEC. 1923. (a) IMPLEMENTATION OF REQUIREMENT.—

(1) * * *

* * * * * * *

(2)(A) * * *

* * * * * * *

(D) A State plan under this title shall not be considered to meet the requirements of section 1902(a)(13)(A)(iv) (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs), as of October 1, 1998, un-

less the State has submitted to the Secretary by such date a description of the methodology used by the State to identify and to make payments to disproportionate share hospitals, including children's hospitals, on the basis of the proportion of low-income and medicaid patients *(including such patients who receive benefits through a managed care entity)* served by such hospitals. The State shall provide an annual report to the Secretary describing the disproportionate share payments to each such disproportionate share hospital.

* * * * * * *

(b) HOSPITALS DEEMED DISPROPORTIONATE SHARE.—

(1) * * *

* * * * * * *

(2) For purposes of paragraph (1)(A), the term "medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this title in a period *(regardless of whether they receive benefits on a fee-for-service basis or through a managed care entity)*, and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

(3) For purposes of paragraph (1)(B), the term "low-income utilization rate" means, for a hospital, the sum of—

(A) the fraction (expressed as a percentage)—

(i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under a State plan under this title *(regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity)* and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and

* * * * * * *

(f) LIMITATION ON FEDERAL FINANCIAL PARTICIPATION.—

(1) * * *

(2) STATE DSH ALLOTMENTS FOR FISCAL YEARS 1998 THROUGH [2002] *2000*.—The DSH allotment for a State for each fiscal year during the period beginning with fiscal year 1998 and ending with fiscal year [2002] *2000* is determined in accordance with the following table:

State or District	DSH Allotment (in millions of dollars)				
	FY 98	FY 99	FY 00	[FY 01]	[FY 02]
Alabama	293	269	248	[246]	[246]
Alaska	10	10	10	[9]	[9]
Arizona	81	81	81	[81]	[81]
Arkansas	2	2	2	[2]	[2]

State or District	DSH Allotment (in millions of dollars)				
	FY 98	FY 99	FY 00	[FY 01]	[FY 02]
California	1,085	1,068	986	[931]	[877]
Colorado	93	85	79	[74]	[74]
Connecticut	200	194	164	[160]	[160]
Delaware	4	4	4	[4]	[4]
District of Columbia	23	23	[32] *49*	[32]	[32]
Florida	207	203	197	[188]	[160]
Georgia	253	248	241	[228]	[215]
Hawaii	0	0	0	[0]	[0]
Idaho	1	1	1	[1]	[1]
Illinois	203	199	193	[182]	[172]
Indiana	201	197	191	[181]	[171]
Iowa	8	8	8	[8]	[8]
Kansas	51	49	42	[36]	[33]
Kentucky	137	134	130	[123]	[116]
Louisiana	880	795	713	[658]	[631]
Maine	103	99	84	[84]	[84]
Maryland	72	70	68	[64]	[61]
Massachusetts	288	282	273	[259]	[244]
Michigan	249	244	237	[224]	[212]
Minnesota	16		33	[33]	[33]
Mississippi	143	141	136	[129]	[122]
Missouri	436	423	379	[379]	[379]
Montana	0.2	0.2	0.2	[0.2]	[0.2]
Nebraska	5	5	5	[5]	[5]
Nevada	37	37	37	[37]	[37]
New Hampshire	140	136	130	[130]	[130]
New Jersey	600	582	515	[515]	[515]
New Mexico	5		9	[9]	[9]
New York	1,512	1,482	1,436	[1,361]	[1,285]
North Carolina	278	272	264	[250]	[236]
North Dakota	1	1	1	[1]	[1]
Ohio	382	374	363	[344]	[325]
Oklahoma	16	16	16	[16]	[16]
Oregon	20	20	20	[20]	[20]
Pennsylvania	529	518	502	[476]	[449]
Rhode Island	62	60	58	[55]	[52]
South Carolina	313	303	262	[262]	[262]
South Dakota	1	1	1	[1]	[1]
Tennessee	0	0	0	[0]	[0]
Texas	979	950	806	[765]	[765]
Utah	3	3	3	[3]	[3]
Vermont	18	18	18	[18]	[18]
Virginia	70	68	66	[63]	[59]
Washington	174	171	166	[157]	[148]
West Virginia	64	63	61	[58]	[54]
Wisconsin	7	7	7	[7]	[7]
Wyoming	0	[3]0	0.1	[0.1]	[0.1]

(3) STATE DSH ALLOTMENTS FOR FISCAL YEAR [2003] *2001* AND THEREAFTER.—

(A) IN GENERAL.—The DSH allotment for any State for fiscal year [2003] *2001* and each succeeding fiscal year is equal to the DSH allotment for the State for the preceding fiscal year under paragraph (2) [or this paragraph], *this paragraph, or paragraph (4)*, increased, subject to [subparagraph (B)] *subparagraphs (B) and (C)*, by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

* * * * * * *

(C) SPECIAL RULE FOR EXTREMELY LOW DSH STATES.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 1999, as reported to the Administrator of the Health Care Financing Administration as of August 31, 2000, is greater than 0 but less than 1 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2001 shall be increased to 1 percent of the State's total amount of expenditures under such plan for such assistance during such fiscal year. In subsequent fiscal years, such increased allotment is subject to an increase for inflation as provided in subparagraph (A).

* * * * * * *

EXTENSION OF ELIGIBILITY FOR MEDICAL ASSISTANCE

SEC. 1925. (a) INITIAL 6-MONTH EXTENSION.—

(1) REQUIREMENT.—Notwithstanding any other provision of this title, *but subject to subsection (g),* each State plan approved under this title must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of title IV in at least 3 of the 6 months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of, or income from, employment of the caretaker relative (as defined in subsection (e)) or because of section 402(a)(8)(B)(ii)(II) (providing for a time-limited earned income disregard), shall, subject to paragraph (3) and without any reapplication for benefits under the plan, remain eligible for assistance under the plan approved under this title during the immediately succeeding 6-month period in accordance with this subsection.

* * * * * * *

(b) ADDITIONAL 6-MONTH EXTENSION.—

(1) REQUIREMENT.—Notwithstanding any other provision of this title, *but subject to subsection (g),* each State plan approved under this title shall provide that the State shall offer to each family, which has received assistance during the entire 6-month period under subsection (a) and which meets the requirement of paragraph (2)(B)(i), in the last month of the period the option of extending coverage under this subsection for the succeeding 6-month period, subject to paragraph (3).

(2) NOTICE AND REPORTING REQUIREMENTS.—

(A) * * *

* * * * * * *

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

* * * * * * *

(f) SUNSET.—This section shall not apply with respect to families that cease to be eligible for aid under part A of title IV after September 30, [2001] *2002*.

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

(1) IN GENERAL.—At State option, the provisions of this section shall not apply to a State that uses the authority under section 1931(b)(2)(C) to make medical assistance available under the State plan under this title, at a minimum, to all individuals described in section 1931(b)(1) in families with gross incomes (determined without regard to work-related child care expenses of such individuals) at or below 185 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

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

* * * * * * *

HOME AND COMMUNITY CARE FOR FUNCTIONALLY DISABLED ELDERLY INDIVIDUALS

SEC. 1929. (a) * * *

* * * * * * *

(e) CEILING ON PAYMENT AMOUNTS AND MAINTENANCE OF EFFORT.—

(1) * * *

* * * * * * *

(2) MAINTENANCE OF EFFORT.—

(A) ANNUAL REPORTS.—As a condition for the receipt of payment under section 1903(a) with respect to medical assistance provided by a State for home and community care (other than a waiver under section 1915(c) and other than home health care services described in section 1905(a)(7) and personal care services specified under regulations under section [1905(a)(23)] *1905(a)(24)*), the State shall report to the Secretary, with respect to each Federal fiscal year (beginning with fiscal year 1990) and in a format developed or approved by the Secretary, the amount of funds obligated by the State with respect to the provision of home and community care to the functionally disabled elderly in that fiscal year.

* * * * * * *

PROVISIONS RELATING TO MANAGED CARE

SEC. 1932. (a) * * *

* * * * * * *

(g) IDENTIFICATION OF PATIENTS FOR PURPOSES OF MAKING DSH PAYMENTS.—Each contract with a managed care entity under sec-

tion 1903(m) or under section 1905(t)(3) shall require the entity either—

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

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

* * * * * * *

TITLE XXI—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

* * * * * * *

SEC. 2104. ALLOTMENTS.

(a) * * *

* * * * * * *

(g) RULE FOR REDISTRIBUTION AND EXTENDED AVAILABILITY OF FISCAL YEARS 1998 AND 1999 ALLOTMENTS.—

(1) AMOUNT REDISTRIBUTED.—

(A) IN GENERAL.—In the case of a State that expends all of its allotment under subsection (b) or (c) for fiscal year 1998 by the end of fiscal year 2000, or for fiscal year 1999 by the end of fiscal year 2001, the Secretary shall redistribute to the State under subsection (f) (from the fiscal year 1998 or 1999 allotments of other States, respectively, as determined by the application of paragraphs (2) and (3) with respect to the respective fiscal year)) the following amount:

(i) STATE.—In the case of 1 of the 50 States or the District of Columbia, with respect to—

(I) the fiscal year 1998 allotment, the amount by which the State's expenditures under this title in fiscal years 1998, 1999, and 2000 exceed the State's allotment for fiscal year 1998 under subsection (b); or

(II) the fiscal year 1999 allotment, the amount by which the State's expenditures under this title in fiscal years 1999, 2000, and 2001 exceed the State's allotment for fiscal year 1999 under subsection (b).

(ii) TERRITORY.—In the case of a commonwealth or territory described in subsection (c)(3), an amount that bears the same ratio to 1.05 percent of the total amount described in paragraph (2)(B)(i)(I) as the ratio of the commonwealth's or territory's fiscal year 1998 or 1999 allotment under subsection (c) (as the case may be) bears to the total of all such allotments for such fiscal year under such subsection.

(B) EXPENDITURE RULES.—An amount redistributed to a State under this paragraph with respect to fiscal year 1998 or 1999—

(i) shall not be included in the determination of the State's allotment for any fiscal year under this section;

(ii) notwithstanding subsection (e), shall remain available for expenditure by the State through the end of fiscal year 2002; and

(iii) shall be counted as being expended with respect to a fiscal year allotment in accordance with applicable regulations of the Secretary.

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

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

(i) FISCAL YEAR 1998 ALLOTMENT.—Of the amounts allotted to a State pursuant to this section for fiscal year 1998 that were not expended by the State by the end of fiscal year 2000, the amount specified in subparagraph (B) for fiscal year 1998 for such State shall remain available for expenditure by the State through the end of fiscal year 2002.

(ii) FISCAL YEAR 1999 ALLOTMENT.—Of the amounts allotted to a State pursuant to this subsection for fiscal year 1999 that were not expended by the State by the end of fiscal year 2001, the amount specified in subparagraph (B) for fiscal year 1999 for such State shall remain available for expenditure by the State through the end of fiscal year 2002.

(B) AMOUNT REMAINING AVAILABLE FOR EXPENDITURE.—The amount specified in this subparagraph for a State for a fiscal year is equal to—

(i) the amount by which (I) the total amount available for redistribution under subsection (f) from the allotments for that fiscal year, exceeds (II) the total amounts redistributed under paragraph (1) for that fiscal year; multiplied by

(ii) the ratio of the amount of such State's unexpended allotment for that fiscal year to the total amount described in clause (i)(I) for that fiscal year.

(C) USE OF UP TO 10 PERCENT OF RETAINED 1998 ALLOTMENTS FOR OUTREACH ACTIVITIES.—Notwithstanding section 2105(c)(2)(A), with respect to any State described in subparagraph (A)(i), the State may use up to 10 percent of the amount specified in subparagraph (B) for fiscal year 1998 for expenditures for outreach activities approved by the Secretary.

(3) DETERMINATION OF AMOUNTS.—For purposes of calculating the amounts described in paragraphs (1) and (2) relating to the allotment for fiscal year 1998 or fiscal year 1999, the Secretary shall use the amounts reported by the States not later than November 30, 2000, or November 30, 2001, respectively, on HCFA Form 64 or HCFA Form 21, as approved by the Secretary.

* * * * * * *

SEC. 2107. STRATEGIC OBJECTIVES AND PERFORMANCE GOALS; PLAN ADMINISTRATION.

(a) * * *

* * * * * * *

(e) APPLICATION OF CERTAIN GENERAL PROVISIONS.—The following sections of this Act shall apply to States under this title in the same manner as they apply to a State under title XIX:

(1) TITLE XIX PROVISIONS.—

(A) * * *

* * * * * * *

(D) Section 1920A (relating to presumptive eligibility).".

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

MEDICARE, MEDICAID, AND SCHIP BALANCED BUDGET REFINEMENT ACT OF 1999

* * * * * * *

TITLE II—PROVISIONS RELATING TO PART B

* * * * * * *

Subtitle C—Other Services

SEC. 221. REVISION OF PROVISIONS RELATING TO THERAPY SERVICES.

(a) 2-YEAR MORATORIUM ON CAPS.—

(1) * * *

* * * * * * *

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

* * * * * * *

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

If the Secretary of Health and Human Services implements a revised prospective payment system for services of ambulatory surgical facilities under section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i)), prior to incorporating data from the 1999 Medicare cost survey or a subsequent cost survey, such system shall be implemented in a manner so that—

[(1) in the first year of its implementation, only a proportion (specified by the Secretary and not to exceed ⅓) of the payment for such services shall be made in accordance with such system and the remainder shall be made in accordance with current regulations; and

[(2) in the following year a proportion (specified by the Secretary and not to exceed ⅔) of the payment for such services shall be made under such system and the remainder shall be made in accordance with current regulations.]

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

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

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

* * * * * * *

TITLE III—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

* * * * * * *

SEC. 302. DELAY IN APPLICATION OF 15 PERCENT REDUCTION IN PAYMENT RATES FOR HOME HEALTH SERVICES UNTIL ONE YEAR AFTER IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.

(a) * * *

* * * * * * *

(c) REPORT.—Not later than the date that is [six] *18* months after the date the Secretary of Health and Human Services implements the prospective payment system for home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff), the Secretary shall submit to Congress a report analyzing the need for the 15 percent reduction under subsection (b)(3)(A)(ii) of such section, or for any reduction, in the computation of the base payment amounts under the prospective payment system for home health services established under such section.

* * * * * * *

BALANCED BUDGET ACT OF 1997

* * * * * * *

TITLE IV—MEDICARE, MEDICAID, AND CHILDREN'S HEALTH PROVISIONS

* * * * * * *

Subtitle C—Rural Initiatives

* * * * * * *

SEC. 4206. MEDICARE REIMBURSEMENT FOR TELEHEALTH SERVICES.

[(a) IN GENERAL.—Not later than January 1, 1999, the Secretary of Health and Human Services shall make payments from the Federal Supplementary Medical Insurance Trust Fund under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) in accordance with the methodology described in subsection (b) for professional consultation via telecommunications systems with a physician (as defined in section 1861(r) of such Act (42 U.S.C. 1395x(r)) or a practitioner (described in section 1842(b)(18)(C) of such Act (42 U.S.C. 1395u(b)(18)(C)) furnishing a service for which payment may be made under such part to a beneficiary under the medicare program residing in a county in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) 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)), notwithstanding that the individual physician or practitioner providing the professional consultation is not at the same location as the physician or practitioner furnishing the service to that beneficiary.

[(b) METHODOLOGY FOR DETERMINING AMOUNT OF PAYMENTS.—Taking into account the findings of the report required under section 192 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 1988), the findings of the report required under paragraph (c), and any other findings related to the clinical efficacy and cost-effectiveness of telehealth applications, the Secretary shall establish a methodology for determining the amount of payments made under subsection (a) within the following parameters:

[(1) The payment shall shared between the referring physician or practitioner and the consulting physician or practitioner. The amount of such payment shall not be greater than the current fee schedule of the consulting physician or practitioner for the health care services provided.

[(2) The payment shall not include any reimbursement for any telephone line charges or any facility fees, and a beneficiary may not be billed for any such charges or fees.

[(3) The payment shall be made 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).

[(4) The payment differential of section 1848(a)(3) of such Act (42 U.S.C. 1395w–4(a)(3)) shall apply to services furnished by non-participating physicians. The provisions of section 1848(g) of such Act (42 U.S.C. 1395w–4(g)) and section 1842(b)(18) of such Act (42 U.S.C. 1395u(b)(18)) shall apply. Payment for such service shall be increased annually by the

update factor for physicians' services determined under section 1848(d) of such Act (42 U.S.C. 1395w–4(d)).

[(c) SUPPLEMENTAL REPORT.—Not later than January 1, 1999, the Secretary shall submit a report to Congress which shall contain a detailed analysis of—

[(1) how telemedicine and telehealth systems are expanding access to health care services;

[(2) the clinical efficacy and cost-effectiveness of telemedicine and telehealth applications;

[(3) the quality of telemedicine and telehealth services delivered; and

[(4) the reasonable cost of telecommunications charges incurred in practicing telemedicine and telehealth in rural, frontier, and underserved areas.

[(d) EXPANSION OF TELEHEALTH SERVICES FOR CERTAIN MEDICARE BENEFICIARIES.—

[(1) IN GENERAL.—Not later than January 1, 1999, the Secretary shall submit a report to Congress that examines the possibility of making payments from the Federal Supplementary Medical Insurance Trust Fund under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) for professional consultation via telecommunications systems with such a physician or practitioner furnishing a service for which payment may be made under such part to a beneficiary described in paragraph (2), notwithstanding that the individual physician or practitioner providing the professional consultation is not at the same location as the physician or practitioner furnishing the service to that beneficiary.

[(2) BENEFICIARY DESCRIBED.—A beneficiary described in this paragraph is a beneficiary under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) who does not reside in a rural area (as so defined) 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)), who is homebound or nursing homebound, and for whom being transferred for health care services imposes a serious hardship.

[(3) REPORT.—The report described in paragraph (1) shall contain a detailed statement of the potential costs and savings to the medicare program of making the payments described in that paragraph using various reimbursement schemes.]

(a) TELEHEALTH SERVICES REIMBURSED.—

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

(2) USE OF STORE-AND-FORWARD TECHNOLOGIES.—For purposes of paragraph (1), in the case of any Federal telemedicine demonstration program in Alaska or Hawaii, the term "telecommunications system" includes store-and-forward tech-

nologies that provide for the asynchronous transmission of health care information in single or multimedia formats.

(b) METHODOLOGY FOR DETERMINING AMOUNT OF PAYMENTS.—

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

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

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

(i) for 2001 (beginning with April 1, 2001) and 2002, $20; and

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

(2) APPLICATION OF PART B COINSURANCE AND DEDUCTIBLE.—Any payment made under this section shall be subject to the coinsurance and deductible requirements under subsections (a)(1) and (b) of section 1833 of the Social Security Act (42 U.S.C. 1395l).

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

(c) TELEPRESENTER NOT REQUIRED.—Nothing in this section shall be construed as requiring an eligible telehealth beneficiary to be presented by a physician or practitioner at the originating site for the furnishing of a service via a telecommunications system, unless it is medically necessary as determined by the physician or practitioner at the distant site.

(d) COVERAGE OF ADDITIONAL SERVICES.—

(1) STUDY AND REPORT ON ADDITIONAL SERVICES.—

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

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

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

(e) CONSTRUCTION RELATING TO HOME HEALTH SERVICES.—

(1) IN GENERAL.—Nothing in this section or in section 1895 of the Social Security Act (42 U.S.C. 1395fff) shall be construed as preventing a home health agency furnishing a home health unit of service for which payment is made under the prospective payment system established in such section from furnishing the service via a telecommunications system.

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

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

(B) any requirement relating to the certification of a physician required under section 1814(a)(2)(C) or section 1835(a)(2)(A) of such Act (42 U.S.C. 1395f(a)(2)(C), 1395n(a)(2)(A)).

(3) CONSTRUCTION.—Nothing in this section shall be construed as waiving the requirement for a physician certification under section 1814(a)(2)(C) or section 1835(a)(2)(A) of such Act (42 U.S.C. 1395f(a)(2)(C), 1395n(a)(2)(A)) for the payment for home health services, whether or not furnished via a telecommunications system.

(f) COVERAGE OF ITEMS AND SERVICES.—

(1) IN GENERAL.—Subject to paragraph (2), payment for items and services provided pursuant to subsection (a) shall include payment for professional consultations, office visits, office psychiatry services, including any service identified as of July 1, 2000, by HCPCS codes 99241–99275, 99201–99215, 90804–90809, and 90862, and any additional item or service specified by the Secretary.

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

(g) DEFINITIONS.—In this section:

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

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

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

(C) effective January 1, 2002, in an inner-city area that is medically underserved (as defined in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3))); or

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

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

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

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

(5) ORIGINATING SITE.—

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

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

(i) On or after April 1, 2001—

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

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

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

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

(ii) On or after January 1, 2002—

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

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

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

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

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

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

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

(6) FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—The term "Federal Supplementary Medical Insurance Trust Fund" means the trust fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t).

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Subtitle H—Medicaid

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CHAPTER 2—FLEXIBILITY IN PAYMENT OF PROVIDERS

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SEC. 4712. PAYMENT FOR CENTER AND CLINIC SERVICES.

(a) * * *

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[(c) END OF TRANSITIONAL PAYMENT RULES.—Effective for services furnished on or after October 1, 2003—

[(1) subparagraph (C) of section 1902(a)(13) (42 U.S.C. 1396a(a)(13)), as so redesignated, is repealed, and

[(2) clause (ix) of section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is repealed.]

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Subtitle J—State Children's Health Insurance Program

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CHAPTER 3—DIABETES GRANT PROGRAMS

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SEC. 4923. REPORT ON DIABETES GRANT PROGRAMS.

(a) * * *

(b) REPORTS.—The Secretary shall submit to the appropriate committees of Congress—

(1) [an interim report] *interim reports* on the evaluation conducted under subsection (a) not later than January 1[, 2000] *in each of 2000, 2002, and 2004*, and

(2) a final report on such evaluation not later than January 1, [2002] *2007*.

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SECTION 13501 OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1993

SEC. 13501. PAYMENTS FOR PPS HOSPITALS.

(a) * * *

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(e) EXTENSION FOR MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—

(1) * * *

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(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—If any hospital fails to qualify as a medicare-dependent, small rural hospital under section 1886(d)(5)(G)(i) of the Social Security Act as a result of a decision by the Medicare Geographic Classification Review Board under section 1886(d)(10) of such Act to reclassify the hospital as being located in an urban area for fiscal year 1993, fiscal year 1994, fiscal year 1998, fiscal year 1999, [or fiscal year 2000 through fiscal year 2005] *fiscal year 2000, or any subsequent fiscal year*, the Secretary of Health and Human Services shall—

(A) * * *

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SECTION 9517 OF THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

SEC. 9517. MODIFYING APPLICATION OF MEDICAID HMO PROVISIONS FOR CERTAIN HEALTH CENTERS.

(a) * * *

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(c) HEALTH INSURING ORGANIZATIONS.—(1) * * *

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(3)(A) Subject to subparagraph (C), in the case of up to 3 health insuring organizations which are described in subparagraph (B), which first become operational on or after January 1, 1986, and which are designated by the Governor, and approved by the Legislature, of California, the amendments made by paragraph (1) shall not apply.

* * * * * * *

(C) Subparagraph (A) shall not apply with respect to any period for which the Secretary of Health and Human Services determines that the number of medicaid beneficiaries enrolled with health insuring organizations described in subparagraph (B) exceeds **[**10**]** *14* percent of the number of such beneficiaries in the State of California.

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PUBLIC HEALTH SERVICE ACT

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TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

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PART D—PRIMARY HEALTH CARE

Subpart I—Health Centers

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SEC. 330B. SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES.

(a) * * *

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

SEC. 330C. SPECIAL DIABETES PROGRAMS FOR INDIANS.

(a) * * *

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

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