

Dodd	Hutchinson	Reed
Domenici	Inhofe	Reid
Dorgan	Inouye	Robb
Durbin	Jeffords	Roberts
Edwards	Johnson	Rockefeller
Enzi	Kennedy	Roth
Feingold	Kerrey	Santorum
Feinstein	Kerry	Sarbanes
Fitzgerald	Kohl	Schumer
Frist	Kyl	Sessions
Gorton	Landrieu	Shelby
Graham	Lautenberg	Smith (NH)
Gramm	Leahy	Smith (OR)
Grams	Lieberman	Snowe
Grassley	Lincoln	Specter
Gregg	Lott	Stevens
Hagel	McConnell	Thompson
Harkin	Mikulski	Thurmond
Hatch	Moynihan	Torricelli
Helms	Murkowski	Voinovich
Hollings	Murray	Warner
Hutchinson	Nickles	Wellstone

NOT VOTING—7

Boxer	Mack	Wyden
Levin	McCain	
Lugar	Thomas	

The amendment (No. 1824) was agreed to.

Mr. COVERDELL. I move to reconsider the vote.

Mr. HATCH. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. DASCHLE. Mr. President, I ask to proceed as in morning business.

The PRESIDING OFFICER (Mr. GORTON). Without objection, it is so ordered

MEDICARE BENEFICIARY ACCESS TO CARE ACT OF 1999

Mr. DASCHLE. Mr. President, 2 years ago, we passed the Balanced Budget Act. It was a monumental example of what Congress can achieve when we work together.

Not only did we end 30 years of deficit spending with the Balanced Budget Act, we also extended the life of the Medicare Part A Trust Fund by 13 years. And we added important new preventive benefits, including mammograms and Pap smears, for Medicare beneficiaries.

We made many changes that achieved a lot of good.

We also know now that we made some miscalculations.

Frankly, that is to be expected. Very often, when you make a lot of changes, you don't get everything right the first time.

But the miscalculations we made about Medicare in the Balanced Budget Act are causing real hardships for some of our most vulnerable citizens—hardships that cannot be justified on either financial or medical grounds. We did not anticipate these consequences when we passed the Balanced Budget Act. But now that we know about them, we have a responsibility to address them.

Today I am introducing the Medicare Beneficiary Access to Care Act of 1999.

This bill is not a comprehensive Medicare reform plan. Nor is it a

wholesale revision of the Balanced Budget Act. Instead, it is a reasonable, targeted solution to certain specific problems with Medicare that Congress created inadvertently as part of the Balanced Budget Act.

Before I outline the specific remedies in my bill, I want to tell you about the real-life consequences of one of the changes we made to Medicare under the Balanced Budget Act.

Two years ago, Congress decided to limit how much Medicare would pay for rehabilitation therapy. The new limits are \$1,500 a year per patient for physical and speech therapy combined, and another \$1,500 for occupational therapy.

For some Medicare patients who need rehabilitation therapy, the new limits on payments are not a problem. But for Ruth Irwin, they are a nightmare.

A while back, Mrs. Irwin had to have one of her legs amputated because of complications of diabetes. With an incredible amount of effort and the help of regular physical therapy, Mrs. Irwin was learning how to walk with a prosthetic leg and two canes.

Her goal was to learn to walk with one cane, so she would have one hand free. She was on the verge of reaching that goal—when she hit the \$1,500 physical-therapy limit. She couldn't afford to pay out-of-pocket, so she stopped seeing her physical therapist. Her condition deteriorated. A few months later, she tripped on a curb and broke three ribs. Ruth Irwin is not alone.

It is estimated that 1 in 7 Medicare recipients who need physical therapy—about 200,000 Americans—will hit the caps this year. These are mostly patients who are recuperating from amputations, strokes, and head trauma, and people who suffer from serious degenerative diseases such as multiple sclerosis, Alzheimer's, and Parkinson's disease.

Mr. President, between 1990 and 1996, Medicare spending on rehabilitation therapy grew 18 percent a year, to \$1 billion. We had good reason to try to curb that growth. But we now know, we chose the wrong way to accomplish our goal. It's wrong to force stroke victims in nursing homes to decide whether they want to learn how to walk or talk. The Medicare Beneficiary Access to Care Act repeals the current, arbitrary caps rehabilitation therapy and replaces it with limits based on individual patients' specific needs.

It also makes a number of other, targeted adjustments.

First: It adjusts the new payment system for nursing homes and skilled nursing facilities to better reflect the increased costs of caring for very sick patients.

Second: It postpones additional cuts in home health care payments for two years and addresses the more serious problems that have come to light while the current "interim payment system" has been in place.

Third: It protects hospitals from crippling losses they might otherwise suffer as the result of a new Medicare payment system for outpatient medical services.

This protection is especially important for people who depend on rural hospitals—like Mobridge Hospital, in Mobridge, South Dakota. Mobridge Hospital is the only source of inpatient hospital care for 100 miles. If it were forced to drastically reduce its services, or close, that would have a devastating impact on scores of communities. Because they serve a population that is generally older and less wealthy than average, America's rural hospitals operate on lower profit margins, and they have virtually no margin for error. They need the relief that is in this bill.

A fourth area addressed by the bill are the deep cuts made by the BBA in payments to teaching hospitals. Major teaching hospitals represent only 6% of all hospitals. But they account for 70% of the burn units in America, more than half of the pediatric intensive care units, and they provide 44% of the indigent care in this country. The bill moderates these cuts.

When you combine other BBA cuts in payments with reductions in payments for indirect medical education, nearly half of America's major teaching hospitals are projected to lose money during the next few years. We cannot sacrifice the high-quality care, teaching, and research activities these hospitals provide. We must make this fix, and keep these hospitals whole. This bill does it.

Fifth, Mr. President, the Medicare Beneficiary Access to Care Act provides new protections for seniors enrolled in Medicare+Choice, when their plan pulls out of their community.

Finally, the bill includes additional provisions to protect access to rural hospitals, hospice care, community health centers, and rural health clinics.

As I said, this is not a comprehensive solution to Medicare. There are still many questions we must work together to answer. How can we add the prescription drug plan both our parties—and the vast majority of Americans—say we support? How can we make sure Medicare remains solvent when the Baby Boomers retire—and beyond?

These are questions that must be answered. They are important and must be addressed in legislation that falls outside the purview of the bill we introduce today. But make no mistake, they are high priorities, and ones which will not go away, and will be addressed in future bills.

For now, though, there is no question that we made some miscalculations in 1997, when we changed the way Medicare pays for certain services. There is no question that those miscalculations are causing real hardships today for

some of America's sickest and frailest citizens, and for the institutions that care for them. And there should be no delay in correcting those miscalculations.

We should make these changes not just because of the human suffering they are causing. There are compelling economic reasons to make them as well. That is the other part of Ruth Irwin's story. As a result of her three broken ribs, Mrs. Irwin received regular visits by a registered nurse and a home health aide—all paid for by Medicare. She also received physical therapy three times a week.

The bottom line: Her recovery was far longer, more painful—and more costly—than it needed to be. We did a lot of good in 1997. We made some tough decisions that added years of solvency to Medicare, and enabled us to add life-saving new preventive benefits. But we also made some miscalculations.

We didn't know at the time the harsh consequences some of these miscalculations would have.

Now that we do, we need to correct them—the sooner, the better. So I urge all my colleagues to support this bill and to work with us to ensure its prompt consideration and passage.

This legislation was the result of a tremendous amount of work by a number of our colleagues. This is clearly a team effort. I thank in particular Senator MOYNIHAN for his extensive efforts to help us draft and craft this legislation. His expertise was invaluable in making very important decisions. I thank Senators MIKULSKI and DURBIN and KERREY for their commitment to solving the problem. I thank Senator JACK REED for his help on home health and Senators BAUCUS and CONRAD for their efforts on rural health. I thank especially Senator ROCKEFELLER and the distinguished senior Senator from Massachusetts for their commitment to access to health care, to education, and to the array of issues they have raised throughout the work we have done on this bill to this date.

Mr. President, I now yield the floor and again thank Senator KENNEDY and others for their efforts on the floor this morning.

I ask unanimous consent that the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD.

S. 1678

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

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

(a) **SHORT TITLE.**—This Act may be cited as the "Medicare Beneficiary Access to Care Act of 1999".

(b) **AMENDMENTS TO SOCIAL SECURITY ACT.**—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or re-

peal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

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

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

TITLE I—HOSPITALS

Sec. 101. Multiyear transition to prospective payment system for hospital outpatient department services.

Sec. 102. Limitation in reduction of payments to disproportionate share hospitals.

Sec. 103. Changes to DSH allotments and transition rule.

Sec. 104. Revision of criteria for designation as a critical access hospital.

Sec. 105. Sole community hospitals and medicare dependent hospitals.

TITLE II—GRADUATE MEDICAL EDUCATION

Sec. 201. Revision of multiyear reduction of indirect graduate medical education payments.

Sec. 202. Acceleration of GME phase-in.

Sec. 203. Exclusion of nursing and allied health education costs in calculating Medicare+Choice payment rate.

Sec. 204. Adjustments to limitations on number of interns and residents.

TITLE III—HOSPICE CARE

Sec. 301. Increase in payments for hospice care.

TITLE IV—SKILLED NURSING FACILITIES

Sec. 401. Modification of case mix categories for certain conditions.

Sec. 402. Exclusion of clinical social worker services and services performed under a contract with a rural health clinic or Federally qualified health center from the PPS for SNFs.

Sec. 403. Exclusion of certain services from the PPS for SNFs.

Sec. 404. Exclusion of swing beds in critical access hospitals from the PPS for SNFs.

TITLE V—OUTPATIENT REHABILITATION SERVICES

Sec. 501. Modification of financial limitation on rehabilitation services.

TITLE VI—PHYSICIANS' SERVICES

Sec. 601. Technical amendment to update adjustment factor and physician sustainable growth rate.

Sec. 602. Publication of estimate of conversion factor and MedPAC review.

TITLE VII—HOME HEALTH

Sec. 701. Delay in the 15 percent reduction in payments under the PPS for home health services.

Sec. 702. Increase in per visit limit.

Sec. 703. Treatment of Outliers.

Sec. 704. Elimination of 15-minute billing requirement.

Sec. 705. Recoupment of overpayments.

Sec. 706. Refinement of home health agency consolidated billing.

TITLE VIII—MEDICARE+CHOICE

Sec. 801. Delay in ACR deadline under the Medicare+Choice program.

Sec. 802. Change in time period for exclusion of Medicare+Choice organizations that have had a contract terminated.

Sec. 803. Enrollment of medicare beneficiaries in alternative Medicare+Choice plans and medigap coverage in case of involuntary termination of Medicare+Choice enrollment.

Sec. 804. Applying medigap and Medicare+Choice protections to disabled and ESRD medicare beneficiaries.

Sec. 805. Extended Medicare+Choice disenrollment window for certain involuntarily terminated enrollees.

Sec. 806. Nonpreemption of State prescription drug coverage mandates in case of approved State medigap waivers.

Sec. 807. Modification of payment rules for certain frail elderly medicare beneficiaries.

Sec. 808. Extension of medicare community nursing organization demonstration projects.

TITLE IX—CLINICS

Sec. 901. New prospective payment system for Federally-qualified health centers and rural health clinics under the medicaid program.

TITLE I—HOSPITALS

SEC. 101. MULTIYEAR TRANSITION TO PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) **IN GENERAL.**—Section 1833(t) (42 U.S.C. 1395(t)) is amended by adding at the end the following:

“(10) **MULTIYEAR TRANSITION.**—

“(A) **IN GENERAL.**—In the case of covered OPD services furnished by a hospital during a transition year, the Secretary shall increase the payments for such services under the prospective payment system established under this subsection by the amount (if any) that the Secretary determines is necessary to ensure that the payment to cost ratio of the hospital for the transition year equals the applicable percentage of the payment to cost ratio of the hospital for 1996.

“(B) **PAYMENT TO COST RATIO.**—

“(i) **IN GENERAL.**—The payment to cost ratio of a hospital for any year is the ratio which—

“(I) the hospital's reimbursement under this part for covered OPD services furnished during the year, including through cost-sharing described in subparagraph (D)(ii), bears to

“(II) the cost of such services.

“(ii) **CALCULATION OF 1996 PAYMENT TO COST RATIO.**—The Secretary shall determine each hospital's payment to cost ratio for 1996 as if the amendments to this title by the provisions of section 4521 of the Balanced Budget Act of 1997 were in effect in 1996.

“(iii) **TRANSITION YEARS.**—The Secretary shall estimate each payment to cost ratio of a hospital for any transition year before the beginning of such year.

“(C) **INTERIM PAYMENTS.**—

“(i) **IN GENERAL.**—The Secretary shall make interim payments to a hospital during any transition year for which the Secretary estimates a payment is required under subparagraph (A).

“(ii) **ADJUSTMENTS.**—If the Secretary makes payments under clause (i) for any transition year, the Secretary shall make retrospective adjustments to each hospital based on its settled cost report so that the amount of any additional payment to a hospital for such year equals the amount described in subparagraph (A).

“(D) **DEFINITIONS.**—In this paragraph:

“(i) APPLICABLE PERCENTAGE.—The term ‘applicable percentage’ means, with respect to covered OPD services furnished during—

“(I) the first full year (and any portion of the immediately preceding year) for which the prospective payment system under this subsection is in effect, 95 percent;

“(II) the second full calendar year for which such system is in effect, 90 percent; and

“(III) the third full calendar year for which such system is in effect, 85 percent.

“(ii) COST-SHARING.—The term ‘cost-sharing’ includes—

“(I) copayment amounts described in paragraph (5);

“(II) coinsurance described in section 1866(a)(2)(A)(ii); and

“(III) the deductible described under section 1833(b).

“(iii) TRANSITION YEAR.—The term ‘transition year’ means any year (or portion thereof) described in clause (i).

“(E) EFFECT ON COPAYMENTS.—Nothing in this paragraph shall be construed as affecting the unadjusted copayment amount described in paragraph (3)(B).

“(F) APPLICATION WITHOUT REGARD TO BUDGET NEUTRALITY.—The transitional payments made under this paragraph—

“(i) shall not be considered an adjustment under paragraph (2)(E); and

“(ii) shall not be implemented in a budget neutral manner.”

(b) SPECIAL RULE FOR RURAL AND CANCER HOSPITALS.—Section 1833(t) (42 U.S.C. 1395(t)), as amended by subsection (a), is amended by adding at the end the following:

“(1) SPECIAL RULE FOR RURAL AND CANCER HOSPITALS.—

“(A) IN GENERAL.—For each year (or portion thereof), beginning in 2000, in the case of covered OPD services furnished by a medicare-dependent, small rural hospital (as defined in section 1886(d)(5)(G)(iv)), a sole community hospital (as defined in section 1886(d)(5)(D)(iii)), or in a hospital described in section 1886(d)(1)(B)(v), the Secretary shall increase the payments for such services under the prospective payment system established under this subsection by the amount (if any) that the Secretary determines is necessary to ensure that the payment to cost ratio of the hospital (as determined pursuant to paragraph (10)(B)) for the year equals the payment to cost ratio of the hospital for 1996 (as calculated under clause (ii) of such paragraph).

“(B) INTERIM PAYMENTS.—

“(i) IN GENERAL.—The Secretary shall make interim payments to a hospital during any year for which the Secretary estimates a payment is required under subparagraph (A).

“(ii) ADJUSTMENTS.—If the Secretary makes payments under clause (i) for any year, the Secretary shall make retrospective adjustments to each hospital based on its settled cost report so that the amount of any additional payment to a hospital for such year equals the amount described in subparagraph (A).

“(C) EFFECT ON COPAYMENTS.—Nothing in this paragraph shall be construed as affecting the unadjusted copayment amount described in paragraph (3)(B).

“(D) APPLICATION WITHOUT REGARD TO BUDGET NEUTRALITY.—The payments made under this paragraph—

“(i) shall not be considered an adjustment under paragraph (2)(E); and

“(ii) shall not be implemented in a budget neutral manner.”

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if

included in the amendments made by section 4523 of the Balanced Budget Act of 1997 (Public Law 105-33; 111 Stat. 445).

SEC. 102. LIMITATION IN REDUCTION OF PAYMENTS TO DISPROPORTIONATE SHARE HOSPITALS.

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

(1) in subclause (II)—

(A) by striking “fiscal year 1999,” and inserting “each of fiscal years 1999, 2000, 2001, and 2002,”; and

(B) by inserting “and” after the semicolon;

(2) by striking subclauses (III), (IV), and (V); and

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

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in the amendments made by section 4403 of the Balanced Budget Act of 1997 (Public Law 105-33; 111 Stat. 398).

SEC. 103. CHANGES TO DSH ALLOTMENTS AND TRANSITION RULE.

(a) CHANGE IN DISPROPORTIONATE SHARE HOSPITAL ALLOTMENTS.—Section 1923(f)(2) (42 U.S.C. 1396r-4(f)(2)) is amended, in the table contained in such section and in the DSH Allotments for fiscal years 2000, 2001, and 2002—

(1) for Minnesota, by striking “16” and inserting “33”;

(2) for New Mexico, by striking “5” and inserting “9”; and

(3) for Wyoming, by striking “0” and inserting “0.1”.

(b) MAKING MEDICAID DSH TRANSITION RULE PERMANENT.—Section 4721(e) of the Balanced Budget Act of 1997 is amended—

(1) in the matter before paragraph (1), by striking “1923(g)(2)(A)” and “1396r-4(g)(2)(A)” and inserting “1923(g)(2)” and “1396r-4(g)(2)”, respectively;

(2) in paragraphs (1) and (2)—

(A) by striking “, and before July 1, 1999”; and

(B) by striking “in such section” and inserting “in subparagraph (A) of such section”; and

(3) by striking “and” at the end of paragraph (1), by striking the period at the end of paragraph (2) and inserting “; and”, and by adding at the end the following:

“(3) effective for State fiscal years that begin on or after July 1, 1999, ‘or (b)(1)(B)’ were inserted in 1923(g)(2)(B)(ii)(I) after ‘(b)(1)(A)’.”

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of the Balanced Budget Act of 1997 (Public Law 105-33; 111 Stat. 251).

SEC. 104. REVISION OF CRITERIA FOR DESIGNATION AS A CRITICAL ACCESS HOSPITAL.

(a) CRITERIA FOR DESIGNATION.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395i-4(c)(2)(B)(iii)) is amended by striking “to exceed 96 hours” and all that follows before the semicolon and inserting “to exceed, on average, 96 hours per patient”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect 60 days after the date of enactment of this Act.

SEC. 105. SOLE COMMUNITY HOSPITALS AND MEDICARE DEPENDENT HOSPITALS.

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

(1) in subclause (III), by striking “and” at the end;

(2) in subclause (IV)—

(A) by striking “fiscal year 1996 and each subsequent fiscal year” and inserting “fiscal years 1996 through 1999”; and

(B) by striking the period at the end and inserting “, and”; and

(3) by adding at the end the following:

“(V) for fiscal year 2000 and each subsequent fiscal year, the market basket percentage increase.”

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

TITLE II—GRADUATE MEDICAL EDUCATION

SEC. 201. REVISION OF MULTIYEAR REDUCTION OF INDIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.

(a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended by striking subclauses (III), (IV), and (V) and inserting the following:

“(III) during each of fiscal years 1999, 2000, and 2001, ‘c’ is equal to 1.6; and

“(IV) on or after October 1, 2001, ‘c’ is equal to 1.35.”

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in section 4621 of the Balanced Budget Act of 1997 (Public Law 105-33; 111 Stat. 475).

SEC. 202. ACCELERATION OF GME PHASE-IN.

(a) ACCELERATION OF PAYMENT TO HOSPITALS OF INDIRECT AND DIRECT MEDICAL EDUCATION COSTS FOR MEDICARE+CHOICE ENROLLEES.—

(1) IN GENERAL.—Section 1886(h)(3)(D)(ii) (42 U.S.C. 1395ww(h)(3)(D)(ii)) is amended by striking subclauses (IV) and (V) and inserting the following:

“(IV) 100 percent in 2001 and subsequent years.”

(2) ACCELERATION OF CARVE-OUT.—Section 1853(c)(3)(B)(ii) (42 U.S.C. 1395w-23(c)(3)(B)(ii)) is amended—

(A) in subclause (III), by inserting “and” at the end;

(B) by striking subclause (IV); and

(C) by redesignating subclause (V) as subclause (IV).

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in the enactment of the Balanced Budget Act of 1997 (Public Law 105-33; 111 Stat. 251).

SEC. 203. EXCLUSION OF NURSING AND ALLIED HEALTH EDUCATION COSTS IN CALCULATING MEDICARE+CHOICE PAYMENT RATE.

(a) EXCLUDING COSTS IN CALCULATING PAYMENT RATE.—

(1) IN GENERAL.—Section 1853(c)(3)(C)(i) (42 U.S.C. 1395w-23(c)(3)(C)(i)) is amended—

(A) in subclause (I), by striking “and” at the end;

(B) in subclause (II), by striking the period at the end and inserting “, and”; and

(C) by adding at the end the following:

“(III) for costs attributable to approved nursing and allied health education programs under section 1861(v).”

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply in determining the annual per capita rate of payment for years beginning with 2001.

(b) PAYMENT TO HOSPITALS OF NURSING AND ALLIED HEALTH EDUCATION PROGRAM COSTS FOR MEDICARE+CHOICE ENROLLEES.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following:

“(V)(i) In determining the amount of payment to a hospital for portions of cost reporting periods occurring on or after January 1, 2001, with respect to the reasonable costs for approved nursing and allied health education programs, individuals who are enrolled with a Medicare+Choice organization under part C shall be treated as if they were not so enrolled.

“(ii) The Secretary shall establish rules for applying clause (i) 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.”.

SEC. 204. ADJUSTMENTS TO LIMITATIONS ON NUMBER OF INTERNS AND RESIDENTS.

(a) INDIRECT GRADUATE MEDICAL EDUCATION ADJUSTMENT.—Section 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is amended—

(1) by striking “(v) In determining” and inserting “(v)(I) Subject to subclause (II), in determining”;

(2) by striking “in the hospital with respect to the hospital’s most recent cost reporting period ending on or before December 31, 1996” and inserting “who were appointed by the hospital’s approved medical residency training programs for the hospital’s most recent cost reporting period ending on or before December 31, 1996”; and

(3) by adding at the end the following:
“(II) Beginning on or after January 1, 1997, in the case of a hospital that sponsors only 1 allopathic or osteopathic residency program, the limit determined for such hospital under subclause (I) may, at the hospital’s discretion, be increased by 1 for each calendar year but shall not exceed a total of 3 more than the limit determined for the hospital under subclause (I).”.

(b) DIRECT GRADUATE MEDICAL EDUCATION ADJUSTMENT.—

(1) LIMITATION ON NUMBER OF RESIDENTS.—Section 1886(h)(4)(F) (42 U.S.C. 1395ww(h)(4)(F)) is amended by inserting “who were appointed by the hospital’s approved medical residency training programs” after “may not exceed the number of such full-time equivalent residents”.

(2) FUNDING FOR PROGRAMS.—Section 1886(h)(4)(H)(i) (42 U.S.C. 1395ww(h)(4)(H)(i)) is amended in the second sentence, by inserting “, including facilities that are not located in an underserved rural area but have established separately accredited rural training tracks” before the period.

(c) GME PAYMENTS FOR CERTAIN INTERNS AND RESIDENTS.—

(1) INDIRECT AND DIRECT MEDICAL EDUCATION.—Each limitation regarding the number of residents or interns for which payment may be made under section 1886 of the Social Security Act (42 U.S.C. 1395ww) is increased by the number of applicable residents (as defined in paragraph (2)).

(2) APPLICABLE RESIDENT DEFINED.—In this subsection, the term “applicable resident” means a resident or intern that—

(A) participated in graduate medical education at a facility of the Department of Veterans Affairs;

(B) was subsequently transferred on or after January 1, 1997, and before July 31, 1998, to a hospital and the hospital was not a Department of Veterans Affairs facility; and

(C) was transferred because the approved medical residency program in which the resident or intern participated would lose accreditation by the Accreditation Council on Graduate Medical Education if such program continued to train residents at the Department of Veterans Affairs facility.

(d) EFFECTIVE DATE.—This section shall take effect as if included in the enactment of the Balanced Budget Act of 1997 (Public Law 105-33; 111 Stat. 251).

TITLE III—HOSPICE CARE

SEC. 301. INCREASE IN PAYMENTS FOR HOSPICE CARE.

(a) IN GENERAL.—Section 1814(i)(1)(C)(ii)(VI) (42 U.S.C. 1395f(i)(1)(C)(ii)(VI)) is amended by striking “through 2002” and inserting “and 1999”.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the amendments made by section 441 of the Balanced Budget Act of 1997 (Public Law 105-33; 111 Stat. 422).

TITLE IV—SKILLED NURSING FACILITIES
SEC. 401. MODIFICATION OF CASE MIX CATEGORIES FOR CERTAIN CONDITIONS.

(a) IN GENERAL.—For purposes of applying any formula under paragraph (1) of section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)), for services provided on or after April 1, 2000, and before the earlier of October 1, 2001, or the date described in subsection (d), the Secretary of Health and Human Services shall increase the adjusted Federal per diem rate otherwise determined under paragraph (4) of such section for services provided to any individual during the period in which such individual is in a RUG III category by the applicable payment add-on as determined in accordance with the following table:

RUG III category	Applicable payment add-on
RUB	\$23.06
RVC	\$76.25
RVB	\$30.36
RHC	\$54.07
RHB	\$27.28
RMC	\$69.98
RMB	\$30.09
SE3	\$98.41
SE2	\$89.05
SSC	\$46.80
SSB	\$55.56
SSA	\$59.94.

(b) UPDATE.—The Secretary shall update the applicable payment add-on under subsection (a) for fiscal year 2001 by the skilled nursing facility market basket percentage change (as defined under section 1888(e)(5)(B) of the Social Security Act (42 U.S.C. 1395yy(e)(5)(B))) applicable to such fiscal year.

(c) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as permitting the Secretary of Health and Human Services to include any applicable payment add-on determined under subsection (a) in updating the Federal per diem rate under section 1888(e)(4) of the Social Security Act (42 U.S.C. 1395yy(e)(4)).

(d) DATE DESCRIBED.—The date described in this subsection is the date that the Secretary of Health and Human Services—

(1) refines the case mix classification system under section 1888(e)(4)(G)(i) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(G)(i)) to better account for medically complex patients; and

(2) implements such refined system.

SEC. 402. EXCLUSION OF CLINICAL SOCIAL WORKER SERVICES AND SERVICES PERFORMED UNDER A CONTRACT WITH A RURAL HEALTH CLINIC OR FEDERALLY QUALIFIED HEALTH CENTER FROM THE PPS FOR SNFS.

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

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

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

(b) CONFORMING AMENDMENT.—Section 1861(hh)(2) (42 U.S.C. 1395x(hh)(2)) is amended

by striking “and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation”.

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

SEC. 403. EXCLUSION OF CERTAIN SERVICES FROM THE PPS FOR SNFS.

(a) IN GENERAL.—Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)), as amended by section 402, is amended—

(1) in the first sentence, by inserting “ambulance services, services identified by HCPCS code in Program Memorandum Transmittal No. A-98-37 issued in November 1998 (but without regard to the setting in which such services are furnished),” after “subparagraphs (F) and (O) of section 1861(s)(2).”; and

(2) by inserting after the second sentence the following: “In addition to the services described in the previous sentences, services described in this clause include chemotherapy items (identified as of July 1, 1999, by HCPCS codes J9000-J9020, J9040-J9151, J9170-J9185, J9200-J9201, J9206-J9208, J9211, J9230-J9245, and J9265-J9600), chemotherapy administration services (identified as of July 1, 1999, by HCPCS codes 36260-36262, 36489, 36530-36535, 36640, 36823, and 96405-96542), radioisotope services (identified as of July 1, 1999, by HCPCS codes 79030-79440), and customized prosthetic devices (identified as of July 1, 1999, by HCPCS codes L5050-L5340, L5500-L5610, L5613-L5986, L5988, L6050-L6370, L6400-L6880, L6920-L7274, and L7362-L7366).”.

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

SEC. 404. EXCLUSION OF SWING BEDS IN CRITICAL ACCESS HOSPITALS FROM THE PPS FOR SNFS.

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

(1) in the heading, by striking “TRANSITION” and inserting “SPECIAL RULES”;

(2) in subparagraph (A), by striking “IN GENERAL.—The” and inserting “TRANSITION.—Except as provided in subparagraph (C), the”;

(3) by adding at the end the following:
“(C) EXEMPTION OF SWING BEDS IN CRITICAL ACCESS HOSPITALS FROM PPS.—The prospective payment system under this subsection shall not apply (and section 1834(g) shall apply) to services provided by a critical access hospital under an agreement described in subparagraph (B).”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided on or after October 1, 1999.

TITLE V—OUTPATIENT REHABILITATION SERVICES

SEC. 501. MODIFICATION OF FINANCIAL LIMITATION ON REHABILITATION SERVICES.

(a) 3-YEAR REPEAL.—Section 1833(g) (42 U.S.C. 1395l(g)) is amended by adding at the end the following:

“(4) Subject to paragraph (6), the provisions of paragraphs (1) through (3) shall not apply to outpatient physical therapy services, outpatient occupational therapy services, and outpatient speech-language pathology services covered under this title and furnished on or after January 1, 2000.

“(5)(A) Notwithstanding the preceding provisions of this subsection and subject to subparagraph (B), with respect to services described in paragraph (4) that are furnished on

or after January 1, 2003, the Secretary shall implement, by not later than January 1, 2003, a payment system for such services that takes into account the needs of beneficiaries under this title for differing amounts of therapy based on factors such as diagnosis, functional status, and prior use of services.

“(B) The payment system established under subparagraph (A) shall be designed so that the system shall not result in any increase or decrease in the expenditures under this title on a fiscal year basis, determined as if paragraph (4) had not been enacted.

“(6) If the Secretary for any reason does not implement the payment system described in paragraph (5) on or before January 1, 2003, paragraph (4) shall not apply with respect to services described in such paragraph that are furnished on or after such date and before the date on which the Secretary implements such payment system.”.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect as if included in the enactment of the Balanced Budget Act of 1997 (Public Law 105-33; 111 Stat. 251).

TITLE VI—PHYSICIANS' SERVICES

SEC. 601. TECHNICAL AMENDMENT TO UPDATE ADJUSTMENT FACTOR AND PHYSICIAN SUSTAINABLE GROWTH RATE.

(a) UPDATE ADJUSTMENT FACTOR.—

(1) CHANGE TO CALENDAR YEAR BASIS.—Section 1848(d) (42 U.S.C. 1395w-4(d)) is amended—

(A) in paragraph (1), by striking subparagraph (E) and inserting the following:

“(E) PUBLICATION.—The Secretary shall publish in the Federal Register—

“(i) not later than November 1 of each year (beginning with 1999), the conversion factor that will apply to physicians' services for the succeeding year and the update determined under paragraph (3) for such year; and

“(ii) not later than November 1 of 1999—

“(I) the special update for the year 2000 under paragraph (3)(E)(i); and

“(II) the estimated special adjustments for years 2001 through 2006 under paragraph (3)(E)(ii).”; and

(B) in paragraph (3)(C)—

(i) in the matter preceding clause (i), by striking “the 12-month period ending with March 31 of”;

(ii) in clause (i)—

(I) by striking “1997” and inserting “1996.”; and

(II) by striking “such 12-month period” and inserting “1996.”; and

(iii) in clause (ii)—

(I) by inserting a comma after “subsequent year.”; and

(II) by striking “fiscal year which begins during such 12-month period” and inserting “year involved”.

(2) FORMULA FOR DETERMINING THE UPDATE ADJUSTMENT FACTOR.—Section 1848(d)(3) (42 U.S.C. 1395w-4(d)(3)) is amended—

(A) in subparagraph (A)—

(i) in clause (ii), by striking “(divided by 100),” and inserting a period; and

(ii) by striking the matter following clause (ii);

(B) in subparagraph (B)—

(i) in the matter preceding clause (i), by inserting “the sum of” after “Secretary to”; and

(ii) by striking clauses (i) and (ii) and inserting the following:

“(i) the figure arrived at by—

“(I) determining the difference between the allowed expenditures for physicians' services for the prior year (as determined under subparagraph (C)) and the actual expenditures for such services for that year;

“(II) dividing that difference by the actual expenditures for such services in that year; and

“(III) multiplying that quotient by 0.75; and

“(ii) the figure arrived at by—

“(I) determining the difference between the allowed expenditures for physicians' services (as determined under subparagraph (C)) from 1996 through the prior year and the actual expenditures for such services during that period, corrected with the best available data;

“(II) dividing that difference by actual expenditures for such services for the prior year as increased by the sustainable growth rate under subsection (f) for the year whose update adjustment factor is to be determined; and

“(III) multiplying that quotient by 0.33.”; and

(C) by amending subparagraph (D) to read as follows:

“(D) RESTRICTION ON UPDATE ADJUSTMENT FACTOR.—The update adjustment factor determined under subparagraph (B) for a year may not be less than negative 0.07 or greater than 0.03.”.

(3) SPECIAL PROVISIONS.—Section 1848(d)(3) (42 U.S.C. 1395w-4(d)(3)) is amended—

(A) in subparagraph (A), in the matter preceding clause (i), by striking “subparagraph (D)” and inserting “subparagraphs (D) and (E).”; and

(B) by adding at the end the following:

“(E) SPECIAL UPDATE AND ADJUSTMENTS.—

“(i) YEAR 2000.—For the year 2000, the update under this paragraph shall be the percentage that the Secretary estimates will, without regard to any otherwise applicable restriction, result in expenditures equal to the expenditures that would have occurred in that year in the absence of the amendments made by section 601 of the Medicare Beneficiary Access to Care Act of 1999.

“(ii) YEARS 2001–2006.—For each of the years 2001 through 2006, the Secretary shall make that adjustment to the update for that year which the Secretary estimates will, without regard to any otherwise applicable restriction, result in expenditures equal to the expenditures that would have occurred for that year in the absence of the amendments made by section 601 of the Medicare Beneficiary Access to Care Act of 1999.”.

(b) SUSTAINABLE GROWTH RATE.—Section 1848(f) (42 U.S.C. 1395w-4(f)) is amended—

(1) by striking paragraph (1) and inserting the following:

“(1) PUBLICATION.—Not later than November 1 of each year (beginning with 1999), the Secretary shall publish in the Federal Register the sustainable growth rate as determined under this subsection for the succeeding year, the current year, and each of the preceding 2 years.”; and

(2) in paragraph (2)—

(A) by striking “fiscal” each place it appears; and

(B) in the matter preceding subparagraph (A), by striking “year 1998” and inserting “1997.”.

(c) DATA TO BE USED IN DETERMINING THE SUSTAINABLE GROWTH RATE.—Section 1848(f) (42 U.S.C. 1395w-4(f)) is amended—

(1) by redesignating paragraph (3) as paragraph (4); and

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

“(3) METHODOLOGY.—For purposes of determining the update adjustment factor under subsection (d)(3)(B) and the allowed expenditures under subsection (d)(3)(C) for a year, the sustainable growth rate for each year

taken into consideration in the determination under paragraph (2) shall be determined as follows:

“(A) For purposes of such calculations for the year 2000, the sustainable growth rate shall be determined on the basis of the best data available to the Secretary as of September 1, 1999.

“(B) For purposes of such calculations for each year after the year 2000—

“(i) the sustainable growth rate for such year and each of the 2 preceding years shall be determined on the basis of the best data available to the Secretary as of September 1 of such year; and

“(ii) the sustainable growth rate for each year preceding the years specified in clause (i) shall be the rate used for such year in such calculation for the immediately preceding year.”.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by this section shall take effect as if included in the enactment of the Balanced Budget Act of 1997 (Public Law 105-33; 111 Stat. 251).

(2) NO EFFECT ON UPDATES FOR 1998 AND 1999.—The amendments made by this section shall have no effect on the updates established by the Secretary for 1998 and 1999, and such established updates may not be changed.

SEC. 602. PUBLICATION OF ESTIMATE OF CONVERSION FACTOR AND MEDPAC REVIEW.

(a) PUBLICATION.—Not later than April 15 of each year (beginning in 2000), the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall publish in the Federal Register—

(1) an estimate of the single conversion factor to be used in the next calendar year for reimbursement of physicians services under section 1848 of the Social Security Act (42 U.S.C. 1395w-4); and

(2) the data on which such estimate is based.

(b) MEDPAC REVIEW AND REPORT.—

(1) REVIEW.—The Medicare Payment Advisory Commission (in this section referred to as “MedPAC”) shall annually review the estimates and data published by the Secretary pursuant to subsection (a).

(2) REPORT.—Not later than June 30 of each year (beginning in 2000), MedPAC shall submit a report to the Secretary and to the committees of jurisdiction in Congress on the review conducted pursuant to paragraph (1), together with any recommendations as determined appropriate by MedPAC.

TITLE VII—HOME HEALTH

SEC. 701. DELAY IN THE 15 PERCENT REDUCTION IN PAYMENTS UNDER THE PPS FOR HOME HEALTH SERVICES.

(a) CONTINGENCY REDUCTION.—Section 4603(e) of the Balanced Budget Act of 1997 (42 U.S.C. 1395fff note), as amended by section 5101(c)(3) of the Tax and Trade Relief Extension Act of 1998 (contained in division J of Public Law 105-277), is amended by striking “September 30, 2000” and inserting “September 30, 2002”.

(b) PROSPECTIVE PAYMENT SYSTEM.—Section 1895(b)(3)(A) (42 U.S.C. 1395fff(b)(3)(A)), as amended by section 5101 of the Tax and Trade Relief Extension Act of 1998 (contained in division J of Public Law 105-277), is amended by striking clause (i) and inserting the following:

“(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—

“(I) for fiscal year 2001, shall be equal to the total amount that would have been made if the system had not been in effect;

“(II) for fiscal year 2002, shall be equal to the amount determined under subclause (I), updated under subparagraph (B); and

“(III) for fiscal year 2003, shall be equal to the total amount that would have been made for fiscal year 2001 if the system had not been in effect but if the reduction in limits described in clause (ii) had been in effect, and updated under subparagraph (B) for fiscal years 2001 and 2002.

Each 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.”

SEC. 702. INCREASE IN PER VISIT LIMIT.

(a) INTERIM PAYMENT SYSTEM.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)), as amended by section 701(b), is amended—

- (1) in subclause (IV), by striking “or”;
- (2) in subclause (V)—

(A) by inserting “and before October 1, 1999,” after “October 1, 1998.”; and

(B) by striking the period and inserting “, or”;

- (3) by adding at the end the following:

“(VI) October 1, 1999, 112 percent of such median.”.

(b) ENSURING THE INCREASE IN PER VISIT LIMIT HAS NO EFFECT ON THE PROSPECTIVE PAYMENT SYSTEM.—The second sentence of section 1895(b)(3)(A)(i) (42 U.S.C. 1395fff(b)(3)(A)(i)), as amended by section 5101(c)(1)(B) of the Tax and Trade Relief Extension Act of 1998 (contained in division J of Public Law 105-277) and section 701(b), is amended—

(1) in subclause (I), by inserting “but if the reference in section 1861(v)(1)(L)(i)(VI) to 112 percent were a reference to 106 percent” after “if the system had not been in effect”;

(2) in subclause (III), by inserting “and if the reference in section 1861(v)(1)(L)(i)(VI) to 112 percent were a reference to 106 percent” after “clause (ii) had been in effect”.

SEC. 703. TREATMENT OF OUTLIERS.

(a) WAIVER OF PER BENEFICIARY LIMITS FOR OUTLIERS.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)), as amended by section 5101 of the Tax and Trade Relief Extension Act of 1998 (contained in division J of Public Law 105-277), is amended—

(1) by redesignating clause (ix) as clause (x); and

(2) by inserting after clause (viii) the following:

“(ix)(I) Notwithstanding the applicable per beneficiary limit under clause (v), (vi), or (viii), but subject to the applicable per visit limit under clause (i), in the case of a provider that demonstrates to the Secretary that with respect to an individual to whom the provider furnished home health services appropriate to the individual’s condition (as determined by the Secretary) at a reasonable cost (as determined by the Secretary), and that such reasonable cost significantly exceeded such applicable per beneficiary limit because of unusual variations in the type or

amount of medically necessary care required to treat the individual, the Secretary, upon application by the provider, shall pay to such provider for such individual such reasonable cost.

“(II) The total amount of the additional payments made to home health agencies pursuant to subclause (I) in any fiscal year shall not exceed an amount equal to 2 percent of the amounts that would have been paid under this subparagraph in such year if this clause had not been enacted.”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date of enactment of this Act, and shall apply to each application for payment of reasonable costs for outliers submitted by any home health agency for cost reporting periods ending on or after October 1, 1999.

SEC. 704. ELIMINATION OF 15-MINUTE BILLING REQUIREMENT.

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

“(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 the claim has the unique identifier (provided under section 1842(r)) for the physician who prescribed the services or made the certification described in section 1814(a)(2) or 1835(a)(2)(A).”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to claims submitted on or after the date which is 60 days after the date of enactment of this section.

SEC. 705. RECOUPMENT OF OVERPAYMENTS.

(a) 36-MONTH REPAYMENT PERIOD.—In the case of an overpayment by the Secretary of Health and Human Services to a home health agency for home health services furnished during a cost reporting period beginning on or after October 1, 1997, as a result of payment limitations provided for under clause (v), (vi), or (viii) of section 1861(v)(1)(L) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)), the home health agency may elect to repay the amount of such overpayment ratably over a 36-month period beginning on the date of notification of such overpayment.

(b) NO INTEREST ON OVERPAYMENT AMOUNTS.—In the case of an agency that makes an election under subsection (a), no interest shall accrue on the outstanding balance of the amount of overpayment during such 36-month period.

(c) TERMINATION.—No election under subsection (a) may be made for cost reporting periods, or portions of cost reporting periods, beginning on or after the date of the implementation of the prospective payment system for home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff).

(d) EFFECTIVE DATE.—The provisions of subsection (a) shall apply to debts that are outstanding as of the date of enactment of this Act.

SEC. 706. REFINEMENT OF HOME HEALTH AGENCY CONSOLIDATED BILLING.

(a) IN GENERAL.—Section 1842(b)(6)(F) (42 U.S.C. 1395u(b)(6)(F)) is amended by inserting “(including medical supplies described in section 1861(m)(5), but excluding durable medical equipment described in such section)” after “home health services”.

(b) CONFORMING AMENDMENT.—Section 1862(a)(21) (42 U.S.C. 1395y(a)(21)) is amended by inserting “(including medical supplies described in section 1861(m)(5), but excluding durable medical equipment described in such section)” after “home health services”.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the amendments made by section 4603 of the Balanced Budget Act of 1997 (Public Law 105-33; 111 Stat. 467).

TITLE VIII—MEDICARE+CHOICE

SEC. 801. DELAY IN ACR DEADLINE UNDER THE MEDICARE+CHOICE PROGRAM.

(a) DELAY IN DEADLINE FOR SUBMISSION OF ADJUSTED COMMUNITY RATES AND RELATED INFORMATION.—Section 1854(a)(1) (42 U.S.C. 1395w-24(a)(1)) is amended by striking “May 1” and inserting “July 1”.

(b) ADJUSTMENT IN INFORMATION DISCLOSURE PROVISIONS.—Section 1851(d)(2)(A)(ii) (42 U.S.C. 1395w-21(d)(2)(A)(ii)) is amended in the first sentence by inserting “, to the extent such information is available at the time of preparation of the material for mailing” before the period.

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

SEC. 802. CHANGE IN TIME PERIOD FOR EXCLUSION OF MEDICARE+CHOICE ORGANIZATIONS THAT HAVE HAD A CONTRACT TERMINATED.

(a) IN GENERAL.—Section 1857(c)(4) (42 U.S.C. 1395w-27(c)(4)) is amended by striking “5-year period” and inserting “3-year period”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to contract years beginning on or after January 1, 1999.

SEC. 803. ENROLLMENT OF MEDICARE BENEFICIARIES IN ALTERNATIVE MEDICARE+CHOICE PLANS AND MEDIGAP COVERAGE IN CASE OF INVOLUNTARY TERMINATION OF MEDICARE+CHOICE ENROLLMENT.

(a) PERMITTING ENROLLMENT IN ALTERNATIVE PLANS UPON RECEIPT OF NOTICE OF MEDICARE+CHOICE PLAN TERMINATION.—

(1) MEDICARE+CHOICE PLANS.—Section 1851(e)(4) (42 U.S.C. 1395w-21(e)(4)) is amended by striking subparagraph (A) and inserting the following:

“(A)(i) the certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or

“(ii) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuation of such plan;”.

(2) MEDIGAP PLANS.—

(A) IN GENERAL.—Section 1882(s)(3)(A) (42 U.S.C. 1395ss(s)(3)(A)) is amended in the matter following clause (iii)—

(i) by inserting “(92 days in the case of a termination or discontinuation of coverage under the types of circumstances described in section 1851(e)(4)(A))” after “63 days”;

(ii) by inserting “(or, if elected by the individual, the date of notification of the individual by the plan or organization of the impending termination or discontinuation of the plan in the area in which the individual resides)” after “the date of the termination of enrollment described in such subparagraph”; and

(iii) by inserting “(or date of such notification)” after “the date of termination or disenrollment”.

(B) EFFECTIVE DATE.—The amendments made by this paragraph shall apply to notices of intended termination made by group health plans and Medicare+Choice organizations after the date of enactment of this Act.

(b) GUARANTEED ACCESS FOR CERTAIN MEDICARE BENEFICIARIES TO MEDIGAP POLICIES IN

CASE OF INVOLUNTARY TERMINATION OF COVERAGE UNDER A MEDICARE+CHOICE PLAN.—

(1) **IN GENERAL.**—Section 1882(s)(3)(C)(iii) (42 U.S.C. 1395ss(s)(3)(C)(iii)) is amended by inserting “or an individual described in clause (ii) or (iii) of subparagraph (B) in the case of circumstances described in section 1851(e)(4)(A)” after “subparagraph (B)(vi)”.

(2) EFFECTIVE DATE.—

(A) **IN GENERAL.**—Subject to subparagraph (B), the amendment made by paragraph (1) shall apply to terminations of coverage effected on or after the date of enactment of this Act.

(B) **TRANSITIONAL MEDIGAP OPEN ENROLLMENT PERIOD FOR CERTAIN INDIVIDUALS AFFECTED BY PLAN WITHDRAWALS.**—In the case of an individual described in clause (ii) or (iii) of subparagraph (B) of section 1882(s)(3) of the Social Security Act in the case of circumstances described in section 1851(e)(4)(A) of such Act (relating to discontinuation of a plan or organization entirely or in an area), if the termination or discontinuation of coverage occurred after December 31, 1998, and before the date of enactment of this Act, the provisions of subparagraph (A) of section 1882(s)(3) such Act (in the matter up to and including clause (iii) thereof) shall apply to such an individual who seeks enrollment under a Medicare supplemental policy during the 92-day period beginning with the first month that begins more than 30 days after the date of enactment of this Act in the same manner as such provisions apply to an individual described in the matter following such clause (iii).

SEC. 804. APPLYING MEDIGAP AND MEDICARE+CHOICE PROTECTIONS TO DISABLED AND ESRD MEDICARE BENEFICIARIES.

(a) **ASSURING AVAILABILITY OF MEDIGAP COVERAGE.**—

(1) **IN GENERAL.**—Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(A) in paragraph (2)(A), by striking “is 65 years of age or older and is” and inserting “is first”;

(B) in paragraph (2)(D), by striking “who is 65 years of age or older as of the date of issuance and”; and

(C) in paragraph (3)(B)(vi), by striking “at age 65”.

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall apply to terminations of coverage effected on or after the date of enactment of this Act, regardless of when the individuals become eligible for benefits under part A or B of title XVIII of the Social Security Act.

(b) **PERMITTING ESRD BENEFICIARIES TO ELECT ANOTHER MEDICARE+CHOICE PLAN IN CASE OF PLAN DISCONTINUANCE.**—

(1) **IN GENERAL.**—Section 1851(a)(3)(B) (42 U.S.C. 1395w-21(a)(3)(B)) is amended by striking “except that” and all that follows and inserting the following: “except that—

“(i) an individual who develops end-stage renal disease while enrolled in a Medicare+Choice plan may continue to be enrolled in that plan; and

“(ii) in the case of such an individual who is enrolled in a Medicare+Choice plan under clause (i) (or subsequently under this clause), if the enrollment is discontinued under section 1851(e)(4)(A) the individual will be treated as a ‘Medicare+Choice eligible individual’ for purposes of electing to continue enrollment in another Medicare+Choice plan.”.

(2) EFFECTIVE DATE.—

(A) The amendment made by paragraph (1) shall apply to terminations and discontinuations occurring on or after the date of enactment of this Act.

(B) Clause (ii) of section 1851(a)(3)(B) of the Social Security Act (as inserted by such amendment) also shall apply to individuals whose enrollment in a Medicare+Choice plan was terminated or discontinued after December 31, 1998, and before the date of enactment of this Act. In applying this subparagraph, such an individual shall be treated, for purposes of part C of title XVIII of the Social Security Act, as having discontinued enrollment in such a plan as of the date of enactment of this Act.

SEC. 805. EXTENDED MEDICARE+CHOICE DISENROLLMENT WINDOW FOR CERTAIN INVOLUNTARILY TERMINATED ENROLLEES.

(a) **PREVIOUS MEDIGAP ENROLLEES.**—Section 1882(s)(3)(B)(v)(III) (42 U.S.C. 1395ss(s)(3)(B)(v)(III)) is amended—

(1) by inserting “(aa)” after “(III)”;

(2) by striking the period and inserting “, or”;

(3) by adding at the end the following: “(bb) during the 12-month period described in item (aa), is disenrolled under the circumstances described in section 1851(e)(4)(A) from the organization described in subclause (II); enrolls, without an intervening enrollment, with another such organization; and subsequently disenrolls during such period (during which the enrollee is permitted to disenroll under section 1851(e)).”.

(b) **INITIAL MEDIGAP ENROLLEES.**—Section 1882(s)(3)(B)(vi) (42 U.S.C. 1395ss(s)(3)(B)(vi)), as amended by section 804(a)(1)(C), is amended—

(1) by striking “benefits under part A, enrolls” and inserting “benefits under part A—“(I) enrolls”;

(2) by striking the period and inserting “, or”;

(3) by adding at the end the following:

“(II)(aa) enrolls in a Medicare+Choice plan under part C, which enrollment is terminated or discontinued under the circumstances described in section 1851(e)(4)(A), and

“(bb) subsequently enrolls, without an intervening enrollment, in another Medicare+Choice plan, and disenrolls from such plan by not later than 12 months after the effective date of the enrollment in the Medicare+Choice plan described in item (aa).”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to terminations and discontinuations occurring on or after the date of enactment of this Act.

SEC. 806. NONPREEMPTION OF STATE PRESCRIPTION DRUG COVERAGE MANDATES IN CASE OF APPROVED STATE MEDIGAP WAIVERS.

(a) **IN GENERAL.**—Section 1856(b)(3) (42 U.S.C. 1395w-26(b)(3)) is amended—

(1) in subparagraph (A), by striking “The standards” and inserting “Subject to subparagraph (C), the standards”; and

(2) by adding at the end the following:

“(C) CONTINUATION OF STATE PRESCRIPTION DRUG LAWS.—Subparagraph (A) shall not supersede any State law that requires the comprehensive coverage of prescription drugs or any regulation that carries out such a law, if—

“(i) the State has a waiver in effect under section 1882(p)(6)(A) with respect to requiring such coverage under Medicare supplemental policies; or

“(ii) the Secretary provides for a waiver for the State to impose such a requirement under section 1882(p)(6)(B).”.

(b) **MEDIGAP WAIVER.**—Section 1882(p)(6) (42 U.S.C. 1395ss(p)(6)) is amended—

(1) by inserting “(A)” after “(6)”;

(2) by adding at the end the following:

“(B) The Secretary also may waive the application of the standards described in paragraph (1)(A)(i) so that a State may include comprehensive prescription drug coverage among the benefits required for all Medicare supplemental policies.”.

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

SEC. 807. MODIFICATION OF PAYMENT RULES FOR CERTAIN FRAIL ELDERLY MEDICARE BENEFICIARIES.

(a) **MODIFICATION OF PAYMENT RULES.**—Section 1853 (42 U.S.C. 1395w-23) is amended—

(1) in subsection (a)—

(A) in paragraph (1)(A), by striking “subsections (e) and (f)” and inserting “subsections (e) through (i)”;

(B) in paragraph (3)(D), by inserting “and paragraph (4)” after “section 1859(e)(4)”;

(C) by adding at the end the following:

“(4) EXEMPTION FROM RISK-ADJUSTMENT SYSTEM FOR FRAIL ELDERLY BENEFICIARIES ENROLLED IN SPECIALIZED PROGRAMS FOR THE FRAIL ELDERLY.—

“(A) **IN GENERAL.**—During the period described in subparagraph (B), the risk-adjustment described in paragraph (3) shall not apply to a frail elderly Medicare+Choice beneficiary (as defined in subsection (i)(3)) who is enrolled in a Medicare+Choice plan under a specialized program for the frail elderly (as defined in subsection (i)(2)).

“(B) **PERIOD OF APPLICATION.**—The period described in this subparagraph begins with January 2000, and ends with the first month for which the Secretary certifies to Congress that a comprehensive risk adjustment methodology under paragraph (3)(C) (that takes into account the types of factors described in subsection (i)(1)) is being fully implemented.”; and

(2) by adding at the end the following:

“(i) **SPECIAL RULES FOR FRAIL ELDERLY ENROLLED IN SPECIALIZED PROGRAMS FOR THE FRAIL ELDERLY.**—

“(1) **DEVELOPMENT AND IMPLEMENTATION OF NEW PAYMENT SYSTEM.**—The Secretary shall develop and implement (as soon as possible after the date of enactment of this subsection), during the period described in subsection (a)(4)(B), a payment methodology for frail elderly Medicare+Choice beneficiaries enrolled in a Medicare+Choice plan under a specialized program for the frail elderly (as defined in paragraph (2)(A)). Such methodology shall account for the prevalence, mix, and severity of chronic conditions among such beneficiaries and shall include medical diagnostic factors from all provider settings (including hospital and nursing facility settings). It shall include functional indicators of health status and such other factors as may be necessary to achieve appropriate payments for plans serving such beneficiaries.

“(2) **SPECIALIZED PROGRAM FOR THE FRAIL ELDERLY DESCRIBED.**—

“(A) **IN GENERAL.**—For purposes of this part, the term ‘specialized program for the frail elderly’ means a program which the Secretary determines—

“(i) is offered under this part as a distinct part of a Medicare+Choice plan;

“(ii) primarily enrolls frail elderly Medicare+Choice beneficiaries; and

“(iii) has a clinical delivery system that is specifically designed to serve the special needs of such beneficiaries and to coordinate short-term and long-term care for such beneficiaries through the use of a team described in subparagraph (B) and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

“(B) SPECIALIZED TEAM.—A team described in this subparagraph—

“(i) includes—

“(I) a physician; and

“(II) a nurse practitioner or geriatric care manager, or both; and

“(ii) has as members individuals who have special training and specialize in the care and management of the frail elderly beneficiaries.

“(3) FRAIL ELDERLY MEDICARE+CHOICE BENEFICIARY DESCRIBED.—For purposes of this part, the term ‘frail elderly Medicare+Choice beneficiary’ means a Medicare+Choice eligible individual who—

“(A) is residing in a skilled nursing facility or a nursing facility (as defined for purposes of title XIX) for an indefinite period and without any intention of residing outside the facility; and

“(B) has a severity of condition that makes the individual frail (as determined under guidelines approved by the Secretary).”

(b) CONTINUOUS OPEN ENROLLMENT FOR CERTAIN FRAIL ELDERLY MEDICARE BENEFICIARIES.—

(1) IN GENERAL.—Section 1851(e) (42 U.S.C. 1395w-21(e)) is amended by adding at the end the following:

“(7) SPECIAL RULES FOR FRAIL ELDERLY MEDICARE+CHOICE BENEFICIARIES ENROLLING IN SPECIALIZED PROGRAMS FOR THE FRAIL ELDERLY.—There shall be a continuous open enrollment period for any frail elderly Medicare+Choice beneficiary (as defined in section 1853(i)(3)) who is seeking to enroll in a Medicare+Choice plan under a specialized program for the frail elderly (as defined in section 1853(i)(2)).”

(2) CONFORMING AMENDMENTS.—

(A) OPEN ENROLLMENT PERIODS.—Section 1851(e)(6) (42 U.S.C. 1395w-21(e)(6)) is amended—

(i) in subparagraph (A), by striking “and” at the end;

(ii) by redesignating subparagraph (B) as subparagraph (C); and

(iii) by inserting after subparagraph (A) the following:

“(B) that is offering a specialized program for the frail elderly (as defined in section 1853(i)(2)), shall accept elections at any time for purposes of enrolling frail elderly Medicare+Choice beneficiaries (as defined in section 1853(i)(3)) in such program; and”

(B) EFFECTIVENESS OF ELECTIONS.—Section 1851(f)(4) (42 U.S.C. 1395w-21(f)(4)) is amended by striking “subsection (e)(4)” and inserting “paragraph (4) or (7) of subsection (e)”.

(c) DEVELOPMENT OF QUALITY MEASUREMENT PROGRAM FOR SPECIALIZED PROGRAMS FOR THE FRAIL ELDERLY.—Section 1852(e) (42 U.S.C. 1395w-22(e)) is amended by adding at the end the following:

“(5) QUALITY MEASUREMENT PROGRAM FOR SPECIALIZED PROGRAMS FOR THE FRAIL ELDERLY AS PART OF MEDICARE+CHOICE PLANS.—The Secretary shall develop and implement a program to measure the quality of care provided in specialized programs for the frail elderly (as defined in section 1853(i)(2)) in order to reflect the unique health aspects and needs of frail elderly Medicare+Choice beneficiaries (as defined in section 1853(i)(3)). Such quality measurements may include indicators of the prevalence of pressure sores, reduction of iatrogenic disease, use of urinary catheters, use of antianxiety medications, use of advance directives, incidence of pneumonia, and incidence of congestive heart failure.”

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this

section shall take effect on the date of enactment of this Act.

(2) DEVELOPMENT OF QUALITY MEASUREMENT PROGRAM FOR SPECIALIZED PROGRAMS FOR THE FRAIL ELDERLY.—The Secretary of Health and Human Services shall first provide for the implementation of the quality measurement program for specialized programs for the frail elderly under the amendment made by subsection (c) by not later than July 1, 2000.

SEC. 808. EXTENSION OF MEDICARE COMMUNITY NURSING ORGANIZATION DEMONSTRATION PROJECTS.

Notwithstanding any other provision of law and in addition to the extension provided under section 4019 of the Balanced Budget Act of 1997 (Public Law 105-33; 111 Stat. 347), demonstration projects conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203; 101 Stat. 1330-121) shall be conducted for an additional period of 3 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.

TITLE IX—CLINICS

SEC. 901. NEW PROSPECTIVE PAYMENT SYSTEM FOR FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS UNDER THE MEDICAID PROGRAM.

(a) IN GENERAL.—Section 1902(a)(13) (42 U.S.C. 1396a(a)(13)) is amended—

(1) in subparagraph (A), by adding “and” at the end;

(2) in subparagraph (B), by striking “and” at the end; and

(3) by striking subparagraph (C).

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

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

“(1) IN GENERAL.—Beginning with fiscal year 2000 and each succeeding fiscal year, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by a Federally-qualified health center and services described in section 1905(a)(2)(B) furnished by a rural health clinic in accordance with the provisions of this subsection.

“(2) FISCAL YEAR 2000.—For fiscal year 2000, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of the center or clinic of furnishing such services during fiscal year 1999 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or in the case of services to which such regulations do not apply, the same methodology used under section 1833(a)(3), adjusted to take into account any increase in the scope of such services furnished by the center or clinic during fiscal year 2000.

“(3) FISCAL YEAR 2001 AND SUCCEEDING YEARS.—For fiscal year 2001 and each succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this subsection for the preceding fiscal year—

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

“(B) adjusted to take into account any increase in the scope of such services furnished

by the center or clinic during that fiscal year.

“(4) ESTABLISHMENT OF INITIAL YEAR PAYMENT AMOUNT FOR NEW CENTERS OR CLINICS.—In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after October 1, 2000, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by the center or services described in section 1905(a)(2)(B) furnished by the clinic in the first fiscal year in which the center or clinic qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year in accordance with the regulations and methodology referred to in paragraph (2). For each fiscal year following the fiscal year in which the entity first qualifies as a Federally-qualified health center or rural health clinic, the State plan shall provide for the payment amount to be calculated in accordance with paragraph (3) of this subsection.

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

“(6) ALTERNATIVE PAYMENT SYSTEM.—Notwithstanding any other provision of this section, the State plan may provide for payment in any fiscal year to a Federally-qualified health center for services described in section 1905(a)(2)(C) or to a rural health clinic for services described in section 1905(a)(2)(B) in an amount that is in excess of the amount otherwise required to be paid to the center or clinic under this subsection.”

(c) CONFORMING AMENDMENTS.—

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

(2) Section 1915(b) (42 U.S.C. 1396n(b)) is amended by striking “1902(a)(13)(E)” and inserting “1902(aa)”.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on October 1, 1999.

Mr. KENNEDY. Mr. President, we all want to express our appreciation to our leader, Senator DASCHLE, for the development of this proposal. As he has pointed out, we have worked closely with Senator MOYNIHAN and the members of the Finance Committee. We hope this will be the basis of the coming together here in the Senate. This should not be a partisan issue. The kinds of problems Senator DASCHLE pointed out are problems not only in urban areas but in rural communities, too. The program he has advocated touches the health care needs of people all over this country. This particular issue cries for a response and action from this Congress in these final few days.

I join with him and others who say we should not leave, we cannot leave, we will not leave this session without addressing these problems. We have the time now to work this process through.

I think the way this has been fashioned has demonstrated a sensitivity to the range of different emergencies that are out there across the landscape affecting real people.

So I join others on our side in commending him for the leadership he has provided on this issue as in so many other areas. Hopefully, he will be successful in reaching across the aisle so that we can all work on this issue together.

Mr. President, no senior citizen should be forced to enter a hospital or a nursing home because Medicare can't afford to pay for services to keep her in her own home and in her own community.

No person with a disability should be told that occupational therapy services are no longer available because legislation to balance the budget reduced the rehabilitation services they need.

No community should be told that their number one employer and provider of health care will be closing its doors or engaging in massive layoffs because Medicare can no longer pay its fair share of health costs.

No freestanding children's hospital should wonder whether it can continue to train providers to care for children because it receives no federal support for its teaching activities. Yet these scenes and many others are playing out in towns and cities across the country today, in large part due to the unexpectedly deep Medicare cuts in the Balanced Budget Act passed two years ago.

The 1997 Act was the final part of a process undertaken since 1993 to balance the federal budget and lay the groundwork for the current economic boom and the large budget surpluses we anticipate in the years ahead. However, our ability to balance the budget was primarily attributable to deep savings achieved by cuts in Medicare—by slowing the rate of growth in provider payments and other policy reforms. These cuts were expected to total \$116 billion over five years, and nearly \$400 billion over ten years. Clearly, as experience now shows, these cuts are too deep for the Medicare program to sustain.

In fact, these cuts were more than double the amount ever enacted in any previous legislation. The Congressional Budget Office has now increased the estimate of the savings to total \$200 billion over five years and more than \$600 billion over ten years—far greater than Congress intended.

Not surprisingly, we are now hearing from large numbers of the nation's safety net providers—especially teaching hospitals, community hospitals, and community health centers. We are hearing from those who care for the elderly and disabled when they leave the hospital—nursing homes, home health agencies and rehabilitation specialists. We are hearing from virtually every

group that cares for the 40 million senior citizens and disabled citizens on Medicare. They are saying—with great alarm and anxiety—that Congress went too far.

The Medicare Beneficiary Access to Quality Health Care Act that we are introducing today will alleviate much of this damage. It will provide \$20 billion over the next ten years to reduce the pain created by the harshest cuts in the Balanced Budget Act. It will ensure that the nation's health care system is able to care responsibly for today's senior citizens, and is adequately prepared to take care of those who will be retiring in the future.

The current Balanced Budget Act is unfairly imposing a \$1.7 billion cut over the next five years for Massachusetts hospitals alone. Our community hospitals are reeling. Many of our teaching hospitals have laid off staff, and are unable to continue to participate in Medicare HMO contracts. Some say that these cuts are needed to make Medicare more efficient. But Massachusetts teaching hospitals are already efficient. In the past six years, one out of five of our teaching hospitals and one out of four hospital beds have been closed. We cannot afford to compromise on patient care, doctor training, and the state-of-the-art medical research conducted at the nation's top hospitals.

In addition, children's hospitals deserve help as well. They currently receive almost no federal support for their important teaching and training activities. They train a majority of the nation's pediatricians and pediatric specialists. Yet current rules keep them from receiving the level of federal support available to other teaching hospitals. While this particular legislation does not address this problem, Senator Bob KERREY and I have proposed a separate bill with strong bipartisan support to correct this injustice and give children's hospitals the funding they deserve to train the pediatricians needed to care for the nation's children in the years ahead.

The home-bound elderly—our most vulnerable senior citizens—are also suffering. In Massachusetts alone, home health agencies are losing \$160 million annually, and 20 agencies have closed their doors since the Balanced Budget Act went into effect. The ones that remain are seeing fewer patients, and seeing their current patients less often.

Massachusetts nursing homes are predicting losses of \$500 million over the next five years. Eleven facilities have declared bankruptcy this year, and more are expected to follow.

With the impending retirement of the baby boom generation, the last thing we should do now is jeopardize the viability and commitment of the essential institutions that care for Medicare beneficiaries. Yet that is now hap-

pening in cities and towns across the nation. In the vast majority of cases, the providers who care for Medicare patients are the same ones who care for working families and everyone else in their community. When hospitals who serve Medicare beneficiaries are threatened, health care for the entire community is threatened.

Nearly one million elderly and disabled Massachusetts residents rely on Medicare for their health care. This legislation is a sensible, affordable step to ensure that our health care system will continue to be there for them when they need it. It deserves prompt consideration and passage. I commend Senator DASCHLE for his leadership on this vital issue, and I urge the Senate to approve this important measure.

The PRESIDING OFFICER. The Democratic leader.

Mr. DASCHLE. Mr. President, I congratulate and thank my colleague from Massachusetts for his remarks and for his extraordinary commitment to this effort. He has been at every meeting. He has been engaged from the very beginning, and we are grateful, as on so many of the issues our caucus cares deeply about, for the leadership he has provided.

I am proud of the fact we have had the participation of well over 20 Members, and the senior Senator from Massachusetts has been the leader of the pack, as he is on so many other issues.

I also thank Senator ROCKEFELLER for the extraordinary effort he has put forth. As a member of the Finance Committee, no one has worked harder on many of these issues than has he. I am grateful for the participation and leadership he has provided to get us to this point.

Before I yield the floor, let me say how urgent this matter is. My colleagues yesterday discussed the urgency of this legislation again and again. I am disappointed and deeply concerned about the fact that, at least to date, there is no date yet set for consideration and markup of a bill to repair the damage done in the 1997 act. We have to address and consider and ultimately pass such a bill prior to the time we leave the Senate this year. We will do anything, and everything we know how, to ensure this becomes one of the highest legislative priorities left prior to the end of this session of Congress. It must be addressed. It must be passed. We must take this legislation up soon in order for us to accomplish what I know is a bipartisan recognition of the shortcomings and the miscalculations made in the 1997 act.

I will say again, the fact that we have over half of our caucus already, and will probably have two-thirds of our caucus as cosponsors in the not-too-distant future, is a clear recognition of the depth of feeling our Members have on this bill and the importance we place on getting something

done this year. We must do it. We will do it, and we will work with our Republican colleagues to make that happen.

I yield the floor.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. ROCKEFELLER. Mr. President, I strongly agree with the words our Democratic leader has offered, and I congratulate him for mobilizing this effort, but it is a mobilization not so much of Democrats as it is of Senators in general. Hospitals and patients and skilled nursing facilities and home health agencies are not Republican or Democrat. The shortages, the closings, the health care denied is not Republican or Democrat. It has to do with the people of our States and of our country.

This is a bipartisan matter. I know, without even having talked to but five or six of my colleagues on the other side of the aisle, when they went back to their homes during the August recess and when they have been back since, this has been the subject with which we have all been, in a sense, lobbied in the best sense; that is, lobbied by our own constituents, by our own voters, by people who are patients, by people who have had these problems.

It is right; we should be fixing this because Congress, in 1997, when we passed the Balanced Budget Act, made changes that were larger in Medicare than any in the history of the program, and we made mistakes. This is actually one of the reasons our colleagues on the other side of the aisle often criticize congressional action because we are trying to play doctor. We often try, but we often do not do it very well. In this case, we did not. We made mistakes.

When we make a mistake, we are causing skilled working facilities, home health agencies, and hospitals to close; we are putting in jeopardy margins of profit, which have gone into the red already, of other hospitals, particularly rural hospitals. We have to correct it.

There is nothing more self-evident to me than the need for this Congress to take up the BBA corrections and, in fact, do them on a bipartisan basis. We do not have very much time. There seems to be quite a lot of anxiousness to get out of here. That is not shared by the junior Senator from West Virginia. In that case, it puts more pressure on us to do it. We need a date. We need to do this. This is not makeup stuff. These are real problems.

In my State of West Virginia, which is not large but our citizens are no less important than anybody else's, and to me they are more important, in the next 4 years our hospitals are going to face an almost \$600 million cut in payment because of mistakes we made in the 1997 Budget Act. They did not make the mistakes. They have not been keeping their books incorrectly.

They have not been trying to be inefficient. We made the mistakes. We made the mistakes in Congress, and it is up to us to correct them.

Many critical public health services will be cut back. That has happened already. It will continue to happen. Home care agencies in my State expect there will be almost 5,000 less Medicare patients being admitted for their services than before.

Eleven home health care providers in West Virginia have closed. That is not a lot, but that is a lot in West Virginia, and it is in a lot of places. We have 55 counties and 1.8 million people. Eleven home health agencies is a lot; 2,500 on a nationwide basis are closed. They are not thinking about closing but have closed because of mistakes we in Congress have made in making these enormous changes to Medicare. They have been forced to close down because the current payment system does not adequately reimburse them for what they have to do.

CBO originally estimated home health reimbursement reductions would be \$16 billion. It turned out the reduction was \$47 billion. That was not the hospitals' fault; that was not the home health agencies' fault; that was our fault. We made that mistake. We have to correct that mistake.

The \$1,500 cap on therapy is having bad results on nursing home patients with Parkinson's disease, burns, and other things. We need to correct that because we made the mistakes.

I will end by saying, I agree on teaching hospitals. We have three teaching hospitals in West Virginia. Whatever happens in general happens in a much worse way in rural States. That is by definition, that is by nature, whether it is hospitals, nursing homes, or anything else. That has always been the case.

Rural hospitals have very little to fall back on because they do not have margins. They depend on Medicare more than those in larger and more urban States. These were unintended cuts we made, but we nevertheless made them. The mistake is ours. It is a bipartisan mistake. It came along with a very good bill, the Balanced Budget Act of 1997. Within it, there was some cancer, and the cancer was caused by us, and it is the mistakes we made which are causing havoc all over the health care world. We can change it easily and change it before we leave here, and surely we should. I yield the floor.

Ms. MIKULSKI. Mr. President, I rise today as a cosponsor of Senator DASCHLE's bill to address the draconian cuts to Medicare under the Balanced Budget Act of 1997 (BBA). I thank Senator DASCHLE for introducing this important piece of legislation.

I support this bill for two reasons. First, I believe the BBA went too far when it cut reimbursements to Medi-

care. Second, as we move towards the millennium and our senior population continues to grow, our seniors must be able to rely on a sound and secure Medicare Program. This bill will help them do just that.

When I travel throughout the State of Maryland, the issue my constituents want to talk about most is cuts in services for the elderly. I have worked long and hard to find solutions to these cuts. That is why I cosponsored an amendment to the recent tax bill which placed a priority on fixing Medicare before providing for a tax cut. That is why I am working on a new and improved Older Americans Act, and that is why I am cosponsoring Senator DASCHLE's legislation, which helps providers who are struggling under BBA cuts to Medicare.

The BBA is one of the reasons why we have a projected budget surplus. It put us on the right track of fiscal prudence, but it went too far in the case of Medicare by imposing deep cuts on providers: It cut reimbursements to home health agencies; it cut reimbursements to nursing homes; it cut reimbursements to Medicare HMOs. Our seniors and our providers are now feeling the effects of these cuts.

What exactly do these cuts mean? In my State of Maryland, this means that 34 Home Health Agencies have closed their doors and only two public Home Health Agencies remain. This is a particular problem in rural counties in Maryland. Agencies in these areas are committed to providing health care to those who cannot travel to hospitals or doctors offices. In fact, they are so committed to providing home-bound patients with care, I know some health care providers who have traveled to homes by a snowmobile in winter months just to get to a patient. But because of substantial cuts in reimbursements under BBA, these agencies are left with no choice but to close their doors; families lose these services, employees lose their jobs, and nobody wins.

Our Skilled Nursing Facilities (SNFs) also need the relief provided by this legislation. The BBA changed the way that payments are calculated so that facilities do not get paid more money when they provide expensive services such as chemotherapy or prosthetics. In some cases, the reimbursement is so low, that facilities cannot afford to take the patients who need a high level of care. I hear stories about patients who need chemotherapy treatment but cannot find a facility to provide it. Why? The answer is because Medicare doesn't pay enough to cover the cost of the chemotherapy treatment. Where does this patient go? They could go to a hospital, but frequently this is more expensive, or might not specialize in these services. Patients and their families do not want to hear complex stories about payment methodologies, or resource utilization

groups. What these families want to hear is that their loved ones can get the care that they need.

My State of Maryland has also had a devastating problem with Medicare HMOs. Because of payment changes, reimbursements to many HMOs were cut. What are the effects of these cuts? One HMO in my state is projecting losses of over \$5 million this year in the rural counties of Maryland alone. This HMO can no longer afford to cover Medicare patients so it is closing up shop. 14,000 senior citizens in Maryland will lose their Medicare HMO. Where do these seniors go? In the rural counties of Maryland, these seniors do not have any other Medicare HMO to choose. They all left—not because they weren't making a profit—these HMOs couldn't even break even. Rural counties throughout Maryland and the nation will have seniors with little or no access to the extra benefits many HMOs provide, including prescription drug coverage and preventive benefits such as dental, vision and hearing screenings.

Imagine if your 85-year-old grandmother, living on a fixed income, got a letter in the mail that says in 4 months she will no longer have a Medicare HMO. She might not understand what it means. Is she losing her health care coverage altogether? Is she losing her doctor? Is she losing her medicine coverage? In many cases, my constituents aren't wondering where they should go for a mammogram or prostate screening, but if they can even go at all because their HMO is leaving town.

Some will say these cuts aren't so bad—why can't you just buy a Medigap policy? For around \$150 a month you could get some of the supplemental benefits that HMOs provide. But many of these senior citizens only have \$11,000 or \$12,000 a year in retirement income and many times their income is much less. These seniors cannot afford \$150 a month for a Medigap policy, so many of them will be forced to make difficult choices between food, rent, health care and prescription medications. This legislation provides needed relief so that our seniors would not have to make these terrible decisions.

I also know that our non-profit health facilities are having a particularly rough time. These are providers such as Hebrew Home in Rockville, Maryland, or Mercy Hospital in Baltimore, who are struggling to provide care under current reimbursements. It is especially difficult for these providers because the care they provide is frequently uncompensated. This is health care that they frequently do not get reimbursed for, also known as charity care. In many cases, they provide the health services to seniors who have no other place to go. If we do not take steps to fairly reimburse them, where will these seniors go to get the care they need?

One of my priorities as a United States Senator has always been to honor your mother and father. It is a good commandment and good public policy—in the federal law books and checkbooks. We must address these cuts in Medicare because our safety net for seniors is badly frayed, and senior citizens are being left stranded because many health care providers have no choice but to close their doors.

In 1965 when Medicare was created, the Federal Government promised that Americans who work hard all of their lives can count on Medicare when they retire. I believe that promises made should be promises kept. Senator DASCHLE's bill will help us keep the promise we have made to the Nation's senior citizens.

Mr. JOHNSON. Mr. President, I am pleased to cosponsor the Medicare Beneficiary Access to Quality Health Care Act introduced today that works to correct the inequities of Medicare reforms included in the Balanced Budget Act of 1997.

I commend Senator DASCHLE for his tremendous efforts on this issue and for his leadership with the introduction of this bill. As well, I congratulate a number of my other colleagues who have contributed immensely to the crafting of this critical piece of legislation, including Senators MOYNIHAN, KENNEDY, ROCKEFELLER, BAUCUS, CONRAD, and others.

As part of the effort to balance the Federal budget, the Balanced Budget Act of 1997 (BBA) provided for major reforms in the way Medicare pays for medical services. The Balanced Budget Act of 1997 (BBA) included numerous cuts in Medicare payments to health care providers. These changes were originally expected to cut Medicare spending by about \$115 over five years, but recent CBO projections show spending falling nearly twice that much. In the face of these deep cuts, health care providers are struggling, and beneficiary access to care is threatened. The Medicare Beneficiary Access to Care Act is a targeted solution to certain specific problems that the Balanced Budget Act has created.

As implementation of these reforms proceeds, health care providers and patient advocacy groups have asserted that some of the reforms are having—or are likely to have—undesirable or unintended consequences. Areas in patient care such as rehabilitative therapy, skilled nursing facilities, home health services, and hospital outpatient services have already begun to feel the effects of the reforms set forth in 1997.

Not surprising, I have heard from many safety net providers in South Dakota about the devastating effects such reductions in reimbursements are having throughout the health care industry. Consumers are also feeling the pain, as many individuals are being

turned away from hospitals and nursing homes who cannot afford to accept new patients because of the lower reimbursement rates included in the Balanced Budget Act. These cuts are devastating and feared to have severe implications on the quality and access of health care throughout our nation, including South Dakota, unless Congress acts immediately to correct these problems. In South Dakota, and other rural parts of the country, hospitals and other health care providers have an extremely high percentage of Medicare beneficiaries making these cuts in reimbursement even more devastating. If Congress does not act in a timely fashion many of these providers may be forced to close their doors.

I look forward to continue working with my colleagues on passage of the Medicare Beneficiary Access to Quality Health Care Act which develops creative, cost-effective approaches to address the unintended, long-term consequences of the BBA. The proposed budget surplus provides Congress the unique opportunity to address many of the deficiencies in our nation's health care system. We need to address the valid concerns of teaching hospitals, skilled nursing facilities, home health providers, rural and community hospitals, and other health care providers who require relief from the consequences of the BBA.

Mr. CLELAND. Mr. President, we are all hearing from our constituents about the hardships they have encountered from the unintended consequences of the Balanced Budget Act (BBA) of 1997. From rural hospitals to home health care agencies, cuts in Medicare reimbursement have forced these health care providers to absorb tremendous debt and have threatened patients' access to care. Senator DASCHLE has proposed over 30 items that will provide immediate relief across the health care continuum. Among these provisions, the bill would redirect BBA surplus monies to provide a cap on hospital outpatient Prospective Payment System (PPS) loss, a delay on the proposed 15 percent cut to home health care reimbursement, a fix for the graduate medical education resident cap and the indigent care problem, the repeal of nursing home therapy caps, a technical correction to limit oscillations to Medicare physician reimbursement, a delay of risk adjustment for frail elderly/Evercare. Senator DASCHLE is to be commended for developing this comprehensive BBA relief bill in an incredibly short period of time. My colleague has more than met the challenge of this urgent health care dilemma. I am proud to be an original cosponsor of this critical remedial legislation for a BBA fix. I will support Senator DASCHLE with all my resources to pass a BBA fix this session.

Mr. KERREY. Mr. President, I support the legislation offered earlier by

the Senator from South Dakota, the Medicare Beneficiary Access to Care Act of 1999.

I supported strongly the balanced budget amendment of 1997, the deficit reduction acts of 1993 and 1990, and am proud of the supporting role I played over the last 7 or 8 years in taking the United States of America to the point where the Federal Government was borrowing hundreds of billions of dollars—\$300 billion when I came in 1989—to a point where we now have a surplus. It is quite an exciting change in the dynamics of this country.

This morning's New York Times had a story by Louis Uchitelle about 1.1 million Americans having been lifted off the rolls of poverty as a consequence of demands of wages that occur because interest rates are low, corporate profits are good, and the American economy is as strong as it has been in my lifetime. It is quite impressive what a strong economy will do with low interest rates and what increased rates in productivity will do. The report also pointed out the significant problems we still have with income growth, especially with African Americans.

But I am proud of the role I played in eliminating the deficit and creating a surplus that has contributed enormously to the growth of the U.S. economy. Certainly lots of action in the private sector contributed to it, but Congress and those who were here—Republicans and Democrats—over the last 7 or 8 years who voted for these three pieces of legislation can take some pride in taking the United States not just into recovery economically, but I remember how frustrating the deficit was—politically frustrating—that caused Americans to lose confidence that Congress could get anything done. It seemed a relatively small “bone” in a great nation and I am glad we finally coughed it up. I don't want to back-track on that.

That is why I am pleased Senator DASCHLE has indicated this bill has to be paid for. Not only do we have to be careful to not drain the Social Security trust fund, but we have to be careful we not do this in a fashion that takes America back to the bad old days of deficit financing. It is easy to do that.

The 1997 act had an impressive number of people in the Senate and the House voting for the legislation. The United States was to produce \$100 million of savings in 10 years. It is now estimated it will produce \$200 million in savings. I voted for \$100 million. That is what I thought the legislation would produce. Not all of that \$200 million estimate occurs as a consequence of the changes in reimbursement. Some has occurred as a result of the vigorous effort by Secretary Shalala and HCFA to reduce fraud and, as a consequence, save taxpayer money. They made billing changes that produced some sav-

ings. They are doing a better job of managing the taxpayers' money. Some of the savings has occurred as a consequence.

There is no question there is a fraction of that excess \$100 million that has come as a result of our making some changes to take more out of the providers than anyone anticipated. This legislation will put \$23 billion back. I believe that is fair, reasonable, and defensible. I think it will have a tremendously positive impact on the ability of my State of Nebraska to get high-quality health care; that is what is at stake. What is at stake is not just the health of health care institutions but the health of the citizens of the country who depend upon those institutions.

I believe this piece of legislation is needed. It is needed in Nebraska and by citizens who depend upon their doctors, who depend upon their hospitals, who depend upon this thing we call the health care system in the United States of America. It is an issue of life and death for them. It is a very important issue. It is a very personal issue.

When we talk to somebody in a hospital, it is easy to acquire the right sense of urgency to overcome whatever ideological differences we might have. The people of Nebraska need this Congress to act. It is not just something that we are being asked to do; it is something that is necessary in order to improve the quality of life in our State.

I will go through some of the things this legislation does. For hospitals, the 1997 act cuts hospital payments in several ways: Lower inpatient payments; a new outpatient prospective payment system; a special payments cut for low-income patients; and cuts in graduate medical education.

This legislation does not restore all of those cuts. It creates a 3-year transition period to protect hospitals under this new outpatient system, and there is additional protection for rural and cancer hospitals. The bill also moderates the cut in DSH and GME payments, a central concern of teaching and academic centers. And it takes action for pediatric hospitals.

I urge colleagues who have not studied this to examine the very low reimbursements for graduate medical education for pediatric hospitals. There is a glaring difference and it will create tremendous problems as we try to train pediatricians—a very important profession in the health care industry.

There are a number of changes that increase the quality of care in Nebraska hospitals and increase the chances, especially in rural hospitals, that we will not see a continuation of what we had in 1998 when two rural hospitals closed. My hospital administrators tell me there may be more of the same unless we make some reasonable adjustments.

The Balanced Budget Act made some changes in skilled nursing facilities. We understand the need to balance the budget. This does not undo that. It is paid for. The Balanced Budget Act created a prospective payment system for skilled nursing facilities. This does not adequately account for the costs of very sick patients and rare high-cost services. This bill attempts to address both of these problems by increasing payments for groups of patients for whom payment is low and by paying separately for high-cost services, such as prosthetics, to ensure the nursing homes receive adequate payment.

We have heard about the impact of therapy caps. I hope in addition to putting some money back into the providers, we can take the advice of the Senator from Oklahoma and get some structural changes enacted in Medicare. One of the problems we have as a Congress trying to make changes in Medicare is we don't know the full impact of changes.

Senators BREAUX and THOMAS were proposing the creation of a new Senate-confirmed board that has authority over HCFA to make certain HCFA has the authority to offer fee-for-service plans on a competitive basis and make sure competitors have a level playing field to compete and offer their plans against the fee for service that HCFA has. I think it would be easier to solve the problem of dealing with waste, fraud, and abuse and make it more likely the consumers receive good information when they are trying to make decisions about what to buy. Consolidating Part A and Part B was also in the proposal of Senator BREAUX, and as a consequence of consolidating those two programs, it would make it much more likely when dealing with medical procedures, such as therapy, that we get it right.

What we did with the Balanced Budget Act is create a 1,500-per-annual-beneficiary cap, but these are arbitrary. They don't allow any flexibility based upon the need of the patient. What we have done with the legislation is repeal the caps until 2003 and require HCFA to implement a new system for therapy payments that is budget neutral to caps. It is designed to address the needs for varying amounts of therapy based upon a patient's condition. That is the point I was trying to make earlier, why we need structural changes, as well.

There are varying needs of the patient that are extremely difficult for HCFA to address. It is a central system. They have fiscal intermediaries in the country making payments. It is still a centrally controlled system and awfully difficult to get it right in Ohio, Nebraska, and Missouri simultaneously. They have to apply a system nationwide. It is better, in my judgment, if we have a board of directors, Senate-confirmed, to manage HCFA, moving in a direction where the private sector is able to compete for

HCFA's fee for service simultaneously, with HCFA offering its fee-for-service plans.

It makes changes in home health. We created under the BBA an interim payment system for home health agencies which limits payments on both a per beneficiary as well as a per visit basis. The temporary system locked in very low rates. This affects rural areas more than urban areas. There are very low rates for areas that had traditionally low costs such as Nebraska. We have low costs.

The IPS locked in those very low costs in October 2000, and the IPS is scheduled to be replaced by a new PPS system for home health services. Those payments will be reduced in an arbitrary fashion by 15 percent. We make three changes in the legislation that are vital: First, we postpone this 15-percent cut for 2 years; second, we assist low-cost agencies that have been disadvantaged under the IPS by increasing the per visit limit; finally, the bill reduce administrative burdens placed upon the providers by eliminating interest on overpayments, eliminating a 15-minute reporting requirement, and eliminating a requirement for home health agencies to do the billing for durable medical equipment.

We make changes for physicians. The BBA created a new system for physician payments based on a target rate of growth. The system includes bonus payments and reductions intended to create incentives to meet the target rate of growth. However, what we have done will cause payments to fluctuate widely, creating tremendous uncertainty in the physician communities and causing physicians who are out there trying to manage a clinic or their business to say: We can't depend upon HCFA. We can't depend upon a revenue stream. There is too much uncertainty in the system. We may opt out as a consequence.

They are facing a very big challenge in dealing with HCFA's representation that there may be fraud when, in fact, all that has occurred is there are a number of additional changes that will be very constructive for physicians, for Medicare+Choice, for rural health clinics, federally qualified health centers, and for hospice care where we have not had any rebasing of payments since 1982. It is a \$1 billion—an extremely important program.

Unfortunately, we do not pay a lot of attention to the problem we are facing when individuals know for certain they are dying. Hospice addresses that. This is an important change, in my view, and I urge colleagues on both sides of the aisle to say, whether it is with the Daschle bill, which I support, or a bill that comes out of the Finance Committee, which I am apt to support as well: This is one of the things we need to do. We need to get this done.

I hope we can at least get some minimal changes in Medicare as well, but we need to address this.

Mr. BINGAMAN. Mr. President, I rise today to join my colleagues in introducing the "Medicare Beneficiary Access to Care Act of 1999." I want to commend the leadership in the development of this legislation and hope that the Congress will act upon this now, before we adjourn.

The bill is designed to modify some of the many, unforeseen consequences of the Balanced Budget Act of 1997. Daily I receive letters and calls citing the negative impact of the Balanced Budget Act on access to patient care and to the delivery of quality care in an ongoing and coordinated fashion. In my State of New Mexico, the health care delivery system has been particularly hard hit. Essentially, the system for delivery of health care that we have worked so hard to attain is being eroded and must be bolstered before patients face a crisis.

I represent a state where 21 out of 33 counties are designated as health professional shortage areas. I represent a state that has seen an exodus of physician specialists and rural doctors this past year. Over the last year, New Mexico had 70 home care agencies close despite yeoman's efforts to keep these agencies open and serving our citizens. This represents closure of over 40 percent of our home health care agencies. We currently have one county, Catron, that has no home care entity available for serving patients. Failure to deal with the additional 15-percent cut that is slated to go into effect in October of 2000 would be the end of numerous other home health agencies throughout my state. It would be inexcusable not to address this issue this session.

Additionally, the system is further under stress in the nursing home arena. We have seen one nationally based entity declare bankruptcy and face the demise of others. Long term care facilities must be reimbursed at a level that reflects the acuity of the residents for whom they care. Long term care is key not only for the residents but for their families near and far.

Mr. President, several of my colleagues have addressed the issue of GME and the plight of our teaching hospitals. Hospitals have a multitude of services that they provide and which we should bolster. I must note, for example, that in New Mexico, declining Medicare reimbursement is forcing the only acute care hospital in Dona Anna County to close a 15 bed skilled nursing unit because of mounting financial losses. Realities such as this must make us mindful of the far reaching and adverse effects the BBA of 1997 is now having on communities and their residents. We want to ensure that no other facilities face closure.

Finally, I must add that rural and frontier clinics are critical components

to care for seniors and others in the community with limited resources and serve to allow for timely, geographic access where there otherwise would be no health care available. I am pleased that some redress of their needs is provided in this legislation.

Others have outlined the components of this legislation and I will not repeat the specifics. It is sufficient to say, that these changes are needed to avert a crisis in the health care delivery system of this country, to maintain access to quality care for our seniors and to rectify problems for the system that were created inadvertently. We must act now to provide for easy access to quality, continued health care for our citizens.

I look forward to working with all of my colleagues here in the Senate to see that this legislation is passed prior to adjournment.

Mr. MURRAY. Mr. President, I am pleased to join with my Democratic colleagues in introducing this important legislation. In the Balanced Budget Act of 1997, we reformed the Medicare program to extend its solvency. In the past year, we have seen the dramatic and negative impact of those reforms on patients and health care providers. The bill we are introducing today will fix those unintended consequences and will ensure that millions of seniors have access to high quality health care. I urge the Republican leadership to act on it before we adjourn for the year.

Two years ago, the Medicare Program was in serious trouble—facing bankruptcy within 5 years. We had to make substantial changes to the program to extend its solvency. It was a painful and difficult process, but we made changes intended to slow the growth of Medicare expenditures.

And overall, it worked. Medicare is still functioning and is on a more sound financial footing.

But the revisions we implemented went too far. Let me give you an example. Based on the estimates we had at the time, our changes were supposed to reduce the overall growth in Medicare expenditures by \$100 billion over 10 years. In reality, the changes we enacted will result in more than \$200 billion in lost Medicare revenue for health care providers over the same period. This was not the order of change I supported.

And today we see that those revisions are hurting our health care providers and making it more difficult for them to give patients the high quality care they need.

When I meet with health care providers in my state, this is their top concern. Each day we delay making these corrections, we make it harder for them to ensure that quality health care is available to millions of seniors.

I have heard from hundreds of hospital administrators, home health care

workers, doctors, rehabilitation therapists, teaching hospitals, skilled nursing facilities, and hospice providers. For example, I've received letters from Providence General Medical Center in Everett, Washington, from hospital caregivers at Prosser Memorial Hospital, from the University of Washington's School of Medicine and from hundreds of others. They have shared with me the impact of the 1997 changes and what it means for patient care. I believe the situation is critical.

If we fail to correct this, we will see hospitals closing. We will see home health agencies turning away patients. We will see skilled nursing facilities unable to take complex patients. We will see a devastated rural health system. Our health care system is in jeopardy.

The bill we are introducing today will go a long way toward correcting some of the unintended consequences of the Balanced Budget Act of 1997. I worked with my Democratic colleagues in drafting what I believe is a reasonable bill that provides immediate relief to hospitals, home health care agencies, skilled nursing facilities and hospice care to ensure that seniors in this country have access to quality, affordable health care services. The bill we have put forth is modest. It is not a cure-all, but it addresses the most pressing challenges. This is not about repealing the fiscal discipline imposed in BBA97. This is about adjusting the changes we made to reflect the current estimates. Our bill fixes the problems and provides legislative remedies. It does not jeopardize the solvency of Medicare. We can and should make changes to improve access and ensure access without jeopardizing solvency.

There is still much we have to address from quality care to affordable health insurance to prescription drugs. However, if the hospitals close or seniors are denied quality care, the ability to pay is not an issue. The very foundation of our health care system is at stake. This legislation is long overdue. We need to pass it and make the Medicare Program function better today.

Mr. President, at the same time, we cannot forget that the entire Medicare Program will run out of money in 2015. So, I want to remind my colleagues there is still much work to be done to ensure Medicare remains a stable program that our children will be able to count on for their health care.

Mr. President, from my point of view, this Congress has failed on too many vital issues this year. This Congress failed to pass a real Patients' Bill of Rights—that would put patients and doctors, not insurance companies, in charge of their medical decisions. Earlier this week, this Senate failed our children, by cutting our commitment to putting 100,000 teachers in the classroom to reduce the size of our overcrowded classrooms. This Congress

failed to help our farmers, and all those facing too many challenges in rural America. Let me just say, that I am not giving up or letting up on any of those fights—because they are too important. And let's not forget that this Congress even failed to do one of its most basic work—passing our appropriations bill on time, with real numbers—not gimmicks.

Mr. President, it is high time we bring some good news back to our constituents. I want my hospitals and health care providers, as well as the senior citizens in Washington State, to know I have heard their concerns and I recognize the dangerous implications of BBA97 on health care. It is high time we show them we see the problems facing Medicare, we understand them, and we are acting to fix them. It is high time we move on our priorities. This is one of them. I urge my colleagues to support this legislation.

Mrs. LINCOLN. Mr. President, today I rise to voice my support for a bill which addresses the unintended consequences of the Balanced Budget Act of 1997. I am pleased to join my Democratic colleagues as an original cosponsor of the Medicare Beneficiaries Access to Care Act.

Since I've been in the Senate, one of the greatest concerns of Arkansans is the lowered Medicare reimbursement rate for a variety of services that resulted from the Balanced Budget Act. Yes, we must continue to rid our Medicare system of waste, fraud and abuse. That is a high priority for our government and it should remain so. However, when Medicare changes were made as part of the Balanced Budget Act of 1997, Members of Congress did not intend to wreak havoc on the health care industry.

Enough time has elapsed to know the unintended consequences of the Balanced Budget Act. Hospitals have lost tremendous amounts of money due to changes in the outpatient prospective payment system. Many hospitals in my state are on the brink of closing due to the tremendous financial losses they have suffered. Nursing homes have not been reimbursed by Medicare at rates that cover the cost of patients with acute care needs. Payments for physical and rehabilitation therapy have been arbitrarily capped. Teaching hospitals have lost funding to support their training programs. Home health agencies have been forced to absorb huge losses and limit services to the elderly. Rural health clinics have been forced to cope with even more losses and operate on a shoestring budget.

Not only do these cuts and changes in Medicare reimbursement wreak havoc on the health care community and force them to absorb unfair financial losses, but Medicare beneficiaries, the very people that Medicare was set up to help, lose access to critical services. We cannot allow our parents and

grandparents to be denied access to coverage or receive limited Medicare care because we didn't take action to correct the devastating cuts of the Balanced Budget Act.

As a member of the Senate Rural Health Caucus and a member of the Senate Special Committee on Aging, I care deeply about the quality of health care and our citizens' access to health care. Over the past few months I have cosponsored various pieces of legislation which address all of the above-mentioned issues and the need to restore Medicare cuts. However, this legislation is "all encompassing" and if passed, would ensure that hospitals, skilled nursing facilities, physical therapy clinics, home health agencies, rural health clinics, and hospice programs receive important financial relief.

Above all, this legislation is about priorities. Ensuring the health and well-being of our Nation's seniors and most vulnerable citizens should be our highest priority. I thank my colleagues for their hard work on this proposal and I look forward to the quick passage of this legislation so we can deliver relief to our health care communities and let them know how much we value their services.

Mr. KERRY. Mr. President, I am pleased to join with Senators DASCHLE, KENNEDY, ROCKEFELLER and others to introduce the Medicare Beneficiary Access to Care Act of 1999.

In July, during consideration of tax relief legislation, I offered an amendment on the floor of the Senate to carve out \$20 billion from the tax bill and devote it towards relief for Medicare providers from the unintended consequences of the Balanced Budget Act. Although the amendment received the support of 50 Senators, including seven of my Republican colleagues, it did not gather the necessary three-fifths majority required for passage. Today's legislation, a \$20 billion package of specific measures to address the shortcomings of the Balanced Budget Act, represents the embodiment of our continued commitment to ensure that this relief is enacted before the end of the congressional session.

Mr. President, I cannot fully express the urgency of this matter. Here in Washington, we often throw around numbers with little realization of the real impact on America's communities. In this instance, I assure you, the impact is real. Take the town of Quincy, Massachusetts, population 88,000, and the birthplace of former presidents John Adams and John Quincy Adams. As we introduce this bill, the community hospital in Quincy, Massachusetts stands at the edge of closure. Jeffrey Doran, the hospital's CEO, has been working overtime to ensure that if the hospital closes, patients will be safely transferred to health care providers outside the community. Over the past

several weeks, I have been on the phone multiple times with our State leaders asking them to step in and provide the needed relief where the Federal Government has failed. Failed, Mr. President, because the Medicare cuts enacted in 1997 have gone above and beyond what we intended or desired. The budget savings have exceeded the levels we envisioned at the time of enactment.

Alternatively, Mr. President, let's take a look at the home health care industry. Home health care providers deliver rehabilitative services to Medicare beneficiaries in the safety and comfort of their home. In the State of Massachusetts, just since passage of the Balanced Budget Act, we have witnessed the closure of 20 home health care agencies who are no longer able to cover their costs as a result of cuts in Medicare payment reimbursements. The same is true with our nursing homes and extended care facilities.

And just to provide some perspective, the cost of the legislation we introduce today amounts to less than three percent of the cost of the tax bill President Clinton vetoed last month. The cost of the entire bill is less than one provision in the tax bill to subsidize the interest expenses of American multinational corporations operating overseas. In fact, we could have passed this bill, repealed the interest expense provision, and saved American taxpayers an additional \$4 billion.

What a sad reflection on our state of affairs when the Senate would approve a tax provision to expand eligibility for Roth IRAs for people making over \$100,000 a year, a provision that would cost over \$6 billion, but has yet to address the dire needs of our teaching hospitals. A full legislative remedy for the Medicare payment problems facing teaching hospitals would cost \$5.7 billion.

Mr. President, the time will come for this debate, and the time will come before we adjourn. The bipartisan support exists. Let's keep the doors of our teaching and community hospitals, nursing homes, home health care agencies, and rural clinics open. Let's accept responsibility for the unintended effects of our previous legislation. Let's not wait any longer.

DEPARTMENTS OF LABOR,
HEALTH AND HUMAN SERVICES,
AND EDUCATION, AND RELATED
AGENCIES APPROPRIATIONS
ACT, 2000—Continued

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, what is the pending business?

The PRESIDING OFFICER. S. 1650, the Labor-HHS appropriations bill.

AMENDMENT NO. 1851

(Purpose: To prevent the plundering of the Social Security Trust Fund)

Mr. NICKLES. Mr. President, I call up amendment No. 1851.

The PRESIDING OFFICER. The clerk will report.

The legislative assistant read as follows:

The Senator from Oklahoma [Mr. NICKLES] proposes an amendment numbered 1851.

Mr. NICKLES. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place, insert the following:

SEC. . PROTECTING SOCIAL SECURITY SURPLUSES.

(a) FINDINGS.—Congress finds that—

(1) Congress and the President should balance the budget excluding the surpluses generated by the Social Security trust funds; and

(2) Social Security surpluses should only be used for Social Security reform or to reduce the debt held by the public and should not be spent on other programs.

(b) SENSE OF THE SENATE.—It is the Sense of the Senate that conferees on the fiscal year 2000 appropriations measures should ensure that total discretionary spending does not result in an on-budget deficit (excluding the surpluses generated by the Social Security trust funds) by adopting an across-the-board reduction in all discretionary appropriations sufficient to eliminate such deficit.

AMENDMENT NO. 1889 TO AMENDMENT NO. 1851

(Purpose: To prevent the plundering of the Social Security Trust Fund)

Mr. NICKLES. Mr. President, I send a second-degree amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative assistant read as follows:

The Senator from Oklahoma [Mr. NICKLES] proposes an amendment numbered 1889 to amendment No. 1851.)

Mr. NICKLES. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

Strike all after the first word, and insert the following:

PROTECTING SOCIAL SECURITY SURPLUSES.

(a) FINDINGS.—Congress finds that—

(1) Congress and the President should balance the budget excluding the surpluses generated by the social security trust funds; and

(2) social security surpluses should only be used for social security reform or to reduce the debt held by the public and should not be spent on other programs.

(b) SENSE OF THE SENATE.—It is the Sense of the Senate that Congress should ensure that the fiscal year 2000 appropriations measures do not result in an on-budget deficit (excluding the surpluses generated by the Social Security trust funds) by adopting an across-the-board reduction in all discretionary appropriations sufficient to eliminate such deficit if necessary.

Mr. NICKLES. Mr. President, the modification of the amendment is very minor and technical. I will tell you what it is:

It is the sense of the Senate that the Congress should ensure that the fiscal year 2000 appropriations measures do not result in an on-budget deficit (excluding the surpluses generated by Social Security trust funds) by adopting an across-the-board reduction in all discretionary appropriations sufficient to eliminate such deficit. . . .

The original amendment I filed said it is the sense of the Senate that conferees would make sure they did not dip into Social Security funds. Now I am saying the Congress should make sure we do not dip into the Social Security funds and, if necessary, that we have across-the-board reductions in spending to make sure we do not touch Social Security funds.

I have stated—and I think all of our colleagues on both sides of the aisle have done so as well—that we do not want to touch Social Security, we absolutely do not want to touch the Social Security trust funds.

We are going to have a surplus next year and it is in large part, if not totally, because of the Social Security surplus. Many have drawn the line and said: We are not going to touch that. Maybe because of emergencies we will spend the non-social security surplus. Those funds may well be spent—as a result of the hurricane, agricultural disasters, the events in Kosovo or East Timor, or whatever. There may be some emergencies that that \$14 billion is going to be spent on, but absolutely not a dime more.

As we total all of these appropriations bills—the numbers are growing, or at least some people are trying to make them grow. I am saying that no matter what we do, at the end of this process, we will have across-the-board cuts if they are necessary. Hopefully, we won't have to. If we do our jobs, we will not need to have across-the-board cuts.

Senator STEVENS, the Appropriations chairman, said we are not going to need the cut because he is going to make sure we come in below the amounts necessary. He said that he will make sure outlays do not exceed the level that would intrude upon or have us spend Social Security trust funds. I respect that and I agree with it. But just in case I am saying—let's go on record; let's make sure that, if necessary we will have across-the-board cuts.

What are we talking about? I have added up all the bills. Just for the information of colleagues, I have added up all the bills including the Labor-HHS bill we have before us. If you add them all up, we are about \$5 billion into the Social Security surplus right now. According to the calculations I am using, the same ones I believe CBO and OMB are using, we are about \$5 billion over. That is about \$5 billion out