''(VII) Self-Sufficiency First programs or other programs designed to reduce dependence by reducing the number of future entrants into the Temporary Assistance to Needy Families program.

''(ii) REQUIRED BENEFICIARIES.—Except with regard to funds expended on activities described in subclauses (VI) and (VII) of clause (i), an''.

AMENDMENT NO. 437

On page 947, between lines 2 and 3, insert the following:

(n) ADJUSTING THE MATCHING REQUIREMENT.—Section 409(a)(7)(B)(ii) (42 U.S.C. 609(a)(7)(B)(ii)) is amended by—

(1) striking ''80'' and inserting ''70''; and

(2) striking ''75'' and inserting ''65''.

AMENDMENT NO. 438

Beginning on page 929, strike line 20 and all that follows through line 14, page 930 and insert the following:

(k) CLARIFICATION OF NUMBER OF INDIVIDUALS COUNTED AS PARTICIPATING IN WORK ACTIVITIES.—Section 407(c)(2) (42 U.S.C. 607(c)(2)) is amended—

(1) by striking subparagraph (C); and

(2) in subparagraph (D)—

(A) in the heading, by striking ''OR BEING A TEEN HEAD OF HOUSEHOLD WHO MAINTAINS SATISFACTORY SCHOOL ATTENDANCE''; and

(B) by striking ''or deemed to be engaged in work by reason of subparagraph (C) of this paragraph''.

AMENDMENT NO. 439

Beginning on page 929, strike line 20 and all that follows through page 930, line 14 and insert the following:

(i) CLARIFICATION OF NUMBER OF INDIVIDUALS COUNTED AS PARTICIPATING IN WORK ACTIVITIES.—Section 407 (42 U.S.C. 607) is amended—.

(1) in subsection (c)—

(A) in paragraph (1)(A), by striking ''(8)''; and

(B) in paragraph (2)(D)—

(i) in the heading, by striking ''PARTICIPATION IN VOCATIONAL EDUCATION ACTIVITIES''; and

(ii) by striking ''determined to be engaged in work in the State for a month by reason of participation in vocational educational training or''; and

(2) by striking subsection (d)(8).

KENNEDY (AND MIKULSKI) AMENDMENT NO. 440

Mr. KENNEDY (for himself and Ms. MIKULSKI) proposed an amendment to the bill, S. 947, supra; as follows:

On page 1047, between lines 5 and 6, insert the following:

SEC. 6004. MEDICARE MEANS TESTING STANDARD APPLICABLE TO SENATORS' HEALTH COVERAGE UNDER THE FEHBP.

(a) PURPOSE.—The purpose of this section is to apply the Medicare means testing requirements for part B premiums to individuals with adjusted gross incomes in excess of $100,000 as enacted under section 5542 of this Act, to United States Senators with respect to their employee contributions under the Federal Employees Health Benefits Program.

(b) IN GENERAL.—Section 8906 of title 5, United States Code, is amended by adding at the end the following:

''(j) Notwithstanding any other provision of this section, each employee who is a Senator and is paid at an annual rate of pay exceeding $100,000 shall pay the employee contribution and the full amount of the Government contribution which applies under this section. The Secretary of the Senate shall deduct and withhold the contributions required under this section and deposit such contributions in the Employees Health Benefits Fund.''.

(c) EFFECTIVE DATE.—This section shall take effect on the first day of the first pay period beginning on or after the date of enactment of this Act.

GRASSLEY AMENDMENT NO. 441

(Ordered to lie on the table.)

Mr. GRASSLEY submitted an amendment intended to be proposed by him to the bill, S. 947, supra; as follows:

On page 689, between lines 2 and 3, insert the following:

''(iii) RELIGIOUS CHOICE.—The State, in permitting an individual to choose a managed care entity under clause (i) shall permit the individual to have access to appropriate faith-based facilities. With respect to such access, the State shall permit an individual to select a facility that is not a part of the network of the managed care entity if such network does not provide access to appropriate faith-based facilities. A faith-based facility that provides care under this clause shall accept the terms and conditions offered by the managed care entity to other providers in the network.

THE CHINA SANCTIONS AND HUMAN RIGHTS ADVANCEMENT ACT

COVERDELL (AND ABRAHAM) AMENDMENT NO. 442

(Ordered referred to the Committee on Foreign Relations.)

Mr. COVERDELL (for himself and Mr. ABRAHAM) submitted an amendment intended to be proposed by them to the bill, S. 810, to impose certain sanctions on the People's Republic of China, and for other purposes; as follows:

On page 18, below line 2, add the following:

SEC. 8. TRANSFERS OF SENSITIVE EQUIPMENT AND TECHNOLOGY BY THE PEOPLE'S REPUBLIC OF CHINA.

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

(1) Credible allegations exist that the People's Republic of China has transferred equipment and technology as follows:

(A) Gyroscopes, accelerometers, and test equipment for missiles to Iran.

(B) Chemical weapons equipment and technology to Iran.

(C) Missile guidance systems and computerized machine tools to Iran.

(D) Industrial furnace equipment and high technology diagnostic equipment to a nuclear facility in Pakistan.

(E) Blueprints and equipment to manufacture M–11 missiles to Pakistan.

(F) M–11 missiles and components to Pakistan.

(2) The Department of State has failed to determine whether most such transfers violate provisions of relevant United States and Executive orders relating to the proliferation of sensitive equipment and technology, including the Arms Export Control Act, the Nuclear Proliferation Prevention Act of 1994, the Export Administration Act of 1979, the Export-Import Bank Act of 1945, and the Iran-Iraq Arms Non-Proliferation Act of 1992, and Executive Order 12938.

(3) Where the Department of State has made such determinations, it has imposed the least onerous form of sanction, which significantly weakens the intended deterrent effect of the sanctions provided for in such laws.

(4) The Clinton Administration decided not to impose sanctions on the People's Republic of China for its transfer of C–802 anti-ship cruise missiles to Iran, finding that the transfer was not ''destabilizing''.

(5) That finding is contrary to the judgment of the commander of the United States Fifth Fleet, elements of which are frequently deployed in and around the Persian Gulf.

(6) Despite the fact that officials of the People's Republic of China were responsible for the sale to Pakistan of specialized ring magnets, which are used to enrich uranium for use in nuclear weapons, the Clinton Administration did not impose sanctions on either the People's Republic of China or Pakistan for such sale, even though sanctions are required for such sale under law.

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

(1) the transfers of equipment and technology by the People's Republic of China described in subsection (a)(1) pose a threat to the national security interests of the United States;

(2) the failure of the Clinton Administration to initiate a formal process to determine whether to impose sanctions for such transfers under United States laws intended to halt the proliferation of sensitive equipment and technology contributes to the threat posed to the national security interests of the United States by the proliferation of such equipment and technology; and

(3) the President should immediately initiate the procedures necessary to determine whether sanctions should be imposed under United States law for such transfers.

(c) REPORT.—Not later than 60 days after the date of enactment of this Act, the President shall submit to Congress a report, in both classified and unclassified form, setting forth—

(1) the date, if any, of the commencement and of the conclusion of each formal process conducted by the Department of State to determine whether to impose sanctions for each transfer described in subsection (a)(1);

(2) the facts providing the basis for each determination not to impose sanctions on the Government of the People's Republic of China, or entities within or having a relationship with that government, for each transfer, and the legal analysis supporting such determinations; and

(3) a schedule for initiating a formal process described in paragraph (10 for each transfer not yet addressed by such formal process and an explanation for the failure to commence such formal process with respect to such transfer before the date of the report.

THE BALANCED BUDGET ACT OF 1997

JEFFORDS AMENDMENT NO. 443

(Ordered to lie on the table.)

Mr. JEFFORDS submitted an amendment intended to be proposed by him to the bill, S. 947, supra; as follows:

At the end of section 1839(h) of the Social Security Act, as added by section 5542(a) of the bill, strike the end quotation marks and insert the following:

''(7) UPDATE.—The Secretary shall adjust annually (after 1998) the dollar amount set forth—

''(A) in paragraph (5)(B)(i) under procedures providing for adjustments in the same

manner and to the same extent as adjustments are provided for under the procedures used to adjust benefit amounts under section 215(i)(2)(A), except that any amount so adjusted that is not a multiple of $100 shall be rounded to the nearest lowest multiple of $100; and

''(B) in paragraph (5)(B)(ii) to an amount that is equal to 150 percent of the dollar amount set forth in paragraph (5)(B)(i) after the adjustment made in subparagraph (A).''.

GRAMM AMENDMENT NO. 444

Mr. GRAMM proposed an amendment to the bill, S. 947, supra; as follows:

On page 947, between lines 2 and 3, insert the following:

(n) FAILURE TO SATISFY MINIMUM PARTICIPATION RATES.—Section 409(a)(3) (42 U.S.C. 609(a)(3)) is amended—

(1) in subparagraph (A), by striking ''not more than''; and

(2) in subparagraph (C), by inserting before the period the following: ''or in the noncompliance is due to extraordinary circumstances such as a natural disaster or regional recession. The Secretary shall provide a written report to Congress to justify any waiver or penalty reduction due to such extraordinary circumstances''.

REED AMENDMENT NO. 445

Mr. REED proposed an amendment to the bill, S. 947, supra; as follows:

Strike division 1 of title V and insert the following:

DIVISION 1—MEDICARE

Subtitle A—Medicare Choice Program

CHAPTER 1—MEDICARE CHOICE PROGRAM

SEC. 5001. ESTABLISHMENT OF MEDICARE CHOICE PROGRAM.

Title XVIII is amended by redesignating part C as part D and by inserting after part B the following new part:

''PART C—MEDICARE CHOICE PROGRAM

''ELIGIBILITY, ELECTION, AND ENROLLMENT

''SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICARE CHOICE PLANS.—

''(1) IN GENERAL.—Subject to the provisions of this section, each Medicare Choice eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits under this title—

''(A) through the traditional medicare fee-for-service program under parts A and B, or

''(B) through enrollment in a Medicare Choice plan under this part.

''(2) TYPES OF MEDICARE CHOICE PLANS THAT MAY BE AVAILABLE.—A Medicare Choice plan may be any of the following types of plans of health insurance:

''(A) FEE-FOR-SERVICE PLANS.—A plan that reimburses hospitals, physicians, and other providers on the basis of a privately determined fee schedule or other basis.

''(B) PLANS OFFERED BY PREFERRED PROVIDER ORGANIZATIONS.—A Medicare Choice plan offered by a preferred provider organization.

''(C) POINT OF SERVICE PLANS.—A point of service plan.

''(D) PLANS OFFERED BY PROVIDER-SPONSORED ORGANIZATION.—A Medicare Choice plan offered by a provider-sponsored organization, as defined in section 1855(e).

''(E) PLANS OFFERED BY HEALTH MAINTENANCE ORGANIZATIONS.—A Medicare Choice plan offered by a health maintenance organization.

''(F) OTHER HEALTH CARE PLANS.—Any other private plan for the delivery of health care items and services that is not described in a preceding subparagraph.

''(3) MEDICARE CHOICE ELIGIBLE INDIVIDUAL.—

''(A) IN GENERAL.—In this title, subject to subparagraph (B), the term 'Medicare Choice eligible individual' means an individual who is entitled to benefits under part A and enrolled under part B.

''(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—Such term shall not include an individual medically determined to have end-stage renal disease, except that an individual who develops end-stage renal disease while enrolled in a Medicare Choice plan may continue to be enrolled in that plan.

''(b) Residence requirement.—

''(1) IN GENERAL.—Except as the Secretary may otherwise provide, an individual is eligible to elect a Medicare Choice plan offered by a Medicare Choice organization only if the plan serves the geographic area in which the individual resides.

''(2) CONTINUATION OF ENROLLMENT PERMITTED.—Pursuant to rules specified by the Secretary, the Secretary shall provide that an individual may continue enrollment in a plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides benefits for enrollees located in the area in which the individual resides.

''(c) PROCESS FOR EXERCISING CHOICE.—

''(1) IN GENERAL.—The Secretary shall establish a process through which elections described in subsection (a) are made and changed, including the form and manner in which such elections are made and changed. Such elections shall be made or changed as provided in subsection (e) and shall become effective as provided in subsection (f).

''(2) COORDINATION THROUGH MEDICARE CHOICE ORGANIZATIONS.—

''(A) ENROLLMENT.—Such process shall permit an individual who wishes to elect a Medicare Choice plan offered by a Medicare Choice organization to make such election through the filing of an appropriate election form with the organization.

''(B) DISENROLLMENT.—Such process shall permit an individual, who has elected a Medicare Choice plan offered by a Medicare Choice organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

''(3) DEFAULT.—

''(A) INITIAL ELECTION.—

''(i) IN GENERAL.—Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the traditional medicare fee-for-service program option.

''(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary may establish procedures under which an individual who is enrolled in a health plan (other than Medicare Choice plan) offered by a Medicare Choice organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the Medicare Choice plan offered by the organization (or, if the organization offers more than one such plan, such plan or plans as the Secretary identifies under such procedures).

''(B) CONTINUING PERIODS.—An individual who has made (or is deemed to have made) an election under this section is considered to have continued to make such election until such time as—

''(i) the individual changes the election under this section, or

''(ii) the Medicare Choice plan with respect to which such election is in effect is discontinued.

''(d) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

''(1) IN GENERAL.—The Secretary shall provide for activities under this subsection to broadly disseminate information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options.

''(2) PROVISION OF NOTICE.—

''(A) OPEN SEASON NOTIFICATION.—At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each Medicare Choice eligible individual residing in an area the following:

''(i) GENERAL INFORMATION.—The general information described in paragraph (3).

''(ii) LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.—A list identifying the Medicare Choice plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative, chart-like form.

''(iii) ADDITIONAL INFORMATION.—Any other information that the Secretary determines will assist the individual in making the election under this section.

The mailing of such information shall be coordinated with the mailing of any annual notice under section 1804.

''(B) NOTIFICATION TO NEWLY MEDICARE CHOICE ELIGIBLE INDIVIDUALS.—To the extent practicable, the Secretary shall, not later than 30 days before the beginning of the initial Medicare Choice enrollment period for an individual described in subsection (e)(1)(A), mail to the individual the information described in subparagraph (A).

''(C) FORM.—The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

''(D) PERIODIC UPDATING.—The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of Medicare Choice plans and the benefits and net monthly premiums for such plans.

''(3) GENERAL INFORMATION.—General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

''(A) BENEFITS UNDER TRADITIONAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—A general description of the benefits covered under the traditional medicare fee-for-service program under parts A and B, including—

''(i) covered items and services,

''(ii) beneficiary cost sharing, such as deductibles, coinsurance, and copayment amounts, and

''(iii) any beneficiary liability for balance billing.

''(B) PART B PREMIUM.—The part B premium rates that will be charged for part B coverage.

''(C) ELECTION PROCEDURES.—Information and instructions on how to exercise election options under this section.

''(D) RIGHTS.—A general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the traditional medicare fee-for-service program and the Medicare Choice program and the right to be protected against discrimination based on health status-related factors under section 1852(b).

''(E) INFORMATION ON MEDIGAP AND MEDICARE SELECT.—A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1882 and provisions relating to medicare select policies described in section 1882(t).

''(F) POTENTIAL FOR CONTRACT TERMINATION.—The fact that a Medicare Choice organization may terminate or refuse to renew

its contract under this part and the effect the termination or nonrenewal of its contract may have on individuals enrolled with the Medicare Choice plan under this part.

''(4) INFORMATION COMPARING PLAN OPTIONS.—Information under this paragraph, with respect to a Medicare Choice plan for a year, shall include the following:

''(A) BENEFITS.—The benefits covered under the plan, including—

''(i) covered items and services beyond those provided under the traditional medicare fee-for-service program,

''(ii) any beneficiary cost sharing, and

''(iii) any maximum limitations on out-of-pocket expenses.

''(B) PREMIUMS.—The net monthly premium, if any, for the plan.

''(C) SERVICE AREA.—The service area of the plan.

''(D) QUALITY AND PERFORMANCE.—To the extent available, plan quality and performance indicators for the benefits under the plan (and how they compare to such indicators under the traditional medicare fee-for-service program under parts A and B in the area involved), including—

''(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area),

''(ii) information on medicare enrollee satisfaction,

''(iii) information on health outcomes,

''(iv) the extent to which a medicare enrollee may select the health care provider of their choice, including health care providers within the plan's network and out-of-network health care providers (if the plan covers out-of-network items and services), and

''(v) an indication of medicare enrollee exposure to balance billing and the restrictions on coverage of items and services provided to such enrollee by an out-of-network health care provider.

''(E) SUPPLEMENTAL BENEFITS OPTIONS.—Whether the organization offering the plan offers optional supplemental benefits and the terms and conditions (including premiums) for such coverage.

''(F) PHYSICIAN COMPENSATION.—An overall summary description as to the method of compensation of participating physicians.

''(5) MAINTAINING A TOLL-FREE NUMBER AND INTERNET SITE.—The Secretary shall maintain a toll-free number for inquiries regarding Medicare Choice options and the operation of this part in all areas in which Medicare Choice plans are offered and an Internet site through which individuals may electronically obtain information on such options and Medicare Choice plans.

''(6) USE OF NON-FEDERAL ENTITIES.—The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

''(7) PROVISION OF INFORMATION.—A Medicare Choice organization shall provide the Secretary with such information on the organization and each Medicare Choice plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

''(8) COORDINATION WITH STATES.—The Secretary shall coordinate with States to the maximum extent feasible in developing and distributing information provided to beneficiaries.

''(e) COVERAGE ELECTION PERIODS.—

''(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION IF MEDICARE CHOICE PLANS AVAILABLE TO INDIVIDUAL.—If, at the time an individual first becomes entitled to benefits under part A and enrolled under part B, there is one or more Medicare Choice plans offered in the area in which the individual resides, the individual shall make the election under this section during a period specified by the Secretary such that if the individual elects a Medicare Choice plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage.

''(2) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—A Medicare Choice eligible individual may change the election under subsection (a)(1) at any time, except that such individual may only enroll in a Medicare Choice plan which has an open enrollment period in effect at that time.

''(3) ANNUAL, COORDINATED ELECTION PERIOD.—

''(A) IN GENERAL.—Subject to paragraph (5), a Medicare Choice eligible individual may change an election under subsection (a)(1) during an annual, coordinated election period.

''(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term 'annual, coordinated election period' means, with respect to a calendar year (beginning with 1998), the month of November before such year.

''(C) MEDICARE CHOICE HEALTH INFORMATION FAIRS.—In the month of November of each year (beginning with 1997), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform Medicare Choice eligible individuals about Medicare Choice plans and the election process provided under this section.

''(4) SPECIAL ELECTION PERIODS.—A Medicare Choice individual may make a new election under this section if—

''(A) the organization's or plan's certification under this part has been terminated or the organization has terminated or otherwise discontinued providing the plan;

''(B) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of the individual's enrollment on the basis described in clause (i) or (ii) subsection (g)(3)(B));

''(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

''(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards); or

''(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the plan's provisions in marketing the plan to the individual; or

''(D) the individual meets such other exceptional conditions as the Secretary may provide.

''(5) OPEN ENROLLMENT PERIODS.—A Medicare Choice organization—

''(A) shall accept elections or changes to elections described in paragraphs (1), (3), and (4) during the periods prescribed in such paragraphs, and

''(B) may accept other changes to elections at such other times as the organization provides.

''(f) EFFECTIVENESS OF ELECTIONS AND CHANGES OF ELECTIONS.—

''(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1)(A) shall take effect upon the date the individual becomes entitled to benefits under part A and enrolled under part B, except as the Secretary may provide (consistent with section 1838) in order to prevent retroactive coverage.

''(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 is made.

''(3) ANNUAL, COORDINATED ELECTION PERIOD.—An election or change of coverage made during an annual, coordinated election period (as defined in subsection (e)(3)(B)) in a year shall take effect as of the first day of the following year unless the individual elects to have it take effect on December 1 of the election year.

''(4) OTHER PERIODS.—An election or change of coverage made during any other period under subsection (e)(4) shall take effect in such manner as the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

''(g) GUARANTEED ISSUE AND RENEWAL.—

''(1) IN GENERAL.—Except as provided in this subsection, a Medicare Choice organization shall provide that at any time during which elections are accepted under this section with respect to a Medicare Choice plan offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

''(2) PRIORITY.—If the Secretary determines that a Medicare Choice organization, in relation to a Medicare Choice plan it offers, has a capacity limit and the number of Medicare Choice eligible individuals who elect the plan under this section exceeds the capacity limit, the organization may limit the election of individuals of the plan under this section but only if priority in election is provided—

''(A) first to such individuals as have elected the plan at the time of the determination, and

''(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1852(b), among the individuals (who seek to elect the plan).

The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

''(3) LIMITATION ON TERMINATION OF ELECTION.—

''(A) IN GENERAL.—Subject to subparagraph (B), a Medicare Choice organization may not for any reason terminate the election of any individual under this section for a Medicare Choice plan it offers.

''(B) BASIS FOR TERMINATION OF ELECTION.—A Medicare Choice organization may terminate an individual's election under this section with respect to a Medicare Choice plan it offers if—

''(i) any net monthly premiums required with respect to such plan are not paid on a timely basis (consistent with standards under section 1856 that provide for a grace period for late payment of net monthly premiums),

''(ii) the individual has engaged in disruptive behavior (as specified in such standards), or

''(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

''(C) CONSEQUENCE OF TERMINATION.—

''(i) TERMINATIONS FOR CAUSE.—Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected the traditional medicare fee-for-service program option described in subsection (a)(1)(A).

''(ii) TERMINATION BASED ON PLAN TERMINATION OR SERVICE AREA REDUCTION.—Any individual whose election is terminated under subparagraph (B)(iii) shall have a special election period under subsection (e)(4)(A) in which to change coverage to coverage under another Medicare Choice plan. Such an individual who fails to make an election during such period is deemed to have chosen to change coverage to the traditional medicare fee-for-service program option described in subsection (a)(1)(A).

''(D) ORGANIZATION OBLIGATION WITH RESPECT TO ELECTION FORMS.—Pursuant to a contract under section 1857, each Medicare Choice organization receiving an election form under subsection (c)(3) shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

''(h) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—

''(1) SUBMISSION.—No marketing material or application form may be distributed by a Medicare Choice organization to (or for the use of) Medicare Choice eligible individuals unless—

''(A) at least 45 days before the date of distribution the organization has submitted the material or form to the Secretary for review, and

''(B) the Secretary has not disapproved the distribution of such material or form.

''(2) REVIEW.—The standards established under section 1856 shall include guidelines for the review of any material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

''(3) DEEMED APPROVAL (1-STOP SHOPPING).—In the case of material or form that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing material or form under paragraph (1)(B) with respect to a Medicare Choice plan in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the plan and organization except to the extent that such material or form is specific only to an area involved.

''(4) PROHIBITION OF CERTAIN MARKETING PRACTICES.—Each Medicare Choice organization shall conform to fair marketing standards, in relation to Medicare Choice plans offered under this part, included in the standards established under section 1856.

''(i) EFFECT OF ELECTION OF MEDICARE CHOICE PLAN OPTION.—Subject to sections 1852(a)(5) and 1857(f)(2)—

''(1) payments under a contract with a Medicare Choice organization under section 1853(a) with respect to an individual electing a Medicare Choice plan offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A and B for items and services furnished to the individual, and

''(2) subject to subsections (e) and (g) of section 1853, only the Medicare Choice organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

''BENEFITS AND BENEFICIARY PROTECTIONS

''SEC. 1852. (a) BASIC BENEFITS.—

''(1) IN GENERAL.—Each Medicare Choice plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

''(A) those items and services for which benefits are available under parts A and B to individuals residing in the area served by the plan, and

''(B) additional benefits required under section 1854(f)(1)(A).

''(2) SUPPLEMENTAL BENEFITS.—

''(A) BENEFITS INCLUDED SUBJECT TO SECRETARY'S APPROVAL.—Each Medicare Choice organization may provide to individuals enrolled under this part (without affording those individuals an option to decline the coverage) supplemental health care benefits that the Secretary may approve. The Secretary shall approve any such supplemental benefits unless the Secretary determines that including such supplemental benefits would substantially discourage enrollment by Medicare Choice eligible individuals with the organization.

''(B) AT ENROLLEES' OPTION.—A Medicare Choice organization may provide to individuals enrolled under this part supplemental health care benefits that the individuals may elect, at their option, to have covered.

''(3) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a Medicare Choice organization may (in the case of the provision of items and services to an individual under a Medicare Choice plan under circumstances in which payment under this title is made secondary pursuant to section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section—

''(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

''(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

''(4) NATIONAL COVERAGE DETERMINATIONS.—If there is a national coverage determination made in the period beginning on the date of an announcement under section 1853(b) and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a Medicare Choice organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the annual Medicare Choice capitation rate under section 1853 included in the announcement made at the beginning of such period, then, unless otherwise required by law—

''(A) such determination shall not apply to contracts under this part until the first contract year that begins after the end of such period, and

''(B) if such coverage determination provides for coverage of additional benefits or coverage under additional circumstances, section 1851(i) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period.

''(b) ANTIDISCRIMINATION.—

''(1) BENEFICIARIES.—

''(A) IN GENERAL.—A Medicare Choice organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(B) CONSTRUCTION.—Subparagraph (A) shall not be construed as requiring a Medicare Choice organization to enroll individuals who are determined to have end-stage renal disease, except as provided under section 1851(a)(3)(B).

''(2) PROVIDERS.—A Medicare Choice organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

''(c) DISCLOSURE REQUIREMENTS.—

''(1) DETAILED DESCRIPTION OF PLAN PROVISIONS.—A Medicare Choice organization shall disclose, in clear, accurate, and standardized form to each enrollee with a Medicare Choice plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

''(A) SERVICE AREA.—The plan's service area.

''(B) BENEFITS.—Benefits offered under the plan, including information described in section 1851(d)(3)(A) and exclusions from coverage.

''(C) ACCESS.—The number, mix, and distribution of plan providers.

''(D) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan.

''(E) EMERGENCY COVERAGE.—Coverage of emergency services and urgently needed care, including—

''(i) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

''(ii) the process and procedures of the plan for obtaining emergency services; and

''(iii) the locations of (I) emergency departments, and (II) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

''(F) SUPPLEMENTAL BENEFITS.—Supplemental benefits available from the organization offering the plan, including—

''(i) whether the supplemental benefits are optional,

''(ii) the supplemental benefits covered, and

''(iii) the premium price for the supplemental benefits.

''(G) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in nonpayment.

''(H) PLAN GRIEVANCE AND APPEALS PROCEDURES.—All plan appeal or grievance rights and procedures.

''(I) QUALITY ASSURANCE PROGRAM.—A description of the organization's quality assurance program under subsection (e).

''(J) OUT-OF-NETWORK COVERAGE.—The out-of-network coverage (if any) provided by the plan.

''(2) DISCLOSURE UPON REQUEST.—Upon request of a Medicare Choice eligible individual, a Medicare Choice organization must provide the following information to such individual:

''(A) The information described in paragraphs (3) and (4) of section 1851(d).

''(B) Information on utilization review procedures.

''(d) ACCESS TO SERVICES.—

''(1) IN GENERAL.—A Medicare Choice organization offering a Medicare Choice plan, other than an unrestricted fee-for-service plan, may select the providers from whom the benefits under the plan are provided so long as—

''(A) the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

''(B) when medically necessary the organization makes such benefits available and accessible 24 hours a day and 7 days a week;

''(C) the plan provides for reimbursement with respect to services which are covered under subparagraphs (A) and (B) and which are provided to such an individual other than through the organization, if—

''(i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and it was not reasonable given the circumstances to obtain the services through the organization, or

''(ii) the services were renal dialysis services and were provided other than through the organization because the individual was temporarily out of the plan's service area;

''(D) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services;

''(E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization; and

''(F) except as provided by the Secretary on a case-by-case basis, the organization provides primary care services within 30 minutes or 30 miles from an enrollee's place of residence if the enrollee resides in a rural area.

''(2) GUIDELINES RESPECTING COORDINATION OF POST-STABILIZATION CARE.—

''(A) IN GENERAL.—A Medicare Choice plan shall comply with such guidelines as the Secretary shall prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867.

''(B) CONTENT OF GUIDELINES.—The guidelines prescribed under subparagraph (A) shall provide that—

''(i) a provider of emergency services shall make a documented good faith effort to contact the plan in a timely fashion from the point at which the individual is stabilized to request approval for medically necessary post-stabilization care,

''(ii) the plan shall respond in a timely fashion to the initial contact with the plan with a decision as to whether the services for which approval is requested will be authorized, and

''(iii) if a denial of a request is communicated, the plan shall, upon request from the treating physician, arrange for a physician who is authorized by the plan to review the denial to communicate directly with the treating physician in a timely fashion.

''(3) DEFINITION OF EMERGENCY SERVICES.—In this subsection—

''(A) IN GENERAL.—The term 'emergency services' means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

''(i) are furnished by a provider that is qualified to furnish such services under this title, and

''(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

''(B) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

''(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

''(ii) serious impairment to bodily functions, or

''(iii) serious dysfunction of any bodily organ or part.

''(e) QUALITY ASSURANCE PROGRAM.—

''(1) IN GENERAL.—Each Medicare Choice organization must have arrangements, consistent with any regulation, for an ongoing quality assurance program for health care services it provides to individuals enrolled with Medicare Choice plans of the organization.

''(2) ELEMENTS OF PROGRAM.—The quality assurance program shall—

''(A) stress health outcomes and provide for the collection, analysis, and reporting of data (in accordance with a quality measurement system that the Secretary recognizes) that will permit measurement of outcomes and other indices of the quality of Medicare Choice plans and organizations;

''(B) provide for the establishment of written protocols for utilization review, based on current standards of medical practice;

''(C) provide review by physicians and other health care professionals of the process followed in the provision of such health care services;

''(D) monitor and evaluate high volume and high risk services and the care of acute and chronic conditions;

''(E) evaluate the continuity and coordination of care that enrollees receive;

''(F) have mechanisms to detect both underutilization and overutilization of services;

''(G) after identifying areas for improvement, establish or alter practice parameters;

''(H) take action to improve quality and assesses the effectiveness of such action through systematic followup;

''(I) make available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options (in such form and on such quality and outcomes measures as the Secretary determines to be appropriate);

''(J) be evaluated on an ongoing basis as to its effectiveness;

''(K) include measures of consumer satisfaction; and

''(L) provide the Secretary with such access to information collected as may be appropriate to monitor and ensure the quality of care provided under this part.

''(3) EXTERNAL REVIEW.—Each Medicare Choice organization shall, for each Medicare Choice plan it operates, have an agreement with an independent quality review and improvement organization approved by the Secretary to perform functions of the type described in sections 1154(a)(4)(B) and 1154(a)(14) with respect to services furnished by Medicare Choice plans for which payment is made under this title.

''(4) EXCEPTION FOR MEDICARE CHOICE UNRESTRICTED FEE-FOR-SERVICE PLANS.—Paragraphs (1) through (3) of this subsection and subsection (h)(2) (relating to maintaining medical records) shall not apply in the case of a Medicare Choice organization in relation to a Medicare Choice unrestricted fee-for-service plan.

''(5) TREATMENT OF ACCREDITATION.—The Secretary shall provide that a Medicare Choice organization is deemed to meet requirements of paragraphs (1) and (2) of this subsection and subsection (h) (relating to confidentiality and accuracy of enrollee records) if the organization is accredited (and periodically reaccredited) by a private organization under a process that the Secretary has determined assures that the organization, as a condition of accreditation, applies and enforces standards with respect to the requirements involved that are no less stringent than the standards established under section 1856 to carry out the respective requirements.

''(f) COVERAGE DETERMINATIONS.—

''(1) DECISIONS ON NONEMERGENCY CARE.—A Medicare Choice organization shall make determinations regarding authorization requests for nonemergency care on a timely basis, depending on the urgency of the situation.

''(2) RECONSIDERATIONS.—

''(A) IN GENERAL.—Subject to subsection (g)(4), a reconsideration of a determination of an organization denying coverage shall be made within 30 days of the date of receipt of medical information, but not later than 60 days after the date of the determination.

''(B) PHYSICIAN DECISION ON CERTAIN RECONSIDERATIONS.—A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician other than a physician involved in the initial determination.

''(g) GRIEVANCES AND APPEALS.—

''(1) GRIEVANCE MECHANISM.—Each Medicare Choice organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees with Medicare Choice plans of the organization under this part.

''(2) APPEALS.—An enrollee with a Medicare Choice plan of a Medicare Choice organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is $1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the organization shall be entitled to be parties to that judicial review. In applying subsections (b) and (g) of section 205 as provided in this paragraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

''(3) INDEPENDENT REVIEW OF CERTAIN COVERAGE DENIALS.—The Secretary shall contract with an independent, outside entity to review and resolve reconsiderations that affirm denial of coverage.

''(4) EXPEDITED DETERMINATIONS AND RECONSIDERATIONS.—

''(A) RECEIPT OF REQUESTS.—An enrollee in a Medicare Choice plan may request, either in writing or orally, an expedited determination or reconsideration by the Medicare Choice organization regarding a matter described in paragraph (2). The organization shall also permit the acceptance of such requests by physicians.

''(B) ORGANIZATION PROCEDURES.—

''(i) IN GENERAL.—The Medicare Choice organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the

application of normal time frames for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

''(ii) TIMELY RESPONSE.—In an urgent case described in clause (i), the organization shall notify the enrollee (and the physician involved, as appropriate) of the determination (or determination on the reconsideration) as expeditiously as the enrollee's health condition requires, but not later than 72 hours (or 24 hours in the case of a reconsideration) of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

''(h) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Each Medicare Choice organization shall establish procedures—

''(1) to safeguard the privacy of individually identifiable enrollee information,

''(2) to maintain accurate and timely medical records and other health information for enrollees, and

''(3) to assure timely access of enrollees to their medical information.

''(i) INFORMATION ON ADVANCE DIRECTIVES.—Each Medicare Choice organization shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

''(j) RULES REGARDING PHYSICIAN PARTICIPATION.—

''(1) PROCEDURES.—Each Medicare Choice organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under Medicare Choice plans offered by the organization under this part. Such procedures shall include—

''(A) providing notice of the rules regarding participation,

''(B) providing written notice of participation decisions that are adverse to physicians, and

''(C) providing a process within the organization for appealing such adverse decisions, including the presentation of information and views of the physician regarding such decision.

''(2) CONSULTATION IN MEDICAL POLICIES.—A Medicare Choice organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality, and medical management procedures.

''(3) LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.—

''(A) IN GENERAL.—No Medicare Choice organization may operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

''(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

''(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

''(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or group, and

''(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

''(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

''(B) PHYSICIAN INCENTIVE PLAN DEFINED.—In this paragraph, the term 'physician incentive plan' means any compensation arrangement between a Medicare Choice organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

''(4) LIMITATION ON PROVIDER INDEMNIFICATION.—A Medicare Choice organization may not provide (directly or indirectly) for a provider (or group of providers) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a Medicare Choice plan of the organization under this part by the organization's denial of medically necessary care.

''PAYMENTS TO MEDICARE CHOICE ORGANIZATIONS

''SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

''(1) MONTHLY PAYMENTS.—

''(A) IN GENERAL.—Under a contract under section 1857 and subject to subsections (e) and (f), the Secretary shall make monthly payments under this section in advance to each Medicare Choice organization, with respect to coverage of an individual under this part in a Medicare Choice payment area for a month, in an amount equal to 1/12 of the annual Medicare Choice capitation rate (as calculated under subsection (c)) with respect to that individual for that area, adjusted for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such factors, if such changes will improve the determination of actuarial equivalence.

''(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment to a Medicare Choice organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a Medicare Choice plan of the organization. Such rates of payment shall be actuarially equivalent to rates paid to other enrollees in the Medicare Choice payment area (or such other area as specified by the Secretary). In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1881(b)(7) to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence.

''(2) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—

''(A) IN GENERAL.—The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

''(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a Medicare Choice organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

''(ii) EXCEPTION.—No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1852(c) at the time the individual enrolled with the organization.

''(3) ESTABLISHMENT OF RISK ADJUSTMENT FACTORS.—

''(A) IN GENERAL.—The Secretary shall develop and implement a method of risk adjustment of payment rates under this section that accounts for variations in per capita costs based on health status. Such method shall not be implemented before the Secretary receives an evaluation by an outside, independent actuary of the actuarial soundness of such method.

''(B) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require Medicare Choice organizations (and eligible organizations with risk-sharing contracts under section 1876) to submit, for periods beginning on or after January 1, 1998, data regarding inpatient hospital services and other services and other information the Secretary deems necessary.

''(4) INTERIM RISK ADJUSTMENT.—

''(A) IN GENERAL.—In the case of an applicable enrollee in a Medicare Choice plan, the payment to the Medicare Choice organization under this section shall be reduced by an amount equal to the applicable percentage of the amount of such payment (determined without regard to this paragraph).

''(B) APPLICABLE ENROLLEE.—For purposes of this paragraph—

''(i) IN GENERAL.—The term 'applicable enrollee' means, with respect to any month, a medicare eligible individual who—

''(I) is enrolled in a Medicare Choice plan, and

''(II) has not been enrolled in Medicare Choice plans and plans operated by eligible organizations with risk-sharing contracts under section 1876 for an aggregate number of months greater than 60 (including the month for which the determination is being made).

''(ii) EXCEPTION FOR BENEFICIARIES MAINTAINING ENROLLMENT IN CERTAIN PLANS.—The term 'applicable enrollee' shall not include any individual enrolled in a Medicare Choice plan offered by a Medicare Choice organization if such individual was enrolled in a health plan (other than a Medicare Choice plan) offered by such organization at the time of the individual's initial election period under section 1851(e)(1) and has been continuously enrolled in such Medicare Choice plan (or another Medicare Choice plan offered by such organization) since such election period.

''(C) APPLICABLE PERCENTAGE.—For purposes of this paragraph, the applicable percentage shall be determined in accordance with the following table:

''Months enrolled in HMOs:	Applicable percentage:
1–12	5
13–24	4
25–36	3

''Months enrolled in HMOs:	Applicable percentage:
37–48	2
49–60	1.

''(D) EXCEPTION FOR NEW PLANS.—This paragraph shall not apply to applicable enrollees in a Medicare Choice plan for any month if—

''(i) such month occurs during the first 12 months during which the plan enrolls Medicare Choice eligible individuals in the Medicare Choice payment area, and

''(ii) the annual Medicare Choice capitation rate for such area for the calendar year preceding the calendar year in which such 12-month period begins is less than the annual national Medicare Choice capitation rate (as determined under subsection (c)(4)) for such preceding calendar year.

In the case of 1998, clause (ii) shall be applied by using the adjusted average per capita cost under section 1876 for 1997 rather than such capitation rate.

''(E) TERMINATION.—This paragraph shall not apply to any month beginning on or after the first day of the first month to which the method for risk adjustment described in paragraph (3) applies.

''(b) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—

''(1) ANNUAL ANNOUNCEMENT.—The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than August 1 before the calendar year concerned—

''(A) the annual Medicare Choice capitation rate for each Medicare Choice payment area for the year, and

''(B) the risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) for payments for months in that year.

''(2) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (1) for a year, the Secretary shall provide for notice to Medicare Choice organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

''(3) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that Medicare Choice organizations can compute monthly adjusted Medicare Choice capitation rates for individuals in each Medicare Choice payment area which is in whole or in part within the service area of such an organization.

''(c) CALCULATION OF ANNUAL MEDICARE CHOICE CAPITATION RATES.—

''(1) IN GENERAL.—For purposes of this part, 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) BLENDED CAPITATION RATE.—The sum of—

''(i) the area-specific percentage for the year (as specified under paragraph (2) for the year) of the annual area-specific Medicare Choice capitation rate for the year for the Medicare Choice payment area, as determined under paragraph (3), and

''(ii) the national percentage (as specified under paragraph (2) for the year) of the annual national Medicare Choice capitation rate for the year, as determined under paragraph (4),

multiplied by the payment adjustment factors described in subparagraphs (A) and (B) of paragraph (5).

''(B) MINIMUM AMOUNT.—Subject to paragraph (8)—

''(i) For 1998, $4,200 (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 each subsequent year, 101 percent of the amount in effect under this subparagraph for the previous year.

''(C) MINIMUM PERCENTAGE INCREASE.—Subject to paragraph (8)—

''(i) For 1998, 101 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the Medicare Choice payment area.

''(ii) For each subsequent year, 101 percent of the annual Medicare Choice capitation rate under this paragraph for the area for the previous year.

''(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

''(A) for 1998, the 'area-specific percentage' is 90 percent and the 'national percentage' is 10 percent,

''(B) for 1999, the 'area-specific percentage' is 80 percent and the 'national percentage' is 20 percent,

''(C) for 2000, the 'area-specific percentage' is 70 percent and the 'national percentage' is 30 percent,

''(D) for 2001, the 'area-specific percentage' is 60 percent and the 'national percentage' is 40 percent, and

''(E) for a year after 2001, the 'area-specific percentage' is 50 percent and the 'national percentage' is 50 percent.

''(3) ANNUAL AREA-SPECIFIC MEDICARE CHOICE CAPITATION RATE.—

''(A) IN GENERAL.—For purposes of paragraph (1)(A), the annual area-specific Medicare Choice capitation rate for a Medicare Choice payment area—

''(i) for 1998 is the modified annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area, increased by the national average per capita growth percentage for 1998 (as defined in paragraph (6)); or

''(ii) for a subsequent year is the annual area-specific Medicare Choice capitation rate for the previous year determined under this paragraph for the area, increased by the national average per capita growth percentage for such subsequent year.

''(B) MODIFIED ANNUAL PER CAPITA RATE OF PAYMENT.—For purposes of subparagraph (A), the modified annual per capita rate of payment for a Medicare Choice payment area for 1997 shall be equal to the annual per capita rate of payment for such area for such year which would have been determined under section 1876(a)(1)(C) if 25 percent of any payments attributable to sections 1886(d)(5)(B), 1886(h), and 1886(d)(5)(F) (relating to IME, GME, and DSH payments) were not taken into account.

''(C) SPECIAL RULES FOR 1999, 2000, AND 2001.—In applying subparagraph (A)(ii) for 1999, 2000, and 2001, the annual area-specific Medicare Choice capitation rate for the preceding calendar year shall be the amount which would have been determined if subparagraph (B) had been applied by substituting the following percentages for '25 percent':

''(i) In 1999, 50 percent.

''(ii) In 2000, 75 percent.

''(iii) In 2001, 100 percent.

''(4) ANNUAL NATIONAL MEDICARE CHOICE CAPITATION RATE.—For purposes of paragraph (1)(A), the annual national Medicare Choice capitation rate for a Medicare Choice payment area for a year is equal to—

''(A) the sum (for all Medicare Choice payment areas) of the product of—

''(i) the annual area-specific Medicare Choice capitation rate for that year for the area under paragraph (3), and

''(ii) the average number of medicare beneficiaries residing in that area in the year; divided by

''(B) the sum of the amounts described in subparagraph (A)(ii) for all Medicare Choice payment areas for that year.

''(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTORS.—For purposes of paragraph (1)(A)—

''(A) BLENDED RATE PAYMENT ADJUSTMENT FACTOR.—For each year, the Secretary shall compute a blended rate payment adjustment factor such that, not taking into account subparagraphs (B) and (C) of paragraph (1) and the application of the payment adjustment factor described in subparagraph (B) but taking into account paragraph (7), the aggregate of the payments that would be made under this part is equal to the aggregate payments that would have been made under this part (not taking into account such subparagraphs and such other adjustment factor) if the area-specific percentage under paragraph (1) for the year had been 100 percent and the national percentage had been 0 percent.

''(B) FLOOR-AND-MINIMUM-UPDATE PAYMENT ADJUSTMENT FACTOR.—For each year, the Secretary shall compute a floor-and-minimum-update payment adjustment factor so that, taking into account the application of the blended rate payment adjustment factor under subparagraph (A) and subparagraphs (B) and (C) of paragraph (1) and the application of the adjustment factor under this subparagraph, the aggregate of the payments under this part shall not exceed the aggregate payments that would have been made under this part if subparagraphs (B) and (C) of paragraph (1) did not apply and if the floor-and-minimum-update payment adjustment factor under this subparagraph was 1.

''(6) NATIONAL AVERAGE PER CAPITA GROWTH PERCENTAGE DEFINED.—In this part, the 'national average per capita growth percentage' for any year (beginning with 1998) is equal to the sum of—

''(A) the percentage increase in the gross domestic product per capita for the 12-month period ending on June 30 of the preceding year, plus

''(B) 0.5 percentage points.

''(7) TREATMENT OF AREAS WITH HIGHLY VARIABLE PAYMENT RATES.—In the case of a Medicare Choice payment area for which the annual per capita rate of payment determined under section 1876(a)(1)(C) for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for 1997 a rate that is more representative of the costs of the enrollees in the area.

''(8) ADJUSTMENTS TO MINIMUM AMOUNTS AND MINIMUM PERCENTAGE INCREASES.—

''(A) IN GENERAL.—After computing all amounts under this subsection (without regard to this paragraph) for any year, the Secretary shall—

''(i) redetermine the amount under paragraph (1)(C) for such year by substituting '100 percent' for '101 percent' each place it appears, and

''(ii) subject to subparagraph (B), increase the amount determined under paragraph (1)(B) for such year to the amount equal to 85 percent of the annual national Medicare Choice capitation rate.

''(B) LIMITATION ON INCREASE IN MINIMUM AMOUNT.—The Secretary shall not under subparagraph (A)(ii) increase the minimum amount under paragraph (1)(B) to an amount

that is greater than the amount the Secretary estimates will result in increased payments under such paragraph equal to the decrease in payments by reason of the redetermination under subparagraph (A)(i).

''(9) STUDY OF LOCAL PRICE INDICATORS.—The Secretary and the Medicare Payment Advisory Commission shall each conduct a study with respect to appropriate measures for adjusting the annual Medicare Choice capitation rates determined under this section to reflect local price indicators, including the medicare hospital wage index and the case-mix of a geographic region. The Secretary and the Advisory Commission shall report the results of such study to the appropriate committees of Congress, including recommendations (if any) for legislation.

''(d) MEDICARE CHOICE PAYMENT AREA DEFINED.—

''(1) IN GENERAL.—In this part, except as provided in paragraph (3), the term 'Medicare Choice payment area' means a county, or equivalent area specified by the Secretary.

''(2) RULE FOR ESRD BENEFICIARIES.—In the case of individuals who are determined to have end stage renal disease, the Medicare Choice payment area shall be a State or such other payment area as the Secretary specifies.

''(3) GEOGRAPHIC ADJUSTMENT.—

''(A) IN GENERAL.—Upon written request of the chief executive officer of a State for a contract year (beginning after 1998) made at least 7 months before the beginning of the year, the Secretary shall make a geographic adjustment to a Medicare Choice payment area in the State otherwise determined under paragraph (1)—

''(i) to a single statewide Medicare Choice payment area,

''(ii) to the metropolitan based system described in subparagraph (C), or

''(iii) to consolidating into a single Medicare Choice payment area noncontiguous counties (or equivalent areas described in paragraph (1)) within a State.

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

''(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the Secretary shall adjust the payment rates otherwise established under this section for Medicare Choice payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for Medicare Choice payment areas in the State in the absence of the adjustment under this paragraph.

''(C) METROPOLITAN BASED SYSTEM.—The metropolitan based system described in this subparagraph is one in which—

''(i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area, all of the portions of each primary metropolitan statistical area within the consolidated area within the State, are treated as a single Medicare Choice payment area, and

''(ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single Medicare Choice payment area.

''(D) AREAS.—In subparagraph (C), the terms 'metropolitan statistical area', 'consolidated metropolitan statistical area', and 'primary metropolitan statistical area' mean any area designated as such by the Secretary of Commerce.

''(e) PAYMENTS FROM TRUST FUND.—The payment to a Medicare Choice organization under this section for individuals enrolled under this part with the organization shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this title. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001. Monthly payments otherwise payable under this section for October 2006 shall be paid on the first business day of October 2006.

''(f) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

''(1) election under this part of a Medicare Choice plan offered by a Medicare Choice organization—

''(A) payment for such services until the date of the individual's discharge shall be made under this title through the Medicare Choice plan or the traditional medicare fee-for-service program option described in section 1851(a)(1)(A) (as the case may be) elected before the election with such organization,

''(B) the elected organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

''(C) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

''(2) termination of election with respect to a Medicare Choice organization under this part—

''(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

''(B) payment for such services during the stay shall not be made under section 1886(d) or by any succeeding Medicare Choice organization, and

''(C) the terminated organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

''PREMIUMS

''SEC. 1854. (a) SUBMISSION AND CHARGING OF PREMIUMS.—

''(1) IN GENERAL.—Subject to paragraph (3), each Medicare Choice organization shall file with the Secretary each year, in a form and manner and at a time specified by the Secretary—

''(A) the amount of the monthly premium for coverage for services under section 1852(a) under each Medicare Choice plan it offers under this part in each Medicare Choice payment area (as defined in section 1853(d)) in which the plan is being offered; and

''(B) the enrollment capacity in relation to the plan in each such area.

''(2) TERMINOLOGY.—In this part—

''(A) the term 'monthly premium' means, with respect to a Medicare Choice plan offered by a Medicare Choice organization, the monthly premium filed under paragraph (1), not taking into account the amount of any payment made toward the premium under section 1853; and

''(B) the term 'net monthly premium' means, with respect to such a plan and an individual enrolled with the plan, the premium (as defined in subparagraph (A)) for the plan reduced by the amount of payment made toward such premium under section 1853.

''(b) MONTHLY PREMIUM CHARGED.—The monthly amount of the premium charged by a Medicare Choice organization for a Medicare Choice plan offered in a Medicare Choice payment area to an individual under this part shall be equal to the net monthly premium plus any monthly premium charged in accordance with subsection (e)(2) for supplemental benefits.

''(c) UNIFORM PREMIUM.—The monthly premium and monthly amount charged under subsection (b) of a Medicare Choice organization under this part may not vary among individuals who reside in the same Medicare Choice payment area.

''(d) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each Medicare Choice organization shall permit the payment of net monthly premiums on a monthly basis and may terminate election of individuals for a Medicare Choice plan for failure to make premium payments only in accordance with section 1851(g)(3)(B)(i). A Medicare Choice organization is not authorized to provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

''(e) LIMITATION ON ENROLLEE COST-SHARING.—

''(1) FOR BASIC AND ADDITIONAL BENEFITS.—Except as provided in paragraph (2), in no event may—

''(A) the net monthly premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with a Medicare Choice plan of an organization with respect to required benefits described in section 1852(a)(1) and additional benefits (if any) required under subsection (f)(1) for a year, exceed

''(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a Medicare Choice organization for the year.

''(2) FOR SUPPLEMENTAL BENEFITS.—If the Medicare Choice organization provides to its members enrolled under this part supplemental benefits described in section 1852(a)(3), the sum of the monthly premium rate (multiplied by 12) charged for such supplemental benefits and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits may not exceed the adjusted community rate for such benefits (as defined in subsection (f)(4)).

''(3) EXCEPTION FOR UNRESTRICTED FEE-FOR-SERVICE PLANS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), paragraphs (1) and (2) do not apply to an unrestricted fee-for-service plan.

''(B) APPLICATION OF BALANCE BILLING FOR PHYSICIAN SERVICES.—Section 1848(g) shall apply to the provision of physician services (as defined in section 1848(j)(3)) to an individual enrolled in an unrestricted fee-for-service plan under this title in the same manner as such section applies to such services that are provided to an individual who is not enrolled in a Medicare Choice plan under this title.

''(4) DETERMINATION ON OTHER BASIS.—If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A) or (2), the Secretary may determine such amount with respect to all individuals in the Medicare Choice payment area, the State, or in the United States, eligible to enroll in the Medicare Choice plan involved under this part or on the basis of other appropriate data.

''(f) REQUIREMENT FOR ADDITIONAL BENEFITS.—

''(1) REQUIREMENT.—

''(A) IN GENERAL.—Each Medicare Choice organization (in relation to a Medicare Choice plan it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of

this subsection, the organization shall provide to individuals such additional benefits (as the organization may specify) in a value which is at least equal to the adjusted excess amount (as defined in subparagraph (C)).

''(B) EXCESS AMOUNT.—For purposes of this paragraph, the 'excess amount', for an organization for a plan, is the amount (if any) by which—

''(i) the average of the capitation payments made to the organization under section 1853 for the plan at the beginning of contract year, exceeds

''(ii) the actuarial value of the required benefits described in section 1852(a)(1) under the plan for individuals under this part, as determined based upon an adjusted community rate described in paragraph (4) (as reduced for the actuarial value of the coinsurance and deductibles under parts A and B).

''(C) ADJUSTED EXCESS AMOUNT.—For purposes of this paragraph, the 'adjusted excess amount', for an organization for a plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (3).

''(D) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a plan in a Medicare Choice payment area.

''(E) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a Medicare Choice organization from providing health care benefits that are in addition to the benefits otherwise required to be provided under this paragraph and from imposing a premium for such additional benefits.

''(2) STABILIZATION FUND.—A Medicare Choice organization may provide that a part of the value of an excess amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the Medicare Choice plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

''(3) DETERMINATION BASED ON INSUFFICIENT DATA.—For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience to determine an average of the capitation payments to be made under this part at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part.

''(4) ADJUSTED COMMUNITY RATE.—

''(A) IN GENERAL.—For purposes of this subsection, subject to subparagraph (B), the term 'adjusted community rate' for a service or services means, at the election of a Medicare Choice organization, either—

''(i) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a Medicare Choice plan under this part if the rate of payment were determined under a 'community rating system' (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)), or

''(ii) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to such an individual, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the plan (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals selecting other Medicare Choice coverage, or Medicare Choice eligible individuals in the area, in the State, or in the United States, eligible to elect Medicare Choice coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

''(B) SPECIAL RULE FOR PROVIDER-SPONSORED ORGANIZATIONS.—In the case of a Medicare Choice organization that is a provider-sponsored organization, the adjusted community rate under subparagraph (A) for a Medicare Choice plan of the organization may be computed (in a manner specified by the Secretary) using data in the general commercial marketplace or (during a transition period) based on the costs incurred by the organization in providing such a plan.

''(g) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of the financial records (including data relating to medicare utilization, costs, and computation of the adjusted community rate) of at least one-third of the Medicare Choice organizations offering Medicare Choice plans under this part. The Comptroller General shall monitor auditing activities conducted under this subsection.

''(h) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to payments on Medicare Choice plans or the offering of such plans.

''ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR MEDICARE CHOICE ORGANIZATIONS; PROVIDER-SPONSORED ORGANIZATIONS

''SEC. 1855. (a) ORGANIZED AND LICENSED UNDER STATE LAW.—

''(1) IN GENERAL.—Subject to paragraphs (2) and (3), a Medicare Choice organization shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a Medicare Choice plan.

''(2) SPECIAL EXCEPTION BEFORE 2001 FOR PROVIDER-SPONSORED ORGANIZATIONS.—

''(A) IN GENERAL.—In the case of a provider-sponsored organization that seeks to offer a Medicare Choice plan in a State, the Secretary shall waive the requirement of paragraph (1) that the organization be licensed in that State for any year before 2001 if—

''(i) the organization files an application for such waiver with the Secretary, and

''(ii) the contract with the organization under section 1857 requires the organization to meet all requirements of State law which relate to the licensing of the organization (other than solvency requirements or a prohibition on licensure for such organization).

''(B) TREATMENT OF WAIVER.—

''(i) IN GENERAL.—In the case of a waiver granted under this paragraph for a provider-sponsored organization—

''(I) the waiver shall be effective for the years specified in the waiver, except it may be renewed based on a subsequent application, and

''(II) subject to subparagraph (A)(ii), any provisions of State law which would otherwise prohibit the organization from providing coverage pursuant to a contract under this part shall be superseded.

''(ii) TERMINATION.—A waiver granted under this paragraph shall in no event extend beyond the earlier of—

''(I) December 31, 2000; or

''(II) the date on which the Secretary determines that the State has in effect solvency standards described in subsection (d)(1)(B).

''(C) PROMPT ACTION ON APPLICATION.—The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete application has been filed.

''(D) ENFORCEMENT OF STATE STANDARDS.—

''(i) IN GENERAL.—The Secretary shall enter into agreements with States subject to a waiver under this paragraph to ensure the adequate enforcement of standards incorporated into the contract under subparagraph (A)(ii). Such agreements shall provide methods by which States may notify the Secretary of any failure by an organization to comply with such standards.

''(ii) ENFORCEMENT.—If the Secretary determines that an organization is not in compliance with the standards described in clause (i), the Secretary shall take appropriate actions under subsections (g) and (h) with respect to civil penalties and termination of the contract. The Secretary shall allow an organization 60 days to comply with the standards after notification of failure.

''(E) REPORT.—The Secretary shall, not later than December 31, 1998, report to Congress on the waiver procedure in effect under this paragraph. Such report shall include an analysis of State efforts to adopt regulatory standards that take into account health plan sponsors that provide services directly to enrollees through affiliated providers.

''(3) EXCEPTION IF REQUIRED TO OFFER MORE THAN MEDICARE CHOICE PLANS.—Paragraph (1) shall not apply to a Medicare Choice organization in a State if the State requires the organization, as a condition of licensure, to offer any product or plan other than a Medicare Choice plan.

''(4) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an organization is licensed in accordance with paragraph (1) does not deem the organization to meet other requirements imposed under this part.

''(b) PREPAID PAYMENT.—A Medicare Choice organization shall be compensated (except for premiums, deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members under the contract under this part by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

''(c) ASSUMPTION OF FULL FINANCIAL RISK.—The Medicare Choice organization shall assume full financial risk on a prospective basis for the provision of the health care services (except, at the election of the organization, hospice care) for which benefits are required to be provided under section 1852(a)(1), except that the organization—

''(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which for any year exceeds the applicable amount determined under the last sentence of this subsection for the year,

''(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization,

''(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

''(4) may make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

For purposes of paragraph (1), the applicable amount for 1998 is the amount established by the Secretary, and for 1999 and any succeeding year is the amount in effect for the previous year increased by the percentage change 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.

''(d) CERTIFICATION OF PROVISION AGAINST RISK OF INSOLVENCY FOR PSOS.—

''(1) IN GENERAL.—Each Medicare Choice organization that is a provider-sponsored organization shall—

''(A) meet standards established under section 1856(a) relating to the financial solvency and capital adequacy of the organization, or

''(B) meet solvency standards established by the State that are no less stringent than the standards described in subparagraph (A).

''(2) CERTIFICATION PROCESS FOR SOLVENCY STANDARDS FOR PSOS.—The Secretary shall establish a process for the receipt and approval of applications of a provider-sponsored organization for certification (and periodic recertification) of the organization as meeting such solvency standards. Under such process, the Secretary shall act upon such an application not later than 60 days after the date the application has been received.

''(e) PROVIDER-SPONSORED ORGANIZATION DEFINED.—

''(1) IN GENERAL.—In this part, the term 'provider-sponsored organization' means a public or private entity—

''(A) that is established or organized and operated by a local health care provider, or local group of affiliated health care providers,

''(B) that provides a substantial proportion (as defined by the Secretary in accordance with paragraph (2)) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers, and

''(C) with respect to which those affiliated providers that share, directly or indirectly, substantial financial risk with respect to the provision of such items and services have at least a majority financial interest in the entity.

''(2) SUBSTANTIAL PROPORTION.—In defining what is a 'substantial proportion' for purposes of paragraph (1)(B), the Secretary—

''(A) shall take into account the need for such an organization to assume responsibility for providing—

''(i) significantly more than the majority of the items and services under the contract under this section through its own affiliated providers; and

''(ii) most of the remainder of the items and services under the contract through providers with which the organization has an agreement to provide such items and services,

in order to assure financial stability and to address the practical considerations involved in integrating the delivery of a wide range of service providers;

''(B) shall take into account the need for such an organization to provide a limited proportion of the items and services under the contract through providers that are neither affiliated with nor have an agreement with the organization; and

''(C) may allow for variation in the definition of substantial proportion among such organizations based on relevant differences among the organizations, such as their location in an urban or rural area.

''(3) AFFILIATION.—For purposes of this subsection, a provider is 'affiliated' with another provider if, through contract, ownership, or otherwise—

''(A) one provider, directly or indirectly, controls, is controlled by, or is under common control with the other,

''(B) both providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986,

''(C) each provider is a participant in a lawful combination under which each provider shares substantial financial risk in connection with the organization's operations, or

''(D) both providers are part of an affiliated service group under section 414 of such Code.

''(4) CONTROL.—For purposes of paragraph (3), control is presumed to exist if one party, directly or indirectly, owns, controls, or holds the power to vote, or proxies for, not less than 51 percent of the voting rights or governance rights of another.

''(5) HEALTH CARE PROVIDER DEFINED.—In this subsection, the term 'health care provider' means—

''(A) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, and

''(B) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

''(6) REGULATIONS.—The Secretary shall issue regulations to carry out this subsection.

''ESTABLISHMENT OF STANDARDS

''SEC. 1856. (a) ESTABLISHMENT OF SOLVENCY STANDARDS FOR PROVIDER-SPONSORED ORGANIZATIONS.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code, standards described in section 1855(d)(1) (relating to the financial solvency and capital adequacy of the organization) that entities must meet to qualify as provider-sponsored organizations under this part.

''(B) FACTORS TO CONSIDER FOR SOLVENCY STANDARDS.—In establishing solvency standards under subparagraph (A) for provider-sponsored organizations, the Secretary shall consult with interested parties and shall take into account—

''(i) the delivery system assets of such an organization and ability of such an organization to provide services directly to enrollees through affiliated providers,

''(ii) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care, and

''(iii) any standards developed by the National Association of Insurance Commissioners specifically for risk-based health care delivery organizations.

''(C) ENROLLEE PROTECTION AGAINST INSOLVENCY.—Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the Medicare Choice organization's debts in the event of the organization's insolvency.

''(2) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this subsection, the Secretary, after consultation with the National Association of Insurance Commissioners, the American Academy of Actuaries, organizations representative of medicare beneficiaries, and other interested parties, shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this section.

''(3) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under paragraph (2), and for purposes of this subsection, the 'target date for publication' (referred to in section 564(a)(5) of such title) shall be April 1, 1998.

''(4) ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.—In applying section 564(c) of such title under this subsection, '15 days' shall be substituted for '30 days'.

''(5) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

''(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

''(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

''(6) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than January 1, 1998, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before 1 month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

''(7) FINAL COMMITTEE REPORT.—If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than 1 month before the target date of publication.

''(8) INTERIM, FINAL EFFECT.—The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target date of publication. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

''(9) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target date of publication.

''(b) ESTABLISHMENT OF OTHER STANDARDS.—

''(1) IN GENERAL.—The Secretary shall establish by regulation other standards (not described in subsection (a)) for Medicare Choice organizations and plans consistent with, and to carry out, this part.

''(2) USE OF CURRENT STANDARDS.—Consistent with the requirements of this part, standards established under this subsection shall be based on standards established under

section 1876 to carry out analogous provisions of such section.

''(3) USE OF INTERIM STANDARDS.—For the period in which this part is in effect and standards are being developed and established under the preceding provisions of this subsection, the Secretary shall provide by not later than June 1, 1998, for the application of such interim standards (without regard to any requirements for notice and public comment) as may be appropriate to provide for the expedited implementation of this part. Such interim standards shall not apply after the date standards are established under the preceding provisions of this subsection.

''(4) APPLICATION OF NEW STANDARDS TO ENTITIES WITH A CONTRACT.—In the case of a Medicare Choice organization with a contract in effect under this part at the time standards applicable to the organization under this section are changed, the organization may elect not to have such changes apply to the organization until the end of the current contract year (or, if there is less than 6 months remaining in the contract year, until 1 year after the end of the current contract year).

''(5) RELATION TO STATE LAWS.—The standards established under this subsection shall supersede any State law or regulation with respect to Medicare Choice plans which are offered by Medicare Choice organizations under this part to the extent such law or regulation is inconsistent with such standards.

''CONTRACTS WITH MEDICARE CHOICE ORGANIZATIONS

''SEC. 1857. (a) IN GENERAL.—The Secretary shall not permit the election under section 1851 of a Medicare Choice plan offered by a Medicare Choice organization under this part, and no payment shall be made under section 1853 to an organization, unless the Secretary has entered into a contract under this section with the organization with respect to the offering of such plan. Such a contract with an organization may cover more than 1 Medicare Choice plan. Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

''(b) MINIMUM ENROLLMENT REQUIREMENTS.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary may not enter into a contract under this section with a Medicare Choice organization unless the organization has at least 1,500 individuals who are receiving health benefits through the organization (500 such individuals if the organization primarily serves individuals residing outside of urbanized areas).

''(2) ALLOWING TRANSITION.—The Secretary may waive the requirement of paragraph (1) during the first 2 contract years with respect to an organization.

''(3) SPECIAL RULE FOR PSO.—In the case of a Medicare Choice organization which is a provider-sponsored organization, paragraph (1) shall be applied by taking into account individuals for whom the organization has assumed substantial financial risk.

''(c) CONTRACT PERIOD AND EFFECTIVENESS.—

''(1) PERIOD.—Each contract under this section shall be for a term of at least 1 year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

''(2) TERMINATION AUTHORITY.—In accordance with procedures established under subsection (h), the Secretary may at any time terminate any such contract, or may impose the intermediate sanctions described in an applicable paragraph of subsection (g)(3) on the Medicare Choice organization, if the Secretary determines that the organization—

''(A) has failed substantially to carry out the contract;

''(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part; or

''(C) no longer substantially meets the applicable conditions of this part.

''(3) EFFECTIVE DATE OF CONTRACTS.—The effective date of any contract executed pursuant to this section shall be specified in the contract.

''(4) PREVIOUS TERMINATIONS.—The Secretary may not enter into a contract with a Medicare Choice organization if a previous contract with that organization under this section was terminated at the request of the organization within the preceding 5-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

''(5) NO CONTRACTING AUTHORITY.—The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

''(d) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—

''(1) INSPECTION AND AUDIT.—Each contract under this section shall provide that the Secretary, or any person or organization designated by the Secretary—

''(A) shall have the right to inspect or otherwise evaluate (i) the quality, appropriateness, and timeliness of services performed under the contract and (ii) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

''(B) shall have the right to audit and inspect any books and records of the Medicare Choice organization that pertain (i) to the ability of the organization to bear the risk of potential financial losses, or (ii) to services performed or determinations of amounts payable under the contract.

''(2) ENROLLEE NOTICE AT TIME OF TERMINATION.—Each contract under this section shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled with the organization under this part.

''(3) DISCLOSURE.—

''(A) IN GENERAL.—Each Medicare Choice organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

''(i) Such information as the Secretary may require demonstrating that the organization has a fiscally sound operation.

''(ii) A copy of the report, if any, filed with the Health Care Financing Administration containing the information required to be reported under section 1124 by disclosing entities.

''(iii) A description of transactions, as specified by the Secretary, between the organization and a party in interest. Such transactions shall include—

''(I) any sale or exchange, or leasing of any property between the organization and a party in interest;

''(II) any furnishing for consideration of goods, services (including management services), or facilities between the organization and a party in interest, but not including salaries paid to employees for services provided in the normal course of their employment and health services provided to members by hospitals and other providers and by staff, medical group (or groups), individual practice association (or associations), or any combination thereof; and

''(III) any lending of money or other extension of credit between an organization and a party in interest.

The Secretary may require that information reported respecting an organization which controls, is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

''(B) PARTY IN INTEREST DEFINED.—For the purposes of this paragraph, the term 'party in interest' means—

''(i) any director, officer, partner, or employee responsible for management or administration of a Medicare Choice organization, any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 percent of the organization, and, in the case of a Medicare Choice organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

''(ii) any entity in which a person described in clause (i)—

''(I) is an officer or director;

''(II) is a partner (if such entity is organized as a partnership);

''(III) has directly or indirectly a beneficial interest of more than 5 percent of the equity; or

''(IV) has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of such entity;

''(iii) any person directly or indirectly controlling, controlled by, or under common control with an organization; and

''(iv) any spouse, child, or parent of an individual described in clause (i).

''(C) ACCESS TO INFORMATION.—Each Medicare Choice organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

''(4) LOAN INFORMATION.—The contract shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties.

''(e) ADDITIONAL CONTRACT TERMS.—

''(1) IN GENERAL.—The contract shall contain such other terms and conditions not inconsistent with this part (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

''(2) COST-SHARING IN ENROLLMENT-RELATED COSTS.—The contract with a Medicare Choice organization shall require the payment to the Secretary for the organization's pro rata share (as determined by the Secretary) of the estimated costs to be incurred by the Secretary in carrying out section 1851 (relating to enrollment and dissemination of information). Such payments are appropriated to defray the costs described in the preceding sentence, to remain available until expended.

''(3) NOTICE TO ENROLLEES IN CASE OF DECERTIFICATION.—If a contract with a Medicare Choice organization is terminated under this section, the organization shall notify each enrollee with the organization under this part of such termination.

''(f) PROMPT PAYMENT BY MEDICARE CHOICE ORGANIZATION.—

''(1) REQUIREMENT.—A contract under this part shall require a Medicare Choice organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2)

and 1842(c)(2)) of claims submitted for services and supplies furnished to individuals pursuant to the contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

''(2) SECRETARY'S OPTION TO BYPASS NONCOMPLYING ORGANIZATION.—In the case of a Medicare Choice eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with paragraph (1), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for covered services and supplies furnished to individuals enrolled under this part under the contract. If the Secretary provides for the direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this part to reflect the amount of the Secretary's payments (and the Secretary's costs in making the payments).

''(g) INTERMEDIATE SANCTIONS.—

''(1) IN GENERAL.—If the Secretary determines that a Medicare Choice organization with a contract under this section—

''(A) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

''(B) imposes net monthly premiums on individuals enrolled under this part in excess of the net monthly premiums permitted;

''(C) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this part;

''(D) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this part) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

''(E) misrepresents or falsifies information that is furnished—

''(i) to the Secretary under this part, or

''(ii) to an individual or to any other entity under this part;

''(F) fails to comply with the requirements of section 1852(j)(3); or

''(G) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services; the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2).

''(2) REMEDIES.—The remedies described in this paragraph are—

''(A) civil money penalties of not more than $25,000 for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than $100,000 for each such determination, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), $15,000 for each individual not enrolled as a result of the practice involved,

''(B) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

''(C) suspension of payment to the organization under this part for individuals enrolled after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

''(3) OTHER INTERMEDIATE SANCTIONS.—In the case of a Medicare Choice organization for which the Secretary makes a determination under subsection (c)(2) the basis of which is not described in paragraph (1), the Secretary may apply the following intermediate sanctions:

''(A) Civil money penalties of not more than $25,000 for each determination under subsection (c)(2) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

''(B) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under subsection (g) during which the deficiency that is the basis of a determination under subsection (c)(2) exists.

''(C) Suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under subsection (c)(2) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

''(4) CIVIL MONEY PENALTIES.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subsection (f) or under paragraph (2) or (3) of this subsection in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

''(h) PROCEDURES FOR TERMINATION.—

''(1) IN GENERAL.—The Secretary may terminate a contract with a Medicare Choice organization under this section in accordance with formal investigation and compliance procedures established by the Secretary under which—

''(A) the Secretary provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under subsection (c)(2);

''(B) the Secretary shall impose more severe sanctions on an organization that has a history of deficiencies or that has not taken steps to correct deficiencies the Secretary has brought to the organization's attention;

''(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

''(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

''(2) EXCEPTION FOR IMMINENT AND SERIOUS RISK TO HEALTH.—Paragraph (1) shall not apply if the Secretary determines that a delay in termination, resulting from compliance with the procedures specified in such paragraph prior to termination, would pose an imminent and serious risk to the health of individuals enrolled under this part with the organization.

''DEFINITIONS; MISCELLANEOUS PROVISIONS

''SEC. 1859. (a) DEFINITIONS RELATING TO MEDICARE CHOICE ORGANIZATIONS.—In this part—

''(1) MEDICARE CHOICE ORGANIZATION.—The term 'Medicare Choice organization' means a public or private entity that is certified under section 1856 as meeting the requirements and standards of this part for such an organization.

''(2) PROVIDER-SPONSORED ORGANIZATION.—The term 'provider-sponsored organization' is defined in section 1855(e)(1).

''(b) DEFINITIONS RELATING TO MEDICARE CHOICE PLANS.—

''(1) MEDICARE CHOICE PLAN.—The term 'Medicare Choice plan' means health benefits coverage offered under a policy, contract, or plan by a Medicare Choice organization pursuant to and in accordance with a contract under section 1857.

''(2) MEDICARE CHOICE UNRESTRICTED FEE-FOR-SERVICE PLAN.—The term 'Medicare Choice unrestricted fee-for-service plan' means a Medicare Choice plan that provides for coverage of benefits without restrictions relating to utilization and without regard to whether the provider has a contract or other arrangement with the organization offering the plan for the provision of such benefits.

''(c) OTHER REFERENCES TO OTHER TERMS.—

''(1) MEDICARE CHOICE ELIGIBLE INDIVIDUAL.—The term 'Medicare Choice eligible individual' is defined in section 1851(a)(3).

''(2) MEDICARE CHOICE PAYMENT AREA.—The term 'Medicare Choice payment area' is defined in section 1853(d).

''(3) NATIONAL AVERAGE PER CAPITA GROWTH PERCENTAGE.—The 'national average per capita growth percentage' is defined in section 1853(c)(6).

''(4) MONTHLY PREMIUM; NET MONTHLY PREMIUM.—The terms 'monthly premium' and 'net monthly premium' are defined in section 1854(a)(2).

''(d) COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER A MEDICARE CHOICE PLAN.—Nothing in this part shall be construed as preventing a State from coordinating benefits under a medicaid plan under title XIX with those provided under a Medicare Choice plan in a manner that assures continuity of a full-range of acute care and long-term care services to poor elderly or disabled individuals eligible for benefits under this title and under such plan.

''(e) RESTRICTION ON ENROLLMENT FOR CERTAIN MEDICARE CHOICE PLANS.—

''(1) IN GENERAL.—In the case of a Medicare Choice religious fraternal benefit society plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the society offering the plan may restrict the enrollment of individuals under this part to individuals who are members of the church, convention, or group described in paragraph (3)(B) with which the society is affiliated.

''(2) MEDICARE CHOICE RELIGIOUS FRATERNAL BENEFIT SOCIETY PLAN DESCRIBED.—For purposes of this subsection, a Medicare Choice religious fraternal benefit society plan described in this paragraph is a Medicare Choice plan described in section 1851(a)(2)(A) that—

''(A) is offered by a religious fraternal benefit society described in paragraph (3) only to members of the church, convention, or group described in paragraph (3)(B); and

''(B) permits all such members to enroll under the plan without regard to health status-related factors.

Nothing in this subsection shall be construed as waiving any plan requirements relating to financial solvency. In developing solvency standards under section 1856, the Secretary shall take into account open contract and assessment features characteristic of fraternal insurance certificates.

''(3) RELIGIOUS FRATERNAL BENEFIT SOCIETY DEFINED.—For purposes of paragraph (2)(A), a 'religious fraternal benefit society' described in this section is an organization that—

''(A) is exempt from Federal income taxation under section 501(c)(8) of the Internal Revenue Code of 1986;

''(B) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches;

''(C) offers, in addition to a Medicare Choice religious fraternal benefit society plan, at least the same level of health coverage to individuals not entitled to benefits under this title who are members of such church, convention, or group; and

''(D) does not impose any limitation on membership in the society based on any health status-related factor.

''(4) PAYMENT ADJUSTMENT.—Under regulations of the Secretary, in the case of individuals enrolled under this part under a Medicare Choice religious fraternal benefit society plan described in paragraph (2), the Secretary shall provide for such adjustment to the payment amounts otherwise established under section 1854 as may be appropriate to assure an appropriate payment level, taking into account the actuarial characteristics and experience of such individuals.''.

SEC. 5002. TRANSITIONAL RULES FOR CURRENT MEDICARE HMO PROGRAM.

(a) AUTHORIZING TRANSITIONAL WAIVER OF 50:50 RULE.—Section 1876(f) (42 U.S.C. 1395mm(f)) is amended—

(1) in paragraph (1)—

(A) by striking ''Each'' and inserting ''For contract periods beginning before January 1, 1999, each''; and

(B) by striking ''or under a State plan approved under title XIX'';

(2) in paragraph (2), by striking ''The Secretary'' and inserting ''Subject to paragraph (4), the Secretary'', and

(3) by adding at the end the following:

''(4) The Secretary may waive the requirement imposed by paragraph (1) if the Secretary determines that the plan meets all other beneficiary protections and quality standards under this section.''.

(b) TRANSITION.—Section 1876 (42 U.S.C. 1395mm) is amended by adding at the end the following new subsection:

''(k)(1) Except as provided in paragraph (2) or (3), the Secretary shall not enter into, renew, or continue any risk-sharing contract under this section with an eligible organization for any contract year beginning on or after—

''(A) the date standards for Medicare Choice organizations and plans are first established under section 1856 with respect to Medicare Choice organizations that are insurers or health maintenance organizations, or

''(B) in the case of such an organization with such a contract in effect as of the date such standards were first established, 1 year after such date.

''(2) The Secretary shall not enter into, renew, or continue any risk-sharing contract under this section with an eligible organization for any contract year beginning on or after January 1, 2000.

''(3) An individual who is enrolled in part B only and is enrolled in an eligible organization with a risk-sharing contract under this section on December 31, 1998, may continue enrollment in such organization in accordance with regulations issued by not later than July 1, 1998.

''(4) Notwithstanding subsection (a), the Secretary shall provide that payment amounts under risk-sharing contracts under this section for months in a year (beginning with January 1998) shall be computed—

''(A) with respect to individuals entitled to benefits under both parts A and B, by substituting payment rates under section 1853(a) for the payment rates otherwise established under section 1876(a), and

''(B) with respect to individuals only entitled to benefits under part B, by substituting an appropriate proportion of such rates (reflecting the relative proportion of payments under this title attributable to such part) for the payment rates otherwise established under subsection (a).

For purposes of carrying out this paragraph for payments for months in 1998, the Secretary shall compute, announce, and apply the payment rates under section 1853(a) (notwithstanding any deadlines specified in such section) in as timely a manner as possible and may (to the extent necessary) provide for retroactive adjustment in payments made under this section not in accordance with such rates.''.

(c) ENROLLMENT TRANSITION RULE.—An individual who is enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm) shall be considered to be enrolled with that organization on January 1, 1999, under part C of title XVIII of such Act if that organization has a contract under that part for providing services on January 1, 1999 (unless the individual has disenrolled effective on that date).

(d) ADVANCE DIRECTIVES.—Section 1866(f) (42 U.S.C. 1395cc(f)) is amended—

(1) in paragraph (1)—

(A) by inserting ''1855(i),'' after ''1833(s),'', and

(B) by inserting '', Medicare Choice organization,'' after ''provider of services''; and

(2) in paragraph (2)(E), by inserting ''or a Medicare Choice organization'' after ''section 1833(a)(1)(A)''.

(e) EXTENSION OF PROVIDER REQUIREMENT.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended—

(1) by striking ''in the case of hospitals and skilled nursing facilities,'';

(2) by striking ''inpatient hospital and extended care'';

(3) by inserting ''with a Medicare Choice organization under part C or'' after ''any individual enrolled''; and

(4) by striking ''(in the case of hospitals) or limits (in the case of skilled nursing facilities)''.

(f) ADDITIONAL CONFORMING CHANGES.—

(1) CONFORMING REFERENCES TO PREVIOUS PART C.—Any reference in law (in effect before the date of the enactment of this Act) to part C of title XVIII of the Social Security Act is deemed a reference to part D of such title (as in effect after such date).

(2) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this chapter.

(g) IMMEDIATE EFFECTIVE DATE FOR CERTAIN REQUIREMENTS FOR DEMONSTRATIONS.—Section 1857(e)(2) of the Social Security Act (requiring contribution to certain costs related to the enrollment process comparative materials) applies to demonstrations with respect to which enrollment is effected or coordinated under section 1851 of such Act.

(h) USE OF INTERIM, FINAL REGULATIONS.—In order to carry out the amendments made by this chapter in a timely manner, the Secretary of Health and Human Services may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

(i) TRANSITION RULE FOR PSO ENROLLMENT.—In applying subsection (g)(1) of section 1876 of the Social Security Act (42 U.S.C. 1395mm) to a risk-sharing contract entered into with an eligible organization that is a provider-sponsored organization (as defined in section 1855(e)(1) of such Act, as inserted by section 5001) for a contract year beginning on or after January 1, 1998, there shall be substituted for the minimum number of enrollees provided under such section the minimum number of enrollees permitted under section 1857(b)(1) of such Act (as so inserted).

SEC. 5003. CONFORMING CHANGES IN MEDIGAP PROGRAM.

(a) CONFORMING AMENDMENTS TO MEDICARE CHOICE CHANGES.—Section 1882(d)(3)(A)(i) (42 U.S.C. 1395ss(d)(3)(A)(i)) is amended—

(1) in the matter before subclause (I), by inserting ''(including an individual electing a Medicare Choice plan under section 1851)'' after ''of this title''; and

(2) in subclause (II)—

(A) by inserting ''in the case of an individual not electing a Medicare Choice plan'' after ''(II)'', and

(B) by inserting before the comma at the end the following: ''or in the case of an individual electing a Medicare Choice plan, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under the Medicare Choice plan or under another medicare supplemental policy''.

(b) CONFORMING AMENDMENTS.—Section 1882(d)(3)(B)(i)(I) (42 U.S.C. 1395ss(d)(3)(B)(i)(I)) is amended by inserting ''(including any Medicare Choice plan)'' after ''health insurance policies''.

(c) MEDICARE CHOICE PLANS NOT TREATED AS MEDICARE SUPPLEMENTARY POLICIES.—Section 1882(g)(1) (42 U.S.C. 1395ss(g)(1)) is amended by inserting ''or a Medicare Choice plan or'' after ''does not include''

CHAPTER 2—INTEGRATED LONG-TERM CARE PROGRAMS

Subchapter A—Programs of All-Inclusive Care for the Elderly (PACE)

SEC. 5011. COVERAGE OF PACE UNDER THE MEDICARE PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''PAYMENTS TO, AND COVERAGE OF BENEFITS UNDER, PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

''SEC. 1894. (a) RECEIPT OF BENEFITS THROUGH ENROLLMENT IN PACE PROGRAM; DEFINITIONS FOR PACE PROGRAM RELATED TERMS.—

''(1) BENEFITS THROUGH ENROLLMENT IN A PACE PROGRAM.—In accordance with this section, in the case of an individual who is entitled to benefits under part A or enrolled under part B and who is a PACE program eligible individual (as defined in paragraph (5)) with respect to a PACE program offered by a PACE provider under a PACE program agreement—

''(A) the individual may enroll in the program under this section; and

''(B) so long as the individual is so enrolled and in accordance with regulations—

''(i) the individual shall receive benefits under this title solely through such program; and

''(ii) the PACE provider is entitled to payment under and in accordance with this section and such agreement for provision of such benefits.

''(2) PACE PROGRAM DEFINED.—For purposes of this section and section 1932, the term 'PACE program' means a program of all-inclusive care for the elderly that meets the following requirements:

''(A) OPERATION.—The entity operating the program is a PACE provider (as defined in paragraph (3)).

''(B) COMPREHENSIVE BENEFITS.—The program provides comprehensive health care

services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

''(C) TRANSITION.—In the case of an individual who is enrolled under the program under this section and whose enrollment ceases for any reason (including that the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or otherwise), the program provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.

''(3) PACE PROVIDER DEFINED.—

''(A) IN GENERAL.—For purposes of this section, the term 'PACE provider' means an entity that—

''(i) subject to subparagraph (B), is (or is a distinct part of) a public entity or a private, nonprofit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986; and

''(ii) has entered into a PACE program agreement with respect to its operation of a PACE program.

''(B) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.—Clause (i) of subparagraph (A) shall not apply—

''(i) to entities subject to a demonstration project waiver under subsection (h); and

''(ii) after the date the report under section 5013(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C), or (D) of paragraph (2) of such section are true.

''(4) PACE PROGRAM AGREEMENT DEFINED.—For purposes of this section, the term 'PACE program agreement' means, with respect to a PACE provider, an agreement, consistent with this section, section 1932 (if applicable), and regulations promulgated to carry out such sections, between the PACE provider and the Secretary, or an agreement between the PACE provider and a State administering agency for the operation of a PACE program by the provider under such sections.

''(5) PACE PROGRAM ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term 'PACE program eligible individual' means, with respect to a PACE program, an individual who—

''(A) is 55 years of age or older;

''(B) subject to subsection (c)(4), is determined under subsection (c) to require the level of care required under the State medicaid plan for coverage of nursing facility services;

''(C) resides in the service area of the PACE program; and

''(D) meets such other eligibility conditions as may be imposed under the PACE program agreement for the program under subsection (e)(2)(A)(ii).

''(6) PACE PROTOCOL.—For purposes of this section, the term 'PACE protocol' means the Protocol for the Program of All-inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995, or any successor protocol that may be agreed upon between the Secretary and On Lok, Inc.

''(7) PACE DEMONSTRATION WAIVER PROGRAM DEFINED.—For purposes of this section, the term 'PACE demonstration waiver program' means a demonstration program under either of the following sections (as in effect before the date of their repeal):

''(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21), as extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

''(B) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

''(8) STATE ADMINISTERING AGENCY DEFINED.—For purposes of this section, the term 'State administering agency' means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under title XIX in the State) responsible for administering PACE program agreements under this section and section 1932 in the State.

''(9) TRIAL PERIOD DEFINED.—

''(A) IN GENERAL.—For purposes of this section, the term 'trial period' means, with respect to a PACE program operated by a PACE provider under a PACE program agreement, the first 3 contract years under such agreement with respect to such program.

''(B) TREATMENT OF ENTITIES PREVIOUSLY OPERATING PACE DEMONSTRATION WAIVER PROGRAMS.—Each contract year (including a year occurring before the effective date of this section) during which an entity has operated a PACE demonstration waiver program shall be counted under subparagraph (A) as a contract year during which the entity operated a PACE program as a PACE provider under a PACE program agreement.

''(10) REGULATIONS.—For purposes of this section, the term 'regulations' refers to interim final or final regulations promulgated under subsection (f) to carry out this section and section 1932.

''(b) SCOPE OF BENEFITS; BENEFICIARY SAFEGUARDS.—

''(1) IN GENERAL.—Under a PACE program agreement, a PACE provider shall—

''(A) provide to PACE program eligible individuals, regardless of source of payment and directly or under contracts with other entities, at a minimum—

''(i) all items and services covered under this title (for individuals enrolled under this section) and all items and services covered under title XIX, but without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost-sharing that would otherwise apply under this title or such title, respectively; and

''(ii) all additional items and services specified in regulations, based upon those required under the PACE protocol;

''(B) provide such enrollees access to necessary covered items and services 24 hours per day, every day of the year;

''(C) provide services to such enrollees through a comprehensive, multidisciplinary health and social services delivery system which integrates acute and long-term care services pursuant to regulations; and

''(D) specify the covered items and services that will not be provided directly by the entity, and to arrange for delivery of those items and services through contracts meeting the requirements of regulations.

''(2) QUALITY ASSURANCE; PATIENT SAFEGUARDS.—The PACE program agreement shall require the PACE provider to have in effect at a minimum—

''(A) a written plan of quality assurance and improvement, and procedures implementing such plan, in accordance with regulations; and

''(B) written safeguards of the rights of enrolled participants (including a patient bill of rights and procedures for grievances and appeals) in accordance with regulations and with other requirements of this title and Federal and State law that are designed for the protection of patients.

''(c) ELIGIBILITY DETERMINATIONS.—

''(1) IN GENERAL.—The determination of whether an individual is a PACE program eligible individual—

''(A) shall be made under and in accordance with the PACE program agreement; and

''(B) who is entitled to medical assistance under title XIX, shall be made (or who is not so entitled, may be made) by the State administering agency.

''(2) CONDITION.—An individual is not a PACE program eligible individual (with respect to payment under this section) unless the individual's health status has been determined by the Secretary or the State administering agency, in accordance with regulations, to be comparable to the health status of individuals who have participated in the PACE demonstration waiver programs. Such determination shall be based upon information on health status and related indicators (such as medical diagnoses and measures of activities of daily living, instrumental activities of daily living, and cognitive impairment) that are part of a uniform minimum data set collected by PACE providers on potential eligible individuals.

''(3) ANNUAL ELIGIBILITY RECERTIFICATIONS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the determination described in subsection (a)(5)(B) for an individual shall be reevaluated at least annually.

''(B) EXCEPTION.—The requirement of annual reevaluation under subparagraph (A) may be waived during a period in accordance with regulations in those cases where the State administering agency determines that there is no reasonable expectation of improvement or significant change in an individual's condition during the period because of the advanced age, severity of the advanced age, severity of chronic condition, or degree of impairment of functional capacity of the individual involved.

''(4) CONTINUATION OF ELIGIBILITY.—An individual who is a PACE program eligible individual may be deemed to continue to be such an individual notwithstanding a determination that the individual no longer meets the requirement of subsection (a)(5)(B) if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6-month period.

''(5) ENROLLMENT; DISENROLLMENT.—The enrollment and disenrollment of PACE program eligible individuals in a PACE program shall be pursuant to regulations and the PACE program agreement and shall permit enrollees to voluntarily disenroll without cause at any time. Such regulations and agreement shall provide that the PACE program may not disenroll a PACE program eligible individual on the ground that the individual has engaged in noncompliant behavior if such behavior is related to a mental or physical condition of the individual. For purposes of the preceding sentence, the term 'noncompliant behavior' includes repeated noncompliance with medical advice and repeated failure to appear for appointments.

''(d) PAYMENTS TO PACE PROVIDERS ON A CAPITATED BASIS.—

''(1) IN GENERAL.—In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the Secretary shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section in the same manner and from the same sources as payments are made to an eligible organization under a risk-sharing contract under section 1876. Such payments shall be subject to adjustment in the manner described in section 1876(a)(1)(E).

''(2) CAPITATION AMOUNT.—The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be based upon payment rates established under section 1876 for risk-sharing contracts

and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. Such amount under such an agreement shall be computed in a manner so that the total payment level for all PACE program eligible individuals enrolled under a program is less than the projected payment under this title for a comparable population not enrolled under a PACE program.

''(e) PACE PROGRAM AGREEMENT.—

''(1) REQUIREMENT.—

''(A) IN GENERAL.—The Secretary, in close cooperation with the State administering agency, shall establish procedures for entering into, extending, and terminating PACE program agreements for the operation of PACE programs by entities that meet the requirements for a PACE provider under this section, section 1932, and regulations.

''(B) NUMERICAL LIMITATION.—

''(i) IN GENERAL.—The Secretary shall not permit the number of PACE providers with which agreements are in effect under this section or under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 to exceed—

''(I) 40 as of the date of the enactment of this section; or

''(II) as of each succeeding anniversary of such date, the numerical limitation under this subparagraph for the preceding year plus 20.

Subclause (II) shall apply without regard to the actual number of agreements in effect as of a previous anniversary date.

''(ii) TREATMENT OF CERTAIN PRIVATE, FOR-PROFIT PROVIDERS.—The numerical limitation in clause (i) shall not apply to a PACE provider that—

''(I) is operating under a demonstration project waiver under subsection (h); or

''(II) was operating under such a waiver and subsequently qualifies for PACE provider status pursuant to subsection (a)(3)(B)(ii).

''(2) SERVICE AREA AND ELIGIBILITY.—

''(A) IN GENERAL.—A PACE program agreement for a PACE program—

''(i) shall designate the service area of the program;

''(ii) may provide additional requirements for individuals to qualify as PACE program eligible individuals with respect to the program;

''(iii) shall be effective for a contract year, but may be extended for additional contract years in the absence of a notice by a party to terminate and is subject to termination by the Secretary and the State administering agency at any time for cause (as provided under the agreement);

''(iv) shall require a PACE provider to meet all applicable State and local laws and requirements; and

''(v) shall have such additional terms and conditions as the parties may agree to, provided that such terms and conditions are consistent with this section and regulations.

''(B) SERVICE AREA OVERLAP.—In designating a service area under a PACE program agreement under subparagraph (A)(i), the Secretary (in consultation with the State administering agency) may exclude from designation an area that is already covered under another PACE program agreement, in order to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program.

''(3) DATA COLLECTION; DEVELOPMENT OF OUTCOME MEASURES.—

''(A) DATA COLLECTION.—

''(i) IN GENERAL.—Under a PACE program agreement, the PACE provider shall—

''(I) collect data;

''(II) maintain, and afford the Secretary and the State administering agency access to, the records relating to the program, including pertinent financial, medical, and personnel records; and

''(III) make to the Secretary and the State administering agency reports that the Secretary finds (in consultation with State administering agencies) necessary to monitor the operation, cost, and effectiveness of the PACE program under this Act.

''(ii) REQUIREMENTS DURING TRIAL PERIOD.—During the first 3 years of operation of a PACE program (either under this section or under a PACE demonstration waiver program), the PACE provider shall provide such additional data as the Secretary specifies in regulations in order to perform the oversight required under paragraph (4)(A).

''(B) DEVELOPMENT OF OUTCOME MEASURES.—Under a PACE program agreement, the PACE provider, the Secretary, and the State administering agency shall jointly cooperate in the development and implementation of health status and quality of life outcome measures with respect to PACE program eligible individuals.

''(4) OVERSIGHT.—

''(A) ANNUAL, CLOSE OVERSIGHT DURING TRIAL PERIOD.—During the trial period (as defined in subsection (a)(9)) with respect to a PACE program operated by a PACE provider, the Secretary (in cooperation with the State administering agency) shall conduct a comprehensive annual review of the operation of the PACE program by the provider in order to assure compliance with the requirements of this section and regulations. Such a review shall include—

''(i) an on-site visit to the program site;

''(ii) comprehensive assessment of a provider's fiscal soundness;

''(iii) comprehensive assessment of the provider's capacity to provide all PACE services to all enrolled participants;

''(iv) detailed analysis of the entity's substantial compliance with all significant requirements of this section and regulations; and

''(v) any other elements the Secretary or State agency considers necessary or appropriate.

''(B) CONTINUING OVERSIGHT.—After the trial period, the Secretary (in cooperation with the State administering agency) shall continue to conduct such review of the operation of PACE providers and PACE programs as may be appropriate, taking into account the performance level of a provider and compliance of a provider with all significant requirements of this section and regulations.

''(C) DISCLOSURE.—The results of reviews under this paragraph shall be reported promptly to the PACE provider, along with any recommendations for changes to the provider's program, and shall be made available to the public upon request.

''(5) TERMINATION OF PACE PROVIDER AGREEMENTS.—

''(A) IN GENERAL.—Under regulations—

''(i) the Secretary or a State administering agency may terminate a PACE program agreement for cause; and

''(ii) a PACE provider may terminate an agreement after appropriate notice to the Secretary, the State agency, and enrollees.

''(B) CAUSES FOR TERMINATION.—In accordance with regulations establishing procedures for termination of PACE program agreements, the Secretary or a State administering agency may terminate a PACE program agreement with a PACE provider for, among other reasons, the fact that—

''(i) the Secretary or State administering agency determines that—

''(I) there are significant deficiencies in the quality of care provided to enrolled participants; or

''(II) the provider has failed to comply substantially with conditions for a program or provider under this section or section 1932; and

''(ii) the entity has failed to develop and successfully initiate, within 30 days of the receipt of written notice of such a determination, a plan to correct the deficiencies, or has failed to continue implementation of such a plan.

''(C) TERMINATION AND TRANSITION PROCEDURES.—An entity whose PACE provider agreement is terminated under this paragraph shall implement the transition procedures required under subsection (a)(2)(C).

''(6) SECRETARY'S OVERSIGHT; ENFORCEMENT AUTHORITY.—

''(A) IN GENERAL.—Under regulations, if the Secretary determines (after consultation with the State administering agency) that a PACE provider is failing substantially to comply with the requirements of this section and regulations, the Secretary (and the State administering agency) may take any or all of the following actions:

''(i) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

''(ii) Withhold some or all further payments under the PACE program agreement under this section or section 1932 with respect to PACE program services furnished by such provider until the deficiencies have been corrected.

''(iii) Terminate such agreement.

''(B) APPLICATION OF INTERMEDIATE SANCTIONS.—Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in section 1876(i)(6)(B) or 1903(m)(5)(B) in the case of violations by the provider of the type described in section 1876(i)(6)(A) or 1903(m)(5)(A), respectively (in relation to agreements, enrollees, and requirements under this section or section 1932, respectively).

''(7) PROCEDURES FOR TERMINATION OR IMPOSITION OF SANCTIONS.—Under regulations, the provisions of section 1876(i)(9) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and an eligible organization under section 1876.

''(8) TIMELY CONSIDERATION OF APPLICATIONS FOR PACE PROGRAM PROVIDER STATUS.—In considering an application for PACE provider program status, the application shall be deemed approved unless the Secretary, within 90 days after the date of the submission of the application to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information that is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

''(f) REGULATIONS.—

''(1) IN GENERAL.—The Secretary shall issue interim final or final regulations to carry out this section and section 1932.

''(2) USE OF PACE PROTOCOL.—

''(A) IN GENERAL.—In issuing such regulations, the Secretary shall, to the extent consistent with the provisions of this section, incorporate the requirements applied to PACE demonstration waiver programs under the PACE protocol.

''(B) FLEXIBILITY.—In order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use nonstaff physicians according to State licensing law requirements) under this section and section 1932, the Secretary

(in close consultation with State administering agencies) may modify or waive provisions of the PACE protocol so long as any such modification or waiver is not inconsistent with and would not impair the essential elements, objectives, and requirements of this section, but may not modify or waive any of the following provisions:

''(i) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

''(ii) The delivery of comprehensive, integrated acute and long-term care services.

''(iii) The interdisciplinary team approach to care management and service delivery.

''(iv) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

''(v) The assumption by the provider of full financial risk.

''(3) APPLICATION OF CERTAIN ADDITIONAL BENEFICIARY AND PROGRAM PROTECTIONS.—

''(A) IN GENERAL.—In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of sections 1876 and 1903(m) relating to protection of beneficiaries and program integrity as would apply to eligible organizations under risk-sharing contracts under section 1876 and to health maintenance organizations under prepaid capitation agreements under section 1903(m).

''(B) CONSIDERATIONS.—In issuing such regulations, the Secretary shall—

''(i) take into account the differences between populations served and benefits provided under this section and under sections 1876 and 1903(m);

''(ii) not include any requirement that conflicts with carrying out PACE programs under this section; and

''(iii) not include any requirement restricting the proportion of enrollees who are eligible for benefits under this title or title XIX.

''(g) WAIVERS OF REQUIREMENTS.—With respect to carrying out a PACE program under this section, the following requirements of this title (and regulations relating to such requirements) are waived and shall not apply:

''(1) Section 1812, insofar as it limits coverage of institutional services.

''(2) Sections 1813, 1814, 1833, and 1886, insofar as such sections relate to rules for payment for benefits.

''(3) Sections 1814(a)(2)(B), 1814(a)(2)(C), and 1835(a)(2)(A), insofar as they limit coverage of extended care services or home health services.

''(4) Section 1861(i), insofar as it imposes a 3-day prior hospitalization requirement for coverage of extended care services.

''(5) Paragraphs (1) and (9) of section 1862(a), insofar as they may prevent payment for PACE program services to individuals enrolled under PACE programs.

''(h) DEMONSTRATION PROJECT FOR FOR-PROFIT ENTITIES.—

''(1) IN GENERAL.—In order to demonstrate the operation of a PACE program by a private, for-profit entity, the Secretary (in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) that a PACE provider may not be a for-profit, private entity.

''(2) SIMILAR TERMS AND CONDITIONS.—

''(A) IN GENERAL.—Except as provided under subparagraph (B), and paragraph (1), the terms and conditions for operation of a PACE program by a provider under this subsection shall be the same as those for PACE providers that are nonprofit, private organizations.

''(B) NUMERICAL LIMITATION.—The number of programs for which waivers are granted under this subsection shall not exceed 10. Programs with waivers granted under this subsection shall not be counted against the numerical limitation specified in subsection (e)(1)(B).

''(i) MISCELLANEOUS PROVISIONS.—Nothing in this section or section 1932 shall be construed as preventing a PACE provider from entering into contracts with other governmental or nongovernmental payers for the care of PACE program eligible individuals who are not eligible for benefits under part A, or enrolled under part B, or eligible for medical assistance under title XIX.''.

SEC. 5012. EFFECTIVE DATE; TRANSITION.

(a) TIMELY ISSUANCE OF REGULATIONS; EFFECTIVE DATE.—The Secretary of Health and Human Services shall promulgate regulations to carry out this subtitle in a timely manner. Such regulations shall be designed so that entities may establish and operate PACE programs under sections 1894 and 1932 of the Social Security Act (as added by sections 5011 and 5751 of this Act) for periods beginning not later than 1 year after the date of the enactment of this Act.

(b) EXPANSION AND TRANSITION FOR PACE DEMONSTRATION PROJECT WAIVERS.—

(1) EXPANSION IN CURRENT NUMBER OF DEMONSTRATION PROJECTS.—Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 4118(g) of the Omnibus Budget Reconciliation Act of 1987, is amended—

(A) in paragraph (1), by inserting before the period at the end the following: '', except that the Secretary shall grant waivers of such requirements up to the applicable numerical limitation specified in section 1894(e)(1)(B) of the Social Security Act''; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking '', including permitting the organization to assume progressively (over the initial 3-year period of the waiver) the full financial risk''; and

(ii) in subparagraph (C), by adding at the end the following: ''In granting further extensions, an organization shall not be required to provide for reporting of information which is only required because of the demonstration nature of the project.''.

(2) ELIMINATION OF REPLICATION REQUIREMENT.—Subparagraph (B) of paragraph (2) of such section shall not apply to waivers granted under such section after the date of the enactment of this Act.

(3) TIMELY CONSIDERATION OF APPLICATIONS.—In considering an application for waivers under such section before the effective date of repeals made under subsection (d), subject to the numerical limitation under the amendment made by paragraph (1), the application shall be deemed approved unless the Secretary of Health and Human Services, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information which is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

(c) PRIORITY AND SPECIAL CONSIDERATION IN APPLICATION.—During the 3-year period beginning on the date of enactment of this Act:

(1) PROVIDER STATUS.—The Secretary of Health and Human Services shall give priority, in processing applications of entities to qualify as PACE programs under section 1894 or 1932 of the Social Security Act—

(A) first, to entities that are operating a PACE demonstration waiver program (as defined in section 1894(a)(7) of such Act); and

(B) then entities that have applied to operate such a program as of May 1, 1997.

(2) NEW WAIVERS.—The Secretary shall give priority, in the awarding of additional waivers under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986—

(A) to any entities that have applied for such waivers under such section as of May 1, 1997; and

(B) to any entity that, as of May 1, 1997, has formally contracted with a State to provide services for which payment is made on a capitated basis with an understanding that the entity was seeking to become a PACE provider.

(3) SPECIAL CONSIDERATION.—The Secretary shall give special consideration, in the processing of applications described in paragraph (1) and the awarding of waivers described in paragraph (2), to an entity which as of May 1, 1997 through formal activities (such as entering into contracts for feasibility studies) has indicated a specific intent to become a PACE provider.

(d) REPEAL OF CURRENT PACE DEMONSTRATION PROJECT WAIVER AUTHORITY.—

(1) IN GENERAL.—Subject to paragraph (2), the following provisions of law are repealed:

(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21).

(B) Section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

(C) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

(2) DELAY IN APPLICATION.—

(A) IN GENERAL.—Subject to subparagraph (B), the repeals made by paragraph (1) shall not apply to waivers granted before the initial effective date of regulations described in subsection (a).

(B) APPLICATION TO APPROVED WAIVERS.—Such repeals shall apply to waivers granted before such date only after allowing such organizations a transition period (of up to 24 months) in order to permit sufficient time for an orderly transition from demonstration project authority to general authority provided under the amendments made by this subtitle.

SEC. 5013. STUDY AND REPORTS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in close consultation with State administering agencies, as defined in section 1894(a)(8) of the Social Security Act) shall conduct a study of the quality and cost of providing PACE program services under the medicare and medicaid programs under the amendments made by this subtitle.

(2) STUDY OF PRIVATE, FOR-PROFIT PROVIDERS.—Such study shall specifically compare the costs, quality, and access to services by entities that are private, for-profit entities operating under demonstration projects waivers granted under section 1894(h) of the Social Security Act with the costs, quality, and access to services of other PACE providers.

(b) REPORT.—

(1) IN GENERAL.—Not later than 4 years after the date of enactment of this Act, the Secretary shall provide for a report to Congress on the impact of such amendments on quality and cost of services. The Secretary shall include in such report such recommendations for changes in the operation of such amendments as the Secretary deems appropriate.

(2) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.—The report shall include specific findings on whether any of the following findings is true:

(A) The number of covered lives enrolled with entities operating under demonstration

project waivers under section 1894(h) of the Social Security Act is fewer than 800 (or such lesser number as the Secretary may find statistically sufficient to make determinations respecting findings described in the succeeding subparagraphs).

(B) The population enrolled with such entities is less frail than the population enrolled with other PACE providers.

(C) Access to or quality of care for individuals enrolled with such entities is lower than such access or quality for individuals enrolled with other PACE providers.

(D) The application of such section has resulted in an increase in expenditures under the medicare or medicaid programs above the expenditures that would have been made if such section did not apply.

(c) INFORMATION INCLUDED IN ANNUAL RECOMMENDATIONS.—The Physician Payment Review Commission shall include in its annual recommendations under section 1845(b) of the Social Security Act (42 U.S.C. 1395w–1), and the Prospective Payment Review Commission shall include in its annual recommendations reported under section 1886(e)(3)(A) of such Act (42 U.S.C. 1395ww(e)(3)(A)), recommendations on the methodology and level of payments made to PACE providers under section 1894(d) of such Act and on the treatment of private, for-profit entities as PACE providers. References in the preceding sentence to the Physician Payment Review Commission and the Prospective Payment Review Commission shall be deemed to be references to the Medicare Payment Advisory Commission (MedPAC) established under section 5022(a) after the termination of the Physician Payment Review Commission and the Prospective Payment Review Commission provided for in section 5022(c)(2).

Subchapter B—Social Health Maintenance Organizations

SEC. 5015. SOCIAL HEALTH MAINTENANCE ORGANIZATIONS (SHMOS).

(a) EXTENSION OF DEMONSTRATION PROJECT AUTHORITIES.—Section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 is amended—

(1) in paragraph (1), by striking ''1997'' and inserting ''2000'', and

(2) in paragraph (4), by striking ''1998'' and inserting ''2001''.

(b) EXPANSION OF CAP.—Section 13567(c) of the Omnibus Budget Reconciliation Act of 1993 is amended by striking ''12,000'' and inserting ''36,000''.

(c) REPORT ON INTEGRATION AND TRANSITION.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall submit to Congress, by not later than January 1, 1999, a plan for the integration of health plans offered by social health maintenance organizations (including SHMO I and SHMO II sites developed under section 2355 of the Deficit Reduction Act of 1984 and under the amendment made by section 4207(b)(3)(B)(i) of OBRA–1990, respectively) and similar plans as an option under the Medicare Choice program under part C of title XVIII of the Social Security Act.

(2) PROVISION FOR TRANSITION.—Such plan shall include a transition for social health maintenance organizations operating under demonstration project authority under such section.

(3) PAYMENT POLICY.—The report shall also include recommendations on appropriate payment levels for plans offered by such organizations, including an analysis of the application of risk adjustment factors appropriate to the population served by such organizations.

Subchapter C—Other Programs

SEC. 5018. EXTENSION OF CERTAIN MEDICARE COMMUNITY NURSING ORGANIZATION DEMONSTRATION PROJECTS.

Notwithstanding any other provision of law, demonstration projects conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987 may be conducted for an additional period of 2 years, and the deadline for any report required relating to the results of such projects shall be not later than 6 months before the end of such additional period.

CHAPTER 3—COMMISSIONS

SEC. 5021. NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE.

(a) ESTABLISHMENT.—There is established a commission to be known as the National Bipartisan Commission on the Future of Medicare (in this section referred to as the ''Commission'').

(b) FINDINGS.—Congress finds that—

(1) the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) provides essential health care coverage to this Nation's senior citizens and to individuals with disabilities;

(2) the Federal Hospital Insurance Trust Fund established under that Act has been spending more than it receives since 1995, and will be bankrupt in the year 2001;

(3) the Federal Hospital Insurance Trust Fund faces even greater solvency problems in the long run with the aging of the baby boom generation and the continuing decline in the number of workers paying into the medicare program for each medicare beneficiary;

(4) the trustees of the trust funds of the medicare program have reported that growth in spending within the Federal Supplementary Medical Insurance Trust Fund established under that Act is unsustainable; and

(5) expeditious action is needed in order to restore the financial integrity of the medicare program and to maintain this Nation's commitment to senior citizens and to individuals with disabilities.

(c) DUTIES OF THE COMMISSION.—The Commission shall—

(1) review and analyze the long-term financial condition of the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.);

(2) identify problems that threaten the financial integrity of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under that title (42 U.S.C. 1395i, 1395t);

(3) analyze potential solutions to the problems identified under paragraph (2) that will ensure both the financial integrity of the medicare program and the provision of appropriate benefits under such program, including the extent to which current medicare update indexes do not accurately reflect inflation;

(4) make recommendations to restore the solvency of the Federal Hospital Insurance Trust Fund and the financial integrity of the Federal Supplementary Medical Insurance Trust Fund through the year 2030, when the last of the baby boomers reaches age 65;

(5) make recommendations for establishing the appropriate financial structure of the medicare program as a whole;

(6) make recommendations for establishing the appropriate balance of benefits covered and beneficiary contributions to the medicare program;

(7) make recommendations for the time periods during which the recommendations described in paragraphs (4), (5), and (6) should be implemented;

(8) make recommendations regarding the financing of graduate medical education (GME), including consideration of alternative broad-based sources of funding for such education and funding for institutions not currently eligible for such GME support under the medicare program that conduct approved graduate medical residency programs, such as children's hospitals;

(9) make recommendations on the feasibility of allowing individuals between the age of 62 and the medicare eligibility age to buy into the medicare program;

(10) make recommendations on the impact of chronic disease and disability trends on future costs and quality of services under the current benefit, financing, and delivery system structure of the medicare program; and

(11) review and analyze such other matters as the Commission deems appropriate.

(d) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members, of whom—

(A) three shall be appointed by the President;

(B) six shall be appointed by the Majority Leader of the Senate, in consultation with the Minority Leader of the Senate, of whom not more than 4 shall be of the same political party; and

(C) six shall be appointed by the Speaker of the House of Representatives, in consultation with the Minority Leader of the House of Representatives, of whom not more than 4 shall be of the same political party.

(2) COMPTROLLER GENERAL.—The Comptroller General of the United States shall advise the Commission on the methodology to be used in identifying problems and analyzing potential solutions in accordance with the duties of the Commission described in subsection (c).

(3) TERMS OF APPOINTMENT.—The members shall serve on the Commission for the life of the Commission.

(4) MEETINGS.—The Commission shall locate its headquarters in the District of Columbia, and shall meet at the call of the Chairperson.

(5) QUORUM.—Ten members of the Commission shall constitute a quorum, but a lesser number may hold hearings.

(6) CHAIRPERSON.—The Speaker of the House of Representatives, in consultation with the Majority Leader of the Senate, shall designate 1 of the members appointed under paragraph (1) as Chairperson of the Commission.

(7) VACANCIES.—A vacancy on the Commission shall be filled in the same manner in which the original appointment was made not later than 30 days after the Commission is given notice of the vacancy.

(8) COMPENSATION.—Members of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission.

(9) EXPENSES.—Each member of the Commission shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(e) STAFF AND SUPPORT SERVICES.—

(1) EXECUTIVE DIRECTOR.—

(A) APPOINTMENT.—The Chairperson shall appoint an executive director of the Commission.

(B) COMPENSATION.—The executive director shall be paid the rate of basic pay for level V of the Executive Schedule.

(2) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director considers appropriate.

(3) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and

shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

(4) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(5) STAFF OF FEDERAL AGENCIES.—Upon the request of the Commission, the head of any Federal agency may detail any of the personnel of such agency to the Commission to assist in carrying out the duties of the Commission.

(6) OTHER RESOURCES.—The Commission shall have reasonable access to materials, resources, statistical data, and other information from the Library of Congress and agencies and elected representatives of the executive and legislative branches of the Federal Government. The Chairperson of the Commission shall make requests for such access in writing when necessary.

(7) PHYSICAL FACILITIES.—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

(f) POWERS OF COMMISSION.—

(1) HEARINGS.—The Commission may conduct public hearings or forums at the discretion of the Commission, at any time and place the Commission is able to secure facilities and witnesses, for the purpose of carrying out the duties of the Commission.

(2) GIFTS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(3) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as other Federal agencies.

(g) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Commission shall submit a report to the President and Congress which shall contain a detailed statement of the recommendations, findings, and conclusions of the Commission.

(h) TERMINATION.—The Commission shall terminate on the date which is 30 days after the date the Commission submits its report to the President and to Congress under subsection (g).

(i) FUNDING.—There is authorized to be appropriated to the Commission such sums as are necessary to carry out the purposes of this section. Sums appropriated under this subsection shall be paid equally from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t).

SEC. 5022. MEDICARE PAYMENT ADVISORY COMMISSION.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1804 the following new section:

''MEDICARE PAYMENT ADVISORY COMMISSION

''SEC. 1805. (a) ESTABLISHMENT.—There is hereby established the Medicare Payment Advisory Commission (in this section referred to as the 'Commission').

''(b) DUTIES.—

''(1) REVIEW OF PAYMENT POLICIES AND ANNUAL REPORTS.—The Commission shall—

''(A) review payment policies under this title, including the topics described in paragraph (2);

''(B) make recommendations to Congress concerning such payment policies;

''(C) by not later than March 1 of each year (beginning with 1998), submit a report to Congress containing the results of such reviews and its recommendations concerning such policies; and

''(D) by not later than June 1 of each year (beginning with 1998), submit a report to Congress containing an examination of issues affecting the medicare program, including the implications of changes in health care delivery in the United States and in the market for health care services on the medicare program.

''(2) SPECIFIC TOPICS TO BE REVIEWED.—

''(A) MEDICARE CHOICE PROGRAM.—Specifically, the Commission shall review, with respect to the Medicare Choice program under part C, the following:

''(i) The methodology for making payment to plans under such program, including the making of differential payments and the distribution of differential updates among different payment areas.

''(ii) The mechanisms used to adjust payments for risk and the need to adjust such mechanisms to take into account health status of beneficiaries.

''(iii) The implications of risk selection both among Medicare Choice organizations and between the Medicare Choice option and the traditional medicare fee-for-service option.

''(iv) The development and implementation of mechanisms to assure the quality of care for those enrolled with Medicare Choice organizations.

''(v) The impact of the Medicare Choice program on access to care for medicare beneficiaries.

''(vi) Other major issues in implementation and further development of the Medicare Choice program.

''(B) TRADITIONAL MEDICARE FEE-FOR-SERVICE SYSTEM.—Specifically, the Commission shall review payment policies under parts A and B, including—

''(i) the factors affecting expenditures for services in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees,

''(ii) payment methodologies, and

''(iii) their relationship to access and quality of care for medicare beneficiaries.

''(C) INTERACTION OF MEDICARE PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—Specifically, the Commission shall review the effect of payment policies under this title on the delivery of health care services other than under this title and assess the implications of changes in health care delivery in the United States and in the general market for health care services on the medicare program.

''(3) COMMENTS ON CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to payment policies under this title, the Secretary shall transmit a copy of the report to the Commission. The Commission shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Commission deems appropriate.

''(4) AGENDA AND ADDITIONAL REVIEWS.—The Commission shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding the Commission's agenda and progress towards achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title as may be requested by such chairmen and members and as the Commission deems appropriate.

''(5) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

''(6) APPROPRIATE COMMITTEES OF CONGRESS.—For purposes of this section, the term 'appropriate committees of Congress' means the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate.

''(c) MEMBERSHIP.—

''(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members appointed by the Comptroller General.

''(2) QUALIFICATIONS.—

''(A) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(B) INCLUSION.—The membership of the Commission shall include (but not be limited to) physicians and other health professionals, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

''(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under this title shall not constitute a majority of the membership of the Commission.

''(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

''(3) TERMS.—

''(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

''(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

''(4) COMPENSATION.—While serving on the business of the Commission (including traveltime), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee

Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

''(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment.

''(6) MEETINGS.—The Commission shall meet at the call of the Chairman.

''(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General deems necessary to assure the efficient administration of the Commission, the Commission may—

''(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(4) make advance, progress, and other payments which relate to the work of the Commission;

''(5) provide transportation and subsistence for persons serving without compensation; and

''(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

''(e) POWERS.—

''(1) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

''(2) DATA COLLECTION.—In order to carry out its functions, the Commission shall—

''(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

''(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and

''(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

''(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data of the Commission, immediately upon request.

''(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General.

''(f) AUTHORIZATION OF APPROPRIATIONS.—

''(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

''(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Sixty percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.''.

(b) ABOLITION OF PROPAC AND PPRC.—

(1) PROPAC.—

(A) IN GENERAL.—Section 1886(e) (42 U.S.C. 1395ww(e)) is amended—

(i) by striking paragraphs (2) and (6); and

(ii) in paragraph (3), by striking ''(A) The Commission'' and all that follows through ''(B)''.

(B) CONFORMING AMENDMENT.—Section 1862 (42 U.S.C. 1395y) is amended by striking ''Prospective Payment Assessment Commission'' each place it appears in subsection (a)(1)(D) and subsection (i) and inserting ''Medicare Payment Advisory Commission''.

(2) PPRC.—

(A) IN GENERAL.—Title XVIII is amended by striking section 1845 (42 U.S.C. 1395w–1).

(B) ELIMINATION OF CERTAIN REPORTS.—Section 1848 (42 U.S.C. 1395w–4) is amended—

(i) by striking subparagraph (F) of subsection (d)(2),

(ii) by striking subparagraph (B) of subsection (f)(1), and

(iii) in subsection (f)(3), by striking ''Physician Payment Review Commission,''.

(C) CONFORMING AMENDMENTS.—Section 1848 (42 U.S.C. 1395w–4) is amended by striking ''Physician Payment Review Commission'' and inserting ''Medicare Payment Advisory Commission'' each place it appears in subsections (c)(2)(B)(iii), (g)(6)(C), and (g)(7)(C).

(c) EFFECTIVE DATE; TRANSITION.—

(1) IN GENERAL.—The Comptroller General shall first provide for appointment of members to the Medicare Payment Advisory Commission (in this subsection referred to as ''MedPAC'') by not later than September 30, 1997.

(2) TRANSITION.—As quickly as possible after the date a majority of members of MedPAC are first appointed, the Comptroller General, in consultation with the Prospective Payment Assessment Commission (in this subsection referred to as ''ProPAC'') and the Physician Payment Review Commission (in this subsection referred to as ''PPRC''), shall provide for the termination of the ProPAC and the PPRC. As of the date of termination of the respective Commissions, the amendments made by paragraphs (1) and (2), respectively, of subsection (b) become effective. The Comptroller General, to the extent feasible, shall provide for the transfer to the MedPAC of assets and staff of the ProPAC and the PPRC, without any loss of benefits or seniority by virtue of such transfers. Fund balances available to the ProPAC or the PPRC for any period shall be available to the MedPAC for such period for like purposes.

(3) CONTINUING RESPONSIBILITY FOR REPORTS.—The MedPAC shall be responsible for the preparation and submission of reports required by law to be submitted (and which have not been submitted by the date of establishment of the MedPAC) by the ProPAC and the PPRC, and, for this purpose, any reference in law to either such Commission is deemed, after the appointment of the MedPAC, to refer to the MedPAC.

CHAPTER 4—MEDIGAP PROTECTIONS

SEC. 5031. MEDIGAP PROTECTIONS.

(a) GUARANTEEING ISSUE WITHOUT PRE-EXISTING CONDITIONS FOR CONTINUOUSLY COVERED INDIVIDUALS.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(1) in paragraph (3), by striking ''paragraphs (1) and (2)'' and inserting ''this subsection'',

(2) by redesignating paragraph (3) as paragraph (4), and

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

''(3)(A) The issuer of a medicare supplemental policy—

''(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (C) that is offered and is available for issuance to new enrollees by such issuer;

''(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

''(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such subparagraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

''(B) An individual described in this subparagraph is an individual described in any of the following clauses:

''(i) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under this title and the plan terminates or ceases to provide all such supplemental health benefits to the individual.

''(ii) The individual is enrolled with a Medicare Choice organization under a Medicare Choice plan under part C, and there are circumstances permitting discontinuance of the individual's election of the plan under section 1851(e)(4).

''(iii) The individual is enrolled with an eligible organization under a contract under section 1876, a similar organization operating under demonstration project authority, with an organization under an agreement under section 1833(a)(1)(A), or with an organization under a policy described in subsection (t), and such enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under section 1851(c)(4) and, in the case of a policy described in subsection (t), there is no provision under applicable State law for the continuation of coverage under such policy.

''(iv) The individual is enrolled under a medicare supplemental policy under this section and such enrollment ceases because—

''(I) of the bankruptcy or insolvency of the issuer or because of other involuntary termination of coverage or enrollment under such policy and there is no provision under applicable State law for the continuation of such coverage;

''(II) the issuer of the policy substantially violated a material provision of the policy; or

''(III) the issuer (or an agent or other entity acting on the issuer's behalf) materially misrepresented the policy's provisions in marketing the policy to the individual.

''(v) The individual—

''(I) was enrolled under a medicare supplemental policy under this section,

''(II) subsequently terminates such enrollment and enrolls, for the first time, with any Medicare Choice organization under a Medicare Choice plan under part C, any eligible organization under a contract under section 1876, any similar organization operating under demonstration project authority, any organization under an agreement under section 1833(a)(1)(A), or any policy described in subsection (t), and

''(III) the subsequent enrollment under subclause (II) is terminated by the enrollee during the first 12 months of such enrollment.

''(vi) The individual, upon first becoming eligible for medicare at age 65, enrolls in a

Medicare Choice plan and within 12 months of such enrollment, disenrolls from such plan.

''(C)(i) Subject to clauses (ii), a medicare supplemental policy described in this subparagraph is a policy the benefits under which are comparable or lessor in relation to the benefits under the plan, policy, or contract described in the applicable clause of subparagraph (B).

''(ii) Only for purposes of an individual described in subparagraph (B)(vi), a medicare supplemental policy described in this subparagraph shall include any medicare supplemental policy.

''(D) At the time of an event described in subparagraph (B) because of which an individual ceases enrollment or loses coverage or benefits under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, the insurer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the rights of the individual, and obligations of issuers of medicare supplemental policies, under subparagraph (A).''.

(b) LIMITATION ON IMPOSITION OF PREEXISTING CONDITION EXCLUSION DURING INITIAL OPEN ENROLLMENT PERIOD.—Section 1882(s)(2) (42 U.S.C. 1395ss(s)(2)) is amended—

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

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

''(D) In the case of a policy issued during the 6-month period described in subparagraph (A) to an individual who is 65 years of age or older as of the date of issuance and who as of the date of the application for enrollment has a continuous period of creditable coverage (as defined in section 2701(c) of the Public Health Service Act) of—

''(i) at least 6 months, the policy may not exclude benefits based on a pre-existing condition; or

''(ii) less than 6 months, if the policy excludes benefits based on a preexisting condition, the policy shall reduce the period of any preexisting condition exclusion by the aggregate of the periods of creditable coverage (if any, as so defined) applicable to the individual as of the enrollment date.

The Secretary shall specify the manner of the reduction under clause (ii), based upon the rules used by the Secretary in carrying out section 2701(a)(3) of such Act.''.

(c) EXTENDING 6-MONTH INITIAL ENROLLMENT PERIOD TO NON-ELDERLY MEDICARE BENEFICIARIES.—Section 1882(s)(2)(A)(ii) of (42 U.S.C. 1395ss(s)(2)(A)) is amended by striking ''is submitted'' and all that follows and inserting the following: ''is submitted—

''(I) before the end of the 6-month period beginning with the first month as of the first day on which the individual is 65 years of age or older and is enrolled for benefits under part B; and

''(II) at the time the individual first becomes eligible for benefits under part A pursuant to section 226(b) and is enrolled for benefits under part B, before the end of the 6-month period beginning with the first month as of the first day on which the individual is so eligible and so enrolled.''.

(d) EFFECTIVE DATES.—

(1) GUARANTEED ISSUE.—The amendment made by subsection (a) shall take effect on July 1, 1998.

(2) LIMIT ON PREEXISTING CONDITION EXCLUSIONS.—The amendment made by subsection (b) shall apply to policies issued on or after July 1, 1998.

(3) NON-ELDERLY MEDICARE BENEFICIARIES.—The amendment made by subsection (c) shall apply to policies issued on or after July 1, 1998.

(e) TRANSITION PROVISIONS.—

(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section, the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act due solely to failure to make such change until the date specified in paragraph (4).

(2) NAIC STANDARDS.—If, within 9 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (in this subsection referred to as the ''NAIC'') modifies its NAIC Model regulation relating to section 1882 of the Social Security Act (referred to in such section as the 1991 NAIC Model Regulation, as modified pursuant to section 171(m)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432) and as modified pursuant to section 1882(d)(3)(A)(vi)(IV) of the Social Security Act, as added by section 271(a) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191) to conform to the amendments made by this section, such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate Regulation for the purposes of such section.

(4) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or

(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section, but

(ii) having a legislature which is not scheduled to meet in 1999 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after July 1, 1999. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 5032. ADDITION OF HIGH DEDUCTIBLE MEDIGAP POLICY.

(a) IN GENERAL.—Section 1882(p) (42 U.S.C. 1395ss(p)) is amended by adding at the end the following:

''(11)(A) On and after the date specified in subparagraph (C)—

''(i) each State with an approved regulatory program, and

''(ii) in the case of a State without an approved regulatory program, the Secretary,

shall, in addition to the 10 policies allowed under paragraph (2)(C), allow at least 1 other policy described in subparagraph (B).

''(B)(i) A policy is described in this subparagraph if it consists of—

''(I) one of the 10 benefit packages described in paragraph (2)(C), and

''(II) a high deductible feature.

''(ii) For purposes of clause (i), a high deductible feature is one which requires the beneficiary of the policy to pay annual out-of-pocket expenses (other than premiums) of $1,500 before the policy begins payment of benefits.

''(C)(i) Subject to clause (ii), the date described in this subparagraph is one year after the date of the enactment of this paragraph.

''(ii) In the case of a State which the Secretary identifies as—

''(I) requiring State legislation (other than legislation appropriating funds) in order to meet the requirements of this paragraph, but

''(II) having a legislature which is not scheduled to meet in 1997 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1998. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.''.

(b) CONFORMING AMENDMENT.—Section 1882(p)(2)(C) (42 U.S.C. 1395ss(p)(2)(C)) is amended by inserting ''or (11)'' after ''paragraph (4)(B)''.

CHAPTER 5—DEMONSTRATIONS

Subchapter A—Medicare Choice Competitive Pricing Demonstration Project

SEC. 5041. MEDICARE CHOICE COMPETITIVE PRICING DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services (in this subchapter referred to as the ''Secretary'') shall, beginning January 1, 1999, conduct demonstration projects in applicable areas (in this section referred to as the ''project'') for the purpose of—

(1) applying a pricing methodology for payments to Medicare Choice organizations under part C of title XVIII of the Social Security Act (as amended by section 5001 of this Act) that uses the competitive market approach described in section 5042;

(2) applying a benefit structure and beneficiary premium structure described in section 5043; and

(3) evaluating the effects of the methodology and structures described in the preceding paragraphs on medicare fee-for-service spending under parts A and B of the Social Security Act in the project area.

(b) APPLICABLE AREA DEFINED.—

(1) IN GENERAL.—In subsection (a), the term ''applicable area'' means, as determined by the Secretary—

(A) 10 urban areas with respect to which less than 25 percent of medicare beneficiaries are enrolled with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm); and

(B) 3 rural areas not described in paragraph (1).

(2) TREATMENT AS MEDICARE CHOICE PAYMENT AREA.—For purposes of this subchapter and part C of title XVIII of the Social Security Act, any applicable area shall be treated as a Medicare Choice payment area (hereinafter referred to as the ''applicable Medicare Choice payment area'').

(c) TECHNICAL ADVISORY GROUP.—Upon the selection of an area for inclusion in the project, the Secretary shall appoint a technical advisory group, composed of representatives of Medicare Choice organizations,

medicare beneficiaries, employers, and other persons in the area affected by the project who have technical expertise relative to the design and implementation of the project to advise the Secretary concerning how the project will be implemented in the area.

(d) EVALUATION.—

(1) IN GENERAL.—Not later than December 31, 2001, the Secretary shall submit to the President a report regarding the demonstration projects conducted under this section.

(2) CONTENTS OF REPORT.—The report described in paragraph (1) shall include the following:

(A) A description of the demonstration projects conducted under this section.

(B) An evaluation of the effectiveness of the demonstration projects conducted under this section and any legislative recommendations determined appropriate by the Secretary.

(C) Any other information regarding the demonstration projects conducted under this section that the Secretary determines to be appropriate.

(D) An evaluation as to whether the method of payment under section 5042 which was used in the demonstration projects for payment to Medicare Choice plans should be extended to the entire medicare population and if such evaluation determines that such method should not be extended, legislative recommendations to modify such method so that it may be applied to the entire medicare population.

(3) SUBMISSION TO CONGRESS.—The President shall submit the report under paragraph (2) to the Congress and if the President determines appropriate, any legislative recommendations for extending the project to the entire medicare population.

(e) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of titles XI, XVIII, and XIX of the Social Security Act (42 U.S.C. 1301 et seq., 1395 et seq., 1396 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

SEC. 5042. DETERMINATION OF ANNUAL MEDICARE CHOICE CAPITATION RATES.

(a) IN GENERAL.—In the case of an applicable Medicare Choice payment area within which a project is being conducted under section 5041, the annual Medicare Choice capitation rate under part C of title XVIII of the Social Security Act for Medicare Choice plans within such area shall be the standardized payment amount determined under this section rather than the amount determined under section 1853 of such Act.

(b) DETERMINATION OF STANDARDIZED PAYMENT AMOUNT.—

(1) SUBMISSION AND CHARGING OF PREMIUMS.—

(A) IN GENERAL.—Not later than June 1 of each calendar year, each Medicare Choice organization offering one or more Medicare Choice plans in an applicable Medicare Choice payment area shall file with the Secretary, in a form and manner and at a time specified by the Secretary, a bid which contains the amount of the monthly premium for coverage under each such Medicare Choice plan.

(B) UNIFORM PREMIUM.—The premiums charged by a Medicare Choice plan sponsor under this part may not vary among individuals who reside in the same applicable Medicare Choice payment area.

(C) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each Medicare Choice organization shall permit the payment of premiums on a monthly basis.

(2) ANNOUNCEMENT OF STANDARDIZED PAYMENT AMOUNT.—

(A) AUTHORITY TO NEGOTIATE.—After bids are submitted under paragraph (1), the Secretary may negotiate with Medicare Choice organizations in order to modify such bids if the Secretary determined that the bids do not provide enough revenues to ensure the plan's actuarial soundness, are too high relative to the applicable Medicare Choice payment area, foster adverse selection, or otherwise require renegotiation under this paragraph.

(B) IN GENERAL.—Not later than July 31 of each calendar year (beginning with 1998), the Secretary shall determine, and announce in a manner intended to provide notice to interested parties, a standardized payment amount determined in accordance with this paragraph for the following calendar year for each applicable Medicare Choice payment area.

(3) CALCULATION OF PAYMENT AMOUNTS.—

(A) IN GENERAL.—The standardized payment amount for a calendar year after 1998 for any applicable Medicare Choice payment area shall be equal to the maximum premium determined for such area under subparagraph (B).

(B) MAXIMUM PREMIUM.—The maximum premium for any applicable Medicare Choice payment area shall be equal to the amount determined under subparagraph (C) for the payment area, but in no case shall such amount be greater than the sum of—

(i) the average per capita amount, as determined by the Secretary as appropriate for the population eligible to enroll in Medicare Choice plans in such payment area, for such calendar year that the Secretary would have expended for an individual in such payment area enrolled under the medicare fee-for-service program under parts A and B, plus

(ii) the amount equal to the actuarial value of deductibles, coinsurance, and copayments charged an individual for services provided under the medicare fee-for-service program (as determined by the Secretary).

(C) DETERMINATION OF AMOUNT.—

(i) IN GENERAL.—The Secretary shall determine for each applicable Medicare Choice payment area for each calendar year an amount equal to the average of the bids (weighted based on capacity) submitted to the Secretary under paragraph (1)(A) for that payment area.

(ii) DISREGARD CERTAIN PLANS.—In determining the amount under clause (i), the Secretary may disregard any plan that the Secretary determines would unreasonably distort the amount determined under such subparagraph.

(4) ADJUSTMENTS FOR PAYMENTS TO PLAN SPONSORS.—

(A) IN GENERAL.—For purposes of determining the amount of payment under part C of title XVIII of the Social Security Act to a Medicare Choice organization with respect to any Medicare Choice eligible individual enrolled in a Medicare Choice plan of the sponsor, the standardized payment amount for the applicable Medicare Choice payment area and the premium charged by the plan sponsor shall be adjusted with respect to such individual for such risk factors as age, disability status, gender, institutional status, health status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

(B) RECOMMENDATIONS.—

(i) IN GENERAL.—In addition to any other duties required by law, the Physician Payment Review Commission and the Prospective Payment Assessment Commission (or their successors) shall each develop recommendations on—

(I) the risk factors that the Secretary should use in adjusting the standardized payment amount and premium under subparagraph (A), and

(II) the methodology that the Secretary should use in determining the risk factors to be used in adjusting the standardized payment amount and premium under subparagraph (A).

(ii) TIME.—The recommendations described in clause (i) shall be developed not later than January 1, 1999.

(iii) ANNUAL REPORT.—The Physician Payment Review Commission and the Prospective Payment Assessment Commission (or their successors) shall include the recommendations described in clause (i) in their respective annual reports to Congress.

(c) PAYMENTS TO PLAN SPONSORS.—

(1) MONTHLY PAYMENTS.—

(A) IN GENERAL.—Subject to paragraph (4), for each individual enrolled with a plan under this subchapter, the Secretary shall make monthly payments in advance to the Medicare Choice organization of the Medicare Choice plan with which the individual is enrolled in an amount equal to 1/12 of the amount determined under paragraph (2).

(B) RETROACTIVE ADJUSTMENTS.—The amount of payment under this paragraph may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

(2) AMOUNT OF PAYMENT TO MEDICARE CHOICE PLANS.—The amount determined under this paragraph with respect to any individual shall be equal to the sum of—

(A) the lesser of—

(i) the standardized payment amount for the applicable Medicare Choice payment area, as adjusted for such individual under subsection (a)(4), or

(ii) the premium charged by the plan for such individual, as adjusted for such individual under section (a)(4), minus

(B) the amount such individual paid to the plan pursuant to section 5043 (relating to 10 percent of the premium).

(3) PAYMENTS FROM TRUST FUNDS.—The payment to a Medicare Choice organization or to a Medicare Choice account under this section for a medicare-eligible individual shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under parts A and B are representative of the actuarial value of the total benefits under this part.

(4) LIMITATION ON AMOUNTS AN OUT-OF-PLAN PHYSICIAN OR OTHER ENTITY MAY COLLECT.—A physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this subchapter with a Medicare Choice organization shall accept as payment in full for services that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a Medicare Choice organization under this part) also applies with respect to an individual so enrolled.

(d) OFFICE OF COMPETITION.—

(1) ESTABLISHMENT.—There is established within the Department of Health and Human Services an office to be known as the 'Office of Competition'.

(2) DIRECTOR.—The Secretary shall appoint the Director of the Office of Competition.

(3) DUTIES.—

(A) IN GENERAL.—The Director shall administer this subchapter and so much of part C of title XVIII of the Social Security Act as relates to this subchapter.

(B) TRANSFER AUTHORITY.—The Secretary shall transfer such personnel, administrative support systems, assets, records, funds, and other resources in the Health Care Financing Administration to the Office of Competition as are used in the administration of section 1876 and as may be required to implement the provisions of this part promptly and efficiently.

(4) USE OF NON-FEDERAL ENTITIES.—The Secretary shall, to the maximum extent feasible, enter into contracts with appropriate non-Federal entities to carry out activities under this subchapter.

SEC. 5043. BENEFITS AND BENEFICIARY PREMIUMS.

(a) BENEFITS PROVIDED TO INDIVIDUALS.—

(1) BASIC BENEFIT PLAN.—Each Medicare Choice plan in an applicable Medicare Choice payment area shall provide to members enrolled under this subchapter, through providers and other persons that meet the applicable requirements of title XVIII of the Social Security Act and part A of title XI of such Act—

(A) those items and services covered under parts A and B of title XVIII of such Act which are available to individuals residing in such area, subject to nominal copayments as determined by the Secretary,

(B) prescription drugs, subject to such limits as established by the Secretary, and

(C) additional health services as the Secretary may approve.

(2) SUPPLEMENTAL BENEFITS.—

(A) IN GENERAL.—Each Medicare Choice plan may offer any of the optional supplemental benefit plans described in subparagraph (B) to an individual enrolled in the basic benefit plan offered by such organization under this subchapter for an additional premium amount. If the supplemental benefits are offered only to individuals enrolled in the sponsor's plan under this subchapter, the additional premium amount shall be the same for all enrolled individuals in the applicable Medicare Choice payment area. Such benefits may be marketed and sold by the Medicare Choice organization outside of the enrollment process described in part C of title XVIII of the Social Security Act.

(B) OPTIONAL SUPPLEMENTAL BENEFIT PLANS DESCRIBED.—The Secretary shall provide for 2 optional supplemental benefit plans. Such plans shall include such standardized items and services that the Secretary determines must be provided to enrollees of such plans described in order to offer the plans to Medicare Choice eligible individuals.

(C) LIMITATION.—A Medicare Choice organization may not offer an optional benefit plan to a Medicare Choice eligible individual unless such individual is enrolled in a basic benefit plan offered by such organization.

(D) LIMITATION ON PREMIUM.—If a Medicare Choice organization provides to individuals enrolled in a Medicare Choice plan supplemental benefits described in subparagraph (A), the sum of—

(i) the annual premiums for such benefits, plus

(ii) the actuarial value of any deductibles, coinsurance, and copayments charged with respect to such benefits for the year,

shall not exceed the amount that would have been charged for a plan in the applicable Medicare Choice payment area which is not a Medicare Choice plan (adjusted in such manner as the Secretary may prescribe to reflect that only medicare beneficiaries are enrolled in such plan). The Secretary shall negotiate the limitation under this subparagraph with each plan to which this paragraph applies.

(3) OTHER RULES.—Rules similar to rules of paragraphs (3) and (4) of section 1852 of the Social Security Act (relating to national coverage determinations and secondary payor provisions) shall apply for purposes of this subchapter.

(b) PREMIUM REQUIREMENTS FOR BENEFICIARIES.—

(1) PREMIUM DIFFERENTIALS.—If a Medicare Choice eligible individual enrolls in a Medicare Choice plan under this subchapter, the individual shall be required to pay—

(A) 10 percent of the plan's premium;

(B) if the premium of the plan is higher than the standardized payment amount (as determined under section 5042), 100 percent of such difference; and

(C) an amount equal to cost-sharing under the medicare fee-for-service program, except that such amount shall not exceed the actuarial value of the deductibles and coinsurance under such program less the actual value of nominal copayments for benefits under such plan for basic benefits described in subsection (a)(1).

(2) PART B PREMIUM.—An individual enrolled in a Medicare Choice plan under this subchapter shall not be required to pay the premium amount (determined under section 1839 of the Social Security Act) under part B of title XVIII of such Act for so long as such individual is so enrolled.

Subchapter B—Other Projects

SEC. 5045. MEDICARE ENROLLMENT DEMONSTRATION PROJECT.

(a) DEMONSTRATION PROJECT.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall implement a demonstration project (in this section referred to as the ''project'') for the purpose of evaluating the use of a third-party contractor to conduct the Medicare Choice plan enrollment and disenrollment functions, as described in part C of the Social Security Act (as added by section 5001 of this Act), in an area.

(2) CONSULTATION.—Before implementing the project under this section, the Secretary shall consult with affected parties on—

(A) the design of the project;

(B) the selection criteria for the third-party contractor; and

(C) the establishment of performance standards, as described in paragraph (3).

(3) PERFORMANCE STANDARDS.—

(A) IN GENERAL.—The Secretary shall establish performance standards for the accuracy and timeliness of the Medicare Choice plan enrollment and disenrollment functions performed by the third-party contractor.

(B) NONCOMPLIANCE.—If the Secretary determines that a third-party contractor is out of compliance with the performance standards established under subparagraph (A), such enrollment and disenrollment functions shall be performed by the Medicare Choice plan until the Secretary appoints a new third-party contractor.

(C) DISPUTE.—In the event that there is a dispute between the Secretary and a Medicare Choice plan regarding whether or not the third-party contractor is in compliance with the performance standards, such enrollment and disenrollment functions shall be performed by the Medicare Choice plan.

(b) REPORT TO CONGRESS.—The Secretary shall periodically report to Congress on the progress of the project conducted pursuant to this section.

(c) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of part C of the Social Security Act (as amended by section 5001 of this Act) to such extent and for such period as the Secretary determines is necessary to conduct the project.

(d) DURATION.—A demonstration project under this section shall be conducted for a 3-year period.

(e) SEPARATE FROM OTHER DEMONSTRATION PROJECTS.—A project implemented by the Secretary under this section shall not be conducted in conjunction with any other demonstration project.

SEC. 5046. MEDICARE COORDINATED CARE DEMONSTRATION PROJECT.

(a) DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct demonstration projects for the purpose of evaluating methods, such as case management and other models of coordinated care, that—

(A) improve the quality of items and services provided to target individuals; and

(B) reduce expenditures under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for items and services provided to target individuals.

(2) TARGET INDIVIDUAL DEFINED.—In this section, the term ''target individual'' means an individual that has a chronic illness, as defined and identified by the Secretary, and is enrolled under the fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.).

(b) PROGRAM DESIGN.—

(1) INITIAL DESIGN.—The Secretary shall evaluate best practices in the private sector of methods of coordinated care for a period of 1 year and design the demonstration project based on such evaluation.

(2) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of enactment of this Act, the Secretary shall implement at least 9 demonstration projects, including—

(A) 6 projects in urban areas; and

(B) 3 projects in rural areas.

(3) EXPANSION OF PROJECTS; IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—

(A) EXPANSION OF PROJECTS.—If the initial report under subsection (c) contains an evaluation that demonstration projects—

(i) reduce expenditures under the medicare program; or

(ii) do not increase expenditures under the medicare program and increase the quality of health care services provided to target individuals and satisfaction of beneficiaries and health care providers;

the Secretary shall continue the existing demonstration projects and may expand the number of demonstration projects.

(B) IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—If a report under subsection (c) contains an evaluation as described in subparagraph (A), the Secretary may issue regulations to implement, on a permanent basis, the components of the demonstration project that are beneficial to the medicare program.

(c) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 2 years after the Secretary implements the initial demonstration projects under this section, and biannually thereafter, the Secretary shall submit to Congress a report regarding the demonstration projects conducted under this section.

(2) CONTENTS OF REPORT.—The report in paragraph (1) shall include the following:

(A) A description of the demonstration projects conducted under this section.

(B) An evaluation of—

(i) the cost-effectiveness of the demonstration projects;

(ii) the quality of the health care services provided to target individuals under the demonstration projects; and

(iii) beneficiary and health care provider satisfaction under the demonstration project.

(C) Any other information regarding the demonstration projects conducted under this section that the Secretary determines to be appropriate.

(d) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of titles XI, XVIII, and XIX of the Social Security Act (42 U.S.C. 1301 et seq., 1395 et seq., 1396 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(e) FUNDING.—

(1) DEMONSTRATION PROJECTS.—

(A) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t), in such proportions as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration projects under this section.

(B) LIMITATION.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration projects under this section were not implemented.

(2) EVALUATION AND REPORT.—There are authorized to be appropriated such sums as are necessary for the purpose of developing and submitting the report to Congress under subsection (c).

SEC. 5047. ESTABLISHMENT OF MEDICARE REIMBURSEMENT DEMONSTRATION PROJECTS.

Title XVIII (42 U.S.C. 1395 et seq.) (as amended by section 5343) is amended by adding at the end the following:

''MEDICARE SUBVENTION DEMONSTRATION PROJECT FOR VETERANS

''SEC. 1896. (a) DEFINITIONS.—In this section:

''(1) ADMINISTERING SECRETARIES.—The term 'administering Secretaries' means the Secretary and the Secretary of Veterans Affairs acting jointly.

''(2) DEMONSTRATION PROJECT; PROJECT.—The terms 'demonstration project' and 'project' mean the demonstration project carried out under this section.

''(3) MILITARY RETIREE.—The term 'military retiree' means a member or former member of the Armed Forces who is entitled to retired pay.

''(4) TARGETED MEDICARE-ELIGIBLE VETERAN.—The term 'targeted medicare-eligible veteran' means an individual who—

''(A) is a veteran (as defined in section 101(2) of title 38, United States Code) and is described in section 1710(a)(3) of title 38, United States Code; and

''(B) is entitled to benefits under part A of this title and is enrolled under part B of this title.

''(5) TRUST FUNDS.—The term 'trust funds' means the Federal Hospital Insurance Trust Fund established in section 1817 and the Federal Supplementary Medical Insurance Trust Fund established in section 1841.

''(b) DEMONSTRATION PROJECT.—

''(1) IN GENERAL.—

''(A) ESTABLISHMENT.—The administering Secretaries are authorized to establish a demonstration project (under an agreement entered into by the administering Secretaries) under which the Secretary shall reimburse the Secretary of Veterans Affairs, from the trust funds, for medicare health care services furnished to certain targeted medicare-eligible veterans.

''(B) AGREEMENT.—The agreement entered into under subparagraph (A) shall include at a minimum—

''(i) a description of the benefits to be provided to the participants of the demonstration project established under this section;

''(ii) a description of the eligibility rules for participation in the demonstration project, including any criteria established under subsection (c) and any cost sharing under subsection (d);

''(iii) a description of how the demonstration project will satisfy the requirements under this title;

''(iv) a description of the sites selected under paragraph (2);

''(v) a description of how reimbursement and maintenance of effort requirements under subsection (l) will be implemented in the demonstration project; and

''(vi) a statement that the Secretary shall have access to all data of the Department of Veterans Affairs that the Secretary determines is necessary to conduct independent estimates and audits of the maintenance of effort requirement, the annual reconciliation, and related matters required under the demonstration project.

''(2) NUMBER OF SITES.—The administering Secretaries shall establish a plan for the selection of up to 12 medical centers under the jurisdiction of the Secretary of Veterans Affairs and located in geographically dispersed locations to participate in the project.

''(3) GENERAL CRITERIA.—The selection plan shall favor selection of those medical centers that are suited to serve targeted medicare-eligible individuals because—

''(A) there is a high potential demand by targeted medicare-eligible veterans for their services;

''(B) they have sufficient capability in billing and accounting to participate;

''(C) they have favorable indicators of quality of care, including patient satisfaction;

''(D) they deliver a range of services required by targeted medicare-eligible veterans; and

''(E) they meet other relevant factors identified in the plan.

''(4) MEDICAL CENTER NEAR CLOSED BASE.—The administering Secretaries shall endeavor to include at least 1 medical center that is in the same catchment area as a military medical facility which was closed pursuant to either of the following laws:

''(A) The Defense Base Closure and Realignment Act of 1990.

''(B) Title II of the Defense Authorization Amendments and Base Closure and Realignment Act.

''(5) RESTRICTION.—No new facilities will be built or expanded with funds from the demonstration project.

''(6) DURATION.—The administering Secretaries shall conduct the demonstration project during the 3-year period beginning on January 1, 1998.

''(c) VOLUNTARY PARTICIPATION.—Participation of targeted medicare-eligible veterans in the demonstration project shall be voluntary, subject to the capacity of participating medical centers and the funding limitations specified in subsection (l), and shall be subject to such terms and conditions as the administering Secretaries may establish. In the case of a demonstration project at a medical center described in subsection (b)(3), targeted medicare-eligible veterans who are military retirees shall be given preference in participating in the project.

''(d) COST SHARING.—The Secretary of Veterans Affairs may establish cost-sharing requirements for veterans participating in the demonstration project. If such cost sharing requirements are established, those requirements shall be the same as the requirements that apply to targeted medicare-eligible patients at nongovernmental facilities.

''(e) CREDITING OF PAYMENTS.—A payment received by the Secretary of Veterans Affairs under the demonstration project shall be credited to the applicable Department of Veterans Affairs medical appropriation and (within that appropriation) to funds that have been allotted to the medical center that furnished the services for which the payment is made. Any such payment received during a fiscal year for services provided during a prior fiscal year may be obligated by the Secretary of Veterans Affairs during the fiscal year during which the payment is received.

''(f) AUTHORITY TO WAIVE CERTAIN MEDICARE REQUIREMENTS.—The Secretary may, to the extent necessary to carry out the demonstration project, waive any requirement under this title. If the Secretary waives any such requirement, the Secretary shall include a description of such waiver in the agreement described in subsection (b)(1)(B).

''(g) INSPECTOR GENERAL.—Nothing in the agreement entered into under subsection (b) shall limit the Inspector General of the Department of Health and Human Services from investigating any matters regarding the expenditure of funds under this title for the demonstration project, including compliance with the provisions of this title and all other relevant laws.

''(h) REPORT.—At least 30 days prior to the commencement of the demonstration project, the administering Secretaries shall submit a copy of the agreement entered into under subsection (b) to the committees of jurisdiction in Congress.

''(i) MANAGED HEALTH CARE PLANS.—(1) In carrying out the demonstration project, the Secretary of Veterans Affairs may establish and operate managed health care plans.

''(2) Any such plan shall be operated by or through a Department of Veterans Affairs medical center or group of medical centers and may include the provision of health care services through other facilities under the jurisdiction of the Secretary of Veterans Affairs as well as public and private entities under arrangements made between the Department and the other public or private entity concerned. Any such managed health care plan shall be established and operated in conformance with standards prescribed by the administering Secretaries.

''(3) The administering Secretaries shall prescribe the minimum health care benefits to be provided under such a plan to veterans enrolled in the plan. Those benefits shall include at least all health care services covered under the medicare program under this title.

''(4) The establishment of a managed health care plan under this section shall be counted as the selection of a medical center for purposes of applying the numerical limitation under subsection (b)(1).

''(j) MEDICAL CENTER REQUIREMENTS.—The Secretary of Veterans Affairs may establish a managed health care plan using 1 or more medical centers and other facilities only after the Secretary of Veterans Affairs submits to Congress a report setting forth a plan for the use of such centers and facilities. The plan may not be implemented until the Secretary of Veterans Affairs has received from the Inspector General of the Department of Veterans Affairs, and has forwarded to Congress, certification of each of the following:

''(1) The cost accounting system of the Veterans Health Administration (known as the Decision Support System) is operational and is providing reliable cost information on care delivered on an inpatient and outpatient basis at such centers and facilities.

''(2) The centers and facilities have operated in conformity with the eligibility reform amendments made by title I of the Veterans Health Care Act of 1996 for not less than 3 months.

''(3) The centers and facilities have developed a credible plan (on the basis of market surveys, data from the Decision Support System, actuarial analysis, and other appropriate methods and taking into account the level of payment under subsection (l) and the costs of providing covered services at the centers and facilities) to minimize, to the extent feasible, the risk that appropriated funds allocated to the centers and facilities will be required to meet the centers' and facilities' obligation to targeted medicare-eligible veterans under the demonstration project.

''(4) The centers and facilities collectively have available capacity to provide the contracted benefits package to a sufficient number of targeted medicare-eligible veterans.

''(5) The entity administering the health plan has sufficient systems and safeguards in place to minimize any risk that instituting the managed care model will result in reducing the quality of care delivered to enrollees in the demonstration project or to other veterans receiving care under paragraphs subsection (1) or (2) of section 1710(a) of title 38, United States Code.

''(k) RESERVES.—The Secretary of Veterans Affairs shall maintain such reserves as may be necessary to ensure against the risk that appropriated funds, allocated to medical centers and facilities participating in the demonstration project through a managed health care plan under this section, will be required to meet the obligations of those medical centers and facilities to targeted medicare-eligible veterans.

''(l) PAYMENTS BASED ON REGULAR MEDICARE PAYMENT RATES.—

''(1) PAYMENTS.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall reimburse the Secretary of Veterans Affairs for services provided under the demonstration project at the following rates:

''(i) NONCAPITATION.—Except as provided in clause (ii) and subject to subparagraphs (B)(i) and (D), at a rate equal to 95 percent of the amounts that otherwise would be payable under this title on a noncapitated basis for such services if the medical center were not a Federal medical center, were participating in the program, and imposed charges for such services.

''(ii) CAPITATION.—Subject to subparagraphs (B)(ii) and (D), in the case of services provided to an enrollee under a managed health care plan established under subsection (i), at a rate equal to 95 percent of the amount paid to a Medicare Choice organization under part C with respect to such an enrollee.

In cases in which a payment amount may not otherwise be readily computed, the Secretaries shall establish rules for computing equivalent or comparable payment amounts.

''(B) EXCLUSION OF CERTAIN AMOUNTS.—

''(i) NONCAPITATION.—In computing the amount of payment under subparagraph (A)(i), the following shall be excluded:

''(I) DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT.—Any amount attributable to an adjustment under subsection (d)(5)(F) of section 1886 of the Social Security Act (42 U.S.C. 1395ww).

''(II) DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.—Any amount attributable to a payment under subsection (h) of such section.

''(III) PERCENTAGE OF INDIRECT MEDICAL EDUCATION ADJUSTMENT.—40 percent of any amount attributable to the adjustment under subsection (d)(5)(B) of such section.

''(IV) PERCENTAGE OF CAPITAL PAYMENTS.—67 percent of any amounts attributable to payments for capital-related costs under subsection (g) of such section.

''(ii) CAPITATION.—In the case of years before 2001, in computing the amount of payment under subparagraph (A)(ii), the payment rate shall be computed as though the amounts excluded under clause (i) had been excluded in the determination of the amount paid to a Medicare Choice organization under part C with respect to an enrollee.

''(C) PERIODIC PAYMENTS FROM MEDICARE TRUST FUNDS.—Payments under this subsection shall be made—

''(i) on a periodic basis consistent with the periodicity of payments under this title; and

''(ii) in appropriate part, as determined by the Secretary, from the trust funds.

''(D) ANNUAL LIMIT ON MEDICARE PAYMENTS.—The amount paid to the Department of Veterans Affairs under this subsection for any year for the demonstration project may not exceed $50,000,000.

''(2) REDUCTION IN PAYMENT FOR VA FAILURE TO MAINTAIN EFFORT.—

''(A) IN GENERAL.—In order to avoid shifting onto the medicare program under this title costs previously assumed by the Department of Veterans Affairs for the provision of medicare-covered services to targeted medicare-eligible veterans, the payment amount under this subsection for the project for a fiscal year shall be reduced by the amount (if any) by which—

''(i) the amount of the VA effort level for targeted veterans (as defined in subparagraph (B)) for the fiscal year ending in such year, is less than

''(ii) the amount of the VA effort level for targeted veterans for fiscal year 1997.

''(B) VA EFFORT LEVEL FOR TARGETED VETERANS DEFINED.—For purposes of subparagraph (A), the term 'VA effort level for targeted veterans' means, for a fiscal year, the amount, as estimated by the administering Secretaries, that would have been expended under the medicare program under this title for VA-provided medicare-covered services for targeted veterans (as defined in subparagraph (C)) for that fiscal year if benefits were available under the medicare program for those services. Such amount does not include expenditures attributable to services for which reimbursement is made under the demonstration project.

''(C) VA-PROVIDED MEDICARE-COVERED SERVICES FOR TARGETED VETERANS.—For purposes of subparagraph (B), the term 'VA-provided medicare-covered services for targeted veterans' means, for a fiscal year, items and services—

''(i) that are provided during the fiscal year by the Department of Veterans Affairs to targeted medicare-eligible veterans;

''(ii) that constitute hospital care and medical services under chapter 17 of title 38, United States Code; and

''(iii) for which benefits would be available under the medicare program under this title if they were provided other than by a Federal provider of services that does not charge for those services.

''(3) ASSURING NO INCREASE IN COST TO MEDICARE PROGRAM.—

''(A) MONITORING EFFECT OF DEMONSTRATION PROGRAM ON COSTS TO MEDICARE PROGRAM.—

''(i) IN GENERAL.—The Secretaries, in consultation with the Comptroller General, shall closely monitor the expenditures made under the medicare program for targeted medicare-eligible veterans during the period of the demonstration project compared to the expenditures that would have been made for such veterans during that period if the demonstration project had not been conducted.

''(ii) ANNUAL REPORT BY THE COMPTROLLER GENERAL.—Not later than December 31 of each year during which the demonstration project is conducted, the Comptroller General shall submit to the Secretaries and the appropriate committees of Congress a report on the extent, if any, to which the costs of the Secretary under the medicare program under this title increased during the preceding fiscal year as a result of the demonstration project.

''(B) REQUIRED RESPONSE IN CASE OF INCREASE IN COSTS.—

''(i) IN GENERAL.—If the administering Secretaries find, based on subparagraph (A), that the expenditures under the medicare program under this title increased (or are expected to increase) during a fiscal year because of the demonstration project, the administering Secretaries shall take such steps as may be needed—

''(I) to recoup for the medicare program the amount of such increase in expenditures; and

''(II) to prevent any such increase in the future.

''(ii) STEPS.—Such steps—

''(I) under clause (i)(I) shall include payment of the amount of such increased expenditures by the Secretary of Veterans Affairs from the current medical care appropriation of the Department of Veterans Affairs to the trust funds; and

''(II) under clause (i)(II) shall include suspending or terminating the demonstration project (in whole or in part) or lowering the amount of payment under paragraph (1)(A).

''(m) EVALUATION AND REPORTS.—

''(1) INDEPENDENT EVALUATION.—The administering Secretaries shall arrange for an independent entity with expertise in the evaluation of health services to conduct an evaluation of the demonstration project. The entity shall submit annual reports on the demonstration project to the administering Secretaries and to the committees of jurisdiction in the Congress. The first report shall be submitted not later than 12 months after the date on which the demonstration project begins operation, and the final report not later than 3½ years after that date. The evaluation and reports shall include an assessment, based on the agreement entered into under subsection (b), of the following:

''(A) The cost to the Department of Veterans Affairs of providing care to veterans under the project.

''(B) Compliance of participating medical centers with applicable measures of quality of care, compared to such compliance for other medicare-participating medical centers.

''(C) A comparison of the costs of medical centers' participation in the program with the reimbursements provided for services of such medical centers.

''(D) Any savings or costs to the medicare program under this title from the project.

''(E) Any change in access to care or quality of care for targeted medicare-eligible veterans participating in the project.

''(F) Any effect of the project on the access to care and quality of care for targeted medicare-eligible veterans not participating in the project and other veterans not participating in the project.

''(G) The provision of services under managed health care plans under subsection (l), including the circumstances (if any) under which the Secretary of Veterans Affairs uses reserves described in subsection (k) and the Secretary of Veterans Affairs' response to such circumstances (including the termination of managed health care plans requiring the use of such reserves).

''(H) Any effect that the demonstration project has on the enrollment in Medicare Choice organizations under part C of this title in the established site areas.

''(2) REPORT ON EXTENSION AND EXPANSION OF DEMONSTRATION PROJECT.—Not later than six months after the date of the submission

of the penultimate report under paragraph (1), the administering Secretaries shall submit to Congress a report containing their recommendation as to—

''(A) whether to extend the demonstration project or make the project permanent;

''(B) whether to expand the project to cover additional sites and areas and to increase the maximum amount of reimbursement (or the maximum amount of reimbursement permitted for managed health care plans under this section) under the project in any year; and

''(C) whether the terms and conditions of the project should be continued (or modified) if the project is extended or expanded.

''MEDICARE SUBVENTION DEMONSTRATION PROJECT FOR MILITARY RETIREES

''SEC. 1897. (a) DEFINITIONS.—In this section:

''(1) ADMINISTERING SECRETARIES.—The term 'administering Secretaries' means the Secretary and the Secretary of Defense acting jointly.

''(2) DEMONSTRATION PROJECT; PROJECT.—The terms 'demonstration project' and 'project' mean the demonstration project carried out under this section.

''(3) DESIGNATED PROVIDER.—The term 'designated provider' has the meaning given that term in section 721(5) of the National Defense Authorization Act For Fiscal Year 1997 (Public Law 104–201; 110 Stat. 2593; 10 U.S.C. 1073 note).

''(4) MEDICARE-ELIGIBLE MILITARY RETIREE OR DEPENDENT.—The term 'medicare-eligible military retiree or dependent' means an individual described in section 1074(b) or 1076(b) of title 10, United States Code, who—

''(A) would be eligible for health benefits under section 1086 of such title by reason of subsection (c)(1) of such section 1086 but for the operation of subsection (d) of such section 1086;

''(B)(i) is entitled to benefits under part A of this title; and

''(ii) if the individual was entitled to such benefits before July 1, 1996, received health care items or services from a health care facility of the uniformed services before that date, but after becoming entitled to benefits under part A of this title;

''(C) is enrolled for benefits under part B of this title; and

''(D) has attained age 65.

''(5) MEDICARE HEALTH CARE SERVICES.—The term 'medicare health care services' means items or services covered under part A or B of this title.

''(6) MILITARY TREATMENT FACILITY.—The term 'military treatment facility' means a facility referred to in section 1074(a) of title 10, United States Code.

''(7) TRICARE.—The term 'TRICARE' has the same meaning as the term 'TRICARE program' under section 711 of the National Defense Authorization Act for Fiscal Year 1996 (10 U.S.C. 1073 note).

''(5) TRUST FUNDS.—The term 'trust funds' means the Federal Hospital Insurance Trust Fund established in section 1817 and the Federal Supplementary Medical Insurance Trust Fund established in section 1841.

''(b) DEMONSTRATION PROJECT.—

''(1) IN GENERAL.—

''(A) ESTABLISHMENT.—The administering Secretaries are authorized to establish a demonstration project (under an agreement entered into by the administering Secretaries) under which the Secretary shall reimburse the Secretary of Defense, from the trust funds, for medicare health care services furnished to certain medicare-eligible military retirees or dependents.

''(B) AGREEMENT.—The agreement entered into under subparagraph (A) shall include at a minimum—

''(i) a description of the benefits to be provided to the participants of the demonstration project established under this section;

''(ii) a description of the eligibility rules for participation in the demonstration project, including any cost sharing requirements established under subsection (h);

''(iii) a description of how the demonstration project will satisfy the requirements under this title;

''(iv) a description of the sites selected under paragraph (2);

''(v) a description of how reimbursement and maintenance of effort requirements under subsection (j) will be implemented in the demonstration project; and

''(vi) a statement that the Secretary shall have access to all data of the Department of Defense that the Secretary determines is necessary to conduct independent estimates and audits of the maintenance of effort requirement, the annual reconciliation, and related matters required under the demonstration project.

''(2) IN GENERAL.—The project established under this section shall be conducted in no more than 6 sites, designated jointly by the administering Secretaries after review of all TRICARE regions.

''(3) RESTRICTION.—No new military treatment facilities will be built or expanded with funds from the demonstration project.

''(4) DURATION.—The administering Secretaries shall conduct the demonstration project during the 3-year period beginning on January 1, 1998.

''(c) CREDITING OF PAYMENTS.—A payment received by the Secretary of Defense under the demonstration project shall be credited to the applicable Department of Defense medical appropriation and (within that appropriation). Any such payment received during a fiscal year for services provided during a prior fiscal year may be obligated by the Secretary of Defense during the fiscal year during which the payment is received.

''(d) AUTHORITY TO WAIVE CERTAIN MEDICARE REQUIREMENTS.—The Secretary may, to the extent necessary to carry out the demonstration project, waive any requirement under this title. If the Secretary waives any such requirement, the Secretary shall include a description of such waiver in the agreement described in subsection (b).

''(e) INSPECTOR GENERAL.—Nothing in the agreement entered into under subsection (b) shall limit the Inspector General of the Department of Health and Human Services from investigating any matters regarding the expenditure of funds under this title for the demonstration project, including compliance with the provisions of this title and all other relevant laws.

''(f) REPORT.—At least 30 days prior to the commencement of the demonstration project, the administering Secretaries shall submit a copy of the agreement entered into under subsection (b) to the committees of jurisdiction in Congress.

''(g) VOLUNTARY PARTICIPATION.—Participation of medicare-eligible military retirees or dependents in the demonstration project shall be voluntary, subject to the capacity of participating military treatment facilities and designated providers and the funding limitations specified in subsection (j), and shall be subject to such terms and conditions as the administering Secretaries may establish.

''(h) COST-SHARING BY DEMONSTRATION ENROLLEES.—The Secretary of Defense may establish cost-sharing requirements for medicare-eligible military retirees and dependents who enroll in the demonstration project consistent with part C of this title.

''(i) TRICARE HEALTH CARE PLANS.—

''(1) TRICARE PROGRAM ENROLLMENT FEE WAIVER.—The Secretary of Defense shall waive the enrollment fee applicable to any medicare-eligible military retiree or dependent enrolled in the managed care option of the TRICARE program for any period for which reimbursement is made under this section with respect to such retiree or dependent.

''(2) MODIFICATION OF TRICARE CONTRACTS.—In carrying out the demonstration project, the Secretary of Defense is authorized to amend existing TRICARE contracts in order to provide the medicare health care services to the medicare-eligible military retirees and dependents enrolled in the demonstration project.

''(3) HEALTH CARE BENEFITS.—The administering Secretaries shall prescribe the minimum health care benefits to be provided under such a plan to medicare-eligible military retirees or dependents enrolled in the plan. Those benefits shall include at least all medicare health care services covered under this title.

''(j) PAYMENTS BASED ON REGULAR MEDICARE PAYMENT RATES.—

''(1) PAYMENTS.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall reimburse the Secretary of Defense for services provided under the demonstration project at the following rates:

''(i) NONCAPITATION.—Except as provided in clause (ii) and subject to subparagraphs (B)(i) and (D), at a rate equal to 95 percent of the amounts that otherwise would be payable under this title on a noncapitated basis for such services if the military treatment facility or designated provider were not a Federal medical center, were participating in the program, and imposed charges for such services.

''(ii) CAPITATION.—Subject to subparagraphs (B)(ii) and (D), in the case of services provided to an enrollee under a managed health care plan established under subsection (i), at a rate equal to 95 percent of the amount paid to a Medicare Choice organization under part C with respect to such an enrollee.

In cases in which a payment amount may not otherwise be readily computed, the Secretaries shall establish rules for computing equivalent or comparable payment amounts.

''(B) EXCLUSION OF CERTAIN AMOUNTS.—

''(i) NONCAPITATION.—In computing the amount of payment under subparagraph (A)(i), the following shall be excluded:

''(I) SPECIAL PAYMENTS.—Any amount attributable to an adjustment under subparagraphs (B) and (F) of section 1886(d)(5) and subsection (h) of such section.

''(II) PERCENTAGE OF CAPITAL PAYMENTS.—An amount determined by the administering Secretaries for amounts attributable to payments for capital-related costs under subsection (g) of such section.

''(ii) CAPITATION.—In the case of years before 2001, in computing the amount of payment under subparagraph (A)(ii), the payment rate shall be computed as though the amounts excluded under clause (i) had been excluded in the determination of the amount paid to a Medicare Choice organization under part C with respect to an enrollee.

''(C) PERIODIC PAYMENTS FROM MEDICARE TRUST FUNDS.—Payments under this subsection shall be made—

''(i) on a periodic basis consistent with the periodicity of payments under this title; and

''(ii) in appropriate part, as determined by the Secretary, from the trust funds.

''(D) CAP ON AMOUNT.—The aggregate amount to be reimbursed under this paragraph pursuant to the agreement entered into between the administering Secretaries under subsection (b) shall not exceed a total of—

''(i) $55,000,000 for calendar year 1998;

''(ii) $65,000,000 for calendar year 1999; and

''(iii) $75,000,000 for calendar year 2000.

''(2) ASSURING NO INCREASE IN COST TO MEDICARE PROGRAM.—

''(A) MONITORING EFFECT OF DEMONSTRATION PROGRAM ON COSTS TO MEDICARE PROGRAM.—

''(i) IN GENERAL.—The Secretaries, in consultation with the Comptroller General, shall closely monitor the expenditures made under the medicare program for medicare-eligible military retirees or dependents during the period of the demonstration project compared to the expenditures that would have been made for such medicare-eligible military retirees or dependents during that period if the demonstration project had not been conducted. The agreement entered into by the administering Secretaries under subsection (b) shall require any participating military treatment facility to maintain the level of effort for space available care to medicare-eligible military retirees or dependents.

''(ii) ANNUAL REPORT BY THE COMPTROLLER GENERAL.—Not later than December 31 of each year during which the demonstration project is conducted, the Comptroller General shall submit to the Secretaries and the appropriate committees of Congress a report on the extent, if any, to which the costs of the Secretary under the medicare program under this title increased during the preceding fiscal year as a result of the demonstration project.

''(B) REQUIRED RESPONSE IN CASE OF INCREASE IN COSTS.—

''(i) IN GENERAL.—If the administering Secretaries find, based on subparagraph (A), that the expenditures under the medicare program under this title increased (or are expected to increase) during a fiscal year because of the demonstration project, the administering Secretaries shall take such steps as may be needed—

''(I) to recoup for the medicare program the amount of such increase in expenditures; and

''(II) to prevent any such increase in the future.

''(ii) STEPS.—Such steps—

''(I) under clause (i)(I) shall include payment of the amount of such increased expenditures by the Secretary of Defense from the current medical care appropriation of the Department of Defense to the trust funds; and

''(II) under clause (i)(II) shall include suspending or terminating the demonstration project (in whole or in part) or lowering the amount of payment under paragraph (1)(A).

''(k) EVALUATION AND REPORTS.—

''(1) INDEPENDENT EVALUATION.—The administering Secretaries shall arrange for an independent entity with expertise in the evaluation of health services to conduct an evaluation of the demonstration project. The entity shall submit annual reports on the demonstration project to the administering Secretaries and to the committees of jurisdiction in the Congress. The first report shall be submitted not later than 12 months after the date on which the demonstration project begins operation, and the final report not later than 3½ years after that date. The evaluation and reports shall include an assessment, based on the agreement entered into under subsection (b), of the following:

''(A) The number of medicare-eligible military retirees and dependents opting to participate in the demonstration project instead of receiving health benefits through another health insurance plan (including benefits under this title).

''(B) Compliance by the Department of Defense with the requirements under this title.

''(C) The cost to the Department of Defense of providing care to medicare-eligible military retirees and dependents under the demonstration project.

''(D) Compliance by the Department of Defense with the standards of quality required of entities that furnish medicare health care services.

''(E) An analysis of whether, and in what manner, easier access to the uniformed services treatment system affects the number of medicare-eligible military retirees and dependents receiving medicare health care services.

''(F) Any savings or costs to the medicare program under this title resulting from the demonstration project.

''(G) An assessment of the access to care and quality of care for medicare-eligible military retirees and dependents under the demonstration project.

''(H) Any impact of the demonstration project on the access to care for medicare-eligible military retirees and dependents who did not enroll in the demonstration project and for other individuals entitled to benefits under this title.

''(I) Any impact of the demonstration project on private health care providers.

''(J) Any impact of the demonstration project on access to care for active duty military personnel and their dependents.

''(K) A list of the health insurance plans and programs that were the primary payers for medicare-eligible military retirees and dependents during the year prior to their participation in the demonstration project and the distribution of their previous enrollment in such plans and programs.

''(L) An identification of cost-shifting (if any) between the medicare program under this title and the Defense health program as a result of the demonstration project and a description of the nature of any such cost-shifting.

''(M) An analysis of how the demonstration project affects the overall accessibility of the uniformed services treatment system and the amount of space available for point-of-service care, and a description of the unintended effects (if any) upon the normal treatment priority system.

''(N) A description of the difficulties (if any) experienced by the Department of Defense in managing the demonstration project.

''(O) A description of the effects of the demonstration project on military treatment facility readiness and training and the probable effects of the project on overall Department of Defense medical readiness and training.

''(P) A description of the effects that the demonstration project, if permanent, would be expected to have on the overall budget of the Defense health program, the budgets of individual military treatment facilities and designated providers, and on the budget of the medicare program under this title.

''(Q) An analysis of whether the demonstration project affects the cost to the Department of Defense of prescription drugs or the accessibility, availability, and cost of such drugs to demonstration program beneficiaries.

''(R) Any additional elements specified in the agreement entered into under subsection (b).

''(2) REPORT ON EXTENSION AND EXPANSION OF DEMONSTRATION PROJECT.—Not later than six months after the date of the submission of the penultimate report under paragraph (1), the administering Secretaries shall submit to Congress a report containing their recommendation as to—

''(A) whether to extend the demonstration project or make the project permanent;

''(B) whether to expand the project to cover additional sites and areas and to increase the maximum amount of reimbursement (or the maximum amount of reimbursement permitted for managed health care plans under this section) under the project in any year; and

''(C) whether the terms and conditions of the project should be continued (or modified) if the project is extended or expanded.''.

CHAPTER 6—TAX TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS

SEC. 5049. TAX TREATMENT OF HOSPITALS WHICH PARTICIPATE IN PROVIDER-SPONSORED ORGANIZATIONS.

(a) IN GENERAL.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

''(o) TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS.—An organization shall not fail to be treated as organized and operated exclusively for a charitable purpose for purposes of subsection (c)(3) solely because a hospital which is owned and operated by such organization participates in a provider-sponsored organization (as defined in section 1853(e) of the Social Security Act), whether or not the provider-sponsored organization is exempt from tax. For purposes of subsection (c)(3), any person with a material financial interest in such a provider-sponsored organization shall be treated as a private shareholder or individual with respect to the hospital.''.

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

Subtitle B—Prevention Initiatives

SEC. 5101. ANNUAL SCREENING MAMMOGRAPHY FOR WOMEN OVER AGE 39.

(a) IN GENERAL.—Section 1834(c)(2)(A) (42 U.S.C. 1395m(c)(2)(A)) is amended by striking clauses (iii), (iv), and (v) and inserting the following:

''(iii) in the case of a woman over 39 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.''

(b) WAIVER OF COINSURANCE.—

(1) IN GENERAL.—Section 1834(c)(1)(C) (42 U.S.C. 1395m(c)(1)(C)) is amended by striking ''80 percent of''.

(2) WAIVER OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—The third sentence of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting after ''1861(s)(10)(A)'' the following: '', with respect to screening mammography (as defined in section 1861(jj),''.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) apply to items and services furnished on or after January 1, 1998.

SEC. 5102. COVERAGE OF COLORECTAL SCREENING.

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

(1) in subsection (s)(2)—

(A) by striking ''and'' at the end of subparagraphs (N) and (O); and

(B) by inserting after subparagraph (O) the following:

''(P) colorectal cancer screening tests (as defined in subsection (oo)); and''; and

(2) by adding at the end the following:

''Colorectal Cancer Screening Test

''(oo)(1)(A) The term 'colorectal cancer screening test' means a procedure furnished to an individual that the Secretary prescribes in regulations as appropriate for the

purpose of early detection of colorectal cancer, taking into account availability, effectiveness, costs, changes in technology and standards of medical practice, and such other factors as the Secretary considers appropriate.

''(B) The Secretary shall consult with appropriate organizations in prescribing regulations under subparagraph (A).''.

(b) FREQUENCY AND PAYMENT LIMITS.—Section 1834 (42 U.S.C. 1395m) is amended by inserting after subsection (c) the following new subsection:

''(d) FREQUENCY AND PAYMENT LIMITS FOR COLORECTAL CANCER SCREENING TESTS.—

''(1) IN GENERAL.—The Secretary shall prescribe regulations that—

''(A) establish frequency limits for colorectal cancer screening tests that take into account the risk status of an individual and that are consistent with frequency limits for similar or related services; and

''(B) establish payment limits (including limits on charges of nonparticipating physicians) for colorectal cancer screening tests that are consistent with payment limits for similar or related services.

''(2) REVISIONS.—The Secretary shall periodically review and, to the extent the Secretary considers appropriate, revise the frequency and payment limits established under paragraph (1).

''(3) FACTORS TO DETERMINE INDIVIDUALS AT RISK.—In establishing criteria for determining whether an individual is at risk for purposes of this subsection, the Secretary shall take into consideration family history, prior experience of cancer, a history of chronic digestive disease condition, and the presence of any appropriate recognized gene markers for colorectal cancer.

''(4) CONSULTATION.—In establishing and revising frequency and payment limits under this subsection, the Secretary shall consult with appropriate organizations.''

(c) CONFORMING AMENDMENTS.—(1) Paragraphs (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended by inserting ''or section 1834(d)'' after ''subsection (h)(1)''.

(2) Section 1833(h)(1)(A) (42 U.S.C. 1395l(h)(1)(A)) is amended by striking ''The Secretary'' and inserting ''Subject to section 1834(d), the Secretary''.

(3) Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (E), by striking ''and'' at the end,

(ii) in subparagraph (F), by striking the semicolon at the end and inserting '', and'', and

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

''(G) in the case of colorectal cancer screening tests, which are performed more frequently than is covered under section 1834(d);''; and

(B) in paragraph (7), by striking ''paragraph (1)(B) or under paragraph (1)(F)'' and inserting ''subparagraph (B), (F), or (G) of paragraph (1)''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

(2) REGULATIONS.—The Secretary of Health and Human Services shall issue final regulations described in sections 1861(oo) and 1834(d) of the Social Security Act (as added by this section) within 3 months after the date of enactment of this Act.

SEC. 5103. DIABETES SCREENING TESTS.

(a) DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES.—

(1) IN GENERAL.—Section 1861(s) (42 U.S.C. 1395x(s)), as amended by section 5102, is amended—

(A) in subsection (s)(2)—

(i) by striking ''and'' at the end of subparagraph (P);

(ii) by inserting ''and'' at the end of subparagraph (Q); and

(iii) by adding at the end the following:

''(R) diabetes outpatient self-management training services (as defined in subsection (pp));'', and

(B) by adding at the end the following:

''Diabetes Outpatient Self-Management Training Services

''(pp)(1) The term 'diabetes outpatient self-management training services' means educational and training services furnished to an individual with diabetes by a certified provider (as described in paragraph (2)(A)) in an outpatient setting by an individual or entity that meets the quality standards described in paragraph (2)(B), but only if the physician who is managing the individual's diabetic condition certifies that the services are needed under a comprehensive plan of care related to the individual's diabetic condition to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual's condition.

''(2) In paragraph (1)—

''(A) 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 other such individual or entity, meets the quality standards described in this subparagraph 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 as meeting standards for furnishing the services.''

(2) CONSULTATION WITH ORGANIZATIONS IN ESTABLISHING PAYMENT AMOUNTS FOR SERVICES PROVIDED BY PHYSICIANS.—In establishing payment amounts under section 1848 of the Social Security Act for physicians' services consisting of diabetes outpatient self-management training services, the Secretary of Health and Human Services shall consult with appropriate organizations, including such organizations representing individuals or medicare beneficiaries with diabetes, in determining the relative value for such services under section 1848(c)(2) of such Act.

(b) BLOOD-TESTING STRIPS FOR INDIVIDUALS WITH DIABETES.—

(1) INCLUDING STRIPS AND MONITORS AS DURABLE MEDICAL EQUIPMENT.—The first sentence of section 1861(n) (42 U.S.C. 1395x(n)) is amended by inserting before the semicolon the following: '', and includes blood-testing strips and blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individual's use of insulin (as determined under standards established by the Secretary in consultation with the appropriate organizations)''.

(2) 10 PERCENT REDUCTION IN PAYMENTS FOR TESTING STRIPS.—Section 1834(a)(2)(B)(iv) (42 U.S.C. 1395m(a)(2)(B)(iv)) is amended by adding before the period the following: ''(reduced by 10 percent, in the case of a blood glucose testing strip furnished after 1997 for an individual with diabetes)''.

(c) ESTABLISHMENT OF OUTCOME MEASURES FOR BENEFICIARIES WITH DIABETES.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with appropriate organizations, shall establish outcome measures, including glysolated hemoglobin (past 90-day average blood sugar levels), for purposes of evaluating the improvement of the health status of medicare beneficiaries with diabetes mellitus.

(2) RECOMMENDATIONS FOR MODIFICATIONS TO SCREENING BENEFITS.—Taking into account information on the health status of medicare beneficiaries with diabetes mellitus as measured under the outcome measures established under subparagraph (A), the Secretary shall from time to time submit recommendations to Congress regarding modifications to the coverage of services for such beneficiaries under the medicare program.

(d) EFFECTIVE DATE.—The amendments made by this section apply to items and services furnished on or after January 1, 1998.

SEC. 5104. COVERAGE OF BONE MASS MEASUREMENTS.

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

(1) in subsection (s)—

(A) in paragraph (12)(C), by striking ''and'' at the end;

(B) by striking the period at the end of paragraph (14) and inserting ''; and'';

(C) by redesignating paragraphs (15) and (16) as paragraphs (16) and (17), respectively; and

(D) by inserting after paragraph (14) the following:

''(15) bone mass measurement (as defined in subsection (oo)).''; and

(2) by inserting after subsection (pp), as added by section 5103, the following:

''Bone Mass Measurement

''(gg)(1) The term 'bone mass measurement' means a radiologic or radioscopic procedure or other Food and Drug Administration approved technology performed on a qualified individual (as defined in paragraph (2)) for the purpose of identifying bone mass, detecting bone loss, or determining bone quality, and includes a physician's interpretation of the results of the procedure.

''(2) For purposes of paragraph (1), the term 'qualified individual' means an individual who is (in accordance with regulations prescribed by the Secretary)—

''(A) an estrogen-deficient woman at clinical risk for osteoporosis and who is considering treatment;

''(B) an individual with vertebral abnormalities;

''(C) an individual receiving long-term glucocorticoid steroid therapy;

''(D) an individual with primary hyperparathyroidism; or

''(E) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.''.

(b) CONFORMING AMENDMENTS.—Sections 1864(a), 1865(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) (42 U.S.C. 1395aa(a), 1395bb(a), 1396a(a)(9)(C), and 1396n(a)(1)(B)(ii)(I)) are amended by striking ''paragraphs (15) and (16)'' each place such term appears and inserting ''paragraphs (16) and (17)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to bone mass measurements performed on or after January 1, 1998.

Subtitle C—Rural Initiatives

SEC. 5151. SOLE COMMUNITY HOSPITALS.

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

(1) in clause (i), by redesignating subclauses (I) and (II) as items (aa) and (bb), respectively;

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

(3) by striking ''(C) In'' and inserting ''(C)(i) Subject to clause (ii), in''; and

(4) by striking the last sentence and inserting the following:

''(ii)(I) There shall be substituted for the base cost reporting period described in clause (i)(I) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

''(II) Beginning with discharges occurring in fiscal year 1998, there shall be substituted for the base cost reporting period described in clause (i)(I) either—

''(aa) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital's cost reporting period (if any) beginning during fiscal year 1994 increased (in a compounded manner) by the applicable percentage increases applied to the hospital under this paragraph for discharges occurring in fiscal years 1995, 1996, 1997, and 1998, or

''(bb) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital's cost reporting period (if any) beginning during fiscal year 1995 increased (in a compounded manner) by the applicable percentage increase applied to the hospital under this paragraph for discharges occurring in fiscal years 1995, 1996, 1997, and 1998,

if such substitution results in an increase in the target amount for the hospital.''.

SEC. 5152. MEDICARE-DEPENDENT, SMALL RURAL HOSPITAL PAYMENT EXTENSION.

(a) SPECIAL TREATMENT EXTENDED.—

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

(A) in clause (i), by striking ''October 1, 1994,'' and inserting ''October 1, 1994, or beginning on or after October 1, 1997, and before October 1, 2001,''; and

(B) in clause (ii)(II), by striking ''October 1, 1994,'' and inserting ''October 1, 1994, or beginning on or after October 1, 1997, and before October 1, 2001,''.

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

(A) in the matter preceding clause (i), by striking ''September 30, 1994,'' and inserting ''September 30, 1994, and for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2001,'';

(B) in clause (ii), by striking ''and'' at the end;

(C) in clause (iii), by striking the period at the end and inserting '', and''; and

(D) by adding after clause (iii) the following new clause:

''(iv) with respect to discharges occurring during fiscal year 1998 through fiscal year 2000, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).''.

(3) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of OBRA–93 (42 U.S.C. 1395ww note) is amended by striking ''or fiscal year 1994'' and inserting '', fiscal year 1994, fiscal year 1998, fiscal year 1999, or fiscal year 2000''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to discharges occurring on or after October 1, 1997.

SEC. 5153. MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.

(a) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.—Section 1820 (42 U.S.C. 1395i–4) is amended to read as follows:

''MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

''SEC. 1820. (a) ESTABLISHMENT.—Any State that submits an application in accordance with subsection (b) may establish a medicare rural hospital flexibility program described in subsection (c).

''(b) APPLICATION.—A State may establish a medicare rural hospital flexibility program described in subsection (c) if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing—

''(1) assurances that the State—

''(A) has developed, or is in the process of developing, a State rural health care plan that—

''(i) provides for the creation of 1 or more rural health networks (as defined in subsection (d)) in the State;

''(ii) promotes regionalization of rural health services in the State; and

''(iii) improves access to hospital and other health services for rural residents of the State; and

''(B) has developed the rural health care plan described in subparagraph (A) in consultation with the hospital association of the State, rural hospitals located in the State, and the State Office of Rural Health (or, in the case of a State in the process of developing such plan, that assures the Secretary that the State will consult with its State hospital association, rural hospitals located in the State, and the State Office of Rural Health in developing such plan);

''(2) assurances that the State has designated (consistent with the rural health care plan described in paragraph (1)(A)), or is in the process of so designating, rural nonprofit or public hospitals or facilities located in the State as critical access hospitals; and

''(3) such other information and assurances as the Secretary may require.

''(c) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM DESCRIBED.—

''(1) IN GENERAL.—A State that has submitted an application in accordance with subsection (b), may establish a medicare rural hospital flexibility program that provides that—

''(A) the State shall develop at least 1 rural health network (as defined in subsection (d)) in the State; and

''(B) at least 1 facility in the State shall be designated as a critical access hospital in accordance with paragraph (2).

''(2) STATE DESIGNATION OF FACILITIES.—

''(A) IN GENERAL.—A State may designate 1 or more facilities as a critical access hospital in accordance with subparagraph (B).

''(B) CRITERIA FOR DESIGNATION AS CRITICAL ACCESS HOSPITAL.—A State may designate a facility as a critical access hospital if the facility—

''(i) is a nonprofit or public hospital and is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D)) that—

''(I) is located more than a 35-mile drive from a hospital, or another facility described in this subsection; or

''(II) is certified by the State as being a necessary provider of health care services to residents in the area;

''(ii) makes available 24-hour emergency care services that a State determines are necessary for ensuring access to emergency care services in each area served by a critical access hospital;

''(iii) provides not more than 15 acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period not to exceed 96 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions), except that a peer review organization or equivalent entity may, on request, waive the 96-hour restriction on a case-by-case basis;

''(iv) meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

''(I) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open and fully staffed, except insofar as the facility is required to make available emergency care services as determined under clause (ii) and must have nursing services available on a 24-hour basis, but need not otherwise staff the facility except when an inpatient is present;

''(II) the facility may provide any services otherwise required to be provided by a full-time, on site dietitian, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, off site basis under arrangements as defined in section 1861(w)(1); and

''(III) the inpatient care described in clause (iii) may be provided by a physician's assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who need not be present in the facility; and

''(v) meets the requirements of section 1861(aa)(2)(I).

''(d) DEFINITION OF RURAL HEALTH NETWORK.—

''(1) IN GENERAL.—In this section, the term 'rural health network' means, with respect to a State, an organization consisting of—

''(A) at least 1 facility that the State has designated or plans to designate as a critical access hospital; and

''(B) at least 1 hospital that furnishes acute care services.

''(2) AGREEMENTS.—

''(A) IN GENERAL.—Each critical access hospital that is a member of a rural health network shall have an agreement with respect to each item described in subparagraph (B) with at least 1 hospital that is a member of the network.

''(B) ITEMS DESCRIBED.—The items described in this subparagraph are the following:

''(i) Patient referral and transfer.

''(ii) The development and use of communications systems including (where feasible)—

''(I) telemetry systems; and

''(II) systems for electronic sharing of patient data.

''(iii) The provision of emergency and nonemergency transportation among the facility and the hospital.

''(C) CREDENTIALING AND QUALITY ASSURANCE.—Each critical access hospital that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least—

''(i) 1 hospital that is a member of the network;

''(ii) 1 peer review organization or equivalent entity; or

''(iii) 1 other appropriate and qualified entity identified in the State rural health care plan.

''(e) CERTIFICATION BY THE SECRETARY.—The Secretary shall certify a facility as a critical access hospital if the facility—

''(1) is located in a State that has established a medicare rural hospital flexibility program in accordance with subsection (c);

''(2) is designated as a critical access hospital by the State in which it is located; and

''(3) meets such other criteria as the Secretary may require.

''(f) PERMITTING MAINTENANCE OF SWING BEDS.—Nothing in this section shall be construed to prohibit a critical access hospital from entering into an agreement with the Secretary under section 1883 under which the facility's inpatient hospital facilities are used for the furnishing of extended care services.

''(g) GRANTS.—

''(1) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.—The Secretary may award grants to States that have submitted applications in accordance with subsection (b) for—

''(A) engaging in activities relating to planning and implementing a rural health care plan;

''(B) engaging in activities relating to planning and implementing rural health networks; and

''(C) designating facilities as critical access hospitals.

''(2) RURAL EMERGENCY MEDICAL SERVICES.—

''(A) IN GENERAL.—The Secretary may award grants to States that have submitted applications in accordance with subparagraph (B) for the establishment or expansion of a program for the provision of rural emergency medical services.

''(B) APPLICATION.—An application is in accordance with this subparagraph if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing the assurances described in subparagraphs (A)(ii), (A)(iii), and (B) of subsection (b)(1) and paragraph (3) of that subsection.

''(h) GRANDFATHERING OF CERTAIN FACILITIES.—

''(1) IN GENERAL.—Any medical assistance facility operating in Montana and any rural primary care hospital designated by the Secretary under this section prior to the date of the enactment of the Balanced Budget Act of 1997 shall be deemed to have been certified by the Secretary under subsection (e) as a critical access hospital if such facility or hospital is otherwise eligible to be designated by the State as a critical access hospital under subsection (c).

''(2) CONTINUATION OF MEDICAL ASSISTANCE FACILITY AND RURAL PRIMARY CARE HOSPITAL TERMS.—Notwithstanding any other provision of this title, with respect to any medical assistance facility or rural primary care hospital described in paragraph (1), any reference in this title to a 'critical access hospital' shall be deemed to be a reference to a 'medical assistance facility' or 'rural primary care hospital'.

''(i) WAIVER OF CONFLICTING PART A PROVISIONS.—The Secretary is authorized to waive such provisions of this part and part D as are necessary to conduct the program established under this section.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for making grants to all States under subsection (g), $25,000,000 in each of the fiscal years 1998 through 2002.''.

(b) REPORT ON ALTERNATIVE TO 96-HOUR RULE.—Not later than January 1, 1998, the Administrator of the Health Care Financing Administration shall submit to Congress a report on the feasibility of, and administrative requirements necessary to establish an alternative for certain medical diagnoses (as determined by the Administrator) to the 96-hour limitation for inpatient care in critical access hospitals required by section 1820(c)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395i–4), as added by subsection (a) of this section.

(c) CONFORMING AMENDMENTS RELATING TO RURAL PRIMARY CARE HOSPITALS AND CRITICAL ACCESS HOSPITALS.—

(1) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) and title XVIII of that Act (42 U.S.C. 1395 et seq.) are each amended by striking ''rural primary care'' each place it appears and inserting ''critical access''.

(2) DEFINITIONS.—Section 1861(mm) of the Social Security Act (42 U.S.C. 1395x(mm)) is amended to read as follows:

''CRITICAL ACCESS HOSPITAL; CRITICAL ACCESS HOSPITAL SERVICES

''(mm)(1) The term 'critical access hospital' means a facility certified by the Secretary as a critical access hospital under section 1820(e).

''(2) The term 'inpatient critical access hospital services' means items and services, furnished to an inpatient of a critical access hospital by such facility, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.

''(3) The term 'outpatient critical access hospital services' means medical and other health services furnished by a critical access hospital on an outpatient basis.''.

(3) PART A PAYMENT.—Section 1814 of the Social Security Act (42 U.S.C. 1395f) is amended—

(A) in subsection (a)(8), by striking ''72'' and inserting ''96''; and

(B) by amending subsection (*l*) to read as follows:

''Payment for Inpatient Critical Access Hospital Services

''(*l*) The amount of payment under this part for inpatient critical access hospital services is the reasonable costs of the critical access hospital in providing such services.''.

(4) PAYMENT CONTINUED TO DESIGNATED EACHS.—Section 1886(d)(5)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(D)) is amended—

(A) in clause (iii)(III), by inserting ''as in effect on September 30, 1997'' before the period at the end; and

(B) in clause (v)—

(i) by inserting ''as in effect on September 30, 1997'' after ''1820(i)(1)''; and

(ii) by striking ''1820(g)'' and inserting ''1820(d)''.

(5) PART B PAYMENT.—Section 1834(g) of the Social Security Act (42 U.S.C. 1395m(g)) is amended to read as follows:

''(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—The amount of payment under this part for outpatient critical access hospital services is the reasonable costs of the critical access hospital in providing such services.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 1997.

SEC. 5154. PROHIBITING DENIAL OF REQUEST BY RURAL REFERRAL CENTERS FOR RECLASSIFICATION ON BASIS OF COMPARABILITY OF WAGES.

(a) IN GENERAL.—Section 1886(d)(10)(D) (42 U.S.C. 1395ww(d)(10)(D)) is amended—

(1) by redesignating clause (iii) as clause (iv); and

(2) by inserting after clause (ii) the following new clause:

''(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which has ever been classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.''.

(b) CONTINUING TREATMENT OF PREVIOUSLY DESIGNATED CENTERS.—

(1) IN GENERAL.—Any hospital classified as a rural referral center by the Secretary of Health and Human Services under section 1886(d)(5)(C) of the Social Security Act for fiscal year 1991 shall be classified as such a rural referral center for fiscal year 1998 and each subsequent fiscal year.

(2) BUDGET NEUTRALITY.—The provisions of section 1886(d)(8)(D) of the Social Security Act shall apply to reclassifications made pursuant to paragraph (1) in the same manner as such provisions apply to a reclassification under section 1886(d)(10) of such Act.

SEC. 5155. RURAL HEALTH CLINIC SERVICES.

(a) PER-VISIT PAYMENT LIMITS FOR PROVIDER-BASED CLINICS.—

(1) EXTENSION OF LIMIT.—

(A) IN GENERAL.—The matter in section 1833(f) (42 U.S.C. 1395l(f)) preceding paragraph (1) is amended by striking ''independent rural health clinics'' and inserting ''rural health clinics (other than such clinics in rural hospitals with less than 50 beds)''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) applies to services furnished after 1997.

(2) TECHNICAL CLARIFICATION.—Section 1833(f)(1) (42 U.S.C. 1395l(f)(1)) is amended by inserting ''per visit'' after ''$46''.

(b) ASSURANCE OF QUALITY SERVICES.—

(1) IN GENERAL.—Subparagraph (I) of the first sentence of section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended to read as follows:

''(I) has a quality assessment and performance improvement program, and appropriate procedures for review of utilization of clinic services, as the Secretary may specify,''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 1998.

(c) WAIVER OF CERTAIN STAFFING REQUIREMENTS LIMITED TO CLINICS IN PROGRAM.—

(1) IN GENERAL.—Section 1861(aa)(7)(B)) (42 U.S.C. 1395x(aa)(7)(B)) is amended by inserting before the period '', or if the facility has not yet been determined to meet the requirements (including subparagraph (J) of the first sentence of paragraph (2)) of a rural health clinic.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) applies to waiver requests made after 1997.

(d) REFINEMENT OF SHORTAGE AREA REQUIREMENTS.—

(1) DESIGNATION REVIEWED TRIENNIALLY.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended in the second sentence, in the matter in clause (i) preceding subclause (I)—

(A) by striking ''and that is designated'' and inserting ''and that, within the previous 3-year period, has been designated''; and

(B) by striking ''or that is designated'' and inserting ''or designated''.

(2) AREA MUST HAVE SHORTAGE OF HEALTH CARE PRACTITIONERS.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)), as amended by paragraph (1), is further amended in the second sentence, in the matter in clause (i) preceding subclause (I)—

(A) by striking the comma after ''personal health services''; and

(B) by inserting ''and in which there are insufficient numbers of needed health care practitioners (as determined by the Secretary),'' after ''Bureau of the Census)''.

(3) PREVIOUSLY QUALIFYING CLINICS GRANDFATHERED ONLY TO PREVENT SHORTAGE.—

(A) IN GENERAL.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended in the third sentence by inserting before the period ''if it is determined, in accordance with criteria established by the Secretary in regulations, to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic''.

(B) PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT SERVICES.—

(i) IN GENERAL.—With respect to any regulations issued to implement section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) (as amended by subparagraph (A)), the Secretary of

Health and Human Services shall include in such regulations provisions providing for the direct payment to the physician assistant for any physician assistant services as described in clause (ii).

(ii) SERVICES DESCRIBED.—Services described in this clause are physician assistant services provided at a rural health clinic that is principally owned, as determined by the Secretary, by a physician assistant—

(I) as of the date of enactment of this Act; and

(II) continuously from such date through the date on which such services are provided.

(iii) SUNSET.—The provisions of this subparagraph shall not apply after January 1, 2003.

(4) EFFECTIVE DATES; IMPLEMENTING REGULATIONS.—

(A) IN GENERAL.—Except as otherwise provided, the amendments made by the preceding paragraphs take effect on January 1 of the first calendar year beginning at least 1 month after enactment of this Act.

(B) CURRENT RURAL HEALTH CLINICS.—The amendments made by the preceding paragraphs take effect, with respect to entities that are rural health clinics under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) on the date of enactment of this Act, on January 1 of the second calendar year following the calendar year specified in subparagraph (A).

(C) GRANDFATHERED CLINICS.—

(i) IN GENERAL.—The amendment made by paragraph (3) shall take effect on the effective date of regulations issued by the Secretary under clause (ii).

(ii) REGULATIONS.—The Secretary shall issue final regulations implementing paragraph (3) that shall take effect no later than January 1 of the third calendar year beginning at least 1 month after the date of enactment of this Act.

SEC. 5156. MEDICARE REIMBURSEMENT FOR TELEHEALTH SERVICES.

(a) IN GENERAL.—Not later than July 1, 1998, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') 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 health care provider furnishing a service for which payment may be made under such part to a beneficiary under the medicare program residing 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 health care provider providing the professional consultation is not at the same location as the health care provider 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 include a bundled payment to be shared between the referring health care provider and the consulting health care provider. The amount of such bundled payment shall not be greater than the current fee schedule of the consulting health care provider for the health care services provided.

(2) The payment shall not include any reimbursement for any line charges or any facility fees.

(c) SUPPLEMENTAL REPORT.—Not later than January 1, 1998, 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 a health care provider furnishing a service for which payment may be made under such part to a beneficiary described in paragraph (2), notwithstanding that the individual health care provider providing the professional consultation is not at the same location as the health care provider 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 to the medicare program of making the payments described in that paragraph using various reimbursement schemes.

SEC. 5157. TELEMEDICINE, INFORMATICS, AND EDUCATION DEMONSTRATION PROJECT.

(a) PURPOSE AND AUTHORIZATION.—

(1) IN GENERAL.—Not later than 9 months after the date of enactment of this section, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a demonstration project described in paragraph (2).

(2) DESCRIPTION OF PROJECT.—The demonstration project described in this paragraph is a single demonstration project to study the use of eligible health care provider telemedicine networks to implement high-capacity computing and advanced networks to improve primary care (and prevent health care complications), improve access to specialty care, and provide educational and training support to rural practitioners.

(3) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of titles XI, XVIII, and XIX of the Social Security Act (42 U.S.C. 1301 et seq., 1395 et seq., 1396 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct the demonstration project.

(4) DURATION OF PROJECT.—The project shall be conducted for a 5-year period.

(b) OBJECTIVES OF PROJECT.—The objectives of the demonstration project conducted under this section shall include the following:

(1) The improvement of patient access to primary and specialty care and the reduction of inappropriate hospital visits in order to improve patient quality-of-life and reduce overall health care costs.

(2) The development of a curriculum to train and development of standards for required credentials and licensure of health professionals (particularly primary care health professionals) in the use of medical informatics and telecommunications.

(3) The demonstration of the application of advanced technologies such as video-conferencing from a patient's home and remote monitoring of a patient's medical condition.

(4) The development of standards in the application of telemedicine and medical informatics.

(5) The development of a model for cost-effective delivery of primary and related care in both a managed care environment and in a fee-for-service environment.

(c) ELIGIBLE HEALTH CARE PROVIDER TELEMEDICINE NETWORK DEFINED.—In this section, the term ''eligible health care provider telemedicine network'' means a consortium that—

(1) includes—

(A) at least 1 tertiary care hospital with an existing telemedicine network with an existing relationship with a medical school; and

(B) not more than 6 facilities, including at least 3 rural referral centers, in rural areas; and

(2) meets the following requirements:

(A) The consortium is located in a region that is predominantly rural.

(B) The consortium submits to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the use the consortium would make of any amounts received under the demonstration project and the source and amount of non-Federal funds used in the project.

(C) The consortium guarantees that it will be responsible for payment for all costs of the project that are not paid under this section and that the maximum amount of payment that may be made to the consortium under this section shall not exceed the amount specified in subsection (d)(3).

(d) COVERAGE AS MEDICARE PART B SERVICES.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, services for medicare beneficiaries furnished under the demonstration project shall be considered to be services covered under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j).

(2) PAYMENTS.—

(A) IN GENERAL.—Subject to paragraph (3), payment for services provided under this section shall be made at a rate of 50 percent of the costs that are reasonable and related to the provision of such services. In computing such costs, the Secretary shall include costs described in subparagraph (B), but may not include costs described in subparagraph (C).

(B) COSTS THAT MAY BE INCLUDED.—The costs described in this subparagraph are the permissible costs (as recognized by the Secretary) for the following:

(i) The acquisition of telemedicine equipment for use in patients' homes (but only in the case of patients located in medically underserved areas).

(ii) Curriculum development and training of health professionals in medical informatics and telemedicine.

(iii) Payment of telecommunications costs including salaries, maintenance of equipment, and costs of telecommunications between patients' homes and the eligible network and between the network and other entities under the arrangements described in subsection (c).

(iv) Payments to practitioners and providers under the medicare programs.

(C) OTHER COSTS.—The costs described in this subparagraph include the following:

(i) The purchase or installation of transmission equipment (other than such equipment used by health professionals to deliver medical informatics services under the project).

(ii) The establishment or operation of a telecommunications common carrier network.

(iii) Construction that is limited to minor renovations related to the installation of equipment.

(3) LIMITATION AND FUNDS.—The Secretary shall make the payments under the demonstration project conducted under this section from the Federal Supplementary Medical Insurance Trust Fund, established under section 1841 of the Social Security Act (42 U.S.C. 1395t), except that the total amount of the payments that may be made by the Secretary under this section shall not exceed $27,000,000.

Subtitle D—Anti-Fraud and Abuse Provisions and Improvements in Protecting Program Integrity

CHAPTER 1—REVISIONS TO SANCTIONS FOR FRAUD AND ABUSE

SEC. 5201. AUTHORITY TO REFUSE TO ENTER INTO MEDICARE AGREEMENTS WITH INDIVIDUALS OR ENTITIES CONVICTED OF FELONIES.

(a) MEDICARE PART A.—Section 1866(b)(2) (42 U.S.C. 1395cc(b)(2)) is amended—

(1) in subparagraph (B), by striking ''or'' at the end;

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

(3) by adding at the end the following:

''(D) has ascertained that the provider has been convicted of a felony under Federal or State law for an offense that the Secretary determines is inconsistent with the best interests of program beneficiaries.''.

(b) MEDICARE PART B.—Section 1842 (42 U.S.C. 1395u) is amended by adding at the end the following:

''(s) The Secretary may refuse to enter into an agreement with a physician or supplier under subsection (h), or may terminate or refuse to renew such agreement, in the event that such physician or supplier has been convicted of a felony under Federal or State law for an offense which the Secretary determines is inconsistent with the best interests of program beneficiaries.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and apply to the entry and renewal of contracts on or after such date.

SEC. 5202. EXCLUSION OF ENTITY CONTROLLED BY FAMILY MEMBER OF A SANCTIONED INDIVIDUAL.

(a) IN GENERAL.—Section 1128 (42 U.S.C. 1320a–7) is amended—

(1) in subsection (b)(8)(A)—

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

(B) in clause (ii), by striking the dash at the end and inserting ''; or''; and

(C) by inserting after clause (ii) the following:

''(iii) who was described in clause (i) but is no longer so described because of a transfer of ownership or control interest, in anticipation of (or following) a conviction, assessment, or exclusion described in subparagraph (B) against the person, to an immediate family member (as defined in subsection (j)(1)) or a member of the household of the person (as defined in subsection (j)(2)) who continues to maintain an interest described in such clause—''; and

(2) by adding at the end the following:

''(j) DEFINITION OF IMMEDIATE FAMILY MEMBER AND MEMBER OF HOUSEHOLD.—For purposes of subsection (b)(8)(A)(iii):

''(1) The term 'immediate family member' means, with respect to a person—

''(A) the husband or wife of the person;

''(B) the natural or adoptive parent, child, or sibling of the person;

''(C) the stepparent, stepchild, stepbrother, or stepsister of the person;

''(D) the father-, mother-, daughter-, son-, brother-, or sister-in-law of the person;

''(E) the grandparent or grandchild of the person; and

''(F) the spouse of a grandparent or grandchild of the person.

''(2) The term 'member of the household' means, with respect to any person, any individual sharing a common abode as part of a single family unit with the person, including domestic employees and others who live together as a family unit, but not including a roomer or boarder.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date that is 45 days after the date of the enactment of this Act.

SEC. 5203. IMPOSITION OF CIVIL MONEY PENALTIES.

(a) CIVIL MONEY PENALTIES FOR PERSONS THAT CONTRACT WITH EXCLUDED INDIVIDUALS.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(1) in paragraph (4), by striking ''or'' at the end;

(2) in paragraph (5), by adding ''or'' at the end; and

(3) by inserting after paragraph (5) the following:

''(6) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in section 1128B(f)), for the provision of items or services for which payment may be made under such a program;''.

(b) CIVIL MONEY PENALTIES FOR SERVICES ORDERED OR PRESCRIBED BY AN EXCLUDED INDIVIDUAL OR ENTITY.—Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1)) is amended—

(1) in subparagraph (D)—

(A) by inserting '', ordered, or prescribed by such person'' after ''other item or service furnished'';

(B) by inserting ''(pursuant to this title or title XVIII)'' after ''period in which the person was excluded'';

(C) by striking ''pursuant to a determination by the Secretary'' and all that follows through ''the provisions of section 1842(j)(2)''; and

(D) by striking ''or'' at the end;

(2) by redesignating subparagraph (E) as subparagraph (F); and

(3) by inserting after subparagraph (D) the following:

''(E) is for a medical or other item or service ordered or prescribed by a person excluded pursuant to this title or title XVIII from the program under which the claim was made, and the person furnishing such item or service knows or should know of such exclusion, or''.

(c) CIVIL MONEY PENALTIES FOR KICKBACKS.—

(1) PERMITTING SECRETARY TO IMPOSE CIVIL MONEY PENALTY.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by subsection (a), is amended—

(A) in paragraph (5), by striking ''or'' at the end;

(B) in paragraph (6), by adding ''or'' at the end; and

(C) by adding after paragraph (6) the following:

''(7) commits an act described in paragraph (1) or (2) of section 1128B(b);''.

(2) DESCRIPTION OF CIVIL MONEY PENALTY APPLICABLE.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by paragraph (1), is amended in the matter following paragraph (7)—

(A) by striking ''occurs).'' and inserting ''occurs; or in cases under paragraph (7), $50,000 for each such act).''; and

(B) by inserting after ''of such claim'' the following: ''(or, in cases under paragraph (7), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose)''.

(d) EFFECTIVE DATES.—

(1) CONTRACTS WITH EXCLUDED PERSONS.—The amendments made by subsection (a) shall apply to arrangements and contracts entered into after the date of the enactment of this Act.

(2) SERVICES ORDERED OR PRESCRIBED.—The amendments made by subsection (b) shall apply to items and services furnished, ordered, or prescribed after the date of the enactment of this Act.

(3) KICKBACKS.—The amendments made by subsection (c) shall apply to acts taken after the date of the enactment of this Act.

CHAPTER 2—IMPROVEMENTS IN PROTECTING PROGRAM INTEGRITY

SEC. 5211. DISCLOSURE OF INFORMATION, SURETY BONDS, AND ACCREDITATION.

(a) DISCLOSURE OF INFORMATION, SURETY BOND, AND ACCREDITATION REQUIREMENT FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by inserting after paragraph (15) the following:

''(16) DISCLOSURE OF INFORMATION, SURETY BOND, AND ACCREDITATION.—The Secretary shall not provide for the issuance (or renewal) of a provider number for a supplier of durable medical equipment, for purposes of payment under this part for durable medical equipment furnished by the supplier, unless the supplier provides the Secretary on a continuing basis—

''(A) with—

''(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1124(a)(3)) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest; and

''(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1124(a)(2)) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity;

''(B) with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000; and

''(C) at the discretion of the Secretary, with evidence of compliance with the applicable conditions or requirements of this title through an accreditation survey conducted by a national accreditation body under section 1865(b).

The Secretary may waive the requirement of a bond under subparagraph (B) in the case of a supplier that provides a comparable surety bond under State law.''.

(b) SURETY BOND REQUIREMENT FOR HOME HEALTH AGENCIES.—

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

(A) in paragraph (7), by inserting ''and including providing the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000'' after ''financial security of the program''; and

(B) by adding at the end the following: ''The Secretary may waive the requirement of a surety bond under paragraph (7) in the case of an agency or organization that provides a comparable surety bond under State law.''

(2) CONFORMING AMENDMENTS.—Section 1861(v)(1)(H) (42 U.S.C. 1395x(v)(1)(H)) is amended—

(A) in clause (i), by striking ''the financial security requirement'' and inserting ''the financial security and surety bond requirements''; and

(B) in clause (ii), by striking ''the financial security requirement described in subsection (o)(7) applies'' and inserting ''the financial security and surety bond requirements described in subsection (o)(7) apply''.

(3) REFERENCE TO CURRENT DISCLOSURE REQUIREMENT.—For additional provisions requiring home health agencies to disclose information on ownership and control interests, see section 1124 of the Social Security Act (42 U.S.C. 1320a–3).

(c) AUTHORIZING APPLICATION OF DISCLOSURE AND SURETY BOND REQUIREMENTS TO AMBULANCE SERVICES AND CERTAIN CLINICS.—Section 1834(a)(16) (42 U.S.C. 1395m(a)(16)), as added by subsection (a), is amended by adding at the end the following flush sentence:

The Secretary, in the Secretary's discretion, may impose the requirements of the previous sentence with respect to some or all classes of suppliers of ambulance services described in section 1861(s)(7) and clinics that furnish medical and other health services (other than physicians' services) under this part.''.

(d) APPLICATION TO COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORFS).—Section 1861(cc)(2) (42 U.S.C. 1395x(cc)(2)) is amended—

(1) in subparagraph (I), by inserting before the period at the end the following: ''and providing the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000''; and

(2) by adding at the end the following flush sentence:

''The Secretary may waive the requirement of a bond under subparagraph (I) in the case of a facility that provides a comparable surety bond under State law.''.

(e) APPLICATION TO REHABILITATION AGENCIES.—Section 1861(p) (42 U.S.C. 1395x(p)) is amended—

(1) in paragraph (4)(A)(v), by inserting after ''as the Secretary may find necessary,'' the following: ''and provides the Secretary, to the extent required by the Secretary, on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000,'', and

(2) by adding at the end the following: ''The Secretary may waive the requirement of a bond under paragraph (4)(A)(v) in the case of a clinic or agency that provides a comparable surety bond under State law.''.

(f) EFFECTIVE DATES.—

(1) SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.—The amendment made by subsection (a) shall apply to suppliers of durable medical equipment with respect to such equipment furnished on or after January 1, 1998.

(2) HOME HEALTH AGENCIES.—The amendments made by subsection (b) shall apply to home health agencies with respect to services furnished on or after January 1, 1998. The Secretary of Health and Human Services shall modify participation agreements under section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) with respect to home health agencies to provide for implementation of such amendments on a timely basis.

(3) OTHER AMENDMENTS.—The amendments made by subsections (c) through (e) shall take effect on the date of the enactment of this Act and may be applied with respect to items and services furnished on or after the date specified in paragraph (1).

SEC. 5212. PROVISION OF CERTAIN IDENTIFICATION NUMBERS.

(a) REQUIREMENTS TO DISCLOSE EMPLOYER IDENTIFICATION NUMBERS (EINS) AND SOCIAL SECURITY ACCOUNT NUMBERS (SSNS).—Section 1124(a)(1) (42 U.S.C. 1320a–3(a)(1)) is amended by inserting before the period at the end the following: ''and supply the Secretary with the both the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing entity, each person with an ownership or control interest (as defined in subsection (a)(3)), and any subcontractor in which the entity directly or indirectly has a 5 percent or more ownership interest''.

(b) OTHER MEDICARE PROVIDERS.—Section 1124A (42 U.S.C. 1320a–3a) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking ''and'' at the end;

(B) in paragraph (2), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(3) including the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing part B provider and any person, managing employee, or other entity identified or described under paragraph (1) or (2).''; and

(2) in subsection (c)(1), by inserting ''(or, for purposes of subsection (a)(3), any entity receiving payment)'' after ''on an assignment-related basis''.

(c) VERIFICATION BY SOCIAL SECURITY ADMINISTRATION (SSA).—Section 1124A (42 U.S.C. 1320a–3a), as amended by subsection (b), is amended—

(1) by redesignating subsection (c) as subsection (d); and

(2) by inserting after subsection (b) the following:

''(c) VERIFICATION.—

''(1) TRANSMITTAL BY HHS.—The Secretary shall transmit—

''(A) to the Commissioner of Social Security information concerning each social security account number (assigned under section 205(c)(2)(B)), and

''(B) to the Secretary of the Treasury information concerning each employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986),

supplied to the Secretary pursuant to subsection (a)(3) or section 1124(c) to the extent necessary for verification of such information in accordance with paragraph (2).

''(2) VERIFICATION.—The Commissioner of Social Security and the Secretary of the Treasury shall verify the accuracy of, or correct, the information supplied by the Secretary to such official pursuant to paragraph (1), and shall report such verifications or corrections to the Secretary.

''(3) FEES FOR VERIFICATION.—The Secretary shall reimburse the Commissioner and Secretary of the Treasury, at a rate negotiated between the Secretary and such official, for the costs incurred by such official in performing the verification and correction services described in this subsection.''.

(d) REPORT.—The Secretary of Health and Human Services shall submit to Congress a report on steps the Secretary has taken to assure the confidentiality of social security account numbers that will be provided to the Secretary under the amendments made by this section.

(e) EFFECTIVE DATES.—

(1) DISCLOSURE REQUIREMENTS.—The amendment made by subsection (a) shall apply to the application of conditions of participation, and entering into and renewal of contracts and agreements, occurring more than 90 days after the date of submission of the report under subsection (d).

(2) OTHER PROVIDERS.—The amendments made by subsection (b) shall apply to payment for items and services furnished more than 90 days after the date of submission of such report.

SEC. 5213. APPLICATION OF CERTAIN PROVISIONS OF THE BANKRUPTCY CODE.

(a) RESTRICTED APPLICABILITY OF BANKRUPTCY STAY, DISCHARGE, AND PREFERENTIAL TRANSFER PROVISIONS TO MEDICARE AND MEDICAID DEBTS.—Part A of title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1143 the following:

''APPLICATION OF CERTAIN PROVISIONS OF THE BANKRUPTCY CODE

''SEC. 1144. (a) MEDICARE AND MEDICAID-RELATED ACTIONS NOT STAYED BY BANKRUPTCY PROCEEDINGS.—The commencement or continuation of any action against a debtor under this title or title XVIII or XIX (other than an action with respect to health care services for the debtor under title XVIII), including any action or proceeding to exclude or suspend the debtor from program participation, assess civil money penalties, recoup or set off overpayments, or deny or suspend payment of claims shall not be subject to the provisions of section 362(a) of title 11, United States Code.

''(b) CERTAIN MEDICARE- AND MEDICAID-RELATED DEBT NOT DISCHARGEABLE IN BANKRUPTCY.—A debt owed to the United States or to a State for an overpayment under title XVIII or XIX (other than an overpayment for health care services for the debtor under title XVIII) resulting from the fraudulent actions of the debtor, or for a penalty, fine, or assessment under this title or title XVIII or XIX, shall not be dischargeable under any provision of title 11, United States Code.

''(c) REPAYMENT OF CERTAIN DEBTS CONSIDERED FINAL.—Payments made to repay a debt to the United States or to a State with respect to items or services provided, or claims for payment made, under title XVIII or XIX (including repayment of an overpayment (other than an overpayment for health care services for the debtor under title XVIII) resulting from the fraudulent actions of the debtor), or to pay a penalty, fine, or assessment under this title or title XVIII or XIX, shall be considered final and not preferential transfers under section 547 of title 11, United States Code.''.

(b) MEDICARE RULES APPLICABLE TO BANKRUPTCY PROCEEDINGS.—Title XVIII (42 U.S.C. 1395 et seq.) is amended by adding at the end the following:

''APPLICATION OF PROVISIONS OF THE BANKRUPTCY CODE

''SEC. 1894. (a) USE OF MEDICARE STANDARDS AND PROCEDURES.—Notwithstanding any provision of title 11, United States Code, or any other provision of law, in the case of claims by a debtor in bankruptcy for payment under this title, the determination of whether the claim is allowable and of the amount payable, shall be made in accordance with the provisions of this title and title XI and implementing regulations.

''(b) NOTICE TO CREDITOR OF BANKRUPTCY PETITIONER.—In the case of a debt owed to the United States with respect to items or services provided, or claims for payment made, under this title (including a debt arising from an overpayment or a penalty, fine, or assessment under title XI or this title), the notices to the creditor of bankruptcy petitions, proceedings, and relief required under title 11, United States Code (including under section 342 of that title and section 2002(j) of the Federal Rules of Bankruptcy Procedure), shall be given to the Secretary. Provision of such notice to a fiscal agent of the Secretary shall not be considered to satisfy this requirement.

''(c) TURNOVER OF PROPERTY TO THE BANKRUPTCY ESTATE.—For purposes of section 542(b) of title 11, United States Code, a claim for payment under this title shall not be considered to be a matured debt payable to the estate of a debtor until such claim has been allowed by the Secretary in accordance with procedures under this title.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to bankruptcy petitions filed after the date of the enactment of this Act.

SEC. 5214. REPLACEMENT OF REASONABLE CHARGE METHODOLOGY BY FEE SCHEDULES.

(a) IN GENERAL.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended in the matter preceding subparagraph (A) by striking ''the reasonable charges for the services'' and inserting ''the lesser of the actual charges for the services and the amounts determined by the applicable fee schedules developed by the Secretary for the particular services''.

(b) CONFORMING AMENDMENTS.—

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

(A) in subparagraph (A), by striking ''reasonable charges for'' and inserting ''payment bases otherwise applicable to'';

(B) in subparagraph (B), by striking ''reasonable charges'' and inserting ''fee schedule amounts''; and

(C) by inserting after subparagraph (F) the following: ''(G) with respect to services described in clause (i) or (ii) of section 1861(s)(2)(K) (relating to physician assistants and nurse practitioners), the amounts paid shall be 80 percent of the lesser of the actual charge for the services and the applicable amount determined under subclause (I) or (II) of section 1842(b)(12)(A)(ii),''.

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

(A) in subparagraph (B), in the matter preceding clause (i), by striking ''(C), (D),'' and inserting ''(D)''; and

(B) by striking subparagraph (C).

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

(A) in paragraph (3)—

(i) by striking subparagraph (B); and

(ii) by striking ''(3)(A)'' and inserting ''(3)''; and

(B) by striking paragraph (6).

(4) Section 1834(a)(10)(B) (42 U.S.C. 1395m(a)(10)(B)) is amended by striking ''paragraphs (8) and (9)'' and all that follows through ''section 1848(i)(3).'' and inserting ''section 1842(b)(8) to covered items and suppliers of such items and payments under this subsection as such provisions would otherwise apply to physicians' services and physicians.''.

(5) Section 1834(g)(1)(A)(ii) (42 U.S.C. 1395m(g)(1)(A)(ii)) is amended in the heading by striking ''REASONABLE CHARGES FOR PROFESSIONAL'' and inserting ''PROFESSIONAL''.

(6) Section 1842(a) (42 U.S.C. 1395u(a)) is amended—

(A) in the matter preceding paragraph (1), by striking ''reasonable charge'' and inserting ''fee schedule''; and

(B) in paragraph (1)(A), by striking ''reasonable charge'' and inserting ''other''.

(7) Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(A) in subparagraph (B)—

(i) in the matter preceding clause (i), by striking ''where payment'' and all that follows through ''made—'' and inserting ''where payment under this part for a service is on a basis other than a cost basis, such payment will (except as otherwise provided in section 1870(f)) be made—''; and

(ii) by striking clause (ii)(I) and inserting the following: ''(I) the amount determined by the applicable payment basis under this part is the full charge for the service,''; and

(B) by striking the second, third, fourth, fifth, sixth, eighth, and ninth sentences.

(8) Section 1842(b)(4) (42 U.S.C. 1395u(b)(4)) is amended to read as follows:

''(4) In the case of an enteral or parenteral pump that is furnished on a rental basis during a period of medical need—

''(A) monthly rental payments shall not be made under this part for more than 15 months during that period, and

''(B) after monthly rental payments have been made for 15 months during that period, payment under this part shall be made for maintenance and servicing of the pump in amounts that the Secretary determines to be reasonable and necessary to ensure the proper operation of the pump.''.

(9) Section 6112(b) (42 U.S.C. 1395m note; Public Law 101–239) of OBRA—1989 is repealed.

(10) Section 1842(b)(7) (42 U.S.C. 1395u(b)(7)) is amended—

(A) in subparagraph (D)(i), in the matter preceding subclause (I), by striking '', to the extent that such payment is otherwise allowed under this paragraph,'';

(B) in subparagraph (D)(ii), by striking ''subparagraph'' and inserting ''paragraph'';

(C) by striking ''(7)(A) In the case of'' and all that follows through subparagraph (C);

(D) by striking ''(D)(i)'' and inserting ''(7)(A)'';

(E) by redesignating clauses (ii) and (iii) as subparagraphs (B) and (C), respectively; and

(F) by redesignating subclauses (I), (II), and (III) of subparagraph (A) (as redesignated by subparagraph (D) of this paragraph) as clauses (i), (ii), and (iii), respectively.

(11) Section 1842(b)(9) (42 U.S.C. 1395u(b)(9)) is repealed.

(12) Section 1842(b)(10) (42 U.S.C. 1395u(b)(10)) is repealed.

(13) Section 1842(b)(11) (42 U.S.C. 1395u(b)(11)) is amended—

(A) by striking subparagraphs (B) through (D);

(B) by striking ''(11)(A)'' and inserting ''(11)''; and

(C) by redesignating clauses (i) and (ii) as subparagraphs (A) and (B), respectively.

(14) Section 1842(b)(12)(A)(ii) (42 U.S.C. 1395u(b)(12)(A)(ii)) is amended—

(A) in the matter preceding subclause (I), by striking ''prevailing charges determined under paragraph (3)'' and inserting ''the amounts determined under section 1833(a)(1)(G)''; and

(B) in subclause (II), by striking ''prevailing charge rate'' and all that follows up to the period and inserting ''fee schedule amount specified in section 1848 for such services performed by physicians''.

(15) Paragraphs (14) through (17) of section 1842(b) (42 U.S.C. 1395u(b)) are repealed.

(16) Section 1842(b) (42 U.S.C. 1395u(b)) is amended—

(A) in paragraph (18)(A), by striking ''reasonable charge or''; and

(B) by redesignating paragraph (18) as paragraph (14).

(17) Section 1842(j)(1) (42 U.S.C. 1395u(j)) is amended to read as follows:

''(j)(1) See subsections (k), (l), (m), (n), and (p) as to the cases in which sanctions may be applied under paragraph (2).''.

(18) Section 1842(j)(4) (42 U.S.C. 1395u(j)(4)) is amended by striking ''under paragraph (1)''.

(19) Section 1842(n)(1)(A) (42 U.S.C. 1395u(n)(1)(A)) is amended by striking ''reasonable charge (or other applicable limit)'' and inserting ''other applicable limit''.

(20) Section 1842(q) (42 U.S.C. 1395u(q)) is amended—

(A) by striking paragraph (1)(B); and

(B) by striking ''(q)(1)(A)'' and inserting ''(q)(1)''.

(21) Section 1845(b)(1) (42 U.S.C. 1395w–1(b)(1)) is amended by striking ''adjustments to the reasonable charge levels for physicians' services recognized under section 1842(b) and''.

(22) Section 1848(i)(3) (42 U.S.C. 1395w–4(i)(3)) is repealed.

(23) Section 1866(a)(2)(A)(ii) (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by striking ''reasonable charges'' and all that follows through ''provider)'' and inserting ''amount customarily charged for the items and services by the provider''.

(24) Section 1881(b)(3)(A) (42 U.S.C. 1395rr(b)(3)(A)) is amended by striking ''a reasonable charge'' and all that follows through ''section 1848)'' and inserting ''the basis described in section 1848''.

(25) Section 9340 of OBRA—1986 (42 U.S.C. 1395u note; Public Law 99-509) is repealed.

(c) EFFECTIVE DATES.—The amendments made by this section to the extent such amendments substitute fee schedules for reasonable charges, shall apply to particular services as of the date specified by the Secretary of Health and Human Services.

(d) INITIAL BUDGET NEUTRALITY.—The Secretary, in developing a fee schedule for particular services (under the amendments made by this section), shall set amounts for the first year period to which the fee schedule applies at a level so that the total payments under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for those services for that year period shall be approximately equal to the estimated total payments if those amendments had not been made.

SEC. 5215. APPLICATION OF INHERENT REASONABLENESS TO ALL PART B SERVICES OTHER THAN PHYSICIANS' SERVICES.

(a) IN GENERAL.—Section 1842(b)(8) (42 U.S.C. 1395u(b)(8)) is amended to read as follows:

''(8) The Secretary shall describe by regulation the factors to be used in determining the cases (of particular items or services) in which the application of this part (other than to physicians' services paid under section 1848) results in the determination of an amount that, because of its being grossly excessive or grossly deficient, is not inherently reasonable, and provide in those cases for the factors to be considered in establishing an amount that is realistic and equitable.''.

(b) CONFORMING AMENDMENT.—Section 1834(a)(10) (42 U.S.C. 1395m(a)(10)(B)) is amended—

(1) by striking subparagraph (B); and

(2) by redesignating subparagraph (C) as subparagraph (B).

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

SEC. 5216. REQUIREMENT TO FURNISH DIAGNOSTIC INFORMATION.

(a) INCLUSION OF NON-PHYSICIAN PRACTITIONERS IN REQUIREMENT TO PROVIDE DIAGNOSTIC CODES FOR PHYSICIAN SERVICES.—Paragraphs (1) and (2) of section 1842(p) (42 U.S.C. 1395u(p)) are each amended by inserting ''or practitioner specified in subsection (b)(18)(C)'' after ''by a physician''.

(b) REQUIREMENT TO PROVIDE DIAGNOSTIC INFORMATION WHEN ORDERING CERTAIN ITEMS OR SERVICES FURNISHED BY ANOTHER ENTITY.—Section 1842(p) (42 U.S.C. 1395u(p)), is amended by adding at the end the following:

''(4) In the case of an item or service defined in paragraph (3), (6), (8), or (9) of subsection 1861(s) ordered by a physician or a practitioner specified in subsection (b)(18)(C), but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 5217. REPORT BY GAO ON OPERATION OF FRAUD AND ABUSE CONTROL PROGRAM.

Section 1817(k)(6) (42 U.S.C. 1395i(k)(6)) is amended by inserting ''June 1, 1998, and'' after ''Not later than''.

SEC. 5218. COMPETITIVE BIDDING.

(a) GENERAL RULE.—Part B of title XVIII (42 U.S.C. 1395j et seq.) is amended by inserting after section 1846 the following:

''SEC. 1847. COMPETITIVE ACQUISITION OF ITEMS AND SERVICES.

''(a) ESTABLISHMENT OF BIDDING AREAS.—

''(1) IN GENERAL.—The Secretary shall establish competitive acquisition areas for contract award purposes for the furnishing under this part after 1997 of the items and services described in subsection (c). The Secretary may establish different competitive acquisition areas under this subsection for different classes of items and services.

''(2) CRITERIA FOR ESTABLISHMENT.—The competitive acquisition areas established under paragraph (1) shall be chosen based on the availability and accessibility of entities able to furnish items and services, and the probable savings to be realized by the use of competitive bidding in the furnishing of items and services in the area.

''(b) AWARDING OF CONTRACTS IN AREAS.—

''(1) IN GENERAL.—The Secretary shall conduct a competition among individuals and entities supplying items and services described in subsection (c) for each competitive acquisition area established under subsection (a) for each class of items and services.

''(2) CONDITIONS FOR AWARDING CONTRACT.—The Secretary may not award a contract to any entity under the competition conducted pursuant to paragraph (1) to furnish an item or service unless the Secretary finds that the entity meets quality standards specified by the Secretary, and subject to paragraph (3), that the total amounts to be paid under the contract are expected to be less than the total amounts that would otherwise be paid.

''(3) LIMIT ON AMOUNT OF PAYMENT.—The Secretary may not under a contract awarded under this section provide for payment for an item or service in an amount in excess of the applicable fee schedule under this part for similar or related items or services. The preceding sentence shall not apply if the Secretary determines that an amount in excess of such amount is warranted by reason of technological innovation, quality improvement, or similar reasons, except that the total amount paid under the contract shall not exceed the limit under paragraph (2).

''(4) CONTENTS OF CONTRACT.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

''(5) LIMIT ON NUMBER OF CONTRACTORS.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts.

''(c) SERVICES DESCRIBED.—The items and services to which this section applies are all items and services covered under this part (except for physician services as defined by 1861(r)) that the Secretary may specify.''.

(b) ITEMS AND SERVICES TO BE FURNISHED ONLY THROUGH COMPETITIVE ACQUISITION.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) by striking ''or'' at the end of paragraph (14),

(2) by striking the period at the end of paragraph (15) and inserting ''; or'', and

(3) by inserting after paragraph (15) the following:

''(16) where the expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1847(a)) by an entity other than an entity with which the Secretary has entered into a contract under section 1847(b) for the furnishing of such an item or service in that area, unless the Secretary finds that the expenses were incurred in a case of urgent need, or in other circumstances specified by the Secretary.''.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) apply to items and services furnished after December 31, 1997.

CHAPTER 3—CLARIFICATIONS AND TECHNICAL CHANGES

SEC. 5221. OTHER FRAUD AND ABUSE RELATED PROVISIONS.

(a) REFERENCE CORRECTION.—(1) Section 1128D(b)(2)(D) (42 U.S.C. 1320a–7d(b)(2)(D)), as added by section 205 of the Health Insurance Portability and Accountability Act of 1996, is amended by striking ''1128B(b)'' and inserting ''1128A(b)''.

(2) Section 1128E(g)(3)(C) (42 U.S.C. 1320a–7e(g)(3)(C)) is amended by striking ''Veterans' Administration'' and inserting ''Department of Veterans Affairs''.

(b) LANGUAGE IN DEFINITION OF CONVICTION.—Section 1128E(g)(5) (42 U.S.C. 1320a–7e(g)(5)), as inserted by section 221(a) of the Health Insurance Portability and Accountability Act of 1996, is amended by striking ''paragraph (4)'' and inserting ''paragraphs (1) through (4)''.

(c) IMPLEMENTATION OF EXCLUSIONS.—Section 1128 (42 U.S.C. 1320a–7) is amended—

(1) in subsection (a), by striking ''any program under title XVIII and shall direct that the following individuals and entities be excluded from participation in any State health care program (as defined in subsection (h))'' and inserting ''any Federal health care program (as defined in section 1128B(f))''; and

(2) in subsection (b), by striking ''any program under title XVIII and may direct that the following individuals and entities be excluded from participation in any State health care program'' and inserting ''any Federal health care program (as defined in section 1128B(f))''.

(d) SANCTIONS FOR FAILURE TO REPORT.—Section 1128E(b) (42 U.S.C. 1320a–7e(b)), as inserted by section 221(a) of the Health Insurance Portability and Accountability Act of 1996, is amended by adding at the end the following:

''(6) SANCTIONS FOR FAILURE TO REPORT.—

''(A) HEALTH PLANS.—Any health plan that fails to report information on an adverse action required to be reported under this subsection shall be subject to a civil money penalty of not more than $25,000 for each such adverse action not reported. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) GOVERNMENTAL AGENCIES.—The Secretary shall provide for a publication of a public report that identifies those Government agencies that have failed to report information on adverse actions as required to be reported under this subsection.''.

(e) CLARIFICATION OF TREATMENT OF CERTAIN WAIVERS AND PAYMENTS OF PREMIUMS.—

(1) Section 1128A(i)(6) (42 U.S.C. 1320a–7a(i)(6)) is amended—

(A) in subparagraph (A)(iii)—

(i) in subclause (I), by adding ''or'' at the end;

(ii) in subclause (II), by striking ''or'' at the end; and

(iii) by striking subclause (III);

(B) by redesignating subparagraphs (B) and (C) as subparagraphs (C) and (D); and

(C) by inserting after subparagraph (A) the following:

''(B) any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;''.

(2) Section 1128A(i)(6) (42 U.S.C. 1320a–7a(i)(6)), is amended—

(A) in subparagraph (C), as redesignated by paragraph (1), by striking ''or'' at the end;

(B) in subparagraph (D), as so redesignated, by striking the period at the end and inserting ''; or''; and

(C) by adding at the end the following:

''(D) the waiver of deductible and coinsurance amounts pursuant to medicare supplemental policies under section 1882(t).''.

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in this subsection, the amendments made by this section shall be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996.

(2) FEDERAL HEALTH PROGRAM.—The amendments made by subsection (c) shall take effect on the date of the enactment of this Act.

(3) SANCTION FOR FAILURE TO REPORT.—The amendment made by subsection (d) shall apply to failures occurring on or after the date of the enactment of this Act.

(4) CLARIFICATION.—The amendments made by subsection (e)(2) shall take effect on the date of the enactment of this Act.

Subtitle E—Prospective Payment Systems

CHAPTER 1—PROVISIONS RELATING TO PART A

SEC. 5301. PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION HOSPITAL SERVICES.

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

''(j) PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION SERVICES.—

''(1) PAYMENT DURING TRANSITION PERIOD.—

''(A) IN GENERAL.—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation hospital or a rehabilitation unit (in this subsection referred to as a 'rehabilitation facility'), in a cost reporting period beginning on or after October 1, 2000, and before October 1, 2003, is equal to the sum of—

''(i) the TEFRA percentage (as defined in subparagraph (C)) of the amount that would have been paid under part A of this title with respect to such costs if this subsection did not apply, and

''(ii) the prospective payment percentage (as defined in subparagraph (C)) of the product of (I) the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service

occurs, and (II) the number of such payment units occurring in the cost reporting period.

''(B) FULLY IMPLEMENTED SYSTEM.—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation facility for a payment unit in a cost reporting period beginning on or after October 1, 2003, is equal to the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs.

''(C) TEFRA AND PROSPECTIVE PAYMENT PERCENTAGES SPECIFIED.—For purposes of subparagraph (A), for a cost reporting period beginning—

''(i) on or after October 1, 2000, and before October 1, 2001, the 'TEFRA percentage' is 75 percent and the 'prospective payment percentage' is 25 percent;

''(ii) on or after October 1, 2001, and before October 1, 2002, the 'TEFRA percentage' is 50 percent and the 'prospective payment percentage' is 50 percent; and

''(iii) on or after October 1, 2002, and before October 1, 2003, the 'TEFRA percentage' is 25 percent and the 'prospective payment percentage' is 75 percent.

''(D) PAYMENT UNIT.—For purposes of this subsection, the term 'payment unit' means a discharge, day of inpatient hospital services, or other unit of payment defined by the Secretary.

''(2) PATIENT CASE MIX GROUPS.—

''(A) ESTABLISHMENT.—The Secretary shall establish—

''(i) classes of patients of rehabilitation facilities (each in this subsection referred to as a 'case mix group'), based on such factors as the Secretary deems appropriate, which may include impairment, age, related prior hospitalization, comorbidities, and functional capability of the patient; and

''(ii) a method of classifying specific patients in rehabilitation facilities within these groups.

''(B) WEIGHTING FACTORS.—For each case mix group the Secretary shall assign an appropriate weighting which reflects the relative facility resources used with respect to patients classified within that group compared to patients classified within other groups.

''(C) ADJUSTMENTS FOR CASE MIX.—

''(i) IN GENERAL.—The Secretary shall from time to time adjust the classifications and weighting factors established under this paragraph as appropriate to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment is made under this title, and other factors which may affect the relative use of resources. Such adjustments shall be made in a manner so that changes in aggregate payments under the classification system are a result of real changes and are not a result of changes in coding that are unrelated to real changes in case mix.

''(ii) ADJUSTMENT.—Insofar as the Secretary determines that such adjustments for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under the classification system during the fiscal year that are a result of changes in the coding or classification of patients that do not reflect real changes in case mix, the Secretary shall adjust the per payment unit payment rate for subsequent years so as to discount the effect of such coding or classification changes.

''(D) DATA COLLECTION.—The Secretary is authorized to require rehabilitation facilities that provide inpatient hospital services to submit such data as the Secretary deems necessary to establish and administer the prospective payment system under this subsection.

''(3) PAYMENT RATE.—

''(A) IN GENERAL.—The Secretary shall determine a prospective payment rate for each payment unit for which such rehabilitation facility is entitled to receive payment under this title. Subject to subparagraph (B), such rate for payment units occurring during a fiscal year shall be based on the average payment per payment unit under this title for inpatient operating and capital costs of rehabilitation facilities using the most recent data available (as estimated by the Secretary as of the date of establishment of the system) adjusted—

''(i) by updating such per-payment-unit amount to the fiscal year involved by the weighted average of the applicable percentage increases provided under subsection (b)(3)(B)(ii) (for cost reporting periods beginning during the fiscal year) covering the period from the midpoint of the period for such data through the midpoint of fiscal year 2000 and by an increase factor (described in subparagraph (C)) specified by the Secretary for subsequent fiscal years up to the fiscal year involved;

''(ii) by reducing such rates by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on prospective payment amounts which are additional payments described in paragraph (4) (relating to outlier and related payments) or paragraph (7);

''(iii) for variations among rehabilitation facilities by area under paragraph (6);

''(iv) by the weighting factors established under paragraph (2)(B); and

''(v) by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

''(B) BUDGET NEUTRAL RATES.—The Secretary shall establish the prospective payment amounts under this subsection for payment units during fiscal years 2001 through 2004 at levels such that, in the Secretary's estimation, the amount of total payments under this subsection for such fiscal years (including any payment adjustments pursuant to paragraph (7)) shall be equal to 99 percent of the amount of payments that would have been made under this title during the fiscal years for operating and capital costs of rehabilitation facilities had this subsection not been enacted. In establishing such payment amounts, the Secretary shall consider the effects of the prospective payment system established under this subsection on the total number of payment units from rehabilitation facilities and other factors described in subparagraph (A).

''(C) INCREASE FACTOR.—For purposes of this subsection for payment units in each fiscal year (beginning with fiscal year 2001), the Secretary shall establish an increase factor. Such factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under this subsection, which may be the market basket percentage increase described in subsection (b)(3)(B)(iii).

''(4) OUTLIER AND SPECIAL PAYMENTS.—

''(A) OUTLIERS.—

''(i) IN GENERAL.—The Secretary may provide for an additional payment to a rehabilitation facility for patients in a case mix group, based upon the patient being classified as an outlier based on an unusual length of stay, costs, or other factors specified by the Secretary.

''(ii) PAYMENT BASED ON MARGINAL COST OF CARE.—The amount of such additional payment under clause (i) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable under clause (i).

''(iii) TOTAL PAYMENTS.—The total amount of the additional payments made under this subparagraph for payment units in a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on prospective payment rates for payment units in that year.

''(B) ADJUSTMENT.—The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of rehabilitation facilities located in Alaska and Hawaii.

''(5) PUBLICATION.—The Secretary shall provide for publication in the Federal Register, on or before September 1 before each fiscal year (beginning with fiscal year 2001, of the classification and weighting factors for case mix groups under paragraph (2) for such fiscal year and a description of the methodology and data used in computing the prospective payment rates under this subsection for that fiscal year.

''(6) AREA WAGE ADJUSTMENT.—The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under paragraph (3) for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. Not later than October 1, 2001 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under this paragraph for a fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.

''(7) ADDITIONAL ADJUSTMENTS.—The Secretary may provide by regulation for—

''(A) an additional payment to take into account indirect costs of medical education and the special circumstances of hospitals that serve a significantly disproportionate number of low-income patients in a manner similar to that provided under subparagraphs (B) and (F), respectively, of subsection (d)(5); and

''(B) such other exceptions and adjustments to payment amounts under this subsection in a manner similar to that provided under subsection (d)(5)(I) in relation to payments under subsection (d).

''(8) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the establishment of—

''(A) case mix groups, of the methodology for the classification of patients within such groups, and of the appropriate weighting factors thereof under paragraph (2),

''(B) the prospective payment rates under paragraph (3),

''(C) outlier and special payments under paragraph (4),

''(D) area wage adjustments under paragraph (6), and

''(E) additional adjustments under paragraph (7).''.

(b) CONFORMING AMENDMENTS.—Section 1886(b) (42 U.S.C. 1395ww(b)) is amended—

(1) in paragraph (1), by inserting ''and other than a rehabilitation facility described

in subsection (j)(1)'' after ''subsection (d)(1)(B)'', and

(2) in paragraph (3)(B)(i), by inserting ''and subsection (j)'' after ''For purposes of subsection (d)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 2000, except that the Secretary of Health and Human Services may require the submission of data under section 1886(j)(2)(D) of the Social Security Act (as added by subsection (a)) on and after the date of the enactment of this section.

SEC. 5302. STUDY AND REPORT ON PAYMENTS FOR LONG-TERM CARE HOSPITALS.

(a) STUDY.—The Secretary of Health and Human Services shall—

(1) collect data to develop, establish, administer and evaluate a case-mix adjusted prospective payment system for hospitals described in section 1886(d)(1)(B)(iv) (42 U.S.C. 1395ww(d)(1)(B)(iv)); and

(2) develop a legislative proposal for establishing and administering such a payment system that includes an adequate patient classification system that reflects the differences in patient resource use and costs among such hospitals.

(b) REPORT.—Not later than October 1, 1999, the Secretary of Health and Human Services shall submit the proposal described in subsection (a)(2) to the appropriate committees of Congress.

CHAPTER 2—PROVISIONS RELATING TO PART B

Subchapter A—Payment for Hospital Outpatient Department Services

SEC. 5311. ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS (FDO) FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.

(a) ELIMINATION OF FDO FOR AMBULATORY SURGICAL CENTER PROCEDURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C. 1395l(i)(3)(B)(i)(II)) is amended—

(1) by striking ''of 80 percent''; and

(2) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(b) ELIMINATION OF FDO FOR RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i) (42 U.S.C. 1395l(n)(1)(B)(i)) is amended—

(1) by striking ''of 80 percent'', and

(2) by inserting before the period at the end the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished during portions of cost reporting periods occurring on or after October 1, 1997.

SEC. 5312. EXTENSION OF REDUCTIONS IN PAYMENTS FOR COSTS OF HOSPITAL OUTPATIENT SERVICES.

(a) REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS.—Section 1861(v)(1)(S)(ii)(I) (42 U.S.C. 1395x(v)(1)(S)(ii)(I)) is amended by striking ''through 1998'' and inserting ''through 1999 and during fiscal year 2000 before January 1, 2000''.

(b) REDUCTION IN PAYMENTS FOR OTHER COSTS.—Section 1861(v)(1)(S)(ii)(II) (42 U.S.C. 1395x(v)(1)(S)(ii)(II)) is amended by striking ''through 1998'' and inserting ''through 1999 and during fiscal year 2000 before January 1, 2000''.

SEC. 5313. PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l) is amended by adding at the end the following:

''(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

''(1) IN GENERAL.—With respect to hospital outpatient services designated by the Secretary (in this section referred to as 'covered OPD services') and furnished during a year beginning with 1999, the amount of payment under this part shall be determined under a prospective payment system established by the Secretary in accordance with this subsection.

''(2) SYSTEM REQUIREMENTS.—Under the payment system—

''(A) the Secretary shall develop a classification system for covered OPD services;

''(B) the Secretary may establish groups of covered OPD services, within the classification system described in subparagraph (A), so that services classified within each group are comparable clinically and with respect to the use of resources;

''(C) the Secretary shall, using data on claims from 1997 and using data from the most recent available cost reports, establish relative payment weights for covered OPD services (and any groups of such services described in subparagraph (B)) based on median hospital costs and shall determine projections of the frequency of utilization of each such service (or group of services) in 1999;

''(D) the Secretary shall determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner;

''(E) the Secretary shall establish other adjustments as determined to be necessary to ensure equitable payments, such as outlier adjustments or 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.

''(3) CALCULATION OF BASE AMOUNTS.—

''(A) AGGREGATE AMOUNTS THAT WOULD BE PAYABLE IF DEDUCTIBLES WERE DISREGARDED.—The Secretary shall estimate the total amounts that would be payable from the Trust Fund under this part for covered OPD services in 1999, determined without regard to this subsection, as though the deductible under section 1833(b) did not apply, and as though the coinsurance described in section 1866(a)(2)(A)(ii) (as in effect before the date of the enactment of this subsection) continued to apply.

''(B) UNADJUSTED COPAYMENT AMOUNT.—

''(i) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the 'unadjusted copayment amount' applicable to a covered OPD service (or group of such services) is 20 percent of the national median of the charges for the service (or services within the group) furnished during 1997, updated to 1999 using the Secretary's estimate of charge growth during the period.

''(ii) ADJUSTMENTS WHEN FULLY PHASED IN.—If the pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year would be equal to or exceed 80 percent, then the unadjusted copayment amount shall be 25 percent of amount determined under subparagraph (D)(i).

''(iii) RULES FOR NEW SERVICES.—The Secretary shall establish rules for establishment of an unadjusted copayment amount for a covered OPD service not furnished during 1997, based upon its classification within a group of such services.

''(C) CALCULATION OF CONVERSION FACTORS.—

''(i) FOR 1999.—

''(I) IN GENERAL.—The Secretary shall establish a 1999 conversion factor for determining the medicare pre-deductible OPD fee payment amounts for each covered OPD service (or group of such services) furnished in 1999. Such conversion factor shall be established—

''(aa) on the basis of the weights and frequencies described in paragraph (2)(C), and

''(bb) in such manner that the sum of the products determined under subclause (II) for each service or group equals the total project amount described in subparagraph (A).

''(II) PRODUCT.—The Secretary shall determine for each service or group the product of the medicare pre-deductible OPD fee payment amount (taking into account appropriate adjustments described in paragraphs (2)(D) and (2)(E)) and the frequencies for such service or group.

''(ii) SUBSEQUENT YEARS.—Subject to paragraph (8)(B), the Secretary shall establish a conversion factor for covered OPD services furnished in subsequent years in an amount equal to the conversion factor established under this subparagraph and applicable to such services furnished in the previous year increased by the OPD payment increase factor specified under clause (iii) for the year involved.

''(iii) OPD PAYMENT INCREASE FACTOR.—For purposes of this subparagraph, the 'OPD payment increase factor' for services furnished in a year is equal to the sum of—

''(I) the market basket percentage increase applicable under section 1886(b)(3)(B)(iii) to hospital discharges occurring during the fiscal year ending in such year, plus

''(II) in the case of a covered OPD service (or group of such services) furnished in a year in which the pre-deductible payment percentage would not exceed 80 percent, 3.5 percentage points.

In applying the previous sentence for years beginning with 2000, the Secretary may substitute for the market basket percentage increase under subclause (I) an annual percentage increase that is computed and applied with respect to covered OPD services furnished in a year in the same manner as the market basket percentage increase is determined and applied to inpatient hospital services for discharges occurring in a fiscal year.

''(D) PRE-DEDUCTIBLE PAYMENT PERCENTAGE.—The pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year is equal to the ratio of—

''(i) the conversion factor established under subparagraph (C) for the year, multiplied by the weighting factor established under paragraph (2)(C) for the service (or group), to

''(ii) the sum of the amount determined under clause (i) and the unadjusted copayment amount determined under subparagraph (B) for such service or group.

''(E) CALCULATION OF MEDICARE OPD FEE SCHEDULE AMOUNTS.—The Secretary shall compute a medicare OPD fee schedule amount for each covered OPD service (or group of such services) furnished in a year, in an amount equal to the product of—

''(i) the conversion factor computed under subparagraph (C) for the year, and

''(ii) the relative payment weight (determined under paragraph (2)(C)) for the service or group.

''(4) MEDICARE PAYMENT AMOUNT.—The amount of payment made from the Trust Fund under this part for a covered OPD service (and such services classified within a group) furnished in a year is determined as follows:

''(A) FEE SCHEDULE AND COPAYMENT AMOUNT.—Add (i) the medicare OPD fee schedule amount (computed under paragraph (3)(E)) for the service or group and year, and (ii) the unadjusted copayment amount (determined under paragraph (3)(B)) for the service or group.

''(B) SUBTRACT APPLICABLE DEDUCTIBLE.—Reduce the sum under subparagraph (A) by the amount of the deductible under section 1833(b), to the extent applicable.

''(C) APPLY PAYMENT PROPORTION TO REMAINDER.—Multiply the amount determined under subparagraph (B) by the pre-deductible payment percentage (as determined under paragraph (3)(D)) for the service or group and year involved.

''(D) LABOR-RELATED ADJUSTMENT.—The amount of payment is the product determined under subparagraph (C) with the labor-related portion of such product adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraph (2)(D).

''(5) COPAYMENT AMOUNT.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the copayment amount under this subsection is determined as follows:

''(i) UNADJUSTED COPAYMENT.—Compute the amount by which the amount described in paragraph (4)(B) exceeds the amount of payment determined under paragraph (4)(C).

''(ii) LABOR ADJUSTMENT.—The copayment amount is the difference determined under clause (i) with the labor-related portion of such difference adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraphs (2)(D). The adjustment under this clause shall be made in a manner that does not result in any change in the aggregate copayments made in any year if the adjustment had not been made.

''(B) ELECTION TO OFFER REDUCED COPAYMENT AMOUNT.—The Secretary shall establish a procedure under which a hospital, before the beginning of a year (beginning with 1999), may elect to reduce the copayment amount otherwise established under subparagraph (A) for some or all covered OPD services to an amount that is not less than 25 percent of the medicare OPD fee schedule amount (computed under paragraph (3)(E)) for the service involved, adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under subparagraphs (D) and (E) of paragraph (2). Under such procedures, such reduced copayment amount may not be further reduced or increased during the year involved and the hospital may disseminate information on the reduction of copayment amount effected under this subparagraph.

''(C) NO IMPACT ON DEDUCTIBLES.—Nothing in this paragraph shall be construed as affecting a hospital's authority to waive the charging of a deductible under section 1833(b).

''(6) PERIODIC REVIEW AND ADJUSTMENTS COMPONENTS OF PROSPECTIVE PAYMENT SYSTEM.—

''(A) PERIODIC REVIEW.—The Secretary may periodically review and revise the groups, the relative payment weights, and the wage and other adjustments described in paragraph (2) to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

''(B) BUDGET NEUTRALITY ADJUSTMENT.—If the Secretary makes adjustments under subparagraph (A), then the adjustments for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expenditures under this part that would have been made if the adjustments had not been made.

''(C) UPDATE FACTOR.—If the Secretary determines under methodologies described in subparagraph (2)(F) that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary may appropriately adjust the update to the conversion factor otherwise applicable in a subsequent year.

''(7) SPECIAL RULE FOR AMBULANCE SERVICES.—The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in the matter in subsection (a)(1) preceding subparagraph (A).

''(8) SPECIAL RULES FOR CERTAIN HOSPITALS.—In the case of hospitals described in section 1886(d)(1)(B)(v)—

''(A) the system under this subsection shall not apply to covered OPD services furnished before January 1, 2000; and

''(B) the Secretary may establish a separate conversion factor for such services in a manner that specifically takes into account the unique costs incurred by such hospitals by virtue of their patient population and service intensity.

''(9) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

''(A) the development of the classification system under paragraph (2), including the establishment of groups and relative payment weights for covered OPD services, of wage adjustment factors, other adjustments, and methods described in paragraph (2)(F);

''(B) the calculation of base amounts under paragraph (3);

''(C) periodic adjustments made under paragraph (6); and

''(D) the establishment of a separate conversion factor under paragraph (8)(B).''.

(b) COINSURANCE.—Section 1866(a)(2)(A)(ii) (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by adding at the end the following: ''In the case of items and services for which payment is made under part B under the prospective payment system established under section 1833(t), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1833(t)(5).''.

(c) TREATMENT OF REDUCTION IN COPAYMENT AMOUNT.—Section 1128A(i)(6) (42 U.S.C. 1320a–7a(i)(6)) is amended—

(1) by striking ''or'' at the end of subparagraph (B),

(2) by striking the period at the end of subparagraph (C) and inserting ''; or'', and

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

''(D) a reduction in the copayment amount for covered OPD services under section 1833(t)(5)(B).''.

(d) CONFORMING AMENDMENTS.—

(1) APPROVED ASC PROCEDURES PERFORMED IN HOSPITAL OUTPATIENT DEPARTMENTS.—

(A)(i) Section 1833(i)(3)(A) (42 U.S.C. 13951(i)(3)(A)) is amended—

(I) by inserting ''before January 1, 1999'' after ''furnished'', and

(II) by striking ''in a cost reporting period''.

(ii) The amendment made by clause (i) shall apply to services furnished on or after January 1, 1999.

(B) Section 1833(a)(4) (42 U.S.C. 13951(a)(4)) is amended by inserting ''or subsection (t)'' before the semicolon.

(2) RADIOLOGY AND OTHER DIAGNOSTIC PROCEDURES.—

(A) Section 1833(n)(1)(A) (42 U.S.C. 1395l(n)(1)(A)) is amended by inserting ''and before January 1, 1999'' after ''October 1, 1988,'' and after ''October 1, 1989,''.

(B) Section 1833(a)(2)(E) (42 U.S.C. 1395l(a)(2)(E)) is amended by inserting ''or , for services or procedures performed on or after January 1, 1999, subsection (t)'' before the semicolon.

(3) OTHER HOSPITAL OUTPATIENT SERVICES.—Section –1833(a)(2)(B) (42 U.S.C. 1395l(a)(2)(B)) is amended—

(A) in clause (i), by inserting ''furnished before January 1, 1999,'' after ''(i)'',

(B) in clause (ii), by inserting ''before January 1, 1999,'' after ''furnished'',

(C) by redesignating clause (iii) as clause (iv), and

(D) by inserting after clause (ii), the following new clause:

''(iii) if such services are furnished on or after January 1, 1999, the amount determined under subsection (t), or''.

Subchapter B—Ambulance Services

SEC. 5321. PAYMENTS FOR AMBULANCE SERVICES.

(a) INTERIM REDUCTIONS.—

(1) PAYMENTS DETERMINED ON REASONABLE COST BASIS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

''(V) In determining the reasonable cost of ambulance services (as described in subsection (s)(7)) provided during a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2002), the Secretary shall not recognize any costs in excess of costs recognized as reasonable for ambulance services provided during the previous fiscal year (after application of this subparagraph), increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the fiscal year involved reduced in the case of fiscal year 1998 by 1.0 percentage point.''

(2) PAYMENTS DETERMINED ON REASONABLE CHARGE BASIS.—Section 1842(b) (42 U.S.C. 1395u(b)) is amended by adding at the end the following new paragraph:

''(19) For purposes of section 1833(a)(1), the reasonable charge for ambulance services (as described in section 1861(s)(7)) provided during a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2002) may not exceed the reasonable charge for such services provided during the previous fiscal year (after application of this paragraph), increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved reduced in the case of fiscal year 1998 by 1.0 percentage point.''

(b) ESTABLISHMENT OF PROSPECTIVE FEE SCHEDULE.—

(1) PAYMENT IN ACCORDANCE WITH FEE SCHEDULE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking ''and (P)'' and inserting ''(P)''; and

(B) by striking the semicolon at the end and inserting the following: '', and (Q) with respect to ambulance service, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary under section 1834(k);''.

(2) ESTABLISHMENT OF SCHEDULE.—Section 1834 (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(k) ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.—

''(1) IN GENERAL.—The Secretary shall establish a fee schedule for payment for ambulance services under this part through a negotiated rulemaking process described in title 5, United States Code, and in accordance with the requirements of this subsection.

''(2) CONSIDERATIONS.—In establishing such fee schedule, the Secretary shall—

''(A) establish mechanisms to control increases in expenditures for ambulance services under this part;

''(B) establish definitions for ambulance services which link payments to the type of services provided;

''(C) consider appropriate regional and operational differences;

''(D) consider adjustments to payment rates to account for inflation and other relevant factors; and

''(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner.

''(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 1999 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 5321 of the Balanced Budget Act of 1997 had not been made; and

''(B) set the payment amounts provided under the fee schedule for services furnished in 2000 and each subsequent year at amounts equal to the payment amounts under the fee schedule for service 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 (but not below zero) by 1.0 percentage points.

''(4) CONSULTATION.—In establishing the fee schedule for ambulance services under this subsection, the Secretary shall consult with various national organizations representing individuals and entities who furnish and regulate ambulance services and share with such organizations relevant data in establishing such schedule.

''(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of the amounts established under the fee schedule for ambulance services under this subsection, including matters described in paragraph (2).

''(6) RESTRAINT ON BILLING.—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to ambulance services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).''.

(3) EFFECTIVE DATE.—The amendments made by this section apply to ambulance services furnished on or after January 1, 1999.

(c) AUTHORIZING PAYMENT FOR PARAMEDIC INTERCEPT SERVICE PROVIDERS IN RURAL COMMUNITIES.—In promulgating regulations to carry out section 1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7)) with respect to the coverage of ambulance service, the Secretary of Health and Human Services may include coverage of advanced life support services (in this subsection referred to as ''ALS intercept services'') provided by a paramedic intercept service provider in a rural area if the following conditions are met:

(1) The ALS intercept services are provided under a contract with one or more volunteer ambulance services and are medically necessary based on the health condition of the individual being transported.

(2) The volunteer ambulance service involved—

(A) is certified as qualified to provide ambulance service for purposes of such section,

(B) provides only basic life support services at the time of the intercept, and

(C) is prohibited by State law from billing for any services.

(3) The entity supplying the ALS intercept services—

(A) is certified as qualified to provide such services under the medicare program under title XVIII of the Social Security Act, and

(B) bills all recipients who receive ALS intercept services from the entity, regardless of whether or not such recipients are medicare beneficiaries.

CHAPTER 3—PROVISIONS RELATING TO PARTS A AND B

Subchapter A—Payments to Skilled Nursing Facilities

SEC. 5331. BASING UPDATES TO PER DIEM LIMITS EFFECTIVE FOR FISCAL YEAR 1998 ON COST LIMITS EFFECTIVE FOR FISCAL YEAR 1997.

The last sentence of section 1888(a) (42 U.S.C. 1395yy(a)) is amended by striking ''subsection'' the last place it appears and all that follows and inserting ''subsection, except that the limits effective for cost reporting periods beginning on or after October 1, 1997, shall be based on the limits effective for cost reporting periods beginning on or after October 1, 1996, increased by the skilled nursing facility market basket index to account for inflation and adjusted to account for the most recent changes in metropolitan statistical areas and wage index data.''.

SEC. 5332. PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITY SERVICES.

(a) IN GENERAL.—Section 1888 (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

''(e) PROSPECTIVE PAYMENT.—

''(1) PAYMENT PROVISION.—Notwithstanding any other provision of this title, subject to paragraph (7), the amount of the payment for all costs (as defined in paragraph (2)(B)) of covered skilled nursing facility services (as defined in paragraph (2)(A)) for each day of such services furnished—

''(A) in a cost reporting period during the transition period (as defined in paragraph (2)(E)), is equal to the sum of—

''(i) the non-Federal percentage of the facility-specific per diem rate (computed under paragraph (3)), and

''(ii) the Federal percentage of the adjusted Federal per diem rate (determined under paragraph (4)) applicable to the facility; and

''(B) after the transition period is equal to the adjusted Federal per diem rate applicable to the facility.

''(2) DEFINITIONS.—For purposes of this subsection:

''(A) COVERED SKILLED NURSING FACILITY SERVICES.—

''(i) IN GENERAL.—The term 'covered skilled nursing facility services'—

''(I) means post-hospital extended care services as defined in section 1861(i) for which benefits are provided under part A; and

''(II) includes all items and services (other than services described in clause (ii)) for which payment may be made under part B and which are furnished to an individual who is a resident of a skilled nursing facility during the period in which the individual is provided covered post-hospital extended care services.

''(ii) SERVICES EXCLUDED.—Services described in this clause are physicians' services, services described by clauses (i) through (iii) of section 1861(s)(2)(K), certified nurse-midwife services, qualified psychologist services, services of a certified registered nurse anesthetist, items and services described in subparagraphs in (F) and (O) of section 1861(s)(2), and, only with respect to services furnished during 1998, the transportation costs of electrocardiogram equipment for electrocardiogram tests services (HCPCS Code R0076). Services described in this clause do not include any physical, occupational, or speech-language therapy services regardless of whether or not the services are furnished by, or under the supervision of, a physician or other health care professional.

''(B) ALL COSTS.—The term 'all costs' means routine service costs, ancillary costs, and capital-related costs of covered skilled nursing facility services, but does not include costs associated with approved educational activities.

''(C) NON-FEDERAL PERCENTAGE; FEDERAL PERCENTAGE.—For—

''(i) the first cost reporting period (as defined in subparagraph (D)) of a facility, the 'non-Federal percentage' is 75 percent and the 'Federal percentage' is 25 percent;

''(ii) the next cost reporting period of such facility, the 'non-Federal percentage' is 50 percent and the 'Federal percentage' is 50 percent; and

''(iii) the subsequent cost reporting period of such facility, the 'non-Federal percentage' is 25 percent and the 'Federal percentage' is 75 percent.

''(D) FIRST COST REPORTING PERIOD.—The term 'first cost reporting period' means, with respect to a skilled nursing facility, the first cost reporting period of the facility beginning on or after October 1, 1998.

''(E) TRANSITION PERIOD.—

''(i) IN GENERAL.—The term 'transition period' means, with respect to a skilled nursing facility, the 3 cost reporting periods of the facility beginning with the first cost reporting period.

''(ii) TREATMENT OF NEW SKILLED NURSING FACILITIES.—In the case of a skilled nursing facility that does not have a settled cost report for a cost reporting period before July 1, 1998, payment for such services shall be made under this subsection as if all services were furnished after the transition period.

''(3) DETERMINATION OF FACILITY SPECIFIC PER DIEM RATES.—The Secretary shall determine a facility-specific per diem rate for each skilled nursing facility for a cost reporting period as follows:

''(A) DETERMINING BASE PAYMENTS.—The Secretary shall determine, on a per diem basis, the total of—

''(i) the allowable costs of extended care services for the facility for cost reporting periods beginning in 1995 with appropriate adjustments (as determined by the Secretary) to non-settled cost reports, and

''(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during such period to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

''(B) UPDATE TO COST REPORTING PERIODS THROUGH 1998.—The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase.

''(C) UPDATING TO APPLICABLE COST REPORTING PERIOD.—The Secretary shall further update such amount for each cost reporting period beginning with the first cost reporting period and up to and including the cost reporting period involved by a factor equal to the skilled nursing facility market basket percentage increase.

''(D) CERTAIN DEMONSTRATION PROJECTS.—In the case of a facility participating in the Nursing Home Case-Mix and Quality Demonstration (RUGS–III), the Secretary shall determine the facility specific per diem rate for any year after 1997 by computing the base period payments by using the RUGS–III rate received by the facility for 1997, increased by a factor equal to the skilled nursing facility market basket percentage increase.

''(4) FEDERAL PER DIEM RATE.—

''(A) DETERMINATION OF HISTORICAL PER DIEM FOR FACILITIES.—For each skilled nursing facility that received payments for post-hospital extended care services during a cost reporting period beginning in fiscal year 1995

and that was subject to (and not exempted from) the per diem limits referred to in paragraph (1) or (2) of subsection (a) (and facilities described in subsection (d)), the Secretary shall estimate, on a per diem basis for such cost reporting period, the total of—

''(i) subject to subparagraph (I), the allowable costs of extended care services for the facility for cost reporting periods beginning in 1995 with appropriate adjustments (as determined by the Secretary) to non-settled cost reports, and

''(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during such period to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

''(B) UPDATE TO COST REPORTING PERIODS THROUGH 1998.—The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase reduced (on an annualized basis) by 1 percentage point.

''(C) COMPUTATION OF STANDARDIZED PER DIEM RATE.—The Secretary shall standardize the amount updated under subparagraph (B) for each facility by—

''(i) adjusting for variations among facility by area in the average facility wage level per diem, and

''(ii) adjusting for variations in case mix per diem among facilities.

''(D) COMPUTATION OF WEIGHTED AVERAGE PER DIEM RATE.—The Secretary shall compute a weighted average per diem rate by computing an average of the standardized amounts computed under subparagraph (C), weighted for each facility by the number of days of extended care services furnished during the cost reporting period referred to in subparagraph (A). The Secretary may compute and apply such average separately for facilities located in urban and rural areas (as defined in section 1886(d)(2)(D)).

''(E) UPDATING.—

''(i) FISCAL YEAR 1999.—For fiscal year 1999, the Secretary shall compute for each skilled nursing facility an unadjusted Federal per diem rate equal to the weighted average per diem rate computed under subparagraph (D) and applicable to the facility increased by skilled nursing facility market basket percentage change for the fiscal year involved.

''(ii) SUBSEQUENT FISCAL YEARS.—For each subsequent fiscal year the Secretary shall compute for each skilled nursing facility an unadjusted Federal per diem rate equal to the Federal per diem rate computed under this subparagraph for the previous fiscal year and applicable to the facility increased by the skilled nursing facility market basket percentage change for the fiscal year involved.

''(F) ADJUSTMENT FOR CASE MIX CREEP.—Insofar as the Secretary determines that such adjustments under subparagraph (G)(i) for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in the coding or classification of residents that do not reflect real changes in case mix, the Secretary may adjust unadjusted Federal per diem rates for subsequent years so as to discount the effect of such coding or classification changes.

''(G) APPLICATION TO SPECIFIC FACILITIES.—The Secretary shall compute for each skilled nursing facility for each fiscal year (beginning with fiscal year 1998) an adjusted Federal per diem rate equal to the unadjusted Federal per diem rate determined under subparagraph (E), as adjusted under subparagraph (F), and as further adjusted as follows:

''(i) ADJUSTMENT FOR CASE MIX.—The Secretary shall provide for an appropriate adjustment to account for case mix. Such adjustment shall be based on a resident classification system, established by the Secretary, that accounts for the relative resource utilization of different patient types. The case mix adjustment shall be based on resident assessment data and other data that the Secretary considers appropriate.

''(ii) ADJUSTMENT FOR GEOGRAPHIC VARIATIONS IN LABOR COSTS.—The Secretary shall adjust the portion of such per diem rate attributable to wages and wage-related costs for the area in which the facility is located compared to the national average of such costs using an appropriate wage index as determined by the Secretary. Such adjustment shall be done in a manner that does not result in aggregate payments under this subsection that are greater or less than those that would otherwise be made if such adjustment had not been made.

''(H) PUBLICATION OF INFORMATION ON PER DIEM RATES.—The Secretary shall provide for publication in the Federal Register, before the July 1 preceding each fiscal year (beginning with fiscal year 1999), of—

''(i) the unadjusted Federal per diem rates to be applied to days of covered skilled nursing facility services furnished during the fiscal year,

''(ii) the case mix classification system to be applied under subparagraph (G)(i) with respect to such services during the fiscal year, and

''(iii) the factors to be applied in making the area wage adjustment under subparagraph (G)(ii) with respect to such services.

''(I) EXCLUSION OF EXCEPTION PAYMENTS FROM DETERMINATION OF HISTORICAL PER DIEM.—In determining allowable costs under subparagraph (A)(i), the Secretary shall not take into account any payments described in subsection (c).

''(5) SKILLED NURSING FACILITY MARKET BASKET INDEX, PERCENTAGE, AND HISTORICAL TREND FACTOR.—For purposes of this subsection:

''(A) SKILLED NURSING FACILITY MARKET BASKET INDEX.—The Secretary shall establish a skilled nursing facility market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered skilled nursing facility services.

''(B) SKILLED NURSING FACILITY MARKET BASKET PERCENTAGE.—The term 'skilled nursing facility market basket percentage' means, for a fiscal year or other annual period and as calculated by the Secretary, the percentage change in the skilled nursing facility market basket index (established under subparagraph (A)) from the midpoint of the prior fiscal year (or period) to the midpoint of the fiscal year (or other period) involved.

''(6) SUBMISSION OF RESIDENT ASSESSMENT DATA.—A skilled nursing facility shall provide the Secretary, in a manner and within the timeframes prescribed by the Secretary, the resident assessment data necessary to develop and implement the rates under this subsection. For purposes of meeting such requirement, a skilled nursing facility may submit the resident assessment data required under section 1819(b)(3), using the standard instrument designated by the State under section 1819(e)(5).

''(7) TRANSITION FOR MEDICARE SWING BED HOSPITALS.—

''(A) IN GENERAL.—The Secretary shall determine an appropriate manner in which to apply this subsection to the facilities described in subparagraph (B), taking into account the purposes of this subsection, and shall provide that at the end of the transition period (as defined in paragraph (2)(E)) such facilities shall be paid only under this subsection. Payment shall not be made under this subsection to such facilities for cost reporting periods beginning before such date (not earlier than July 1, 1999) as the Secretary specifies.

''(B) FACILITIES DESCRIBED.—The facilities described in this subparagraph are facilities that have in effect an agreement described in section 1883, for which payment is made for the furnishing of extended care services on a reasonable cost basis under section 1814(l) (as in effect on and after such date).

''(8) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

''(A) the establishment of Federal per diem rates under paragraph (4), including the computation of the standardized per diem rates under paragraph (4)(C), adjustments and corrections for case mix under paragraphs (4)(F) and (4)(G)(i), and adjustments for variations in labor-related costs under paragraph (4)(G)(ii); and

''(B) the establishment of transitional amounts under paragraph (7).''.

(b) CONSOLIDATED BILLING.—

(1) FOR SNF SERVICES.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) by striking ''or'' at the end of paragraph (15),

(B) by striking the period at the end of paragraph (16) and inserting ''; or'', and

(C) by inserting after paragraph (16) the following new paragraph:

''(17) which are covered skilled nursing facility services described in section 1888(e)(2)(A)(i)(II) and which are furnished to an individual who is a resident of a skilled nursing facility 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, or such services are furnished by a physician described in section 1861(r)(1).''.

(2) REQUIRING PAYMENT FOR ALL PART B ITEMS AND SERVICES TO BE MADE TO FACILITY.—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended—

(A) by striking ''and (D)'' and inserting ''(D)''; and

(B) by striking the period at the end and inserting the following: '', and (E) in the case of an item or service (other than services described in section 1888(e)(2)(A)(ii)) furnished to an individual who (at the time the item or service is furnished) is a resident of a skilled nursing facility, 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).''.

(3) PAYMENT RULES.—Section 1888(e) (42 U.S.C. 1395yy(e)), as added by subsection (a), is amended by adding at the end the following:

''(9) PAYMENT FOR CERTAIN SERVICES.—

''(A) IN GENERAL.—In the case of an item or service furnished by a skilled nursing facility (or by others under arrangement with them made by a skilled nursing facility or under any other contracting or consulting arrangement or otherwise) for which payment would otherwise (but for this paragraph) be made under part B in an amount determined in accordance with section 1833(a)(2)(B), the amount of the payment under such part shall be based on the part B

methodology applicable to the item or service, except that for items and services that would be included in a facility's cost report if not for this section, the facility may continue to use a cost report for reimbursement purposes until the prospective payment system established under this section is implemented.

''(B) THERAPY AND PATHOLOGY SERVICES.—Payment for physical therapy, occupational therapy, respiratory therapy, and speech language pathology services shall reflect new salary equivalency guidelines calculated pursuant to section 1861(v)(5) when finalized through the regulatory process.

''(10) REQUIRED CODING.—No payment may be made under part B for items and services (other than services described in paragraph (2)(A)(ii)) furnished to an individual who is a resident of a skilled nursing facility unless the claim for such payment includes a code (or codes) under a uniform coding system specified by the Secretary that identifies the items or services delivered.''.

(4) CONFORMING AMENDMENTS.—

(A) Section 1819(b)(3)(C)(i) (42 U.S.C. 1395i–3(b)(3)(C)(i)) is amended by striking ''Such'' and inserting ''Subject to the timeframes prescribed by the Secretary under section 1888(t)(6), such''.

(B) Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)) is amended by striking ''(2);'' and inserting ''(2) and section 1842(b)(6)(E);''.

(C) Section 1833(a)(2)(B) (42 U.S.C. 1395l(a)(2)(B)) is amended by inserting ''or section 1888(e)(9)'' after ''section 1886''.

(D) Section 1861(h) (42 U.S.C 1395x(h)) is amended—

(i) in the opening paragraph, by striking ''paragraphs (3) and (6)'' and inserting ''paragraphs (3), (6), and (7)'', and

(ii) in paragraph (7), after ''skilled nursing facilities'', by inserting '', or by others under arrangements with them made by the facility''.

(E) Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)) is amended—

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

(ii) by inserting ''(i)'' after ''(H)'', and

(iii) by adding after clause (i), as so redesignated, the following new clause:

''(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, and

''(II) for which the individual is entitled to have payment made under this title,

to have items and services (other than services described in section 1888(e)(2)(A)(ii)) furnished by the skilled nursing facility or otherwise under arrangements (as defined in section 1861(w)(1)) made by the skilled nursing facility,''.

(c) MEDICAL REVIEW PROCESS.—In order to ensure that medicare beneficiaries are furnished appropriate services in skilled nursing facilities, the Secretary of Health and Human Services shall establish and implement a thorough medical review process to examine the effects of the amendments made by this section on the quality of covered skilled nursing facility services furnished to medicare beneficiaries. In developing such a medical review process, the Secretary shall place a particular emphasis on the quality of non-routine covered services and physicians' services for which payment is made under title XVIII of the Social Security Act for which payment is made under section 1848 of such Act.

(d) EFFECTIVE DATE.—The amendments made by this section are effective for cost reporting periods beginning on or after July 1, 1998; except that the amendments made by subsection (b) shall apply to items and services furnished on or after July 1, 1998.

Subchapter B—Home Health Services and Benefits

PART I—PAYMENTS FOR HOME HEALTH SERVICES

SEC. 5341. RECAPTURING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES FOR HOME HEALTH SERVICES.

(a) BASING UPDATES TO PER VISIT COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the end the following:

''(iv) In establishing limits under this subparagraph for cost reporting periods beginning after September 30, 1997, the Secretary shall not take into account any changes in the home health market basket, as determined by the Secretary, with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.''.

(b) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by subsection (a) in making any exemptions and exceptions pursuant to section 1861(v)(1)(L)(ii) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(ii)).

SEC. 5342. INTERIM PAYMENTS FOR HOME HEALTH SERVICES.

(a) REDUCTIONS IN COST LIMITS.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) by moving the indentation of subclauses (I) through (III) 2-ems to the left;

(2) in subclause (I), by inserting ''of the mean of the labor-related and nonlabor per visit costs for freestanding home health agencies'' before the comma at the end;

(3) in subclause (II), by striking '', or'' and inserting ''of such mean,'';

(4) in subclause (III)—

(A) by inserting ''and before October 1, 1997,'' after ''July 1, 1987'', and

(B) by striking the period at the end and inserting ''of such mean, or''; and

(5) by striking the matter following subclause (III) and inserting the following:

''(IV) October 1, 1997, 105 percent of the median of the labor-related and nonlabor per visit costs for freestanding home health agencies.''.

(b) DELAY IN UPDATES.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by inserting '', or on or after July 1, 1997, and before October 1, 1997'' after ''July 1, 1996''.

(c) ADDITIONS TO COST LIMITS.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)), as amended by section 5341(a), is amended by adding at the end the following:

''(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the Secretary shall provide for an interim system of limits. Payment shall be the lower of—

''(I) costs determined under the preceding provisions of this subparagraph, or

''(II) an agency-specific per beneficiary annual limitation calculated from the agency's 12-month cost reporting period ending on or after January 1, 1994, and on or before December 31, 1994, based on reasonable costs (including nonroutine medical supplies), updated by the home health market basket index.

The per beneficiary limitation in subclause (II) shall be multiplied by the agency's unduplicated census count of patients (entitled to benefits under this title) for the cost reporting period subject to the limitation to determine the aggregate agency-specific per beneficiary limitation.

''(vi) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the following rules apply:

''(I) For new providers and those providers without a 12-month cost reporting period ending in calendar year 1994, the per beneficiary limitation shall be equal to the median of these limits (or the Secretary's best estimates thereof) applied to other home health agencies as determined by the Secretary. A home health agency that has altered its corporate structure or name shall not be considered a new provider for this purpose.

''(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitations shall be prorated among the agencies.''.

(d) DEVELOPMENT OF CASE MIX SYSTEM.—The Secretary of Health and Human Services shall expand research on a prospective payment system for home health agencies under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) that ties prospective payments to a unit of service, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of the variances in costs.

(e) SUBMISSION OF DATA FOR CASE MIX SYSTEM.—Effective for cost reporting periods beginning on or after October 1, 1997, the Secretary of Health and Human Services may require all home health agencies to submit additional information that the Secretary considers necessary for the development of a reliable case mix system.

SEC. 5343. PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 5011, is amended by adding at the end the following new section:

''PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

''SEC. 1895. (a) IN GENERAL.—Notwithstanding section 1861(v), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 1999, for payments for home health services in accordance with a prospective payment system established by the Secretary under this section.

''(b) SYSTEM OF PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary shall establish under this subsection a prospective payment system for payment for all costs of home health services. Under the system under this subsection all services covered and paid on a reasonable cost basis under the medicare home health benefit as of the date of the enactment of the this section, including medical supplies, shall be paid for on the basis of a prospective payment amount determined under this subsection and applicable to the services involved. In implementing the system, the Secretary may provide for a transition (of not longer than 4 years) during which a portion of such payment is based on agency-specific costs, but only if such transition does not result in aggregate payments under this title that exceed the aggregate payments that would be made if such a transition did not occur.

''(2) UNIT OF PAYMENT.—In defining a prospective payment amount under the system under this subsection, the Secretary shall consider an appropriate unit of service and the number, type, and duration of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

''(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). 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 fiscal year 2000 shall be equal to the total amount that would have been made if the system had not been in effect but if the reduction in limits described in clause (ii) had been in effect. Such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

''(ii) REDUCTION.—The reduction described in this clause is a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L), as those limits are in effect on September 30, 1999.

''(B) ANNUAL UPDATE.—

''(i) IN GENERAL.—The standard prospective payment amount (or amounts) shall be adjusted for each fiscal year (beginning with fiscal year 2001) in a prospective manner specified by the Secretary by the home health market basket percentage increase applicable to the fiscal year involved.

''(ii) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE.—For purposes of this subsection, the term 'home health market basket percentage increase' means, with respect to a fiscal year, a percentage (estimated by the Secretary before the beginning of the fiscal year) determined and applied with respect to the mix of goods and services included in home health services in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to the mix of goods and services comprising inpatient hospital services for the fiscal year.

''(C) ADJUSTMENT FOR OUTLIERS.—The Secretary shall reduce the standard prospective payment amount (or amounts) under this paragraph applicable to home health services furnished during a period by such proportion as will result in an aggregate reduction in payments for the period equal to the aggregate increase in payments resulting from the application of paragraph (5) (relating to outliers).

''(4) PAYMENT COMPUTATION.—

''(A) IN GENERAL.—The payment amount for a unit of home health services shall be the applicable standard prospective payment amount adjusted as follows:

''(i) CASE MIX ADJUSTMENT.—The amount shall be adjusted by an appropriate case mix adjustment factor (established under subparagraph (B)).

''(ii) AREA WAGE ADJUSTMENT.—The portion of such amount that the Secretary estimates to be attributable to wages and wage-related costs shall be adjusted for geographic differences in such costs by an area wage adjustment factor (established under subparagraph (C)) for the area in which the services are furnished or such other area as the Secretary may specify.

''(B) ESTABLISHMENT OF CASE MIX ADJUSTMENT FACTORS.—The Secretary shall establish appropriate case mix adjustment factors for home health services in a manner that explains a significant amount of the variation in cost among different units of services.

''(C) ESTABLISHMENT OF AREA WAGE ADJUSTMENT FACTORS.—The Secretary shall establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services in a geographic area compared to the national average applicable level. Such factors may be the factors used by the Secretary for purposes of section 1886(d)(3)(E).

''(5) OUTLIERS.—The Secretary may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year.

''(6) PRORATION OF PROSPECTIVE PAYMENT AMOUNTS.—If a beneficiary elects to transfer to, or receive services from, another home health agency within the period covered by the prospective payment amount, the payment shall be prorated between the home health agencies involved.

''(c) REQUIREMENTS FOR PAYMENT INFORMATION.—With respect to home health services furnished on or after October 1, 1998, no claim for such a service may be paid under this title unless—

''(1) the claim has the unique identifier for the physician who prescribed the services or made the certification described in section 1814(a)(2) or 1835(a)(2)(A); and

''(2) in the case of a service visit described in paragraph (1), (2), (3), or (4) of section 1861(m), the claim has information (coded in an appropriate manner) on the length of time of the service visit, as measured in 15 minute increments.

''(d) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

''(1) the establishment of a transition period under subsection (b)(1);

''(2) the definition and application of payment units under subsection (b)(2);

''(3) the computation of initial standard prospective payment amounts under subsection (b)(3)(A) (including the reduction described in clause (ii) of such subsection);

''(4) the adjustment for outliers under subsection (b)(3)(C);

''(5) case mix and area wage adjustments under subsection (b)(4);

''(6) any adjustments for outliers under subsection (b)(5); and

''(7) the amounts or types of exceptions or adjustments under subsection (b)(7).''.

(b) ELIMINATION OF PERIODIC INTERIM PAYMENTS FOR HOME HEALTH AGENCIES.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(1) by inserting ''and'' at the end of subparagraph (C),

(2) by striking subparagraph (D), and

(3) by redesignating subparagraph (E) as subparagraph (D).

(c) CONFORMING AMENDMENTS.—

(1) PAYMENTS UNDER PART A.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended in the matter preceding paragraph (1) by striking ''and 1886'' and inserting ''1886, and 1895''.

(2) TREATMENT OF ITEMS AND SERVICES PAID UNDER PART B.—

(A) PAYMENTS UNDER PART B.—Section 1833(a)(2) (42 U.S.C. 13951(a)(2)) is amended—

(i) by amending subparagraph (A) to read as follows:

''(A) with respect to home health services (other than a covered osteoporosis drug) (as defined in section 1861(kk)), the amount determined under the prospective payment system under section 1895;'';

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

(iii) by adding ''and'' at the end of subparagraph (F); and

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

''(G) with respect to items and services described in section 1861(s)(10)(A), the lesser of—

''(i) the reasonable cost of such services, as determined under section 1861(v), or

''(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);''.

(B) REQUIRING PAYMENT FOR ALL ITEMS AND SERVICES TO BE MADE TO AGENCY.—

(i) IN GENERAL.—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) (as amended by section 5332(b)(2)) is amended—

(I) by striking ''and (E)'' and inserting ''(E)''; and

(II) by striking the period at the end and inserting the following: '', and (F) in the case of home health services 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).''.

(ii) CONFORMING AMENDMENT.—Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)) (as amended by section 5332(b)(4)(B)) is amended by striking ''section 1842(b)(6)(E);'' and inserting ''subparagraphs (E) and (F) of section 1842(b)(6);''.

(C) EXCLUSIONS FROM COVERAGE.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 5332(b)(1), is amended—

(i) by striking ''or'' at the end of paragraph (16);

(ii) by striking the period at the end of paragraph (17) and inserting ''or''; and

(iii) by inserting after paragraph (17) the following:

''(18) where such expenses are for home health services furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency.''.

(d) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 1999.

(e) CONTINGENCY.—If the Secretary of Health and Human Services for any reason does not establish and implement the prospective payment system for home health services described in section 1895(b) of the Social Security Act (as added by subsection (a)) for cost reporting periods described in subsection (d), for such cost reporting periods the Secretary shall provide for a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L) of such Act, as those limits would otherwise be in effect on September 30, 1999.

SEC. 5344. PAYMENT BASED ON LOCATION WHERE HOME HEALTH SERVICE IS FURNISHED.

(a) CONDITIONS OF PARTICIPATION.—Section 1891 (42 U.S.C. 1395bbb) is amended by adding at the end the following:

''(g) PAYMENT ON BASIS OF LOCATION OF SERVICE.—A home health agency shall submit claims for payment for home health services under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.''.

(b) WAGE ADJUSTMENT.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking ''agency is located'' and inserting ''service is furnished''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to cost reporting periods beginning on or after October 1, 1997.

PART II—HOME HEALTH BENEFITS

SEC. 5361. MODIFICATION OF PART A HOME HEALTH BENEFIT FOR INDIVIDUALS ENROLLED UNDER PART B.

(a) IN GENERAL.—Section 1812 (42 U.S.C. 1395d) is amended—

(1) in subsection (a)(3), by striking ''home health services'' and inserting ''for individuals not enrolled in part B, home health services, and for individuals so enrolled, part A home health services (as defined in subsection (g))'';

(2) by redesignating subsection (g) as subsection (h); and

(3) by inserting after subsection (f) the following new subsection:

''(g)(1) For purposes of this section, the term 'part A home health services' means—

''(A) for services furnished during each year beginning with 1998 and ending with 2003, home health services subject to the transition reduction applied under paragraph (2)(C) for services furnished during the year, and

''(B) for services furnished on or after January 1, 2004, post-institutional home health services for up to 100 visits during a home health spell of illness.

''(2) For purposes of paragraph (1)(A), the Secretary shall specify, before the beginning of each year beginning with 1998 and ending with 2003, a transition reduction in the home health services benefit under this part as follows:

''(A) The Secretary first shall estimate the amount of payments that would have been made under this part for home health services furnished during the year if—

''(i) part A home health services were all home health services, and

''(ii) part A home health services were limited to services described in paragraph (1)(B).

''(B)(i) The Secretary next shall compute a transfer reduction amount equal to the appropriate proportion (specified under clause (ii)) of the amount by which the amount estimated under subparagraph (A)(i) for the year exceeds the amount estimated under subparagraph (A)(ii) for the year.

''(ii) For purposes of clause (i), the 'appropriate proportion' is equal to—

''(I) 1/7 for 1998,

''(II) 2/7 for 1999,

''(III) 3/7 for 2000,

''(IV) 4/7 for 2001,

''(V) 5/7 for 2002, and

''(V) 6/7 for 2003.

''(C) The Secretary shall establish a transition reduction by specifying such a visit limit (during a home health spell of illness) or such a post-institutional limitation on home health services furnished under this part during the year as the Secretary estimates will result in a reduction in the amount of payments that would otherwise be made under this part for home health services furnished during the year equal to the transfer amount computed under subparagraph (B)(i) for the year.

''(3) Payment under this part for home health services furnished an individual enrolled under part B—

''(A) during a year beginning with 1998 and ending with 2003, may not be made for services that are not within the visit limit or other limitation specified by the Secretary under the transition reduction under paragraph (3)(C) for services furnished during the year; or

''(B) on or after January 1, 2004, may not be made for home health services that are not post-institutional home health services or for post-institutional furnished to the individual after such services have been furnished to the individual for a total of 100 visits during a home health spell of illness.''.

(b) POST-INSTITUTIONAL HOME HEALTH SERVICES DEFINED.—Section 1861 (42 U.S.C. 1395x), as amended by sections 5102(a) and 5103(a), is amended by adding at the end the following:

''Post-Institutional Home Health Services; Home Health Spell of Illness

''(qq)(1) The term 'post-institutional home health services' means home health services furnished to an individual—

''(A) after discharge from a hospital or rural primary care hospital in which the individual was an inpatient for not less than 3 consecutive days before such discharge if such home health services were initiated within 14 days after the date of such discharge; or

''(B) after discharge from a skilled nursing facility in which the individual was provided post-hospital extended care services if such home health services were initiated within 14 days after the date of such discharge.

''(2) The term 'home health spell of illness' with respect to any individual means a period of consecutive days—

''(A) beginning with the first day (not included in a previous home health spell of illness) (i) on which such individual is furnished post-institutional home health services, and (ii) which occurs in a month for which the individual is entitled to benefits under part A, and

''(B) ending with the close of the first period of 60 consecutive days thereafter on each of which the individual is neither an inpatient of a hospital or rural primary care hospital nor an inpatient of a facility described in section 1819(a)(1) or subsection (y)(1) nor provided home health services.''.

(c) MAINTAINING APPEAL RIGHTS FOR HOME HEALTH SERVICES.—Section 1869(b)(2)(B) (42 U.S.C. 1395ff(b)(2)(B)) is amended by inserting ''(or $100 in the case of home health services)'' after ''$500''.

(d) MAINTAINING SEAMLESS ADMINISTRATION THROUGH FISCAL INTERMEDIARIES.—Section 1842(b)(2) (42 U.S.C. 1395u(b)(2)) is amended by adding at the end the following:

''(E) With respect to the payment of claims for home health services under this part that, but for the amendments made by section 5361, would be payable under part A instead of under this part, the Secretary shall continue administration of such claims through fiscal intermediaries under section 1816.''.

(e) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after January 1, 1998. For the purpose of applying such amendments, any home health spell of illness that began, but did not end, before such date shall be considered to have begun as of such date.

SEC. 5362. CLARIFICATION OF PART-TIME OR INTERMITTENT NURSING CARE.

(a) IN GENERAL.—Section 1861(m) (42 U.S.C. 1395x(m)) is amended by adding at the end the following: ''For purposes of paragraphs (1) and (4), the term 'part-time or intermittent services' means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of sections 1814(a)(2)(C) and 1835(a)(2)(A), 'intermittent' means skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to services furnished on or after October 1, 1997.

SEC. 5363. STUDY ON DEFINITION OF HOMEBOUND.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the criteria that should be applied, and the method of applying such criteria, in the determination of whether an individual is homebound for purposes of qualifying for receipt of benefits for home health services under the medicare program. Such criteria shall include the extent and circumstances under which a person may be absent from the home but nonetheless qualify.

(b) REPORT.—Not later than October 1, 1998, the Secretary shall submit a report to the Congress on the study conducted under subsection (a). The report shall include specific recommendations on such criteria and methods.

SEC. 5364. NORMATIVE STANDARDS FOR HOME HEALTH CLAIMS DENIALS.

(a) IN GENERAL.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by section 5102(c), is amended—

(1) by striking ''and'' at the end of subparagraph (F),

(2) by striking the semicolon at the end of subparagraph (G) and inserting '', and'', and

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

''(H) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation;''.

(b) NOTIFICATION.—The Secretary of Health and Human Services may establish a process for notifying a physician in cases in which the number of home health service visits furnished under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) pursuant to a prescription or certification of the physician significantly exceeds such threshold (or thresholds) as the Secretary specifies. The Secretary may adjust such threshold to reflect demonstrated differences in the need for home health services among different beneficiaries.

(c) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after October 1, 1997.

SEC. 5365. INCLUSION OF COST OF SERVICE IN EXPLANATION OF MEDICARE BENEFITS.

(a) IN GENERAL.—Section 1842(h)(7) of the Social Security Act (42 U.S.C. 1395u(h)(7)) is amended—

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

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

(3) by adding at the end the following:

''(E) in the case of home health services furnished to an individual enrolled under this part, the total amount that the home health agency or other provider of such services billed for such services.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to explanation of benefits provided on and after October 1, 1997.

Subtitle F—Provisions Relating to Part A

CHAPTER 1—PAYMENT OF PPS HOSPITALS

SEC. 5401. PPS HOSPITAL PAYMENT UPDATE.

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

(1) in subclause (XII)—

(A) by inserting ''and the period beginning on October 1, 1997, and ending on December 31, 1997,'' after ''fiscal year 1997,''; and

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

(2) by striking subclause (XIII) and inserting the following:

''(XIII) for calendar year 1998 for hospitals in all areas, the market basket percentage increase minus 2.5 percentage points,

''(XIV) for calendar years 1999 through 2002 for hospitals in all areas, the market basket percentage increase minus 1.0 percentage points, and

''(XV) for calendar year 2003 and each subsequent calendar year for hospitals in all areas, the market basket percentage increase.''.

(b) RULE OF CONSTRUCTION.—Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

''(j) PPS CALENDAR YEAR PAYMENTS.—Notwithstanding any other provision of this title, any updates or payment amounts determined under this section shall on and after December 31, 1998, take effect and be applied on a calendar year basis. With respect to any cost reporting periods that relate to any such updates or payment amounts, the Secretary shall revise such cost reporting periods to ensure that on and after December 31, 1998, such cost reporting periods relate to updates and payment amounts made under this section on a calendar year basis in the same manner as such cost reporting periods applied to updates and payment amounts under this section on the day before the date of enactment of this subsection.''.

SEC. 5402. CAPITAL PAYMENTS FOR PPS HOSPITALS.

(a) MAINTAINING SAVINGS FROM TEMPORARY REDUCTION IN PPS CAPITAL RATES.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following: ''In addition to the reduction described in the preceding sentence, for discharges occurring on or after October 1, 1997, the Secretary shall apply the budget neutrality adjustment factor used to determine the Federal capital payment rate in effect on September 30, 1995 (as described in section 412.352 of title 42 of the Code of Federal Regulations), to (i) the unadjusted standard Federal capital payment rate (as described in section 412.308(c) of that title, as in effect on September 30, 1997), and (ii) the unadjusted hospital-specific rate (as described in section 412.328(e)(1) of that title, as in effect on September 30, 1997).''.

(b) SYSTEM EXCEPTION PAYMENTS FOR TRANSITIONAL CAPITAL.—

(1) IN GENERAL.—Section 1886(g)(l) (42 U.S.C. 1395ww(g)(1)) is amended—

(A) by redesignating subparagraph (C) as subparagraph (F), and

(B) by inserting after subparagraph (B) the following:

''(C) The exceptions under the system provided by the Secretary under subparagraph (B)(iii) shall include the provision of exception payments under the special exceptions process provided under section 412.348(g) of title 42, Code of Federal Regulations (as in effect on September 1, 1995), except that the Secretary shall revise such process, effective for discharges occurring after September 30, 1997, as follows:

''(i) Eligible hospital requirements, as described in section 412.348(g)(1) of title 42, Code of Federal Regulations, shall apply except that subparagraph (ii) shall be revised to require that hospitals located in an urban area with at least 300 beds shall be eligible under such process and that such a hospital shall be eligible without regard to its disproportionate patient percentage under subsection (d)(5)(F) or whether it qualifies for additional payment amounts under such subsection.

''(ii) Project size requirements, as described in section 412.348(g)(5) of title 42, Code of Federal Regulations, shall apply except that subparagraph (ii) shall be revised to require that the project costs of a hospital are at least 150 percent of its operating cost during the first 12 month cost reporting period beginning on or after October 1, 1991.

''(iii) The minimum payment level for qualifying hospitals shall be 85 percent.

''(iv) A hospital shall be considered to meet the requirement that it complete the project involved no later than the end of the last cost reporting period of the hospital beginning before October l, 2001, if—

''(I) the hospital has obtained a certificate of need for the project approved by the State or a local planning authority by September 1, 1995; and

''(II) by September 1, 1995, the hospital has expended on the project at least $750,000 or 10 percent of the estimated cost of the project.

''(v) Offsetting amounts, as described in section 412.348(g)(8)(ii) of title 42, Code of Federal Regulations, shall apply except that subparagraph (B) of such section shall be revised to require that the additional payment that would otherwise be payable for the cost reporting period shall be reduced by the amount (if any) by which the hospital's current year medicare capital payments (excluding, if applicable, 75 percent of the hospital's capital-related disproportionate share payments) exceeds its medicare capital costs for such year.

''(D)(i) The Secretary shall reduce the Federal capital and hospital rates up to $50,000,000 for a calendar year to ensure that the application of subparagraph (C) does not result in an increase in the total amount that would have been paid under this subsection in the fiscal year if such subparagraph did not apply.

''(ii) Payments made pursuant to the application of subparagraph (C) shall not be considered for purposes of calculating total estimated payments under section 412.348(h), Title 42, Code of Federal Regulations.

''(E) The Secretary shall provide for publication in the Federal Register each year (beginning with 1999) of a description of the distributional impact of the application of subparagraph (C) on hospitals which receive, and do not receive, an exception payment under such subparagraph.''.

(2) CONFORMING AMENDMENT.—Section 1886(g)(1)(B)(iii) (42 U.S.C. 1395ww(g)(1)(B)(iii)) is amended by striking ''may provide'' and inserting ''shall provide (in accordance with subparagraph (C))''.

CHAPTER 2—PAYMENT OF PPS EXEMPT HOSPITALS

SEC. 5421. PAYMENT UPDATE.

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

(1) in clause (ii)—

(A) by striking ''and'' at the end of subclause (V);

(B) by redesignating subclause (VI) as subclause (VIII); and

(C) by inserting after subclause (V), the following subclauses:

''(VI) for fiscal year 1998, is 0 percent;

''(VII) for fiscal years 1999 through 2002, is the applicable update factor specified under clause (vi) for the fiscal year; and''; and

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

''(vi) For purposes of clause (ii)(VII) for a fiscal year, if a hospital's allowable operating costs of inpatient hospital services recognized under this title for the most recent cost reporting period for which information is available—

''(I) is equal to, or exceeds, 110 percent of the hospital's target amount (as determined under subparagraph (A)) for such cost reporting period, the applicable update factor specified under this clause is the market basket percentage;

''(II) exceeds 100 percent, but is less than 110 percent, of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 0.25 percentage points for each percentage point by which such allowable operating costs (expressed as a percentage of such target amount) is less than 110 percent of such target amount;

''(III) is equal to, or less than 100 percent, but exceeds ⅔ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 1.5 percentage points; or

''(IV) does not exceed ⅔ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent.''.

(b) NO EFFECT OF PAYMENT REDUCTION ON EXCEPTIONS AND ADJUSTMENTS.—Section 1886(b)(4)(A)(ii) (42 U.S.C. 1395ww(b)(4)(A)(ii)) is amended by adding at the end the following new sentence: ''In making such reductions, the Secretary shall treat the applicable update factor described in paragraph (3)(B)(vi) for a fiscal year as being equal to the market basket percentage for that year.''.

SEC. 5422. REDUCTIONS TO CAPITAL PAYMENTS FOR CERTAIN PPS-EXEMPT HOSPITALS AND UNITS.

Section 1886(g) (42 U.S.C. 1395ww(g)) is amended by adding at the end the following new paragraph:

''(4) In determining the amount of the payments that are attributable to portions of cost reporting periods occurring during fiscal years 1998 through 2002 and that may be made under this title with respect to capital-related costs of inpatient hospital services of a hospital which is described in clause (i), (ii), or (iv) of subsection (d)(1)(B) or a unit described in the matter after clause (v) of such subsection, the Secretary shall reduce the amounts of such payments otherwise determined under this title by 15 percent.''.

SEC. 5423. CAP ON TEFRA LIMITS.

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

(1) in subparagraph (A) by striking ''subparagraphs (C), (D), and (E)'' and inserting ''subparagraph (C) and succeeding subparagraphs'', and

(2) by adding at the end the following:

''(F)(i) In the case of a hospital or unit that is within a class of hospital described in clause (ii), for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002, such target amount may not be greater than the 90th percentile of the target amounts for such hospitals within such class for cost reporting periods beginning during that fiscal year.

''(ii) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

''(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

''(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

''(III) Hospitals described in clause (iv) of such subsection.''.

SEC. 5424. CHANGE IN BONUS AND RELIEF PAYMENTS.

(a) CHANGE IN BONUS PAYMENT.—Section 1886(b)(1)(A) (42 U.S.C. 1395ww(b)(1)(A)) is amended by striking all that follows ''plus—'' and inserting the following:

''(i) 10 percent of the amount by which the target amount exceeds the amount of the operating costs, or

''(ii) 1 percent of the operating costs, whichever is less;''.

(b) CHANGE IN RELIEF PAYMENTS.—Section 1886(b)(1) (42 U.S.C. 1395ww(b)(1)) is amended—

(1) in subparagraph (B)—

(A) by striking ''greater than the target amount'' and inserting ''greater than 110 percent of the target amount'',

(B) by striking ''exceed the target amount'' and inserting ''exceed 110 percent of the target amount'',

(C) by striking ''10 percent'' and inserting ''20 percent'', and

(D) by redesignating such subparagraph as subparagraph (C); and

(2) by inserting after subparagraph (A) the following new subparagraph:

''(B) are greater than the target amount but do not exceed 110 percent of the target amount, the amount of the payment with respect to those operating costs payable under part A on a per discharge basis shall equal the target amount; or''.

SEC. 5425. TARGET AMOUNTS FOR REHABILITATION HOSPITALS, LONG-TERM CARE HOSPITALS, AND PSYCHIATRIC HOSPITALS.

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

(1) in subparagraph (A), in the matter preceding clause (i), by striking ''and (E)'' and inserting ''(E), (F), and (G)''; and

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

''(F) In the case of a rehabilitation hospital (or unit thereof) (as described in clause (ii) of subsection (d)(1)(B)), for cost reporting periods beginning on or after October 1, 1997—

''(i) in the case of a hospital which first receives payments under this section before October 1, 1997, the target amount determined under subparagraph (A) for such hospital or unit for a cost reporting period beginning during a fiscal year shall not be less than 50 percent of the national mean of the target amounts determined under such subparagraph for all such hospitals for cost reporting periods beginning during such fiscal year (determined without regard to this subparagraph); and

''(ii) in the case of a hospital which first receives payments under this section on or after October 1, 1997, such target amount may not be greater than 130 percent of the national mean of the target amounts for such hospitals (and units thereof) for cost reporting periods beginning during fiscal year 1991.

''(G) In the case of a hospital which has an average inpatient length of stay of greater than 25 days (as described in clause (iv) of subsection (d)(1)(B)), for cost reporting periods beginning on or after October 1, 1997—

''(i) in the case of a hospital which first receives payments under this section as a hospital that is not a subsection (d) hospital or a subsection (d) Puerto Rico hospital before October 1, 1997, the target amount determined under subparagraph (A) for such hospital for a cost reporting period beginning during a fiscal year shall not be less than 50 percent of the national mean of the target amounts determined under such subparagraph for all such hospitals for cost reporting periods beginning during such fiscal year (determined without regard to this subparagraph); and

''(ii) in the case of any other hospital which first receives payment under this section on or after October 1, 1997, such target amount may not be greater than 130 percent of such national mean of the target amounts for such hospitals for cost reporting periods beginning during fiscal year 1991.

''(H) In the case of a psychiatric hospital (as defined in section 1861(f)), for cost reporting periods beginning on or after October 1, 1997—

''(i) in the case of a hospital which first receives payments under this section before October 1, 1997, the target amount determined under subparagraph (A) for such hospital for a cost reporting period beginning during a fiscal year shall not be less than 50 percent of the national mean of the target amounts determined under such subparagraph for all such hospitals for cost reporting periods beginning during such fiscal year (determined without regard to this subparagraph); and

''(ii) in the case of any other hospital which first receives payment under this section on or after October 1, 1997, such target amount may not be greater than 130 percent of such national mean of the target amounts for such hospitals for cost reporting periods beginning during fiscal year 1991.''.

SEC. 5426. TREATMENT OF CERTAIN LONG-TERM CARE HOSPITALS LOCATED WITHIN OTHER HOSPITALS.

(a) IN GENERAL.—Section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended by adding at the end the following new sentence: ''A hospital that was classified by the Secretary on or before September 30, 1995, as a hospital described in clause (iv) shall continue to be so classified notwithstanding that it is located in the same building as, or on the same campus as, another hospital.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to discharges occurring on or after October 1, 1995.

SEC. 5427. ELIMINATION OF EXEMPTIONS; REPORT ON EXCEPTIONS AND ADJUSTMENTS.

(a) ELIMINATION OF EXEMPTIONS.—

(1) IN GENERAL.—Section 1886(b)(4)(A)(i) (42 U.S.C. 1395ww(b)(4)(A)(i)) is amended by striking ''exemption from, or an exception and adjustment to,'' and inserting ''an exception and adjustment to'' each place it appears.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to hospitals that first qualify as a hospital described in clause (i), (ii), or (iv) of section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) on or after October 1, 1997.

(b) REPORT.—The Secretary of Health and Human Services shall publish annually in the Federal Register a report describing the total amount of payments made to hospitals by reason of section 1886(b)(4) of the Social Security Act (42 U.S.C. 1395ww(b)(4)), as amended by subsection (a), for cost reporting periods ending during the previous fiscal year.

SEC. 5428. TECHNICAL CORRECTION RELATING TO SUBSECTION (d) HOSPITALS.

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

(1) in subparagraph (B)(v)—

(A) by inserting ''(I)'' after ''(v)''; and

(B) by striking the semicolon at the end and inserting '', or''; and

(C) by adding at the end the following:

''(II) a hospital that—

''(aa) was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, or is able to demonstrate, for any six-month period, that at least 50 percent of its total discharges have a principal diagnosis that reflects a finding of neoplastic disease, as defined in subparagraph (E);

''(bb) applied on or before December 31, 1990, for classification as a hospital involved extensively in treatment for or research on cancer under this clause (as in effect on the day before the date of the enactment of this subclause), but was not approved for such classification; and

''(cc) is located in a State which, as of December 19, 1989, was not operating a demonstration project under section 1814(b);''; and

(2) by adding at the end the following:

''(E) For purposes of subparagraph (B)(v)(II)(aa), the term 'principal diagnosis that reflects a finding of neoplastic disease' means the condition established after study to be chiefly responsible for occasioning the admission of a patient to a hospital, except that only discharges with ICD–9–CM principal diagnosis codes of 140 through 239, V58.0, V58.1, V66.1, or 990 will be considered to reflect such a principal diagnosis.''.

(b) PAYMENTS.—Any classification by reason of section 1886(d)(1)(B)(v)(II) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(v)(II)) (as added by subsection (a)) shall apply to all cost reporting periods beginning on or after January 1, 1991. Any payments owed to a hospital as a result of such section (as so amended) shall be made expeditiously, but in no event later than 1 year after the date of enactment of this Act.

SEC. 5429. CERTAIN CANCER HOSPITALS.

(a) IN GENERAL.—Section 1886(d)(1) (42 U.S.C. 1395ww(d)(1)), as amended by section 5428, is amended—

(1) in subparagraph (B)(v), by striking the semicolon at the end of subclause (II)(cc) and inserting the following: '', or'', and by adding at the end the following:

''(III) a hospital—

''(aa) that was classified under subsection (iv) beginning on or before December 31, 1990, and through December 31, 1995; and

''(bb) throughout the period described in item (aa) and currently has greater than 49 percent of its total patient discharges with a principal diagnosis that reflects a finding of neoplastic disease;''; and

(2) by adding at the end the following:

''(F) In the case of a hospital that is classified under subparagraph (B)(v)(III), no rebasing is permitted by such hospital and such hospital shall use the base period in effect at the time of such hospital's December 31, 1995, cost report.''.

CHAPTER 3—GRADUATE MEDICAL EDUCATION PAYMENTS

Subchapter A—Direct Medical Education

SEC. 5441. LIMITATION ON NUMBER OF RESIDENTS AND ROLLING AVERAGE FTE COUNT.

Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended by adding after subparagraph (E) the following:

''(F) LIMITATION ON NUMBER OF RESIDENTS IN ALLOPATHIC AND OSTEOPATHIC MEDICINE.—Except as provided in subparagraph (H), such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number of full-time equivalent residents with respect to such programs for the hospital's most recent cost reporting period ending on or before December 31, 1996.

''(G) COUNTING INTERNS AND RESIDENTS FOR 1998 AND SUBSEQUENT YEARS.—

''(i) IN GENERAL.—For cost reporting periods beginning on or after October 1, 1997, subject to the limit described in subparagraph (F) and except as provided in subparagraph (H), the total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.

''(ii) ADJUSTMENT FOR SHORT PERIODS.—If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve

months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent resident counts pursuant to clause (ii) are based on the equivalent of full twelve-month cost reporting periods.

''(iii) TRANSITION RULE FOR 1998.—In the case of a hospital's first cost reporting period beginning on or after October 1, 1997, clause (i) shall be applied by using the average for such period and the preceding cost reporting period.

''(H) SPECIAL RULES FOR NEW FACILITIES.—

''(i) IN GENERAL.—If a hospital is an applicable facility under clause (iii) for any year with respect to any approved medical residency training program described in subsection (h)—

''(I) subject to the applicable annual limit under clause (ii), the Secretary may provide an additional amount of full-time equivalent residents which may be taken into account with respect to such program under subparagraph (F) for cost reporting periods beginning during such year, and

''(II) the averaging rules under subparagraph (G) shall not apply for such year.

''(ii) APPLICABLE ANNUAL LIMIT.—The total of additional full-time equivalent residents which the Secretary may authorize under clause (i) for all applicable facilities for any year shall not exceed the amount which would result in the number of full-time equivalent residents with respect to approved medical residency training programs in the fields of allopathic and osteopathic medicine for all hospitals exceeding such number for the preceding year. In allocating such additional residents, the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

''(iii) APPLICABLE FACILITY.—For purposes of this subparagraph, a hospital shall be treated as an applicable facility with respect to an approved medical residency training program only during the first 5 years during which such program is in existence. A hospital shall not be treated as such a facility if the 5-year period described in the preceding sentence ended on or before December 31, 1996.

''(iv) COORDINATION WITH LIMIT.—For purposes of applying subparagraph (F), the number of full-time equivalent residents of an applicable facility with respect to any approved medical residency training program in the fields of allopathic and osteopathic medicine for the facility's most recent cost reporting period ending on or before December 31, 1996, shall be increased by the number of such residents allocated to such facility under clause (i).''

SEC. 5442. PERMITTING PAYMENT TO NONHOSPITAL PROVIDERS.

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

''(j) PAYMENT TO NONHOSPITAL PROVIDERS.—

''(1) IN GENERAL.—For cost reporting periods beginning on or after October 1, 1997, the Secretary may establish rules for payment to qualified nonhospital providers for their direct costs of medical education, if those costs are incurred in the operation of an approved medical residency training program described in subsection (h). Such rules shall specify the amounts, form, and manner in which payments will be made and the portion of such payments that will be made from each of the trust funds under this title.

''(2) QUALIFIED NONHOSPITAL PROVIDERS.—For purposes of this subsection, the term 'qualified nonhospital providers' means—

''(A) a federally qualified health center, as defined in section 1861(aa)(4);

''(B) a rural health clinic, as defined in section 1861(aa)(2); and

''(C) such other providers (other than hospitals) as the Secretary determines to be appropriate.''

(b) PROHIBITION ON DOUBLE PAYMENTS.—Section 1886(h)(3)(B) (42 U.S.C. 1395ww(h)(3)(B)) is amended by adding at the end the following:

''The Secretary shall reduce the aggregate approved amount to the extent payment is made under subsection (j) for residents included in the hospital's count of full-time equivalent residents.''

Subchapter B—Indirect Medical Education

SEC. 5446. INDIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.

(a) MULTIYEAR TRANSITION REGARDING PERCENTAGES.—

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

''(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to c (((1+r) to the nth power) − 1), where 'r' is the ratio of the hospital's full-time equivalent interns and residents to beds and 'n' equals .405. For discharges occurring—

''(I) on or after May 1, 1986, and before October 1, 1997, 'c' is equal to 1.89;

''(II) during fiscal year 1998, 'c' is equal to 1.72;

''(III) during fiscal year 1999, 'c' is equal to 1.6;

''(IV) during fiscal year 2000, 'c' is equal to 1.47; and

''(V) on or after October 1, 2000, 'c' is equal to 1.35.''

(2) NO RESTANDARDIZATION OF PAYMENT AMOUNTS REQUIRED.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by adding at the end the following: ''except that the Secretary shall not take into account any reduction in the amount of additional payments under paragraph (5)(B)(ii) resulting from the amendment made by section 5446(a)(1) of the Balanced Budget Act of 1997,''.

(b) LIMITATION.—

(1) IN GENERAL.—Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding after clause (iv) the following:

''(v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full-time equivalent interns and residents in either a hospital or nonhospital setting may not exceed the number of such full-time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996.

''(vi) For purposes of clause (ii)—

''(I) 'r' may not exceed the ratio of the number of interns and residents as determined under clause (v) with respect to the hospital for its most recent cost reporting period ending on or before December 31, 1996, to the hospital's available beds (as defined by the Secretary) during that cost reporting period, and

''(II) for the hospital's cost reporting periods beginning on or after October 1, 1997, subject to the limits described in clauses (iv) and (v), the total number of full-time equivalent residents for payment purposes shall equal the average of the actual full-time equivalent resident count for the cost reporting period and the preceding two cost reporting periods.

In the case of the first cost reporting period beginning on or after October 1, 1997, subclause (II) shall be applied by using the average for such period and the preceding cost reporting period.

''(vii)(I) If a hospital is an applicable facility under subclause (III) for any year with respect to any approved medical residency training program described in subsection (h)—

''(aa) subject to the applicable annual limit under subclause (II), the Secretary may provide an additional amount of full-time equivalent interns and residents which may be taken into account with respect to such program under clauses (v) and (vi) for cost reporting periods beginning during such year, and

''(bb) the averaging rules under clause (vi)(II) shall not apply for such year.

''(II) The total of additional full-time equivalent interns and residents which the Secretary may authorize under subclause (I) for all applicable facilities for any year shall not exceed the amount which would result in the number of full-time equivalent interns or residents for all hospitals exceeding such number for the preceding year. In allocating such additional residents, the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

''(III) For purposes of this clause, a hospital shall be treated as an applicable facility with respect to an approved medical residency training program only during the first 5 years during which such program is in existence. A hospital shall not be treated as such a facility if the 5-year period described in the preceding sentence ended on or before December 31, 1996.

''(IV) For purposes of applying clause (v), the number of full-time equivalent residents of an applicable facility with respect to any approved medical residency training program for the facility's most recent cost reporting period ending on or before December 31, 1996, shall be increased by the number of such residents allocated to such facility under subclause (I).

''(viii) If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent residency count pursuant to subclause (II) of clause (vi) is based on the equivalent of full twelve-month cost reporting periods.''

(2) PAYMENT FOR INTERNS AND RESIDENTS PROVIDING OFF-SITE SERVICES.—Section 1886(d)(5)(B)(iv) (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended to read as follows:

''(iv) Effective for discharges occurring on or after October 1, 1997, all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.''

Subchapter C—Graduate Medical Education Payments for Managed Care Enrollees

SEC. 5451. DIRECT AND INDIRECT MEDICAL EDUCATION PAYMENTS TO HOSPITALS FOR MANAGED CARE ENROLLEES.

(a) PAYMENTS TO HOSPITALS FOR DIRECT COSTS OF GRADUATE MEDICAL EDUCATION.—Section 1886(h)(3) (42 U.S.C. 1395ww(h)(3)) is amended by adding after subparagraph (C) the following:

''(D) PAYMENT FOR MEDICARE CHOICE ENROLLEES.—

''(i) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount under this subsection for services furnished to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 and who are entitled to part A or with a Medicare Choice organization under part C. The amount of such a payment shall

equal the applicable percentage of the product of—

''(I) the aggregate approved amount (as defined in subparagraph (B)) for that period; and

''(II) the fraction of the total number of inpatient-bed days (as established by the Secretary) during the period which are attributable to such enrolled individuals.

''(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the applicable percentage is—

''(I) 25 percent in 1998,

''(II) 50 percent in 1999,

''(III) 75 percent in 2000, and

''(IV) 100 percent in 2001 and subsequent years.

''(iii) SPECIAL RULE FOR HOSPITALS UNDER REIMBURSEMENT SYSTEM.—The Secretary shall establish rules for the application of this subparagraph to a hospital reimbursed under a reimbursement system authorized under section 1814(b)(3) in the same manner as it would apply to the hospital if it were not reimbursed under such section.''

(b) PAYMENT TO HOSPITALS OF INDIRECT MEDICAL EDUCATION COSTS.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following:

''(11) ADDITIONAL PAYMENTS FOR MANAGED CARE SAVINGS.—

''(A) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital (or any hospital reimbursed under a reimbursement system authorized under section 1814(b)(3)) that has an approved medical residency training program.

''(B) APPLICABLE DISCHARGE.—For purposes of this paragraph, the term 'applicable discharge' means the discharge of any individual who is enrolled under a risk-sharing contract with an eligible organization under section 1876 and who is entitled to benefits under part A or any individual who is enrolled with a Medicare Choice organization under part C.

''(C) DETERMINATION OF AMOUNT.—The amount of the payment under this paragraph with respect to any applicable discharge shall be equal to the applicable percentage (as defined in subsection (h)(3)(D)(ii)) of the estimated average per discharge amount that would otherwise have been paid under paragraph (1)(A) if the individuals had not been enrolled as described in subparagraph (B).''

SEC. 5452. DEMONSTRATION PROJECT ON USE OF CONSORTIA.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a demonstration project under which, instead of making payments to teaching hospitals pursuant to section 1886(h) of the Social Security Act, the Secretary shall make payments under this section to each consortium that meets the requirements of subsection (b).

(b) QUALIFYING CONSORTIA.—For purposes of subsection (a), a consortium meets the requirements of this subsection if the consortium is in compliance with the following:

(1) The consortium consists of an approved medical residency training program in a teaching hospital and one or more of the following entities:

(A) A school of allopathic medicine or osteopathic medicine.

(B) Another teaching hospital, which may be a children's hospital.

(C) Another approved medical residency training program.

(D) A federally qualified health center.

(E) A medical group practice.

(F) A managed care entity.

(G) An entity furnishing outpatient services.

(I) Such other entity as the Secretary determines to be appropriate.

(2) The members of the consortium have agreed to participate in the programs of graduate medical education that are operated by the entities in the consortium.

(3) With respect to the receipt by the consortium of payments made pursuant to this section, the members of the consortium have agreed on a method for allocating the payments among the members.

(4) The consortium meets such additional requirements as the Secretary may establish.

(c) AMOUNT AND SOURCE OF PAYMENT.—The total of payments to a qualifying consortium for a fiscal year pursuant to subsection (a) shall not exceed the amount that would have been paid under section 1886(h) of the Social Security Act for the teaching hospital (or hospitals) in the consortium. Such payments shall be made in such proportion from each of the trust funds established under title XVIII of such Act as the Secretary specifies.

CHAPTER 4—OTHER HOSPITAL PAYMENTS

SEC. 5461. DISPROPORTIONATE SHARE PAYMENTS TO HOSPITALS FOR MANAGED CARE AND MEDICARE CHOICE ENROLLEES.

Section 1886(d) (42 U.S.C. 1395ww(d)) (as amended by section 5451) is amended by adding at the end the following:

''(12) ADDITIONAL PAYMENTS FOR MANAGED CARE AND MEDICARE CHOICE SAVINGS.—

''(A) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each applicable discharge of—

(i) any subsection (d) hospital that is a disproportionate share hospital (as described in paragraph (5)(F)(i)); or

(ii) any hospital reimbursed under a reimbursement system authorized under section 1814(b)(3)) if such hospital would qualify as a disproportionate share hospital were it not so reimbursed.

''(B) APPLICABLE DISCHARGE.—For purposes of this paragraph, the term 'applicable discharge' means the discharge of any individual who is enrolled under a risk-sharing contract with an eligible organization under section 1876 and who is entitled to benefits under part A or any individual who is enrolled with a Medicare Choice organization under part C.

''(C) DETERMINATION OF AMOUNT.—The amount of the payment under this paragraph with respect to any applicable discharge shall be equal to the applicable percentage (as defined in subsection (h)(3)(D)(ii)) of the estimated average per discharge amount that would otherwise have been paid under paragraph (1)(A) if the individuals had not been enrolled as described in subparagraph (B).''.

SEC. 5462. REFORM OF DISPROPORTIONATE SHARE PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS.

(a) IN GENERAL.—Section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (i), by inserting ''and before December 31, 1998,'' after ''May, 1, 1986,'';

(2) in clause (ii), by striking ''The amount'' and inserting ''Subject to clauses (ix) and (x), the amount''; and

(3) by adding at the end the following:

''(ix) In the case of discharges occurring on or after October 1, 1997, and before December 31, 1998, the additional payment amount otherwise determined under clause (ii) shall be reduced by 4 percent.

''(x)(I) In the case of discharges occurring during calendar years 1999 and succeeding calendar years, the additional payment amount shall be determined in accordance with the formula established under subclause (II).

''(II) Not later than January 1, 1999, the Secretary shall establish a formula for determining additional payment amounts under this subparagraph. In determining such formula the Secretary shall—

''(aa) establish a single threshold for costs incurred by hospitals in serving low-income patients,

''(bb) consider the costs described in subclause (III), and

''(cc) ensure that such formula complies with the requirement described in subclause (IV).

''(III) The costs described in this subclause are as follows:

''(aa) The costs incurred by the hospital during a period (as determined by the Secretary) of furnishing inpatient and outpatient hospital services to individuals who are entitled to benefits under part A of this title and are entitled to supplemental security income benefits under title XVI (excluding any supplementation of those benefits by a State under section 1616).

''(bb) The costs incurred by the hospital during a period (as so determined) of furnishing inpatient and outpatient hospital services to individuals who are eligible for medical assistance under the State plan under title XIX and are not entitled to benefits under part A of this title (including individuals enrolled in a health maintenance organization (as defined in section 1903(m)(1)(A)) or any other managed care plan under such title, individuals who are eligible for medical assistance under such title pursuant to a waiver approved by the Secretary under section 1115, and individuals who are eligible for medical assistance under the State plan under title XIX (regardless of whether the State has provided reimbursement for any such assistance provided under such title)).

''(cc) The costs incurred by the hospital during a period (as so determined) of furnishing inpatient and outpatient hospital services to individuals who are not described in item (aa) or (bb) and who do not have health insurance coverage (or any other source of third party payment for such services) and for which the hospital did not receive compensation.

''(IV)(aa) The requirement described in this subclause is that for each calendar year for which the formula established under this clause applies, the additional payment amount determined for such calendar year under such formula shall not exceed an amount equal to the additional payment amount that, in the absence of such formula, would have been determined under this subparagraph, reduced by the applicable percentage for such calendar year.

''(bb) For purposes of subclause (aa), the applicable percentage for—

''(AA) calendar year 1999 is 8 percent;

''(BB) calendar year 2000 is 12 percent;

''(CC) calendar year 2001 is 16 percent;

''(DD) calendar year 2002 is 20 percent;

''(EE) calendar year 2003 and subsequent calendar years, is 0 percent''.

(b) DATA COLLECTION.—

(1) IN GENERAL.—In developing the formula under section 1886(g)(5)(F)(x) of the Social Security Act (42 U.S.C. 1395ww(g)(5)(F)(x)), as added by subsection (a), and in implementing the provisions of and amendments made by this section, the Secretary of Health and Human Services may require any subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) receiving additional payments by reason of section 1886(d)(5)(F) of that Act (42 U.S.C. 1395ww(d)(5)(F)) (as amended by subsection (a) of this section) to

submit to the Secretary any information that the Secretary determines is necessary to implement the provisions of and amendments made by this section.

(2) FAILURE TO COMPLY.—Any subsection (d) hospital (as so defined) that fails to submit to the Secretary of Health and Human Services any information requested under paragraph (1), shall be deemed ineligible for an additional payment amount under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) (as amended by subsection (a) of this section).

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to discharges occurring on and after October 1, 1997.

SEC. 5463. MEDICARE CAPITAL ASSET SALES PRICE EQUAL TO BOOK VALUE.

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

(1) in clause (i)—

(A) by striking ''and (if applicable) a return on equity capital'';

(B) by striking ''hospital or skilled nursing facility'' and inserting ''provider of services'';

(C) by striking ''clause (iv)'' and inserting ''clause (iii)''; and

(D) by striking ''the lesser of the allowable acquisition cost'' and all that follows and inserting ''the historical cost of the asset, as recognized under this title, less depreciation allowed, to the owner of record as of the date of enactment of the Balanced Budget Act of 1997 (or, in the case of an asset not in existence as of that date, the first owner of record of the asset after that date).'';

(2) by striking clause (ii); and

(3) by redesignating clauses (iii) and (iv) as clauses (ii) and (iii), respectively.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to changes of ownership that occur after the third month beginning after the date of enactment of this section.

SEC. 5464. ELIMINATION OF IME AND DSH PAYMENTS ATTRIBUTABLE TO OUTLIER PAYMENTS.

(a) INDIRECT MEDICAL EDUCATION.—Section 1886(d)(5)(B)(i)(I) (42 U.S.C. 1395ww(d)(5)(B)(i)(I)) is amended by inserting '', for cases qualifying for additional payment under subparagraph (A)(i),'' before ''the amount paid to the hospital under subparagraph (A)''.

(b) DISPROPORTIONATE SHARE ADJUSTMENTS.—Section 1886(d)(5)(F)(ii)(I) (42 U.S.C. 1395ww(d)(5)(F)(ii)(I)) is amended by inserting '', for cases qualifying for additional payment under subparagraph (A)(i),'' before ''the amount paid to the hospital under subparagraph (A)''.

(c) COST OUTLIER PAYMENTS.—Section 1886(d)(5)(A)(ii) (42 U.S.C. 1395ww(d)(5)(A)(ii)) is amended by striking ''exceed the applicable DRG prospective payment rate'' and inserting ''exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under subparagraphs (B) and (F) of subsection (d)(5)''.

(d) EFFECTIVE DATE.—The amendments made by this section apply to discharges occurring after September 30, 1997.

SEC. 5465. TREATMENT OF TRANSFER CASES.

(a) TRANSFERS TO PPS EXEMPT HOSPITALS AND SKILLED NURSING FACILITIES.—Section 1886(d)(5)(I) (42 U.S.C. 1395ww(d)(5)(I)) is amended by adding at the end the following new clause:

''(iii) In carrying out this subparagraph, the Secretary shall treat the term 'transfer case' as including the case of an individual who, upon discharge from a subsection (d) hospital—

''(I) is admitted as an inpatient to a hospital or hospital unit that is not a subsection (d) hospital for the receipt of inpatient hospital services; or

''(II) is admitted to a skilled nursing facility or facility described in section 1861(y)(1) for the receipt of extended care services.''.

(b) TRANSFERS FOR PURPOSES OF HOME HEALTH SERVICES.—Section 1886(d)(5)(I) (42 U.S.C. 1395ww(d)(5)(I)), as amended by subsection (a), is amended—

(1) in clause (iii), by striking the period at the end and inserting ''; or'' and

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

''(III) receives home health services from a home health agency, if such services directly relate to the condition or diagnosis for which such individual received inpatient hospital services from the subsection (d) hospital, and if such services are provided within an appropriate period as determined by the Secretary in regulations promulgated not later than April 1, 1998.''.

(c) EFFECTIVE DATES.—

(1) The amendment made by subsection (a) shall apply with respect to discharges occurring on or after October 1, 1997.

(2) The amendment made by subsection (b) shall apply with respect to discharges occurring on or after April 1, 1998.

SEC. 5466. REDUCTIONS IN PAYMENTS FOR ENROLLEE BAD DEBT.

Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

''(T) In determining such reasonable costs for hospitals, 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) for cost reporting periods beginning on or after October 1, 1997 and on or before December 31, 1998, by 25 percent of such amount otherwise allowable,

''(ii) for cost reporting periods beginning during calendar year 1999, by 40 percent of such amount otherwise allowable, and

''(iii) for cost reporting periods beginning during a subsequent calendar year, by 50 percent of such amount otherwise allowable.''.

SEC. 5467. FLOOR ON AREA WAGE INDEX.

(a) IN GENERAL.—For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)) may not be less than the average of the area wage indices applicable under such section to hospitals located in rural areas in the State in which the hospital is located.

(b) IMPLEMENTATION.—The Secretary of Health and Human Services shall adjust the area wage indices referred to in subsection (a) for hospitals not described in such subsection in a manner which assures that the aggregate payments made under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) in a fiscal year for the operating costs of inpatient hospital services are not greater or less than those which would have been made in the year if this section did not apply.

SEC. 4568. INCREASE BASE PAYMENT RATE TO PUERTO RICO HOSPITALS.

Section 1886(d)(9)(A) (42 U.S.C. 1395ww(d)(9)(A)) is amended—

(1) in the matter preceding clause (i), by striking ''in a fiscal year beginning on or after October 1, 1987,'',

(2) in clause (i), by striking ''75 percent'' and inserting ''for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)'', and

(3) in clause (ii), by striking ''25 percent'' and inserting ''for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987 and September 30, 1997, 25 percent)''.

SEC. 5469. PERMANENT EXTENSION OF HEMOPHILIA PASS-THROUGH.

Effective October 1, 1997, section 6011(d) of OBRA–1989 (as amended by section 13505 of OBRA–1993) is amended by striking ''and shall expire September 30, 1994''.

SEC. 5470. COVERAGE OF SERVICES IN RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONS UNDER THE MEDICARE AND MEDICAID PROGRAMS.

(a) MEDICARE COVERAGE.—

(1) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) (as amended by section 5361) is amended—

(1) in the sixth sentence of subsection (e)—

(A) by striking ''includes'' and all that follows up to ''but only'' and inserting ''includes a religious nonmedical health care institution (as defined in subsection (rr)(1)),'', and

(B) by inserting ''consistent with section 1821'' before the period;

(2) in subsection (y)—

(A) by amending the heading to read as follows:

''Extended Care in Religious Nonmedical Health Care Institutions'',

(B) in paragraph (1), by striking ''includes'' and all that follows up to ''but only'' and inserting ''includes a religious nonmedical health care institution (as defined in subsection (rr)(1)),'', and

(C) by inserting ''consistent with section 1821'' before the period; and

(3) by adding at the end the following:

''Religious Nonmedical Health Care Institution

''(rr)(1) The term 'religious nonmedical health care institution' means an institution that—

''(A) is described in subsection (c)(3) of section 501 of the Internal Revenue Code of 1986 and is exempt from taxes under subsection (a) of such section;

''(B) is lawfully operated under all applicable Federal, State, and local laws and regulations;

''(C) provides only nonmedical nursing items and services exclusively to patients who choose to rely solely upon a religious method of healing and for whom the acceptance of medical health services would be inconsistent with their religious beliefs;

''(D) provides such nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of such patients;

''(E) provides such nonmedical items and services to inpatients on a 24-hour basis;

''(F) on the basis of its religious beliefs, does not provide through its personnel or otherwise medical items and services (including any medical screening, examination, diagnosis, prognosis, treatment, or the administration of drugs) for its patients;

''(G) is not a part of, or owned by, or under common ownership with, or affiliated through ownership with, a health care facility that provides medical services;

''(H) has in effect a utilization review plan which—

''(i) provides for the review of admissions to the institution, of the duration of stays therein, of cases of continuous extended duration, and of the items and services furnished by the institution,

''(ii) requires that such reviews be made by an appropriate committee of the institution that includes the individuals responsible for overall administration and for supervision of nursing personnel at the institution,

''(iii) provides that records be maintained of the meetings, decisions, and actions of such committee, and

''(iv) meets such other requirements as the Secretary finds necessary to establish an effective utilization review plan;

''(I) provides the Secretary with such information as the Secretary may require to implement section 1821, to monitor quality of care, and to provide for coverage determinations; and

''(J) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

''(2) If the Secretary finds that the accreditation of an institution by a State, regional, or national agency or association provides reasonable assurances that any or all of the requirements of paragraph (1) are met or exceeded, the Secretary shall, to the extent the Secretary deems it appropriate, treat such institution as meeting the condition or conditions with respect to which the Secretary made such finding.

''(3)(A)(i) In administering this subsection and section 1821, the Secretary shall not require any patient of a religious nonmedical health care institution to undergo any medical screening, examination, diagnosis, prognosis, or treatment or to accept any other medical health care service, if such patient (or legal representative of the patient) objects thereto on religious grounds.

''(ii) Clause (i) shall not be construed as preventing the Secretary from requiring under section 1821(a)(2) the provision of sufficient information regarding an individual's condition as a condition for receipt of benefits under part A for services provided in such an institution.

''(B)(i) In administering this subsection and section 1821, the Secretary shall not subject a religious nonmedical health care institution to any medical supervision, regulation, or control, insofar as such supervision, regulation, or control would be contrary to the religious beliefs observed by the institution.

''(ii) Clause (i) shall not be construed as preventing the Secretary from reviewing items and services billed by the institution to the extent the Secretary determines such review to be necessary to determine whether such items and services were not covered under part A, are excessive, or are fraudulent.''.

(2) CONDITIONS OF COVERAGE.—Part A of title XVIII of the Social Security Act is amended by adding at the end the following new section:

''CONDITIONS FOR COVERAGE OF RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONAL SERVICES

''SEC. 1821. (a) IN GENERAL.—Subject to subsections (c) and (d), payment under this part may be made for inpatient hospital services or post-hospital extended care services furnished an individual in a religious nonmedical health care institution only if—

''(1) the individual has an election in effect for such benefits under subsection (b); and

''(2) the individual has a condition such that the individual would qualify for benefits under this part for inpatient hospital services or extended care services, respectively, if the individual were an inpatient or resident in a hospital or skilled nursing facility that was not such an institution.

''(b) ELECTION.—

''(1) IN GENERAL.—An individual may make an election under this subsection in a form and manner specified by the Secretary consistent with this subsection. Unless otherwise provided, such an election shall take effect immediately upon its execution. Such an election, once made, shall continue in effect until revoked.

''(2) FORM.—The election form under this subsection shall include the following:

''(A) A statement, signed by the individual (or such individual's legal representative), that—

''(i) the individual is conscientiously opposed to acceptance of nonexcepted medical treatment; and

''(ii) the individual's acceptance of nonexcepted medical treatment would be inconsistent with the individual's sincere religious beliefs.

''(B) A statement that the receipt of nonexcepted medical services shall constitute a revocation of the election and may limit further receipt of services described in subsection (a).

''(3) REVOCATION.—An election under this subsection by an individual may be revoked in a form and manner specified by the Secretary and shall be deemed to be revoked if the individual receives medicare reimbursable non-excepted medical treatment, regardless of whether or not benefits for such treatment are provided under this title.

''(4) LIMITATION ON SUBSEQUENT ELECTIONS.—Once an individual's election under this subsection has been made and revoked twice—

''(A) the next election may not become effective until the date that is 1 year after the date of most recent previous revocation, and

''(B) any succeeding election may not become effective until the date that is 5 years after the date of the most recent previous revocation.

''(5) EXCEPTED MEDICAL TREATMENT.—For purposes of this subsection:

''(A) EXCEPTED MEDICAL TREATMENT.—The term 'excepted medical treatment' means medical care or treatment (including medical and other health services)—

''(i) for the setting of fractured bones,

''(ii) received involuntarily, or

''(iii) required under Federal or State law or law of a political subdivision of a State.

''(B) NON-EXCEPTED MEDICAL TREATMENT.—The term 'nonexcepted medical treatment' means medical care or treatment (including medical and other health services) other than excepted medical treatment.

''(c) MONITORING AND SAFEGUARD AGAINST EXCESSIVE EXPENDITURES.—

''(1) ESTIMATE OF EXPENDITURES.—Before the beginning of each fiscal year (beginning with fiscal year 2000), the Secretary shall estimate the level of expenditures under this part for services described in subsection (a)for that fiscal year.

''(2) ADJUSTMENT IN PAYMENTS.—

''(A) PROPORTIONAL ADJUSTMENT.—If the Secretary determines that the level estimated under paragraph (1) for a fiscal year will exceed the trigger level (as defined in subparagraph (C)) for that fiscal year, the Secretary shall, subject to subparagraph (B), provide for such a proportional reduction in payment amounts under this part for services described in subsection (a) for the fiscal year involved as will assure that such level (taking into account any adjustment under subparagraph (B)) does not exceed the trigger level for that fiscal year.

''(B) ALTERNATIVE ADJUSTMENTS.—The Secretary may, instead of making some or all of the reduction described in subparagraph (A), impose such other conditions or limitations with respect to the coverage of covered services (including limitations on new elections of coverage and new facilities) as may be appropriate to reduce the level of expenditures described in paragraph (1) to the trigger level.

''(C) TRIGGER LEVEL.—For purposes of this subsection, subject to adjustment under paragraph (3)(B), the 'trigger level' for—

''(i) fiscal year 1998, is $20,000,000, or

''(ii) a succeeding fiscal year is the amount specified under this subparagraph for the previous fiscal year increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with July preceding the beginning of the fiscal year.

''(D) PROHIBITION OF ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the estimation of expenditures under subparagraph (A) or the application of reduction amounts under subparagraph (B).

''(E) EFFECT ON BILLING.—Notwithstanding any other provision of this title, in the case of a reduction in payment provided under this subsection for services of a religious nonmedical health care institution provided to an individual, the amount that the institution is otherwise permitted to charge the individual for such services is increased by the amount of such reduction.

''(3) MONITORING EXPENDITURE LEVEL.—

''(A) IN GENERAL.—The Secretary shall monitor the expenditure level described in paragraph (2)(A) for each fiscal year (beginning with fiscal year 1999).

''(B) ADJUSTMENT IN TRIGGER LEVEL.—If the Secretary determines that such level for a fiscal year exceeded, or was less than, the trigger level for that fiscal year, then the trigger level for the succeeding fiscal year shall be reduced, or increased, respectively, by the amount of such excess or deficit.

''(d) SUNSET.—If the Secretary determines that the level of expenditures described in subsection (c)(1) for 3 consecutive fiscal years (with the first such year being not earlier than fiscal year 2002) exceeds the trigger level for such expenditures for such years (as determined under subsection (c)(2)), benefits shall be paid under this part for services described in subsection (a) and furnished on or after the first January 1 that occurs after such 3 consecutive years only with respect to an individual who has an election in effect under subsection (b) as of such January 1 and only during the duration of such election.

''(e) ANNUAL REPORT.—At the beginning of each fiscal year (beginning with fiscal year 1999), the Secretary shall submit to the Committees on Ways and Means of the House of Representatives and the Committee on Finance of the Senate an annual report on coverage and expenditures for services described in subsection (a) under this part and under State plans under title XIX. Such report shall include—

''(1) level of expenditures described in subsection (c)(1) for the previous fiscal year and estimated for the fiscal year involved;

''(2) trends in such level; and

''(3) facts and circumstances of any significant change in such level from the level in previous fiscal years.''.

(b) MEDICAID.—

(1) The third sentence of section 1902(a) of such Act (42 U.S.C. 1396a(a)) is amended by striking all that follows ''shall not apply'' and inserting ''to a religious nonmedical health care institution (as defined in section 1861(rr)(1)).''.

(2) Section 1908(e)(1) of such Act (42 U.S.C. 1396g–1(e)(1)) is amended by striking all that follows ''does not include'' and inserting ''a religious nonmedical health care institution (as defined in section 1861(rr)(1)).''.

(c) CONFORMING AMENDMENTS.—

(1) Section 1122(h) of such Act (42 U.S.C. 1320a–1(h)) is amended by striking all that follows ''shall not apply to'' and inserting ''a religious nonmedical health care institution (as defined in section 1861(rr)(1)).''.

(2) Section 1162 of such Act (42 U.S.C. 1320c–11) is amended—

(A) by amending the heading to read as follows:

''EXEMPTIONS FOR RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONS''; and

(B) by striking all that follows ''shall not apply with respect to a'' and inserting ''religious nonmedical health care institution (as defined in section 1861(rr)(1)).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date. By not later than July 1, 1998, the Secretary of Health and Human Services shall first issue regulations to carry out such amendments. Such regulations may be issued so they are effective on an interim basis pending notice and opportunity for public comment. For periods before the effective date of such regulations, such regulations shall recognize elections entered into in good faith in order to comply with the requirements of section 1821(b) of the Social Security Act.

CHAPTER 5—PAYMENTS FOR HOSPICE SERVICES

SEC. 5481. PAYMENT FOR HOME HOSPICE CARE BASED ON LOCATION WHERE CARE IS FURNISHED.

(a) IN GENERAL.—Section 1814(i)(2) (42 U.S.C. 1395f(i)(2)) is amended by adding at the end the following:

''(D) A hospice program shall submit claims for payment for hospice care furnished in an individual's home under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to cost reporting periods beginning on or after October 1, 1997.

SEC. 5482. HOSPICE CARE BENEFITS PERIODS.

(a) RESTRUCTURING OF BENEFIT PERIOD.—Section 1812 (42 U.S.C. 1395d) is amended in subsections (a)(4) and (d)(1), by striking '', a subsequent period of 30 days, and a subsequent extension period'' and inserting ''and an unlimited number of subsequent periods of 60 days each''.

(b) CONFORMING AMENDMENTS.—(1) Section 1812 (42 U.S.C. 1395d) is amended in subsection (d)(2)(B) by striking ''90- or 30-day period or a subsequent extension period'' and inserting ''90-day period or a subsequent 60-day period''.

(2) Section 1814(a)(7)(A) (42 U.S.C. 1395f(a)(7)(A)) is amended—

(A) in clause (i), by inserting ''and'' at the end;

(B) in clause (ii)—

(i) by striking ''30-day'' and inserting ''60-day''; and

(ii) by striking '', and'' at the end and inserting a period; and

(C) by striking clause (iii).

SEC. 5483. OTHER ITEMS AND SERVICES INCLUDED IN HOSPICE CARE.

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

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

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

(3) by inserting after subparagraph (H) the following:

''(I) any other item or service which is specified in the plan and for which payment may otherwise be made under this title.''.

SEC. 5484. CONTRACTING WITH INDEPENDENT PHYSICIANS OR PHYSICIAN GROUPS FOR HOSPICE CARE SERVICES PERMITTED.

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

(1) in subparagraph (A)(ii)(I), by striking ''(F),''; and

(2) in subparagraph (B)(i), by inserting ''or, in the case of a physician described in subclause (I), under contract with'' after ''employed by''.

SEC. 5485. WAIVER OF CERTAIN STAFFING REQUIREMENTS FOR HOSPICE CARE PROGRAMS IN NON-URBANIZED AREAS.

Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended—

(1) in subparagraph (B), by inserting ''or (C)'' after ''subparagraph (A)'' each place it appears; and

(2) by adding at the end the following:

''(C) The Secretary may waive the requirements of paragraph clauses (i) and (ii) of paragraph (2)(A) for an agency or organization with respect to the services described in paragraph (1)(B) and, with respect to dietary counseling, paragraph (1)(H), if such agency or organization—

''(i) is located in an area which is not an urbanized area (as defined by the Bureau of the Census), and

''(ii) demonstrates to the satisfaction of the Secretary that the agency or organization has been unable, despite diligent efforts, to recruit appropriate personnel.''.

SEC. 5486. LIMITATION ON LIABILITY OF BENEFICIARIES FOR CERTAIN HOSPICE COVERAGE DENIALS.

Section 1879 (42 U.S.C. 1395pp) is amended—

(1) in subsection (a), in the matter following paragraph (2), by inserting ''and except as provided in subsection (i),'' after ''to the extent permitted by this title,'';

(2) in subsection (g)—

(A) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and indenting such subparagraphs appropriately;

(B) by striking ''is,'' and inserting ''is—'';

(C) by making the remaining text of subsection (g) (as amended) that follows ''is—'' a new paragraph (1) and indenting that paragraph appropriately;

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

(E) by adding at the end the following:

''(2) with respect to the provision of hospice care to an individual, a determination that the individual is not terminally ill.''; and

(3) by adding at the end the following:

''(i) In any case involving a coverage denial with respect to hospice care described in subsection (g)(2), only the individual that received such care shall, notwithstanding such determination, be indemnified for any payments that the individual made to a provider or other person for such care that would, but for such denial, otherwise be paid to the individual under part A or B of this title.''.

SEC. 5487. EXTENDING THE PERIOD FOR PHYSICIAN CERTIFICATION OF AN INDIVIDUAL'S TERMINAL ILLNESS.

Section 1814(a)(7)(A)(i) (42 U.S.C. 1395f(a)(7)(A)(i)) is amended, in the matter following subclause (II), by striking '', not later than 2 days after hospice care is initiated (or, if each certify verbally not later than 2 days after hospice care is initiated, not later than 8 days after such care is initiated)'' and inserting ''at the beginning of the period''.

SEC. 5488. EFFECTIVE DATE.

Except as otherwise provided in this chapter, the amendments made by this chapter apply to benefits provided on or after the date of the enactment of this chapter, regardless of whether or not an individual has made an election under section 1812(d) of the Social Security Act (42 U.S.C. 1395d(d)) before such date.

Subtitle G—Provisions Relating to Part B Only

CHAPTER 1—PAYMENTS FOR PHYSICIANS AND OTHER HEALTH CARE PROVIDERS

SEC. 5501. ESTABLISHMENT OF SINGLE CONVERSION FACTOR FOR 1998.

(a) IN GENERAL.—Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)) is amended to read as follows:

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—The conversion factor for each year shall be the conversion factor established under this subsection for the previous year, adjusted by the update established under paragraph (3) for the year involved.

''(B) SPECIAL RULE FOR 1998.—The single conversion factor for 1998 shall be the conversion factor for primary care services for 1997, increased by the Secretary's estimate of the weighted average of the 3 separate updates that would otherwise occur but for the enactment of chapter 1 of subtitle G of title V of the Balanced Budget Act of 1997.

''(C) PUBLICATION.—The Secretary shall, during the last 15 days of October of each year, publish the conversion factor which will apply to physicians' services for the following year and the update determined under paragraph (3) for such year.''

(b) CONFORMING AMENDMENT.—Section 1848(i)(1)(C) (42 U.S.C. 1395w–4(i)(1)(C)) is amended by striking ''conversion factors'' and inserting ''the conversion factor''.

SEC. 5502. ESTABLISHING UPDATE TO CONVERSION FACTOR TO MATCH SPENDING UNDER SUSTAINABLE GROWTH RATE.

(a) UPDATE.—

(1) IN GENERAL.—Section 1848(d)(3) (42 U.S.C. 1395w–4(d)(3)) is amended to read as follows:

''(3) UPDATE.—

''(A) IN GENERAL.—Unless otherwise provided by law, subject to subparagraph (D) and the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii), the update to the single conversion factor established in paragraph (1)(B) for a year beginning with 1999 is equal to the product of—

''(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year (divided by 100), and

''(ii) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100),

minus 1 and multiplied by 100.

''(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), the 'update adjustment factor' for a year is equal to the quotient (as estimated by the Secretary) of—

''(i) the difference between (I) the sum of the allowed expenditures for physicians' services (as determined under subparagraph (C)) for the period beginning July 1, 1997, and ending on June 30 of the year involved, and (II) the amount of actual expenditures for physicians' services furnished during the period beginning July 1, 1997, and ending on June 30 of the preceding year; divided by

''(ii) the actual expenditures for physicians' services for the 12-month period ending on June 30 of the preceding year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

''(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph, the allowed expenditures for physicians' services for the 12-month period ending with June 30 of—

''(i) 1997 is equal to the actual expenditures for physicians' services furnished during such 12-month period, as estimated by the Secretary; or

''(ii) a subsequent year is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

''(D) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

''(i) greater than 100 times the following amount: (1.03 + (MEI percentage/100)) − 1; or

''(ii) less than 100 times the following amount: (0.93 + (MEI percentage/100)) − 1,

where 'MEI percentage' means the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.''.

(b) ELIMINATION OF REPORT.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended by striking paragraph (2).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to the update for years beginning with 1999.

SEC. 5503. REPLACEMENT OF VOLUME PERFORMANCE STANDARD WITH SUSTAINABLE GROWTH RATE.

(a) IN GENERAL.—Section 1848(f) (42 U.S.C. 1395w–4(f)) is amended by striking paragraphs (2) through (5) and inserting the following:

''(2) SPECIFICATION OF GROWTH RATE.—The sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998) shall be equal to the product of—

''(A) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services in the fiscal year involved,

''(B) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than Medicare Choice plan enrollees) from the previous fiscal year to the fiscal year involved,

''(C) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous fiscal year to the fiscal year involved, and

''(D) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the fiscal year (compared with the previous fiscal year) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services resulting from changes in the update to the conversion factor under subsection (d)(3),

minus 1 and multiplied by 100.

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

''(A) SERVICES INCLUDED IN PHYSICIANS' SERVICES.—The term 'physicians' services' includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare Choice plan enrollee.

''(B) MEDICARE CHOICE PLAN ENROLLEE.—The term 'Medicare Choice plan enrollee' means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a Medicare Choice plan offered under part C, and also includes an individual who is receiving benefits under this part through enrollment with an eligible organization with a risk-sharing contract under section 1876.''.

(b) CONFORMING AMENDMENTS.—So much of section 1848(f) (42 U.S.C. 1395w–4(f)) as precedes paragraph (2) is amended to read as follows:

''(f) SUSTAINABLE GROWTH RATE.—

''(1) PUBLICATION.—The Secretary shall cause to have published in the Federal Register the sustainable growth rate for each fiscal year beginning with fiscal year 1998. Such publication shall occur in the last 15 days of October of the year in which the fiscal year begins, except that such rate for fiscal year 1998 shall be published not later than January 1, 1998.''

SEC. 5504. PAYMENT RULES FOR ANESTHESIA SERVICES.

(a) IN GENERAL.—Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)), as amended by section 5501, is amended—

(A) in subparagraph (B), striking ''The single'' and inserting ''Except as provided in subparagraph (C), the single'';

(B) by redesignating subparagraph (C) as subparagraph (D); and

(C) by inserting after subparagraph (B) the following new subparagraph:

''(C) SPECIAL RULES FOR ANESTHESIA SERVICES.—The separate conversion factor for anesthesia services for a year shall be equal to 46 percent of the single conversion factor established for other physicians' services, except as adjusted for changes in work, practice expense, or malpractice relative value units.''.

(b) CLASSIFICATION OF ANESTHESIA SERVICES.—The first sentence of section 1848(j)(1) (42 U.S.C. 1395w–4(j)(1)) is amended—

(1) by striking ''and including anesthesia services''; and

(2) by inserting before the period the following: ''(including anesthesia services)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1998.

SEC. 5505. IMPLEMENTATION OF RESOURCE-BASED PHYSICIAN PRACTICE EXPENSE.

(a) ADJUSTMENTS TO RELATIVE VALUE UNITS FOR 1998.—Section 1848(c)(2) (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraph:

''(G) ADJUSTMENTS IN RELATIVE VALUE UNITS FOR 1998.—

''(i) IN GENERAL.—The Secretary shall—

''(I) reduce the practice expense relative value units applied to any services described in clause (ii) furnished in 1998 to a number equal to 110 percent of the number of work relative value units, and

''(II) increase the practice expense relative value units for primary care services provided in an office setting during 1998 by a uniform percentage which the Secretary estimates will result in an aggregate increase in payments for such services equal to the aggregate decrease in payments by reason of subclause (I).

''(ii) SERVICES COVERED.—For purposes of clause (i), the services described in this clause are physicians' services that are not described in clause (iii) and for which—

''(I) there are work relative value units, and

''(II) the number of practice expense relative value units (determined for 1998) exceeds 110 percent of the number of work relative value units (determined for such year).

''(iii) EXCLUDED SERVICES.—For purposes of clause (ii), the services described in this clause are services which the Secretary determines at least 75 percent of which are provided under this title in an office setting.''

(b) PHASED-IN IMPLEMENTATION.—Section 1848(c)(2) (42 U.S.C. 1395w–4(c)(2)), as amended by subsection (a), is amended—

(1) in subparagraph (C)(ii), in the matter following subclause (II), by inserting '', to the extent provided under subparagraph (H),'' after ''based'', and

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

''(H) TRANSITIONAL RULE FOR RESOURCE-BASED PRACTICE EXPENSE UNITS.—In applying subparagraph (C)(ii) for 1998, 1999, 2000, and any subsequent year, the number of units under such subparagraph shall be based 75 percent, 50 percent, 25 percent, and 0 percent, respectively, on the practice expense relative value units in effect in 1997 (or the Secretary's imputation of such units for new or revised codes) and the remainder on the relative value expense resources involved in furnishing the service.''

(c) REVIEW BY COMPTROLLER GENERAL.—The Comptroller General of the United States shall review and evaluate the proposed rule on resource-based methodology for practice expenses issued by the Health Care Financing Administration. The Comptroller General shall, within 6 months of the date of the enactment of this Act, report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate the results of its evaluation, including an analysis of—

(1) the adequacy of the data used in preparing the rule,

(2) categories of allowable costs,

(3) methods for allocating direct and indirect expenses,

(4) the potential impact of the rule on beneficiary access to services, and

(5) any other matters related to the appropriateness of resource-based methodology for practice expenses.

The Comptroller General shall consult with representatives of physicians' organizations with respect to matters of both data and methodology.

(d) CONSULTATION.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall assemble a group of physicians with expertise in both surgical and nonsurgical areas (including primary care physicians and academics), accounting experts, and the chair of the Prospective Payment Review Commission (or its successor) to solicit their individual views on whether sufficient data exist to allow the Health Care Financing Administration to proceed with implementation of the rule described in subsection (c). After hearing the views of individual members of the group, the Secretary shall determine whether sufficient data exists to proceed with practice expense relative value determination and shall report on such views of the individual members to the committees described in subsection (c), including any recommendations for modifying such rule.

(2) ACTION.—If the Secretary determines under paragraph (1) that insufficient data exists or that the rule described in subsection (c) needs to be revised, the Secretary shall provide for additional data collection and such other actions to correct any deficiencies.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to years beginning on and after January 1, 1998.

SEC. 5506. INCREASED MEDICARE REIMBURSEMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.

(a) REMOVAL OF RESTRICTIONS ON SETTINGS.—

(1) IN GENERAL.—Clause (ii) of section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended to read as follows:

''(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in

which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services;''.

(2) CONFORMING AMENDMENTS.—(A) Section 1861(s)(2)(K) of such Act (42 U.S.C. 1395x(s)(2)(K)) is further amended—

(i) in clause (i), by inserting ''and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service; and'' after ''are performed,''; and

(ii) by striking clauses (iii) and (iv).

(B) Section 1861(b)(4) (42 U.S.C. 1395x(b)(4)) is amended by striking ''clauses (i) or (iii) of subsection (s)(2)(K)'' and inserting ''subsection (s)(2)(K)''.

(C) Section 1862(a)(14) (42 U.S.C. 1395y(a)(14)) is amended by striking ''section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)'' and inserting ''section 1861(s)(2)(K)''.

(D) Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)) is amended by striking ''section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)'' and inserting ''section 1861(s)(2)(K)''.

(E) Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)), as added by section 5301(a), is amended by striking ''through (iii)'' and inserting ''and (ii)''.

(b) INCREASED PAYMENT.—

(1) FEE SCHEDULE AMOUNT.—Clause (O) of section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended to read as follows: ''(O) with respect to services described in section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848, or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery; and''.

(2) CONFORMING AMENDMENTS.—(A) Section 1833(r) (42 U.S.C. 1395l(r)) is amended—

(i) in paragraph (1), by striking ''section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area)'' and inserting ''section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services)'';

(ii) by striking paragraph (2);

(iii) in paragraph (3), by striking ''section 1861(s)(2)(K)(iii)'' and inserting ''section 1861(s)(2)(K)(ii)''; and

(iv) by redesignating paragraph (3) as paragraph (2).

(B) Section 1842(b)(12)(A) (42 U.S.C. 1395u(b)(12)(A)) is amended, in the matter preceding clause (i), by striking ''clauses (i), (ii), or (iv) of section 1861(s)(2)(K) (relating to a physician assistants and nurse practitioners)'' and inserting ''section 1861(s)(2)(K)(i) (relating to physician assistants)''.

(c) DIRECT PAYMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.—

(1) IN GENERAL.—Section 1832(a)(2)(B)(iv) (42 U.S.C. 1395k(a)(2)(B)(iv)) is amended by striking ''provided in a rural area (as defined in section 1886(d)(2)(D))'' and inserting ''but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services''.

(2) CONFORMING AMENDMENT.—Section 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is amended—

(A) by striking ''clauses (i), (ii), or (iv)'' and inserting ''clause (i)''; and

(B) by striking ''or nurse practitioner''.

(d) DEFINITION OF CLINICAL NURSE SPECIALIST CLARIFIED.—Section 1861(aa)(5) (42 U.S.C. 1395x(aa)(5)) is amended—

(1) by inserting ''(A)'' after ''(5)'';

(2) by striking ''The term 'physician assistant'' and all that follows through ''who performs'' and inserting ''The term 'physician assistant' and the term 'nurse practitioner' mean, for purposes of this title, a physician assistant or nurse practitioner who performs''; and

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

''(B) The term 'clinical nurse specialist' means, for purposes of this title, an individual who—

''(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

''(ii) holds a master's degree in a defined clinical area of nursing from an accredited educational institution.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after January 1, 1998.

SEC. 5507. INCREASED MEDICARE REIMBURSEMENT FOR PHYSICIAN ASSISTANTS.

(a) REMOVAL OF RESTRICTION ON SETTINGS.—Section 1861(s)(2)(K)(i) (42 U.S.C. 1395x(s)(2)(K)(i)), as amended by the section 5506, is amended—

(1) by striking ''(I) in a hospital'' and all that follows through ''shortage area,'', and

(2) by adding at the end the following: ''but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services,''.

(b) INCREASED PAYMENT.—Paragraph (12) of section 1842(b) (42 U.S.C. 1395u(b)), as amended by section 5506(b)(2)(B), is amended to read as follows:

''(12) With respect to services described in section 1861(s)(2)(K)(i)—

''(A) payment under this part may only be made on an assignment-related basis; and

''(B) the amounts paid under this part shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848 for the same service provided by a physician who is not a specialist; or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery.''.

(c) REMOVAL OF RESTRICTION ON EMPLOYMENT RELATIONSHIP.—Section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by adding at the end the following new sentence: ''For purposes of clause (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.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after January 1, 1998.

SEC. 5508. CHIROPRACTIC SERVICES COVERAGE DEMONSTRATION PROJECT.

(a) DEMONSTRATION.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct demonstration projects, for a period of 2 years, to begin not later than 1 year after the date of enactment of this Act, for the purpose of evaluating methods under which access to chiropractic services by individuals entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) and enrolled under part B of such title (42 U.S.C. 1395j et seq.) (in this section referred to as ''medicare beneficiaries'') would be provided, on a cost effective basis, as a benefit to medicare beneficiaries.

(b) ELEMENTS OF THE DEMONSTRATION PROJECT.—A demonstration project conducted under this section shall include the evaluation of the following elements:

(1) The effect on the medicare program of allowing chiropractors to order x-rays and to receive payment under the medicare program for providing such x-rays.

(2) The effect on the medicare program of eliminating the requirement for an x-ray under section 1861(r)(5) of such Act (42 U.S.C. 1395x(r)(5)).

(3) The effect on the medicare program of allowing chiropractors, within the scope of their licensure, to provide physicians' services (as defined in section 1861(q) of the Social Security Act (42 U.S.C. 1395x(q))) to medicare beneficiaries.

(4) The cost effectiveness of allowing a medicare beneficiary who is enrolled with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm) or with a Medicare Choice organization under part C of such Act to have direct access to chiropractors.

In this section, the term ''direct access'' means allowing a medicare beneficiary to go directly to a chiropractor affiliated with the organizations referred to in paragraph (4) without prior approval from a physician (other than another chiropractor) or other entity.

(c) CONDUCT OF THE DEMONSTRATION PROJECT.—

(1) PROJECT LOCATIONS.—A demonstration project (that includes each element under subsection (b)) shall be conducted in—

(A) 3 or more rural areas (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)));

(B) 3 or more urban areas (as defined in such section); and

(C) 3 or more areas having a shortage of primary medical care professionals (as designed under section 332 of the Public Health Service Act (42 U.S.C. 254e)).

(2) CONSULTATION.—For the design and conduct of the demonstration project, the Secretary shall consult, on a ongoing basis, with chiropractors, organizations representing chiropractors, and representatives of medicare beneficiary consumer groups.

(3) DIRECT ACCESS ELEMENT.—

(A) IN GENERAL.—The Secretary shall study the element to be evaluated under subsection (b)(4) by involving at least 10 eligible organizations under section 1876 of the Social Security Act (42 U.S.C. 1395mm) or Medicare Choice organizations under part C of such title that have voluntarily elected to participate in the demonstration project.

(B) PAYMENT.—The Secretary shall provide a small incentive payment to each such organization participating in the demonstration project.

(C) FULL SCOPE OF SERVICES.—Any such organization may allow chiropractors to practice the full scope of services for which they are licensed by the State in which those services are furnished, as if those services were both a covered benefit under the medicare program and included in such organization's contract under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). The Secretary shall agree to as many of such proposals as possible, giving due regard for the overall design of the demonstration project.

(d) EVALUATION.—The Secretary shall evaluate the demonstration projects, taking into account the differences in demonstration project locations, in order to determine—

(1) whether medicare beneficiaries who receive chiropractic services use a lesser overall amount of items and services under the

medicare program than medicare beneficiaries who do not receive chiropractic services;

(2) the overall cost effects on medicare program spending of the increased access of medicare beneficiaries to chiropractors;

(3) beneficiary satisfaction with chiropractic services, including quality of care; and

(4) such other matters as the Secretary deems appropriate.

(e) REPORT TO CONGRESS.—

(1) PRELIMINARY REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary shall submit a preliminary report to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and to the Committee on Finance of the Senate on the progress made in the demonstration programs, including—

(A) a description of the locations in which the demonstration projects under this section are being conducted; and

(B) the chiropractic services being furnished in each location.

(2) FINAL REPORT.—

(A) IN GENERAL.—Not later than January l, 2001, the Secretary shall submit a final report on the demonstration project to the committees described in paragraph (1).

(B) CONTENTS.—The report submitted under subparagraph (A) shall include a summary of the evaluation prepared under subsection (d) and recommendations for appropriate legislative changes.

(C) RECOMMENDED LEGISLATION.—The legislative recommendations described in subparagraph (B) shall include a legislative draft of specific amendments to the Social Security Act that authorize payment under the medicare program for elements described in subsection (b) that the Secretary determines to be cost effective, based on the results of the demonstration projects.

(f) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395t) such funds as the Secretary determines to be necessary for the costs of carrying out the demonstration projects under this section.

(2) PAYMENTS OF AMOUNTS.—Grants and payments under contracts for purposes of the demonstration project may be made either in advance or by reimbursement, as determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section.

(g) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of titles XI, XVIII, and XIX of the Social Security Act (42 U.S.C. 1301 et seq., 1395 et seq., 1396 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects under this section.

(h) IMPLEMENTING EXPANDED COVERAGE OF CHIROPRACTIC SERVICES.—As soon as possible after the submission of a final report under subsection (e), the Secretary shall issue regulations to implement, on a permanent basis, the elements of the demonstration project that are cost effective for the medicare program.

CHAPTER 2—OTHER PAYMENT PROVISIONS

SEC. 5521. REDUCTION IN UPDATES TO PAYMENT AMOUNTS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS; STUDY ON LABORATORY SERVICES.

(a) CHANGE IN UPDATE.—Section 1833(h)(2)(A)(ii) (42 U.S.C. 1395l(h)(2)(A)(ii)) is amended by striking ''and'' at the end of subclause (III), by striking the period at the end of subclause (IV) and inserting '', and'', and by adding at the end the following:

''(V) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1998 through 2002 shall be reduced (but not below zero) by 2.0 percentage points.''

(b) LOWERING CAP ON PAYMENT AMOUNTS.—Section 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)) is amended—

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

(2) in clause (vii)—

(A) by inserting ''and before January 1, 1998,'' after ''1995,'', and

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

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

''(viii) after December 31, 1997, is equal to 74 percent of such median.''.

(c) STUDY AND REPORT ON CLINICAL LABORATORY SERVICES.—

(1) IN GENERAL.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to conduct a study of payments under part B of title XVIII of the Social Security Act for clinical laboratory services. The study shall include a review of the adequacy of the current methodology and recommendations regarding alternative payment systems. The study shall also analyze and discuss the relationship between such payment systems and access to high quality laboratory services for medicare beneficiaries, including availability and access to new testing methodologies.

(2) REPORT TO CONGRESS.—The Secretary shall, not later than 2 years after the date of enactment of this section, report to the appropriate committees of Congress the results of the study described in paragraph (1), including any recommendations for legislation.

SEC. 5522. IMPROVEMENTS IN ADMINISTRATION OF LABORATORY SERVICES BENEFIT.

(a) SELECTION OF REGIONAL CARRIERS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall—

(A) divide the United States into no more than 5 regions, and

(B) designate a single carrier for each such region,

for the purpose of payment of claims under part B of title XVIII of the Social Security Act with respect to clinical diagnostic laboratory services furnished on or after such date (not later than January 1, 1999) as the Secretary specifies.

(2) DESIGNATION.—In designating such carriers, the Secretary shall consider, among other criteria—

(A) a carrier's timeliness, quality, and experience in claims processing, and

(B) a carrier's capacity to conduct electronic data interchange with laboratories and data matches with other carriers.

(3) SINGLE DATA RESOURCE.—The Secretary shall select one of the designated carriers to serve as a central statistical resource for all claims information relating to such clinical diagnostic laboratory services handled by all the designated carriers under such part.

(4) ALLOCATION OF CLAIMS.—The allocation of claims for clinical diagnostic laboratory services to particular designated carriers shall be based on whether a carrier serves the geographic area where the laboratory specimen was collected or other method specified by the Secretary.

(5) TEMPORARY EXCEPTION.—Paragraph (1) shall not apply with respect to clinical diagnostic laboratory services furnished by independent physician offices until such time as the Secretary determines that such offices would not be unduly burdened by the application of billing responsibilities with respect to more than one carrier.

(b) ADOPTION OF UNIFORM POLICIES FOR CLINICAL LABORATORY BENEFITS.—

(1) IN GENERAL.—Not later than July 1, 1998, the Secretary shall first adopt, consistent with paragraph (2), uniform coverage, administration, and payment policies for clinical diagnostic laboratory tests under part B of title XVIII of the Social Security Act, using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code.

(2) CONSIDERATIONS IN DESIGN OF UNIFORM POLICIES.—The policies under paragraph (1) shall be designed to promote program integrity and uniformity and simplify administrative requirements with respect to clinical diagnostic laboratory tests payable under such part in connection with the following:

(A) Beneficiary information required to be submitted with each claim or order for laboratory services.

(B) Physicians' obligations regarding documentation requirements and recordkeeping.

(C) Procedures for filing claims and for providing remittances by electronic media.

(D) The documentation of medical necessity.

(E) Limitation on frequency of coverage for the same tests performed on the same individual.

(3) CHANGES IN LABORATORY POLICIES PENDING ADOPTION OF UNIFORM POLICY.—During the period that begins on the date of the enactment of this Act and ends on the date the Secretary first implements uniform policies pursuant to regulations promulgated under this subsection, a carrier under such part may implement changes relating to requirements for the submission of a claim for clinical diagnostic laboratory tests.

(4) USE OF INTERIM POLICIES.—After the date the Secretary first implements such uniform policies, the Secretary shall permit any carrier to develop and implement interim policies of the type described in paragraph (1), in accordance with guidelines established by the Secretary, in cases in which a uniform national policy has not been established under this subsection and there is a demonstrated need for a policy to respond to aberrant utilization or provision of unnecessary services. Except as the Secretary specifically permits, no policy shall be implemented under this paragraph for a period of longer than 2 years.

(5) INTERIM NATIONAL GUIDELINES.—After the date the Secretary first designates regional carriers under subsection (a), the Secretary shall establish a process under which designated carriers can collectively develop and implement interim national guidelines of the type described in paragraph (1). No such policy shall be implemented under this paragraph for a period of longer than 2 years.

(6) BIENNIAL REVIEW PROCESS.—Not less often than once every 2 years, the Secretary shall solicit and review comments regarding changes in the uniform policies established under this subsection. As part of such biennial review process, the Secretary shall specifically review and consider whether to incorporate or supersede interim, regional, or national policies developed under paragraph (4) or (5). Based upon such review, the Secretary may provide for appropriate changes in the uniform policies previously adopted under this subsection.

(7) REQUIREMENT AND NOTICE.—The Secretary shall ensure that any guidelines adopted under paragraph (3), (4), or (5) shall apply to all laboratory claims payable under part B of title XVIII of the Social Security Act, and shall provide for advance notice to interested parties and a 45-day period in

which such parties may submit comments on the proposed change.

(c) INCLUSION OF LABORATORY REPRESENTATIVE ON CARRIER ADVISORY COMMITTEES.—The Secretary shall direct that any advisory committee established by such a carrier, to advise with respect to coverage, administration or payment policies under part B of title XVIII of the Social Security Act, shall include an individual to represent the interest and views of independent clinical laboratories and such other laboratories as the Secretary deems appropriate. Such individual shall be selected by such committee from among nominations submitted by national and local organizations that represent independent clinical laboratories.

SEC. 5523. PAYMENTS FOR DURABLE MEDICAL EQUIPMENT.

(a) REDUCTION IN PAYMENT AMOUNTS FOR ITEMS OF DURABLE MEDICAL EQUIPMENT.—

(1) FREEZE IN UPDATE FOR COVERED ITEMS.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended to read as follows:

''(14) COVERED ITEM UPDATE.—In this subsection—

''(A) IN GENERAL.—The term 'covered item update' means, with respect to any year, 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.

''(B) REDUCTION FOR CERTAIN YEARS.—In the case of each of the years 1998 through 2002, the covered item update under subparagraph (A) shall be reduced (but not below zero) by 2.0 percentage points.''

(2) UPDATE FOR ORTHOTICS AND PROSTHETICS.—Section 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A)) is amended to read as follows:

''(A) the term 'applicable percentage increase' means, with respect to any year, 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, except that in each of the years 1998 through 2000, such increase shall be reduced (but not below zero) by 2.0 percentage points;''.

(3) EFFECTIVE DATE.—The amendments made by this subsection applies to items furnished on and after January 1, 1998.

(b) REDUCTION IN INCREASE FOR PARENTERAL AND ENTERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT.—The reasonable charge under part B of title XVIII of the Social Security Act for parenteral and enteral nutrients, supplies, and equipment furnished during each of the years 1998 through 2002, shall not exceed the reasonable charge for such items furnished during the previous year (after application of this subsection), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year reduced (but not below zero) by 2.0 percentage points.

SEC. 5524. OXYGEN AND OXYGEN EQUIPMENT.

(a) IN GENERAL.—Section 1834(a)(9)(B) (42 U.S.C. 1395m(a)(9)(B)) is amended—

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

(2) in clause (iv)—

(A) by striking ''a subsequent year'' and inserting ''1995, 1996, and 1997'', and

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

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

''(v) in 1998, 75 percent of the amount determined under this subparagraph for 1997;

''(vi) in 1999, 62.5 percent of the amount determined under this subparagraph for 1997; and

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

(b) UPGRADED DURABLE MEDICAL EQUIPMENT.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by inserting after paragraph (15) the following new paragraph:

''(16) CERTAIN UPGRADED ITEMS.—

''(A) INDIVIDUAL'S RIGHT TO CHOOSE UPGRADED ITEM.—Notwithstanding any other provision of law, effective on the date on which the Secretary issues regulations under subparagraph (C), an individual may purchase or rent from a supplier an item of upgraded durable medical equipment for which payment would be made under this subsection if the item were a standard item.

''(B) PAYMENTS TO SUPPLIER.—In the case of the purchase or rental of an upgraded item under subparagraph (A)—

''(i) the supplier shall receive payment under this subsection with respect to such item as if such item were a standard item; and

''(ii) the individual purchasing or renting the item shall pay the supplier an amount equal to the difference between the supplier's charge and the amount under clause (i). In no event may the supplier's charge for an upgraded item exceed the applicable fee schedule amount (if any) for such item.

''(C) CONSUMER PROTECTION SAFEGUARDS.—The Secretary shall issue regulations providing for consumer protection standards with respect to the furnishing of upgraded equipment under subparagraph (A). Such regulations shall provide for—

''(i) determination of fair market prices with respect to an upgraded item;

''(ii) full disclosure of the availability and price of standard items and proof of receipt of such disclosure information by the beneficiary before the furnishing of the upgraded item;

''(iii) conditions of participation for suppliers in the simplified billing arrangement;

''(iv) sanctions of suppliers who are determined to engage in coercive or abusive practices, including exclusion; and

''(v) such other safeguards as the Secretary determines are necessary.''

(c) ESTABLISHMENT OF CLASSES FOR PAYMENT.—Section 1848(a)(9) (42 U.S.C. 1395m(a)(9)) is amended by adding at the end the following:

''(D) AUTHORITY TO CREATE CLASSES.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary may establish separate classes for any item of oxygen and oxygen equipment and separate national limited monthly payment rates for each of such classes.

''(ii) BUDGET NEUTRALITY.—The Secretary may take actions under clause (i) only to the extent such actions do not result in expenditures for any year to be more or less than the expenditures which would have been made if such actions had not been taken.''

(d) STANDARDS AND ACCREDITATION.—The Secretary shall as soon as practicable establish service standards and accreditation requirements for persons seeking payment under part B of title XVIII of the Social Security Act for the providing of oxygen and oxygen equipment to beneficiaries within their homes.

(e) ACCESS TO HOME OXYGEN EQUIPMENT.—

(1) STUDY.—The Comptroller General of the United States shall study issues relating to access to home oxygen equipment and shall, within 6 months after the date of the enactment of this Act, report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate the results of the study, including recommendations (if any) for legislation.

(2) PEER REVIEW EVALUATION.—The Secretary of Health and Human Services shall arrange for peer review organizations established under section 1154 of the Social Security Act to evaluate access to, and quality of, home oxygen equipment.

(f) DEMONSTRATION PROJECT.—Not later than 6 months after the date of enactment of this Act, the Secretary shall, in consultation with appropriate organizations, initiate a demonstration project in which the Secretary utilizes a competitive bidding process for the furnishing of home oxygen equipment to medicare beneficiaries under title XVIII of the Social Security Act.

(g) EFFECTIVE DATE.—

(1) OXYGEN.—The amendments made by subsection (a) shall apply to items furnished on and after January 1, 1998.

(2) OTHER PROVISIONS.—The amendments made by this section other than subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 5525. UPDATES FOR AMBULATORY SURGICAL SERVICES.

Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is amended by inserting at the end the following: ''In each of the fiscal years 1998 through 2002, the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points.''

SEC. 5526. REIMBURSEMENT FOR DRUGS AND BIOLOGICALS.

(a) IN GENERAL.—Section 1842 (42 U.S.C. 1395u) is amended by inserting after subsection (n) the following new subsection:

''(o)(1) If a physician's, supplier's, or any other person's bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the amount payable for the drug or biological is equal to 95 percent of the average wholesale price, as specified by the Secretary.

''(2) In the case of any drug or biological for which payment was made under this part on May 1, 1997, the amount determined under paragraph (1) shall not exceed the amount payable under this part for such drug or biological on such date.

''(3) If payment for a drug or biological is made to a licensed pharmacy approved to dispense drugs or biologicals under this part, the Secretary shall pay a dispensing fee (less the applicable deductible and insurance amounts) to the pharmacy, as the Secretary determines appropriate.''

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to drugs and biologicals furnished on or after January 1, 1999.

CHAPTER 3—PART B PREMIUM AND RELATED PROVISIONS

SEC. 5541. PART B PREMIUM.

(a) IN GENERAL.—Section 1839(a)(3) (42 U.S.C. 1395r(a)(3)) is amended by striking the first 3 sentences and inserting the following: ''The Secretary, during September of each year, shall determine and promulgate a monthly premium rate for the succeeding calendar year that is equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1), for that succeeding calendar year.''.

(b) CONFORMING AND TECHNICAL AMENDMENTS.—

(1) SECTION 1839.—Section 1839 (42 U.S.C. 1395r) is amended—

(A) in subsection (a)(2), by striking ''(b) and (e)'' and inserting ''(b), (c), and (f)'',

(B) in the last sentence of subsection (a)(3)—

(i) by inserting ''rate'' after ''premium'', and

(ii) by striking ''and the derivation of the dollar amounts specified in this paragraph'',

(C) by striking subsection (e), and

(D) by redesignating subsection (g) as subsection (e) and inserting that subsection after subsection (d).

(2) SECTION 1844.—Subparagraphs (A)(i) and (B)(i) of section 1844(a)(1) (42 U.S.C. 1395w(a)(1)) are each amended by striking ''or 1839(e), as the case may be''.

Subtitle H—Provisions Relating to Parts A and B

CHAPTER 1—SECONDARY PAYOR PROVISIONS

SEC. 5601. EXTENSION AND EXPANSION OF EXISTING REQUIREMENTS.

(a) DATA MATCH.—

(1) ELIMINATION OF MEDICARE SUNSET.—Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) ELIMINATION OF INTERNAL REVENUE CODE SUNSET.—Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) APPLICATION TO DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

(1) IN GENERAL.—Section 1862(b)(1)(B) (42 U.S.C. 1395y(b)(1)(B)) is amended—

(A) in clause (i), by striking ''clause (iv)'' and inserting ''clause (iii)'';

(B) by striking clause (iii); and

(C) by redesignating clause (iv) as clause (iii).

(2) CONFORMING AMENDMENTS.—Paragraphs (1) through (3) of section 1837(i) (42 U.S.C. 1395p(i)) and the second sentence of section 1839(b) (42 U.S.C. 1395r(b)) are each amended by striking ''1862(b)(1)(B)(iv)'' each place it appears and inserting ''1862(b)(1)(B)(iii)''.

(c) INDIVIDUALS WITH END STAGE RENAL DISEASE.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the last sentence by striking ''October 1, 1998'' and inserting ''the date of enactment of the Balanced Budget Act of 1997''; and

(2) by adding at the end the following: ''Effective for items and services furnished on or after the date of enactment of the Balanced Budget Act of 1997, (with respect to periods beginning on or after the date that is 18 months prior to such date), clauses (i) and (ii) shall be applied by substituting '30-month' for '12-month' each place it appears.''.

SEC. 5602. IMPROVEMENTS IN RECOVERY OF PAYMENTS.

(a) PERMITTING RECOVERY AGAINST THIRD PARTY ADMINISTRATORS OF PRIMARY PLANS.—Section 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is amended—

(1) by striking ''under this subsection to pay'' and inserting ''(directly, as a third-party administrator, or otherwise) to make payment''; and

(2) by adding at the end the following: ''The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.''.

(b) EXTENSION OF CLAIMS FILING PERIOD.—Section 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amended by adding at the end the following:

''(v) CLAIMS-FILING PERIOD.—Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to items and services furnished on or after the date of enactment of this Act.

CHAPTER 2—OTHER PROVISIONS

SEC. 5611. INCREASED CERTIFICATION PERIOD FOR CERTAIN ORGAN PROCUREMENT ORGANIZATIONS.

Section 1138(b)(1)(A)(ii) (42 U.S.C. 1320b–8(b)(1)(A)(ii)) is amended by striking ''two years'' and inserting ''2 years (3 years if the Secretary determines appropriate for an organization on the basis of its past practices)''.

HUTCHISON (AND SANTORUM) AMENDMENT NO. 446

Mrs. HUTCHISON (for herself and Mr. SANTORUM) proposed an amendment to the bill, S. 947, supra; as follows:

At the end of title I, add the following:

SEC. 10___. DENIAL OF FOOD STAMPS FOR PRISONERS.

(a) STATE PLANS.—

(1) IN GENERAL.—Section 11(e) of the Food Stamp Act of 1977 (7 U.S.C. 2020(e)) is amended by striking paragraph (20) and inserting the following:

''(20) that the State agency shall establish a system and take action on a periodic basis—

''(A) to verify and otherwise ensure that an individual does not receive coupons in more than 1 jurisdiction within the State; and

''(B) to verify and otherwise ensure that an individual who is placed under detention in a Federal, State, or local penal, correctional, or other detention facility for more than 30 days shall not be eligible to participate in the food stamp program as a member of any household, except that—

''(i) the Secretary may determine that extraordinary circumstances make it impracticable for the State agency to obtain information necessary to discontinue inclusion of the individual; and

''(ii) a State agency that obtains information collected under section 1611(e)(1)(I)(i)(I) of the Social Security Act (42 U.S.C. 1382(e)(1)(I)(i)(I)) through an agreement under section 1611(e)(1)(I)(ii)(II) of that Act (42 U.S.C. 1382(e)(1)(I)(ii)(II)), or under another program determined by the Secretary to be comparable to the program carried out under that section, shall be considered in compliance with this subparagraph.''.

(2) LIMITS ON DISCLOSURE AND USE OF INFORMATION.—Section 11(e)(8)(E) of the Food Stamp Act of 1977 (7 U.S.C. 2020(e)(8)(E)) is amended by striking ''paragraph (16)'' and inserting ''paragraph (16) or (20)(B)''.

(3) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this subsection shall take effect on the date that is 1 year after the date of enactment of this Act.

(B) EXTENSION.—The Secretary of Agriculture may grant a State an extension of time to comply with the amendments made by this subsection, not to exceed beyond the date that is 2 years after the date of enactment of this Act, if the chief executive officer of the State submits a request for the extension to the Secretary—

(i) stating the reasons why the State is not able to comply with the amendments made by this subsection by the date that is 1 year after the date of enactment of this Act;

(ii) providing evidence that the State is making a good faith effort to comply with the amendments made by this subsection as soon as practicable; and

(iii) detailing a plan to bring the State into compliance with the amendments made by this subsection as soon as practicable and not later than the date of the requested extension.

(b) INFORMATION SHARING.—Section 11 of the Food Stamp Act of 1977 (7 U.S.C. 2020) is amended by adding at the end the following:

''(q) DENIAL OF FOOD STAMPS FOR PRISONERS.—The Secretary shall assist States, to the maximum extent practicable, in implementing a system to conduct computer matches or other systems to prevent prisoners described in section 11(e)(20)(B) from receiving food stamp benefits.''.

SEC. 10___. NUTRITION EDUCATION.

Section 11(f) of the Food Stamp Act of 1977 (7 U.S.C. 2020(f)) is amended—

(1) by striking ''(f) To encourage'' and inserting the following:

''(f) NUTRITION EDUCATION.—

''(1) IN GENERAL.—To encourage''; and

(2) by adding at the end the following:

''(2) GRANTS.—

''(A) IN GENERAL.—The Secretary shall make available not more than $600,000 for each of fiscal years 1998 through 2001 to pay the Federal share of grants made to eligible private nonprofit organizations and State agencies to carry out subparagraph (B).

''(B) ELIGIBILITY.—A private nonprofit organization or State agency shall be eligible to receive a grant under subparagraph (A) if the organization or agency agrees—

''(i) to use the funds to direct a collaborative effort to coordinate and integrate nutrition education into health, nutrition, social service, and food distribution programs for food stamp participants and other low-income households; and

''(ii) to design the collaborative effort to reach large numbers of food stamp participants and other low-income households through a network of organizations, including schools, child care centers, farmers' markets, health clinics, and outpatient education services.

''(C) PREFERENCE.—In deciding between 2 or more private nonprofit organizations or State agencies that are eligible to receive a grant under subparagraph (B), the Secretary shall give a preference to an organization or agency that conducted a collaborative effort described in subparagraph (B) and received funding for the collaborative effort from the Secretary before the date of enactment of this paragraph.

''(D) FEDERAL SHARE.—

''(i) IN GENERAL.—Subject to subparagraph (E), the Federal share of a grant under this paragraph shall be 50 percent.

''(ii) NO IN-KIND CONTRIBUTIONS.—The non-Federal share of a grant under this paragraph shall be in cash.

''(iii) PRIVATE FUNDS.—The non-Federal share of a grant under this paragraph may include amounts from private nongovernmental sources.

''(E) LIMIT ON INDIVIDUAL GRANT.—A grant under subparagraph (A) may not exceed $200,000 for a fiscal year.''.

HUTCHISON AMENDMENT NO. 447

Mrs. HUTCHISON proposed an amendment to the bill, S. 9947, supra; as follows:

Beginning on page 770, strike line 18 and all that follows through page 774, line 15, and insert the following:

''(2) DETERMINATION OF STATE DSH ALLOTMENTS FOR FISCAL YEARS 1998 THROUGH 2002.—

''(A) NON HIGH DSH STATES.—

''(i) IN GENERAL.—Except as provided in subparagraph (B) and paragraph (4), the DSH allotment for a State for each of fiscal years 1999 through 2002 is equal to the applicable percentage of the State 1995 DSH spending amount.

''(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the applicable percentage with respect to a State described in that clause is—

''(A) for fiscal year 1998, 98 percent;

''(A) for fiscal year 1999, 95 percent;

''(B) for fiscal year 2000, 93 percent;

''(C) for fiscal year 2001, 90 percent; and

''(D) for fiscal year 2002, 85 percent.

''(B) HIGH DSH STATES.—

''(i) IN GENERAL.—In the case of any State that is a high DSH State, the DSH allotment for that State for each of fiscal years 1999 through 2002 is equal to the applicable reduction percentage of the high DSH State modified 1995 spending amount for that fiscal year.

''(ii) HIGH DSH STATE MODIFIED 1995 SPENDING AMOUNT.—

''(i) IN GENERAL.—For purposes of clause (i), the high DSH State modified 1995 spending amount means, with respect to a State and a fiscal year, the sum of—

''(aa) the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for inpatient hospital services provided (based on reporting data specified by the State on HCFA Form 64 as inpatient DSH); and

''(bb) the applicable mental health percentage for such fiscal year of the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for services provided by institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH).

''(II) APPLICABLE MENTAL HEALTH PERCENTAGE.—For purposes of subclause (I)(bb), the applicable mental health percentage for such fiscal year is—

''(aa) for fiscal year 1999, 50 percent;

''(bb) for fiscal year 2000, 20 percent; and

''(cc) for fiscal year 2001 and 2002, 0 percent.

''(iii) APPLICABLE REDUCTION PERCENTAGE.—For purposes of clause (i), the applicable reduction percentage described in that clause is—

''(A) for fiscal year 1998, 98 percent;

''(A) for fiscal year 1999, 93 percent;

''(A) for fiscal year 2000, 90 percent;

''(A) for fiscal year 2001, 85 percent; and

''(B) for fiscal year 2002, 80 percent.

CHAFEE (AND OTHERS) AMENDMENT NO. 448

Mr. CHAFEE (for himself, Mr. ROCKEFELLER, Mr. JEFFORDS, and Mr. D'AMATO) proposed an amendment to the bill, S. 947, supra; as follows:

Beginning on page 846, strike line 18 and all that follows through page 861, line 26, and insert the following:

''(5) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The term 'FEHBP-equivalent children's health insurance coverage' means, with respect to a State, any plan or arrangement that provides, or pays the cost of, health benefits that the Secretary has certified are equivalent to or better than the services covered for a child, including hearing and vision services, under the standard Blue Cross/Blue Shield preferred provider option service benefit plan offered under chapter 89 of title 5, United States Code.

''(6) INDIANS.—The term 'Indians' has the meaning given that term in section 4(c) of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(7) LOW-INCOME CHILD.—The term 'low-income child' means a child in a family whose income is below 200 percent of the poverty line for a family of the size involved.

''(8) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

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

''(10) STATE.—The term 'State' means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands.

''(11) STATE CHILDREN'S HEALTH EXPENDITURES.—The term 'State children's health expenditures' means the State share of expenditures by the State for providing children with health care items and services under—

''(A) the State plan for medical assistance under title XIX;

''(B) the maternal and child health services block grant program under title V;

''(C) the preventive health services block grant program under part A of title XIX of the Public Health Services Act (42 U.S.C. 300w et seq.);

''(D) State-funded programs that are designed to provide health care items and services to children;

''(E) school-based health services programs;

''(F) State programs that provide uncompensated or indigent health care;

''(G) county-indigent care programs for which the State requires a matching share by a county government or for which there are intergovernmental transfers from a county to State government; and

''(H) any other program under which the Secretary determines the State incurs uncompensated expenditures for providing children with health care items and services.

''(12) STATE MEDICAID PROGRAM.—The term 'State medicaid program' means the program of medical assistance provided under title XIX.

''SEC. 2103. APPROPRIATION.

''(a) APPROPRIATION.—

''(1) IN GENERAL.—Subject to subsection (b), out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated for the purpose of carrying out this title—

''(A) for fiscal year 1998, $2,500,000,000;

''(B) for each of fiscal years 1999 and 2000, $3,200,000,000;

''(C) for fiscal year 2001, $3,600,000,000;

''(D) for fiscal year 2002, $3,500,000,000; and

''(E) for each of fiscal years 2003 through 2007, $4,580,000,000.

''(2) AVAILABILITY.—Funds appropriated under this section shall remain available without fiscal year limitation, as provided under section 2105(b)(4).

''(b) REDUCTION FOR INCREASED MEDICAID EXPENDITURES.—With respect to each of the fiscal years described in subsection (a)(1), the amount appropriated under subsection (a)(1) for each such fiscal year shall be reduced by an amount equal to the amount of the total Federal outlays under the medicaid program under title XIX resulting from—

''(1) the amendment made by section 5732 of the Balanced Budget Act of 1997 (regarding the State option to provide 12-month continuous eligibility for children);

''(2) increased enrollment under State plans approved under such program as a result of outreach activities under section 2106(a); and

''(3) the requirement under section 2102(3)A) to provide eligibility for medical assistance under the State plan under title XIX for all children under 19 years of age who have families with income that is at or below the poverty line.

''(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided in accordance with the provisions of this title.

''(d) EFFECTIVE DATE.—No State is eligible for payments under section 2105 for any calendar quarter beginning before October 1, 1997.

''SEC. 2104. PROGRAM OUTLINE.

''(a) GENERAL DESCRIPTION.—A State shall submit to the Secretary a program outline, consistent with the requirements of this title, that—

''(1) identifies which of the 2 options described in section 2101 the State intends to use to provide low-income children in the State with health insurance coverage;

''(2) describes the manner in which such coverage shall be provided;

''(3) describes any cost-sharing intended to be imposed under the State option under section 2107 that is consistent with the requirements of subsection (a)(4) of such section; and

''(4) provides such other information as the Secretary may require.

''(b) OTHER REQUIREMENTS.—The program outline submitted under this section shall include the following:

''(1) ELIGIBILITY STANDARDS AND METHODOLOGIES.—A summary of the standards and methodologies used to determine the eligibility of low-income children for health insurance coverage under a State program funded under this title.

''(2) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE.—A description of the procedures to be used to ensure—

''(A) through both intake and followup screening, that only low-income children are furnished health insurance coverage through funds provided under this title; and

''(B) that any health insurance coverage provided for children through funds under this title does not reduce the number of children who are provided such coverage through any other publicly or privately funded health plan.

''(3) INDIANS.—A description of how the State will ensure that Indians are served through a State program funded under this title.

''(c) DEADLINE FOR SUBMISSION.—A State program outline shall be submitted to the Secretary by not later than March 31 of any fiscal year (October 1, 1997, in the case of fiscal year 1998).

''SEC. 2105. DISTRIBUTION OF FUNDS.

''(a) ESTABLISHMENT OF FUNDING POOLS.—

''(1) IN GENERAL.—From the amount appropriated under section 2103(a)(1) for each fiscal year, determined after the reduction required under section 2103(b), the Secretary shall, for purposes of fiscal year 1998, reserve 85 percent of such amount for distribution to eligible States through the basic allotment pool under subsection (b) and 15 percent of such amount for distribution through the new coverage incentive pool under subsection (c)(2)(B)(ii).

''(2) ANNUAL ADJUSTMENT OF RESERVE PERCENTAGES.—The Secretary shall annually adjust the amount of the percentages described in paragraph (1) in order to provide sufficient basic allotments and sufficient new coverage incentives to achieve the purpose of this title.

''(b) DISTRIBUTION OF FUNDS UNDER THE BASIC ALLOTMENT POOL.—

''(1) STATES.—

''(A) IN GENERAL.—From the total amount reserved under subsection (a) for a fiscal year for distribution through the basic allotment pool, the Secretary shall first set aside

0.25 percent for distribution under paragraph (2) and shall allot from the amount remaining to each eligible State not described in such paragraph the State's allotment percentage for such fiscal year.

''(B) STATE'S ALLOTMENT PERCENTAGE.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the allotment percentage for a fiscal year for each State is the percentage equal to the ratio of the number of low-income children in the base period in the State to the total number of low-income children in the base period in all States not described in paragraph (2).

''(ii) NUMBER OF LOW-INCOME CHILDREN IN THE BASE PERIOD.—In clause (i), the number of low-income children in the base period for a fiscal year in a State is equal to the average of the number of low-income children in the State for the period beginning on October 1, 1992, and ending on September 30, 1995, as reported in the March 1994, March 1995, and March 1996 supplements to the Current Population Survey of the Bureau of the Census.

''(2) OTHER STATES.—

''(A) IN GENERAL.—From the amount set aside under paragraph (1)(A) for each fiscal year, the Secretary shall make allotments for such fiscal year in accordance with the percentages specified in subparagraph (B) to Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands, if such States are eligible States for such fiscal year.

''(B) PERCENTAGES SPECIFIED.—The percentages specified in this subparagraph are in the case of—

''(i) Puerto Rico, 91.6 percent;

''(ii) Guam, 3.5 percent;

''(iii) the Virgin Islands, 2.6 percent;

''(iv) American Samoa, 1.2 percent; and

''(v) the Northern Mariana Islands, 1.1 percent.

''(3) THREE-YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

''(4) PROCEDURE FOR DISTRIBUTION OF UNUSED FUNDS.—The Secretary shall determine an appropriate procedure for distribution of funds to eligible States that remain unused under this subsection after the expiration of the availability of funds required under paragraph (3). Such procedure shall be developed and administered in a manner that is consistent with the purpose of this title.

''(c) PAYMENTS.—

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

''(A) before October 1 of any fiscal year, pay an eligible State an amount equal to 1 percent of the amount allotted to the State under subsection (b) for conducting the outreach activities required under section 2106(a); and

''(B) make quarterly fiscal year payments to an eligible State from the amount remaining of such allotment for such fiscal year in an amount equal to the Federal medical assistance percentage for the State, as determined under section 1905(b)(1), of the Federal and State incurred cost of providing health insurance coverage for a low-income child in the State plus the applicable bonus amount.

''(2) APPLICABLE BONUS.—

''(A) IN GENERAL.—For purposes of paragraph (1), the applicable bonus amount is—

''(i) 5 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the base-year covered low-income child population (measured in full year equivalency); and

''(ii) 10 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the number (as so measured) of low-income children that are in excess of such population.

''(B) SOURCE OF BONUSES.—

''(i) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—A bonus described in subparagraph (A)(i) shall be paid out of an eligible State's allotment for a fiscal year.

''(ii) FOR OTHER LOW-INCOME CHILD POPULATIONS.—A bonus described in subparagraph (A)(ii) shall be paid out of the new coverage incentive pool reserved under subsection (a)(1).

''(3) DEFINITION OF COST OF PROVIDING HEALTH INSURANCE COVERAGE.—For purposes of this subsection the cost of providing health insurance coverage for a low-income child in the State means—

''(A) in the case of an eligible State that opts to use funds provided under this title through the medicaid program, the cost of providing such child with medical assistance under the State plan under title XIX; and

''(B) in the case of an eligible State that opts to use funds provided under this title under section 2107, the cost of providing such child with health insurance coverage under such section.

''(4) LIMITATION ON TOTAL PAYMENTS.—With respect to a fiscal year, the total amount paid to an eligible State under this title (including any bonus payments) shall not exceed 85 percent of the total cost of a State program conducted under this title for such fiscal year.

''(5) MAINTENANCE OF EFFORT.—No funds shall be paid to a State under this title if—

''(A) in the case of fiscal year 1998, the State children's health expenditures are less than the amount of such expenditures for fiscal year 1996; and

''(B) in the case of any succeeding fiscal year, the State children's health expenditures described in section 2102(11)(A) are less than the amount of such expenditures for fiscal year 1996, increased by a medicaid child population growth factor determined by the Secretary.

''(6) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this subsection for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and shall reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

''SEC. 2106. USE OF FUNDS.

''(a) SET-ASIDE FOR OUTREACH ACTIVITIES.—

''(1) IN GENERAL.—From the amount allotted to a State under section 2105(b) for a fiscal year, each State shall conduct outreach activities described in paragraph (2).

''(2) OUTREACH ACTIVITIES DESCRIBED.—The outreach activities described in this paragraph include activities to—

''(A) identify and enroll children who are eligible for medical assistance under the State plan under title XIX; and

''(B) conduct public awareness campaigns to encourage employers to provide health insurance coverage for children.

''(b) STATE OPTIONS FOR REMAINDER.—A State may use the amount remaining of the allotment to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), in accordance with section 2107 or the State medicaid program (but not both).

''(c) PROHIBITION ON USE OF FUNDS.—No funds provided under this title may be used to provide health insurance coverage for—

''(1) families of State public employees; or

''(2) children who are committed to a penal institution.

''(d) USE LIMITED TO STATE PROGRAM EXPENDITURES.—Funds provided to an eligible State under this title shall only be used to carry out the purpose of this title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

''(e) ADMINISTRATIVE EXPENDITURES.—Not more than 10 percent of the amount allotted to a State under section 2105(b), determined after the payment required under section 2105(c)(1)(A), shall be used for administrative expenditures for the program funded under this title.

''(f) NONAPPLICATION OF FIVE-YEAR LIMITED ELIGIBILITY FOR MEANS-TESTED PUBLIC BENEFITS.—The provisions of section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613) shall not apply with respect to a State program funded under this title.

''SEC. 2107. STATE OPTION FOR THE PURCHASE OR PROVISION OF CHILDREN'S HEALTH INSURANCE.

''(a) STATE OPTION.—

''(1) IN GENERAL.—An eligible State that opts to use funds provided under this title under this section shall use such funds to—

''(A) subsidize payment of employee contributions for health insurance coverage for a dependent low-income child that is available through group health insurance coverage offered by an employer in the State; or

''(B) to provide FEHBP-equivalent children's health insurance coverage for low-income children who reside in the State.

''(2) PRIORITY FOR LOW-INCOME CHILDREN.—A State that uses funds provided under this title under this section shall not cover low-income children with higher family income without covering such children with a lower family income.

''(3) DETERMINATION OF ELIGIBILITY AND FORM OF ASSISTANCE.—An eligible State may establish any additional eligibility criteria for the provision of health insurance coverage for a low-income child through funds provided under this title, so long as such criteria and assistance are consistent with the purpose and provisions of this title.

''(4) COST SHARING REQUIREMENTS.—

''(A) NOMINAL COST SHARING FOR VERY LOW-INCOME CHILDREN.—Only nominal cost sharing may be imposed by an eligible State that opts to use funds provided under this title under this section for children in families with income that is less than 133 percent of the poverty line.

''(B) SECRETARIAL REVIEW OF ADEQUACY OF COST-SHARING FOR OTHER LOW-INCOME CHILDREN.—The Secretary shall review the State program outline submitted under section 2104 to ensure that cost sharing for low-income children not described in subparagraph (A) is reasonable, according to such standards as the Secretary shall establish. Such standards shall require consideration of family income and other types of expenses generally incurred by families of low-income children, and shall ensure that any cost sharing requirements imposed by a State program under this section do not unreasonably reduce access to the coverage provided under such program.

''(C) DEFINITION OF COST SHARING.—In this paragraph, the term 'cost sharing' includes premiums, deductibles, coinsurance, copayments, and other required financial contributions for health care insurance coverage or health care items or services.

WELLSTONE (AND OTHERS) AMENDMENT NO. 449

Mr. WELLSTONE (for himself, Mr. DOMENICI, Mr. REID, and Mr. CONRAD)

proposed an amendment to the bill, S. 947, supra; as follows:

On page 862, between lines 14 and 15, insert the following:

"SEC. 2107A. MENTAL HEALTH PARITY.

''(a) PROHIBITION.—In the case of a health plan that enrolls children through the use of assistance provided under a grant program conducted under this title, such plan, if the plan provides both medical and surgical benefits and mental health benefits, shall not impose treatment limitations or financial requirements on the coverage of mental health benefits if similar limitations or requirements are not imposed on medical and surgical benefits.

''(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed—

''(1) as prohibiting a health plan from requiring preadmission screening prior to the authorization of services covered under the plan or from applying other limitations that restrict coverage for mental health services to those services that are medically necessary; and

''(2) as requiring a health plan to provide any mental health benefits.

''(c) SEPARATE APPLICATION TO EACH OPTION OFFERED.—In the case of a health plan that offers a child described in subsection (a) 2 or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

''(d) DEFINITIONS.—In this section:

''(1) MEDICAL OR SURGICAL BENEFITS.—The term 'medical or surgical benefits' means benefits with respect to medical or surgical services, as defined under the terms of the plan, but does not include mental health benefits.

''(2) MENTAL HEALTH BENEFITS.—The term 'mental health benefits' means benefits with respect to mental health services, as defined under the terms of the plan, but does not include benefits with respect to the treatment of substance abuse and chemical dependency.

DURBIN (AND OTHERS) AMENDMENT NO. 450

Mr. DURBIN (for himself, Mr. WELLSTONE, and Mrs. BOXER) proposed an amendment to the bill, S. 947, supra; as follows:

At the end of title I, add the following:

SEC. 10 . FOOD STAMP BENEFITS FOR CHILD IMMIGRANTS.

(a) IN GENERAL.—Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding at the end the following:

''(E) CHILD IMMIGRANTS.—In the case of the program specified in paragraph (3)(B), paragraph (1) shall not apply to a qualified alien who is under 18 years of age.''.

(b) ALLOCATION OF ADMINISTRATIVE COSTS.—Section 408(a) of the Social Security Act (42 U.S.C. 608(a)) is amended by adding at the end the following:

''(12) DESIGNATION OF GRANTS UNDER THIS PART AS PRIMARY PROGRAM IN ALLOCATING ADMINISTRATIVE COSTS.—

''(A) IN GENERAL.—Notwithstanding any other provision of law, a State shall designate the program funded under this part as the primary program for the purpose of allocating costs incurred in serving families eligible or applying for benefits under the State program funded under this part and any other Federal means-tested benefits.

''(B) ALLOCATION OF COSTS.—

''(i) IN GENERAL.—The Secretary shall require that costs described in subparagraph (A) be allocated in the same manner as the costs were allocated by State agencies that designated part A of title IV as the primary program for the purpose of allocating administrative costs before August 22, 1996.

''(ii) FLEXIBLE ALLOCATION.—The Secretary may allocate costs under clause (i) differently, if a State can show good cause for or evidence of increased costs, to the extent that the administrative costs allocated to the primary program are not reduced by more than 33 percent.

''(13) FAILURE TO ALLOCATE ADMINISTRATIVE COSTS TO GRANTS PROVIDED UNDER THIS PART.—If the Secretary determines that, with respect to a preceding fiscal year, a State has not allocated administrative costs in accordance with paragraph (12), the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the succeeding fiscal year by an amount equal to—

''(A) the amount the Secretary determines should have been allocated to the program funded under this part in such preceding fiscal year; minus

''(B) the amount that the State allocated to the program funded under this part in such preceding fiscal year.''.

D'AMATO (AND OTHERS) AMENDMENT NO. 451

Mr. D'AMATO (for himself, Mr. HARKIN, Mr. SPECTER, Mr. MACK, Mr. ROCKEFELLER, Mr. DASCHLE, Mrs. BOXER, Mr. KERRY, Mr. DURBIN, and Mr. KENNEDY) proposed an amendment to the bill, S. 947, supra; as follows:

On page 1027, between lines 7 and 8, insert the following:

Subtitle N—National Fund for Health Research

SEC. 5995. SHORT TITLE.

This subtitle may be cited as the ''National Fund for Health Research Act''.

SEC. 5996. FINDINGS.

Congress makes the following findings:

(1) Nearly 4 of 5 peer reviewed research projects deemed worthy of funding by the National Institutes of Health are not funded.

(2) Less than 3 percent of the nearly one trillion dollars our Nation spends on health care is devoted to health research, while the defense industry spends 15 percent of its budget on research and development.

(3) Public opinion surveys have shown that Americans want more Federal resources put into health research and are willing to pay for it.

(4) Ample evidence exists to demonstrate that health research has improved the quality of health care in the United States. Advances such as the development of vaccines, the cure of many childhood cancers, drugs that effectively treat a host of diseases and disorders, a process to protect our Nation's blood supply from the HIV virus, progress against cardiovascular disease including heart attack and stroke, and new strategies for the early detection and treatment of diseases such as colon, breast, and prostate cancer clearly demonstrates the benefits of health research.

(5) Health research which holds the promise of prevention of intentional and unintentional injury and cure and prevention of disease and disability, is critical to holding down health care costs in the long term.

(6) Expanded medical research is also critical to holding down the long-term costs of the medicare program under title XVIII of the Social Security Act. For example, recent research has demonstrated that delaying the onset of debilitating and costly conditions like Alzheimer's disease could reduce general health care and medicare costs by billions of dollars annually.

(7) The state of our Nation's research facilities at the National Institutes of Health and at universities is deteriorating significantly. Renovation and repair of these facilities are badly needed to maintain and improve the quality of research.

(8) Because discretionary spending is likely to decline in real terms over the next 5 years, the Nation's investment in health research through the National Institutes of Health is likely to decline in real terms unless corrective legislative action is taken.

(9) A health research fund is needed to maintain our Nation's commitment to health research and to increase the percentage of approved projects which receive funding at the National Institutes of Health.

(10) Americans purchase health insurance and participate in the medicare program to protect themselves and their families against the high cost of illness and disability. Because of this, it makes sense to devote 1 cent of every health insurance dollar to finding preventions, cures, and improved treatments for illnesses and disabilities through medical research.

SEC. 5997. ESTABLISHMENT OF FUND.

(a) ESTABLISHMENT.—There is established in the Treasury of the United States a fund, to be known as the ''National Fund for Health Research'' (hereafter in this section referred to as the ''Fund''), consisting of such amounts as are transferred to the Fund under subsection (b) other amounts subsequently enacted into law and any interest earned on investment of amounts in the Fund.

(b) TRANSFERS TO FUND.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall transfer to the Fund amounts equivalent to amounts described in paragraph (2).

(2) AMOUNTS.—

(A) IN GENERAL.—Amounts described in this paragraph for each of the fiscal years 1998 through 2002 shall be equal to the amount of Federal savings derived for each such fiscal year under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and the medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.) that exceeds the amount of Federal savings estimated by the Congressional Budget Office as of the date of enactment, to be achieved in each such program for each such fiscal year for purposes of the Balanced Budget Act of 1997.

(B) DETERMINATION BY SECRETARY.—Not later than 6 months after the end of each of the fiscal years described in subparagraph (A), the Secretary of Health and Human Services shall—

(i) make a determination as to the amount to be transferred to the Fund for the fiscal year involved under this subsection; and

(ii) subject to subparagraphs (E) and subsection (d), transfer such amount to the Fund.

(C) SEPARATE ESTIMATES.—In making a determination under subparagraph (B)(i), the Secretary of Health and Human Services shall maintain a separate estimate for each of the programs described in subparagraph (A).

(D) LIMITATION.—Any savings to which subparagraph (A) applies shall not be counted for purposes of making a transfer under this paragraph if such savings, under current procedures implemented by the Health Care Financing Administration, are specifically dedicated to reducing the incidence of waste, fraud, and abuse in the programs described in subparagraph (A).

(E) CAP ON TRANSFER.—Amounts transferred to the Fund under this subsection for any year in the 5-fiscal year period beginning on October 1, 1997, shall not in combination

with the appropriated sum exceed an amount equal to the amount appropriated for the National Institutes of Health for fiscal year 1997 multiplied by 2.

(c) OBLIGATIONS FROM FUND.—

(1) IN GENERAL.—Subject to the provisions of paragraph (4), with respect to the amounts made available in the Fund in a fiscal year, the Secretary of Health and Human Services shall distribute—

(A) 2 percent of such amounts during any fiscal year to the Office of the Director of the National Institutes of Health to be allocated at the Director's discretion for the following activities:

(i) for carrying out the responsibilities of the Office of the Director, including the Office of Research on Women's Health and the Office of Research on Minority Health, the Office of Alternative Medicine, the Office of Rare Disease Research, the Office of Behavioral and Social Sciences Research (for use for efforts to reduce tobacco use), the Office of Dietary Supplements, and the Office for Disease Prevention; and

(ii) for construction and acquisition of equipment for or facilities of or used by the National Institutes of Health;

(B) 2 percent of such amounts for transfer to the National Center for Research Resources to carry out section 1502 of the National Institutes of Health Revitalization Act of 1993 concerning Biomedical and Behavioral Research Facilities;

(C) 1 percent of such amounts during any fiscal year for carrying out section 301 and part D of title IV of the Public Health Service Act with respect to health information communications; and

(D) the remainder of such amounts during any fiscal year to member institutes and centers, including the Office of AIDS Research, of the National Institutes of Health in the same proportion to the total amount received under this section, as the amount of annual appropriations under appropriations Acts for each member institute and Centers for the fiscal year bears to the total amount of appropriations under appropriations Acts for all member institutes and Centers of the National Institutes of Health for the fiscal year.

(2) PLANS OF ALLOCATION.—The amounts transferred under paragraph (1)(D) shall be allocated by the Director of the National Institutes of Health or the various directors of the institutes and centers, as the case may be, pursuant to allocation plans developed by the various advisory councils to such directors, after consultation with such directors.

(3) GRANTS AND CONTRACTS FULLY FUNDED IN FIRST YEAR.—With respect to any grant or contract funded by amounts distributed under paragraph (1), the full amount of the total obligation of such grant or contract shall be funded in the first year of such grant or contract, and shall remain available until expended.

(4) TRIGGER AND RELEASE OF MONIES.—

(A) TRIGGER AND RELEASE.—No expenditure shall be made under paragraph (1) during any fiscal year in which the annual amount appropriated for the National Institutes of Health is less than the amount so appropriated for the prior fiscal year.

(B) PHASE-IN.—The Secretary of Health and Human Services shall phase-in the distributions required under paragraph (1) so that—

(i) 25 percent of the amount in the Fund is distributed in the first fiscal year for which funds are available;

(ii) 50 percent of the amount in the Fund is distributed in the second fiscal year for which funds are available;

(iii) 75 percent of the amount in the Fund is distributed in the third fiscal year for which funds are available; and

(iv) 100 percent of the amount in the Fund is distributed in the fourth and each succeeding fiscal year for which funds are available.

(d) REQUIRED APPROPRIATION.—No transfer may be made for a fiscal year under subsection (b) unless an appropriations Act providing for such a transfer has been enacted with respect to such fiscal year.

(e) BUDGET TREATMENT OF AMOUNTS IN FUND.—The amounts in the Fund shall be excluded from, and shall not be taken into account, for purposes of any budget enforcement procedure under the Congressional Budget Act of 1974 or the Balanced Budget and Emergency Deficit Control Act of 1985.

LIEBERMAN (AND OTHERS) AMENDMENT NO. 452

Mr. DOMENICI (for Mr. LIEBERMAN, Mr. JEFFORDS, Mr. CHAFEE, Mr. KERREY, Mr. BREAUX, Mr. WYDEN, and Mr. KENNEDY) proposed an amendment to the bill, S. 947, supra; as follows:

At the end of proposed section 1941(d) of the Social Security Act (as added by section 5701), add the following:

''(3) PROVISION OF COMPARATIVE INFORMATION.—

''(A) BY STATE.—A State that requires individuals to enroll with managed care entities under this part shall annually provide to all enrollees and potential enrollees a list identifying the managed care entities that are (or will be) available and information described in subparagraph (C) concerning such entities. Such information shall be presented in a comparative, chart-like form.

''(B) BY ENTITY.—Upon the enrollment, or renewal of enrollment, of an individual with a managed care entity under this part, the entity shall provide such individual with the information described in subparagraph (C) concerning such entity and other entities available in the area, presented in a comparative, chart-like form.

''(C) REQUIRED INFORMATION.—Information under this subparagraph, with respect to a managed care entity for a year, shall include the following:

''(i) BENEFITS.—The benefits covered by the entity, including—

''(I) covered items and services beyond those provided under a traditional fee-for-service program;

''(II) any beneficiary cost sharing; and

''(III) any maximum limitations on out-of-pocket expenses.

''(ii) PREMIUMS.—The net monthly premium, if any, under the entity.

''(iii) SERVICE AREA.—The service area of the entity.

''(iv) QUALITY AND PERFORMANCE.—To the extent available, quality and performance indicators for the benefits under the entity (and how they compare to such indicators under the traditional fee-for-service programs in the area involved), including—

''(I) disenrollment rates for enrollees electing to receive benefits through the entity for the previous 2 years (excluding disenrollment due to death or moving outside the service area of the entity);

''(II) information on enrollee satisfaction;

''(III) information on health process and outcomes;

''(IV) grievance procedures;

''(V) the extent to which an enrollee may select the health care provider of their choice, including health care providers within the network of the entity and out-of-network health care providers (if the entity covers out-of-network items and services); and

''(VI) an indication of enrollee exposure to balance billing and the restrictions on coverage of items and services provided to such enrollee by an out-of-network health care provider.

''(v) SUPPLEMENTAL BENEFITS OPTIONS.—Whether the entity offers optional supplemental benefits and the terms and conditions (including premiums) for such coverage.

''(vi) PHYSICIAN COMPENSATION.—An overall summary description as to the method of compensation of participating physicians.

FEINSTEIN AMENDMENT NO. 453

Mr. DOMENICI (for Mrs. FEINSTEIN) proposed an amendment to the bill, S. 947, supra; as follows:

At the end of proposed section 1852(e) of the Social Security Act (as added by section 5001) add the following:

''(6) ANNUAL REPORT ON NON-HEALTH EXPENDITURES.—Each Medicare Choice organization shall at the request of the enrollee annually provide to enrollees a statement disclosing the proportion of the premiums and other revenues received by the organization that are expended for non-health care items and services.

At the end of proposed section 1945 of the Social Security Act (as added by section 5701) add the following:

''(h) ANNUAL REPORT ON NON-HEALTH EXPENDITURES.—Each medicaid managed care organization shall annually provide to enrollees a statement disclosing the proportion of the premiums and other revenues received by the organization that are expended for non-health care items and services.

CRAIG (AND BINGAMAN) AMENDMENT NO. 454

Mr. DOMENICI (for Mr. CRAIG, for himself and Mr. BINGAMAN) proposed an amendment to the bill, S. 947, supra; as follows:

On page 412, between lines 3 and 4, insert the following:

SEC. 5105. STUDY ON MEDICAL NUTRITION THERAPY SERVICES.

(a) STUDY.—The Secretary of Health and Human Services shall request the National Academy of Sciences, in conjunction with the United States preventive Services Task force, to analyze the expansion or modification of the preventive benefits provided to medicare beneficiaries under title XVIII of the Social Security Act to include medical nutrition therapy services by a registered dietitian.

(b) REPORT.—

(1) INITIAL REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report on the findings of the analysis conducted under subsection (a) 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.

(2) CONTENTS.—Such report shall include specific findings with respect to the expansion or modification of coverage of medical nutrition therapy services by a registered dietitian for medicare beneficiaries regarding—

(A) cost to the medicare system;

(B) savings to the medicare system;

(C) clinical outcomes; and

(D) short and long term benefits to the medicare system.

(3) FUNDING.—From funds appropriated to the Department of Health and Human Services for fiscal years 1998 and 1999, the Secretary shall provide for such funding as may be necessary for the conduct of the analysis by the National Academy of Sciences under this section.

MURKOWSKI AMENDMENT NO. 455

Mr. DOMENICI (for Mr. MURKOWSKI) proposed an amendment to the bill, S. 947, supra; as follows:

On page 130, line 3, strike ''2002'' and insert ''2007''.

ABRAHAM (AND LEVIN) AMENDMENT NO. 456

Mr. DOMENICI for Mr. ABRAHAM, (for himself and Mr. LEVIN) proposed an amendment to the bill, S. 947, supra; as follows:

At the appropriate place in the bill, insert the following new section:

SEC. . EXTENSION OF MORATORIUM.

Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989, as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993 is amended by striking ''December 31, 1995'' and inserting ''December 3, 2002.''.

HARKIN (AND MCCAIN) AMENDMENT NO. 457

Mr. DOMENICI (for Mr. HARKIN, for himself and Mr. MCCAIN) proposed an amendment to the bill, S. 947, supra; as follows:

At the end of the bill, add the following:

SEC. . IMPROVING INFORMATION TO MEDICARE BENEFICIARIES.

(a) CLARIFICATION OF REQUIREMENT TO PROVIDE EXPLANATION OF MEDICARE BENEFITS.—Section 1804 of the Social Security Act (42 U.S.C. 1395b–2) is amended by adding at the end the following new subsection:

''(c)(1) The Secretary shall provide a statement which explains the benefits provided under this title with respect to each item or service for which payment may be made under this title which is furnished to an individual without regard to whether or not a deductible or coinsurance may be imposed against the individual with respect to such item or service.

''(2) Each explanation of benefits provided under paragraph (1) shall include—

''(A) a statement which indicates that because errors do occur and because medicare fraud, waste and abuse is a significant problem, beneficiaries should carefully check the statement for accuracy and report any errors of questionable charges by calling the toll-free phone number described in (C)

(B) a statement of the beneficiary's right to request an itemized bill (as provided in section 1128A(n)); and

''(C) a toll-free telephone number for reporting errors, questionable charges or other acts that would constitute medicare fraud, waste, or abuse, which may be the same number as described in subsection (b).''.

(b) REQUEST FOR ITEMIZED BILL FOR MEDICARE ITEMS AND SERVICES.—

(1) IN GENERAL.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended by adding at the end the following new subsection:

''(m) WRITTEN REQUEST FOR ITEMIZED BILL.—

''(1) IN GENERAL.—A beneficiary may submit a written request for an itemized bill for medical or other items or services provided to such beneficiary by any person (including an organization, agency, or other entity) that receives payment under title XVIII for providing such items for services to such beneficiary.

''(2) 30-DAY PERIOD TO RECEIVE BILL.—

''(A) IN GENERAL.—Not later than 30 days after the date on which a request under paragraph (1) has been received, a person described in such paragraph shall furnish an itemized bill describing each medical or other item or service provided to the beneficiary requesting the itemized bill.

''(B) PENALTY.—Whoever knowingly fails to furnish an itemized bill in accordance with subparagraph (A) shall be subject to a civil fine of not more than $100 for each such failure.

''(3) REVIEW OF ITEMIZED BILL.—

''(A) IN GENERAL.—Not later than 90 days after the receipt of an itemized bill furnished under paragraph (1), a beneficiary may submit a written request for a review of the itemized bill to the appropriate fiscal intermediary or carrier with a contract under section 1816 or 1842.

''(B) SPECIFIC ALLEGATIONS.—A request for a review of the itemized bill shall identify—

''(i) specific medical or other items or services that the beneficiary believes were not provided as claimed, or

''(ii) any other billing irregularity (including duplicate billing).

''(4) FINDINGS OF FISCAL INTERMEDIARY OR CARRIER.—Each fiscal intermediary or carrier with a contract under section 1816 or 1842 shall, with respect to each written request submitted to the fiscal intermediary or carrier under paragraph (3), determine whether the itemized bill identifies specific medical or other items or services that were not provided as claimed or any other billing irregularity (including duplicate billing) that has resulted in unnecessary payments under title XVIII.

''(5) RECOVERY OF AMOUNTS.—The Secretary shall require fiscal intermediaries and carriers to take all appropriate measures to recover amounts unnecessarily paid under title XVIII with respect to a bill described in paragraph (4).''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to medical or other items or services provided on or after January 1, 1998.

SEC. . PROHIBITING UNNECESSARY AND WASTEFUL MEDICARE PAYMENTS FOR CERTAIN ITEMS.

Section 1861(v) of the Social Security Act is amended by adding at the end the following new paragraph:

''(8) ITEMS UNRELATED TO PATIENT CARE—

Reasonable costs do not include costs for the following:

(i) entertainment;

(ii) gifts or donations;

(iii) costs for fines and penalties resulting from violations Federal, State or local laws; and,

(iv) education expenses for spouses or other dependents of providers of services, their employees or contractors.

SEC. . REDUCING EXCESSIVE BILLINGS AND UTILIZATION FOR CERTAIN ITEMS.

Section 1834(a)(15) of the Social Security Act (42 U.S.C. 1395m(a)(15)) is amended by striking ''Secretary may'' both places it appears and inserting ''Secretary shall''.

HELMS AMENDMENTS NOS. 458–459

Mr. DOMENICI (for Mr. HELMS) proposed two amendments to the bill, S. 947, supra; as follows:

AMENDMENT NO. 458

At the appropriate place in division 1 of title V, insert the following:

SEC. . INCLUSION OF STANLY COUNTY, N.C. IN A LARGE URBAN AREA UNDER MEDICARE PROGRAM.

(a) IN GENERAL.—For purposes of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), the large urban area of Charlotte-Gastonia-Rock Hill-North Carolina-South Carolina may be deemed to include Stanly County, North Carolina.

(b) EFFECTIVE DATE.—This section shall apply with respect to discharges occurring on or after October 1, 1997.

AMENDMENT NO. 459

At the appropriate place in division 1 of title V, insert the following:

SEC. . INCLUSION OF STANLY COUNTY, N.C. IN A LARGE URBAN AREA UNDER MEDICARE PROGRAM.

(a) IN GENERAL.—For purposes of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), the large urban area of Charlotte-Gastonia-Rock Hill-North Carolina-South Carolina be deemed to include Stanly County, North Carolina.

(b) EFFECTIVE DATE.—This section shall apply with respect to discharges occurring on or after October 1, 1997.

MCCAIN (AND WYDEN) AMENDMENT NO. 460

Mr. DOMENICI (for Mr. MCCAIN, for himself and Mr. WYDEN) proposed an amendment to the bill, S. 947, supra; as follows:

On page 844, between lines 7 and 8, insert the following:

SEC. 5768. CONTINUATION OF STATE-WIDE SECTION 1115 MEDICAID WAIVERS.

(a) IN GENERAL.—Section 1115 of the Social Security Act (42 U.S.C. 1315) is amended by adding at the end the following:

''(d)(1) The provisions of this subsection shall apply to the extension of statewide comprehensive research and demonstration projects (in this subsection referred to as 'waiver project') for which waivers of compliance with the requirements of title XIX are granted under subsection (a). With respect to a waiver project that, but for the enactment of this subsection, would expire, the State at its option may—

''(A) not later than 1 year before the waiver under subsection (a) would expire (acting through the chief executive officer of the State who is operating the project), submit to the Secretary a written request for an extension of such waiver project for up to 3 years; or

''(B) permanently continue the waiver project if the project meets the requirements of paragraph (2).

''(2) The requirements of this paragraph are that the waiver project—

''(A) has been successfully operated for 5 or more years; and

''(B) has been shown, through independent evaluations sponsored by the Health Care Financing Administration, to successfully contain costs and provide access to health care.

''(3)(A) In the case of waiver projects described in paragraph (1)(A), if the Secretary fails to respond to the request within 6 months after the date on which the request was submitted, the request is deemed to have been granted.

''(B) If the request is granted or deemed to have been granted, the deadline for submittal of a final report shall be 1 year after the date on which the waiver project would have expired but for the enactment of this subsection.

''(C) The Secretary shall release an evaluation of each such project not later than 1 year after the date of receipt of the final report.

''(D) Phase-down provisions which were applicable to waiver projects before an extension was provided under this subsection shall not apply.

''(4) The extension of a waiver project under this subsection shall be on the same terms and conditions (including applicable terms and conditions related to quality and access of services, budget neutrality as adjusted for inflation, data and reporting requirements and special population protections), except for any phase down provisions, and subject to the same set of waivers that applied to the project or were granted before the extension of the project under this subsection. The permanent continuation of a

waiver project shall be on the same terms and conditions, including financing, and subject to the same set of waivers. No test of budget neutrality shall be applied in the case of projects described in paragraph (2) after that date on which the permanent extension was granted.

''(5) In the case of a waiver project described in paragraph (2), the Secretary, acting through the Health Care Financing Administration shall, deem any State's request to expand medicaid coverage in whole or in part to individuals who have an income at or below the Federal poverty level as budget neutral if independent evaluations sponsored by the Health Care Financing Administration have shown that the State's medicaid managed care program under such original waiver is more cost effective and efficient than the traditional fee-for-service medicaid program that, in the absence of any managed care waivers under this section, would have been provided in the State.''.

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

MCCAIN (AND KERRY) AMENDMENT NO. 461

Mr. DOMENICI (for Mr. MCCAIN, for himself and Mr. KERRY) proposed an amendment to the bill, S. 947, supra; as follows:

On page 874, between lines 7 and 8, insert the following:

SEC. 5817A. TREATMENT OF CERTAIN AMERASIAN IMMIGRANTS AS REFUGEES.

(a) AMENDMENTS TO EXCEPTIONS FOR REFUGEES/ASYLEES.—

(1) FOR PURPOSES OF SSI AND FOOD STAMPS.—Section 402(a)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A)) is amended—

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

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

(C) by adding at the end the following:

''(iv) an alien who is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in section 101(e) of Public Law 100–202 and amended by the 9th proviso under MIGRATION AND REFUGEE ASSISTANCE in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1989, Public Law 100–461, as amended).''.

(2) FOR PURPOSES OF TANF, SSBG, AND MEDICAID.—Section 402(b)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A)) is amended—

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

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

(C) by adding at the end the following:

''(iv) an alien described in subsection (a)(2)(A)(iv) until 5 years after the date of such alien's entry into the United States.''.

(3) FOR PURPOSES OF EXCEPTION FROM 5-YEAR LIMITED ELIGIBILITY OF QUALIFIED ALIENS.—Section 403(b)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613(b)(1)) is amended by adding at the end the following:

''(D) An alien described in section 402(a)(2)(A)(iv).''.

(4) FOR PURPOSES OF CERTAIN STATE PROGRAMS.—Section 412(b)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1622(b)(1)) is amended by adding at the end the following new subparagraph:

''(D) An alien described in section 402(a)(2)(A)(iv).''.

(b) FUNDING.—

(1) LEVY OF FEE.—The Attorney General through the Immigration and Naturalization Service shall levy a $150 processing fee upon each alien that the Service determines—

(A) is unlawfully residing in the United States;

(B) has been arrested by a Federal law enforcement officer for the commission of a felony; and

(C) merits deportation after having been determined by a court of law to have committed a felony while residing illegally in the United States.

(2) COLLECTION AND USE.—In addition to any other penalty provided by law, a court shall impose the fee described in paragraph (1) upon an alien described in such paragraph upon the entry of a judgment of deportation by such court. Funds collected pursuant to this subsection shall be credited by the Secretary of the Treasury as offsetting increased Federal outlays resulting from the amendments made by section 5817A of the Balanced Budget Act of 1997.

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective with respect to the period beginning on or after October 1, 1997.

JEFFORDS AMENDMENTS NOS. 462–463

Mr. DOMENICI (for Mr. JEFFORDS) proposed two amendments to the bill, S. 947, supra; as follows:

AMENDMENT NO. 462

On page 685, after line 25, add the following:

SEC. . REQUIREMENT TO PROVIDE INFORMATION REGARDING CERTAIN COST-SHARING ASSISTANCE.

(a) IN GENERAL.—Section 1804(a) (42 U.S.C. 1395b–2(a)) is amended—

(1) in paragraph (2), by striking ''and'' at the end;

(2) in paragraph (3), by striking the period and inserting '', and''; and

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

''(4) an explanation of the medicare cost sharing assistance described in section 1905(p)(3)(A)(ii) that is available for individuals described in section 1902(a)(10)(E)(iii) and information regarding how to request that the Secretary arrange to have an application for such assistance made available to an individual.''.

(b) EFFECTIVE DATE.—The information required to be provided under the amendment made by subsection (a) applies to notices distributed on and after October 1, 1997.

AMENDMENT NO. 463

On page 852, between lines 12 and 13, insert the following:

''(d) EVALUATION AND QUALITY ASSURANCE.—

''(1) IN GENERAL.—Not later than 1 year after the date on which the Secretary approves the program outline of a State, and annually thereafter, the State shall prepare and submit to the Secretary such information as the Secretary may require to enable the Secretary to evaluate the progress of the State with respect to the program outline. Such information shall address the manner in which the State in implementing the program outline has—

''(A) expanded health care coverage to low-income uninsured children;

''(B) provided quality health care to low-income children;

''(C) improved the health status of low-income children;

''(D) served the health care needs of special populations of low-income children; and

''(E) utilized available resources in a cost effective manner.

''(2) AVAILABILITY OF EVALUATIONS.—The Secretary shall make the results of the evaluations conducted under paragraph (1) available to Congress and the States.

''(3) REPORTS.—The Secretary shall annually prepare and submit to the appropriate committees of Congress, and make available to the States, a report containing the findings of the Secretary as a result of the evaluations conducted under paragraph (1) and the recommendations of the Secretary for achieving or exceeding the objectives of this title.

BROWNBACK (AND KOHL) AMENDMENT NO. 464

Mr. DOMENICI (for Mr. BROWNBACK, for himself and Mr. KOHL) proposed an amendment to the bill, S. 947, supra; as follows:

At the end of the ___, add the following:

TITLE ___—BUDGET CONTROL

SEC. ___01. SHORT TITLE; PURPOSE.

(a) SHORT TITLE.—This title may be cited as the ''Bipartisan Budget Enforcement Act of 1997''.

(b) PURPOSE.—The purpose of this title is—

(1) to ensure a balanced Federal budget by fiscal year 2002;

(2) to ensure that the Bipartisan Budget Agreement is implemented; and

(3) to create a mechanism to monitor total costs of direct spending programs, and, in the event that actual or projected costs exceed targeted levels, to require the President and Congress to address adjustments in direct spending.

SEC. ___02. ESTABLISHMENT OF DIRECT SPENDING TARGETS.

(a) IN GENERAL.—The initial direct spending targets for each of fiscal years 1998 through 2002 shall equal total outlays for all direct spending except net interest as determined by the Director of the Office of Management and Budget (hereinafter referred to in this title as the ''Director'') under subsection (b).

(b) INITIAL REPORT BY DIRECTOR.—

(1) IN GENERAL.—Not later than 30 days after the date of enactment of this title, the Director shall submit a report to Congress setting forth projected direct spending targets for each of fiscal years 1998 through 2002.

(2) PROJECTIONS AND ASSUMPTIONS.—The Director's projections shall be based on legislation enacted as of 5 days before the report is submitted under paragraph (1). The Director shall use the same economic and technical assumptions used in preparing the concurrent resolution on the budget for fiscal year 1998 (H.Con.Res. 84).

SEC. ___03. ANNUAL REVIEW OF DIRECT SPENDING AND RECEIPTS BY PRESIDENT.

As part of each budget submitted under section 1105(a) of title 31, United States Code, the President shall provide an annual review of direct spending and receipts, which shall include—

(1) information on total outlays for programs covered by the direct spending targets, including actual outlays for the prior fiscal year and projected outlays for the current fiscal year and the 5 succeeding fiscal years; and

(2) information on the major categories of Federal receipts, including a comparison between the levels of those receipts and the levels projected as of the date of enactment of this title.

SEC. ___04. SPECIAL DIRECT SPENDING MESSAGE BY PRESIDENT.

(a) TRIGGER.—If the information submitted by the President under section ___03 indicates—

(1) that actual outlays for direct spending in the prior fiscal year exceeded the applicable direct spending target; or

(2) that outlays for direct spending for the current or budget year are projected to exceed the applicable direct spending targets,

the President shall include in his budget a special direct spending message meeting the requirements of subsection (b).

(b) CONTENTS.—

(1) INCLUSIONS.—The special direct spending message shall include—

(A) an analysis of the variance in direct spending over the direct spending targets; and

(B) the President's recommendations for addressing the direct spending overages, if any, in the prior, current, or budget year.

(2) ADDITIONAL MATTERS.—The President's recommendations may consist of any of the following:

(A) Proposed legislative changes to recoup or eliminate the overage for the prior, current, and budget years in the current year, the budget year, and the 4 outyears.

(B) Proposed legislative changes to recoup or eliminate part of the overage for the prior, current, and budget year in the current year, the budget year, and the 4 outyears, accompanied by a finding by the President that, because of economic conditions or for other specified reasons, only some of the overage should be recouped or eliminated by outlay reductions or revenue increases, or both.

(C) A proposal to make no legislative changes to recoup or eliminate any overage, accompanied by a finding by the President that, because of economic conditions or for other specified reasons, no legislative changes are warranted.

(c) PROPOSED SPECIAL DIRECT SPENDING RESOLUTION.—If the President recommends reductions consistent with subsection (b)(2)(A) or (B), the special direct spending message shall include the text of a special direct spending resolution implementing the President's recommendations through reconciliation directives instructing the appropriate committees of the House of Representatives and Senate to determine and recommend changes in laws within their jurisdictions. If the President recommends no reductions pursuant to (b)(2)(C), the special direct spending message shall include the text of a special resolution concurring in the President's recommendation of no legislative action.

SEC. ___05. REQUIRED RESPONSE BY CONGRESS.

(a) IN GENERAL.—It shall not be in order in the House of Representatives or the Senate to consider a concurrent resolution on the budget unless that concurrent resolution fully addresses the entirety of any overage contained in the applicable report of the President under section ___04 through reconciliation directives.

(b) WAIVER AND SUSPENSION.—This section may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn. This section shall be subject to the provisions of section 258 of the Balanced Budget and Emergency Deficit Control Act of 1985.

(c) APPEALS.—Appeals in the Senate from the decisions of the Chair relating to any provision of this section shall be limited to 1 hour, to be equally divided between, and controlled by, the appellant and the manager of the bill or joint resolution, as the case may be. An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this section.

SEC. ___06. RELATIONSHIP TO BALANCED BUDGET AND EMERGENCY DEFICIT CONTROL ACT.

Reductions in outlays or increases in receipts resulting from legislation reported pursuant to section ___05 shall not be taken into account for purposes of any budget enforcement procedures under the Balanced Budget and Emergency Deficit Control Act of 1985.

SEC. ___07. ESTIMATING MARGIN.

For any fiscal year for which the overage is less than one-half of 1 percent of the direct spending target for that year, the procedures set forth in sections ___04 and ___05 shall not apply.

SEC. ___08. EFFECTIVE DATE.

This title shall apply to direct spending targets for fiscal years 1998 through 2002 and shall expire at the end of fiscal year 2002.

ALLARD AMENDMENT NO. 465

Mr. DOMENICI (for Mr. ALLARD) proposed an amendment to the bill, S. 947, supra as follows:

On page 865, between lines 2 and 3, insert the following:

SEC. . EXPANSION OF MEDICAL SAVINGS ACCOUNTS TO FAMILIES WITH UNINSURED CHILDREN.

(a) IN GENERAL.—Section 220 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(k) FAMILIES WITH UNINSURED CHILDREN.—

''(1) IN GENERAL.—In the case of an individual who has a qualified dependent as of the first day of any month—

''(A) WAIVER OF EMPLOYER REQUIREMENT.—Clause (iii) of subsection (c)(1)(A) shall not apply.

''(B) WAIVER OF COMPENSATION LIMITATION.—Paragraph (4) of subsection (b) shall not apply.

''(C) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—In lieu of the limitation of subsection (b)(5), the amount allowable for a taxable year as a deduction under subsection (a) to such individual shall be reduced (but not below zero) by the amount not includible in such individual's gross income for such taxable year solely by reason of section 106(b).

''(D) NUMERICAL LIMITATIONS.—Subsection (i) shall not apply to such individual if such individual is the account holder of a medical savings account by reason of this subsection, and subsection (j) shall be applied without regard to any such medical savings account.

''(2) QUALIFIED DEPENDENT.—For purposes of this subsection, the term 'qualified dependent' means a dependent (within the meaning of section 152) who—

''(A) has not attained the age of 19 as of the close of the calendar year in which the taxable year of the taxpayer begins, and with respect to whom the taxpayer is entitled to a deduction for the taxable year under section 151(c),

''(B) is covered by a high deductible health plan, and

''(C) prior to such coverage, was a previously uninsured individual (as defined by subsection (j)(3)).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years ending after the date of the enactment of this Act.

CHAFEE AMENDMENT NO. 466

Mr. DOMENICI (for Mr. CHAFEE) proposed an amendment to the bill, S. 947, supra; as follows:

At the end of the bill, add the following:

TITLE IX—COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS

SEC. 9001. NUCLEAR REGULATORY COMMISSION ANNUAL CHARGES.

Section 6101 of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 2214) is amended—

(1) in subsection (a)(3), by striking ''September 30, 1998'' and inserting ''September 30, 2002''; and

(2) in subsection (c)—

(A) by striking paragraph (2) and inserting the following:

''(2) AGGREGATE AMOUNT OF CHARGES.—The aggregate amount of the annual charge collected from all licensees shall equal an amount that approximates 100 percent of the budget authority of the Commission for the fiscal year for which the charge is collected, less, with respect to the fiscal year, the sum of—

''(A) any amount appropriated to the Commission from the Nuclear Waste Fund;

''(B) the amount of fees collected under subsection (b); and

''(C) for fiscal year 1999 and each fiscal year thereafter, to the extent provided in paragraph (5), the costs of activities of the Commission with respect to which a determination is made under paragraph (5).''; and

(B) by adding at the end the following:

''(5) EXCLUDED BUDGET COSTS.—

''(A) IN GENERAL.—The rulemaking under paragraph (3) shall include a determination of the costs of activities of the Commission for which it would not be fair and equitable to assess annual charges on a Nuclear Regulatory Commission licensee or class of licensee.

''(B) CONSIDERATIONS.—In making the determination under subparagraph (a), the Commission shall consider—

''(i) the extend to which activities of the Commission provide benefits to persons that are not licensees of the Commission;

''(ii) the extent to which the Commission is unable to assess fees or charges on a licensee or class of licensee that benefits from the activities; and

''(iii) the extent to which the costs to the Nuclear Regulatory Commission of activities are commensurate with the benefits provided to the licensees from the activities.

''(C) MAXIMUM EXCLUDED COSTS.—The total amount of costs excluded by the Commission pursuant to the determination under subparagraph (A) shall not exceed $30,000,000 for any fiscal year.''.

GRASSLEY AMENDMENT NO. 467

Mr. DOMENICI (for Mr. GRASSLEY) proposed an amendment to the bill, S. 947, supra; as follows:

On page 689, between lines 2 and 3, insert the following:

''(iii) RELIGIOUS CHOICE.—The State, in permitting an individual to choose a managed care entity under clause (i) shall permit the individual to have access to appropriate faith-based facilities. With respect to such access, the State shall permit an individual to select a facility that is not a part of the network of the managed care entity if such network does not provide access to appropriate faith-based facilities. A faith-based facility that provides care under this clause shall accept the terms and conditions offered by the managed care entity to other providers in the network.

KYL AMENDMENT NO. 468

Mr. DOMENICI (for Mr. KYL) proposed an amendment to the bill, S. 947, supra; as follows:

On page 685, after line 25, add the following:

SEC. . FACILITATING THE USE OF PRIVATE CONTRACTS UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1804 of such Act (42 U.S.C. 1395b–2) the following:

''CLARIFICATION OF PRIVATE CONTRACTS FOR HEALTH SERVICES

''SEC. 1805. (a) IN GENERAL.—Nothing in this title shall prohibit a physician or another health care professional who does not provide items or services under the program under this title from entering into a private contract with a medicare beneficiary for health services for which no claim for payment is to be submitted under this title.

''(b) LIMITATION ON ACTUAL CHARGE NOT APPLICABLE.— Section 1848(g) shall not apply with respect to a health service provided to a medicare beneficiary under a contract described in subsection (a).

''(c) DEFINITION OF MEDICARE BENEFICIARY.—In this section, the term 'medicare beneficiary' means an individual who is entitled to benefits under part A or enrolled under part B.

''(d) REPORT.—Not later than October 1, 2001, the Administrator of the Health Care Financing Administration shall submit a report to Congress on the effect on the program under this title of private contracts entered into under this section. Such report shall include—

''(1) analyses regarding—

''(A) the fiscal impact of such contracts on total Federal expenditures under this title and on out-of-pocket expenditures by medicare beneficiaries for health services under this title; and

''(B) the quality of the health services provided under such contracts; and

''(2) recommendations as to whether medicare beneficiaries should continue to be able to enter private contracts under this section and if so, what legislative changes, if any should be made to improve such contracts.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to contracts entered into on and after October 1, 1997.

SPECTER (AND ROCKEFELLER) AMENDMENT NO. 469

Mr. DOMENICI (for Mr. SPECTER, for himself and Mr. ROCKEFELLER) proposed an amendment to the bill, S. 947, supra; as follows:

Strike section 5544 and in its place insert the following:

SEC. 5544. EXTENSION OF SLMB PROTECTION.

(a) IN GENERAL.—Section 1902(a)(10)(E)(iii) (42 U.S.C. 1396a(a)(10)(E)(iii)) is amended by striking ''and 120 percent in 1995 and years thereafter'' and inserting '', 120 percent in 1995 through 1997, 125 percent in 1998, 130 percent in 1999, 135 percent in 2000, 140 percent in 2001, 145 percent in 2002, and 150 percent in 2003 and years thereafter''.

(b) 100 PERCENT FMAP.—Section 1905(b) (42 U.S.C. 1396d(b)) is amended by adding at the end the following: ''Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 percent with respect to amounts expended as medical assistance for medical assistance described in section 1902(a)(10(E)(iii) for individuals described in such section whose income exceeds 120 percent of the official poverty line referred to in such section.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply on and after October 1, 1997.

SPECTER (AND OTHERS) AMENDMENT NO. 470

Mr. DOMENICI (for Mr. SPECTER for himself, Mr. LEVIN, Mr. LIEBERMAN, Mr. SMITH of Oregon, and Mr. ABRAHAM) proposed an amendment to the bill, S. 947, supra; as follows:

Beginning on page 778, strike line 1 and all that follows through pag3 779, line 23.

SPECTER AMENDMENT NO. 471

Mr. DOMENICI (for Mr. SPECTER) proposed an amendment to the bill, S. 947, supra; as follows:

Beginning on page 585, strike line 21 and all that follows through page 586, line 25.

BURNS AMENDMENT NO. 472

Mr. DOMENICI (for Mr. BURNS) proposed an amendment to the bill, S. 947, supra; as follows:

On page 999, between lines 15 and 16, insert the following:

(f) NATIONAL DIRECTORY OF NEW HIRES.—Section 453(i)92) (42 U.S.C. 653(i)(2)) is amended by adding at the end the following: ''Information entered into such data base shall be deleted 6 months after the date of entry.''.

HUTCHINSON AMENDMENT NO. 473

Mr. DOMENICI (for Mr. HUTCHINSON) proposed an amendment to the bill, S. 947, supra; as follows:

Beginning on page 929, strike line 20 and all that follows through page 930, line 14 and insert the following:

(k) CLARIFICATION OF NUMBER OF INDIVIDUALS COUNTED AS PARTICIPATING IN WORK ACTIVITIES.—Section 407 (42 U.S.C. 607) is amended—.

(1) in subsection (c)—

(A) in paragraph (1)(A), by striking ''(8)''; and

(B) in paragraph (2)(D)—

(i) in the heading, by striking ''PARTICIPATION IN VOCATIONAL EDUCATION ACTIVITIES''; and

(ii) by striking ''determined to be engaged in work in the State for a month by reason of participation in vocational educational training or'': and

(2) by striking subsection (d)(8).

MCCAIN AMENDMENT NO. 474

Mr. DOMENICI (for Mr. MCCAIN) proposed an amendment to the bill, S. 947, supra; as follows:

On page 92, beginning with line 6, strike through line 24 on page 128 and insert the following:

SEC. 3001. SPECTRUM AUCTIONS.

(a) EXTENION AND EXPANSION OF AUCTION AUTHORITY.—

(1) IN GENERAL.—Section 309(j) of the Communications Act of 1934 (47 U.S.C. 309(j) is amended—

(A) by striking paragraphs (1) and (2) and inserting in lieu thereof the following:

''(1) GENERAL AUTHORITY.—If mutually exclusive applications are accepted for any initial license or construction permit that will involve an exclusive use of the electromagnetic spectrum, then, except as provided in paragraph (2), the Commission shall grant the license or permit to a qualified applicant through a system of competitive bidding that meets the requirements of this subsection. The Commission, subject to paragraphs (2) and (7) of this subsection, also may use auctions as a means to assign spectrum when it determines that such an auction is consistent with the public interest, convenience, and necessity, and the purposes of this Act.

''(2) EXCEPTIONS.—The competitive bidding authority granted by this subsection shall not apply to a license or construction permit the Commission issues—

''(A) for public safety services, including private internal radio services used by State and local governments and non-government entities that—

''(i) are used to protect the safety of life, health, or property; and

''(ii) are not made commercially available to the public;

''(B) for public telecommunications services, as defined in section 397(14) of this Act, when the license application is for channels reserved for noncommercial use;

''(C) for spectrum and associated orbits used in the provision of any communications within a global satellite system;

''(D) for initial licenses or construction permits for new digital television service given to existing terrestrial broadcast licensees to replace their current television licenses;

''(E) for terrestrial radio and television broadcasting when the Commission determines that an alternative method of resolving mutually exclusive applications serves the public interest substantially better than competitive bidding; or

''(F) for spectrum allocated for unlicensed use pursuant to part 15 of the Commission's regulations (47 C.F.R. part 15), if the competitive bidding for licenses would interfere with operation of end-user products permitted under such regulations.'';

(B) by striking ''1998'' in paragraph (11) and inserting ''2007''; and

(C) by inserting after paragraph (13) the following:

''(14) OUT-OF-BAND EFFECTS.—The Commission and the National Telecommunications and Information Administration shall seek to create incentives to minimize the effects of out-of-band emissions to promote more efficient use of the electromagnetic spectrum. The Commission and the National Telecommunications and Information Administration also shall encourage licensees to minimize the effects of interference.''.

(2) CONFORMING AMENDMENTS.—Subsection (i) of section 309 of the Communications Act of 1934 is repealed.

(b) AUCTION OF 45 MEGAHERTZ LOCATED AT 1,710–1,755 MEGAHERTZ.—

(1) IN GENERAL.—The Commission shall assign by competitive bidding 45 megahertz located at 1,710–1,755 megahertz no later than December 31, 2001, for commercial use.

(2) FEDERAL GOVERNMENT USERS.—Any Federal government station that, on the date of enactment of this Act, is assigned to use electromagnetic spectrum located in the 1,710–1,755 megahertz band shall retain that use until December 31, 2003, unless exempted from relocation.

(c) COMMISSION TO MAKE ADDITIONAL SPECTRUM AVAILABLE BY AUCTION.—

(1) IN GENERAL.—The Federal Communications Commission shall complete all actions necessary to permit the assignment, by September 30, 2002, by competitive bidding pursuant to section 309(j) of the Communications Act of 1934 (47 U.S.C. 309(j)), of licenses for the use of bands of frequencies currently allocated by the Commission that—

(A) in the aggregate span not less than 55 megahertz;

(B) are located below 3 gigahertz; and

(C) as of the date of enactment of this Act, have not been—

(i) designated by Commission regulation for assignment pursuant to section 309(j);

(ii) identified by the Secretary of Commerce pursuant to section 113 of the National Telecommunications and Information

Administration Organization Act (47 U.S.C. 923); or

(III) allocated for Federal Government use pursuant to section 305 of the Communications Act of 1934 (47 U.S.C. 305).

(2) CRITERIA FOR REASSIGNMENT.—In making available bands of frequencies for competitive bidding pursuant to paragraph (1), the Commission shall—

(A) seek to promote the most efficient use of the electromagnetic spectrum;

(B) consider the cost to incumbent licensees of relocating existing uses to other bands of frequencies or other means of communication;

(C) consider the needs of public safety radio services;

(D) comply with the requirements of international agreements concerning spectrum allocations; and

(E) coordinate with the Secretary of Commerce when there is any impact on Federal Government spectrum use.

(3) NOTIFICATION TO THE SECRETARY OF COMMERCE.—The Commission shall attempt to accommodate incumbent licensees displaced under this section by relocating them to other frequencies available to the Commission. The Commission shall notify the Secretary of Commerce whenever the Commission is not able to provide for the effective relocation of an incumbent licensee to a band of frequencies available to the Commission for assignment. The notification shall include—

(A) specific information on the incumbent licensee;

(B) the bands the Commission considered for relocation of the licensee; and

(C) the reasons the incumbent cannot be accommodated in these bands.

(4) REPORT TO THE SECRETARY OF COMMERCE.—

(A) TECHNICAL REPORT.—The Commission, in consultation with the National Telecommunications and Information Administration, shall submit a detailed technical report to the Secretary of Commerce setting forth—

(i) the reasons the incumbent licensees described in paragraph (5) could not be accommodated in existing non-government spectrum; and

(ii) the Commission's recommendations for relocating those incumbents.

(B) NTIA USE OF REPORT.—The National Telecommunications and Information Administration shall review this report when assessing whether a commercial licensee can be accommodated by being reassigned to a frequency allocated for government use.

(d) IDENTIFICATION AND REALLOCATION OF FREQUENCIES.—

(1) IN GENERAL.—Section 113 of the National Telecommunications and Information Administration Organization Act (47 U.S.C. 901 et seq.) is amended by adding at the end thereof the following:

''(f) ADDITIONAL REALLOCATION REPORT.—If the Secretary receives a report from the Commission pursuant to section 3001(c)(6) of the Balanced Budget Act of 1997, the Secretary shall submit to the President, the Congress, and the Commission a report with the Secretary's recommendations.

''(g) REIMBURSEMENT OF FEDERAL SPECTRUM USERS FOR RELOCATION COSTS.—

''(1) IN GENERAL.—

''(A) ACCEPTANCE OF COMPENSATION AUTHORIZED.—In order to expedite the efficient use of the electromagnetic spectrum, and notwithstanding section 3302(b) of title 31, United States Code, any Federal entity that operates a Federal Government station that has been identified by NTIA for relocation may accept payment, including in-kind compensation and shall be reimbursed if required to relocate by the service applicant, provider, licensee, or representative entering the band as a result of a license assignment by the Commission or otherwise authorized by Commission rules.

''(B) DUTY TO COMPENSATE OUSTED FEDERAL ENTITY.—Any such service applicant, provider, licensee, or representative shall compensate the Federal entity in advance for relocating through monetary or in-kind payment for the cost of relocating the Federal entity's operations from one or more electromagnetic spectrum frequencies to any other frequency or frequencies, or to any other telecommunications transmission media.

''(C) COMPENSABLE COSTS.—Compensation shall include, but not be limited to, the costs of any modification, replacement, or reissuance of equipment, facilities, operating manuals, regulations, or other relocation expenses incurred by that entity.

''(D) DISPOSITION OF PAYMENTS.—Payments, other than in-kind compensation, pursuant to this section shall be deposited by electronic funds transfer in a separate agency account or accounts which shall be used to pay directly the costs of relocation, to repay or make advances to appropriations or funds which do or will initially bear all or part of such costs, or to refund excess sums when necessary, and shall remain available until expended.

''(E) APPLICATION TO CERTAIN OTHER RELOCATIONS.—The provisions of this paragraph also apply to any Federal entity that operates a Federal Government station assigned to use electromagnetic spectrum identified for rellocation under subsection (a), if before the date of enactment of the Balanced Budget Act of 1997 the Commission has not identified that spectrum for service or assigned licenses or otherwise authorized service for that spectrum.

''(2) PETITIONS FOR RELOCATION.—Any person seeking to relocate a Federal Government station that has been assigned a frequency within a band allocated for mixed Federal and non-Federal use under this Act shall submit a petition for relocation to NTIA. The NTIA shall limit or terminate the Federal Government station's operating license within 6 months after receiving the petition if the following requirements are met:

''(A) The proposed relocation is consistent with obligations undertaken by the United States in international agreements and with United States national security and public safety interests.

''(B) The person seeking relocation of the Federal Government station has guaranteed to defray entirely, through payment in advance, advance in-kind payment of costs, or a combination of payment in advance and advance in-kind payment, all relocation costs incurred by the Federal entity, including, but not limited to, all engineering, equipment, site acquisition and construction, and regulatory fee costs.

''(C) The person seeking relocation completes all activities necessary for implementing the relocation, including construction of replacement facilities (if necessary and appropriate and identifying and obtaining on the Federal entity's behalf new frequencies for use by the relocated Federal Government station (if the station is not relocating to spectrum reserved exclusively for Federal use).

''(D) Any necessary replacement facilities, equipment modifications, or other changes have been implemented and tested by the Federal entity to ensure that the Federal Government station is able to accomplish successfully its purposes including maintaining communication system performance.

''(E) The Secretary has determined that the proposed use of any spectrum frequency band to which a Federal entity relocates its operations is suitable for the technical characteristics of the band and consistent with other uses of the band. In exercising authority under this subparagraph, the Secretary shall consult with the Secretary of Defense, the Secretary of State, and other appropriate Federal officials.

''(3) RIGHT TO RECLAIM.—If within one year after the relocation of a Federal Government station, the Federal entity affected demonstrates to the Secretary and the Commission that the new facilities or spectrum are not comparable to the facilities or spectrum from which the Federal Government station was relocated, the person who sought the relocation shall take reasonable steps to remedy any defects or pay the Federal entity for the costs of returning the Federal Government station to the electromagnetic spectrum from which the station was relocated.

''(h) FEDERAL ACTION TO EXPEDITE SPECTRUM TRANSFER.—Any Federal Government station which operates on electromagnetic spectrum that has been identified for reallocation under this Act for mixed Federal and non-Federal use in any reallocation report under subsection (a), to the maximum extent practicable through the use of subsection (g) and any other applicable law, shall take prompt action to make electromagnetic spectrum available for use in a manner that maximizes efficient use of the electromagnetic spectrum.

''(i) FEDERAL SPECTRUM ASSIGNMENT RESPONSIBILITY.—This section does not modify NTIA's authority under section 103(b)(2)(A) of this Act.

''(j) DEFINITIONS.—As used in this section—

''(1) the term 'Federal entity' means any department, agency, or instrumentality of the Federal Government that utilizes a Government station license obtained under section 305 of the 1934 Act (47 U.S.C. 305);

''(2) the term 'digital television services' means television services provided using digital technology to enhance audio quality and video resolution, as further defined in the Memorandum Opinion, Report, and Order of the Commission entitled 'Advanced Television Systems and Their Impact Upon the Existing Television Service,' MM Docket No. 87–268 and any subsequent FCC proceedings dealing with digital television; and

''(3) the term 'analog television licenses' means licenses issued pursuant to 47 CFR 73.682 et seq. .''.

(2) Section 114(a) of that Act (47 U.S.C. 924(a)) is amended by striking ''(a) or (d)(1)'' and inserting ''(a), (d)(1), or (f)''.

(e) IDENTIFICATION AND REALLOCATION OF AUCTIONABLE FREQUENCIES.—

(1) SECOND REPORT REQUIRED.—Section 113(a) of the National Telecommunications and Information Administration Organization Act (47 U.S.C. 923(a)) is amended by inserting ''and within 6 months after the date of enactment of the Balanced Budget Act of 1997'' after ''Act of 1993''.

(2) IN GENERAL.—Section 113(b) of the National Telecommunications and Information Administration Organization Act (47 U.S.C. 923(b)) is amended—

(A) by striking the caption of paragraph (1) and inserting ''INITIAL REALLOCATION REPORT.—'';

(B) by inserting ''in the initial report required by subsection (a)'' after ''recommend for reallocation'' in paragraph (1);

(C) by inserting ''or (3)'' after ''paragraph (1)'' each place it appears in paragraph (2); and

(D) by adding at the end thereof the following:

''(3) SECOND REALLOCATION REPORT.—The Secretary shall make available for reallocation a total of 20 megahertz in the second report required by subsection (a), for use other than by Federal Government stations under section 305 of the 1934 Act (47 U.S.C. 305),

that is located below 3 gigahertz and that meets the criteria specified in paragraphs (1) through (5) of subsection (a).''.

(3) ALLOCATION AND ASSIGNMENT.—Section 115 of that Act (47 U.S.C. 925) is amended—

(A) by striking ''the report required by section 113(a)'' in subsection (b) and inserting ''the initial reallocation report required by section 113(a)''; and

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

''(c) ALLOCATION AND ASSIGNMENT OF FREQUENCIES IDENTIFIED IN THE SECOND ALLOCATION REPORT.—

''(1) PLAN.—Within 12 months after it receives a report from the Secretary under section 113(f) of this Act, the Commission shall—

''(A) submit a plan, prepared in coordination with the Secretary of Commerce, to the President and to the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committee on Commerce, for the allocation and assignment under the 1934 Act of frequencies identified in the report; and

''(B) implement the plan.

''(2) CONTENTS.—The plan prepared by the Commission under paragraph (1) shall consist of a schedule of reallocation and assignment of those frequencies in accordance with section 309(j) of the 1934 Act in time for the assignment of those licenses or permits by September 30, 2002.''.

SEC. 3002. DIGITAL TELEVISION SERVICES.

Section 309(j) of the Communications Act of 1934 (47 U.S.C. 309(j)) is amended by adding at the end thereof the following:

''(15) AUCTION OF RECAPTURED BROADCAST TELEVISION SPECTRUM AND POTENTIAL DIGITAL TELEVISION LICENSE FEES.—

''(A) LIMITATIONS ON TERMS OF TERRESTRIAL TELEVISION BROADCAST LICENSES.—

''(i) A television license that authorizes analog television services may not be renewed to authorize such services for a period that extends beyond December 31, 2006. The Commission shall extend or waive this date for any station in any television market unless 95 percent of the television households have access to digital local television signals, either by direct off-air reception or by other means.

''(ii) A commercial digital television license that is issued shall expire on September 30, 2003. A commercial digital television license shall be re-issued only subject to fulfillment of the licensee's obligations under subparagraph (C).

''(iii) No later than December 31, 2001, and every 2 years thereafter, the Commission shall report to Congress on the status of digital television conversion in each television market. In preparing this report, the Commission shall consult with other departments and agencies of the Federal government. The report shall contain the following information:

''(I) Actual consumer purchases of analog and digital television receivers, including the price, availability, and use of conversion equipment to allow analog sets to receive a digital signal.

''(II) The percentage of television households in each market that has access to digital local television signals as defined in paragraph (a)(1), whether such access is attained by direct off-air reception or by some other means.

''(II) The cost to consumers of purchasing digital television receivers (or conversion equipment to prevent obsolescence of existing analog equipment) and other related changes in the marketplace such as increases in the cost of cable converter boxes.

''(B) SPECTRUM REVERSION AND RESALE.—

''(i) The Commission shall—

''(I) ensure that, as analog television licenses expire pursuant to subparagraph (A)(i), each broadcaster shall return electromagnetic spectrum according to the Commission's direction; and

''(II) reclaim and organize the electromagnetic spectrum in a manner to maximize the deployment of new and existing services.

''(ii) Licenses for new services occupying electromagnetic spectrum previously used for the broadcast of analog television shall be selected by competitive bidding. The Commission shall start the competitive bidding process by July 1, 2001, with payment pursuant to the competitive bidding rules established by the Commission. The Commission shall report the total revenues from the competitive bidding by January 1, 2002.

''(C) DEFINITIONS.—As used in this paragraph—

''(i) the term 'digital television services' means television services provided using digital technology to enhance audio quality and video resolution, as further defined in the Memorandum Opinion, Report, and Order of the Commission entitled 'Advanced Television Systems and their Impact Upon the Existing Television Service,' MM Docket No. 87–268 and any subsequent Commission proceedings dealing with digital television; and

''(ii) the term 'analog television licenses' means licenses issued pursuant to 47 CFR 73.682 et seq. .''.

SEC. 3003. ALLOCATION AND ASSIGNMENT OF NEW PUBLIC SAFETY AND COMMERCIAL LICENSES.

(a) IN GENERAL.—The Federal Communications Commission, not later than January 1, 1998, shall allocate from electromagnetic spectrum between 746 megahertz and 806 megahertz—

(1) 24 megahertz of that spectrum for public safety services according to terms and conditions established by the Commission, in consultation with the Secretary of Commerce and the Attorney General; and

(2) 36 megahertz of that spectrum for commercial purposes to be assigned by competitive bidding.

(b) ASSIGNMENT.—The Commission shall—

(1) commence assignment of the licenses for public safety created pursuant to subsection (a) no later than September 30, 1998; and

(2) commence competitive bidding for the commercial licenses created pursuant to subsection (a) no later than March 31, 1998.

(c) LICENSING OF UNUSED FREQUENCIES FOR PUBLIC SAFETY RADIO SERVICES.—

(1) USE OF UNUSED CHANNELS FOR PUBLIC SAFETY.—It shall be the policy of the Federal Communications Commission, notwithstanding any other provision of this Act or any other law, to waive whatever licensee eligibility and other requirements (including bidding requirements) are applicable in order to permit the use of unassigned frequencies for public safety purposes by a State or local government agency upon a showing that—

(A) no other existing satisfactory public safety channel is immediately available to satisfy the requested use;

(B) the proposed use is technically feasible without causing harmful interference to existing stations in the frequency band entitled to protection from such interference under the rules of the Commission; and

(C) use of the channel for public safety purposes is consistent with other existing public safety channel allocations in the geographic area of proposed use.

(2) APPLICABILITY.—Paragraph (1) shall apply to any application—

(A) is pending before the Commission on the date of enactment of this Act;

(B) was not finally determined under section 402 or 405 of the Communications Act of 1934 (47 U.S.C. 402 or 405) on May 15, 1997; or

(C) is filed after May 15, 1997.

(d) PROTECTION OF BROADCAST TV LICENSEES DURING DIGITAL TRANSITION.—Public safety and commercial licenses granted pursuant to this subsection—

(1) shall enjoy flexibility in use, subject to—

(A) interference limits set by the Commission at the boundaries of the electromagnetic spectrum block and service area; and

(B) any additional technical restrictions imposed by the Commission to protect full-service analog and digital television licenses during a transition to digital television;

(2) may aggregate multiple licenses to create larger spectrum blocks and service areas;

(3) may disaggregate or partition licenses to create smaller spectrum blocks or service areas; and

(4) may transfer a license to any other person qualified to be a licensee.

(e) PROTECTION OF PUBLIC SAFETY LICENSEES DURING DIGITAL TRANSITION.—The Commission shall establish rules insuring that public safety licensees using spectrum reallocated pursuant to subsection (a)(1) shall not be subject to harmful interference from television broadcast licensees.

(f) DIGITAL TELEVISION ALLOTMENT.—In assigning temporary transitional digital licenses, the Commission shall—

(1) minimize the number of allotments between 746 and 806 megahertz and maximize the amount of spectrum available for public safety and new services;

(2) minimize the number of allotments between 698 and 746 megahertz in order to facilitate the recovery of spectrum at the end of the transition;

(3) consider minimizing the number of allotments between 54 and 72 megahertz to facilitate the recovery of spectrum at the end of the transition; and

(4) develop an allotment plan designed to recover 79 megahertz of spectrum to be assigned by competitive bidding, in addition to the 60 megahertz identified in paragraph (a) of this subsection.

(g) INCUMBENT BROADCAST LICENSEES.—Any person who holds an analog television license or a digital television license between 746 and 806 megahertz—

(1) may not operate at that frequency after the date on which the digital television services transition period terminates, as determined by the Commission; and

(2) shall surrender immediately the license or permit to construct pursuant to Commission rules.

(h) DEFINITIONS.—For purposes of this section—

(1) COMMISSION.—The term ''Commission'' means the Federal Communications Commission.

(2) DIGITAL TELEVISION (DTV) SERVICE.—The term ''digital television (DTV) service'' means terrestrial broadcast services provided using digital technology to enhance audio quality and video resolution, as further defined in the Memorandum Opinion, Report, and Order of the Commission entitled ''Advanced Television Systems and Their Impact Upon the Existing Television Service,'' MM Docket No. 87–268, or subsequent findings of the Commission.

(3) DIGITAL TELEVISION LICENSE.—The term ''digital television license'' means a full-service license issued pursuant to rules adopted for digital television service.

(4) ANALOG TELEVISION LICENSE.—The term ''analog television license'' means a full-service license issued pursuant to 47 CFR 73.682 et seq.

(5) PUBLIC SAFETY SERVICES.—The term ''public safety services'' means services whose sole or principal purpose is to protect the safety of life, health, or property.

(6) SERVICE AREA.—The term ''service area'' means the geographic area over which a licensee may provide service and is protected from interference.

(7) SPECTRUM BLOCK.—The term ''spectrum block'' means the range of frequencies over which the apparatus licensed by the Commission is authorized to transmit signals.

SEC. 3004. FLEXIBLE USE OF ELECTROMAGNETIC SPECTRUM.

Section 303 of the Communications Act of 1934 (47 U.S. 303) is amended by adding at the end thereof the following:

''(y) Shall allocate electromagnetic spectrum so as to provide flexibility of use, except—

''(1) as required by international agreements relating to global satellite systems or other telecommunication services to which the United States is a party;

''(2) as required by public safety allocations;

''(3) to the extent that the Commission finds, after notice and an opportunity for public comment, that such an allocation would not be in the public interest;

''(4) to the extent that flexible use would retard investment in communications services and systems, or technology development thereby lessening the value of the electromagnetic spectrum; or

''(5) to the extent that flexible use would result in harmful interference among users.''.

LAUTENBERG AMENDMENT NO. 475

Mr. LAUTENBERG proposed an amendment to the bill, S. 947, supra; as follows:

On page 871, strike lines 9–11.

KERREY AMENDMENT NO. 476

Mr. LAUTENBERG (for Mr. KERREY) proposed an amendment to the bill, S. 947, supra; as follows:

At the appropriate place in the bill insert the following:

SEC. . RESERVE PRICE.

In any auction conducted or supervised by the Federal Communications Commission (hereinafter the Commission) for any license, permit or right which has value, a reasonable reserve price shall be set by the Commission for each unit in the auction. The reserve price shall establish a minimum bid for the unit to be auctioned. If no bid is received above the reserve price for a unit, the unit shall be retained. The Commission shall reassess the reserve price for that unit and place the unit in the next scheduled or next appropriate auction.

DURBIN (AND OTHERS) AMENDMENT NO. 477

Mr. LAUTENBERG (for Mr. DURBIN, for himself, Mr. WELLSTONE, and Mrs. BOXER) proposed an amendment to the bill, S. 947, supra; as follows:

At the end of title I, add the following:

SEC. 10. FOOD STAMP BENEFITS FOR CHILD IMMIGRANTS.

(a) IN GENERAL.—Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding at the end the following:

''(E) CHILD IMMIGRANTS.—In the case of the program specified in paragraph (3)(B), paragraph (1) shall not apply to a qualified alien who is under 18 years of age.''.

(b) ALLOCATION OF ADMINISTRATIVE COSTS.—Section 408(a) of the Social Security Act (42 U.S.C. 608(a)) is amended by adding at the end the following:

''(12) DESIGNATION OF GRANTS UNDER THIS PART AS PRIMARY PROGRAM IN ALLOCATING ADMINISTRATIVE COSTS——

''(A) IN GENERAL.—Notwithstanding any other provision of law, a State shall designate the program funded under this part as the primary program for the purpose of allocating costs incurred in serving families eligible or applying for benefits under the State program funded under this part and any other Federal means-tested benefits.

''(B) ALLOCATION OF COSTS.——

''(i) IN GENERAL.—The Secretary shall require that costs described in subparagraph (A) be allocated in the same manner as the costs were allocated by State agencies that designated part A of title IV as the primary program for the purpose of allocating administrative costs before August 22, 1996.

''(iii) FLEXIBLE ALLOCATION.—The Secretary may allocate costs under clause (i) differently, if a State can show good cause for or evidence of increased costs, to the extent that the administrative costs allocated to the primary program are not reduced by more than 33 percent.

''(13) FAILURE TO ALLOCATE ADMINISTRATIVE COSTS TO GRANTS PROVIDED UNDER THIS PART.—If the Secretary determines that, with respect to a preceding fiscal year, a State has not allocated administrative costs in accordance with paragraph (12), the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the succeeding fiscal year by an amount equal to——

''(A) the amount the Secretary determines should have been allocated to the program funded under this part in such preceding fiscal year; minus

''(B) the amount that the State allocated to the program funded under this part in such preceding fiscal year.''.

ROCKEFELLER (AND WYDEN) AMENDMENT NO. 478

Mr. LAUTENBERG (for Mr. ROCKEFELLER, for himself and Mr. WYDEN) proposed an amendment to the bill, S. 947, supra; as follows:

On page 214, strike lines 21 through 24 and insert the following:

''(3) EXCEPTION FOR MSA PLANS AND UNRESTRICTED FEE-FOR-SERVICE PLANS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), paragraphs (1) and (2) do not apply to an MSA plan or an unrestricted fee-for-service plan.

''(B) APPLICATION OF BALANCE BILLING FOR PHYSICIAN SERVICES.—Section 1848(g) shall apply to the provision of physician services (as defined in section 1848(j)(3)) to an individual enrolled in an unrestricted fee-for-service plan under this title in the same manner as such section applies to such services that are provided to an individual who is not enrolled in a Medicare Choice plan under this title.

DODD AMENDMENT NO. 479

Mr. LAUTENBERG (for Mr. DODD) proposed an amendment to the bill, S. 947, supra; as follows:

On page 874, between lines 7 and 8, insert the following:

SEC. 5817A. CONTINUATION OF MEDICAID ELIGIBILITY FOR DISABLED CHILDREN WHO LOSE SSI BENEFITS.

(a) IN GENERAL.—Section 1902(a)(10)(A)(i)(II) (42 U.S.C. 1396a(a)(10)(A)(i)(II)) is amended by inserting ''(or were being paid as of the date of enactment of section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (Public law 104–193; 110 Stat. 2188) and would continue to be paid but for the enactment of that section)'' after ''title XVI''.

(b) OFFSET.—Section 2103(b) of the Social Security Act (as added by section 5801) is amended——

(1) in paragraph (2), by striking ''and'' and at the end;

(2) in paragraph (3), by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(4) the amendment made by section 5817A(a) of the Balanced Budget Act of 1997 (relating to continued eligibility for certain disabled children).''.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) applies to medical assistance furnished on or after July 1, 1997.

MURRAY (AND WELLSTONE) AMENDMENT NO. 480

Mr. LAUTENBERG (for Mrs. MURRAY, for herself and Mr. WELLSTONE) proposed an amendment to the bill, S. 947, supra; as follows:

On page 960, between lines 3 and 4, insert the following:

SEC. _____. PROTECTING VICTIMS OF FAMILY VIOLENCE.

(a) FINDINGS.—Congress finds that—

(1) the intent of Congress in amending part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.) in section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat 2112) was to allow States to take into account the effects of the epidemic of domestic violence in establishing their welfare programs, by giving States the flexibility to grant individual, temporary waivers for good cause to victims of domestic violence who meet the criteria set forth in section 402(a)(7)(B) of the Social Security Act (42 U.S.C. 602(a)(7)(B));

(2) the allowance of waivers under such sections was not intended to be limited by other, separate, and independent provisions of part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.);

(3) under section 402(a)(7)(A)(iii) of such Act (42 U.S.C. 602(a)(7)(A)(iii)), requirements under the temporary assistance for needy families program under part A of title IV of such Act may, for good cause, be waived for so long as necessary; and

(4) good cause waivers granted pursuant to section 402(a)(7)(A)(iii) of such Act (42 U.S.C. 602(a)(7)(A)(iii)) are intended to be temporary and directed only at particular program requirements when needed on an individual case-by-case basis, and are intended to facilitate the ability of victims of domestic violence to move forward and meet program requirements when safe and feasible without interference by domestic violence.

(b) CLARIFICATION OF WAIVER PROVISIONS.—

(1) IN GENERAL.—Section 402(a)(7) (42 U.S.C. 602(a)(7)) is amended by adding at the end the following:

''(C) NO NUMERICAL LIMITS.—In implementing this paragraph, a State shall not be subject to any numerical limitation in the granting of good cause waivers under subparagraph (A)(iii).

''(D) WAIVERED INDIVIDUALS NOT INCLUDED FOR PURPOSES OF CERTAIN OTHER PROVISIONS OF THIS PART.—Any individual to whom a good cause waiver of compliance with this Act has been granted in accordance with subparagraph (A)(iii) shall not be included for purposes of determining a State's compliance with the participation rate requirements set forth in section 407, for purposes of applying the limitation described in section 408(a)(7)(C)(ii), or for purposes of determining

whether to impose a penalty under paragraph (3), (5), or (9) of section 409(a).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect as if it had been included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2112).

(c) FEDERAL PARENT LOCATOR SERVICE.—

(1) IN GENERAL.—Section 453 (42 U.S.C. 653), as amended by section 5938, is further amended—

(A) in subsection (b)(2)—

(i) in the matter preceding subparagraph (A), by inserting ''or that the health, safety, or liberty or a parent or child would by unreasonably put at risk by the disclosure of such information,'' before ''provided that'';

(ii) in subparagraph (A), by inserting '', that the health, safety, or liberty or a parent or child would by unreasonably put at risk by the disclosure of such information,'' before ''and that information''; and

(iii) in subparagraph (B)(i), by striking ''be harmful to the parent or the child'' and inserting ''place the health, safety, or liberty of a parent or child unreasonably at risk''; and

(B) in subsection (c)(2), by inserting '', or to serve as the initiating court in an action to seek and order,'' before ''against a noncustodial''.

(2) STATE PLAN.—Section 454(26) (42 U.S.C. 654), as amended by section 5956, is further amended—

(A) in subparagraph (C), by striking ''result in physical or emotional harm to the party or the child'' and inserting ''place the health, safety, or liberty of a parent or child unreasonably at risk'';

(B) in subparagraph (D), by striking ''of domestic violence or child abuse against a party or the child and that the disclosure of such information could be harmful to the party or the child'' and inserting ''that the health, safety, or liberty of a parent or child would be unreasonably put at risk by the disclosure of such information''; and

(C) in subparagraph (E), by striking ''of domestic violence'' and all that follows through the semicolon and inserting ''that the health, safety, or liberty of a parent or child would be unreasonably put at risk by the disclosure of such information pursuant to section 453(b)(2), the court shall determine whether disclosure to any other person or persons of information received from the Secretary could place the health, safety, or liberty or a parent or child unreasonably at risk (if the court determines that disclosure to any other person could be harmful, the court and its agents shall not make any such disclosure);''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect 1 day after the effective date described in section 5961(a).

DODD (AND OTHERS) AMENDMENT NO. 481

Mr. LAUTENBERG (for Mr. DODD, for himself, Mr. D'AMATO, and Mr. LEAHY) proposed an amendment to the bill, S. 947, supra; as follows:

On page 562, between line 20 and 21, insert the following:

''(XIV) for calendar year 1999 for hospitals in all areas, the market basket percentage increase minus 1.3 percentage points,''.

On page 562, line 21, strike ''(XIV) for calendar year 1999'' and insert ''(XV) for calendar year 2000.''.

On page 563, line 1, strike ''(XV)'' and insert ''(XVI)''.

On page 604, line 22, strike ''upon discharge from a subsection (d) hospital'' and insert ''immediately upon discharge from, and pursuant to the discharge planning process (as defined in section 1861(ee)) of, a subsection (d) hospital''.

Beginning on page 605, strike line 7 and all that follows through page 606, line 6, and insert the following:

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to discharges occurring on or after October 1, 1997.

LEVIN (AND JEFFORDS) AMENDMENT NO. 482

Mr. LAUTENBERG (for Mr. LEVIN, for himself and Mr. JEFFORDS) proposed an amendment to the bill, S. 947, supra; as follows:

On page 930, between lines 14 and 15, insert the following:

(l) VOCATIONAL EDUCATIONAL TRAINING.—Section 407(d)(8) (42 U.S.C. 607(d)(8)) is amended by striking ''12'' and inserting ''24''.

WYDEN AMENDMENT NO. 483

Mr. LAUTENBERG (for Mr. WYDEN) proposed an amendment to the bill, S. 947, supra; as follows:

On page 844, between lines 7 and 8, insert the following:

SEC. 5768. CONTINUATION OF STATE-WIDE SECTION 1115 MEDICAID WAIVERS.

(a) IN GENERAL.—Section 1115 of the Social Security Act (42 U.S.C. 1315) is amended by adding at the end the following:

''(d)(1) The provisions of this subsection shall apply to the extension of statewide comprehensive research and demonstration projects (in this subsection referred to as 'waiver project') for which waivers of compliance with the requirements of title XIX are granted under subsection (a). With respect to a waiver project that, but for the enactment of this subsection, would expire, the State at its option may—

''(A) not later than 1 year before the waiver under subsection (a) would expire (acting through the chief executive officer of the State who is operating the project), submit to the Secretary a written request for an extension of such waiver project for up to 3 years; or

''(B) permanently continue the waiver project if the project meets the requirements of paragraph (2).

''(2) The requirements of this paragraph are that the waiver project—

''(A) has been successfully operated for 5 or more years; and

''(B) has been shown, through independent evaluations sponsored by the Health Care Financing Administration, to successfully contain costs and provide access to health care.

''(3)(A) In the case of waiver projects described in paragraph (1)(A), if the Secretary fails to respond to the request within 6 months after the date on which the request was submitted, the request is deemed to have been granted.

''(B) If the request is granted or deemed to have been granted, the deadline for submittal of a final report shall be 1 year after the date on which the waiver project would have expired but for the enactment of this subsection.

''(C) The Secretary shall release an evaluation of each such project not later than 1 year after the date of receipt of the final report.

''(D) Phase-down provisions which were applicable to waiver projects before an extension was provided under this subsection shall not apply.

''(4) The extension of a waiver project under this subsection shall be on the same terms and conditions (including applicable terms and conditions related to quality and access of services, budget neutrality as adjusted for inflation, data and reporting requirements and special population protections), except for any phase down provisions, and subject to the same set of waivers that applied to the project or were granted before the extension of the project under this subsection. The permanent continuation of a waiver project shall be on the same terms and conditions, including financing, and subject to the same set of waivers. No test of budget neutrality shall be applied in the case of projects described in paragraph (2) after that date on which the permanent extension was granted.

''(5) In the case of a waiver project described in paragraph (2), the Secretary, acting through the Health Care Financing Administration shall, deem any State's request to expand medicaid coverage in whole or in part to individuals who have an income at or below the Federal poverty level as budget neutral if independent evaluations sponsored by the Health Care Financing Administration have shown that the State's medicaid managed care program under such original waiver is more cost effective and efficient than the traditional fee-for-service medicaid program that, in the absence of any managed care waivers under this section, would have been provided in the State.''.

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

HARKIN (AND GRASSLEY) AMENDMENT NO. 484

Mr. LAUTENBERG (for Mr. HARKIN for himself and Mr. GRASSLEY) proposed an amendment to the bill, S. 947, supra; as follows:

On page 885, line 15, insert after ''State'' the following: ''or a community action agency, community development corporation or other non-profit organizations with demonstrated effectiveness in moving welfare recipients into the workforce''.

FEINSTEIN AMENDMENTS NOS. 485–487

Mr. LAUTENBERG (for Mrs. FEINSTEIN) proposed three amendments to the bill, S. 947, supra; as follows:

AMENDMENT NO. 485

At the end of the proposed section 1852(d) of the Social Security Act (as added by section 5001), add the following:

''(4) DETERMINATION OF HOSPITAL LENGTH OF STAY.—

''(A) IN GENERAL.—A Medicare Choice organization shall cover the length of an inpatient hospital stay under this part as determined by the attending physician, in consultation with the patient, to be medically appropriate.

''(B) CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(i) as requiring the provision of inpatient coverage if the attending physician, in consultation with the patient, determine that a shorter period of hospital stay is medically appropriate, or

''(ii) as affecting the application of deductibles and coinsurance.

At the appropriate place in chapter 2 of subtitle H of division 1 of title V, insert the following new section:

SEC. . HOSPITAL LENGTH OF STAY.

(a) IN GENERAL.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

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

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

(3) by inserting after subparagraph (R) the following:

''(S) in the case of hospitals, not to discharge an inpatient before the date the attending physician and patient determine it to be medically appropriate.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to discharges occurring on or after 6 months after the date of enactment of this Act.

At the appropriate place in chapter 5 of subtitle I of division 2 of title V, insert the following new section:

SEC. . DETERMINATION OF HOSPITAL STAY.

(a) IN GENERAL.—Title XIX (42 U.S.C. 1396 et seq.) is amended—

(1) by redesignating section 1933 as section 1934; and

(2) by inserting after section 1932 the following new section:

''DETERMINATION OF HOSPITAL STAY

''SEC. 1933. (a) IN GENERAL.—A State plan for medical assistance under this title shall cover the length of an inpatient hospital stay under this part as determined by the attending physician, in consultation with the patient, to be medically appropriate.

''(b) CONSTRUCTION.—Nothing in this section shall be construed—

''(1) as requiring the provision of inpatient coverage if the attending physician, in consultation with the patient, determine that a shorter period of hospital stay is medically appropriate, or

''(2) as affecting the application of deductibles and coinsurance.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to discharges occurring on or after 6 months after the date of enactment of this Act.

AMENDMENT NO. 486

At the appropriate place in chapter 1 of subtitle K of division 2 of title V, insert the following new section:

SEC. . ADDITIONAL FUNDING FOR STATE EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS.

(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—There are available for allotments under this section for each of the 5 fiscal years (beginning with fiscal year 1998) $20,000,000 for payments to certain States under this section.

(b) STATE ALLOTMENT AMOUNT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall compute an allotment for each fiscal year beginning with fiscal year 1998 and ending with fiscal year 2002 for each of the 12 States with the highest number of undocumented aliens. The amount of such allotment for each such State for a fiscal year shall bear the same ratio to the total amount available for allotments under subsection (a) for the fiscal year as the ratio of the number of undocumented aliens in the State in the fiscal year bears to the total of such numbers for all States for such fiscal year. The amount of allotment to a State provided under this paragraph for a fiscal year that is not paid out under subsection (c) shall be available for payment during the subsequent fiscal year.

(2) DETERMINATION.—For purposes of paragraph (1), the number of undocumented aliens in a State under this section shall be determined based on estimates of the resident illegal alien population residing in each State prepared by the Statistics Division of the Immigration and Naturalization Service as of October 1992 (or as of such later date if such date is at least 1 year before the beginning of the fiscal year involved).

(c) USE OF FUNDS. —From the allotments made under subsection (b), the Secretary shall pay to each State amounts the State demonstrates were paid by the State (or by a political subdivision of the State) for emergency health services furnished to undocumented aliens.

(d) STATE DEFINED.—For purposes of this section, the term ''State'' includes the District of Columbia.

(e) STATE ENTITLEMENT.—This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided under subsection (c).

AMENDMENT NO. 487

At the appropriate place in section 5721, insert the following:

( ) APPLICATION OF DSH PAYMENT ADJUSTMENT.—Notwithstanding subsection (d), effective July 1, 1997, section 1923(g)(2)(A) of the Social Security Act (42 U.S.C. 1396r–4(g)(2)(A)) shall be applied to the State of California as though—

(1) ''or that begins on or after July 1, 1997, and before July 1, 1999,'' were inserted in such section after ''January 1, 1995,''; and

(2) ''(or 175 percent in the case of a State fiscal year that begins on or after July 1, 1997, and before July 1, 1999)'' were inserted in such section after ''200 percent''.

WELLSTONE (AND OTHERS) AMENDMENT NO. 488

Mr. Lautenberg (for Mr. WELLSTONE, for himself, Mr. DURBIN, and Ms. MIKULSKI) proposed an amendment to the bill, S. 947, supra; as follows:

Beginning on page 764, strike line 7 and all that follows through page 765, line 17, and insert the following:

(a) PLAN AMENDMENTS.—Section 1902(a)(13) is amended—

(1) by striking all that precedes subparagraph (D) and inserting the following:

''(13)(A) provide—

(i) for the State-based determination of rates of payment under the plan for hospital services (and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), nursing facility services , and services provided in intermediate care facilities for the mentally retarded, under which the State provides assurances to the Secretary that proposed rates will be actuarially sufficient to ensure access to and quality of services;

''(ii) that the State will submit such proposed rates for review by an independent actuary selected by the Secretary; and

''(iii) that any new rates or modifications to existing rates will be developed through a public rulemaking procedure under which such new or modified rates are published in 1 or more daily newspapers of general circulation in the State or in any publication used by the State to publish State statutes or rules, and providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on such rates or modifications;''; and

(2) by redesignating subparagraphs (D), (E) and (F) as subparagraphs (B), (C), and (D) respectively.

MIKULSKI (AND WELLSTONE) AMENDMENT NO. 489

Mr. LAUTENBERG (for Ms. MIKULSKI, for herself and Mr. WELLSTONE) proposed an amendment to the bill, S. 947, supra; as follows:

Beginning on page 764, strike line 5 and all that follows through line 23 on page 766.

KENNEDY (AND DODD) AMENDMENT NO. 490

Mr. LAUTENBERG (for Mr. KENNEDY, for himself and Mr. DODD) proposed an amendment to the bill, S. 947, supra; as follows:

Strike title VII and insert the following:

TITLE VII—COMMITTEE ON LABOR AND HUMAN RESOURCES

SEC. 7001. MANAGEMENT AND RECOVERY OF RESERVES.

(a) AMENDMENT.—Section 422 of the Higher Education Act of 1965 (20 U.S.C. 1072) is amended by adding after subsection (g) the following new subsection:

''(h) RECALL OF RESERVES; LIMITATIONS ON USE OF RESERVE FUNDS AND ASSETS.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall, except as otherwise provided in this subsection, recall $1,200,000,000 from the reserve funds held by guaranty agencies under this part on September 1, 2002.

''(2) DEPOSIT.—Funds recalled by the Secretary under this subsection shall be deposited in the Treasury.

''(3) EQUITABLE SHARE.—The Secretary shall require each guaranty agency to return reserve funds under paragraph (1) based on such agency's equitable share of excess reserve funds held by guaranty agencies as of September 30, 1996. For purposes of this paragraph, a guaranty agency's equitable share of excess reserve funds shall be determined as follows:

''(A) The Secretary shall compute each agency's reserve ratio by dividing (i) the amount held in such agency's reserve (including funds held by, or under the control of, any other entity) as of September 30, 1996, by (ii) the original principal amount of all loans for which such agency has an outstanding insurance obligation.

''(B) If the reserve ratio of any agency as computed under subparagraph (A) exceeds 1.12 percent, the agency's equitable share shall include so much of the amounts held in such agency's reserve fund as exceed a reserve ratio of 1.12 percent.

''(C) If any additional amount is required to be recalled under paragraph (1) (after deducting the total of the equitable shares calculated under subparagraph (B)), the agencies' equitable shares shall include additional amounts—

''(i) determined by imposing on each such agency an equal percentage reduction in the amount of each agency's reserve fund remaining after deduction of the amount recalled under subparagraph (B); and

''(ii) the total of which equals the additional amount that is required to be recalled under paragraph (1) (after deducting the total of the equitable shares calculated under subparagraph (B)).

''(4) RESTRICTED ACCOUNTS.—Within 90 days after the beginning of each of fiscal years 1998 through 2002, each guaranty agency shall transfer a portion of each agency's equitable share determined under paragraph (3) to a restricted account established by the guaranty agency that is of a type selected by the guaranty agency with the approval of the Secretary. Funds transferred to such restricted accounts shall be invested in obligations issued or guaranteed by the United States or in other similarly low-risk securities. A guaranty agency shall not use the funds in such a restricted account for any purpose without the express written permission of the Secretary, except that a guaranty agency may use the earnings from such restricted account for activities to reduce student loan defaults under this part. The portion required to be transferred shall be determined as follows:

''(A) In fiscal year 1998—

''(i) all agencies combined shall transfer to a restricted account an amount equal to one-fifth of the total amount recalled under paragraph (1);

''(ii) each agency with a reserve ratio (as computed under paragraph (3)(A)) that exceeds 2 percent shall transfer to a restricted account so much of the amounts held in such agency's reserve fund as exceed a reserve ratio of 2 percent; and

''(iii) each agency shall transfer any additional amount required under clause (i) (after deducting the amount transferred under clause (ii)) by transferring an amount that represents an equal percentage of each agency's equitable share to a restricted account.

''(B) In fiscal years 1999 through 2002, each agency shall transfer an amount equal to one-fourth of the total amount remaining of the agency's equitable share (after deduction of the amount transferred under subparagraph (A)).

''(5) SHORTAGE.—If, on September 1, 2002, the total amount in the restricted accounts described in paragraph (4) is less than the amount the Secretary is required to recall under paragraph (1), the Secretary shall require the return of the amount of the shortage from other reserve funds held by guaranty agencies under procedures established by the Secretary.

''(6) PROHIBITION.—The Secretary shall not have any authority to direct a guaranty agency to return reserve funds under subsection (g)(1)(A) during the period from the date of enactment of this subsection through September 30, 2002, and any reserve funds otherwise returned under subsection (g)(1) during such period shall be treated as amounts recalled under this subsection and shall not be available under subsection (g)(4).

''(7) DEFINITION.—For purposes of this subsection the term 'reserve funds' when used with respect to a guaranty agency—

''(A) includes any reserve funds held by, or under the control of, any other entity; and

''(B) does not include buildings, equipment, or other nonliquid assets.''.

(b) CONFORMING AMENDMENT.—Section 428(c)(9)(A) of the Higher Education Act of 1965 (20 U.S.C. 1078(c)(9)(A)) is amended—

(1) in the first sentence, by striking ''for the fiscal year of the agency that begins in 1993''; and

(2) by striking the third sentence.

SEC. 7002. REPEAL OF DIRECT LOAN ORIGINATION FEES TO INSTITUTIONS OF HIGHER EDUCATION.

Section 452 of the Higher Education Act of 1965 (20 U.S.C. 1087b) is amended—

(1) by striking subsection (b); and

(2) by redesignating subsections (c) and (d) as subsections (b) and (c), respectively.

SEC. 7003. LENDER AND HOLDER RISK SHARING.

Section 428(b)(1)(G) of the Higher Education Act of 1965 (20 U.S.C. 1078(b)(1)(G)) is amended by striking ''not less than 98 percent'' and inserting ''95 percent''.

SEC. 7004. FEES AND INSURANCE PREMIUMS.

(a) IN GENERAL.—Section 428(b)(1)(H) of the Higher Education Act of 1965 (20 U.S.C. 1078(b)(1)(H)) is amended—

(1) by inserting ''(i)'' before ''provides'';

(2) by striking ''the loan,'' and inserting ''any loan made under section 428 before July 1, 1998,'';

(3) by inserting ''and'' after the semicolon; and

(4) by adding at the end the following:

''(ii) provides that no insurance premiums shall be charged to the borrower of any loan made under section 428 on or after July 1, 1998;''.

(b) SPECIAL ALLOWANCES.—Section 438(c) of the Higher Education Act of 1965 (20 U.S.C. 1087–1(c)) is amended—

(1) in paragraph (2), by striking ''paragraph (6)'' and inserting ''paragraphs (6) and (8)''; and

(2) by adding at the end the following:

''(8) ORIGINATION FEE ON SUBSIDIZED LOANS ON OR AFTER JULY 1, 1998.—In the case of any loan made or insured under section 428 on or after July 1, 1998, paragraph (2) shall be applied by substituting '2.0 percent' for '3.0 percent'.''.

(c) DIRECT LOANS.—Section 455(c) of the Higher Education Act of 1965 (20 U.S.C. 1087e(c)) is amended—

(1) by striking ''The Secretary'' and inserting the following:

''(1) IN GENERAL.—For loans made under this part before July 1, 1998, the Secretary'';

(2) by striking ''of a loan made under this part''; and

(3) by adding at the end the following:

''(2) ORIGINATION FEE.—For loans made under this part on or after July 1, 1998, the Secretary shall charge the borrower an origination fee of 2.0 percent of the principal amount of the loan, in the case of Federal Direct Stafford/Ford Loans.''.

SEC. 7005. SECRETARY'S EQUITABLE SHARE.

Section 428(c)(6)(A)(ii) of the Higher Education Act of 1965 (20 U.S.C. 1078(c)(6)(A)(ii) is amended by striking ''27 percent'' and inserting ''18.5 percent''.

SEC. 7006. FUNDS FOR ADMINISTRATIVE EXPENSES.

The first sentence of section 458(a) of the Higher Education Act of 1965 (20 U.S.C. 1087h(a)) is amended by striking ''$260,000,000'' and all that follows through the end of the sentence and inserting ''$532,000,000 in fiscal year 1998, $610,000,000 in fiscal year 1999, $705,000,000 in fiscal year 2000, $750,000,000 in fiscal year 2001, and $750,000,000 in fiscal year 2002.''.

SEC. 7007. EXTENSION OF STUDENT AID PROGRAMS.

Title IV of the Higher Education Act of 1965 (20 U.S.C. 1070 et seq.) is amended—

(1) in section 424(a), by striking ''1998.'' and ''2002.'' and inserting ''2002.'' and ''2006.'', respectively;

(2) in section 428(a)(5), by striking ''1998,'' and ''2002.'' and inserting ''2002,'' and ''2006.'', respectively; and

(3) in section 428C(e), by striking ''1998.'' and inserting ''2002.''.

SEC. 7008. EFFECTIVE DATE.

This subtitle and the amendments made by this subtitle take effect on October 1, 1997.

BAUCUS AMENDMENT NO. 491

Mr. LAUTENBERG (for Mr. BAUCUS) proposed an amendment to the bill, S. 947, supra; as follows:

Section 1916(g)(1) of the Social Security Act, as amended by section 5754, is amended by inserting before the period the following: '', except that no cost-sharing may be imposed with respect to medical assistance provided to an individual who has not attained age 18 if such individual's family income does not exceed 150 percent of the poverty line applicable to a family of the size involved, and if, as of the date of enactment of the Balanced Budget Act of 1997, cost-sharing could not be imposed with respect to medical assistance provided to such individual.''.

KENNEDY AMENDMENTS NOS. 492–493

Mr. LAUTENBERG (for Mr. KENNEDY) proposed two amendments to the bill, S. 947, supra; as follows:

AMENDMENT NO. 492

At the appropriate place in section 2102(5) of the Social Security Act as added by section 5801, insert the following: ''The benefits shall include additional benefits to meet the needs of children with special needs, including—

''(A) rehabilitation and habilitation services, including occupational therapy, physical therapy, speech and language therapy, and respiratory therapy services;

''(B) mental health services;

''(C) personal care services;

''(D) customized durable medical equipment, orthotics, and prosthetics, as medically necessary; and

''(E) case management services.

''With respect to FEHBP-equivalent children's health insurance coverage, services otherwise covered under the coverage involved that are medically necessary to maintain, improve, or prevent the deterioration of the physical, developmental, or mental health of the child may not be limited with respect to scope and duration, except to the degree that such services are not medically necessary. Nothing in the preceding sentence shall be construed to prevent FEHBP-equivalent children's health insurance coverage from utilizing appropriate utilization review techniques to determine medical necessity or to prevent the delivery of such services through a managed care plan.''.

AMENDMENT NO. 493

On page 874, between lines 7 and 8, insert the following:

SEC. 5817A. SSI ELIGIBILITY FOR SEVERELY DISABLED ALIENS.

Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)), as amended by section 5815, is amended by adding at the end the following:

''(I) SSI EXCEPTION FOR SEVERELY DISABLED ALIENS.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1), and the September 30, 1997 application deadline under subparagraph (G), shall not apply to any alien who is lawfully present in the United States and who has been denied approval of an application for naturalization by the Attorney General solely on the ground that the alien is so severely disabled that the alien is otherwise unable to satisfy the requirements for naturalization.''.

CONRAD AMENDMENT NO. 494

Mr. LAUTENBERG (for Mr. CONRAD) proposed an amendment to the bill, S. 947, supra; as follows:

On page 874, between lines 7 and 8, insert the following:

SEC. 5817A. CONTINUATION OF MEDICAID ELIGIBILITY FOR DISABLED CHILDREN WHO LOSE SSI BENEFITS.

(a) IN GENERAL.—Section 1902(a)(10)(A)(i)(II) (42 U.S.C. 1396a(a)(10)(A)(i)(II)) is amended by inserting ''(or were being paid as of the date of enactment of section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (Public Law 104–193; 110 Stat. 2188) and would continue to be paid but for the enactment of that section)'' after ''title XVI''.

(b) OFFSET.—Section 2103(b) of the Social Security Act (as added by section 5801) is amended—

(1) in paragraph (2), by striking ''and'' at the end;

(2) in paragraph (3), by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(4) the amendment made by section 5817A(a) of the Balanced Budget Act of 1997 (relating to continued eligibility for certain disabled children).''.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) applies to medical assistance furnished on or after July 1, 1997.

CONRAD AMENDMENT NO. 495

Mr. LAUTENBERG (for Mr. CONRAD) proposed an amendment to the bill, S. 947, supra; as follows:

On page 844, between lines 7 and 8, insert the following:

SEC. ___. REMOVAL OF NAME FROM NURSE AIDE REGISTRY.

(a) MEDICARE.—Section 1819(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i-3(g)(1)(C)) is amended—

(1) in the first sentence by striking ''The State'' and inserting ''(i) The State''; and

(2) by adding at the end the following:

''(ii)(I) In the case of a finding of neglect, the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that—

''(aa) the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect; and

''(bb) the neglect involved in the original finding was a singular occurrence.

''(II) In no case shall a determination on a petition submitted under clause (I) be made prior to the expiration of the 1-year period beginning on the date on which the name of the petitioner was added to the registry under this subparagraph.''.

(b) MEDICAID.—Section 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1396r(g)(1)(C)) is amended—

(1) in the first sentence by striking ''The State'' and inserting ''(i) The State''; and

(2) by adding at the end the following:

''(ii)(I) In the case of a finding of neglect, the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that—

''(aa) the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect; and

''(bb) the neglect involved in the original finding was a singular occurrence.

''(II) In no case shall a determination on a petition submitted under clause (I) be made prior to the expiration of the 1-year period beginning on the date on which the name of the petitioner was added to the registry under this subparagraph.''.

(c) RETROACTIVE REVIEW.—The procedures developed by a State under the amendments made by subsection (a) and (b) shall permit an individual to petition for a review of any finding made by a State under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i-3(g)(1)(C) or 1396r(g)(1)(C)) after January 1, 1995.

(d) STUDY AND REPORT.—

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

(A) the use of nurse aide registries by States, including the number of nurse aides placed on the registries on a yearly basis and the circumstances that warranted their placement on the registries;

(B) the extent to which institutional environmental factors (such as a lack of adequate training or short staffing) contribute to cases of abuse and neglect at nursing facilities; and

(C) whether alternatives (such as a probational period accompanied by additional training or mentoring or sanctions on facilities that create an environment that encourages abuse or neglect) to the sanctions that are currently applied under the Social Security Act for abuse and neglect at nursing facilities might be more effective in minimizing future cases of abuse and neglect.

(2) REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress, a report concerning the results of the study conducted under paragraph (1) and the recommendation of the Secretary for legislation based on such study.

KERREY AMENDMENT NO. 496

Mr. LAUTENBERG (for Mr. KERREY) proposed an amendment to the bill, S. 947, supra; as follows:

On page 860, strike all matter after line 10 and before line 15, and insert the following:

''(d) USE LIMITED TO STATE PROGRAM EXPENDITURES.—Funds provided to an eligible State under this title shall only be used to carry out the purposes of this title.

KOHL AMENDMENT NO. 497

Mr. LAUTENBERG (for Mr. KOHL) proposed an amendment to the bill, S. 947, supra; as follows:

On page 743, line 6, strike the period and insert ''(but that shall not preempt any State standards that are more stringent than the standards established under this subparagraph).''.

HARKIN AMENDMENT NO. 498

Mr. LAUTENBERG (for Mr. HARKIN) proposed an amendment to the bill, S. 947, supra; as follows:

On page 888, between lines 22 and 23, insert the following:

''(VI) Technical assistance and related services that lead to self-employment through the microloan demonstration program under section 7(m) of the Small Business Act (15 U.S.C. 636(m))

DOMENICI AMENDMENT NO. 499

Mr. DOMENICI proposed an amendment to the bill, S. 947, supra; as follows:

Strike sections 5811 through 5814 and insert the following:

SEC. 5812. EXTENSION OF ELIGIBILITY PERIOD FOR REFUGEES AND CERTAIN OTHER QUALIFIED ALIENS FROM 5 TO 7 YEARS FOR SSI AND MEDICAID.

(a) SSI.—Section 402(a)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A)) is amended to read as follows:

''(A) TIME-LIMITED EXCEPTION FOR REFUGEES AND ASYLEES.—

''(i) SSI.—With respect to the specified Federal program described in paragraph (3)(A) paragraph 1 shall not apply to an alien until 7 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act; or

''(III) an alien's deportation is withheld under section 243(h) of such Act.

''(ii) FOOD STAMPS.—With respect to the specified Federal program described in paragraph (3)(B), paragraph 1 shall not apply to an alien until 5 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act; or

''(III) an alien's deportation is withheld under section 243(h) of such Act.''.

(b) MEDICAID.—Section 402(b)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)(A)) is amended to read as follows:

''(A) TIME-LIMITED EXCEPTION FOR REFUGEES AND ASYLEES.—

''(i) MEDICAID.—With respect to the designated Federal program described in paragraph (3)(C), paragraph 1 shall not apply to an alien until 7 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act; or

''(III) an alien's deportation is withheld under section 243(h) of such Act.

''(ii) OTHER DESIGNATED FEDERAL PROGRAMS.—With respect to the designated Federal programs under paragraph (3) (other than subparagraph (C)), paragraph 1 shall not apply to an alien until 5 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act; or

''(III) an alien's deportation is withheld under section 243(h) of such Act.''.

(c) STATUS OF CUBAN AND HAITIAN ENTRANTS.—For purposes of sections 402(a)(2)(A) and 402(b)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A), (b)(2)(A)), an alien who is a Cuban and Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980, shall be considered a refugee.

SEC. 5813. SSI ELIGIBILITY FOR PERMANENT RESIDENT ALIENS WHO ARE MEMBERS OF AN INDIAN TRIBE.

Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) (as amended by section 5811) is amended by adding at the end the following:

''(F) PERMANENT RESIDENT ALIENS WHO ARE MEMBERS OF AN INDIAN TRIBE.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to an alien who—

''(i) is lawfully admitted for permanent residence under the Immigration and Nationality Act; and

''(ii) is a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act).''.

SEC. 5814. SSI ELIGIBILITY FOR DISABLED LEGAL ALIENS IN THE UNITED STATES ON AUGUST 22, 1996.

(a) Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) (as amended by section 5813) is amended by adding at the end the following:

''(G) SSI ELIGIBILITY FOR DISABLED ALIENS.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply—

''(i) to an alien who—

''(I) is lawfully residing in any State on August 22, 1996; and

''(II) is disabled, as defined in section 1614(a)(3) of the Social Security Act (42 U.S.C. 1382c(a)(3)); or

''(i) to an alien who—

''(I) is lawfully residing in any State after such date;

''(II) is disabled (as so defined); and

''(III) as of June 1, 1997, is receiving benefits under such program.''.

(b) Funds shall be made available for not to exceed 2 years for elderly SSI recipients made ineligible for benefits after August 22, 1996.

CHAFEE (AND ROCKEFELLER) AMENDMENT NOS. 500–501

Mr. DOMENICI (for Mr. CHAFEE for himself and Mr. ROCKEFELLER) proposed two amendments to the bill, S. 947, supra; as follows:

AMENDMENT NO. 500

On page 847, beginning on line 1, strike ''and that otherwise satisfies State insurance standards and requirements.'' and insert ''that includes hearing and vision services for children, and that otherwise satisfies State insurance standards and requirements.''.

AMENDMENT NO. 501

On page 861, after line 26, add the following:

''(4) HEARING AND VISION SERVICES.—Notwithstanding the definition of FEHBP-equivalent children's health insurance coverage in section 2102(5), any package of health insurance benefits offered by a State that opts to use funds provided under this title under this section shall include hearing and vision services for children.''.

D'AMATO AMENDMENT NO. 502

Mr. ROTH (for Mr. D'AMATO) proposed an amendment to the bill, S. 947, supra; as follows:

SECTION 1. In 42 U.S.C. §1395ss(d)(3)(A)(v), insert ''(a)'' before ''For'', and after the first sentence insert:

''(b) For purposes of this subparagraph, a health insurance policy (which may be a contract with a health maintenance organization) is not considered to ''duplicate'' health benefits under this title or title XIX or under another health insurance policy if it—

(I) provides comprehensive health care benefits that replace the benefits provided by another health insurance policy,

(II) is being provided to an individual entitled to benefits under Part A or enrolled under Part B on the basis of section 226(b), and

(III) coordinates against items and services available or paid for under this title or title XIX, provided that payments under this title or title XIX shall not be treated as payments under such policy in determining annual or lifetime benefit limits.

SEC 2. In 42 U.S.C. §1395ss(d)(3)(A)(v), insert ''(c)'' before ''For purposes of this clause''.

ROCKEFELLER AMENDMENT NO. 503

Mr. LAUTENBERG (for Mr. ROCKEFELLER) proposed an amendment to the bill, S. 947, supra; as follows:

At the appropriate place in division 2 of title V, insert the following:

SEC. . EXTENSION OF SLMB PROTECTION.

(a) IN GENERAL.—Section 1902(a)(10)(E)(iii) (42 U.S.C. 1396a(a)(10)(E)(iii)) is amended by striking ''and 120 percent in 1995 and years thereafter'' and inserting '', 120 percent in 1995 through 1997, 125 percent in 1998, 130 percent in 1999, 135 percent in 2000, 140 percent in 2001, 145 percent in 2002, and 150 percent in 2003 and years thereafter''.

(b) 100 PERCENT FMAP.—Section 1905(b) (42 U.S.C. 1396d(b)) is amended by adding at the end the following: ''Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 percent with respect to amounts expended as medical assistance for medical assistance described in section 1902(a)(10)(E)(iii) for individuals described in such section whose income exceeds 120 percent of the official poverty line referred to in such section.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply on and after October 1, 1997.

KENNEDY AMENDMENT NO. 504

Mr. LAUTENBERG (for Mr. KENNEDY) proposed an amendment to the bill, S. 947, supra; as follows:

Strike section 5361 and insert the following:

SEC. 5361. ESTABLISHMENT OF POST-HOSPITAL HOME HEALTH BENEFIT UNDER PART A AND TRANSFER OF OTHER HOME HEALTH SERVICES TO PART B.

(a) IN GENERAL.—Section 1812(a)(3) (42 U.S.C. 1395D(a)(3)) is amended—

(1) by inserting ''post-hospital'' before ''home health services'', and

(2) by inserting ''for up to 100 visits'' before the semicolon.

(b) POST-HOSPITAL HOME HEALTH SERVICES.—Section 1861 (42 U.S.C. 1395x), as amended by sections 5102(a) and 5103(a), is amended by adding at the end the following:

''(qq) POST-HOSPITAL HOME HEALTH SERVICES.—The term 'post-hospital home health services' means home health services furnished to an individual under a plan of treatment established when the individual was an inpatient of a hospital or rural primary care hospital for not less than 3 consecutive days before discharge, or during a covered post-hospital extended care stay, if home health services are initiated for the individual within 30 days after discharge from the hospital, rural primary care hospital or extended care facility.''.

(c) CONFORMING AMENDMENTS.—Section 1812(b) (42 U.S.C. 1395d(b)) is amended—

(1) by striking ''or'' at the end of paragraph (2);

(2) by striking the period at the end of paragraph (3) and inserting '';or'', and

(3) by adding after paragraph (3) the following:

''(4) post-hospital home health services furnished to the individual beginning after such services have been furnished to the individual for a total of 100 visits.''.

(d) PHASE-IN OF ADDITIONAL PART B COSTS IN DETERMINATION OF PART B MONTHLY PREMIUM.—Section 1839(a) (42 U.S.C. 1395r(a)) is amended—

(1) in paragraph (3) in the sentence inserted by section 5541 of this title, by inserting ''(except as provided in paragraph (5)(B))'' before the period, and

(2) by adding after paragraph (4) the following:

''(5)(A) The Secretary shall, at the time of determining the monthly actuarial rate under paragraph (1) for 1998 through 2003, shall determine a transitional monthly actuarial rate for enrollees age 65 and over in the same manner as such rate is determined under paragraph (1), except that there shall be excluded from such determination an estimate of any benefits and administrative costs attributable to home health services for which payment would have been made under part A during the year but for paragraph (4) of section 1812(b).

''(B) The monthly premium for each individual enrolled under this part for each month for a year (beginning with 1998 and ending with 2003) shall be equal to 50 percent of the monthly actuarial rate determined under subparagraph (A) increased by the following proportion of the difference between such premium and the monthly premium otherwise determined under paragraph (3) (without regard to this paragraph):

''(i) For a month in 1998, 1/7.

''(ii) For a month in 1999, 2/7.

''(iii) For a month in 2000, 3/7.

''(iv) For a month in 2001, 4/7.

''(v) For a month in 2002, 5/7.

''(vi) For a month in 2003, 6/7.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section apply to services furnished on or after October 1, 1997.

(2) SPECIAL RULE.—If an individual is entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), but is not enrolled in the insurance program established by part B of that title, the individual also shall be entitled under part A of that title to home health services that are not post-hospital home health services (as those terms are defined under that title) furnished before the 19th month that begins after the date of enactment of this Act.

LOTT AMENDMENT NO. 505

Mr. ROTH (for Mr. LOTT) proposed an amendment to amendment No. 448 proposed by Mr. CHAFEE to the bill, S. 947, supra; as follows:

On page 1, line 6 of the amendment, strike ''means,'' and all that follows and insert the following: ''means, with respect to a State, any plan or arrangement that provides, or pays the cost of, health benefits that the Secretary has certified are equivalent to or better than the items and services covered for a child under one of the 5 plans under chapter 89 of title 5, United States Code, serving the largest number of enrolled families with children in a State, and that otherwise satisfies State insurance standards and requirements.

''(6) INDIANS.—The term 'Indians' has the meaning given that term in section 4(c) of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(7) LOW-INCOME CHILD.—The term 'low-income child' means a child in a family whose income is below 200 percent of the poverty line for a family of the size involved.

''(8) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

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

''(10) STATE.—The term 'State' means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands.

''(11) STATE CHILDREN'S HEALTH EXPENDITURES.—The term 'State children's health expenditures' means the State share of expenditures by the State for providing children with health care items and services under—

''(A) the State plan for medical assistance under title XIX;

''(B) the maternal and child health services block grant program under title V;

''(C) the preventive health services block grant program under part A of title XIX of the Public Health Services Act (42 U.S.C. 300w et seq.);

''(D) State-funded programs that are designed to provide health care items and services to children;

''(E) school-based health services programs;

''(F) State programs that provide uncompensated or indigent health care;

''(G) county-indigent care programs for which the State requires a matching share by a county government or for which there are intergovernmental transfers from a county to State government; and

''(H) any other program under which the Secretary determines the State incurs uncompensated expenditures for providing children with health care items and services.

''(12) STATE MEDICAID PROGRAM.—The term 'State medicaid program' means the program of medical assistance provided under title XIX.

''SEC. 2103. APPROPRIATION.

''(a) APPROPRIATION.—

''(1) IN GENERAL.—Subject to subsection (b), out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated for the purpose of carrying out this title—

''(A) for fiscal year 1998, $2,500,000,000;

''(B) for each of fiscal years 1999 and 2000, $3,200,000,000;

''(C) for fiscal year 2001, $3,600,000,000;

''(D) for fiscal year 2002, $3,500,000,000;

''(E) for each of fiscal years 2003 through 2007, $4,580,000,000.

''(2) AVAILABILITY.—Funds appropriated under this section shall remain available without fiscal year limitation, as provided under section 2105(b)(4).

''(b) REDUCTION FOR INCREASED MEDICAID EXPENDITURES.—With respect to each of the fiscal years described in subsection (a)(1), the amount appropriated under subsection (a)(1) for each such fiscal year shall be reduced by an amount equal to the amount of the total Federal outlays under the medicaid program under title XIX resulting from—

''(1) the amendment made by section 5732 of the Balanced Budget Act of 1997 (regarding the State option to provide 12-month continuous eligibility for children);

''(2) increased enrollment under State plans approved under such program as a result of outreach activities under section 2106(a); and

''(3) the requirement under section 2102(3)A) to provide eligibility for medical assistance under the State plan under title XIX for all children under 19 years of age who have families with income that is at or below the poverty line.

''(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided in accordance with the provisions of this title.

''(d) EFFECTIVE DATE.—No State is eligible for payments under section 2105 for any calendar quarter beginning before October 1, 1997.

''SEC. 2104. PROGRAM OUTLINE.

''(a) GENERAL DESCRIPTION.—A State shall submit to the Secretary for approval a program outline, consistent with the requirements of this title, that—

''(1) identifies, on or after the date of enactment of the Balanced Budget Act of 1997, which of the 2 options described in section 2101 the State intends to use to provide low-income children in the State with health insurance coverage;

''(2) describes the manner in which such coverage shall be provided; and

''(3) provides such other information as the Secretary may require.

''(b) OTHER REQUIREMENTS.—The program outline submitted under this section shall include the following:

''(1) ELIGIBILITY STANDARDS AND METHODOLOGIES.—A summary of the standards and methodologies used to determine the eligibility of low-income children for health insurance coverage under a State program funded under this title.

''(2) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE.—A description of the procedures to be used to ensure—

''(A) through both intake and followup screening, that only low-income children are furnished health insurance coverage through funds provided under this title; and

''(B) that any health insurance coverage provided for children through funds under this title does not reduce the number of children who are provided such coverage through any other publicly or privately funded health plan.

''(3) INDIANS.—A description of how the State will ensure that Indians are served through a State program funded under this title.

''(c) DEADLINE FOR SUBMISSION.—A State program outline shall be submitted to the Secretary by not later than March 31 of any fiscal year (October 1, 1997, in the case of fiscal year 1998).

''SEC. 2105. DISTRIBUTION OF FUNDS.

''(a) ESTABLISHMENT OF FUNDING POOLS.—

''(1) IN GENERAL.—From the amount appropriated under section 2103(a)(1) for each fiscal year, determined after the reduction required under section 2103(b), the Secretary shall, for purposes of fiscal year 1998, reserve 85 percent of such amount for distribution to eligible States through the basic allotment pool under subsection (b) and 15 percent of such amount for distribution through the new coverage incentive pool under subsection (c)(2)(B)(ii).

''(2) ANNUAL ADJUSTMENT OF RESERVE PERCENTAGES.—The Secretary shall annually adjust the amount of the percentages described in paragraph (1) in order to provide sufficient basic allotments and sufficient new coverage incentives to achieve the purpose of this title.

''(b) DISTRIBUTION OF FUNDS UNDER THE BASIC ALLOTMENT POOL.—

''(1) STATES.—

''(A) IN GENERAL.—From the total amount reserved under subsection (a) for a fiscal year for distribution through the basic allotment pool, the Secretary shall first set aside 0.25 percent for distribution under paragraph (2) and shall allot from the amount remaining to each eligible State not described in such paragraph the State's allotment percentage for such fiscal year.

''(B) STATE'S ALLOTMENT PERCENTAGE.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the allotment percentage for a fiscal year for each State is the percentage equal to the ratio of the number of low-income children in the base period in the State to the total number of low-income children in the base period in all States not described in paragraph (2).

''(ii) NUMBER OF LOW-INCOME CHILDREN IN THE BASE PERIOD.—In clause (i), the number of low-income children in the base period for a fiscal year in a State is equal to the average of the number of low-income children in the State for the period beginning on October 1, 1992, and ending on September 30, 1995, as reported in the March 1994, March 1995, and March 1996 supplements to the Current Population Survey of the Bureau of the Census.

''(2) OTHER STATES.—

''(A) IN GENERAL.—From the amount set aside under paragraph (1)(A) for each fiscal year, the Secretary shall make allotments for such fiscal year in accordance with the percentages specified in subparagraph (B) to Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands, if such States are eligible States for such fiscal year.

''(B) PERCENTAGES SPECIFIED.—The percentages specified in this subparagraph are in the case of—

''(i) Puerto Rico, 91.6 percent;

''(ii) Guam, 3.5 percent;

''(iii) the Virgin Islands, 2.6 percent;

''(iv) American Samoa, 1.2 percent; and

''(v) the Northern Mariana Islands, 1.1 percent.

''(3) THREE-YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

''(4) PROCEDURE FOR DISTRIBUTION OF UNUSED FUNDS.—The Secretary shall determine an appropriate procedure for distribution of funds to eligible States that remain unused under this subsection after the expiration of the availability of funds required under paragraph (3). Such procedure shall be developed and administered in a manner that is consistent with the purpose of this title.

''(c) PAYMENTS.—

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

''(A) before October 1 of any fiscal year, pay an eligible State an amount equal to 1 percent of the amount allotted to the State under subsection (b) for conducting the outreach activities required under section 2106(a); and

''(B) make quarterly fiscal year payments to an eligible State from the amount remaining of such allotment for such fiscal year in an amount equal to the Federal medical assistance percentage for the State (as defined under section 2102(4) and determined without regard to the amount of Federal funds received by the State under title XIX before the date of enactment of this title) of the Federal and State incurred cost of providing health insurance coverage for a low-income child in the State plus the applicable bonus amount.

''(2) APPLICABLE BONUS.—

''(A) IN GENERAL.—For purposes of paragraph (1), the applicable bonus amount is—

''(i) 5 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the base-year covered low-income child population (measured in full year equivalency) (including such children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title, but excluding any low-income child described in section 2102(3)(A) that a State must cover in order to be considered an eligible State under this title); and

''(ii) 10 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the number (as so measured) of low-income children that are in excess of such population.

''(B) SOURCE OF BONUSES.—

''(i) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—A bonus described in subparagraph (A)(i) shall be paid out of an eligible State's allotment for a fiscal year.

''(ii) FOR OTHER LOW-INCOME CHILD POPULATIONS.—A bonus described in subparagraph (A)(ii) shall be paid out of the new coverage incentive pool reserved under subsection (a)(1).

''(3) DEFINITION OF COST OF PROVIDING HEALTH INSURANCE COVERAGE.—For purposes of this subsection the cost of providing health insurance coverage for a low-income child in the State means—

''(A) in the case of an eligible State that opts to use funds provided under this title through the medicaid program, the cost of providing such child with medical assistance under the State plan under title XIX; and

''(B) in the case of an eligible State that opts to use funds provided under this title under section 2107, the cost of providing such child with health insurance coverage under such section.

''(4) LIMITATION ON TOTAL PAYMENTS.—With respect to a fiscal year, the total amount

paid to an eligible State under this title (including any bonus payments) shall not exceed 85 percent of the total cost of a State program conducted under this title for such fiscal year.

''(5) MAINTENANCE OF EFFORT.—

''(A) DEEMED COMPLIANCE.—A State shall be deemed to be in compliance with this provision if—

''(i) it does not adopt income and resource standards and methodologies that are more restrictive than those applied as of June 1, 1997, for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX; and

''(ii) in the case of fiscal year 1998 and each fiscal year thereafter, the State children's health expenditures defined in section 2102(11) are not less than the amount of such expenditures for fiscal year 1996.

''(B) FAILURE TO MAINTAIN MEDICAID STANDARDS AND METHODOLOGIES.—A State that fails to meet the conditions described in subparagraph (A) shall not receive—

''(i) funds under this title for any child that would be determined eligible for medical assistance under the State plan under title XIX using the income and resource standards and methodologies applied under such plan as of June 1, 1997; and

''(ii) any bonus amounts described in paragraph (2)(A)(ii).

''(C) FAILURE TO MAINTAIN SPENDING ON CHILD HEALTH PROGRAMS.—A State that fails to meet the condition described in subparagraph (A)(ii) shall not receive funding under this title.

''(6) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this subsection for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and shall reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

''SEC. 2106. USE OF FUNDS.

''(a) SET-ASIDE FOR OUTREACH ACTIVITIES.—

''(1) IN GENERAL.—From the amount allotted to a State under section 2105(b) for a fiscal year, each State shall conduct outreach activities described in paragraph (2).

''(2) OUTREACH ACTIVITIES DESCRIBED.—The outreach activities described in this paragraph include activities to—

''(A) identify and enroll children who are eligible for medical assistance under the State plan under title XIX; and

''(B) conduct public awareness campaigns to encourage employers to provide health insurance coverage for children.

''(b) STATE OPTIONS FOR REMAINDER.—A State may use the amount remaining of the allotment to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), in accordance with section 2107 or the State medicaid program (but not both). Nothing in the preceding sentence shall be construed as limiting a State's eligibility for receiving the 5 percent bonus described in section 2105(c)(2)(A)(i) for children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title.

''(c) PROHIBITION ON USE OF FUNDS.—No funds provided under this title may be used to provide health insurance coverage for—

''(1) families of State public employees; or

''(2) children who are committed to a penal institution.

''(d) USE LIMITED TO STATE PROGRAM EXPENDITURES.—Funds provided to an eligible State under this title shall only be used to carry out the purpose of this title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

''(e) ADMINISTRATIVE EXPENDITURES.—

''(1) IN GENERAL.—Not more than the applicable percentage of the amount allotted to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), shall be used for administrative expenditures for the program funded under this title.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage with respect to a fiscal year is—

''(A) for the first 2 years of a State program funded under this title, 10 percent;

''(B) for the third year of a State program funded under this title, 7.5 percent; and

''(C) for the fourth year of a State program funded under this title and each year thereafter, 5 percent.

''(f) NONAPPLICATION OF FIVE-YEAR LIMITED ELIGIBILITY FOR MEANS-TESTED PUBLIC BENEFITS.—The provisions of section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613) shall not apply with respect to a State program funded under this title.

''(g) AUDITS.—The provisions of section 506(b) shall apply to funds expended under this title to the same extent as they apply to title V.

''(h) REQUIREMENT TO FOLLOW STATE PROGRAM OUTLINE.—The State shall conduct the program in accordance with the program outline approved by the Secretary under section 2104.

''SEC. 2107. STATE OPTION FOR THE PURCHASE OR PROVISION OF CHILDREN'S HEALTH INSURANCE.

''(a) STATE OPTION.—

''(1) IN GENERAL.—An eligible State that opts to use funds provided under this title under this section shall use such funds to provide FEHBP-equivalent children's health insurance coverage for low-income children who reside in the State.

''(2) PRIORITY FOR LOW-INCOME CHILDREN.—A State that uses funds provided under this title under this section shall not cover low-income children with higher family income without covering such children with a lower family income.

''(3) DETERMINATION OF ELIGIBILITY AND FORM OF ASSISTANCE.—An eligible State may establish any additional eligibility criteria for the provision of health insurance coverage for a low-income child through funds provided under this title, so long as such criteria and assistance are consistent with the purpose and provisions of this title.

''(4) AFFORDABILITY.—An eligible State may impose any family premium obligations or cost-sharing requirements otherwise permitted under this title on low-income children with family incomes that exceed 150 percent of the poverty line. In the case of a low-income child whose family income is at or below 150 percent of the poverty line, limits on beneficiary costs generally applicable under title XIX apply to coverage provided such children under this section.

''(5) COVERAGE OF CERTAIN BENEFITS.—Any eligible State that opts to use funds provided under this title under this section for the coverage described in paragraph (1) is encouraged to include as part of such coverage, coverage for items and services needed for vision, hearing, and dental health.''

ROTH AMENDMENT NO. 506

Mr. ROTH proposed an amendment to the bill, S. 947, supra; as follows:

On page 568, beginning with line 9, strike all through line 25 on page 569 and insert the following:

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

(1) by striking ''and'' at the end of subclause (V);

(2) by redesignating subclause (VI) as subclause (VIII); and

(3) by inserting after subclause (V), the following subclauses:

''(VI) for fiscal years 1998 through 2001, is 0 percent;

''(VII) for fiscal year 2002, is the market basket percentage increase minus 3.0 percentage points, and''.

On page 571, strike lines 5 through 21 and insert the following:

''(F)(i) Except as provided in clause (ii), in the case of a hospital or unit that is within a class of hospital described in clause (iii), for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002, such target amount may not be greater than the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods beginning during that fiscal year (determined without regard to clause (ii)).

''(ii) In the case of a hospital or unit—

''(I) that is within a class of hospital described in clause (iii); and

''(II) whose operating costs of inpatient hospital services recognized under this title for the most recent cost reporting period for which information is available are less than the target amount for the hospital or unit under clause (i) (determined without regard to this clause) for its cost reporting period beginning on or after October 1, 1997, and before October 1, 1998,

clause (i) shall be applied for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002, by substituting for the dollar limit on the target amounts established under such clause for such period a dollar limit that is equal to the greater of 90 percent of such dollar limit or the operating costs of the hospital or unit determined under subclause (II).

''(iii) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

''(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

''(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

''(III) Hospitals described in clause (iv) of such subsection.''.

On page 571, beginning with line 23, strike all through page 572, line 7, and insert the following:

(a) CHANGE IN BONUS PAYMENT.—Section 1886(b)(1)(A) (42 U.S.C. 1395ww(b)(1)(A)) is amended by striking all that follows ''plus—'' and inserting the following:

''(i) in the case of a hospital with a target amount that is less than 135 percent of the median of the target amounts for hospitals in the same class of hospital, the lesser of 40 percent of the amount by which the target amount exceeds the amount of the operating costs or 4 percent of the target amount;

''(ii) in the case of a hospital with a target amount that equals or exceeds 135 of such median but is less than 150 percent of such median, the lesser of 30 percent of the amount by which the target amount exceeds the amount of the operating costs or 3 percent of the target amount; and

''(iii) in the case of a hospital with a target amount that equals or exceeds 150 of such median, the lesser of 20 percent of the amount by which the target amount exceeds the amount of the operating costs or 2 percent of the target amount; or''.

On page 574, line 6, strike ''130 percent'' and insert ''110 percent''.

On page 575, line 4, strike ''130 percent'' and insert ''110 percent''.

On page 575, line 23, strike ''130 percent'' and insert ''110 percent''.

On page 576, between lines 13 and 14, insert the following:

SEC. 5426A. REBASING.

Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)), as amended by section 5423, is amended by adding at the end the following:

''(G)(i) In the case of a hospital (or unit described in the matter following clause (v) of subsection (d)(1)(B)) that received payment under this subsection for inpatient hospital services furnished before January 1, 1990, that is within a class of hospital described in clause (iii), and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospital's 12-month cost reporting period beginning during fiscal year 1998 is equal to the average described in clause (ii).

''(ii) The average described in this clause for a hospital or unit shall be determined by the Secretary as follows:

''(I) The Secretary shall determine the allowable operating costs for inpatient hospital services for the hospital or unit for each of the 5 cost reporting periods for which the Secretary has the most recent settled cost reports as of the date of the enactment of this subparagraph.

''(II) The Secretary shall increase the amount determined under subclause (I) for each cost reporting period by the applicable percentage increase under subparagraph (B)(ii) for each subsequent cost reporting period up to the cost reporting period described in clause (i).

''(III) The Secretary shall identify among such 5 cost reporting periods the cost reporting periods for which the amount determined under subclause (II) is the highest, and the lowest.

''(IV) The Secretary shall compute the averages of the amounts determined under subclause (II) for the 3 cost reporting periods not identified under subclause (III).

''(iii) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

''(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

''(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

''(III) Hospitals described in clause (iii) of such subsection.

''(IV) Hospitals described in clause (iv) of such subsection.

''(V) Hospitals described in clause (v) of such subsection.''.

On page 607, between lines 20 and 21, insert the following:

(c) EXCLUSION OF CERTAIN WAGES.—In the case of a hospital that is owned by a municipality and that was reclassified as an urban hospital under section 1886(d)(10) of the Social Security Act for fiscal year 1996, in calculating the hospital's average hourly wage for purposes of geographic reclassification under such section for fiscal year 1998, the Secretary of Health and Human Services shall exclude the general service wages and hours of personnel associated with a skilled nursing facility that is owned by the hospital of the same municipality and that is physically separated from the hospital to the extent that such wages and hours of such personnel are not shared with the hospital and are separately documented. A hospital that applied for and was denied reclassification as an urban hospital for fiscal year 1998, but that would have received reclassification had the exclusion required by this section been applied to it, shall be reclassified as an urban hospital for fiscal year 1998.

Beginning on page 831, strike line 11 and all that follows through page 832, line 13 and insert the following:

SEC. 5758. STUDY AND GUIDELINES REGARDING MANAGED CARE ORGANIZATIONS AND INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS.

(a) STUDY AND RECOMMENDATIONS.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), in consultation with States, managed care organizations, the National Academy of State Health Policy, representatives of beneficiaries with special health care needs, experts in specialized health care, and others, shall conduct a study and develop the guidelines described in subsection (b). Not later than 2 years after the date of enactment of this Act, the Secretary shall report such guidelines to Congress and make recommendations for implementing legislation.

(b) GUIDELINES DESCRIBED.—The guidelines to be developed by the Secretary shall relate to issues such as risk adjustment, solvency, medical necessity definitions, case management, quality controls, adequacy of provider networks, access to specialists (including pediatric specialists and the use of specialists as primary care providers), marketing, compliance with the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), speedy grievance and appeals procedures, data collection, and such other matters as the Secretary may determine, as these issues affect care provided to individuals with special health care needs and chronic conditions in capitated managed care or primary care case management plans. The Secretary shall distinguish which guidelines should apply to primary care case management arrangements, to capitated risk sharing arrangements, or to both. Such guidelines should be designed to be used in reviewing State proposals under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (by waiver request or State plan amendment) to implement mandatory capitated managed care or primary care case management arrangements that enroll beneficiaries with chronic conditions or special health care needs.

On page 843, between lines 10 and 11, insert the following:

SEC. 5766A. WAIVER OF CERTAIN PROVIDER TAX PROVISIONS.

Notwithstanding any other provision of law, taxes, fees, or assessments, as defined in section 1903(w)(3)(A) of the Social Security Act (42 U.S.C. 1396b(w)(3)(A)), that were collected by the State of New York from a health care provider before June 1, 1997, and for which a waiver of the provisions of subparagraph (B) or (C) of section 1903(w)(3) of such Act has been applied for, or that would, but for this paragraph require that such a waiver be applied for, in accordance with subparagraph (E) of such section, and, (if so applied for) upon which action by the Secretary of Health and Human Services (including any judicial review of any such proceeding) has not been completed as of the date of enactment of this Act, are deemed to be permissible health care related taxes and in compliance with the requirements of subparagraphs (B) and (C) of sections 1903(w)(3) of such Act.

SEC. 5766B. CONTINUATION OF STATE-WIDE SECTION 1115 MEDICAID WAIVERS.

(a) IN GENERAL.—Section 1115 of the Social Security Act (42 U.S.C. 1315) is amended by adding at the end the following:

''(d)(1) The provisions of this subsection shall apply to the extension of statewide comprehensive research and demonstration projects (in this subsection referred to as 'waiver project') for which waivers of compliance with the requirements of title XIX are granted under subsection (a). With respect to a waiver project that, but for the enactment of this subsection, would expire, the State at its option may not later than 1 year before the waiver under subsection (a) would expire (acting through the chief executive officer of the State who is operating the project), submit to the Secretary a written request for an extension of such waiver project for up to 2 years.

''(2) The requirements of this paragraph are that the waiver project—

''(A) has been successfully operated for 5 or more years; and

''(B) has been shown, through independent evaluations sponsored by the Health Care Financing Administration, to successfully contain costs and provide access to health care.

''(3)(A) In the case of waiver projects described in paragraph (1)(A), if the Secretary fails to respond to the request within 6 months after the date on which the request was submitted, the request is deemed to have been granted.

''(B) If the request is granted or deemed to have been granted, the deadline for submittal of a final report shall be 1 year after the date on which the waiver project would have expired but for the enactment of this subsection.

''(C) The Secretary shall release an evaluation of each such project not later than 1 year after the date of receipt of the final report.

''(D) Phase-down provisions which were applicable to waiver projects before an extension was provided under this subsection shall not apply.

''(4) The extension of a waiver project under this subsection shall be on the same terms and conditions (including applicable terms and conditions related to quality and access of services, budget neutrality as adjusted for inflation, data and reporting requirements and special population protections), except for any phase down provisions, and subject to the same set of waivers that applied to the project or were granted before the extension of the project under this subsection. The permanent continuation of a waiver project shall be on the same terms and conditions, including financing, and subject to the same set of waivers. No test of budget neutrality shall be applied in the case of projects described in paragraph (2) after that date on which the permanent extension was granted.

''(5) In the case of a waiver project described in paragraph (2), the Secretary, acting through the Health Care Financing Administration shall, deem any State's request to expand medicaid coverage in whole or in part to individuals who have an income at or below the Federal poverty level as budget neutral if independent evaluations sponsored by the Health Care Financing Administration have shown that the State's medicaid managed care program under such original waiver is more cost effective and efficient than the traditional fee-for-service medicaid program that, in the absence of any managed care waivers under this section, would have been provided in the State.''.

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

Beginning on page 869, strike line 21 and all that follows through page 870, line 15 and insert the following:

SEC. 5813. EXCEPTIONS FOR CERTAIN INDIANS FROM LIMITATION ON ELIGIBILITY FOR SUPPLEMENTAL SECURITY INCOME AND MEDICAID BENEFITS.

(a) EXCEPTION FROM LIMITATION ON SSI ELIGIBILITY.—Section 402(a)(2) of the Personal

Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended—

(1) by redesignating subparagraph (D) and subparagraph (E); and

(2) by inserting after subparagraph (C) the following:

''(D) SSI EXCEPTION FOR CERTAIN INDIANS.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to any individual—

''(i) who is an American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (8 U.S.C. 1358) apply; or

''(ii) who is a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)).''.

(b) EXCEPTION FROM LIMITATION ON MEDICAID ELIGIBILITY.—Section 402(b)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended—

(1) by redesignating subparagraph (D) and subparagraph (E); and

(2) by inserting after subparagraph (C) the following:

''(D) MEDICAID EXCEPTION FOR CERTAIN INDIANS.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the medicaid program), paragraph (1) shall not apply to any individual described in subsection (a)(2)(D).''.

(c) SSI AND MEDICAID EXCEPTIONS FROM LIMITATION ON ELIGIBILITY OF NEW ENTRANTS.—Section 403(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613(b)) is amended by adding at the end the following:

''(3) SSI AND MEDICAID EXCEPTION FOR CERTAIN INDIANS.—An individual described in section 402(a)(2)(D), but only with respect to the programs specified in subsections (a)(3)(A) and (b)(3)(C) of section 402.''.

(d) EFFECTIVE DATE.—

(1) SECTION 402.—The amendments made by subsections (a) and (b) shall take effect as though they had been included in the enactment of section 402 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(2) SECTION 403.—The amendment made by subsection (c) shall take effect as though they had been included in the enactment of section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

On page 876, line 21, strike ''subparagraph (C)(i)'' and insert ''clauses (i) and (ii) of subparagraph (C)''.

On page 877, beginning on line 11, strike ''at least'' and all that follows through the period and insert the following: ''the applicable percentage for the immediately preceding fiscal year, as defined by section 409(a)(7)(B)(ii).''.

On page 888, between lines 22 and 23, insert the following flush language:

Contracts or vouchers for job placement services supported by these funds must require that at least ½ of the payment occur after a eligible individual placed into the workforce has been in the workforce for 6 months.

LOTT AMENDMENT NO. 507

Mr. ROTH (for Mr. LOTT) proposed an amendment to amendment No. 501 proposed by Mr. CHAFEE to the bill, S. 947, supra; as follows:

In the pending amendment, No. 501, strike all after the first word and insert the following:

Subtitle J—Children's Health Insurance Initiatives

SEC. 5801. ESTABLISHMENT OF CHILDREN'S HEALTH INSURANCE INITIATIVES.

(a) IN GENERAL.—Notwithstanding any other provision of the Act, the Social Security Act is amended by adding at the end the following:

''TITLE XXI—CHILD HEALTH INSURANCE INITIATIVES

''SEC. 2101. PURPOSE.

The purpose of this title is to provide funds to States to enable such States to expand the provision of health insurance coverage for low-income children. Funds provided under this title shall be used to achieve this purpose through outreach activities described in section 2106(a) and, at the option of the State through—

''(1) a grant program conducted in accordance with section 2107 and the other requirements of this title; or

''(2) expansion of coverage of such children under the State medicaid program who are not required to be provided medical assistance under section 1902(l) (taking into account the process of individuals aging into eligibility under subsection (l)(1)(D)).

''SEC. 2102. DEFINITIONS.

In this title:

''(1) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—The term 'base-year covered low-income child population' means the total number of low-income children with respect to whom, as of fiscal year 1996, an eligible State provides or pays the cost of health benefits either through a State funded program or through expanded eligibility under the State plan under title XIX (including under a waiver of such plan), as determined by the Secretary. Such term does not include any low-income child described in paragraph (3)(A) that a State must cover in order to be considered an eligible State under this title.

''(2) CHILD.—The term 'child' means an individual under 19 years of age.

''(3) ELIGIBLE STATE.—The term 'eligible State' means, with respect to a fiscal year, a State that—

''(A) provides, under section 1902(l)(1)(D) or under a waiver, for eligibility for medical assistance under a State plan under title XIX of individuals under 17 years of age in fiscal year 1998, and under 19 years of age in fiscal year 2000, regardless of date of birth;

''(B) has submitted to the Secretary under section 2104 a program outline that—

''(i) sets forth how the State intends to use the funds provided under this title to provide health insurance coverage for low-income children consistent with the provisions of this title; and

''(ii) is approved under section 2104; and

''(iii) otherwise satisfies the requirements of this title; and

''(C) satisfies the maintenance of effort requirement described in section 2105(c)(5).''.

''(4) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' means, with respect to a State, the meaning given that term under section 1905(b). Any cost-sharing imposed under this title may not be included in determining Federal medical assistance percentage for reimbursement of expenditures under a State program funded under this title.

''(5) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The term 'FEHBP-equivalent children's health insurance coverage' means, with respect to a State, any plan or arrangement that provides, or pays the cost of, health benefits that the Secretary has certified are equivalent to or better than the items and services covered for a child under one of the 5 plans under chapter 89 of title 5, United States Code, serving the largest number of enrolled families with children in a State, and that otherwise satisfies State insurance standards and requirements.

''(6) INDIANS.—The term 'Indians' has the meaning given that term in section 4(c) of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(7) LOW-INCOME CHILD.—The term 'low-income child' means a child in a family whose income is below 200 percent of the poverty line for a family of the size involved.

''(8) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

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

''(10) STATE.—The term 'State' means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands.

''(11) STATE CHILDREN'S HEALTH EXPENDITURES.—The term 'State children's health expenditures' means the State share of expenditures by the State for providing children with health care items and services under—

''(A) the State plan for medical assistance under title XIX;

''(B) the maternal and child health services block grant program under title V;

''(C) the preventive health services block grant program under part A of title XIX of the Public Health Services Act (42 U.S.C. 300w et seq.);

''(D) State-funded programs that are designed to provide health care items and services to children;

''(E) school-based health services programs;

''(F) State programs that provide uncompensated or indigent health care;

''(G) county-indigent care programs for which the State requires a matching share by a county government or for which there are intergovernmental transfers from a county to State government; and

''(H) any other program under which the Secretary determines the State incurs uncompensated expenditures for providing children with health care items and services.

''(12) STATE MEDICAID PROGRAM.—The term 'State medicaid program' means the program of medical assistance provided under title XIX.

''SEC. 2103. APPROPRIATION.

''(a) APPROPRIATION.—

''(1) IN GENERAL.—Subject to subsection (b), out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated for the purpose of carrying out this title—

''(A) for fiscal year 1998, $2,500,000,000;

''(B) for each of fiscal years 1999 and 2000, $3,200,000,000;

''(C) for fiscal year 2001, $3,600,000,000;

''(D) for fiscal year 2002, $3,500,000,000;

''(E) for each of fiscal years 2003 through 2007, $4,580,000,000.

''(2) AVAILABILITY.—Funds appropriated under this section shall remain available without fiscal year limitation, as provided under section 2105(b)(4).

''(b) REDUCTION FOR INCREASED MEDICAID EXPENDITURES.—With respect to each of the fiscal years described in subsection (a)(1), the amount appropriated under subsection (a)(1) for each such fiscal year shall be reduced by an amount equal to the amount of the total Federal outlays under the medicaid program under title XIX resulting from—

''(1) the amendment made by section 5732 of the Balanced Budget Act of 1997 (regarding the State option to provide 12-month continuous eligibility for children);

''(2) increased enrollment under State plans approved under such program as a result of outreach activities under section 2106(a); and

''(3) the requirement under section 2102(3)A) to provide eligibility for medical assistance under the State plan under title XIX for all children under 19 years of age who have families with income that is at or below the poverty line.

''(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided in accordance with the provisions of this title.

''(d) EFFECTIVE DATE.—No State is eligible for payments under section 2105 for any calendar quarter beginning before October 1, 1997.

''SEC. 2104. PROGRAM OUTLINE.

''(a) GENERAL DESCRIPTION.—A State shall submit to the Secretary for approval a program outline, consistent with the requirements of this title, that—

''(1) identifies, on or after the date of enactment of the Balanced Budget Act of 1997, which of the 2 options described in section 2101 the State intends to use to provide low-income children in the State with health insurance coverage;

''(2) describes the manner in which such coverage shall be provided; and

''(3) provides such other information as the Secretary may require.

''(b) OTHER REQUIREMENTS.—The program outline submitted under this section shall include the following:

''(1) ELIGIBILITY STANDARDS AND METHODOLOGIES.—A summary of the standards and methodologies used to determine the eligibility of low-income children for health insurance coverage under a State program funded under this title.

''(2) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE.—A description of the procedures to be used to ensure—

''(A) through both intake and followup screening, that only low-income children are furnished health insurance coverage through funds provided under this title; and

''(B) that any health insurance coverage provided for children through funds under this title does not reduce the number of children who are provided such coverage through any other publicly or privately funded health plan.

''(3) INDIANS.—A description of how the State will ensure that Indians are served through a State program funded under this title.

''(c) DEADLINE FOR SUBMISSION.—A State program outline shall be submitted to the Secretary by not later than March 31 of any fiscal year (October 1, 1997, in the case of fiscal year 1998).

''SEC. 2105. DISTRIBUTION OF FUNDS.

''(a) ESTABLISHMENT OF FUNDING POOLS.—

''(1) IN GENERAL.—From the amount appropriated under section 2103(a)(1) for each fiscal year, determined after the reduction required under section 2103(b), the Secretary shall, for purposes of fiscal year 1998, reserve 85 percent of such amount for distribution to eligible States through the basic allotment pool under subsection (b) and 15 percent of such amount for distribution through the new coverage incentive pool under subsection (c)(2)(B)(ii).

''(2) ANNUAL ADJUSTMENT OF RESERVE PERCENTAGES.—The Secretary shall annually adjust the amount of the percentages described in paragraph (1) in order to provide sufficient basic allotments and sufficient new coverage incentives to achieve the purpose of this title.

''(b) DISTRIBUTION OF FUNDS UNDER THE BASIC ALLOTMENT POOL.—

''(1) STATES.—

''(A) IN GENERAL.—From the total amount reserved under subsection (a) for a fiscal year for distribution through the basic allotment pool, the Secretary shall first set aside 0.25 percent for distribution under paragraph (2) and shall allot from the amount remaining to each eligible State not described in such paragraph the State's allotment percentage for such fiscal year.

''(B) STATE'S ALLOTMENT PERCENTAGE.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the allotment percentage for a fiscal year for each State is the percentage equal to the ratio of the number of low-income children in the base period in the State to the total number of low-income children in the base period in all States not described in paragraph (2).

''(ii) NUMBER OF LOW-INCOME CHILDREN IN THE BASE PERIOD.—In clause (i), the number of low-income children in the base period for a fiscal year in a State is equal to the average of the number of low-income children in the State for the period beginning on October 1, 1992, and ending on September 30, 1995, as reported in the March 1994, March 1995, and March 1996 supplements to the Current Population Survey of the Bureau of the Census.

''(2) OTHER STATES.—

''(A) IN GENERAL.—From the amount set aside under paragraph (1)(A) for each fiscal year, the Secretary shall make allotments for such fiscal year in accordance with the percentages specified in subparagraph (B) to Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands, if such States are eligible States for such fiscal year.

''(B) PERCENTAGES SPECIFIED.—The percentages specified in this subparagraph are in the case of—

''(i) Puerto Rico, 91.6 percent;

''(ii) Guam, 3.5 percent;

''(iii) the Virgin Islands, 2.6 percent;

''(iv) American Samoa, 1.2 percent; and

''(v) the Northern Mariana Islands, 1.1 percent.

''(3) THREE-YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

''(4) PROCEDURE FOR DISTRIBUTION OF UNUSED FUNDS.—The Secretary shall determine an appropriate procedure for distribution of funds to eligible States that remain unused under this subsection after the expiration of the availability of funds required under paragraph (3). Such procedure shall be developed and administered in a manner that is consistent with the purpose of this title.

''(c) PAYMENTS.—

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

''(A) before October 1 of any fiscal year, pay an eligible State an amount equal to 1 percent of the amount allotted to the State under subsection (b) for conducting the outreach activities required under section 2106(a); and

''(B) make quarterly fiscal year payments to an eligible State from the amount remaining of such allotment for such fiscal year in an amount equal to the Federal medical assistance percentage for the State (as defined under section 2102(4) and determined without regard to the amount of Federal funds received by the State under title XIX before the date of enactment of this title) of the Federal and State incurred cost of providing health insurance coverage for a low-income child in the State plus the applicable bonus amount.

''(2) APPLICABLE BONUS.—

''(A) IN GENERAL.—For purposes of paragraph (1), the applicable bonus amount is—

''(i) 5 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the base-year covered low-income child population (measured in full year equivalency) (including such children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title, but excluding any low-income child described in section 2102(3)(A) that a State must cover in order to be considered an eligible State under this title); and

''(ii) 10 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the number (as so measured) of low-income children that are in excess of such population.

''(B) SOURCE OF BONUSES.—

''(i) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—A bonus described in subparagraph (A)(i) shall be paid out of an eligible State's allotment for a fiscal year.

''(ii) FOR OTHER LOW-INCOME CHILD POPULATIONS.—A bonus described in subparagraph (A)(ii) shall be paid out of the new coverage incentive pool reserved under subsection (a)(1).

''(3) DEFINITION OF COST OF PROVIDING HEALTH INSURANCE COVERAGE.—For purposes of this subsection the cost of providing health insurance coverage for a low-income child in the State means—

''(A) in the case of an eligible State that opts to use funds provided under this title through the medicaid program, the cost of providing such child with medical assistance under the State plan under title XIX; and

''(B) in the case of an eligible State that opts to use funds provided under this title under section 2107, the cost of providing such child with health insurance coverage under such section.

''(4) LIMITATION ON TOTAL PAYMENTS.—With respect to a fiscal year, the total amount paid to an eligible State under this title (including any bonus payments) shall not exceed 85 percent of the total cost of a State program conducted under this title for such fiscal year.

''(5) MAINTENANCE OF EFFORT.—

''(A) DEEMED COMPLIANCE.—A State shall be deemed to be in compliance with this provision if—

''(i) it does not adopt income and resource standards and methodologies that are more restrictive than those applied as of June 1, 1997, for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX; and

''(ii) in the case of fiscal year 1998 and each fiscal year thereafter, the State children's health expenditures defined in section 2102(11) are not less than the amount of such expenditures for fiscal year 1996.

''(B) FAILURE TO MAINTAIN MEDICAID STANDARDS AND METHODOLOGIES.—A State that fails to meet the conditions described in subparagraph (A) shall not receive—

''(i) funds under this title for any child that would be determined eligible for medical assistance under the State plan under title XIX using the income and resource standards and methodologies applied under such plan as of June 1, 1997; and

''(ii) any bonus amounts described in paragraph (2)(A)(ii).

''(C) FAILURE TO MAINTAIN SPENDING ON CHILD HEALTH PROGRAMS.—A State that fails to meet the condition described in subparagraph (A)(ii) shall not receive funding under this title.

''(6) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this subsection for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and shall reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

''SEC. 2106. USE OF FUNDS.

''(a) SET-ASIDE FOR OUTREACH ACTIVITIES.—

''(1) IN GENERAL.—From the amount allotted to a State under section 2105(b) for a fiscal year, each State shall conduct outreach activities described in paragraph (2).

''(2) OUTREACH ACTIVITIES DESCRIBED.—The outreach activities described in this paragraph include activities to—

''(A) identify and enroll children who are eligible for medical assistance under the State plan under title XIX; and

''(B) conduct public awareness campaigns to encourage employers to provide health insurance coverage for children.

''(b) STATE OPTIONS FOR REMAINDER.—A State may use the amount remaining of the allotment to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), in accordance with section 2107 or the State medicaid program (but not both). Nothing in the preceding sentence shall be construed as limiting a State's eligibility for receiving the 5 percent bonus described in section 2105(c)(2)(A)(i) for children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title.

''(c) PROHIBITION ON USE OF FUNDS.—No funds provided under this title may be used to provide health insurance coverage for—

''(1) families of State public employees; or

''(2) children who are committed to a penal institution.

''(d) USE LIMITED TO STATE PROGRAM EXPENDITURES.—Funds provided to an eligible State under this title shall only be used to carry out the purpose of this title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

''(e) ADMINISTRATIVE EXPENDITURES.—

''(1) IN GENERAL.—Not more than the applicable percentage of the amount allotted to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), shall be used for administrative expenditures for the program funded under this title.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage with respect to a fiscal year is—

''(A) for the first 2 years of a State program funded under this title, 10 percent;

''(B) for the third year of a State program funded under this title, 7.5 percent; and

''(C) for the fourth year of a State program funded under this title and each year thereafter, 5 percent.

''(f) NONAPPLICATION OF FIVE-YEAR LIMITED ELIGIBILITY FOR MEANS-TESTED PUBLIC BENEFITS.—The provisions of section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613) shall not apply with respect to a State program funded under this title.

''(g) AUDITS.—The provisions of section 506(b) shall apply to funds expended under this title to the same extent as they apply to title V.

''(h) REQUIREMENT TO FOLLOW STATE PROGRAM OUTLINE.—The State shall conduct the program in accordance with the program outline approved by the Secretary under section 2104.

''SEC. 2107. STATE OPTION FOR THE PURCHASE OR PROVISION OF CHILDREN'S HEALTH INSURANCE.

''(a) STATE OPTION.—

''(1) IN GENERAL.—An eligible State that opts to use funds provided under this title under this section shall use such funds to provide FEHBP-equivalent children's health insurance coverage for low-income children who reside in the State.

''(2) PRIORITY FOR LOW-INCOME CHILDREN.—A State that uses funds provided under this title under this section shall not cover low-income children with higher family income without covering such children with a lower family income.

''(3) DETERMINATION OF ELIGIBILITY AND FORM OF ASSISTANCE.—An eligible State may establish any additional eligibility criteria for the provision of health insurance coverage for a low-income child through funds provided under this title, so long as such criteria and assistance are consistent with the purpose and provisions of this title.

''(4) AFFORDABILITY.—An eligible State may impose any family premium obligations or cost-sharing requirements otherwise permitted under this title on low-income children with family incomes that exceed 150 percent of the poverty line. In the case of a low-income child whose family income is at or below 150 percent of the poverty line, limits on beneficiary costs generally applicable under title XIX apply to coverage provided such children under this section.

''(5) COVERAGE OF CERTAIN BENEFITS.—Any eligible State that opts to use funds provided under this title under this section for the coverage described in paragraph (1) is encouraged to include as part of such coverage, coverage for items and services needed for vision, hearing, and dental health.

''(b) NONENTITLEMENT.—Nothing in this section shall be construed as providing an entitlement for an individual or person to any health insurance coverage, assistance, or service provided through a State program funded under this title. If, with respect to a fiscal year, an eligible State determines that the funds provided under this title are not sufficient to provide health insurance coverage for all the low-income children that the State proposes to cover in the State program outline submitted under section 2104 for such fiscal year, the State may adjust the applicable eligibility criteria for such children appropriately or adjust the State program in another manner specified by the Secretary, so long as any such adjustments are consistent with the purpose of this title.

''SEC. 2108. PROGRAM INTEGRITY.

''The following provisions of the Social Security Act shall apply to eligible States under this title in the same manner as such provisions apply to a State under title XIX:

''(1) Section 1116 (relating to administrative and judicial review).

''(2) Section 1124 (relating to disclosure of ownership and related information).

''(3) Section 1126 (relating to disclosure of information about certain convicted individuals).

''(4) Section 1128 (relating to exclusion from individuals and entities from participation in State health care plans).

''(5) Section 1128A (relating to civil monetary penalties).

''(6) Section 1128B (relating to criminal penalties).

''(7) Section 1132 (relating to periods within which claims must be filed).

''(8) Section 1902(a)(4)(C) (relating to conflict of interest standards).

''(9) Section 1903(i) (relating to limitations on payment).

''(10) Section 1903(m)(5) (as in effect on the day before the date of enactment of the Balanced Budget Act of 1997).

''(11) Section 1903(w) (relating to limitations on provider taxes and donations).

''(12) Section 1905(a)(B) (relating to the exclusion of care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases from the definition of medical assistance).

''(13) Section 1921 (relating to state licensure authorities).

''(14) Sections 1902(a)(25), 1912(a)(1)(A), and 1903(o) (insofar as such sections relate to third party liability).

''(15) Sections 1948 and 1949 (as added by section 5701(a)(2) of the Balanced Budget Act of 1997).

''SEC. 2109. ANNUAL REPORTS.

''(a) ANNUAL STATE ASSESSMENT OF PROGRESS.—An eligible State shall—

''(1) assess the operation of the State program funded under this title in each fiscal year, including the progress made in providing health insurance coverage for low-income children; and

''(2) report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

''(b) REPORT OF THE SECRETARY.—The Secretary shall submit to the appropriate committees of Congress an annual report and evaluation of the State programs funded under this title based on the State assessments and reports submitted under subsection (a). Such report shall include any conclusions and recommendations that the Secretary considers appropriate.''.

(b) CONFORMING AMENDMENT.—Section 1128(h) (42 U.S.C. 1320a–7(h)) is amended by—

(1) in paragraph (2), by striking ''or'' at the end;

(2) in paragraph (3), by striking the period and inserting '', or''; and

(3) by adding at the end the following:

''(4) a program funded under title XXI.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply on and after October 3, 1997.

LOTT AMENDMENT NO. 508

Mr. ROTH (for Mr. LOTT) proposed an amendment to amendment No. 500 proposed by Mr. CHAFEE to the bill, S. 947, supra; as follows:

In the pending amendment, No. 500, strike all after the first word and insert the following:

Subtitle J—Children's Health Insurance Initiatives

SEC. 5801. ESTABLISHMENT OF CHILDREN'S HEALTH INSURANCE INITIATIVES.

(a) IN GENERAL.—Notwithstanding any other provision of the Act, the Social Security Act is amended by adding at the end the following:

''TITLE XXI—CHILD HEALTH INSURANCE INITIATIVES

''SEC. 2101. PURPOSE.

The purpose of this title is to provide funds to States to enable such States to expand the provision of health insurance coverage for low-income children. Funds provided under this title shall be used to achieve this purpose through outreach activities described in section 2106(a) and, at the option of the State through—

''(1) a grant program conducted in accordance with section 2107 and the other requirements of this title; or

''(2) expansion of coverage of such children under the State medicaid program who are not required to be provided medical assistance under section 1902(l) (taking into account the process of individuals aging into eligibility under subsection (l)(1)(D)).

''SEC. 2102. DEFINITIONS.

In this title:

''(1) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—The term 'base-year covered low-income child population' means the total number of low-income children with respect to whom, as of fiscal year 1996, an eligible State provides or pays the cost of health benefits either through a State funded program or through expanded eligibility under the State plan under title XIX (including under a waiver of such plan), as determined by the Secretary. Such term does not include any low-income child described in paragraph (3)(A) that a State must cover in order to be considered an eligible State under this title.

''(2) CHILD.—The term 'child' means an individual under 19 years of age.

''(3) ELIGIBLE STATE.—The term 'eligible State' means, with respect to a fiscal year, a State that—

''(A) provides, under section 1902(l)(1)(D) or under a waiver, for eligibility for medical assistance under a State plan under title XIX of individuals under 17 years of age in fiscal year 1998, and under 19 years of age in fiscal year 2000, regardless of date of birth;

''(B) has submitted to the Secretary under section 2104 a program outline that—

''(i) sets forth how the State intends to use the funds provided under this title to provide health insurance coverage for low-income children consistent with the provisions of this title; and

''(ii) is approved under section 2104; and

''(iii) otherwise satisfies the requirements of this title; and

''(C) satisfies the maintenance of effort requirement described in section 2105(c)(5).''.

''(4) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' means, with respect to a State, the meaning given that term under section 1905(b). Any cost-sharing imposed under this title may not be included in determining Federal medical assistance percentage for reimbursement of expenditures under a State program funded under this title.

''(5) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The term 'FEHBP-equivalent children's health insurance coverage' means, with respect to a State, any plan or arrangement that provides, or pays the cost of, health benefits that the Secretary has certified are equivalent to or better than the items and services covered for a child under one of the 5 plans under chapter 89 of title 5, United States Code, serving the largest number of enrolled families with children in a State, and that otherwise satisfies State insurance standards and requirements.

''(6) INDIANS.—The term 'Indians' has the meaning given that term in section 4(c) of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(7) LOW-INCOME CHILD.—The term 'low-income child' means a child in a family whose income is below 200 percent of the poverty line for a family of the size involved.

''(8) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

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

''(10) STATE.—The term 'State' means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands.

''(11) STATE CHILDREN'S HEALTH EXPENDITURES.—The term 'State children's health expenditures' means the State share of expenditures by the State for providing children with health care items and services under—

''(A) the State plan for medical assistance under title XIX;

''(B) the maternal and child health services block grant program under title V;

''(C) the preventive health services block grant program under part A of title XIX of the Public Health Services Act (42 U.S.C. 300w et seq.);

''(D) State-funded programs that are designed to provide health care items and services to children;

''(E) school-based health services programs;

''(F) State programs that provide uncompensated or indigent health care;

''(G) county-indigent care programs for which the State requires a matching share by a county government or for which there are intergovernmental transfers from a county to State government; and

''(H) any other program under which the Secretary determines the State incurs uncompensated expenditures for providing children with health care items and services.

''(12) STATE MEDICAID PROGRAM.—The term 'State medicaid program' means the program of medical assistance provided under title XIX.

''SEC. 2103. APPROPRIATION.

''(a) APPROPRIATION.—

''(1) IN GENERAL.—Subject to subsection (b), out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated for the purpose of carrying out this title—

''(A) for fiscal year 1998, $2,500,000,000;

''(B) for each of fiscal years 1999 and 2000, $3,200,000,000;

''(C) for fiscal year 2001, $3,600,000,000;

''(D) for fiscal year 2002, $3,500,000,000;

''(E) for each of fiscal years 2003 through 2007, $4,580,000,000.

''(2) AVAILABILITY.—Funds appropriated under this section shall remain available without fiscal year limitation, as provided under section 2105(b)(4).

''(b) REDUCTION FOR INCREASED MEDICAID EXPENDITURES.—With respect to each of the fiscal years described in subsection (a)(1), the amount appropriated under subsection (a)(1) for each such fiscal year shall be reduced by an amount equal to the amount of the total Federal outlays under the medicaid program under title XIX resulting from—

''(1) the amendment made by section 5732 of the Balanced Budget Act of 1997 (regarding the State option to provide 12-month continuous eligibility for children);

''(2) increased enrollment under State plans approved under such program as a result of outreach activities under section 2106(a); and

''(3) the requirement under section 2102(3)A) to provide eligibility for medical assistance under the State plan under title XIX for all children under 19 years of age who have families with income that is at or below the poverty line.

''(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided in accordance with the provisions of this title.

''(d) EFFECTIVE DATE.—No State is eligible for payments under section 2105 for any calendar quarter beginning before October 1, 1997.

''SEC. 2104. PROGRAM OUTLINE.

''(a) GENERAL DESCRIPTION.—A State shall submit to the Secretary for approval a program outline, consistent with the requirements of this title, that—

''(1) identifies, on or after the date of enactment of the Balanced Budget Act of 1997, which of the 2 options described in section 2101 the State intends to use to provide low-income children in the State with health insurance coverage;

''(2) describes the manner in which such coverage shall be provided; and

''(3) provides such other information as the Secretary may require.

''(b) OTHER REQUIREMENTS.—The program outline submitted under this section shall include the following:

''(1) ELIGIBILITY STANDARDS AND METHODOLOGIES.—A summary of the standards and methodologies used to determine the eligibility of low-income children for health insurance coverage under a State program funded under this title.

''(2) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE.—A description of the procedures to be used to ensure—

''(A) through both intake and followup screening, that only low-income children are furnished health insurance coverage through funds provided under this title; and

''(B) that any health insurance coverage provided for children through funds under this title does not reduce the number of children who are provided such coverage through any other publicly or privately funded health plan.

''(3) INDIANS.—A description of how the State will ensure that Indians are served through a State program funded under this title.

''(c) DEADLINE FOR SUBMISSION.—A State program outline shall be submitted to the Secretary by not later than March 31 of any fiscal year (October 1, 1997, in the case of fiscal year 1998).

''SEC. 2105. DISTRIBUTION OF FUNDS.

''(a) ESTABLISHMENT OF FUNDING POOLS.—

''(1) IN GENERAL.—From the amount appropriated under section 2103(a)(1) for each fiscal year, determined after the reduction required under section 2103(b), the Secretary shall, for purposes of fiscal year 1998, reserve 85 percent of such amount for distribution to eligible States through the basic allotment pool under subsection (b) and 15 percent of such amount for distribution through the new coverage incentive pool under subsection (c)(2)(B)(ii).

''(2) ANNUAL ADJUSTMENT OF RESERVE PERCENTAGES.—The Secretary shall annually adjust the amount of the percentages described in paragraph (1) in order to provide sufficient basic allotments and sufficient new coverage incentives to achieve the purpose of this title.

''(b) DISTRIBUTION OF FUNDS UNDER THE BASIC ALLOTMENT POOL.—

''(1) STATES.—

''(A) IN GENERAL.—From the total amount reserved under subsection (a) for a fiscal year for distribution through the basic allotment pool, the Secretary shall first set aside 0.25 percent for distribution under paragraph (2) and shall allot from the amount remaining to each eligible State not described in such paragraph the State's allotment percentage for such fiscal year.

''(B) STATE'S ALLOTMENT PERCENTAGE.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the allotment percentage for a fiscal year for each State is the percentage equal to the ratio of the number of low-income children in the base period in the State to the total number of low-income children in the base period in all States not described in paragraph (2).

''(ii) NUMBER OF LOW-INCOME CHILDREN IN THE BASE PERIOD.—In clause (i), the number of low-income children in the base period for a fiscal year in a State is equal to the average of the number of low-income children in the State for the period beginning on October 1, 1992, and ending on September 30, 1995, as reported in the March 1994, March 1995,

and March 1996 supplements to the Current Population Survey of the Bureau of the Census.

''(2) OTHER STATES.—

''(A) IN GENERAL.—From the amount set aside under paragraph (1)(A) for each fiscal year, the Secretary shall make allotments for such fiscal year in accordance with the percentages specified in subparagraph (B) to Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands, if such States are eligible States for such fiscal year.

''(B) PERCENTAGES SPECIFIED.—The percentages specified in this subparagraph are in the case of—

''(i) Puerto Rico, 91.6 percent;

''(ii) Guam, 3.5 percent;

''(iii) the Virgin Islands, 2.6 percent;

''(iv) American Samoa, 1.2 percent; and

''(v) the Northern Mariana Islands, 1.1 percent.

''(3) THREE-YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

''(4) PROCEDURE FOR DISTRIBUTION OF UNUSED FUNDS.—The Secretary shall determine an appropriate procedure for distribution of funds to eligible States that remain unused under this subsection after the expiration of the availability of funds required under paragraph (3). Such procedure shall be developed and administered in a manner that is consistent with the purpose of this title.

''(c) PAYMENTS.—

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

''(A) before October 1 of any fiscal year, pay an eligible State an amount equal to 1 percent of the amount allotted to the State under subsection (b) for conducting the outreach activities required under section 2106(a); and

''(B) make quarterly fiscal year payments to an eligible State from the amount remaining of such allotment for such fiscal year in an amount equal to the Federal medical assistance percentage for the State (as defined under section 2102(4) and determined without regard to the amount of Federal funds received by the State under title XIX before the date of enactment of this title) of the Federal and State incurred cost of providing health insurance coverage for a low-income child in the State plus the applicable bonus amount.

''(2) APPLICABLE BONUS.—

''(A) IN GENERAL.—For purposes of paragraph (1), the applicable bonus amount is—

''(i) 5 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the base-year covered low-income child population (measured in full year equivalency) (including such children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title, but excluding any low-income child described in section 2102(3)(A) that a State must cover in order to be considered an eligible State under this title); and

''(ii) 10 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the number (as so measured) of low-income children that are in excess of such population.

''(B) SOURCE OF BONUSES.—

''(i) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—A bonus described in subparagraph (A)(i) shall be paid out of an eligible State's allotment for a fiscal year.

''(ii) FOR OTHER LOW-INCOME CHILD POPULATIONS.—A bonus described in subparagraph (A)(ii) shall be paid out of the new coverage incentive pool reserved under subsection (a)(1).

''(3) DEFINITION OF COST OF PROVIDING HEALTH INSURANCE COVERAGE.—For purposes of this subsection the cost of providing health insurance coverage for a low-income child in the State means—

''(A) in the case of an eligible State that opts to use funds provided under this title through the medicaid program, the cost of providing such child with medical assistance under the State plan under title XIX; and

''(B) in the case of an eligible State that opts to use funds provided under this title under section 2107, the cost of providing such child with health insurance coverage under such section.

''(4) LIMITATION ON TOTAL PAYMENTS.—With respect to a fiscal year, the total amount paid to an eligible State under this title (including any bonus payments) shall not exceed 85 percent of the total cost of a State program conducted under this title for such fiscal year.

''(5) MAINTENANCE OF EFFORT.—

''(A) DEEMED COMPLIANCE.—A State shall be deemed to be in compliance with this provision if—

''(i) it does not adopt income and resource standards and methodologies that are more restrictive than those applied as of June 1, 1997, for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX; and

''(ii) in the case of fiscal year 1998 and each fiscal year thereafter, the State children's health expenditures defined in section 2102(11) are not less than the amount of such expenditures for fiscal year 1996.

''(B) FAILURE TO MAINTAIN MEDICAID STANDARDS AND METHODOLOGIES.—A State that fails to meet the conditions described in subparagraph (A) shall not receive—

''(i) funds under this title for any child that would be determined eligible for medical assistance under the State plan under title XIX using the income and resource standards and methodologies applied under such plan as of June 1, 1997; and

''(ii) any bonus amounts described in paragraph (2)(A)(ii).

''(C) FAILURE TO MAINTAIN SPENDING ON CHILD HEALTH PROGRAMS.—A State that fails to meet the condition described in subparagraph (A)(ii) shall not receive funding under this title.

''(6) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this subsection for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and shall reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

''SEC. 2106. USE OF FUNDS.

''(a) SET-ASIDE FOR OUTREACH ACTIVITIES.—

''(1) IN GENERAL.—From the amount allotted to a State under section 2105(b) for a fiscal year, each State shall conduct outreach activities described in paragraph (2).

''(2) OUTREACH ACTIVITIES DESCRIBED.—The outreach activities described in this paragraph include activities to—

''(A) identify and enroll children who are eligible for medical assistance under the State plan under title XIX; and

''(B) conduct public awareness campaigns to encourage employers to provide health insurance coverage for children.

''(b) STATE OPTIONS FOR REMAINDER.—A State may use the amount remaining of the allotment to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), in accordance with section 2107 or the State medicaid program (but not both). Nothing in the preceding sentence shall be construed as limiting a State's eligibility for receiving the 5 percent bonus described in section 2105(c)(2)(A)(i) for children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title.

''(c) PROHIBITION ON USE OF FUNDS.—No funds provided under this title may be used to provide health insurance coverage for—

''(1) families of State public employees; or

''(2) children who are committed to a penal institution.

''(d) USE LIMITED TO STATE PROGRAM EXPENDITURES.—Funds provided to an eligible State under this title shall only be used to carry out the purpose of this title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

''(e) ADMINISTRATIVE EXPENDITURES.—

''(1) IN GENERAL.—Not more than the applicable percentage of the amount allotted to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), shall be used for administrative expenditures for the program funded under this title.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage with respect to a fiscal year is—

''(A) for the first 2 years of a State program funded under this title, 10 percent;

''(B) for the third year of a State program funded under this title, 7.5 percent; and

''(C) for the fourth year of a State program funded under this title and each year thereafter, 5 percent.

''(f) NONAPPLICATION OF FIVE-YEAR LIMITED ELIGIBILITY FOR MEANS-TESTED PUBLIC BENEFITS.—The provisions of section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613) shall not apply with respect to a State program funded under this title.

''(g) AUDITS.—The provisions of section 506(b) shall apply to funds expended under this title to the same extent as they apply to title V.

''(h) REQUIREMENT TO FOLLOW STATE PROGRAM OUTLINE.—The State shall conduct the program in accordance with the program outline approved by the Secretary under section 2104.

''SEC. 2107. STATE OPTION FOR THE PURCHASE OR PROVISION OF CHILDREN'S HEALTH INSURANCE.

''(a) STATE OPTION.—

''(1) IN GENERAL.—An eligible State that opts to use funds provided under this title under this section shall use such funds to provide FEHBP-equivalent children's health insurance coverage for low-income children who reside in the State.

''(2) PRIORITY FOR LOW-INCOME CHILDREN.—A State that uses funds provided under this title under this section shall not cover low-income children with higher family income without covering such children with a lower family income.

''(3) DETERMINATION OF ELIGIBILITY AND FORM OF ASSISTANCE.—An eligible State may establish any additional eligibility criteria for the provision of health insurance coverage for a low-income child through funds provided under this title, so long as such criteria and assistance are consistent with the purpose and provisions of this title.

''(4) AFFORDABILITY.—An eligible State may impose any family premium obligations or cost-sharing requirements otherwise permitted under this title on low-income children with family incomes that exceed 150 percent of the poverty line. In the case of a

low-income child whose family income is at or below 150 percent of the poverty line, limits on beneficiary costs generally applicable under title XIX apply to coverage provided such children under this section.

''(5) COVERAGE OF CERTAIN BENEFITS.—Any eligible State that opts to use funds provided under this title under this section for the coverage described in paragraph (1) is encouraged to include as part of such coverage, coverage for items and services needed for vision, hearing, and dental health.

''(b) NONENTITLEMENT.—Nothing in this section shall be construed as providing an entitlement for an individual or person to any health insurance coverage, assistance, or service provided through a State program funded under this title. If, with respect to a fiscal year, an eligible State determines that the funds provided under this title are not sufficient to provide health insurance coverage for all the low-income children that the State proposes to cover in the State program outline submitted under section 2104 for such fiscal year, the State may adjust the applicable eligibility criteria for such children appropriately or adjust the State program in another manner specified by the Secretary, so long as any such adjustments are consistent with the purpose of this title.

''SEC. 2108. PROGRAM INTEGRITY.

''The following provisions of the Social Security Act shall apply to eligible States under this title in the same manner as such provisions apply to a State under title XIX:

''(1) Section 1116 (relating to administrative and judicial review).

''(2) Section 1124 (relating to disclosure of ownership and related information).

''(3) Section 1126 (relating to disclosure of information about certain convicted individuals).

''(4) Section 1128 (relating to exclusion from individuals and entities from participation in State health care plans).

''(5) Section 1128A (relating to civil monetary penalties).

''(6) Section 1128B (relating to criminal penalties).

''(7) Section 1132 (relating to periods within which claims must be filed).

''(8) Section 1902(a)(4)(C) (relating to conflict of interest standards).

''(9) Section 1903(i) (relating to limitations on payment).

''(10) Section 1903(m)(5) (as in effect on the day before the date of enactment of the Balanced Budget Act of 1997).

''(11) Section 1903(w) (relating to limitations on provider taxes and donations).

''(12) Section 1905(a)(B) (relating to the exclusion of care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases from the definition of medical assistance).

''(13) Section 1921 (relating to state licensure authorities).

''(14) Sections 1902(a)(25), 1912(a)(1)(A), and 1903(o) (insofar as such sections relate to third party liability).

''(15) Sections 1948 and 1949 (as added by section 5701(a)(2) of the Balanced Budget Act of 1997).

''SEC. 2109. ANNUAL REPORTS.

''(a) ANNUAL STATE ASSESSMENT OF PROGRESS.—An eligible State shall—

''(1) assess the operation of the State program funded under this title in each fiscal year, including the progress made in providing health insurance coverage for low-income children; and

''(2) report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

''(b) REPORT OF THE SECRETARY.—The Secretary shall submit to the appropriate committees of Congress an annual report and evaluation of the State programs funded under this title based on the State assessments and reports submitted under subsection (a). Such report shall include any conclusions and recommendations that the Secretary considers appropriate.''.

(b) CONFORMING AMENDMENT.—Section 1128(h) (42 U.S.C. 1320a–7(h)) is amended by—

(1) in paragraph (2), by striking ''or'' at the end;

(2) in paragraph (3), by striking the period and inserting '', or''; and

(3) by adding at the end the following:

''(4) a program funded under title XXI.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply on and after October 2, 1997.

LOTT AMENDMENT NO. 509

Mr. ROTH (for Mr. LOTT) proposed an amendment to the bill, S. 947, supra; as follows:

In the pending amendment, strike all after the first word and insert the following:

Subtitle J—Children's Health Insurance Initiatives

SEC. 5801. ESTABLISHMENT OF CHILDREN'S HEALTH INSURANCE INITIATIVES.

(a) IN GENERAL.—Notwithstanding any other provision of the Act, the Social Security Act is amended by adding at the end the following:

''TITLE XXI—CHILD HEALTH INSURANCE INITIATIVES

''SEC. 2101. PURPOSE.

The purpose of this title is to provide funds to States to enable such States to expand the provision of health insurance coverage for low-income children. Funds provided under this title shall be used to achieve this purpose through outreach activities described in section 2106(a) and, at the option of the State through—

''(1) a grant program conducted in accordance with section 2107 and the other requirements of this title; or

''(2) expansion of coverage of such children under the State medicaid program who are not required to be provided medical assistance under section 1902(l) (taking into account the process of individuals aging into eligibility under subsection (l)(1)(D)).

''SEC. 2102. DEFINITIONS.

In this title:

''(1) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—The term 'base-year covered low-income child population' means the total number of low-income children with respect to whom, as of fiscal year 1996, an eligible State provides or pays the cost of health benefits either through a State funded program or through expanded eligibility under the State plan under title XIX (including under a waiver of such plan), as determined by the Secretary. Such term does not include any low-income child described in paragraph (3)(A) that a State must cover in order to be considered an eligible State under this title.

''(2) CHILD.—The term 'child' means an individual under 19 years of age.

''(3) ELIGIBLE STATE.—The term 'eligible State' means, with respect to a fiscal year, a State that—

''(A) provides, under section 1902(l)(1)(D) or under a waiver, for eligibility for medical assistance under a State plan under title XIX of individuals under 17 years of age in fiscal year 1998, and under 19 years of age in fiscal year 2000, regardless of date of birth;

''(B) has submitted to the Secretary under section 2104 a program outline that—

''(i) sets forth how the State intends to use the funds provided under this title to provide health insurance coverage for low-income children consistent with the provisions of this title; and

''(ii) is approved under section 2104; and

''(iii) otherwise satisfies the requirements of this title; and

''(C) satisfies the maintenance of effort requirement described in section 2105(c)(5).''.

''(4) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' means, with respect to a State, the meaning given that term under section 1905(b). Any cost-sharing imposed under this title may not be included in determining Federal medical assistance percentage for reimbursement of expenditures under a State program funded under this title.

''(5) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The term 'FEHBP-equivalent children's health insurance coverage' means, with respect to a State, any plan or arrangement that provides, or pays the cost of, health benefits that the Secretary has certified are equivalent to or better than the items and services covered for a child under one of the 5 plans under chapter 89 of title 5, United States Code, serving the largest number of enrolled families with children in a State, and that otherwise satisfies State insurance standards and requirements.

''(6) INDIANS.—The term 'Indians' has the meaning given that term in section 4(c) of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(7) LOW-INCOME CHILD.—The term 'low-income child' means a child in a family whose income is below 200 percent of the poverty line for a family of the size involved.

''(8) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

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

''(10) STATE.—The term 'State' means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands.

''(11) STATE CHILDREN'S HEALTH EXPENDITURES.—The term 'State children's health expenditures' means the State share of expenditures by the State for providing children with health care items and services under—

''(A) the State plan for medical assistance under title XIX;

''(B) the maternal and child health services block grant program under title V;

''(C) the preventive health services block grant program under part A of title XIX of the Public Health Services Act (42 U.S.C. 300w et seq.);

''(D) State-funded programs that are designed to provide health care items and services to children;

''(E) school-based health services programs;

''(F) State programs that provide uncompensated or indigent health care;

''(G) county-indigent care programs for which the State requires a matching share by a county government or for which there are intergovernmental transfers from a county to State government; and

''(H) any other program under which the Secretary determines the State incurs uncompensated expenditures for providing children with health care items and services.

''(12) STATE MEDICAID PROGRAM.—The term 'State medicaid program' means the program of medical assistance provided under title XIX.

''SEC. 2103. APPROPRIATION.

''(a) APPROPRIATION.—

''(1) IN GENERAL.—Subject to subsection (b), out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated for the purpose of carrying out this title—

''(A) for fiscal year 1998, $2,500,000,000;

''(B) for each of fiscal years 1999 and 2000, $3,200,000,000;

''(C) for fiscal year 2001, $3,600,000,000;

''(D) for fiscal year 2002, $3,500,000,000;

''(E) for each of fiscal years 2003 through 2007, $4,580,000,000.

''(2) AVAILABILITY.—Funds appropriated under this section shall remain available without fiscal year limitation, as provided under section 2105(b)(4).

''(b) REDUCTION FOR INCREASED MEDICAID EXPENDITURES.—With respect to each of the fiscal years described in subsection (a)(1), the amount appropriated under subsection (a)(1) for each such fiscal year shall be reduced by an amount equal to the amount of the total Federal outlays under the medicaid program under title XIX resulting from—

''(1) the amendment made by section 5732 of the Balanced Budget Act of 1997 (regarding the State option to provide 12-month continuous eligibility for children);

''(2) increased enrollment under State plans approved under such program as a result of outreach activities under section 2106(a); and

''(3) the requirement under section 2102(3)A) to provide eligibility for medical assistance under the State plan under title XIX for all children under 19 years of age who have families with income that is at or below the poverty line.

''(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided in accordance with the provisions of this title.

''(d) EFFECTIVE DATE.—No State is eligible for payments under section 2105 for any calendar quarter beginning before October 1, 1997.

''SEC. 2104. PROGRAM OUTLINE.

''(a) GENERAL DESCRIPTION.—A State shall submit to the Secretary for approval a program outline, consistent with the requirements of this title, that—

''(1) identifies, on or after the date of enactment of the Balanced Budget Act of 1997, which of the 2 options described in section 2101 the State intends to use to provide low-income children in the State with health insurance coverage;

''(2) describes the manner in which such coverage shall be provided; and

''(3) provides such other information as the Secretary may require.

''(b) OTHER REQUIREMENTS.—The program outline submitted under this section shall include the following:

''(1) ELIGIBILITY STANDARDS AND METHODOLOGIES.—A summary of the standards and methodologies used to determine the eligibility of low-income children for health insurance coverage under a State program funded under this title.

''(2) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE.—A description of the procedures to be used to ensure—

''(A) through both intake and followup screening, that only low-income children are furnished health insurance coverage through funds provided under this title; and

''(B) that any health insurance coverage provided for children through funds under this title does not reduce the number of children who are provided such coverage through any other publicly or privately funded health plan.

''(3) INDIANS.—A description of how the State will ensure that Indians are served through a State program funded under this title.

''(c) DEADLINE FOR SUBMISSION.—A State program outline shall be submitted to the Secretary by not later than March 31 of any fiscal year (October 1, 1997, in the case of fiscal year 1998).

''SEC. 2105. DISTRIBUTION OF FUNDS.

''(a) ESTABLISHMENT OF FUNDING POOLS.—

''(1) IN GENERAL.—From the amount appropriated under section 2103(a)(1) for each fiscal year, determined after the reduction required under section 2103(b), the Secretary shall, for purposes of fiscal year 1998, reserve 85 percent of such amount for distribution to eligible States through the basic allotment pool under subsection (b) and 15 percent of such amount for distribution through the new coverage incentive pool under subsection (c)(2)(B)(ii).

''(2) ANNUAL ADJUSTMENT OF RESERVE PERCENTAGES.—The Secretary shall annually adjust the amount of the percentages described in paragraph (1) in order to provide sufficient basic allotments and sufficient new coverage incentives to achieve the purpose of this title.

''(b) DISTRIBUTION OF FUNDS UNDER THE BASIC ALLOTMENT POOL.—

''(1) STATES.—

''(A) IN GENERAL.—From the total amount reserved under subsection (a) for a fiscal year for distribution through the basic allotment pool, the Secretary shall first set aside 0.25 percent for distribution under paragraph (2) and shall allot from the amount remaining to each eligible State not described in such paragraph the State's allotment percentage for such fiscal year.

''(B) STATE'S ALLOTMENT PERCENTAGE.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the allotment percentage for a fiscal year for each State is the percentage equal to the ratio of the number of low-income children in the base period in the State to the total number of low-income children in the base period in all States not described in paragraph (2).

''(ii) NUMBER OF LOW-INCOME CHILDREN IN THE BASE PERIOD.—In clause (i), the number of low-income children in the base period for a fiscal year in a State is equal to the average of the number of low-income children in the State for the period beginning on October 1, 1992, and ending on September 30, 1995, as reported in the March 1994, March 1995, and March 1996 supplements to the Current Population Survey of the Bureau of the Census.

''(2) OTHER STATES.—

''(A) IN GENERAL.—From the amount set aside under paragraph (1)(A) for each fiscal year, the Secretary shall make allotments for such fiscal year in accordance with the percentages specified in subparagraph (B) to Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands, if such States are eligible States for such fiscal year.

''(B) PERCENTAGES SPECIFIED.—The percentages specified in this subparagraph are in the case of—

''(i) Puerto Rico, 91.6 percent;

''(ii) Guam, 3.5 percent;

''(iii) the Virgin Islands, 2.6 percent;

''(iv) American Samoa, 1.2 percent; and

''(v) the Northern Mariana Islands, 1.1 percent.

''(3) THREE-YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

''(4) PROCEDURE FOR DISTRIBUTION OF UNUSED FUNDS.—The Secretary shall determine an appropriate procedure for distribution of funds to eligible States that remain unused under this subsection after the expiration of the availability of funds required under paragraph (3). Such procedure shall be developed and administered in a manner that is consistent with the purpose of this title.

''(c) PAYMENTS.—

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

''(A) before October 1 of any fiscal year, pay an eligible State an amount equal to 1 percent of the amount allotted to the State under subsection (b) for conducting the outreach activities required under section 2106(a); and

''(B) make quarterly fiscal year payments to an eligible State from the amount remaining of such allotment for such fiscal year in an amount equal to the Federal medical assistance percentage for the State (as defined under section 2102(4) and determined without regard to the amount of Federal funds received by the State under title XIX before the date of enactment of this title) of the Federal and State incurred cost of providing health insurance coverage for a low-income child in the State plus the applicable bonus amount.

''(2) APPLICABLE BONUS.—

''(A) IN GENERAL.—For purposes of paragraph (1), the applicable bonus amount is—

''(i) 5 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the base-year covered low-income child population (measured in full year equivalency) (including such children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title, but excluding any low-income child described in section 2102(3)(A) that a State must cover in order to be considered an eligible State under this title); and

''(ii) 10 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the number (as so measured) of low-income children that are in excess of such population.

''(B) SOURCE OF BONUSES.—

''(i) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—A bonus described in subparagraph (A)(i) shall be paid out of an eligible State's allotment for a fiscal year.

''(ii) FOR OTHER LOW-INCOME CHILD POPULATIONS.—A bonus described in subparagraph (A)(ii) shall be paid out of the new coverage incentive pool reserved under subsection (a)(1).

''(3) DEFINITION OF COST OF PROVIDING HEALTH INSURANCE COVERAGE.—For purposes of this subsection the cost of providing health insurance coverage for a low-income child in the State means—

''(A) in the case of an eligible State that opts to use funds provided under this title through the medicaid program, the cost of providing such child with medical assistance under the State plan under title XIX; and

''(B) in the case of an eligible State that opts to use funds provided under this title under section 2107, the cost of providing such child with health insurance coverage under such section.

''(4) LIMITATION ON TOTAL PAYMENTS.—With respect to a fiscal year, the total amount paid to an eligible State under this title (including any bonus payments) shall not exceed 85 percent of the total cost of a State program conducted under this title for such fiscal year.

''(5) MAINTENANCE OF EFFORT.—

''(A) DEEMED COMPLIANCE.—A State shall be deemed to be in compliance with this provision if—

''(i) it does not adopt income and resource standards and methodologies that are more

restrictive than those applied as of June 1, 1997, for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX; and

''(ii) in the case of fiscal year 1998 and each fiscal year thereafter, the State children's health expenditures defined in section 2102(11) are not less than the amount of such expenditures for fiscal year 1996.

''(B) FAILURE TO MAINTAIN MEDICAID STANDARDS AND METHODOLOGIES.—A State that fails to meet the conditions described in subparagraph (A) shall not receive—

''(i) funds under this title for any child that would be determined eligible for medical assistance under the State plan under title XIX using the income and resource standards and methodologies applied under such plan as of June 1, 1997; and

''(ii) any bonus amounts described in paragraph (2)(A)(ii).

''(C) FAILURE TO MAINTAIN SPENDING ON CHILD HEALTH PROGRAMS.—A State that fails to meet the condition described in subparagraph (A)(ii) shall not receive funding under this title.

''(6) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this subsection for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and shall reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

''SEC. 2106. USE OF FUNDS.

''(a) SET-ASIDE FOR OUTREACH ACTIVITIES.—

''(1) IN GENERAL.—From the amount allotted to a State under section 2105(b) for a fiscal year, each State shall conduct outreach activities described in paragraph (2).

''(2) OUTREACH ACTIVITIES DESCRIBED.—The outreach activities described in this paragraph include activities to—

''(A) identify and enroll children who are eligible for medical assistance under the State plan under title XIX; and

''(B) conduct public awareness campaigns to encourage employers to provide health insurance coverage for children.

''(b) STATE OPTIONS FOR REMAINDER.—A State may use the amount remaining of the allotment to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), in accordance with section 2107 or the State medicaid program (but not both). Nothing in the preceding sentence shall be construed as limiting a State's eligibility for receiving the 5 percent bonus described in section 2105(c)(2)(A)(i) for children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title.

''(c) PROHIBITION ON USE OF FUNDS.—No funds provided under this title may be used to provide health insurance coverage for—

''(1) families of State public employees; or

''(2) children who are committed to a penal institution.

''(d) USE LIMITED TO STATE PROGRAM EXPENDITURES.—Funds provided to an eligible State under this title shall only be used to carry out the purpose of this title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

''(e) ADMINISTRATIVE EXPENDITURES.—

''(1) IN GENERAL.—Not more than the applicable percentage of the amount allotted to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), shall be used for administrative expenditures for the program funded under this title.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage with respect to a fiscal year is—

''(A) for the first 2 years of a State program funded under this title, 10 percent;

''(B) for the third year of a State program funded under this title, 7.5 percent; and

''(C) for the fourth year of a State program funded under this title and each year thereafter, 5 percent.

''(f) NONAPPLICATION OF FIVE-YEAR LIMITED ELIGIBILITY FOR MEANS-TESTED PUBLIC BENEFITS.—The provisions of section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613) shall not apply with respect to a State program funded under this title.

''(g) AUDITS.—The provisions of section 506(b) shall apply to funds expended under this title to the same extent as they apply to title V.

''(h) REQUIREMENT TO FOLLOW STATE PROGRAM OUTLINE.—The State shall conduct the program in accordance with the program outline approved by the Secretary under section 2104.

''SEC. 2107. STATE OPTION FOR THE PURCHASE OR PROVISION OF CHILDREN'S HEALTH INSURANCE.

''(a) STATE OPTION.—

''(1) IN GENERAL.—An eligible State that opts to use funds provided under this title under this section shall use such funds to provide FEHBP-equivalent children's health insurance coverage for low-income children who reside in the State.

''(2) PRIORITY FOR LOW-INCOME CHILDREN.—A State that uses funds provided under this title under this section shall not cover low-income children with higher family income without covering such children with a lower family income.

''(3) DETERMINATION OF ELIGIBILITY AND FORM OF ASSISTANCE.—An eligible State may establish any additional eligibility criteria for the provision of health insurance coverage for a low-income child through funds provided under this title, so long as such criteria and assistance are consistent with the purpose and provisions of this title.

''(4) AFFORDABILITY.—An eligible State may impose any family premium obligations or cost-sharing requirements otherwise permitted under this title on low-income children with family incomes that exceed 150 percent of the poverty line. In the case of a low-income child whose family income is at or below 150 percent of the poverty line, limits on beneficiary costs generally applicable under title XIX apply to coverage provided such children under this section.

''(5) COVERAGE OF CERTAIN BENEFITS.—Any eligible State that opts to use funds provided under this title under this section for the coverage described in paragraph (1) is encouraged to include as part of such coverage, coverage for items and services needed for vision, hearing, and dental health.

''(b) NONENTITLEMENT.—Nothing in this section shall be construed as providing an entitlement for an individual or person to any health insurance coverage, assistance, or service provided through a State program funded under this title. If, with respect to a fiscal year, an eligible State determines that the funds provided under this title are not sufficient to provide health insurance coverage for all the low-income children that the State proposes to cover in the State program outline submitted under section 2104 for such fiscal year, the State may adjust the applicable eligibility criteria for such children appropriately or adjust the State program in another manner specified by the Secretary, so long as any such adjustments are consistent with the purpose of this title.

''SEC. 2108. PROGRAM INTEGRITY.

''The following provisions of the Social Security Act shall apply to eligible States under this title in the same manner as such provisions apply to a State under title XIX:

''(1) Section 1116 (relating to administrative and judicial review).

''(2) Section 1124 (relating to disclosure of ownership and related information).

''(3) Section 1126 (relating to disclosure of information about certain convicted individuals).

''(4) Section 1128 (relating to exclusion from individuals and entities from participation in State health care plans).

''(5) Section 1128A (relating to civil monetary penalties).

''(6) Section 1128B (relating to criminal penalties).

''(7) Section 1132 (relating to periods within which claims must be filed).

''(8) Section 1902(a)(4)(C) (relating to conflict of interest standards).

''(9) Section 1903(i) (relating to limitations on payment).

''(10) Section 1903(m)(5) (as in effect on the day before the date of enactment of the Balanced Budget Act of 1997).

''(11) Section 1903(w) (relating to limitations on provider taxes and donations).

''(12) Section 1905(a)(B) (relating to the exclusion of care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases from the definition of medical assistance).

''(13) Section 1921 (relating to state licensure authorities).

''(14) Sections 1902(a)(25), 1912(a)(1)(A), and 1903(o) (insofar as such sections relate to third party liability).

''(15) Sections 1948 and 1949 (as added by section 5701(a)(2) of the Balanced Budget Act of 1997).

''SEC. 2109. ANNUAL REPORTS.

''(a) ANNUAL STATE ASSESSMENT OF PROGRESS.—An eligible State shall—

''(1) assess the operation of the State program funded under this title in each fiscal year, including the progress made in providing health insurance coverage for low-income children; and

''(2) report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

''(b) REPORT OF THE SECRETARY.—The Secretary shall submit to the appropriate committees of Congress an annual report and evaluation of the State programs funded under this title based on the State assessments and reports submitted under subsection (a). Such report shall include any conclusions and recommendations that the Secretary considers appropriate.''.

(b) CONFORMING AMENDMENT.—Section 1128(h) (42 U.S.C. 1320a–7(h)) is amended by—

(1) in paragraph (2), by striking ''or'' at the end;

(2) in paragraph (3), by striking the period and inserting '', or''; and

(3) by adding at the end the following:

''(4) a program funded under title XXI.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply on and after October 4, 1997.

ROCKFELLER AMENDMENT NO. 510

Mr. LAUTENBERG (for Mr. ROCKFELLER) proposed an amendment to the bill, S. 947, supra; as follows:

At the appropriate place add the following:

Notwithstanding any other provision of this Act, the following shall be the Hearing and Vision services provided under the Children's Health Insurance Section:

''(4) HEARING AND VISION SERVICES.—Notwithstanding the definition of FEHBP-equivalent children's health insurance coverage in section 2102(5), any package of health insurance benefits offered by a State that opts to

use funds provided under this title under this section shall include hearing and vision services for children.''.

ROTH AMENDMENT NO. 511

Mr. ROTH proposed an amendment to the bill, S. 947, supra; as follows:

Beginning on page 844, strike line 8 and all that follows through page 865, line 2 and insert the following:

Subtitle J—Children's Health Insurance Initiatives

SEC. 5801. ESTABLISHMENT OF CHILDREN'S HEALTH INSURANCE INITIATIVES.

(a) IN GENERAL.—The Social Security Act is amended by adding at the end the following:

''TITLE XXI—CHILD HEALTH INSURANCE INITIATIVES

''SEC. 2101. PURPOSE.

''The purpose of this title is to provide funds to States to enable such States to expand the provision of health insurance coverage for low-income children. Funds provided under this title shall be used to achieve this purpose through outreach activities described in section 2106(a) and, at the option of the State through—

''(1) a grant program conducted in accordance with section 2107 and the other requirements of this title; or

''(2) expansion of coverage of such children under the State medicaid program who are not required to be provided medical assistance under section 1902(l) (taking into account the process of individuals aging into eligibility under subsection (l)(1)(D)).

''SEC. 2102. DEFINITIONS.

''In this title:

''(1) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—The term 'base-year covered low-income child population' means the total number of low-income children with respect to whom, as of fiscal year 1996, an eligible State provides or pays the cost of health benefits either through a State funded program or through expanded eligibility under the State plan under title XIX (including under a waiver of such plan), as determined by the Secretary. Such term does not include any low-income child described in paragraph (3)(A) that a State must cover in order to be considered an eligible State under this title.

''(2) CHILD.—The term 'child' means an individual under 19 years of age.

''(3) ELIGIBLE STATE.—The term 'eligible State' means, with respect to a fiscal year, a State that—

''(A) provides, under section 1902(l)(1)(D) or under a waiver, for eligibility for medical assistance under a State plan under title XIX of individuals under 17 years of age in fiscal year 1998, and under 19 years of age in fiscal year 2000, regardless of date of birth;

''(B) has submitted to the Secretary under section 2104 a program outline that—

''(i) sets forth how the State intends to use the funds provided under this title to provide health insurance coverage for low-income children consistent with the provisions of this title; and

''(ii) is approved under section 2104; and

''(iii) otherwise satisfies the requirements of this title; and

''(C) satisfies the maintenance of effort requirement described in section 2105(c)(5).''.

''(4) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' means, with respect to a State, the meaning given that term under section 1905(b). Any cost-sharing imposed under this title may not be included in determining Federal medical assistance percentage for reimbursement of expenditures under a State program funded under this title.

''(5) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The term 'FEHBP-equivalent children's health insurance coverage' means, with respect to a State, any plan or arrangement that provides, or pays the cost of, health benefits that the Secretary has certified are equivalent to or better than the items and services covered for a child under one of the 5 plans under chapter 89 of title 5, United States Code, serving the largest number of enrolled families with children in a State, and that otherwise satisfies State insurance standards and requirements.

''(6) INDIANS.—The term 'Indians' has the meaning given that term in section 4(c) of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(7) LOW-INCOME CHILD.—The term 'low-income child' means a child in a family whose income is below 200 percent of the poverty line for a family of the size involved.

''(8) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

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

''(10) STATE.—The term 'State' means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands.

''(11) STATE CHILDREN'S HEALTH EXPENDITURES.—The term 'State children's health expenditures' means the State share of expenditures by the State for providing children with health care items and services under—

''(A) the State plan for medical assistance under title XIX;

''(B) the maternal and child health services block grant program under title V;

''(C) the preventive health services block grant program under part A of title XIX of the Public Health Services Act (42 U.S.C. 300w et seq.);

''(D) State-funded programs that are designed to provide health care items and services to children;

''(E) school-based health services programs;

''(F) State programs that provide uncompensated or indigent health care;

''(G) county-indigent care programs for which the State requires a matching share by a county government or for which there are intergovernmental transfers from a county to State government; and

''(H) any other program under which the Secretary determines the State incurs uncompensated expenditures for providing children with health care items and services.

''(12) STATE MEDICAID PROGRAM.—The term 'State medicaid program' means the program of medical assistance provided under title XIX.

''SEC. 2103. APPROPRIATION.

''(a) APPROPRIATION.—

''(1) IN GENERAL.—Subject to subsection (b), out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated for the purpose of carrying out this title—

''(A) for fiscal year 1998, $2,500,000,000;

''(B) for each of fiscal years 1999 and 2000, $3,200,000,000;

''(C) for fiscal year 2001, $3,600,000,000;

''(D) for fiscal year 2002, $3,500,000,000;

''(E) for each of fiscal years 2003 through 2007, $4,580,000,000.

''(2) AVAILABILITY.—Funds appropriated under this section shall remain available without fiscal year limitation, as provided under section 2105(b)(4).

''(b) REDUCTION FOR INCREASED MEDICAID EXPENDITURES.—With respect to each of the fiscal years described in subsection (a)(1), the amount appropriated under subsection (a)(1) for each such fiscal year shall be reduced by an amount equal to the amount of the total Federal outlays under the medicaid program under title XIX resulting from—

''(1) the amendment made by section 5732 of the Balanced Budget Act of 1997 (regarding the State option to provide 12-month continuous eligibility for children);

''(2) increased enrollment under State plans approved under such program as a result of outreach activities under section 2106(a); and

''(3) the requirement under section 2102(3)A) to provide eligibility for medical assistance under the State plan under title XIX for all children under 19 years of age who have families with income that is at or below the poverty line.

''(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided in accordance with the provisions of this title.

''(d) EFFECTIVE DATE.—No State is eligible for payments under section 2105 for any calendar quarter beginning before October 1, 1997.

''SEC. 2104. PROGRAM OUTLINE.

''(a) GENERAL DESCRIPTION.—A State shall submit to the Secretary for approval a program outline, consistent with the requirements of this title, that—

''(1) identifies, on or after the date of enactment of the Balanced Budget Act of 1997, which of the 2 options described in section 2101 the State intends to use to provide low-income children in the State with health insurance coverage;

''(2) describes the manner in which such coverage shall be provided; and

''(3) provides such other information as the Secretary may require.

''(b) OTHER REQUIREMENTS.—The program outline submitted under this section shall include the following:

''(1) ELIGIBILITY STANDARDS AND METHODOLOGIES.—A summary of the standards and methodologies used to determine the eligibility of low-income children for health insurance coverage under a State program funded under this title.

''(2) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE.—A description of the procedures to be used to ensure—

''(A) through both intake and followup screening, that only low-income children are furnished health insurance coverage through funds provided under this title; and

''(B) that any health insurance coverage provided for children through funds under this title does not reduce the number of children who are provided such coverage through any other publicly or privately funded health plan.

''(3) INDIANS.—A description of how the State will ensure that Indians are served through a State program funded under this title.

''(c) DEADLINE FOR SUBMISSION.—A State program outline shall be submitted to the Secretary by not later than March 31 of any fiscal year (October 1, 1997, in the case of fiscal year 1998).

''SEC. 2105. DISTRIBUTION OF FUNDS.

''(a) ESTABLISHMENT OF FUNDING POOLS.—

''(1) IN GENERAL.—From the amount appropriated under section 2103(a)(1) for each fiscal year, determined after the reduction required under section 2103(b), the Secretary shall, for purposes of fiscal year 1998, reserve 85 percent of such amount for distribution to

eligible States through the basic allotment pool under subsection (b) and 15 percent of such amount for distribution through the new coverage incentive pool under subsection (c)(2)(B)(ii).

''(2) ANNUAL ADJUSTMENT OF RESERVE PERCENTAGES.—The Secretary shall annually adjust the amount of the percentages described in paragraph (1) in order to provide sufficient basic allotments and sufficient new coverage incentives to achieve the purpose of this title.

''(b) DISTRIBUTION OF FUNDS UNDER THE BASIC ALLOTMENT POOL.—

''(1) STATES.—

''(A) IN GENERAL.—From the total amount reserved under subsection (a) for a fiscal year for distribution through the basic allotment pool, the Secretary shall first set aside 0.25 percent for distribution under paragraph (2) and shall allot from the amount remaining to each eligible State not described in such paragraph the State's allotment percentage for such fiscal year.

''(B) STATE'S ALLOTMENT PERCENTAGE.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the allotment percentage for a fiscal year for each State is the percentage equal to the ratio of the number of low-income children in the base period in the State to the total number of low-income children in the base period in all States not described in paragraph (2).

''(ii) NUMBER OF LOW-INCOME CHILDREN IN THE BASE PERIOD.—In clause (i), the number of low-income children in the base period for a fiscal year in a State is equal to the average of the number of low-income children in the State for the period beginning on October 1, 1992, and ending on September 30, 1995, as reported in the March 1994, March 1995, and March 1996 supplements to the Current Population Survey of the Bureau of the Census.

''(2) OTHER STATES.—

''(A) IN GENERAL.—From the amount set aside under paragraph (1)(A) for each fiscal year, the Secretary shall make allotments for such fiscal year in accordance with the percentages specified in subparagraph (B) to Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands, if such States are eligible States for such fiscal year.

''(B) PERCENTAGES SPECIFIED.—The percentages specified in this subparagraph are in the case of—

''(i) Puerto Rico, 91.6 percent;

''(ii) Guam, 3.5 percent;

''(iii) the Virgin Islands, 2.6 percent;

''(iv) American Samoa, 1.2 percent; and

''(v) the Northern Mariana Islands, 1.1 percent.

''(3) THREE-YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

''(4) PROCEDURE FOR DISTRIBUTION OF UNUSED FUNDS.—The Secretary shall determine an appropriate procedure for distribution of funds to eligible States that remain unused under this subsection after the expiration of the availability of funds required under paragraph (3). Such procedure shall be developed and administered in a manner that is consistent with the purpose of this title.

''(c) PAYMENTS.—

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

''(A) before October 1 of any fiscal year, pay an eligible State an amount equal to 1 percent of the amount allotted to the State under subsection (b) for conducting the outreach activities required under section 2106(a); and

''(B) make quarterly fiscal year payments to an eligible State from the amount remaining of such allotment for such fiscal year in an amount equal to the Federal medical assistance percentage for the State (as defined under section 2102(4) and determined without regard to the amount of Federal funds received by the State under title XIX before the date of enactment of this title) of the Federal and State incurred cost of providing health insurance coverage for a low-income child in the State plus the applicable bonus amount.

''(2) APPLICABLE BONUS.—

''(A) IN GENERAL.—For purposes of paragraph (1), the applicable bonus amount is—

''(i) 5 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the base-year covered low-income child population (measured in full year equivalency) (including such children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title, but excluding any low-income child described in section 2102(3)(A) that a State must cover in order to be considered an eligible State under this title); and

''(ii) 10 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the number (as so measured) of low-income children that are in excess of such population.

''(B) SOURCE OF BONUSES.—

''(i) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—A bonus described in subparagraph (A)(i) shall be paid out of an eligible State's allotment for a fiscal year.

''(ii) FOR OTHER LOW-INCOME CHILD POPULATIONS.—A bonus described in subparagraph (A)(ii) shall be paid out of the new coverage incentive pool reserved under subsection (a)(1).

''(3) DEFINITION OF COST OF PROVIDING HEALTH INSURANCE COVERAGE.—For purposes of this subsection the cost of providing health insurance coverage for a low-income child in the State means—

''(A) in the case of an eligible State that opts to use funds provided under this title through the medicaid program, the cost of providing such child with medical assistance under the State plan under title XIX; and

''(B) in the case of an eligible State that opts to use funds provided under this title under section 2107, the cost of providing such child with health insurance coverage under such section.

''(4) LIMITATION ON TOTAL PAYMENTS.—With respect to a fiscal year, the total amount paid to an eligible State under this title (including any bonus payments) shall not exceed 85 percent of the total cost of a State program conducted under this title for such fiscal year.

''(5) MAINTENANCE OF EFFORT.—

''(A) DEEMED COMPLIANCE.—A State shall be deemed to be in compliance with this provision if—

''(i) it does not adopt income and resource standards and methodologies that are more restrictive than those applied as of June 1, 1997, for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX; and

''(ii) in the case of fiscal year 1998 and each fiscal year thereafter, the State children's health expenditures defined in section 2102(11) are not less than the amount of such expenditures for fiscal year 1996.

''(B) FAILURE TO MAINTAIN MEDICAID STANDARDS AND METHODOLOGIES.—A State that fails to meet the conditions described in subparagraph (A) shall not receive—

''(i) funds under this title for any child that would be determined eligible for medical assistance under the State plan under title XIX using the income and resource standards and methodologies applied under such plan as of June 1, 1997; and

''(ii) any bonus amounts described in paragraph (2)(A)(ii).

''(C) FAILURE TO MAINTAIN SPENDING ON CHILD HEALTH PROGRAMS.—A State that fails to meet the condition described in subparagraph (A)(ii) shall not receive funding under this title.

''(6) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this subsection for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and shall reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

''SEC. 2106. USE OF FUNDS.

''(a) SET-ASIDE FOR OUTREACH ACTIVITIES.—

''(1) IN GENERAL.—From the amount allotted to a State under section 2105(b) for a fiscal year, each State shall conduct outreach activities described in paragraph (2).

''(2) OUTREACH ACTIVITIES DESCRIBED.—The outreach activities described in this paragraph include activities to—

''(A) identify and enroll children who are eligible for medical assistance under the State plan under title XIX; and

''(B) conduct public awareness campaigns to encourage employers to provide health insurance coverage for children.

''(b) STATE OPTIONS FOR REMAINDER.—A State may use the amount remaining of the allotment to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), in accordance with section 2107 or the State medicaid program (but not both). Nothing in the preceding sentence shall be construed as limiting a State's eligibility for receiving the 5 percent bonus described in section 2105(c)(2)(A)(i) for children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title.

''(c) PROHIBITION ON USE OF FUNDS.—No funds provided under this title may be used to provide health insurance coverage for—

''(1) families of State public employees; or

''(2) children who are committed to a penal institution.

''(d) USE LIMITED TO STATE PROGRAM EXPENDITURES.—Funds provided to an eligible State under this title shall only be used to carry out the purpose of this title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

''(e) ADMINISTRATIVE EXPENDITURES.—

''(1) IN GENERAL.—Not more than the applicable percentage of the amount allotted to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), shall be used for administrative expenditures for the program funded under this title.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage with respect to a fiscal year is—

''(A) for the first 2 years of a State program funded under this title, 10 percent;

''(B) for the third year of a State program funded under this title, 7.5 percent; and

''(C) for the fourth year of a State program funded under this title and each year thereafter, 5 percent.

''(f) NONAPPLICATION OF FIVE-YEAR LIMITED ELIGIBILITY FOR MEANS-TESTED PUBLIC BENEFITS.—The provisions of section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C.

1613) shall not apply with respect to a State program funded under this title.

''(g) AUDITS.—The provisions of section 506(b) shall apply to funds expended under this title to the same extent as they apply to title V.

''(h) REQUIREMENT TO FOLLOW STATE PROGRAM OUTLINE.—The State shall conduct the program in accordance with the program outline approved by the Secretary under section 2104.

''SEC. 2107. STATE OPTION FOR THE PURCHASE OR PROVISION OF CHILDREN'S HEALTH INSURANCE.

''(a) STATE OPTION.—

''(1) IN GENERAL.—An eligible State that opts to use funds provided under this title under this section shall use such funds to provide FEHBP-equivalent children's health insurance coverage for low-income children who reside in the State.

''(2) PRIORITY FOR LOW-INCOME CHILDREN.—A State that uses funds provided under this title under this section shall not cover low-income children with higher family income without covering such children with a lower family income.

''(3) DETERMINATION OF ELIGIBILITY AND FORM OF ASSISTANCE.—An eligible State may establish any additional eligibility criteria for the provision of health insurance coverage for a low-income child through funds provided under this title, so long as such criteria and assistance are consistent with the purpose and provisions of this title.

''(4) AFFORDABILITY.—An eligible State may impose any family premium obligations or cost-sharing requirements otherwise permitted under this title on low-income children with family incomes that exceed 150 percent of the poverty line. In the case of a low-income child whose family income is at or below 150 percent of the poverty line, limits on beneficiary costs generally applicable under title XIX apply to coverage provided such children under this section.

''(5) COVERAGE OF CERTAIN BENEFITS.—Any eligible State that opts to use funds provided under this title under this section for the coverage described in paragraph (1) is encouraged to include as part of such coverage, coverage for items and services needed for vision, hearing, and dental health.

''(b) NONENTITLEMENT.—Nothing in this section shall be construed as providing an entitlement for an individual or person to any health insurance coverage, assistance, or service provided through a State program funded under this title. If, with respect to a fiscal year, an eligible State determines that the funds provided under this title are not sufficient to provide health insurance coverage for all the low-income children that the State proposes to cover in the State program outline submitted under section 2104 for such fiscal year, the State may adjust the applicable eligibility criteria for such children appropriately or adjust the State program in another manner specified by the Secretary, so long as any such adjustments are consistent with the purpose of this title.

''SEC. 2108. PROGRAM INTEGRITY.

''The following provisions of the Social Security Act shall apply to eligible States under this title in the same manner as such provisions apply to a State under title XIX:

''(1) Section 1116 (relating to administrative and judicial review).

''(2) Section 1124 (relating to disclosure of ownership and related information).

''(3) Section 1126 (relating to disclosure of information about certain convicted individuals).

''(4) Section 1128 (relating to exclusion from individuals and entities from participation in State health care plans).

''(5) Section 1128A (relating to civil monetary penalties).

''(6) Section 1128B (relating to criminal penalties).

''(7) Section 1132 (relating to periods within which claims must be filed).

''(8) Section 1902(a)(4)(C) (relating to conflict of interest standards).

''(9) Section 1903(i) (relating to limitations on payment).

''(10) Section 1903(m)(5) (as in effect on the day before the date of enactment of the Balanced Budget Act of 1997).

''(11) Section 1903(w) (relating to limitations on provider taxes and donations).

''(12) Section 1905(a)(B) (relating to the exclusion of care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases from the definition of medical assistance).

''(13) Section 1921 (relating to state licensure authorities).

''(14) Sections 1902(a)(25), 1912(a)(1)(A), and 1903(o) (insofar as such sections relate to third party liability).

''(15) Sections 1948 and 1949 (as added by section 5701(a)(2) of the Balanced Budget Act of 1997).

''SEC. 2109. ANNUAL REPORTS.

''(a) ANNUAL STATE ASSESSMENT OF PROGRESS.—An eligible State shall—

''(1) assess the operation of the State program funded under this title in each fiscal year, including the progress made in providing health insurance coverage for low-income children; and

''(2) report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

''(b) REPORT OF THE SECRETARY.—The Secretary shall submit to the appropriate committees of Congress an annual report and evaluation of the State programs funded under this title based on the State assessments and reports submitted under subsection (a). Such report shall include any conclusions and recommendations that the Secretary considers appropriate.''.

(b) CONFORMING AMENDMENT.—Section 1128(h) (42 U.S.C. 1320a–7(h)) is amended by—

(1) in paragraph (2), by striking ''or'' at the end;

(2) in paragraph (3), by striking the period and inserting '', or''; and

(3) by adding at the end the following:

''(4) a program funded under title XXI.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply on and after October 1, 1997.

CHAFEE AMENDMENT NO. 512

Mr. CHAFEE (for himself and Mr. ROCKEFELLER) proposed an amendment to amendment No. 511 proposed by Mr. ROTH to the bill S. 947, supra; as follows:

On page 4, strike line 17 through line 3 on page 5 and insert the following:

''(5) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The term 'FEHBP-equivalent children's health insurance coverage' means, with respect to a State, any plan or arrangement that provides, or pays the cost of, health benefits that the Secretary has certified are equivalent to or better than the services covered for a child, including hearing and vision services, under the standard Blue Cross/Blue Shield preferred provider option service benefit plan offered under chapter 89 of title 5, United States Code.

LOTT AMENDMENT NO. 513

Mr. ROTH (for Mr. LOTT) proposed an amendment to amendment No. 510 proposed by Mr. ROCKEFELLER to the bill, S. 947, supra; as follows:

In lieu of the matter proposed to be inserted, insert:

Subtitle J—Children's Health Insurance Initiatives

SEC. 5801. ESTABLISHMENT OF CHILDREN'S HEALTH INSURANCE INITIATIVES.

(a) IN GENERAL.—Notwithstanding any other provision of the Act, the Social Security Act is amended by adding at the end the following:

''TITLE XXI—CHILD HEALTH INSURANCE INITIATIVES

''SEC. 2101. PURPOSE.

''The purpose of this title is to provide funds to States to enable such States to expand the provision of health insurance coverage for low-income children. Funds provided under this title shall be used to achieve this purpose through outreach activities described in section 2106(a) and, at the option of the State through—

''(1) a grant program conducted in accordance with section 2107 and the other requirements of this title; or

''(2) expansion of coverage of such children under the State medicaid program who are not required to be provided medical assistance under section 1902(l) (taking into account the process of individuals aging into eligibility under subsection (l)(1)(D)).

''SEC. 2102. DEFINITIONS.

''In this title:

''(1) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—The term 'base-year covered low-income child population' means the total number of low-income children with respect to whom, as of fiscal year 1996, an eligible State provides or pays the cost of health benefits either through a State funded program or through expanded eligibility under the State plan under title XIX (including under a waiver of such plan), as determined by the Secretary. Such term does not include any low-income child described in paragraph (3)(A) that a State must cover in order to be considered an eligible State under this title.

''(2) CHILD.—The term 'child' means an individual under 19 years of age.

''(3) ELIGIBLE STATE.—The term 'eligible State' means, with respect to a fiscal year, a State that—

''(A) provides, under section 1902(l)(1)(D) or under a waiver, for eligibility for medical assistance under a State plan under title XIX of individuals under 17 years of age in fiscal year 1998, and under 19 years of age in fiscal year 2000, regardless of date of birth;

''(B) has submitted to the Secretary under section 2104 a program outline that—

''(i) sets forth how the State intends to use the funds provided under this title to provide health insurance coverage for low-income children consistent with the provisions of this title; and

''(ii) is approved under section 2104; and

''(iii) otherwise satisfies the requirements of this title; and

''(C) satisfies the maintenance of effort requirement described in section 2105(c)(5).''.

''(4) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' means, with respect to a State, the meaning given that term under section 1905(b). Any cost-sharing imposed under this title may not be included in determining Federal medical assistance percentage for reimbursement of expenditures under a State program funded under this title.

''(5) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The term 'FEHBP-equivalent children's health insurance coverage' means, with respect to a State, any plan or arrangement that provides, or pays the cost of, health benefits that the Secretary has certified are equivalent to or better than the items and services

covered for a child under one of the 5 plans under chapter 89 of title 5, United States Code, serving the largest number of enrolled families with children in a State, and that otherwise satisfies State insurance standards and requirements.

''(6) INDIANS.—The term 'Indians' has the meaning given that term in section 4(c) of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(7) LOW-INCOME CHILD.—The term 'low-income child' means a child in a family whose income is below 200 percent of the poverty line for a family of the size involved.

''(8) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

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

''(10) STATE.—The term 'State' means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands.

''(11) STATE CHILDREN'S HEALTH EXPENDITURES.—The term 'State children's health expenditures' means the State share of expenditures by the State for providing children with health care items and services under—

''(A) the State plan for medical assistance under title XIX;

''(B) the maternal and child health services block grant program under title V;

''(C) the preventive health services block grant program under part A of title XIX of the Public Health Services Act (42 U.S.C. 300w et seq.);

''(D) State-funded programs that are designed to provide health care items and services to children;

''(E) school-based health services programs;

''(F) State programs that provide uncompensated or indigent health care;

''(G) county-indigent care programs for which the State requires a matching share by a county government or for which there are intergovernmental transfers from a county to State government; and

''(H) any other program under which the Secretary determines the State incurs uncompensated expenditures for providing children with health care items and services.

''(12) STATE MEDICAID PROGRAM.—The term 'State medicaid program' means the program of medical assistance provided under title XIX.

''SEC. 2103. APPROPRIATION.

''(a) APPROPRIATION.—

''(1) IN GENERAL.—Subject to subsection (b), out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated for the purpose of carrying out this title—

''(A) for fiscal year 1998, $2,500,000,000;

''(B) for each of fiscal years 1999 and 2000, $3,200,000,000;

''(C) for fiscal year 2001, $3,600,000,000;

''(D) for fiscal year 2002, $3,500,000,000;

''(E) for each of fiscal years 2003 through 2007, $4,580,000,000.

''(2) AVAILABILITY.—Funds appropriated under this section shall remain available without fiscal year limitation, as provided under section 2105(b)(4).

''(b) REDUCTION FOR INCREASED MEDICAID EXPENDITURES.—With respect to each of the fiscal years described in subsection (a)(1), the amount appropriated under subsection (a)(1) for each such fiscal year shall be reduced by an amount equal to the amount of the total Federal outlays under the medicaid program under title XIX resulting from—

''(1) the amendment made by section 5732 of the Balanced Budget Act of 1997 (regarding the State option to provide 12-month continuous eligibility for children);

''(2) increased enrollment under State plans approved under such program as a result of outreach activities under section 2106(a); and

''(3) the requirement under section 2102(3)A) to provide eligibility for medical assistance under the State plan under title XIX for all children under 19 years of age who have families with income that is at or below the poverty line.

''(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided in accordance with the provisions of this title.

''(d) EFFECTIVE DATE.—No State is eligible for payments under section 2105 for any calendar quarter beginning before October 1, 1997.

''SEC. 2104. PROGRAM OUTLINE.

''(a) GENERAL DESCRIPTION.—A State shall submit to the Secretary for approval a program outline, consistent with the requirements of this title, that—

''(1) identifies, on or after the date of enactment of the Balanced Budget Act of 1997, which of the 2 options described in section 2101 the State intends to use to provide low-income children in the State with health insurance coverage;

''(2) describes the manner in which such coverage shall be provided; and

''(3) provides such other information as the Secretary may require.

''(b) OTHER REQUIREMENTS.—The program outline submitted under this section shall include the following:

''(1) ELIGIBILITY STANDARDS AND METHODOLOGIES.—A summary of the standards and methodologies used to determine the eligibility of low-income children for health insurance coverage under a State program funded under this title.

''(2) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE.—A description of the procedures to be used to ensure—

''(A) through both intake and followup screening, that only low-income children are furnished health insurance coverage through funds provided under this title; and

''(B) that any health insurance coverage provided for children through funds under this title does not reduce the number of children who are provided such coverage through any other publicly or privately funded health plan.

''(3) INDIANS.—A description of how the State will ensure that Indians are served through a State program funded under this title.

''(c) DEADLINE FOR SUBMISSION.—A State program outline shall be submitted to the Secretary by not later than March 31 of any fiscal year (October 1, 1997, in the case of fiscal year 1998).

''SEC. 2105. DISTRIBUTION OF FUNDS.

''(a) ESTABLISHMENT OF FUNDING POOLS.—

''(1) IN GENERAL.—From the amount appropriated under section 2103(a)(1) for each fiscal year, determined after the reduction required under section 2103(b), the Secretary shall, for purposes of fiscal year 1998, reserve 85 percent of such amount for distribution to eligible States through the basic allotment pool under subsection (b) and 15 percent of such amount for distribution through the new coverage incentive pool under subsection (c)(2)(B)(ii).

''(2) ANNUAL ADJUSTMENT OF RESERVE PERCENTAGES.—The Secretary shall annually adjust the amount of the percentages described in paragraph (1) in order to provide sufficient basic allotments and sufficient new coverage incentives to achieve the purpose of this title.

''(b) DISTRIBUTION OF FUNDS UNDER THE BASIC ALLOTMENT POOL.—

''(1) STATES.—

''(A) IN GENERAL.—From the total amount reserved under subsection (a) for a fiscal year for distribution through the basic allotment pool, the Secretary shall first set aside 0.25 percent for distribution under paragraph (2) and shall allot from the amount remaining to each eligible State not described in such paragraph the State's allotment percentage for such fiscal year.

''(B) STATE'S ALLOTMENT PERCENTAGE.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the allotment percentage for a fiscal year for each State is the percentage equal to the ratio of the number of low-income children in the base period in the State to the total number of low-income children in the base period in all States not described in paragraph (2).

''(ii) NUMBER OF LOW-INCOME CHILDREN IN THE BASE PERIOD.—In clause (i), the number of low-income children in the base period for a fiscal year in a State is equal to the average of the number of low-income children in the State for the period beginning on October 1, 1992, and ending on September 30, 1995, as reported in the March 1994, March 1995, and March 1996 supplements to the Current Population Survey of the Bureau of the Census.

''(2) OTHER STATES.—

''(A) IN GENERAL.—From the amount set aside under paragraph (1)(A) for each fiscal year, the Secretary shall make allotments for such fiscal year in accordance with the percentages specified in subparagraph (B) to Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands, if such States are eligible States for such fiscal year.

''(B) PERCENTAGES SPECIFIED.—The percentages specified in this subparagraph are in the case of—

''(i) Puerto Rico, 91.6 percent;

''(ii) Guam, 3.5 percent;

''(iii) the Virgin Islands, 2.6 percent;

''(iv) American Samoa, 1.2 percent; and

''(v) the Northern Mariana Islands, 1.1 percent.

''(3) THREE-YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

''(4) PROCEDURE FOR DISTRIBUTION OF UNUSED FUNDS.—The Secretary shall determine an appropriate procedure for distribution of funds to eligible States that remain unused under this subsection after the expiration of the availability of funds required under paragraph (3). Such procedure shall be developed and administered in a manner that is consistent with the purpose of this title.

''(c) PAYMENTS.—

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

''(A) before October 1 of any fiscal year, pay an eligible State an amount equal to 1 percent of the amount allotted to the State under subsection (b) for conducting the outreach activities required under section 2106(a); and

''(B) make quarterly fiscal year payments to an eligible State from the amount remaining of such allotment for such fiscal year in an amount equal to the Federal medical assistance percentage for the State (as defined under section 2102(4) and determined without regard to the amount of Federal funds received by the State under title XIX before the date of enactment of this title) of

the Federal and State incurred cost of providing health insurance coverage for a low-income child in the State plus the applicable bonus amount.

''(2) APPLICABLE BONUS.—

''(A) IN GENERAL.—For purposes of paragraph (1), the applicable bonus amount is—

''(i) 5 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the base-year covered low-income child population (measured in full year equivalency) (including such children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title, but excluding any low-income child described in section 2102(3)(A) that a State must cover in order to be considered an eligible State under this title); and

''(ii) 10 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the number (as so measured) of low-income children that are in excess of such population.

''(B) SOURCE OF BONUSES.—

''(i) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—A bonus described in subparagraph (A)(i) shall be paid out of an eligible State's allotment for a fiscal year.

''(ii) FOR OTHER LOW-INCOME CHILD POPULATIONS.—A bonus described in subparagraph (A)(ii) shall be paid out of the new coverage incentive pool reserved under subsection (a)(1).

''(3) DEFINITION OF COST OF PROVIDING HEALTH INSURANCE COVERAGE.—For purposes of this subsection the cost of providing health insurance coverage for a low-income child in the State means—

''(A) in the case of an eligible State that opts to use funds provided under this title through the medicaid program, the cost of providing such child with medical assistance under the State plan under title XIX; and

''(B) in the case of an eligible State that opts to use funds provided under this title under section 2107, the cost of providing such child with health insurance coverage under such section.

''(4) LIMITATION ON TOTAL PAYMENTS.—With respect to a fiscal year, the total amount paid to an eligible State under this title (including any bonus payments) shall not exceed 85 percent of the total cost of a State program conducted under this title for such fiscal year.

''(5) MAINTENANCE OF EFFORT.—

''(A) DEEMED COMPLIANCE.—A State shall be deemed to be in compliance with this provision if—

''(i) it does not adopt income and resource standards and methodologies that are more restrictive than those applied as of June 1, 1997, for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX; and

''(ii) in the case of fiscal year 1998 and each fiscal year thereafter, the State children's health expenditures defined in section 2102(11) are not less than the amount of such expenditures for fiscal year 1996.

''(B) FAILURE TO MAINTAIN MEDICAID STANDARDS AND METHODOLOGIES.—A State that fails to meet the conditions described in subparagraph (A) shall not receive—

''(i) funds under this title for any child that would be determined eligible for medical assistance under the State plan under title XIX using the income and resource standards and methodologies applied under such plan as of June 1, 1997; and

''(ii) any bonus amounts described in paragraph (2)(A)(ii).

''(C) FAILURE TO MAINTAIN SPENDING ON CHILD HEALTH PROGRAMS.—A State that fails to meet the condition described in subparagraph (A)(ii) shall not receive funding under this title.

''(6) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this subsection for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and shall reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

''SEC. 2106. USE OF FUNDS.

''(a) SET-ASIDE FOR OUTREACH ACTIVITIES.—

''(1) IN GENERAL.—From the amount allotted to a State under section 2105(b) for a fiscal year, each State shall conduct outreach activities described in paragraph (2).

''(2) OUTREACH ACTIVITIES DESCRIBED.—The outreach activities described in this paragraph include activities to—

''(A) identify and enroll children who are eligible for medical assistance under the State plan under title XIX; and

''(B) conduct public awareness campaigns to encourage employers to provide health insurance coverage for children.

''(b) STATE OPTIONS FOR REMAINDER.—A State may use the amount remaining of the allotment to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), in accordance with section 2107 or the State medicaid program (but not both). Nothing in the preceding sentence shall be construed as limiting a State's eligibility for receiving the 5 percent bonus described in section 2105(c)(2)(A)(i) for children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title.

''(c) PROHIBITION ON USE OF FUNDS.—No funds provided under this title may be used to provide health insurance coverage for—

''(1) families of State public employees; or

''(2) children who are committed to a penal institution.

''(d) USE LIMITED TO STATE PROGRAM EXPENDITURES.—Funds provided to an eligible State under this title shall only be used to carry out the purpose of this title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

''(e) ADMINISTRATIVE EXPENDITURES.—

''(1) IN GENERAL.—Not more than the applicable percentage of the amount allotted to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), shall be used for administrative expenditures for the program funded under this title.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage with respect to a fiscal year is—

''(A) for the first 2 years of a State program funded under this title, 10 percent;

''(B) for the third year of a State program funded under this title, 7.5 percent; and

''(C) for the fourth year of a State program funded under this title and each year thereafter, 5 percent.

''(f) NONAPPLICATION OF FIVE-YEAR LIMITED ELIGIBILITY FOR MEANS-TESTED PUBLIC BENEFITS.—The provisions of section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613) shall not apply with respect to a State program funded under this title.

''(g) AUDITS.—The provisions of section 506(b) shall apply to funds expended under this title to the same extent as they apply to title V.

''(h) REQUIREMENT TO FOLLOW STATE PROGRAM OUTLINE.—The State shall conduct the program in accordance with the program outline approved by the Secretary under section 2104.

''SEC. 2107. STATE OPTION FOR THE PURCHASE OR PROVISION OF CHILDREN'S HEALTH INSURANCE.

''(a) STATE OPTION.—

''(1) IN GENERAL.—An eligible State that opts to use funds provided under this title under this section shall use such funds to provide FEHBP-equivalent children's health insurance coverage for low-income children who reside in the State.

''(2) PRIORITY FOR LOW-INCOME CHILDREN.—A State that uses funds provided under this title under this section shall not cover low-income children with higher family income without covering such children with a lower family income.

''(3) DETERMINATION OF ELIGIBILITY AND FORM OF ASSISTANCE.—An eligible State may establish any additional eligibility criteria for the provision of health insurance coverage for a low-income child through funds provided under this title, so long as such criteria and assistance are consistent with the purpose and provisions of this title.

''(4) AFFORDABILITY.—An eligible State may impose any family premium obligations or cost-sharing requirements otherwise permitted under this title on low-income children with family incomes that exceed 150 percent of the poverty line. In the case of a low-income child whose family income is at or below 150 percent of the poverty line, limits on beneficiary costs generally applicable under title XIX apply to coverage provided such children under this section.

''(5) COVERAGE OF CERTAIN BENEFITS.—Any eligible State that opts to use funds provided under this title under this section for the coverage described in paragraph (1) is encouraged to include as part of such coverage, coverage for items and services needed for vision, hearing, and dental health.

''(b) NONENTITLEMENT.—Nothing in this section shall be construed as providing an entitlement for an individual or person to any health insurance coverage, assistance, or service provided through a State program funded under this title. If, with respect to a fiscal year, an eligible State determines that the funds provided under this title are not sufficient to provide health insurance coverage for all the low-income children that the State proposes to cover in the State program outline submitted under section 2104 for such fiscal year, the State may adjust the applicable eligibility criteria for such children appropriately or adjust the State program in another manner specified by the Secretary, so long as any such adjustments are consistent with the purpose of this title.

''SEC. 2108. PROGRAM INTEGRITY.

''The following provisions of the Social Security Act shall apply to eligible States under this title in the same manner as such provisions apply to a State under title XIX:

''(1) Section 1116 (relating to administrative and judicial review).

''(2) Section 1124 (relating to disclosure of ownership and related information).

''(3) Section 1126 (relating to disclosure of information about certain convicted individuals).

''(4) Section 1128 (relating to exclusion from individuals and entities from participation in State health care plans).

''(5) Section 1128A (relating to civil monetary penalties).

''(6) Section 1128B (relating to criminal penalties).

''(7) Section 1132 (relating to periods within which claims must be filed).

''(8) Section 1902(a)(4)(C) (relating to conflict of interest standards).

''(9) Section 1903(i) (relating to limitations on payment).

''(10) Section 1903(m)(5) (as in effect on the day before the date of enactment of the Balanced Budget Act of 1997).

''(11) Section 1903(w) (relating to limitations on provider taxes and donations).

''(12) Section 1905(a)(B) (relating to the exclusion of care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases from the definition of medical assistance).

''(13) Section 1921 (relating to state licensure authorities).

''(14) Sections 1902(a)(25), 1912(a)(1)(A), and 1903(o) (insofar as such sections relate to third party liability).

''(15) Sections 1948 and 1949 (as added by section 5701(a)(2) of the Balanced Budget Act of 1997).

''SEC. 2109. ANNUAL REPORTS.

''(a) ANNUAL STATE ASSESSMENT OF PROGRESS.—An eligible State shall—

''(1) assess the operation of the State program funded under this title in each fiscal year, including the progress made in providing health insurance coverage for low-income children; and

''(2) report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

''(b) REPORT OF THE SECRETARY.—The Secretary shall submit to the appropriate committees of Congress an annual report and evaluation of the State programs funded under this title based on the State assessments and reports submitted under subsection (a). Such report shall include any conclusions and recommendations that the Secretary considers appropriate.''.

(b) CONFORMING AMENDMENT.—Section 1128(h) (42 U.S.C. 1320a–7(h)) is amended by—

(1) in paragraph (2), by striking ''or'' at the end;

(2) in paragraph (3), by striking the period and inserting '', or''; and

(3) by adding at the end the following:

''(4) a program funded under title XXI.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply on and after October 5, 1997.

NOTICE OF HEARING

COMMITTEE ON INDIAN AFFAIRS

Mr. CAMPBELL. Mr. President, I would like to announce that the Senate Committee on Indian Affairs will meet on Wednesday, June 25, 1997 at 9:30 a.m. to conduct an oversight hearing on the Administration's proposal to restructure Indian gaming fee assessments. The hearing will be held in room 562 of the Dirksen Senate Office Building.

Those wishing additional information should contact the Committee on Indian Affairs at 224–2251.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. DOMENICI. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet on Tuesday, June 24, 1997, at 10:30 a.m. on the nomination of Jane Garvey to be Federal Aviation Administration Administrator.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON GOVERNMENT AFFAIRS

Mr. DOMENICI. Mr. President, I ask Unanimous Consent on behalf of the Governmental Affairs Committee to meet on Tuesday, June 24, at 10 a.m. to hold a joint hearing with the Senate Appropriations Committee on the subject of Government Performance and Results Act.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. DOMENICI. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate on Tuesday, June 24, 1997, at 10 a.m. to hold a hearing on: ''Punitive Damages in Financial Injury Cases—The Raid Report.''

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. DOMENICI. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to hold an executive business meeting during the session of the Senate on Tuesday, June 24, 1997, following the first vote, at a location yet to be determined.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON SECURITIES

Mr. DOMENICI. Mr. President, I ask unanimous consent that the Subcommittee on Securities of the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on Wednesday, June 25, 1997, to conduct an oversight hearing on social security investment in the securities markets.

The PRESIDING OFFICER. Without objection, it is so ordered.

ADDITIONAL STATEMENTS

CONCERNS WITH THE SELECTION OF THE RAINBOW POOL SITE

● Mr. KERREY. Mr. President, I submit for the RECORD a letter from Richard Longstreth, first vice president for the Society of Architectural Historians and professor of american civilization at George Washington University to the chairman of the Commission on Fine Arts, J. Carter Brown, regarding the site selection for the proposed memorial to World War II.

Professor Longstreth, editor of ''The Mall in Washington, 1791–1991,'' is deeply concerned, as am I, by the selection of the Rainbow Pool site as the location for a proposed memorial to World War II.

I deeply support honoring those who served our Nation during the most pivotal event of the 20th century, as does the professor. I would even argue, Mr. President, that a memorial is not enough. That a museum is necessary to tell the complete story to future generations of our victory over the Axis Powers and our defeat of Nazi Germany. This a story that must be told and retold.

But I am deeply opposed to the selection of this expansive, reflective space at the key axis of the National Mall, lying between the Lincoln Memorial and Washington Monument as the site of a memorial.

The idea of constructing a 50-foot-high, 7.4-acre memorial on this site—smack in the middle of the National Mall—is quite troubling. Any structure of such size and magnitude would forever alter the openness and grandeur that is America's front lawn.

Professor Longstreth states in his letter: ''The whole meaning of one of the greatest civic spaces that exists anywhere in the world today will be irreparably cheapened by any proposed scheme for a major memorial on this site.''

I could not agree more.

Just as disconcerting is the idea that a World War II memorial constructed on this site will have to be closed on the Fourth of July weekend, as ruled by the National Parks Service, for safety reasons related to the fireworks display.

This does not make sense.

As the Commission on Fine Arts, National Capital Planning Commission, and the Secretary of the Interior continue their deliberative process concerning this proposed memorial, you will hear more from me in the coming months, Mr. President. Especially, as my office continues to monitor the process of the environmental and urban impact studies yet to be conducted on this site.

That is right, Mr. President this site was selected without any studies conducted on the impact on The Mall or the city. Currently, the Council on Environmental Quality is reviewing my request for information on the urban and environmental impact on this site. I will keep the Senate informed as to how this process progresses.

The letter follows:

SOCIETY OF ARCHITECTURAL HISTORIANS,
Chicago, IL, June 9, 1997.

J. CARTER BROWN,
Chairman, Commission of Fine Arts, Pension Building, Washington, DC.

DEAR MR. BROWN: As a scholar of the built environment, an officer of the Society of Architectural Historians, and editor of The Mall in Washington, 1791–1991, I am writing to express my very strong personal opposition to current plans for the World War II memorial. My objection lies not with the design. In the abstract I consider the design to possess the sophistication and dignity called for in a work of this nature. I also admire the members of the design team, one of whom I count as an old friend. Rather it is the site that is inappropriate, so much so that I believe this ranks among the very worst proposals ever made for the monumental core. Nothing—from John Russell Pope to Maya Lin—would be suitable at the proposed location.

The basic arguments against the site have been made, often eloquently, by others in recent months. From the practical standpoint, the location on a major artery—one that cannot, and should not be closed if the Mail is to remain a part of this city—will prove a logistical nightmare that could never be solved adequately, no matter how many egregious encroachments were made to what is now grass and pedestrianways.