

Goodling	Manzullo	Sensenbrenner
Goss	McIntyre	Sessions
Graham	Miller (FL)	Sherwood
Green (WI)	Moran (KS)	Smith (MI)
Hall (TX)	Nethercutt	Smith (NJ)
Hansen	Paul	Spence
Hayes	Pease	Stark
Hefley	Peterson (MN)	Stearns
Herger	Peterson (PA)	Stump
Hill (MT)	Petri	Tancredo
Hilleary	Pitts	Tanner
Hoekstra	Pombo	Taylor (MS)
Hostettler	Pomeroy	Thornberry
Hunter	Rahall	Thune
Hutchinson	Roemer	Tiahrt
Istook	Rogers	Toomey
Jenkins	Rohrabacher	Trafficant
Jones (NC)	Roukema	Upton
Kingston	Royce	Wamp
Largent	Ryan (WI)	Watkins
Lewis (KY)	Ryun (KS)	Weldon (FL)
Lucas (KY)	Sanford	
Lucas (OK)	Schaffer	

NOT VOTING—17

Bereuter	Johnson, Sam	Norwood
Clay	Kanjorski	Reyes
Cramer	Martinez	Scarborough
Dickey	McInnis	Taylor (NC)
Gilchrest	Meehan	Young (AK)
Hastings (WA)	Mollohan	

□ 1041

Mr. PETERSON of Pennsylvania and Mrs. ROUKEMA changed their vote from "yea" to "nay."

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF H.R. 3073

Mr. STARK. Mr. Speaker, I ask unanimous consent to have my name removed as a cosponsor from H.R. 3073.

The SPEAKER pro tempore (Mr. PEASE). Is there objection to the request of the gentleman from California?

There was no objection.

MEDICARE, MEDICAID, AND SCHIP BALANCED BUDGET REFINEMENT ACT OF 1999

Mr. ARCHER. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3075) to amend title XVIII of the Social Security Act to make corrections and refinements in the Medicare Program, as revised by the Balanced Budget Act of 1997, as amended.

The Clerk read as follows:

H.R. 3075

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

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

(a) SHORT TITLE.—This Act may be cited as the "Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999".

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

(c) REFERENCES TO BALANCED BUDGET ACT OF 1997.—In this Act, the term "BBA" means the Balanced Budget Act of 1997 (Public Law 105-33).

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

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

TITLE I—PROVISIONS RELATING TO PART A

Subtitle A—PPS Hospitals

Sec. 101. One-year delay in transition for indirect medical education (IME) percentage adjustment.

Sec. 102. Decrease in reductions for disproportionate share hospitals; data collection requirements.

Subtitle B—PPS Exempt Hospitals

Sec. 111. Wage adjustment of percentile cap for PPS-exempt hospitals.

Sec. 112. Enhanced payments for long-term care and psychiatric hospitals until development of prospective payment systems for those hospitals.

Sec. 113. Per discharge prospective payment system for long-term care hospitals.

Sec. 114. Per diem prospective payment system for psychiatric hospitals.

Sec. 115. Refinement of prospective payment system for inpatient rehabilitation services.

Subtitle C—Adjustments to PPS Payments for Skilled Nursing Facilities

Sec. 121. Temporary increase in payment for certain high cost patients.

Sec. 122. Market basket increase.

Sec. 123. Authorizing facilities to elect immediate transition to Federal rate.

Sec. 124. Part A pass-through payment for certain ambulance services, prostheses, and chemotherapy drugs.

Sec. 125. Provision for part B add-ons for facilities participating in the NHCMQ demonstration project.

Sec. 126. Special consideration for facilities serving specialized patient populations.

Sec. 127. MedPAC study on special payment for facilities located in Hawaii and Alaska.

Subtitle D—Other

Sec. 131. Part A BBA technical corrections.

TITLE II—PROVISIONS RELATING TO PART B

Subtitle A—Adjustments to Physician Payment Updates

Sec. 201. Modification of update adjustment factor provisions to reduce update oscillations and require estimate revisions.

Sec. 202. Use of data collected by organizations and entities in determining practice expense relative values.

Sec. 203. GAO study on resources required to provide safe and effective outpatient cancer therapy.

Subtitle B—Hospital Outpatient Services

Sec. 211. Outlier adjustment and transitional pass-through for certain medical devices, drugs, and biologicals.

Sec. 212. Establishing a transitional corridor for application of OPD PPS.

Sec. 213. Delay in application of prospective payment system to cancer center hospitals.

Sec. 214. Limitation on outpatient hospital copayment for a procedure to the hospital deductible amount.

Subtitle C—Other

Sec. 221. Application of separate caps to physical and speech therapy services.

Sec. 222. Transitional outlier payments for therapy services for certain high acuity patients.

Sec. 223. Update in renal dialysis composite rate.

Sec. 224. Temporary update in durable medical equipment and oxygen rates.

Sec. 225. Requirement for new proposed rule-making for implementation of inherent reasonableness policy.

Sec. 226. Increase in reimbursement for pap smears.

Sec. 227. Refinement of ambulance services demonstration project.

Sec. 228. Phase-in of PPS for ambulatory surgical centers.

Sec. 229. Extension of medicare benefits for immunosuppressive drugs.

Sec. 230. Additional studies.

TITLE III—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

Sec. 301. Adjustment to reflect administrative costs not included in the interim payment system.

Sec. 302. Delay in application of 15 percent reduction in payment rates for home health services until 1 year after implementation of prospective payment system.

Sec. 303. Clarification of surety bond requirements.

Sec. 304. Technical amendment clarifying applicable market basket increase for PPS.

Subtitle B—Direct Graduate Medical Education

Sec. 311. Use of national average payment methodology in computing direct graduate medical education (DGME) payments.

Sec. 312. Initial residency period for child neurology residency training programs.

Subtitle C—Other

Sec. 321. GAO study on geographic reclassification.

Sec. 322. MedPAC study on medicare payment for non-physician health professional clinical training in hospitals.

TITLE IV—RURAL PROVIDER PROVISIONS

Sec. 401. Permitting reclassification of certain urban hospitals as rural hospitals.

Sec. 402. Update of standards applied for geographic reclassification for certain hospitals.

Sec. 403. Improvements in the critical access hospital (CAH) program.

Sec. 404. 5-year extension of medicare dependent hospital (MDH) program.

Sec. 405. Rebasing for certain sole community hospitals.

Sec. 406. Increased flexibility in providing graduate physician training in rural areas.

Sec. 407. Elimination of certain restrictions with respect to hospital swing bed program.

Sec. 408. Grant program for rural hospital transition to prospective payment.

- Sec. 409. MedPAC study of rural providers.
 Sec. 410. Expansion of access to paramedic intercept services in rural areas.

TITLE V—PROVISIONS RELATING TO PART C (MEDICARE+CHOICE PROGRAM)

Subtitle A—Medicare+Choice

- Sec. 501. Phase-in of new risk adjustment methodology.
 Sec. 502. Encouraging offering of Medicare+Choice plans in areas without plans.
 Sec. 503. Modification of 5-year re-entry rule for contract terminations.
 Sec. 504. Continued computation and publication of AAPCC data.
 Sec. 505. Changes in Medicare+Choice enrollment rules.
 Sec. 506. Allowing variation in premium waivers within a service area if Medicare+Choice payment rates vary within the area.
 Sec. 507. Delay in deadline for submission of adjusted community rates and related information.
 Sec. 508. 2 year extension of medicare cost contracts.
 Sec. 509. Medicare+Choice nursing and allied health professional education payments.
 Sec. 510. Reduction in adjustment in national per capita Medicare+Choice growth percentage for 2002.
 Sec. 511. Deeming of Medicare+Choice organization to meet requirements.
 Sec. 512. Miscellaneous changes and studies.
 Sec. 513. MedPAC report on medicare MSA (medical savings account) plans.
 Sec. 514. Clarification of nonapplicability of certain provisions of discharge planning process to Medicare+Choice plans.

Subtitle B—Managed Care Demonstration Projects

- Sec. 521. Extension of social health maintenance organization demonstration (SHMO) project authority.
 Sec. 522. Extension of medicare community nursing organization demonstration project.
 Sec. 523. Medicare+Choice competitive bidding demonstration project.
 Sec. 524. Extension of medicare municipal health services demonstration projects.
 Sec. 525. Medicare coordinated care demonstration project.

TITLE VI—MEDICAID

- Sec. 601. Making medicaid DSH transition rule permanent.
 Sec. 602. Increase in DSH allotment for certain States and the District of Columbia.
 Sec. 603. New prospective payment system for Federally-qualified health centers and rural health clinics.
 Sec. 604. Parity in reimbursement for certain utilization and quality control services.

TITLE VII—STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

- Sec. 701. Stabilizing the SCHIP allotment formula.
 Sec. 702. Increased allotments for territories under the State children's health insurance program.

TITLE I—PROVISIONS RELATING TO PART A

Subtitle A—PPS Hospitals

SEC. 101. ONE-YEAR DELAY IN TRANSITION FOR INDIRECT MEDICAL EDUCATION (IME) PERCENTAGE ADJUSTMENT.

(a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)), as amended by section 4621(a)(1) of BBA, is amended—

(1) in subclause (IV), by inserting “and 2001” after “2000”; and

(2) by striking “2000” in subclause (V) and inserting “2001”.

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)), as amended by section 4621(a)(2) of BBA, is amended by inserting

“or any additional payments under such paragraph resulting from the amendment made by section 101(a) of Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999” after “Balanced Budget Act of 1997”.

SEC. 102. DECREASE IN REDUCTIONS FOR DISPROPORTIONATE SHARE HOSPITALS; DATA COLLECTION REQUIREMENTS.

(a) IN GENERAL.—Section 1886(d)(5)(F)(ix) (42 U.S.C. 1395ww(d)(5)(F)(ix)), as added by section 4403(a) of BBA, is amended—

(1) in subclause (III), by striking “during fiscal year 2000” and inserting “during each of fiscal years 2000 and 2001”;
 (2) by striking subclause (IV);
 (3) by redesignating subclauses (V) and (VI) and subclauses (IV) and (V), respectively; and

(4) in subclause (IV), as so redesignated, by striking “reduced by 5 percent” and inserting “reduced by 4 percent”.

(b) DATA COLLECTION.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall require any subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) to submit to the Secretary, in the cost reports submitted to the Secretary by such hospital for discharges occurring during a fiscal year, data on the costs incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated, including non-medicare bad debt, charity care, and charges for medicaid an indigent care.

(2) EFFECTIVE DATE.—The Secretary shall require the submission of the data described in paragraph (1) in cost reports for cost reporting periods beginning on or after the date of the enactment of this Act.

Subtitle B—PPS-Exempt Hospitals

SEC. 111. WAGE ADJUSTMENT OF PERCENTILE CAP FOR PPS-EXEMPT HOSPITALS.

(a) IN GENERAL.—Section 1886(b)(3)(H) (42 U.S.C. 1395ww(b)(3)(H)), as amended by section 4414 of BBA, is amended—

(1) in clause (i), by inserting “, as adjusted under clause (iii)” before the period,
 (2) in clause (ii), by striking “clause (i)” and “such clause” and inserting “subclause (I)” and “such subclause” respectively,
 (3) by striking “(H)(i)” and inserting “(ii)(I)”,
 (4) by redesignating clauses (ii) and (iii) as subclauses (II) and (III),
 (5) by inserting after clause (ii), as so redesignated, the following new clause:

“(iii) In applying clause (ii)(I) in the case of a hospital or unit, the Secretary shall provide for an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-

related costs in the area of the hospital and the national average of such costs within the same class of hospital.”, and

(6) by inserting before clause (ii), as so redesignated, the following new clause:

“(H)(i) In the case of a hospital or unit that is within a class of hospital described in clause (iv), for a cost reporting period beginning during fiscal years 1998 through 2002, the target amount for such a hospital or unit may not exceed the amount as updated up to or for such cost reporting period under clause (ii).”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to cost reporting periods beginning on or after October 1, 1999.

SEC. 112. ENHANCED PAYMENTS FOR LONG-TERM CARE AND PSYCHIATRIC HOSPITALS UNTIL DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEMS FOR THOSE HOSPITALS.

Section 1886(b)(2) (42 U.S.C. 1395ww(b)(2)), as added by section 4415(b) of BBA, is amended—

(1) in subparagraph (A), by striking “In addition to” and inserting “Except as provided in subparagraph (E), in addition to”; and

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

“(E)(i) In the case of an eligible hospital that is a hospital or unit that is within a class of hospital described in clause (ii) with a 12-month cost reporting period beginning before the enactment of this subparagraph, in determining the amount of the increase under subparagraph (A), the Secretary shall substitute for the percentage of the target amount applicable under subparagraph (A)(ii)—

“(I) for a cost reporting period beginning on or after October 1, 2000, and before September 30, 2001, 1.5 percent; and

“(II) for a cost reporting period beginning on or after October 1, 2001, and before September 30, 2002, 2 percent.

“(ii) For purposes of clause (i), each of the following shall be treated as a separate class of hospital:

“(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

“(II) Hospitals described in clause (iv) of such subsection.”.

SEC. 113. PER DISCHARGE PROSPECTIVE PAYMENT SYSTEM FOR LONG-TERM CARE HOSPITALS.

(a) DEVELOPMENT OF SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a per discharge prospective payment system for payment for inpatient hospital services of long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under the medicare program. Such system shall include an adequate patient classification system that is based on diagnosis-related groups (DRGs) and that reflects the differences in patient resource use and costs, and shall maintain budget neutrality.

(2) COLLECTION OF DATA AND EVALUATION.—In developing the system described in paragraph (1), the Secretary may require such long-term care hospitals to submit such information to the Secretary as the Secretary may require to develop the system.

(b) REPORT.—Not later than October 1, 2001, the Secretary shall submit to the appropriate committees of Congress a report that includes a description of the system developed under subsection (a)(1).

(c) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Notwithstanding section

1886(b)(3) of the Social Security Act (42 U.S.C. 1395ww(b)(3)), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2002, for payments for inpatient hospital services furnished by long-term care hospitals under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) in accordance with the system described in subsection (a).

SEC. 114. PER DIEM PROSPECTIVE PAYMENT SYSTEM FOR PSYCHIATRIC HOSPITALS.

(a) DEVELOPMENT OF SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a per diem prospective payment system for payment for inpatient hospital services of psychiatric hospitals and units (as defined in paragraph (3)) under the medicare program. Such system shall include an adequate patient classification system that reflects the differences in patient resource use and costs among such hospitals and shall maintain budget neutrality.

(2) COLLECTION OF DATA AND EVALUATION.—In developing the system described in paragraph (1), the Secretary may require such psychiatric hospitals and units to submit such information to the Secretary as the Secretary may require to develop the system.

(3) DEFINITION.—In this section, the term “psychiatric hospitals and units” means a psychiatric hospital described in clause (1) of section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) and psychiatric units described in the matter following clause (v) of such section.

(b) REPORT.—Not later than October 1, 2001, the Secretary shall submit to the appropriate committees of Congress a report that includes a description of the system developed under subsection (a)(1).

(c) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Notwithstanding section 1886(b)(3) of the Social Security Act (42 U.S.C. 1395ww(b)(3)), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2002, for payments for inpatient hospital services furnished by psychiatric hospitals and units under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) in accordance with the prospective payment system established by the Secretary under this section in a budget neutral manner.

SEC. 115. REFINEMENT OF PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT REHABILITATION SERVICES.

(a) ELECTION TO APPLY FULL PROSPECTIVE PAYMENT RATE WITHOUT PHASE-IN.—

(1) IN GENERAL.—Paragraph (1) of section 1886(j) (42 U.S.C. 1395ww(j)), as added by section 4421(a) of BBA, is amended—

(A) in subparagraph (C), by inserting “subject to subparagraph (E),” after “subparagraph (A),”; and

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

“(E) ELECTION TO APPLY FULL PROSPECTIVE PAYMENT SYSTEM.—A rehabilitation facility may elect for either or both cost reporting periods described in subparagraph (C) to have the TEFRA percentage and prospective payment percentage set at 0 percent and 100 percent, respectively, for the facility.”

(2) BUDGET NEUTRALITY IN APPLICATION.—Paragraph (3)(B) of such section is amended by inserting “and taking into account the election permitted under paragraph (1)(E)” after “in the Secretary’s estimation”.

(3) CASE MIX CREEP ADJUSTMENT.—Paragraph (2)(C) of such section is amended by adding at the end the following new clauses:

“(iii) EXAMINATION OF CHANGES IN CASE MIX.—The Secretary, upon obtaining sub-

stantially complete data from fiscal year 2001, shall analyze the extent to which the changes in case mix during that fiscal year are attributable to changes in coding and classification and do not reflect real changes in case mix.

“(iv) INITIAL ADJUSTMENT OF RATES IN FISCAL YEAR 2004.—Based on the analysis performed under clause (iii) in determining the amount of case mix change due merely to changes in coding or classification, the Secretary shall adjust the prospective payment amounts for fiscal year 2004 by 150 percent of the Secretary’s estimate of the percentage adjustment to the prospective payment rate under this paragraph that would have achieved budget neutrality in fiscal year 2001 if it had applied in setting the rates for that fiscal year.

“(v) FINAL ADJUSTMENT OF RATES IN FISCAL YEAR 2005.—In the case that the adjustment under clause (iv) resulted in—

“(I) a percentage decrease in rates, the Secretary shall increase the prospective payment amounts for fiscal year 2005 by a percentage equal to 1/3 of such percentage decrease; or

“(II) a percentage increase in rates, the Secretary shall decrease the prospective payment amounts for fiscal year 2005 by a percentage equal to 1/3 of such percentage increase.”

(b) USE OF DISCHARGE AS PAYMENT UNIT.—

(1) IN GENERAL.—Paragraph (1)(D) of such section is amended by striking “, day of inpatient hospital services, or other unit of payment defined by the Secretary”.

(2) CONFORMING AMENDMENT TO CLASSIFICATION.—Paragraph (2)(A) of such section is amended by amending clause (i) of to read as follows:

“(i) classes of patient discharges of rehabilitation facilities by functional-related groups (each in this subsection referred to as a ‘case mix group’), based on impairment, age, comorbidities, and functional capability of the patient and such other factors as the Secretary deems appropriate to improve the explanatory power of functional independence measure-function related groups; and”.

(3) CONSTRUCTION RELATING TO TRANSFER AUTHORITY.—Paragraph (1) of such section, as amended by subsection (a)(1), is further amended by adding at the end the following new subparagraph:

“(F) CONSTRUCTION RELATING TO TRANSFER AUTHORITY.—Nothing in this subsection shall be construed as preventing the Secretary from providing for an adjustment to payments to take into account the early transfer of a patient from a rehabilitation facility to another site of care.”

(c) STUDY ON IMPACT OF IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study of the impact on utilization and beneficiary access to services of the implementation of the medicare prospective payment system for inpatient hospital services or rehabilitation facilities under section 1886(j) of the Social Security Act (as added by section 4421(a) of BBA).

(2) REPORT.—Not later than 3 years after the date such system is first implemented, the Secretary shall submit to Congress a report on such study.

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) are effective as if included in the enactment of section 4421(a) of BBA.

Subtitle C—Adjustments to PPS Payments for Skilled Nursing Facilities

SEC. 121. TEMPORARY INCREASE IN PAYMENT FOR CERTAIN HIGH COST PATIENTS.

(a) ADJUSTMENT FOR MEDICALLY COMPLEX PATIENTS UNTIL ESTABLISHMENT OF REFINED CASE-MIX ADJUSTMENT.—For purposes of computing payments for covered skilled nursing facility services under paragraph (1) of section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)), as added by section 4432(a) of BBA, for such services furnished on or after April 1, 2000, and before October 1, 2000, the Secretary of Health and Human Services shall increase by 10 percent the adjusted Federal per diem rate otherwise determined under paragraph (4) of such section (but for this section) for covered skilled nursing facility services for RUG—III groups described in subsection (b) furnished to an individual during the period in which such individual is classified in such a RUG—III category.

(b) GROUPS DESCRIBED.—The RUG—III groups for which the adjustment described in subsection (a) applies are SE3, SE2, SE1, SSC, SSB, SSA, CC2, CC1, CB2, CB1, CA2, and CA1, as specified in Tables 3 and 4 of the final rule published in the Federal Register by the Health Care Financing Administration on July 30, 1999 (64 Fed. Reg. 41684).

SEC. 122. MARKET BASKET INCREASE.

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

(1) by redesignating subclause (III) as subclause (IV); and

(2) by striking subclause (II) and inserting after subclause (I) the following:

“(II) for fiscal year 2001, the rate computed for fiscal year 2000 (determined without regard to section 121 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999) increased by the skilled nursing facility market basket percentage change for the fiscal year involved plus 0.8 percentage point;

“(III) for fiscal year 2002, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved minus 1 percentage point; and”.

SEC. 123. AUTHORIZING FACILITIES TO ELECT IMMEDIATE TRANSITION TO FEDERAL RATE.

(a) IN GENERAL.—Section 1888(e) (42 U.S.C. 1395yy(e)), as added by section 4432(a) of BBA, is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking “paragraph (7)” and inserting “paragraphs (7) and (11)”; and

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

“(11) PERMITTING FACILITIES TO WAIVE 3-YEAR TRANSITION.—Notwithstanding paragraph (1)(A), a facility may elect to have the amount of the payment for all costs of covered skilled nursing facility services for each day of such services furnished in cost reporting periods beginning after the date of such election determined pursuant to subparagraph (B) of paragraph (1).”

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to elections made more than 60 days after the date of enactment of this Act.

SEC. 124. PART A PASS-THROUGH PAYMENT FOR CERTAIN AMBULANCE SERVICES, PROSTHESES, AND CHEMOTHERAPY DRUGS.

(a) IN GENERAL.—Section 1888(e) (42 U.S.C. 1395yy(e)), as added by section 4432(a) of BBA, is amended—

(1) in paragraph (2)(A)(i)(II), by striking "services described in clause (ii)" and inserting "items and services described in clauses (ii) and (iii)";

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

"(iii) EXCLUSION OF CERTAIN ADDITIONAL ITEMS.—Items described in this clause are the following:

"(I) Ambulance services furnished to an individual in conjunction with renal dialysis services described in section 1861(s)(2)(F).

"(II) 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 (and as subsequently modified by the Secretary)).

"(III) Chemotherapy administration services (identified as of July 1, 1999, by HCPCS codes 36260–36262; 36489; 36530–36535; 36640; 36823; and 96405–96542 (and as subsequently modified by the Secretary)).

"(IV) Radioisotope services (identified as of July 1, 1999, by HCPCS codes 79030–79440 (and as subsequently modified by the Secretary)).

"(V) Customized prosthetic devices (commonly known as artificial limbs or components or artificial limbs) under the following HCPCS codes (as of July 1, 1999 (and as subsequently modified by the Secretary)) if delivered to an inpatient for use during the stay in the skilled nursing facility and intended to be used by the individual after discharge from the facility: L5050–L5340; L5500–L5610; L5613–L5986; L5988; L6050–L6370; L6400–L6880; L6920–L7274; and L7362–7366.";

(3) by adding at the end of paragraph (9) the following: "In the case of an item or service described in clause (iii) of paragraph (2)(A) that would be payable under part A but for the exclusion of such item or service under such clause, payment shall be made for the item or service, in an amount otherwise determined under part B of this title for such item or service, from the Federal Hospital Insurance Trust Fund under section 1817 (rather than from the Federal Supplementary Medical Insurance Trust Fund under section 1841)."

(b) CONFORMING FOR BUDGET NEUTRALITY BEGINNING WITH FISCAL YEAR 2001.—Section 1888(e)(4)(G) (42 U.S.C. 1395yy(e)(4)(G)) is amended by adding at the end the following new clause:

"(iii) ADJUSTMENT FOR EXCLUSION OF CERTAIN ADDITIONAL ITEMS.—The Secretary shall provide for an appropriate proportional reduction in payments so that beginning with fiscal year 2001, the aggregate amount of such reductions is equal to the aggregate increase in payments attributable to the exclusion effected under clause (iii) of paragraph (2)(A)."

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments made for items furnished on or after April 1, 2000.

SEC. 125. PROVISION FOR PART B ADD-ONS FOR FACILITIES PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT.

(a) IN GENERAL.—Section 1888(e)(3) (42 U.S.C. 1395yy(e)(3)), as added by section 4432(a) of BBA, is amended—

(1) in subparagraph (A)—

(A) in clause (i), by inserting "or, in the case of a facility participating in the Nursing Home Case-Mix and Quality Demonstration (RUGS-III), the RUGS-III rate received by the facility during the cost reporting period beginning in 1997" after "to non-settled cost reports"; and

(B) in clause (ii), by striking "furnished during such period" and inserting "furnished

during the applicable cost reporting period described in clause (i)"; and

(2) by amending subparagraph (B) to read as follows:

"(B) UPDATE TO FIRST COST REPORTING PERIOD.—The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the applicable cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase minus 1 percentage point (except that for the cost reporting period beginning in fiscal year 2001, the factor shall be equal to such market basket percentage plus 0.8 percentage point)."

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall be effective as if included in the enactment of section 4432(a) of BBA.

SEC. 126. SPECIAL CONSIDERATION FOR FACILITIES SERVING SPECIALIZED PATIENT POPULATIONS.

(a) IN GENERAL.—Section 1888(e) (42 U.S.C. 1395yy(e)), as amended by section 123(a)(1), is further amended—

(1) in paragraph (1), by striking "subject to paragraphs (7) and (11)" and inserting "subject to paragraphs (7), (11), and (12)"; and

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

"(12) PAYMENT RULE FOR CERTAIN FACILITIES.—

"(A) IN GENERAL.—In the case of a qualified acute skilled nursing facility described in subparagraph (B), the per diem amount of payment shall be determined by applying the non-Federal percentage and Federal percentage specified in paragraph (2)(C)(ii).

"(B) FACILITY DESCRIBED.—For purposes of subparagraph (A), a qualified acute skilled nursing facility is a facility that—

"(i) was certified by the Secretary as a skilled nursing facility eligible to furnish services under this title before July 1, 1992;

"(ii) is a hospital-based facility; and

"(iii) for the cost reporting period beginning in fiscal year 1998, the facility had more than 60 percent of total patient days comprised of patients who are described in subparagraph (C).

"(C) DESCRIPTION OF PATIENTS.—For purposes of subparagraph (B), a patient described in this subparagraph is an individual who—

"(i) is entitled to benefits under part A; and

"(ii) is immuno-compromised secondary to an infectious disease, with specific diagnoses as specified by the Secretary."

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply for the period beginning on the date on which after the date of the enactment of this Act the first cost reporting period of the facility begins and ending on September 30, 2001, and applies to skilled nursing facilities furnishing covered skilled nursing facility services on the date of the enactment of this Act for which payment is made under title XVIII of the Social Security Act.

(c) REPORT TO CONGRESS.—By not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall assess the resource use of patients of skilled nursing facilities furnishing services under the Medicare program who are immuno-compromised secondary to an infectious disease, with specific diagnoses as specified by the Secretary (under paragraph (12)(C), as added by subsection (a), of section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e))) to deter-

mine whether any permanent adjustments are needed to the RUGs to take into account the resource uses and costs of these patients.

SEC. 127. MEDPAC STUDY ON SPECIAL PAYMENT FOR FACILITIES LOCATED IN HAWAII AND ALASKA.

(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study on skilled nursing facilities furnishing covered skilled nursing facility services (as defined in section 1888(e)(2)(A) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A))) to determine the need for an additional payment amount under section 1888(e)(4)(G) of such Act (42 U.S.C. 1395yy(e)(4)(G)) to take into account the unique circumstances of skilled nursing facilities located in Alaska and Hawaii.

(b) REPORT.—By not later than 18 months after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit a report to Congress on the study conducted under subsection (a).

Subtitle D—Other

SEC. 131. PART A BBA TECHNICAL CORRECTIONS.

(a) SECTION 4201.—Section 1820(c)(2)(B)(i) (42 U.S.C. 1395i-4(c)(2)(B)(i)), as amended by section 4201(a) of BBA, is amended by striking "and is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D)) that" and inserting "that is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D)), and that".

(b) SECTION 4204.—(1) Section 1886(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(G)), as amended by section 4204(a)(1) of BBA, is amended—

(A) in clause (i), by striking "or beginning on or after October 1, 1997, and before October 1, 2001," and inserting "or discharges on or after October 1, 1997, and before October 1, 2001,"; and

(B) in clause (ii)(II), by striking "or beginning on or after October 1, 1997, and before October 1, 2001," and inserting "or discharges on or after October 1, 1997, and before October 1, 2001,".

(2) Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)), as amended by section 4204(a)(2) of BBA, is amended in the matter preceding clause (i) by striking "and for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2001," and inserting "and for discharges beginning on or after October 1, 1997, and before October 1, 2001,".

(c) SECTION 4319.—Section 1847(b)(2) (42 U.S.C. 1395w-3(b)(2)), as added by section 4319 of BBA, is amended by inserting "and" after "specified by the Secretary".

(d) SECTION 4401.—Section 4401(b)(1)(B) of BBA (42 U.S.C. 1395ww note) is amended by striking "section 1886(b)(3)(B)(i)(XIII) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XIII))" and inserting "section 1886(b)(3)(B)(i)(XIV) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XIV))".

(e) SECTION 4402.—The last sentence of section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)), as added by section 4402 of BBA, is amended by striking "September 30, 2002," and inserting "October 1, 2002,".

(f) SECTION 4419.—The first sentence of section 1886(b)(4)(A)(i) (42 U.S.C. 1395ww(b)(4)(A)(i)), as amended by section 4419(a)(1) of BBA, by striking "or unit".

(g) SECTION 4442.—Section 4442(b) of BBA (42 U.S.C. 1395f note) is amended by striking "applies to cost reporting periods beginning" and inserting "applies to items and services furnished".

(h) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of BBA.

**TITLE II—PROVISIONS RELATING TO
PART B**

**Subtitle A—Adjustments to Physician
Payment Updates**

SEC. 201. MODIFICATION OF UPDATE ADJUSTMENT FACTOR PROVISIONS TO REDUCE UPDATE OSCILLATIONS AND REQUIRE ESTIMATE REVISIONS.

(a) UPDATE ADJUSTMENT FACTOR.—

(1) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w-4(d)) is amended—

(A) in paragraph (3)—

(i) in the heading, by inserting “FOR 1999 AND 2000” after “UPDATE”;

(ii) in subparagraph (A), by striking “a year beginning with 1999” and inserting “1999 and 2000”; and

(iii) in subparagraph (C), by inserting “and paragraph (4)” after “For purposes of this paragraph”;

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

“(4) UPDATE FOR YEARS BEGINNING WITH 2001.—

“(A) IN GENERAL.—Unless otherwise provided by law, subject to the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii) and subject to adjustment under subparagraph (F), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 2001 is equal to the product of—

“(i) 1 plus the Secretary’s estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year (divided by 100), and

“(ii) 1 plus the Secretary’s estimate of the update adjustment factor under subparagraph (B) for the year.

“(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), subject to subparagraph (D), the ‘update adjustment factor’ for a year is equal (as estimated by the Secretary) to the sum of the following:

“(i) PRIOR YEAR ADJUSTMENT COMPONENT.—An amount determined by—

“(I) computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians’ services for the prior year (as determined under subparagraph (C)) and the amount of the actual expenditures for such services for that year;

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

“(III) multiplying that quotient by 0.75.

“(ii) CUMULATIVE ADJUSTMENT COMPONENT.—An amount determined by—

“(I) computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians’ services (as determined under subparagraph (C)) from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for such services during that period;

“(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 for which the update adjustment factor is to be determined; and

“(III) multiplying that quotient by 0.33.

“(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph:

“(i) PERIOD UP TO APRIL 1, 1999.—The allowed expenditures for physicians’ services for a period before April 1, 1999, shall be the amount of the allowed expenditures for such period as determined under paragraph (3)(C).

“(ii) TRANSITION TO CALENDAR YEAR ALLOWED EXPENDITURES.—Subject to subparagraph (E), the allowed expenditures for—

“(I) the 9-month period beginning April 1, 1999, shall be the Secretary’s estimate of the amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such period; and

“(II) the year of 1999, shall be the Secretary’s estimate of the amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such year.

“(iii) YEARS BEGINNING WITH 2000.—The allowed expenditures for a year (beginning with 2000) is equal to the allowed expenditures for physicians’ services for the previous year, increased by the sustainable growth rate under subsection (f) for the year involved.

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

“(E) RECALCULATION OF ALLOWED EXPENDITURES FOR UPDATES BEGINNING WITH 2001.—For purposes of determining the update adjustment factor for a year beginning with 2001, the Secretary shall recompute the allowed expenditures for previous periods beginning on or after April 1, 1999, consistent with subsection (f)(3).

“(F) TRANSITIONAL ADJUSTMENT DESIGNED TO PROVIDE FOR BUDGET NEUTRALITY.—Under this subparagraph the Secretary shall provide for an adjustment to the update under subparagraph (A)—

“(i) for each of 2001, 2002, 2003, and 2004, of -0.2 percent; and

“(ii) for 2005 of +0.8 percent.”.

(2) PUBLICATION CHANGE.—

(A) IN GENERAL.—Section 1848(d)(1)(E) (42 U.S.C. 1395w-4(d)(1)(E)) is amended to read as follows:

“(E) PUBLICATION AND DISSEMINATION OF INFORMATION.—The Secretary shall—

“(i) cause to have published in the Federal Register not later than November 1 of each year (beginning with 2000) the conversion factor which will apply to physicians’ services for the succeeding year, the update determined under paragraph (4) for such succeeding year, and the allowed expenditures under such paragraph for such succeeding year; and

“(ii) make available to the Medicare Payment Advisory Commission and the public by March 1 of each year (beginning with 2000) an estimate of the sustainable growth rate and of the conversion factor which will apply to physicians’ services for the succeeding year and data used in making such estimate.”.

(B) MEDPAC REVIEW OF CONVERSION FACTOR ESTIMATES.—Section 1805(b)(1)(D) (42 U.S.C. 1395b-6(b)(1)(D)) is amended by inserting “and including a review of the estimate of the conversion factor submitted under section 1848(d)(1)(E)(ii)” before the period at the end.

(C) 1-TIME PUBLICATION OF INFORMATION ON TRANSITION.—The Secretary of Health and Human Services shall cause to have published in the Federal Register, not later than 90 days after the date of the enactment of this section, the Secretary’s determination, based upon the best available data, of—

(i) the allowed expenditures under subclauses (I) and (II) of section 1848(d)(4)(C)(ii) of the Social Security Act, as added by subsection (a)(1)(B), for the 9-month period beginning on April 1, 1999, and for 1999;

(ii) the estimated actual expenditures described in section 1848(d) of such Act for 1999; and

(iii) the sustainable growth rate under section 1848(f) of such Act (42 U.S.C. 1395w-4(f)) for 2000.

(3) CONFORMING AMENDMENTS.—

(A) Section 1848 (42 U.S.C. 1395w-4) is amended—

(i) in subsection (d)(1)(A), by inserting “(for years before 2001) and, for years beginning with 2001, multiplied by the update (established under paragraph (4) for the year involved)” after “for the year involved”; and

(ii) in subsection (f)(2)(D), by inserting “or (d)(4)(B), as the case may be” after “(d)(3)(B)”.

(B) Section 1833(1)(4)(A)(i)(VII) (42 U.S.C. 1395l(1)(4)(A)(i)(VII)) is amended by striking “1848(d)(3)” and inserting “1848(d)”.

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

(1) by amending paragraph (1) to read as follows:

“(1) PUBLICATION.—The Secretary shall cause to have published in the Federal Register not later than—

“(A) November 1, 2000, the sustainable growth rate for 2000 and 2001; and

“(B) November 1 of each succeeding year the sustainable growth rate for such succeeding year and each of the preceding 2 years.”;

(2) in paragraph (2)—

(A) in the matter before subparagraph (A), by striking “fiscal year 1998” and inserting “fiscal year 1998 and ending with fiscal year 2000) and a year beginning with 2000”; and

(B) in subparagraphs (A) through (D), by striking “fiscal year” and inserting “applicable period” each place it appears;

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

“(C) APPLICABLE PERIOD.—The term ‘applicable period’ means—

“(i) a fiscal year, in the case of fiscal year 1998, fiscal year 1999, and fiscal year 2000; or

“(ii) a calendar year with respect to a year beginning with 2000;

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

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

“(3) DATA TO BE USED.—For purposes of determining the update adjustment factor under subsection (d)(4)(B) for a year beginning with 2001, the sustainable growth rates taken into consideration in the determination under paragraph (2) shall be determined as follows:

“(A) FOR 2001.—For purposes of such calculations for 2001, the sustainable growth rates for fiscal year 2000 and the years 2000 and 2001 shall be determined on the basis of the best data available to the Secretary as of September 1, 2000.

“(B) FOR 2002.—For purposes of such calculations for 2002, the sustainable growth rates for fiscal year 2000 and for years 2000, 2001, and 2002 shall be determined on the basis of the best data available to the Secretary as of September 1, 2001.

“(C) FOR 2003 AND SUCCEEDING YEARS.—For purposes of such calculations for a year after 2002—

“(i) the sustainable growth rates for that year and the preceding 2 years shall be determined on the basis of the best data available to the Secretary as of September 1 of the year preceding the year for which the calculation is made; and

“(ii) the sustainable growth rate for any year before a year described in clause (i) shall be the rate as most recently determined for that year under this subsection.

Nothing in this paragraph shall be construed as affecting the sustainable growth rates established for fiscal year 1998 or fiscal year 1999.”.

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective in determining the conversion factor under section 1848(d) of the Social Security Act (42 U.S.C. 1395w-4(d)) for years beginning with 2001 and shall not apply to or affect any update (or any update adjustment factor) for any year before 2001.

SEC. 202. USE OF DATA COLLECTED BY ORGANIZATIONS AND ENTITIES IN DETERMINING PRACTICE EXPENSE RELATIVE VALUES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish by regulation (after notice and opportunity for public comment) a process (including data collection standards) under which the Secretary will accept for use and will use, to the maximum extent practicable consistent with sound data practices, data collected or developed by entities and organizations (other than the Department of Health and Human Services) to supplement the data normally collected by that Department in determining the practice expense component under section 1848(c)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)(C)(ii)) for purposes of determining relative values for payment for physicians' services under the fee schedule under section 1848 of such Act (42 U.S.C. 1395w-4). The Secretary shall first promulgate such regulation on an interim final basis in a manner that permits the submission and use of data in the computation of practice expense relative value units for payment rates for 2001.

(b) PUBLICATION OF INFORMATION.—The Secretary shall include, in the publication of the estimated and final updates under section 1848(c) of such Act (42 U.S.C. 1395w-4(c)) for payments for 2001 and for 2002, a description of the process established under subsection (a) for the use of external data in making adjustments in relative value units and the extent to which the Secretary has used such external data in making such adjustments for each such year, particularly in cases in which the data otherwise used are inadequate because they are not based upon a large enough sample size to be statistically reliable.

SEC. 203. GAO STUDY ON RESOURCES REQUIRED TO PROVIDE SAFE AND EFFECTIVE OUTPATIENT CANCER THERAPY.

(a) STUDY.—The Comptroller General of the United States shall conduct a nationwide study to determine the physician and non-physician clinical resources necessary to provide safe outpatient cancer therapy services and the appropriate payment rates for such services under the medicare program. In making such determination, the Comptroller General shall—

(1) determine the adequacy of practice expense relative value units associated with the utilization of those clinical resources;

(2) determine the adequacy of work units in the practice expense formula; and

(3) assess various standards to assure the provision of safe outpatient cancer therapy services.

(b) REPORT TO CONGRESS.—The Comptroller General shall submit to Congress a report on the study conducted under subsection (a). The report shall include recommendations regarding practice expense adjustments to the payment methodology under part B of the medicare program, including the development and inclusion of adequate work units to assure the adequacy of payment amounts for safe outpatient cancer therapy services. The study shall also include an estimate of the cost of implementing such recommendations.

Subtitle B—Hospital Outpatient Services

SEC. 211. OUTLIER ADJUSTMENT AND TRANSITIONAL PASS-THROUGH FOR CERTAIN MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.

(a) OUTLIER ADJUSTMENT.—Section 1833(t) (42 U.S.C. 1395l(t)), as added by section 4523(a) of BBA, is amended—

(1) by redesignating paragraphs (5) through (9) as paragraphs (7) through (11), respectively; and

(2) by inserting after paragraph (4) the following new paragraph:

“(5) OUTLIER ADJUSTMENT.—

“(A) IN GENERAL.—The Secretary shall provide for an additional payment for each covered OPD service (or group of services) for which a hospital's charges, adjusted to cost, exceed—

“(i) a fixed multiple of the sum of—

“(I) the applicable Medicare OPD fee schedule amount determined under paragraph (3)(D), as adjusted under paragraph (4)(A) (other than for adjustments under this paragraph or paragraph (6)); and

“(II) any transitional pass-through payment under paragraph (6); and

“(ii) at the option of the Secretary, such fixed dollar amount as the Secretary may establish.

“(B) AMOUNT OF ADJUSTMENT.—The amount of the additional payment under subparagraph (A) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the applicable cutoff point under such subparagraph.

“(C) LIMIT ON AGGREGATE OUTLIER ADJUSTMENTS.—

“(i) IN GENERAL.—The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as projected or estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments projected or estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied to less than a full year, the previous sentence shall apply only to the portion of such year.

“(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the term ‘applicable percentage’ means a percentage specified by the Secretary up to (but not to exceed)—

“(I) for a year (or portion of a year) before 2004, 2.5 percent; and

“(II) for 2004 and thereafter, 3.0 percent.”.

(b) TRANSITIONAL PASS-THROUGH FOR ADDITIONAL COSTS OF INNOVATIVE MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—Such section is further amended by inserting after paragraph (5) the following new paragraph:

“(6) TRANSITIONAL PASS-THROUGH FOR ADDITIONAL COSTS OF INNOVATIVE MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—

“(A) IN GENERAL.—The Secretary shall provide for an additional payment under this paragraph for any of the following that are provided as part of a covered OPD service (or group of services):

“(i) CURRENT ORPHAN DRUGS.—A drug or biological that is used for a rare disease or condition with respect to which the drug or biological has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act if payment for the drug or biological as an outpatient hospital service under this part was being made on the first date that the system under this subsection is implemented.

“(ii) CURRENT CANCER THERAPY DRUGS AND BIOLOGICALS.—A drug or biological that is used in cancer therapy, including (but not

limited to) a chemotherapeutic agent, antiemetic, hematopoietic growth factor, colony stimulating factor, a biological response modifier, and a bisphosphonate, or brachytherapy, if payment for such drug, biological, or device as an outpatient hospital service under this part was being made on such first date.

“(iii) NEW MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—A medical device, drug, or biological not described in clause (i) or (ii) if—

“(I) payment for the device, drug, or biological as an outpatient hospital service under this part was not being made as of December 31, 1996; and

“(II) the cost of the device, drug, or biological is not insignificant in relation to the OPD fee schedule amount (as calculated under paragraph (3)(D)) payable for the service (or group of services) involved.

“(B) LIMITED PERIOD OF PAYMENT.—The payment under this paragraph with respect to a medical device, drug, or biological shall only apply during a period of at least 2 years, but not more than 3 years, that begins—

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

“(ii) in the case of a device, drug, or biological described in subparagraph (A)(iii) not described in clause (i), on the first date on which payment is made under this part for the device, drug, or biological as an outpatient hospital service.

“(C) AMOUNT OF ADDITIONAL PAYMENT.—Subject to subparagraph (D)(iii), the amount of the payment under this paragraph with respect to a device, drug, or biological provided as part of a covered OPD service is—

“(i) in the case of a drug or biological, the amount by which the amount determined under section 1842(o) for the drug or biological exceeds the portion of the otherwise applicable medicare OPD fee schedule that the Secretary determines is associated with the drug or biological; or

“(ii) in the case of a medical device, the amount by which the hospital's charges for the device, adjusted to cost, exceeds the portion of the otherwise applicable medicare OPD fee schedule that the Secretary determines is associated with the device.

“(D) LIMIT ON AGGREGATE ANNUAL ADJUSTMENT.—

“(i) IN GENERAL.—The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as projected or estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments projected or estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied to less than a full year, the previous sentence shall apply only to the portion of such year.

“(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the term ‘applicable percentage’ means—

“(I) for a year (or portion of a year) before 2004, 2.5 percent; and

“(II) for 2004 and thereafter, a percentage specified by the Secretary up to (but not to exceed) 2.0 percent.

“(iii) UNIFORM PROSPECTIVE REDUCTION IF AGGREGATE LIMIT PROJECTED TO BE EXCEEDED.—If the Secretary projects or estimates before the beginning of a year that the

amount of the additional payments under this paragraph for the year (or portion thereof) as determined under clause (i) without regard to this clause) will exceed the limit established under such clause, the Secretary shall reduce pro rata the amount of each of the additional payments under this paragraph for that year (or portion thereof) in order to ensure that the aggregate additional payments under this paragraph (as so projected or estimated) do not exceed such limit."

(C) APPLICATION OF NEW ADJUSTMENTS ON A BUDGET NEUTRAL BASIS.—Section 1833(t)(2)(E) (42 U.S.C. 1395l(t)(2)(E)) is amended by striking "other adjustments, in a budget neutral manner, as determined to be necessary to ensure equitable payments, such a outlier adjustments or" and inserting "in a budget neutral manner, outlier adjustments under paragraph (5) and transitional pass-through payments under paragraph (6) and other adjustments as determined to be necessary to ensure equitable payments, such as".

(D) LIMITATION ON JUDICIAL REVIEW FOR NEW ADJUSTMENTS.—Section 1833(t)(11), as redesignated by subsection (a)(1), is amended—

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

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

(3) by adding at the end the following: "The determination of the fixed multiple, or a fixed dollar cutoff amount, the marginal cost of care, or applicable percentage under paragraph (5) or the determination of insignificance of cost, the duration of the additional payments (consistent with paragraph (6)(B)), the portion of the Medicare OPD fee schedule amount associated with particular devices, drugs, or biologicals, and the application of any pro rata reduction under paragraph (6)."

(E) INCLUSION OF MEDICAL DEVICES UNDER SYSTEM.—Section 1833(t) (42 U.S.C. 1395l(t)) is amended—

(1) in paragraph (1)(B)(ii), by striking "clause (iii)" and inserting "clause (iv)" and by striking "but";

(2) by redesignating clause (iii) of paragraph (1)(B) as clause (iv) and inserting after clause (ii) of such paragraph the following new clause:

"(iii) includes medical devices (such as implantable medical devices); but"; and

(3) in paragraph (2)(B), by inserting after "resources" the following: "and so that a device is classified to the group that includes the service to which the device relates".

(F) AUTHORIZING PAYMENT WEIGHTS BASED ON MEAN HOSPITAL COSTS.—Section 1833(t)(2)(C) (42 U.S.C. 1395l(t)(2)(C)) is amended by inserting "(or, at the election of the Secretary, mean)" after "median".

(G) LIMITING VARIATION OF COSTS OF SERVICES CLASSIFIED WITH A GROUP.—Section 1833(t)(2) (42 U.S.C. 1395l(t)(2)) is amended by adding at the end the following new flush sentence:

"For purposes of subparagraph (B), items and services within a group shall not be treated as 'comparable with respect to the use of resources' if the highest median cost (or mean cost, if elected by the Secretary under subparagraph (C)) for an item or service within the group is more than 2 times greater than the lowest median cost (or mean cost, if so elected) for an item or service within the group; except that the Secretary may make exceptions in unusual cases, such as low volume items and services, but may not make such an exception in the

case of a drug or biological has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act."

(H) ANNUAL REVIEW OF OPD PPS COMPONENTS.—

(1) IN GENERAL.—Section 1833(t)(8)(A) (42 U.S.C. 1395l(t)(8)(A)), as redesignated by subsection (a), is amended—

(A) by striking "may periodically review" and inserting "shall review not less often than annually"; and

(B) by adding at the end the following: "The Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise the Secretary concerning) the clinical integrity of the groups and weights. Such panel may use data collected or developed by entities and organizations (other than the Department of Health and Human Services) in conducting such review."

(2) EFFECTIVE DATES.—The Secretary of Health and Human Services shall first conduct the annual review under the amendment made by paragraph (1)(A) in 2001 for application in 2002 and the amendment made by paragraph (1)(B) takes effect on the date of the enactment of this Act.

(I) NO IMPACT ON COPAYMENT.—Section 1833(t)(7) (42 U.S.C. 1395l(t)(7)), as redesignated by subsection (a), is amended by adding at the end the following new subparagraph:

"(D) COMPUTATION IGNORING OUTLIER AND PASS-THROUGH ADJUSTMENTS.—The copayment amount shall be computed under subparagraph (A) as if the adjustments under paragraphs (5) and (6) (and any adjustment made under paragraph (2)(E) in relation to such adjustments) had not occurred."

(J) TECHNICAL CORRECTION IN REFERENCE RELATING TO HOSPITAL-BASED AMBULANCE SERVICES.—Section 1833(t)(9) (42 U.S.C. 1395l(t)(9)), as redesignated by subsection (a), is amended by striking "the matter in subsection (a)(1) preceding subparagraph (A)" and inserting "section 1861(v)(1)(U)".

(K) EFFECTIVE DATE.—Except as provided in this section, the amendments made by this section shall be effective as if included in the enactment of BBA.

(L) STUDY OF DELIVERY OF INTRAVENOUS IMMUNE GLOBULIN (IVIG) OUTSIDE HOSPITALS AND PHYSICIANS' OFFICES.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study of the extent to which intravenous immune globulin (IVIG) could be delivered and reimbursed under the medicare program outside of a hospital or physician's office. In conducting the study, the Secretary shall—

(A) consider the sites of service that other payors, including Medicare+Choice plans, use for these drugs and biologicals;

(B) determine whether covering the delivery of these drugs and biologicals in a medicare patient's home raises any additional safety and health concerns for the patient;

(C) determine whether covering the delivery of these drugs and biologicals in a patient's home can reduce overall spending under the medicare program; and

(D) determine whether changing the site of setting for these services would affect beneficiary access to care.

(2) REPORT.—The Secretary shall submit a report on such study to the Committees on Way and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate within 1 year after the date of the enactment of this Act. The Secretary shall include in the report rec-

ommendations regarding on the appropriate manner and settings under which the medicare program should pay for these drugs and biologicals delivered outside of a hospital or physician's office.

SEC. 212. ESTABLISHING A TRANSITIONAL CORRIDOR FOR APPLICATION OF OPD PPS.

(A) IN GENERAL.—Section 1833(t) (42 U.S.C. 1395l(t)), as amended by section 211(a), is further amended—

(1) in paragraph (4), in the matter before subparagraph (A), by inserting "subject to paragraph (7)," after "is determined"; and

(2) by redesignating paragraphs (7) through (11) as paragraphs (8) through (12), respectively; and

(3) by inserting after paragraph (6), as inserted by section 211(b), the following new paragraph:

"(7) TRANSITIONAL ADJUSTMENT TO LIMIT DECLINE IN PAYMENT.—

"(A) BEFORE 2002.—Subject to subparagraph (D), for covered OPD services furnished before January 1, 2002, for which the PPS amount (as defined in subparagraph (E)) is—

"(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount (as defined in subparagraph (F)), the amount of payment under this subsection shall be increased by 80 percent of the amount of such difference;

"(ii) at least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.71 and the pre-BBA amount, exceeds (II) the product of 0.70 and the PPS amount;

"(iii) at least 70 percent, but less than 80 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.63 and the pre-BBA amount, exceeds (II) the product of 0.60 and the PPS amount;

"(iv) less than 70 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 21 percent of the pre-BBA amount.

"(B) 2002.—Subject to subparagraph (D), for covered OPD services furnished during 2002, for which the PPS amount is—

"(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by 70 percent of the amount of such difference;

"(ii) at least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.61 and the pre-BBA amount, exceeds (II) the product of 0.60 and the PPS amount;

"(iii) less than 80 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 13 percent of the pre-BBA amount.

"(C) 2003.—Subject to subparagraph (D), for covered OPD services furnished during 2003, for which the PPS amount is—

"(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by 60 percent of the amount of such difference; or

"(ii) less than 90 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 6 percent of the pre-BBA amount.

"(D) SPECIAL RULE FOR SMALL RURAL HOSPITALS.—In the case of a hospital located in a rural area and that has not more than 100 beds, for covered OPD services furnished before January 1, 2004, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection

shall be increased by 100 percent of the amount of such difference.

“(E) PPS AMOUNT DEFINED.—In this paragraph, the term ‘PPS amount’ means, with respect to covered OPD services, the amount payable under this title for such services (determined without regard to this paragraph), including amounts payable as copayment under paragraph (5), coinsurance under section 1866(a)(2)(A)(ii), and the deductible under section 1833(b).

“(F) PRE-BBA AMOUNT DEFINED.—

“(i) IN GENERAL.—In this paragraph, the ‘pre-BBA amount’ means, with respect to covered OPD services furnished by a hospital in a year, an amount equal to the product of the reasonable cost of the hospital for such services for the portions of the hospital’s cost reporting period (or periods) occurring in the year and the base OPD payment-to-cost ratio for the hospital (as defined in clause (ii)).

“(ii) BASE PAYMENT-TO-COST-RATIO DEFINED.—For purposes of this subparagraph, the ‘base payment-to-cost ratio’ for a hospital means the ratio of—

“(I) the hospital’s reimbursement under this part for covered OPD services furnished during the cost reporting period ending in 1996, including any reimbursement for such services through cost-sharing described in subparagraph (D), to

“(II) the reasonable cost of such services for such period.

“(G) NO EFFECT ON COPAYMENTS.—Nothing in this paragraph shall be construed to affect the unadjusted copayment amount described in paragraph (3)(B) or the copayment amount under paragraph (8).

“(H) APPLICATION WITHOUT REGARD TO BUDGET NEUTRALITY.—The additional 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) EFFECTIVE DATE.—The amendments made by subsection (a) shall be effective as if included in the enactment of BBA.

(c) REPORT ON RURAL HOSPITALS.—Not later than July 1, 2002, the Secretary of Health and Human Services shall submit to Congress a report and recommendations on whether the prospective payment system for covered outpatient services furnished under title XVIII of the Social Security Act should apply to the following providers of services furnishing outpatient items and services for which payment is made under such title:

(1) Medicare-dependent, small rural hospitals (as defined in section 1866(d)(5)(G)(iv) of such Act (42 U.S.C. 1395ww(d)(5)(G)(iv))).

(2) Sole community hospitals (as defined in section 1866(d)(5)(D)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(D)(iii))).

(3) Rural health clinics (as defined in section 1861(aa)(2) of such Act (42 U.S.C. 1395x(aa)(2))).

(4) Rural referral centers (as so classified under section 1866(d)(5)(C) of such Act (42 U.S.C. 1395ww(d)(5)(C))).

(5) Any other rural hospital with not more than 100 beds.

(6) Any other rural hospital that the Secretary determines appropriate.

SEC. 213. DELAY IN APPLICATION OF PROSPECTIVE PAYMENT SYSTEM TO CANCER CENTER HOSPITALS.

Section 1833(t)(11)(A) (42 U.S.C. 1395l(t)(11)(A)), as redesignated by section 212(a), is amended by striking “January 1, 2000” and inserting “the first day of the first year that begins 2 years after the date the prospective payment system under this section is first implemented”.

SEC. 214. LIMITATION ON OUTPATIENT HOSPITAL COPAYMENT FOR A PROCEDURE TO THE HOSPITAL DEDUCTIBLE AMOUNT.

(a) IN GENERAL.—Section 1833(t)(8) (42 U.S.C. 1395l(t)(8)), as redesignated by sections 212(a)(1) and 212(a)(2), is amended—

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

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

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

“(C) LIMITING COPAYMENT AMOUNT TO INPATIENT HOSPITAL DEDUCTIBLE AMOUNT.—In no case shall the copayment amount for a procedure performed in a year exceed the amount of the inpatient hospital deductible established under section 1813(b) for that year.”

(b) INCREASE IN PAYMENT TO REFLECT REDUCTION IN COPAYMENT.—Section 1833(t)(4)(C) (42 U.S.C. 1395l(t)(4)(C)) is amended by inserting “, plus the amount of any reduction in the copayment amount attributable to paragraph (5)(C)” before the period at the end.

(c) EFFECTIVE DATE.—The amendments made by this section apply as if included in the enactment of BBA and shall only apply to procedures performed for which payment is made on the basis of the prospective payment system under section 1833(t) of the Social Security Act.

Subtitle C—Other

SEC. 221. APPLICATION OF SEPARATE CAPS TO PHYSICAL AND SPEECH THERAPY SERVICES.

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

(1) in paragraph (1)—

(A) by inserting “(A)” after “(g)(1)”; and

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

“(B) Subparagraph (A) shall be applied separately for speech-language pathology services described in the fourth sentence of section 1861(p) and for other outpatient physical therapy services.”; and

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

“(4) The limitations of this subsection apply to the services involved on a per beneficiary, per facility (or provider) basis.”.

(b) TECHNICAL AMENDMENT RELATING TO BEING UNDER THE CARE OF A PHYSICIAN.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) in subsection (p)(1), by striking “or (3)” and inserting “, (3), or (4)”; and

(2) in subsection (r)(4), by inserting “for purposes of subsection (p)(1) and” after “but only”.

(c) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after January 1, 2000.

SEC. 222. TRANSITIONAL OUTLIER PAYMENTS FOR THERAPY SERVICES FOR CERTAIN HIGH ACUITY PATIENTS.

Section 1833(g) (42 U.S.C. 1395l(g)), as amended by section 221, is further amended by adding at the end the following new paragraph:

“(5)(A) The Secretary shall establish a process under which a facility or provider that is providing therapy services to which the limitation of this subsection applies to a beneficiary may apply to the Secretary for an increase in such limitation under this paragraph for services furnished in 2000 or in 2001.

“(B) Such process shall take into account the clinical diagnosis and shall provide that the aggregate amount of additional pay-

ments resulting from the application of this paragraph—

“(i) during fiscal year 2000 may not exceed \$40,000,000;

“(ii) during fiscal year 2001 may not exceed \$60,000,000; and

“(iii) during fiscal year 2002 may not exceed \$20,000,000.”.

SEC. 223. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.

(a) IN GENERAL.—Section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by adding at the end the following new flush sentence:

“The Secretary shall increase the amount of each composite rate payment for dialysis services furnished on or after January 1, 2000, and on or before December 31, 2000, by 1.2 percent above such composite rate payment amounts for such services furnished on December 31, 1999, and for such services furnished on or after January 1, 2001, by 1.2 percent above such composite rate payment amounts for such services furnished on December 31, 2000.”.

(b) CONFORMING AMENDMENT.—

(1) IN GENERAL.—Section 9335(a) of the Omnibus Budget Reconciliation Act of 1986 (42 U.S.C. 1395rr note) is amended by striking paragraph (1).

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 2000.

(c) STUDY ON PAYMENT LEVEL FOR HOME HEMODIALYSIS.—The Medicare Payment Advisory Commission shall conduct a study on the appropriateness of the differential in payment under the Medicare program for hemodialysis services furnished in a facility and such services furnished in a home. Not later than 18 months after the date of the enactment of this Act, the Commission shall submit to Congress a report on such study and shall include recommendations regarding changes in Medicare payment policy in response to the study.

SEC. 224. TEMPORARY UPDATE IN DURABLE MEDICAL EQUIPMENT AND OXYGEN RATES.

(a) DURABLE MEDICAL EQUIPMENT AND OXYGEN.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)), as amended by section 4551(a)(1) of BBA, is amended—

(1) by redesignating subparagraph (D) as subparagraph (E); and

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

“(C) for each of the years 1998 through 2000, 0 percentage points;

“(D) for each of the years 2001 and 2002, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year minus 2 percentage points; and”.

(b) CONFORMING AMENDMENTS.—Section 1834(a)(9)(B) (42 U.S.C. 1395m(a)(9)(B)), as amended by section 4552(a) of BBA, is amended—

(1) by striking “and” at the end of clause (v);

(2) in clause (vi), by striking “and each subsequent year” and inserting “and 2000” and by striking the period at the end and inserting “; and”; and

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

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

SEC. 225. REQUIREMENT FOR NEW PROPOSED RULEMAKING FOR IMPLEMENTATION OF INHERENT REASONABLENESS POLICY.

The Secretary of Health and Human Services shall not exercise inherent reasonableness authority provided under section 1842(b)(8) of the Social Security Act (42 U.S.C. 1395u(b)(8)) before such time as—

(1) the Secretary has published in the Federal Register a new notice of proposed rulemaking to implement subparagraph (A) of such section;

(2) has provided for a period of not less than 60 days for public comment on such proposed rule; and

(3) the Secretary has published in the Federal Register a final rule which takes into account comments received during such period.

SEC. 226. INCREASE IN REIMBURSEMENT FOR PAP SMEARS.

(a) PAP SMEAR PAYMENT INCREASE.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following new paragraph:

“(7) Notwithstanding paragraphs (1) and (4), the Secretary shall establish a minimum payment amount under this subsection for all areas for a diagnostic or screening pap smear laboratory test (including all cervical cancer screening technologies that have been approved by the Food and Drug Administration) of not less than \$14.60.”

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

(1) the Health Care Financing Administration has been slow to incorporate or provide incentives for providers to use new screening diagnostic health care technologies in the area of cervical cancer;

(2) some new technologies have been developed which optimize the effectiveness of pap smear screening; and

(3) the Health Care Financing Administration should institute an appropriate increase in the payment rate for new cervical cancer screening technologies that have been approved by the Food and Drug Administration as significantly more effective than a conventional pap smear.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) apply to services items and furnished on or after January 1, 2000.

SEC. 227. REFINEMENT OF AMBULANCE SERVICES DEMONSTRATION PROJECT.

Effective as if included in the enactment of BBA, section 4532 of BBA is amended—

(1) in subsection (a), by adding at the end the following: “The Secretary shall publish by not later than July 1, 2000, a request for proposals for such projects.”; and

(2) by amending paragraph (2) of subsection (b) to read as follows:

“(2) CAPITATED PAYMENT RATE DEFINED.—In this subsection, the ‘capitated payment rate’ means, with respect to a demonstration project—

“(A) in its first year, a rate established for the project by the Secretary, using the most current available data, in a manner that ensures that aggregate payments under the project will not exceed the aggregate payment that would have been made for ambulance services under part B of title XVIII of the Social Security Act in the local area of government’s jurisdiction; and

“(B) in a subsequent year, the capitated payment rate established for the previous year increased by an appropriate inflation adjustment factor.”

SEC. 228. PHASE-IN OF PPS FOR AMBULATORY SURGICAL CENTERS.

If the Secretary of Health and Human Services implements a revised prospective

payment system for services of ambulatory surgical facilities under part B of title XVIII of the Social Security Act, prior to incorporating data from the 1999 Medicare cost survey, such system shall be implemented in a manner so that—

(1) in the first year of its implementation, only a proportion (specified by the Secretary and not to exceed ⅓) of the payment for such services shall be made in accordance with such system and the remainder shall be made in accordance with current regulations; and

(2) in the following year a proportion (specified by the Secretary and not to exceed ⅔) of the payment for such services shall be made under such system and the remainder shall be made in accordance with current regulations.

SEC. 229. EXTENSION OF MEDICARE BENEFITS FOR IMMUNOSUPPRESSIVE DRUGS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall provide under this section for an extension of the period of coverage of immunosuppressive drugs under section 1861(s)(2)(J) of the Social Security Act (42 U.S.C. 1395x(s)(2)(J)) to individuals described in such section under terms and conditions specified by the Secretary consistent with subsection (c) and the objectives—

(1) of improving health outcomes by decreasing transplant rejection rates that are attributable to failure to comply with immunosuppressive drug regimens; and

(2) of achieving cost saving to the medicare program by decreasing the need for secondary transplants and other care relating to post-transplant complications.

(b) AUTHORITY.—In carrying out this section—

(1) the Secretary shall provide priority in eligibility to those medicare beneficiaries who, because of income or other factors, would be less likely to maintain an immunosuppressive drug regimen in the absence of such an extension; and

(2) the Secretary is authorized to vary the beneficiary cost-sharing otherwise applicable in order to promote the objectives described in subsection (a).

(c) LIMITATIONS.—The total amount expended by the Secretary under title XVIII of the Social Security Act to carry out this section shall not exceed \$200,000,000, and with respect to expenditures in fiscal year 2000 shall not exceed \$40,000,000. The Secretary shall not provide an extension of coverage under this section for immunosuppressive drugs furnished after September 30, 2004.

(d) REPORT.—Not later than 36 months after the first month in which the Secretary provides for extended benefits under this section, the Secretary shall submit to Congress a report on the operation of this section. The report shall include—

(1) an analysis of the impact of this section on meeting the objectives described in subsection (a); and

(2) recommendations regarding an appropriate cost-effective method for extending coverage of immunosuppressive drugs under the medicare program on a permanent basis.

SEC. 230. ADDITIONAL STUDIES.

(a) MEDPAC STUDY ON POSTSURGICAL RECOVERY CARE CENTER SERVICES.—

(1) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study on the cost-effectiveness and efficacy of covering under the medicare program services of a post-surgical recovery care center (that provides an intermediate level of recovery care following surgery). In conducting such study, the Commission shall consider data on these centers gathered in demonstration projects.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Commission shall submit to Congress a report on such study and shall include in the report recommendations on the feasibility, costs, and savings of covering such services under the medicare program.

(b) ACHPR STUDY ON EFFECT OF CREDENTIALING OF TECHNOLOGISTS AND SONOGRAPHERS ON QUALITY OF ULTRASOUND AND IMAGING SERVICES.—

(1) STUDY.—The Administrator for Health Care Policy and Research shall provide for a study that compares the differences in quality of ultrasound and other imaging services (including error rates and resulting complications) furnished under the medicare and medicaid programs between such services furnished by individuals who are credentialed by private entities or organizations and by those who are not so credentialed. Such study shall examine and evaluate differences in error rates and patient outcomes as a result of the differences in credentialing. In designing the study, the Administrator shall consult with organizations nationally recognized for their expertise in ultrasound procedures.

(2) REPORT.—By not later than two years after the date of the enactment of this Act, the Administrator shall submit a report to Congress on the study conducted under paragraph (1).

(c) MEDPAC STUDY ON THE COMPLEXITY OF THE MEDICARE PROGRAM AND THE LEVELS OF BURDENS PLACED ON PROVIDERS THROUGH FEDERAL REGULATIONS.—

(1) STUDY.—The Medicare Payment Advisory Commission shall undertake a comprehensive study to review the regulatory burdens placed on all classes of health care providers under parts A and B of the medicare program under title XVIII of the Social Security Act and to determine the costs these burdens impose on the nation’s health care system. The study shall also examine the complexity of the current regulatory system and its impact on providers.

(2) REPORT.—not later than December 31, 2001, the Commission shall submit to Congress a report on the study conducted under paragraph (1). The report shall include recommendations regarding—

(A) how the Health Care Financing Administration can reduce the regulatory burdens placed on patients and providers; and

(B) legislation that may be appropriate to reduce the complexity of the medicare program, including improvement of the rules regarding billing, compliance, and fraud and abuse.

(d) GAO CONTINUED MONITORING OF DEPARTMENT OF JUSTICE APPLICATION OF GUIDELINES ON USE OF FALSE CLAIMS ACT IN CIVIL HEALTH CARE MATTERS.—The Comptroller General of the United States shall—

(1) continue the monitoring, begun under section 118 of the Department of Justice Appropriations Act, 1999 (included in Public Law 105-277) of the compliance of the Department of Justice and all United States Attorneys with the “Guidance on the Use of the False Claims Act in Civil Health Care Matters” issued by the Department of Justice on June 3, 1998, including any revisions to that guidance; and

(2) not later than April 1, 2000, and of each of the two succeeding years, submit a report on such compliance to the appropriate Committees of Congress.

TITLE III—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

SEC. 301. ADJUSTMENT TO REFLECT ADMINISTRATIVE COSTS NOT INCLUDED IN THE INTERIM PAYMENT SYSTEM; GAO REPORT ON COSTS OF COMPLIANCE WITH OASIS DATA COLLECTION REQUIREMENTS.

(a) ADJUSTMENT TO REFLECT ADMINISTRATIVE COSTS.—

(1) IN GENERAL.—In the case of a home health agency that furnishes home health services to a medicare beneficiary, for each such beneficiary to whom the agency furnished such services during the agency's cost reporting period beginning in fiscal year 2000, the Secretary of Health Services shall pay the agency, in addition to any amount of payment made under subsection (v)(1)(L) of such section for the beneficiary and only for such cost reporting period, an aggregate amount of \$10 to defray costs incurred by the agency attributable to data collection and reporting requirements under the Outcome and Assessment Information Set (OASIS) required by reason of section 4602(e) of the Balanced Budget Act of 1997 (42 U.S.C. 1395fff note).

(2) PAYMENT SCHEDULE.—

(A) MIDYEAR PAYMENT.—By not later than April 1, 2000, the Secretary shall pay to a home health agency an amount that the Secretary estimates to be 50 percent of the aggregate amount payable to the agency by reason of this subsection.

(B) UPON SETTLED COST REPORT.—The Secretary shall pay the balance of amounts payable to an agency under this subsection on the date that the cost report submitted by the agency for the cost reporting period beginning in fiscal year 2000 is settled.

(3) PAYMENT FROM TRUST FUNDS.—Payments under this subsection shall be made, in appropriate part as specified by the Secretary, from the Federal Hospital Insurance Trust Fund and from the Federal Supplemental Medical Insurance Trust Fund.

(4) DEFINITIONS.—in this subsection:

(A) HOME HEALTH AGENCY.—The term "home health agency" has the meaning given that term under section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(B) HOME HEALTH SERVICES.—The term "home health services" has the meaning given that term under section 1861(m) of such Act (42 U.S.C. 1395x(m)).

(C) MEDICARE BENEFICIARY.—The term "medicare beneficiary" means a beneficiary described in section 1861(v)(1)(L)(vi)(II) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(vi)(II)).

(b) GAO REPORT ON COSTS OF COMPLIANCE WITH OASIS DATA COLLECTION REQUIREMENTS.—

(1) REPORT TO CONGRESS.—

(A) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Comptroller General of the United States shall submit a report to Congress on matters described in subparagraph (B) with respect to the data collection requirement of patients of such agencies under the Outcome and Assessment Information Set (OASIS) standard as part of the comprehensive assessment of patients.

(B) MATTERS STUDIED.—For purposes of subparagraph (A), the matters described in this subparagraph include the following:

(i) An assessment of the costs incurred by medicare home health agencies in complying with such data collection requirement.

(ii) An analysis of the effect of such data collection requirement on the privacy interests of patients from whom data is collected.

(C) AUDIT.—The Comptroller General shall conduct an independent audit of the costs described in subparagraph (B)(i). Not later than 180 days after receipt of the report under subparagraph (A), the Comptroller General shall submit to Congress a report describing the Comptroller General's findings with respect to such audit, and shall include comments on the report submitted to Congress by the Secretary of Health and Human Services under subparagraph (A).

(2) DEFINITIONS.—In this subsection:

(A) COMPREHENSIVE ASSESSMENT OF PATIENTS.—The term "comprehensive assessment of patients" means the rule published by the Health Care Financing Administration that requires, as a condition of participation in the medicare program, a home health agency to provide a patient-specific comprehensive assessment that accurately reflects the patient's current status and that incorporates the Outcome and Assessment Information Set (OASIS).

(B) OUTCOME AND ASSESSMENT INFORMATION SET.—The term "Outcome and Assessment Information Set" means the standard provided under the rule relating to data items that must be used in conducting a comprehensive assessment of patients.

SEC. 302. DELAY IN APPLICATION OF 15 PERCENT REDUCTION IN PAYMENT RATES FOR HOME HEALTH SERVICES UNTIL 1 YEAR AFTER IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.

(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 "on the date that is 12 months after the date the Secretary implements such system".

(b) PROSPECTIVE PAYMENT SYSTEM.—Section 1895(b)(3)(A)(i) (42 U.S.C. 1395fff(b)(3)(A)(i)) (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 to read as follows:

"(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 the 12-month period beginning on the date the Secretary implements the system, shall be equal to the total amount that would have been made if the system had not been in effect; and

"(II) for periods beginning after the period described in subclause (I), 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 (i) had been in effect, and updated under subparagraph (B).

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."

(c) REPORT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall submit to Con-

gress a report analyzing the need for the 15 percent reduction under section 1895(b)(3)(A)(ii) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(A)(ii)), or for any reduction, in the computation of the base payment amounts under the prospective payment system for home health services under section 1895 of such Act (42 U.S.C. 1395w-29).

(2) DEADLINE.—The Secretary shall submit to Congress the report described in paragraph (1) by not later than the date that is six months after the date the Secretary implements the prospective payment system for home health services under such section 1895.

SEC. 303. CLARIFICATION OF SURETY BOND REQUIREMENTS.

(a) HOME HEALTH AGENCIES.—Section 1861(o)(7) (42 U.S.C. 1395x(o)(7)) is amended to read as follows:

"(7) provides the Secretary with a surety bond—

"(A) effective for a period of 4 years (as specified by the Secretary) or in the case of a change in the ownership or control of the agency (as determined by the Secretary) during or after such 4-year period, an additional period of time that the Secretary determines appropriate, such additional period not to exceed 4 years from the date of such change in ownership or control;

"(B) in a form specified by the Secretary; and

"(C) for a year in the period described in subparagraph (A) in an amount that is equal to the lesser of \$50,000 or 10 percent of the aggregate amount of payments to the agency under this title and title XIX for that year, as estimated by the Secretary; and"

(b) COORDINATION OF SURETY BONDS.—Part A of title XI is amended by adding at the end the following new section:

"COORDINATION OF MEDICARE AND MEDICAID SURETY BOND PROVISIONS

"SEC. 1148. In the case of a home health agency that is subject to a surety bond under title XVIII and title XIX, the surety bond provided to satisfy the requirement under one such title shall satisfy the requirement under the other such title so long as the bond applies to guarantee return of overpayments under both such titles."

(c) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act and in applying section 1861(o)(7) of the Social Security Act, as amended by subsection (a), the Secretary of Health and Human Services may take into account the previous period for which a home health agency had a surety bond in effect under such section before such date.

SEC. 304. TECHNICAL AMENDMENT CLARIFYING APPLICABLE MARKET CLARIFYING INCREASE FOR PPS.

Section 1895(b)(3)(B)(ii)(I) (42 U.S.C. 1395fff(b)(3)(B)(ii)(I)), as added by section 4603 of BBA (as amended by section 5101(d)(2) of the Tax and Trade Relief Extension Act of 1998 (contained in division J of Public Law 105-277)) is amended by striking "fiscal year 2002 or 2003" and inserting "each of fiscal years 2002 and 2003".

Subtitle B—Direct Graduate Medical Education

SEC. 311. USE OF NATIONAL AVERAGE PAYMENT METHODOLOGY IN COMPUTING DIRECT GRADUATE MEDICAL EDUCATION (DGME) PAYMENTS.

Section 1886(h) (42 U.S.C. 1395ww(h)) is amended—

(1) by amending clause (i) of paragraph (3)(B) to read as follows:

“(i)(I) for a cost reporting period beginning before October 1, 2000, the hospital’s approved FTE resident amount (determined under paragraph (2)) for that period;

“(II) for a cost reporting period beginning on or after October 1, 2000, and before October 1, 2004, the national average per resident amount determined under paragraph (7) or, if greater, the sum of the hospital-specific percentage (as defined in subparagraph (E)) of the hospital’s approved FTE resident amount (determined under paragraph (2)) for the period and the national percentage (as defined in such subparagraph) of the national average per resident amount determined under paragraph (7); and

“(III) for a cost reporting period beginning on or after October 1, 2004, the national average per resident amount determined under paragraph (7); and”;

(2) in paragraph (3), by adding at the end the following new subparagraph:

“(E) TRANSITION TO NATIONAL AVERAGE PER RESIDENT PAYMENT SYSTEM.—For purposes of subparagraph (B)(i)(II), for the cost reporting period of a hospital beginning—

“(i) during fiscal year 2001, the hospital-specific percentage is 80 percent and the national percentage is 20 percent;

“(ii) during fiscal year 2002, the hospital-specific percentage is 60 percent and the national percentage is 40 percent;

“(iii) during fiscal year 2003, the hospital-specific percentage is 40 percent and the national percentage is 60 percent; and

“(iv) during fiscal year 2004, the hospital-specific percentage is 20 percent and the national percentage is 80 percent.”; and

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

“(7) NATIONAL AVERAGE PER RESIDENT AMOUNT.—The national average per resident amount for a hospital for a cost reporting period beginning in a fiscal year is an amount determined as follows:

“(A) DETERMINATION OF HOSPITAL SINGLE PER RESIDENT AMOUNT.—The Secretary shall compute for each hospital operating an approved graduate medical education program a single per resident amount equal to the average (weighted by number of full-time equivalent residents) of the primary care per resident amount and the non-primary care per resident amount computed under paragraph (2) for cost reporting periods ending during fiscal year 1997.

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

“(C) STANDARDIZING PER RESIDENT AMOUNTS.—The Secretary shall establish a standardized per resident amount for each such hospital—

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

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

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

“(D) DETERMINATION OF NATIONAL AVERAGE.—The Secretary shall compute a national average per resident amount equal to the average of the standardized per resident amounts computed under subparagraph (C)

for such hospitals, with the amount for each hospital weighted by the average number of full-time equivalent residents at such hospital.

“(E) APPLICATION TO INDIVIDUAL HOSPITALS.—The Secretary shall compute for each such hospital a per resident amount—

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

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

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

In applying clause (ii) for a cost reporting period beginning before October 1, 2004, the factor described in such clause shall be deemed to be 1 for a hospital if the national average per resident amount computed under subparagraph (D) is less than the hospital’s approved FTE resident amount (determined under paragraph (2)) for the period involved and the factor described in subparagraph (C)(ii) for the hospital’s area is less than 1.

“(F) INITIAL UPDATING RATE.—The Secretary shall update such per resident amount for the hospital’s cost reporting period that begins during fiscal year 2001 for each such hospital by the estimated percentage increase in the consumer price index for all urban consumers during the period beginning October 1997 and ending with the midpoint of the hospital’s cost reporting period that begins during fiscal year 2001.

“(G) SUBSEQUENT UPDATING.—For each subsequent cost reporting period, subject to subparagraph (H), the national average per resident amount for a hospital is equal to the amount determined under this paragraph for the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous under- or over-estimations under this subparagraph in the projected percentage change in the consumer price index.

“(H) TRANSITIONAL BUDGET NEUTRALITY ADJUSTMENT.—

“(i) IN GENERAL.—If the Secretary estimates that, as a result of the amendments made by section 311 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, the post-MBBRA expenditures for fiscal year 2005 will be greater or less than the pre-MBBRA expenditures for that fiscal year—

“(I) the Secretary shall adjust the update applied under subparagraph (G) in determining the national average per resident amount for cost reporting periods beginning during fiscal year 2005 so that the amount of the post-MBBRA expenditures for those cost reporting periods is equal to the amount of the pre-MBBRA expenditures for such periods; and

“(II) the Secretary shall, taking into account the adjustment made under subclause (I), adjust the national average per resident amount, as applied for the portion of a cost reporting period beginning during fiscal year 2004 that occur in fiscal year 2005, so that the amount of the post-MBBRA expenditures made during fiscal year 2005 is equal to the amount of the pre-MBBRA expenditures during such fiscal year.

“(ii) DEFINITIONS.—In this subparagraph:

“(I) AGGREGATE SUBSECTION (h)-RELATED EXPENDITURES.—The term ‘aggregate subsection (h)-related expenditures’ means, with respect to cost reporting periods beginning during a fiscal year or with respect to a fiscal year, the aggregate expenditures under this title for such periods or fiscal year, respectively, which are attributable to the operation of this subsection.

“(II) PRE-MBBRA EXPENDITURES.—The term ‘pre-MBBRA expenditures’ means aggregate subsection (h)-related expenditures determined as if the amendments made by section 311 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 had not been enacted.

“(III) POST-MBBRA EXPENDITURES.—The term ‘post-MBBRA expenditures’ means aggregate subsection (h)-related expenditures determined taking into account the amendments made by section 311 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.”.

SEC. 312. INITIAL RESIDENCY PERIOD FOR CHILD NEUROLOGY RESIDENCY TRAINING PROGRAMS.

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

(1) in clause (i) by striking “clause (ii)” and inserting “clause (ii) or (iii)”;

(2) in clause (i), by striking “and” at the end;

(3) in clause (ii), by striking the period at the end and inserting “, and”; and

(4) by inserting after clause (ii), the following new clause:

“(iii) a period, of not more than three years, during which an individual is in a child neurology residency program, shall be treated as part of the initial residency period, but shall not be counted against any limitation on the initial residency period.”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply on and after July 1, 2000, to residency programs that began before, on, or after the date of the enactment of this Act.

(c) MEDPAC REPORT.—The Medicare Payment Advisory Commission shall include in its report submitted to Congress in March of 2001 recommendations on whether there should be an extension of the initial residency period under section 1886(h)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(F)) for other residency training programs in a specialty requiring preliminary years of study in another specialty.

Subtitle C—Other

SEC. 321. GAO STUDY ON GEOGRAPHIC RECLASSIFICATION.

(a) IN GENERAL.—The Comptroller General of the United States shall conduct a study of the current laws and regulations for geographic reclassification of hospitals to determine whether such reclassification is appropriate for purposes of applying wage indices under the medicare program and whether it results in more accurate payments for all hospitals. Such study shall examine data on the number of hospitals that are reclassified and their special designation status in determining payments under the medicare program. The study shall evaluate—

(1) the magnitude of the effect of geographic reclassification on rural hospitals that do not reclassify;

(2) whether the current thresholds used in geographic reclassification reclassify hospitals to the appropriate labor markets;

(3) the effect of eliminating geographic reclassification through use of the occupational mix data;

(4) the group reclassification policy;

(5) changes in the number of reclassifications and the compositions of the groups;

(6) the effect of State-specific budget neutrality compared to national budget neutrality; and

(7) whether there are sufficient controls over the intermediary evaluation of the wage data reported by hospitals.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a).

SEC. 322. MEDPAC STUDY ON MEDICARE PAYMENT FOR NON-PHYSICIAN HEALTH PROFESSIONAL CLINICAL TRAINING IN HOSPITALS.

(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study on medicare payment policy with respect to professional clinical training of different classes of non-physician health care professionals (such as nurses, nurse practitioners, allied health professionals, physician assistants, and psychologists) and the basis for any differences in treatment among such classes.

(b) REPORT.—The Commission shall submit a report to Congress on the study conducted under subsection (a) not later than 18 months after the date of the enactment of this Act.

TITLE IV—RURAL PROVIDER PROVISIONS

SEC. 401. PERMITTING RECLASSIFICATION OF CERTAIN URBAN HOSPITALS AS RURAL HOSPITALS.

(a) IN GENERAL.—Section 1866(d)(8) (42 U.S.C. 1395ww(d)(8)) is amended by adding at the end the following new subparagraph:

“(E)(i) For purposes of this subsection, not later than 60 days after the receipt of an application from a subsection (d) hospital described in clause (ii), the Secretary shall treat the hospital as being located in the rural area (as defined in such paragraph (2)(D)) of the State in which the hospital is located.

“(ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:

“(I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the Goldsmith Modification, as published in the Federal Register on February 27, 1992 (57 FR 6725)).

“(II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).

“(III) The hospital would qualify as a rural or regional or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.

“(IV) The hospital meets such other criteria as the Secretary may specify.”

(b) CONFORMING CHANGES.—(1) Section 1833(t) (42 U.S.C. 1395l(t)), as amended by sections 211 and 212, is further amended by adding at the end the following new paragraph:

“(13) MISCELLANEOUS PROVISIONS.—

“(A) APPLICATION OF RECLASSIFICATION OF CERTAIN HOSPITALS.—If a hospital is being treated as being located a rural under section 1866(d)(8)(E), that hospital shall be treated under this subsection as being located in that rural area.”

(2) Section 1820(c)(2)(B)(i) (42 U.S.C. 1395i-4(c)(2)(B)(i)) is amended by inserting “or is treated as being located in a rural area pursuant to section 1866(d)(8)(E)” after “section 1866(d)(2)(D)”.’

(c) EFFECTIVE DATE.—The amendments made by this section shall become effective on January 1, 2000.

SEC. 402. UPDATE OF STANDARDS APPLIED FOR GEOGRAPHIC RECLASSIFICATION FOR CERTAIN HOSPITALS.

(a) IN GENERAL.—Section 1866(d)(8)(B) (42 U.S.C. 1395ww(d)(8)(B)) is amended—

(1) by inserting “(i)” after “(B)”;

(2) by striking “published in the Federal Register on January 3, 1980” and inserting “described in clause (ii)”;

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

“(ii) The standards described in this clause for cost reporting periods beginning in a fiscal year—

“(I) before fiscal year 2003, are the standards published in the Federal Register on January 3, 1980, or, at the election of the hospital with respect to fiscal years 2001 and 2002, standards so published on March 30, 1990; and

“(II) after fiscal year 2002, are the standards published in the Federal Register by the Director of the Office of Management and Budget based on the most recent available decennial population data.

Subparagraphs (C) and (D) shall not apply with respect to the application of subclause (I).’

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply with respect to discharges occurring during cost reporting periods beginning on or after October 1, 1999.

SEC. 403. IMPROVEMENTS IN THE CRITICAL ACCESS HOSPITAL (CAH) PROGRAM.

(a) APPLYING 96-HOUR LIMIT ON A AVERAGE ANNUAL BASIS.—

(1) IN GENERAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395i-4(c)(2)(B)(iii)), as added by section 4201(a) of BBA, is amended by striking “for a period not to exceed 96 hours” and all that follows and inserting “for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect on the date of the enactment of this Act.

(b) PERMITTING FOR-PROFIT HOSPITALS TO QUALIFY FOR DESIGNATION AS A CRITICAL ACCESS HOSPITAL.—Section 1820(c)(2)(B)(i) (42 U.S.C. 1395i-4(c)(2)(B)(i)), as added by section 4201(a) of BBA, is amended in the matter preceding subclause (I), by striking “nonprofit or public hospital” and inserting “hospital”.

(c) ALLOWING CLOSED OR DOWNSIZED HOSPITALS TO CONVERT TO CRITICAL ACCESS HOSPITALS.—Section 1820(c)(2) (42 U.S.C. 1395i-4(c)(2)), as added by section 4201(a) of BBA, is amended—

(1) in subparagraph (A), by striking “subparagraph (B)” and inserting “subparagraphs (B), (C), and (D)”;

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

“(C) RECENTLY CLOSED FACILITIES.—A State may designate a facility as a critical access hospital if the facility—

“(i) was a hospital that ceased operations on or after the date that is 10 years before the date of enactment of this subparagraph; and

“(ii) as of the effective date of such designation, meets the criteria for designation under subparagraph (B).

“(D) DOWNSIZED FACILITIES.—A State may designate a health clinic or a health center (as defined by the State) as a critical access hospital if such clinic or center—

“(i) is licensed by the State as a health clinic or a health center;

“(ii) was a hospital that was downsized to a health clinic or health center; and

“(iii) as of the effective date of such designation, meets the criteria for designation under subparagraph (B).’

(d) ALL-INCLUSIVE PAYMENT OPTION FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

(1) IN GENERAL.—Section 1834(g) (42 U.S.C. 1395m(g)), as added by section 4201(c)(5) of BBA, is amended to read as follows:

“(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

“(1) ELECTION OF CAH.—At the election of a critical access hospital, the amount of payment for outpatient critical access hospital services under this part shall be determined under paragraph (2) or (3), such amount determined under either paragraph without regard to the amount of the customary or other charge.

“(2) COST-BASED HOSPITAL OUTPATIENT SERVICE PAYMENT PLUS FEE SCHEDULE FOR PROFESSIONAL SERVICES.—If a hospital elects this paragraph to apply, there shall be paid amounts equal to the sum of the following, less the amount that such hospital may charge as described in section 1866(a)(2)(A):

“(A) FACILITY FEE.—With respect to facility services, not including any services for which payment may be made under subparagraph (B), the reasonable costs of the critical access hospital in providing such services.

“(B) FEE SCHEDULE FOR PROFESSIONAL SERVICES.—With respect to professional services otherwise included within outpatient critical access hospital services, such amounts as would otherwise be paid under this part if such services were not included in outpatient critical access hospital services.

“(3) ALL-INCLUSIVE RATE.—If a hospital elects this paragraph to apply, with respect to both facility services and professional services, there shall be paid amounts equal to the reasonable costs of the critical access hospital in providing such services, less the amount that such hospital may charge as described in section 1866(a)(2)(A).’

(2) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply for cost reporting periods beginning on or after October 1, 1999.

(e) ELIMINATION OF COINSURANCE FOR CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED BY A CRITICAL ACCESS HOSPITAL ON AN OUTPATIENT BASIS.—

(1) IN GENERAL.—Section 1833(a)(1)(D) (42 U.S.C. 1395l(a)(1)(D)) is amended by inserting “or which are furnished on an outpatient basis by a critical access hospital” after “on an assignment-related basis”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after the date of the enactment of this Act.

(f) PARTICIPATION IN SWING BED PROGRAM.—Section 1883 (42 U.S.C. 1395tt) is amended—

(1) in subsection (a)(1), by striking “(other than a hospital which has in effect a waiver under subparagraph (A) of the last sentence of section 1861(e))”; and

(2) in subsection (c), by striking “, or during which there is in effect for the hospital a waiver under subparagraph (A) of the last sentence of section 1861(e)”.

SEC. 404. 5-YEAR EXTENSION OF MEDICARE DEPENDENT HOSPITAL (MDH) PROGRAM.

(a) EXTENSION OF PAYMENT METHODOLOGY.—Section 1866(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(G)), as amended by section 4204(a)(1) of BBA, is amended—

(1) in clause (i), by striking “and before October 1, 2001,” and inserting “and before October 1, 2006”; and

(2) in clause (ii)(II), by striking “and before October 1, 2001,” and inserting “and before October 1, 2006”.

(b) CONFORMING AMENDMENTS.—

(1) **EXTENSION OF TARGET AMOUNT.**—Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)), as amended by section 4204(a)(2) of BBA, is amended—

(A) in the matter preceding clause (i), by striking “and before October 1, 2001,” and inserting “and before October 1, 2006”; and

(B) in clause (iv), by striking “during fiscal year 1998 through fiscal year 2000” and inserting “during fiscal year 1998 through fiscal year 2005”.

(2) **PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.**—Section 13501(e)(2) of Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note), as amended by section 4204(a)(3) of BBA, is amended by striking “or fiscal year 2000” and inserting “or fiscal year 2000 through fiscal year 2005”.

SEC. 405. REBASING FOR CERTAIN SOLE COMMUNITY HOSPITALS.

Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)), as amended by sections 4413 and 4414 of BBA, is amended—

(1) in subparagraph (C), by inserting “subject to subparagraph (I)” before “the term ‘target amount’ means”; and

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

“(I)(i) For cost reporting periods beginning on or after October 1, 2000, in the case of a sole community hospital that for its cost reporting period beginning during 1999 is paid on the basis of the target amount applicable to the hospital under subparagraph (C) and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, there shall be substituted for the base cost reporting period described in subparagraph (C) the rebased target amount determined under this subparagraph.

“(ii) For purposes of clause (i), the rebased target amount applicable to a hospital making an election under this subparagraph is equal to the sum of the following:

“(I) With respect to discharges occurring in fiscal year 2001, 75 percent of the target amount applicable to the hospital under subparagraph (C) (hereinafter in this subparagraph referred to as the ‘subparagraph (C) target amount’) and 25 percent of the amount of the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4) recognized under this title for the hospital for the 12-month cost reporting period beginning during fiscal year 1996 (hereinafter in this subparagraph referred to as the ‘rebased target amount’), increased by the applicable percentage increase under subparagraph (B)(iv).

“(II) With respect to discharges occurring in fiscal year 2002, 50 percent of the subparagraph (C) target amount and 50 percent of the rebased target amount, increased by the applicable percentage increase under subparagraph (B)(iv).

“(III) With respect to discharges occurring in fiscal year 2003, 25 percent of the subparagraph (C) target amount and 75 percent of the rebased target amount, increased by the applicable percentage increase under subparagraph (B)(iv).

“(IV) With respect to discharges occurring in fiscal year 2003 or any subsequent fiscal year, 100 percent of the rebased target amount, increased by the applicable percentage increase under subparagraph (B)(iv).”

SEC. 406. INCREASED FLEXIBILITY IN PROVIDING GRADUATE PHYSICIAN TRAINING IN RURAL AREAS.

(a) **PERMITTING 30 PERCENT EXPANSION IN CURRENT GME TRAINING PROGRAMS FOR HOSPITALS LOCATED IN RURAL AREAS.**—

(1) **PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS.**—Section 1886(h)(4)(F) (42 U.S.C. 1395ww(h)(4)(F)), as added by section 4623 of BBA, is amended by inserting “(or, 130 percent of such number in the case of a hospital located in a rural area)” after “may not exceed the number”.

(2) **PAYMENT FOR INDIRECT GRADUATE MEDICAL EDUCATION COSTS.**—Section 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)), as added by section 4621(b)(1) of BBA, is amended by inserting “(or, 130 percent of such number in the case of a hospital located in a rural area)” after “may not exceed the number”.

(3) **EFFECTIVE DATES.**—(A) The amendment made by paragraph (1) applies to cost reporting periods beginning on or after October 1, 1999.

(B) The amendment made by paragraph (2) applies to discharges occurring on or after October 1, 1999.

(b) SPECIAL RULE FOR NON-RURAL FACILITIES SERVING RURAL AREAS.—

(1) **IN GENERAL.**—Section 1886(h)(4)(H) (42 U.S.C. 1395ww(h)(4)(H)), as added by section 4623 of BBA, is amended by adding at the end the following new clause:

“(iv) **NON-RURAL HOSPITALS OPERATING TRAINING PROGRAMS IN UNDERSERVED RURAL AREAS.**—In the case of a hospital that is not located in a rural area but establishes separately accredited approved medical residency training programs (or rural tracks) in an underserved rural area or has an accredited training program with an integrated rural track, the Secretary shall adjust the limitation under subparagraph (F) in an appropriate manner insofar as it applies to such programs in such underserved rural areas in order to encourage the training of physicians in underserved rural areas.”

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) applies with respect to—

(A) payments to hospitals under section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) for cost reporting periods beginning on or after October 1, 1999; and

(B) payments to hospitals under section 1886(d)(5)(B)(v) of such Act (42 U.S.C. 1395ww(d)(5)(B)(v)) for discharges occurring on or after October 1, 1999.

SEC. 407. ELIMINATION OF CERTAIN RESTRICTIONS WITH RESPECT TO HOSPITAL SWING BED PROGRAM.

(a) **ELIMINATION OF REQUIREMENT FOR STATE CERTIFICATE OF NEED.**—Section 1883(b) (42 U.S.C. 1395tt(b)) is amended to read as follows:

“(b) The Secretary may not enter into an agreement under this section with any hospital unless, except as provided under subsection (g), the hospital is located in a rural area and has less than 100 beds.”

(b) **ELIMINATION OF SWING BED RESTRICTIONS ON CERTAIN HOSPITALS WITH MORE THAN 49 BEDS.**—Section 1883(d) (42 U.S.C. 1395tt(d)) is amended—

(1) by striking paragraphs (2) and (3); and

(2) by striking “(d)(1)” and inserting “(d)”.

(c) **EFFECTIVE DATE.**—The amendments made by this section take effect on the date that is the first day after the expiration of the transition period under section 1888(e)(2)(E) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(E)), as added by section 4432(a) of BBA, for payments for covered skilled nursing facility services under the medicare program.

SEC. 408. GRANT PROGRAM FOR RURAL HOSPITAL TRANSITION TO PROSPECTIVE PAYMENT.

Section 1820(g) (42 U.S.C. 1395i-4(g)), as added by section 4201(a) of BBA, is amended

by adding at the end the following new paragraph:

“(3) **UPGRADING DATA SYSTEMS.**—

“(A) **GRANTS TO HOSPITALS.**—The Secretary may award grants to hospitals that have submitted applications in accordance with subparagraph (C) to assist eligible small rural hospitals in meeting the costs of implementing data systems required to meet requirements established under the medicare program pursuant to amendments made by the Balanced Budget Act of 1997.

“(B) **ELIGIBLE SMALL RURAL HOSPITAL DEFINED.**—For purposes of this paragraph, the term ‘eligible small rural hospital’ means a non-Federal, short-term general acute care hospital that—

“(i) is located in a rural area (as defined for purposes of section 1886(d)); and

“(ii) has less than 50 beds.

“(C) **APPLICATION.**—A hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

“(D) **AMOUNT OF GRANT.**—A grant to a hospital under this paragraph may not exceed \$50,000.

“(E) **USE OF FUNDS.**—A hospital receiving a grant under this paragraph may use the funds for the purchase of computer software and hardware and for the education and training of hospital staff on computer information systems and costs related to the implementation of prospective payment systems.

“(F) **REPORT.**—

“(i) **INFORMATION.**—A hospital receiving a grant under this section shall furnish the Secretary with such information as the Secretary may require to evaluate the project for which the grant is made and to ensure that the grant is expended for the purposes for which it is made.

“(ii) **REPORTING.**—

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

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

SEC. 409. MEDPAC STUDY OF RURAL PROVIDERS.

(a) **STUDY.**—The Medicare Payment Advisory Commission shall conduct a study on rural providers furnishing items and services for which payment is made under title XVIII of the Social Security Act. Such study shall examine and evaluate the adequacy and appropriateness of the categories of special payments (and payment methodologies) established for rural hospitals under the medicare program, and their impact on beneficiary access and quality of health care services.

(b) **REPORT.**—By not later than 18 months after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the study conducted under subsection (a).

SEC. 410. EXPANSION OF ACCESS TO PARAMEDIC INTERCEPT SERVICES IN RURAL AREAS.

(a) **EXPANSION OF PAYMENT AREAS.**—Section 4531(c) of BBA (42 U.S.C. 1395x(s)(7) note,

111 Stat. 452) is amended by adding at the end the following flush sentence:

“For purposes of this subsection, an area shall be treated as a rural area if it is designated as a rural area by any law or regulation of the State or if it is located in a rural census tract of a metropolitan statistical area (as determined under the Goldsmith Modification, as published in the Federal Register on February 27, 1992 (57 FR 6725)).”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on January 1, 2000, and applies to paramedic intercept services furnished on or after such date.

TITLE V—PROVISIONS RELATING TO PART C (MEDICARE+CHOICE PROGRAM)

Subtitle A—Medicare+Choice

SEC. 501. PHASE-IN OF NEW RISK ADJUSTMENT METHODOLOGY.

Section 1853(a)(3)(C) (42 U.S.C. 1395w-23(a)(3)(C)) is amended—

(1) by redesignating the first sentence as clause (i) with the heading “IN GENERAL.—” and appropriate indentation; and

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

“(ii) PHASE-IN.—Such risk adjustment methodology shall be implemented in a phased-in manner so that the methodology insofar as it makes adjustments for health status based on clinical data applies to—

“(I) not more than 10 percent of the payment amount in 2000 and 2001;

“(II) not more than 20 percent of such amount in 2002;

“(III) not more than 30 percent of such amount in 2003; and

“(IV) 100 percent of such amount in any subsequent year (at which time the risk adjustment methodology should reflect data from multiple settings).”.

SEC. 502. ENCOURAGING OFFERING OF MEDICARE+CHOICE PLANS IN AREAS WITHOUT PLANS.

Section 1853 (42 U.S.C. 1395w-23) is amended—

(1) in subsection (a)(1), by striking “subsections (e) and (f)” and inserting “subsections (e), (g), and (i)”;

(2) in subsection (c)(5), by inserting “(other than those attributable to subsection (i))” after “payments under this part”; and

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

“(i) NEW ENTRY BONUS.—

“(1) IN GENERAL.—Subject to paragraphs (2) and (3), in the case of Medicare+Choice payment area in which a Medicare+Choice plan has not been offered since 1997 (or in which all organizations that offered a plan since such date have filed notice with the Secretary, as of October 13, 1999, that they will not be offering such a plan as of January 1, 2000), the amount of the monthly payment otherwise made under this subsection shall be increased—

“(A) only for the first 12 months in which any Medicare+Choice plan is offered in the area, by 5 percent of the total monthly payment otherwise computed for such payment area; and

“(B) only for the subsequent 12 months, by 3 percent of the total monthly payment otherwise computed for such payment area.

“(2) PERIOD OF APPLICATION.—Paragraph (1) shall only apply to payment for Medicare+Choice plans which are first offered in a Medicare+Choice payment area during the 2-year period beginning with January 1, 2000.

“(3) LIMITATION TO ORGANIZATION OFFERING FIRST PLAN IN AN AREA.—Paragraph (1) shall only apply to payment to the first

Medicare+Choice organization that offers a Medicare+Choice plan in each Medicare+Choice payment area, except that if more than one such organization first offers such a plan in an area on the same date, paragraph (1) shall apply to payment for such organizations.

“(4) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as affecting the calculation of the annual Medicare+Choice capitation rate for any payment area under subsection (c) or as applying to payment for any period not described in such paragraph.

“(5) OFFERED DEFINED.—In this subsection, the term ‘offered’ means, with respect to a Medicare+Choice plan as of a date, that a Medicare+Choice eligible individual may enroll with the plan on that date, regardless of when the enrollment takes effect or the individual obtain benefits under the plan.”.

SEC. 503. MODIFICATION OF 5-YEAR RE-ENTRY RULE FOR CONTRACT TERMINATIONS.

(a) IN GENERAL.—Section 1857(c)(4) (42 U.S.C. 1395w-27(c)(4)) is amended—

(1) by inserting “as provided in paragraph (2) and except” after “except”;

(2) by redesignating the first sentence as a subparagraph (A) with an appropriate indentation and the heading “IN GENERAL.—”; and

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

“(B) EARLIER RE-ENTRY PERMITTED WHERE CHANGE IN PAYMENT POLICY AND NO MORE THAN ONE OTHER PLAN AVAILABLE.—Subparagraph (A) shall not apply with respect to the offering by a Medicare+Choice organization of a Medicare+Choice plan in a Medicare+Choice payment area if—

“(i) during the 6-month period beginning on the date the organization notified the Secretary of the intention to terminate the most recent previous contract, there was a legislative change enacted (or a regulatory change adopted) that has the effect of increasing payment rates under section 1853 for that Medicare+Choice payment area; and

“(ii) at the time the organization notifies the Secretary of its intent to enter into a contract to offer such a plan in the area, there is no more than one Medicare+Choice plan offered in the area.”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to contract terminations occurring before, on, or after the date of the enactment of this Act.

SEC. 504. CONTINUED COMPUTATION AND PUBLICATION OF AAPCC DATA.

(a) IN GENERAL.—Section 1853(b) (42 U.S.C. 1395w-23(b)) is amended by adding at the end the following new paragraph:

“(4) CONTINUED COMPUTATION AND PUBLICATION OF COUNTY-SPECIFIC PER CAPITA FEE-FOR-SERVICE EXPENDITURE INFORMATION.—The Secretary, through the Chief Actuary of the Health Care Financing Administration, shall provide for the computation and publication, on an annual basis at the time of publication of the annual Medicare+Choice capitation rates, of information on the level of the average annual per capita costs (described in section 1876(a)(4)) for each Medicare+Choice payment area.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and apply to publications of the annual Medicare+Choice capitation rates made on or after such date.

SEC. 505. CHANGES IN MEDICARE+CHOICE ENROLLMENT RULES.

(a) PERMITTING ENROLLMENT IN ALTERNATIVE MEDICARE+CHOICE PLANS AND MEDIGAP COVERAGE IN CASE OF INVOLUNTARY

TERMINATION OF MEDICARE+CHOICE ENROLLMENT.—

(1) IN GENERAL.—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 or the Secretary 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 or Secretary of an impending termination or discontinuation of such plan;”.

(2) CONFORMING MEDIGAP AMENDMENT.—Section 1882(s)(3) (42 U.S.C. 1395ss(s)(3)) is amended—

(A) in subparagraph (A), by inserting “, subject to subparagraph (E),” after “in the case of an individual described in subparagraph (B) who”; and

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

“(E)(i) An individual described in subparagraph (B)(ii) may elect to apply subparagraph (A) by substituting, for the date of termination of enrollment, the date on which the individual or Secretary was notified by the Medicare+Choice organization of the impending termination or discontinuance of the Medicare+Choice plan in the area in which the individual resides, but only if the individual disenrolls from the plan as a result of such notification.

“(ii) In the case of an individual making such an election, the issuer involved shall accept the application of the individual submitted before the date of termination of enrollment, but the coverage under subparagraph (A) shall only become effective upon termination of coverage under the Medicare+Choice plan involved.”.

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

(b) CONTINUOUS OPEN ENROLLMENT FOR INSTITUTIONALIZED INDIVIDUALS.—Section 1851(e)(2) (42 U.S.C. 1395w-21(e)(2)) is amended—

(1) in subparagraph (B)(i), by inserting “and subparagraph (D)” after “clause (ii)”;

(2) in subparagraph (C)(i), by inserting “and subparagraph (D)” after “clause (ii)”;

and

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

“(D) CONTINUOUS OPEN ENROLLMENT FOR INSTITUTIONALIZED INDIVIDUALS.—At any time after 2001 in the case of a Medicare+Choice eligible individual who is institutionalized, the individual may change the election under subsection (a)(1).”.

(c) CONTINUING ENROLLMENT FOR CERTAIN ENROLLEES.—Section 1851(b)(1) (42 U.S.C. 1395w-21(b)(1)) is amended—

(1) in subparagraph (A), by inserting “and except as provided in subparagraph (C)” after “may otherwise provide”; and

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

“(C) CONTINUATION OF ENROLLMENT PERMITTED WHERE SERVICE CHANGED.—Notwithstanding subparagraph (B), if a Medicare+Choice organization eliminates from its service area a geographic area that was previously within its service area, the organization may elect to offer individuals residing in all or portions of the affected geographic area who would otherwise be ineligible to continue enrollment the option to

continue enrollment in a Medicare+Choice plan it offers so long as—

“(i) the enrollee agrees to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan service area; and

“(ii) there is no other Medicare+Choice plan offered in the area in which the enrollee resides at the time of the organization’s election.”

(d) **EFFECTIVE DATE.**—The amendments made by subsection (b) and (c) apply as if included in the enactment of BBA and the amendments made by subsection (c) apply to eliminations of geographic areas from a service area that occur before, on, or after the date of the enactment of this Act.

SEC. 506. ALLOWING VARIATION IN PREMIUM WAIVERS WITHIN A SERVICE AREA IF MEDICARE+CHOICE PAYMENT RATES VARY WITHIN THE AREA.

(a) **IN GENERAL.**—Section 1854(c) (42 U.S.C. 1395w–24(c)) is amended—

(1) by striking “The” and inserting “Subject to paragraph (2), the”;

(2) by redesignating the first sentence as a paragraph (1) with an appropriate indentation and the heading “IN GENERAL.—”;

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

“(2) **VARIATION IN PREMIUM WAIVER PERMITTED.**—A Medicare+Choice organization may waive part or all of a premium described in paragraph (1) for one or more Medicare+Choice payment areas within its service area if the annual Medicare+Choice capitation rates under section 1853(c) vary between such payment area and other payment areas within such service area.”

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

SEC. 507. DELAY IN DEADLINE FOR SUBMISSION OF ADJUSTED COMMUNITY RATES AND RELATED INFORMATION.

(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 by inserting after “information described in paragraph (4) concerning such plans” the following: “, to the extent such information is available at the time of preparation of the material for mailing”.

(c) **EFFECTIVE DATE.**—The amendments made by this section apply with respect to information submitted by Medicare+Choice organizations (and provided to beneficiaries) for years beginning with 1999.

SEC. 508. 2 YEAR EXTENSION OF MEDICARE COST CONTRACTS.

Section 1876(h)(5)(B) (42 U.S.C. 1395mm(h)(5)(B)) is amended by striking “2002” and inserting “2004”.

SEC. 509. MEDICARE+CHOICE NURSING AND ALLIED HEALTH PROFESSIONAL EDUCATION PAYMENTS.

Section 1886(d)(11) (42 U.S.C. 1395ww(d)(11)) is amended—

(1) in subparagraph (A)—

(A) by designating the portion following “IN GENERAL.—” as a clause (i) with the heading “GRADUATE MEDICAL TRAINING.—” and appropriate indentation; and

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

“(ii) **NURSING AND ALLIED HEALTH TRAINING.**—For portions of cost reporting periods

occurring on or after January 1, 2000, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital that has direct costs of approved education activities for nurse and allied health professional training.”;

(2) in subparagraph (C)—

(A) designating the portion following “DETERMINATION OF AMOUNT.—” as a clause (i) with the heading “GRADUATE MEDICAL TRAINING.—” and appropriate indentation;

(B) by striking “under this paragraph” and inserting “under subparagraph (A)(i)”;

(C) by inserting “the DGME portion (as defined in clause (iii)) of” after “shall be equal to”;

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

“(ii) **NURSING AND ALLIED HEALTH TRAINING.**—The amount of the payment under subparagraph (A)(ii) with respect to any applicable discharge shall be equal to an amount specified by the Secretary in a manner consistent with the following:

“(I) The total payments under such subparagraph in a year shall bear the same ratio to the Secretary’s estimate of the total payments under subparagraph (A)(i) in the year as the ratio (as estimated by the Secretary) of the total payments under this title for direct costs described in subparagraph (A)(ii) in the year bear to the total payments under section 1886(h) in the year; but in no case shall the total payments under subparagraph (A)(ii) exceed \$60,000,000 in a year.

“(II) The payments to different hospitals are proportional to the direct costs of each hospital described in subparagraph (A)(ii).

“(iii) **DGME PORTION DEFINED.**—For purposes of this subparagraph, the ‘DGME portion’ means, for a year, the ratio of—

“(I) the amount by which (aa) the Secretary’s estimate of the total additional payments that would be payable under this paragraph for the year if subparagraph (A)(ii) and clause (ii) of this subparagraph did not apply, exceeds (bb) the total payments in the year under subparagraph (A)(ii); to

“(II) the total additional payments estimated under subclause (I)(aa) for the year.”

SEC. 510. REDUCTION IN ADJUSTMENT IN NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE FOR 2002.

Section 1853(c)(6)(B)(iv) (42 U.S.C. 1395w–23(c)(6)(B)(iv)) is amended by striking “0.5 percentage points” and inserting “0.3 percentage points”.

SEC. 511. DEEMING OF MEDICARE+CHOICE ORGANIZATION TO MEET REQUIREMENTS.

Section 1852(e)(4) (42 U.S.C. 1395w–22(e)(4)) is amended to read as follows:

“(4) **TREATMENT OF ACCREDITATION.**—The Secretary shall provide that a Medicare+Choice organization is deemed to meet requirements of paragraphs (1) and (2) of this subsection and subsection (h) (relating to confidentiality and accuracy of enrollee records) if the organization is accredited (and periodically reaccredited) by a private accrediting organization under a process that the Secretary has determined assures that the accrediting organization applies standards that meet or exceed the standards established under section 1856 to carry out the respective requirements. The Secretary shall determine, within 210 days after the date the Secretary receives an application by a private accrediting organization, whether the process of the private accrediting organization meets the requirements of the preceding sentence using the

criteria specified in section 1865(b)(2). The Secretary shall, using the process described in section 1865(b), deem a Medicare+Choice organization that is so accredited as meeting the requirements of paragraphs (1) and (2) of this subsection and subsection (h).”

SEC. 512. MISCELLANEOUS CHANGES AND STUDIES.

(a) **PERMITTING RELIGIOUS FRATERNAL BENEFIT SOCIETIES TO OFFER A RANGE OF MEDICARE+CHOICE PLANS.**—Section 1859(e)(2) (42 U.S.C. 1395w–29(e)(2)) is amended in the matter preceding subparagraph (A) by striking “section 1851(a)(2)(A)” and inserting “section 1851(a)(2)”.

(b) **STUDY OF ACCOUNTING FOR VA AND DOD EXPENDITURES FOR MEDICARE BENEFICIARIES.**—The Secretary of Health and Human Services, jointly with the Secretaries of Defense and of Veterans Affairs, shall submit to Congress not later than 1 year after the date of the enactment of this Act a report on the estimated use of health care services furnished by the Departments of Defense and of Veterans Affairs to Medicare beneficiaries, including both beneficiaries under the original Medicare fee-for-service program and under the Medicare+Choice program. The report shall include an analysis of how best to properly account for expenditures for such services in the computation of Medicare+Choice capitation rates.

(c) **PROMOTING PROMPT IMPLEMENTATION OF INFORMATICS, TELEMEDICINE, AND EDUCATION DEMONSTRATION PROJECT.**—Section 4207 of BBA is amended—

(1) in subsection (a)(1), by adding at the end the following: “The Secretary shall make an award for such project not later than 3 months after the date of the enactment of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999. The Secretary shall accept the proposal adjudged to be the best technical proposal as of such date of enactment without the need for additional review or resubmission of proposals.”;

(2) in subsection (a)(2)(A), by inserting before the period at the end the following: “that qualify as Federally designated medically underserved areas or health professional shortage areas at the time of enrollment of beneficiaries under the project”;

(3) in subsection (c)(2), by striking “and the source and amount of non-Federal funds used in the project”;

(4) in subsection (d)(2)(A), by striking “at a rate of 50 percent of the costs that are reasonable and” and inserting “for the costs that are related”;

(5) in subsection (d)(2)(B)(i), by striking “(but only in the case of patients located in medically underserved areas)” and inserting “or at sites providing health care to patients located in medically underserved areas”;

(6) in subsection (d)(2)(C)(i), by striking “to deliver medical informatics services under” and inserting “for activities related to”;

(7) by amending paragraph (4) of subsection (d) to read as follows:

“(4) **COST-SHARING.**—The project may not impose cost sharing on a Medicare beneficiary for the receipt of services under the project. Project costs will cover all costs to patients and providers related to participation in the project.”

SEC. 513. MEDPAC REPORT ON MEDICARE MSA (MEDICAL SAVINGS ACCOUNT) PLANS.

Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on specific legislative changes that should be made to make MSA

plans a viable option under the Medicare+Choice program.

SEC. 514. CLARIFICATION OF NONAPPLICABILITY OF CERTAIN PROVISIONS OF DISCHARGE PLANNING PROCESS TO MEDICARE+CHOICE PLANS.

(a) IN GENERAL.—Section 1861(ee)(2)(H) (42 U.S.C. 1395x(ee)(2)(H)), as added by section 4431 of BBA, is amended—

- (1) in clause (i)—
 - (A) by striking “not specify” and inserting “subject to clause (iii), not specify”; and
 - (B) by striking “and” at the end; and
- (2) in clause (ii), by striking the period at the end and inserting “, and”; and
- (3) by adding at the end the following new clause:

“(iii) for individuals enrolled under a Medicare+Choice plan, under a contract with the Secretary under section 1857, for whom a hospital furnishes inpatient hospital services, the hospital may specify with respect to such individual the provider of post-hospital home health services or other post-hospital services under the plan.”

Subtitle B—Managed Care Demonstration Projects

SEC. 521. EXTENSION OF SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATION (SHMO) PROJECT AUTHORITY.

(a) EXTENSION.—Section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203), as amended by section 4014(a)(1) of BBA, is amended—

- (1) in paragraph (1), by striking “December 31, 2000” and inserting “the date that is 18 months after the date that the Secretary submits to Congress the report described in section 4014(c) of the Balanced Budget Act of 1997”; and

(2) by adding at the end of paragraph (4) the following: “Not later than 6 months after the date the Secretary submits such final report, the Medicare Payment Advisory Commission shall submit to Congress a report containing recommendations regarding such project.”

(b) SUBSTITUTION OF AGGREGATE CAP.—Section 13567(c) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66), as amended by section 4014(b) of BBA, is amended to read as follows:

“(c) AGGREGATE LIMIT ON NUMBER OF MEMBERS.—The Secretary of Health and Human Services may not impose a limit on the number of individuals that may participate in a project conducted under section 2355 of the Deficit Reduction Act of 1984, other than an aggregate limit of not less than 324,000 for all sites.”

SEC. 522. EXTENSION OF MEDICARE COMMUNITY NURSING ORGANIZATION DEMONSTRATION PROJECT.

(a) EXTENSION.—Notwithstanding any other provision of law, any demonstration project conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-123) and conducted for the additional period of 2 years as provided for under section 4019 of BBA, shall be conducted for an additional period of 2 years.

(b) REPORT.—By not later than July 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report describing the results of any demonstration project conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987, and describing the data collected by the Secretary relevant to the analysis of the results of such project, including the most recently available data through the end of 2000.

SEC. 523. MEDICARE+CHOICE COMPETITIVE BIDDING DEMONSTRATION PROJECT.

Section 4011 of BBA is amended—

(1) in subsection (a)—

(A) by striking “The Secretary” and inserting the following:

“(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary”; and

(B) by adding at the end the following:

“(2) DELAY IN IMPLEMENTATION.—The Secretary shall not implement the project until January 1, 2002, or, if later, 6 months after the date the Competitive Pricing Advisory Committee has submitted to Congress a report on each of the following topics:

“(A) INCORPORATION OF ORIGINAL FEE-FOR-SERVICE MEDICARE PROGRAM INTO PROJECT.—What changes would be required in the project to feasibly incorporate the original fee-for-service medicare program into the project in the areas in which the project is operational.

“(B) QUALITY ACTIVITIES.—The nature and extent of the quality reporting and monitoring activities that should be required of plans participating in the project, the estimated costs that plans will incur as a result of these requirements, and the current ability of the Health Care Financing Administration to collect and report comparable data, sufficient to support comparable quality reporting and monitoring activities with respect to beneficiaries enrolled in the original fee-for-service medicare program generally.

“(C) RURAL PROJECT.—The current viability of initiating a project site in a rural area, given the site specific budget neutrality requirements of the project, and insofar as the Committee decides that the addition of such a site is not viable, recommendations on how the project might best be changed so that such a site is viable.

“(D) BENEFIT STRUCTURE.—The nature and extent of the benefit structure that should be required of plans participating in the project, the rationale for such benefit structure, the potential implications that any benefit standardization requirement may have on the number of plan choices available to a beneficiary in an area designated under the project, the potential implications of requiring participating plans to offer variations on any standardized benefit package the committee might recommend, such that a beneficiary could elect to pay a higher percentage of out-of-pocket costs in exchange for a lower premium (or premium rebate as the case may be), and the potential implications of expanding the project (in conjunction with the potential inclusion of the original fee-for-service medicare program) to require medicare supplemental insurance plans operating in an area designated under the project to offer a coordinated and comparable standardized benefit package.

“(3) CONFORMING DEADLINES.—Any dates specified in the succeeding provisions of this section shall be delayed (as specified by the Secretary) in a manner consistent with the delay effected under paragraph (2).”

(2) in subsection (c)(1)(A)—

(A) by striking “and” at the end of clause (i); and

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

“(iii) establish beneficiary premiums for plans offered in such area in a manner such that a beneficiary who enrolls in an offered plan with a below average price (as established by the competitive pricing methodology established for such area) may, at the plan's election, be offered a rebate of some or all of the medicare part B premium that such individual must otherwise pay in order to participate in a Medicare+Choice plan under the Medicare+Choice program; and”

SEC. 524. EXTENSION OF MEDICARE MUNICIPAL HEALTH SERVICES DEMONSTRATION PROJECTS.

Section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended by section 6135 of the Omnibus Budget Reconciliation Act of 1989, section 13557 of the Omnibus Budget Reconciliation Act of 1993, and section 4017 of BBA, is amended by striking “December 31, 2000” and inserting “December 31, 2001”.

SEC. 525. MEDICARE COORDINATED CARE DEMONSTRATION PROJECT.

Section 4016(e)(1)(A)(ii) of the Balanced Budget Act of 1997 (42 U.S.C. 1395b-1 note) is amended to read as follows:

“(ii) CANCER HOSPITAL.—In the case of the project described in subsection (b)(2)(C), the Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t), in such proportions as the Secretary determines to be appropriate, of such funds as are necessary to cover costs of the project, including costs for information infrastructure and recurring costs of case management services, flexible benefits, and program management.”

TITLE VI—MEDICAID

SEC. 601. MAKING MEDICAID DSH TRANSITION RULE PERMANENT.

(a) IN GENERAL.—Section 4721(e) of the Balanced Budget Act of 1997 (42 U.S.C. 1396r-4 note) 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 new paragraph:

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

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in the enactment of section 4721(e) of the Balanced Budget Act of 1997 (Public Law 105-33; 110 Stat. 514).

SEC. 602. INCREASE IN DSH ALLOTMENT FOR CERTAIN STATES AND THE DISTRICT OF COLUMBIA.

(a) IN GENERAL.—The table in section 1923(f)(2) (42 U.S.C. 1396r-4(f)(2)) is amended under each of the columns for FY 00, FY 01, and FY 02—

(1) in the entry for the District of Columbia, by striking “23” and inserting “32”;

(2) in the entry for Minnesota, by striking “16” and inserting “33”;

(3) in the entry for New Mexico, by striking “5” and inserting “9”; and

(4) in the entry for Wyoming, by striking “0” and inserting “100”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on October 1, 1999, and applies to expenditures made on or after such date.

SEC. 603. NEW PROSPECTIVE PAYMENT SYSTEM FOR FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (13)—

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

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

(C) by striking subparagraph (C); and

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

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

(b) **NEW PROSPECTIVE PAYMENT SYSTEM.**—Section 1902 of the Social Security Act (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.**—Subject to paragraph (4), for services furnished during 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 FISCAL YEARS.**—Subject to paragraph (4), for services furnished during fiscal year 2001 or a succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this subsection for the preceding fiscal year—

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

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

“(4) **ESTABLISHMENT OF INITIAL YEAR PAYMENT AMOUNT FOR NEW CENTERS OR CLINICS.**—In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after fiscal year 1999, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by the center or services described in section 1905(a)(2)(B) furnished by the clinic in the first fiscal year in which the center or clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year in accordance with the regulations and methodology referred to in paragraph (2). For each fiscal year following the fiscal year in which the entity first qualifies as a Federally-qualified health center or rural health clinic, the State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

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

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

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

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

(c) **CONFORMING AMENDMENTS.**—

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

(2) Section 1915(b) of the Social Security Act (42 U.S.C. 1396n(b)) is amended by striking “1902(a)(13)(E)” and inserting “1902(a)(15), 1902(aa).”

(d) **EFFECTIVE DATE.**—The amendments made by this section take effect on October 1, 1999, and apply to services furnished on or after such date.

SEC. 604. PARITY IN REIMBURSEMENT FOR CERTAIN UTILIZATION AND QUALITY CONTROL SERVICES.

(a) **IN GENERAL.**—Section 1903(a)(3)(C)(i) (42 U.S.C. 1396b(a)(3)(C)(i)) is amended—

(1) by inserting “(other than a review described in clause (ii))” after “quality review”; and

(2) by inserting “(or under a contract with the State that sets forth standards of performance equivalent to those under section 1902(d))” before the semicolon.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) apply to expenditures made on and after the date of the enactment of this Act.

TITLE VII—STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

SEC. 701. STABILIZING THE SCHIP ALLOTMENT FORMULA.

(a) **IN GENERAL.**—Section 2104(b) (42 U.S.C. 1397dd(b)) is amended—

(1) in paragraph (2)(A)—

(A) in clause (i), by striking “through 2000” and inserting “and 1999”; and

(B) in clause (ii), by striking “2001” and inserting “2000”;

(2) by amending paragraph (4) to read as follows:

“(4) **FLOORS AND CEILINGS IN STATE ALLOTMENTS.**—

“(A) **IN GENERAL.**—The proportion of the allotment under this subsection for a subsection (b) State (as defined in subparagraph (D)) for fiscal year 2000 and each fiscal year thereafter shall be subject to the following floors and ceilings:

“(i) **FLOOR OF \$2,000,000.**—A floor equal to \$2,000,000 divided by the total of the amount available under this subsection for all such allotments for the fiscal year.

“(ii) **ANNUAL FLOOR OF 10 PERCENT BELOW PRECEDING FISCAL YEAR'S PROPORTION.**—A

floor of 90 percent of the proportion for the State for the preceding fiscal year.

“(iii) **CUMULATIVE FLOOR OF 30 PERCENT BELOW THE FY 1999 PROPORTION.**—A floor of 70 percent of the proportion for the State for fiscal year 1999.

“(iv) **CUMULATIVE CEILING OF 45 PERCENT ABOVE FY 1999 PROPORTION.**—A ceiling of 145 percent of the proportion for the State for fiscal year 1999.

“(B) **RECONCILIATION.**—

“(i) **ELIMINATION OF ANY DEFICIT BY ESTABLISHING A PERCENTAGE INCREASE CEILING FOR STATES WITH HIGHEST ANNUAL PERCENTAGE INCREASES.**—To the extent that the application of subparagraph (A) would result in the sum of the proportions of the allotments for all subsection (b) States exceeding 1.0, the Secretary shall establish a maximum percentage increase in such proportions for all subsection (b) States for the fiscal year in a manner so that such sum equals 1.0.

“(ii) **ALLOCATION OF SURPLUS THROUGH PRO RATA INCREASE.**—To the extent that the application of subparagraph (A) would result in the sum of the proportions of the allotments for all subsection (b) States being less than 1.0, the proportions of such allotments (as computed before the application of floors under clauses (i), (ii), and (iii) of subparagraph (A)) for all subsection (b) States shall be increased in a pro rata manner (but not to exceed the ceiling established under subparagraph (A)(iv)) so that (after the application of such floors and ceiling) such sum equals 1.0.

“(C) **CONSTRUCTION.**—This paragraph shall not be construed as applying to (or taking into account) amounts of allotments redistributed under subsection (f).

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

“(i) **PROPORTION OF ALLOTMENT.**—The term ‘proportion’ means, with respect to the allotment of a subsection (b) State for a fiscal year, the amount of the allotment of such State under this subsection for the fiscal year divided by the total of the amount available under this subsection for all such allotments for the fiscal year.

“(ii) **SUBSECTION (b) STATE.**—The term ‘subsection (b) State’ means one of the 50 States or the District of Columbia.”

(3) in paragraph (2)(B), by striking “the fiscal year” and inserting “the calendar year in which such fiscal year begins”; and

(4) in paragraph (3)(B), by striking “the fiscal year involved” and inserting “the calendar year in which such fiscal year begins”.

(b) **EFFECTIVE DATE.**—The amendments made by this section apply to allotments determined under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) for fiscal year 2000 and each fiscal year thereafter.

SEC. 702. INCREASED ALLOTMENTS FOR TERRITORIES UNDER THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

Section 2104(c)(4)(B) (42 U.S.C. 1397dd(c)(4)(B)) is amended by inserting “, \$34,200,000 for each of fiscal years 2000 and 2001, \$25,200,000 for each of fiscal years 2002 through 2004, \$32,400,000 for each of fiscal years 2005 and 2006, and \$40,000,000 for fiscal year 2007” before the period.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Texas (Mr. ARCHER) and the gentleman from New York (Mr. RANGEL) each will control 20 minutes.

The Chair recognizes the gentleman from Texas (Mr. ARCHER).

GENERAL LEAVE

Mr. ARCHER. Mr. Speaker, I ask unanimous consent that all Members

may have 5 legislative days within which to revise and extend their remarks on the bill, H.R. 3075, as amended.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. ARCHER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, 2 years ago Congress embarked on a monumental task to strengthen Medicare for the 39 million Americans that depend on the program every day for their health care needs. We made the tough decisions because it was the right thing to do, and we did it on a bipartisan basis, in conjunction with the administration.

Today, as a result of those decisions, America's elderly and disabled have more health care choices than ever before. We increased preventative benefits to detect and treat conditions early, which means less time in a hospital or nursing facility and more time at home; we passed 65 new steps to crack down on fraud and abuse that rob seniors of vital care; and on a bipartisan basis, we set Medicare on the right financial footing, extending the life of the program for future beneficiaries.

□ 1045

In fact, earlier this year, the Medicare trustees reported that the Medicare program is now solvent until the year 2015. With any legislation of this size, however, adjustments are always necessary and even with the technocratic jargon of new prospective payment systems, DSH adjustments and RUG fixes, we have not lost sight of those that we help, our Nation's elderly and disabled.

Under our proposal today, families will not have to drive to the next county to visit the emergency room. Seniors will have the flexibility to enroll in new plans to get the comprehensive benefits that they need and want, and that is what this bill is all about.

For over 30 years, Medicare has been there for millions of seniors, and as we enter the next millennium the Medicare program will be stronger than ever, thanks to our bipartisan efforts.

Two years ago, the President joined us in enacting this landmark legislation, and I now ask him to join us in again building upon our historic success by implementing those provisions that Congress intended for the administration when it first passed the Balanced Budget Act.

Congress and the White House must work together for the good of seniors and the disabled who depend on Medicare.

I commend the Subcommittee on Health, the gentleman from California (Mr. THOMAS), the Committee on Commerce, the gentleman from Virginia (Mr. BLILEY) and members of both the

Committee on Ways and Means and the Committee on Commerce for their tireless efforts to ensure that quality medical treatment is there when seniors need it.

I urge my colleagues to support this important legislation.

Mr. Speaker, I reserve the balance of my time.

Mr. RANGEL. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, my friend the gentleman from Texas (Mr. ARCHER), the chairman of the Committee on Ways and Means, spoke a great deal about bipartisanship in 1997 and the need for the Congress and the White House to work together.

I agree with him, but can we not start with Republicans and Democrats in the House working together? That would be a good beginning. It is almost insulting to take a bill of this importance and then put it on the suspension calendar. This bipartisanship does not start with the Republican leaders and the President of the United States. If it is going to work, it should start right here, with Members of this House having mutual respect for each other, with important bills going through committee, with Members being given the opportunity to amend them, and if the amendment is not worth the majority of the votes then the amendment is defeated. That is how democracy works. That is how this is supposed to work.

This suspension calendar is supposed to be for noncontroversial legislation. It is supposed to be that we already agreed on something; that there is no need for amendments, no need for debate.

We are restricted to 20 minutes on each side, but what we are talking about is our teaching hospitals. We are talking about making a mistake in 1997 and trying to remedy it by bringing it to the floor so that we could remedy it. No one can deny that lowering the price for prescription drugs for seniors is a very, very important thing. We tried to do this in our committee and we were unable to do it, and this would be the perfect time to find out what the people, Republican and Democrat, liberals and conservatives, would want to do.

We are not being given that opportunity, and the gentleman is talking about bipartisan and working with the President of the United States when he is not even working with his Democratic colleagues because we are in the minority.

Indeed, the rule that we had in the Committee on Ways and Means was a gag rule to make certain that none of our amendments would ever get an opportunity to pass.

I do hope that somewhere along the line, before we adjourn, that we start allowing each other to set the standard for bipartisanship, that we start talking with each other and we do not find

just a hand of Republicans, because they have the leadership going in the back room and deciding what is good for the whole House and because they have the votes, putting it on the suspension calendar where Members cannot work their will, and then when it is all over and they find out that they have a train wreck on their hands they are going to ask the President of the United States to work with them. They did not ask the President to work with them when they went into the Social Security trust funds. They did not ask the President to work with them when they came up with a \$792 billion tax cut, but when they work themselves into a corner and they cannot get out of the box, then they have to call for bipartisanship.

Bipartisanship starts now and it starts today, and it should not be put in a bill like this on the suspension calendar.

Mr. Speaker, I ask unanimous consent that the balance of my time be divided equally between the gentleman from California (Mr. STARK) for the Committee on Ways and Means, and the gentleman from Ohio (Mr. Brown) for the Committee on Commerce.

The SPEAKER pro tempore (Mr. LAHOOD). Is there objection to the request of the gentleman from New York?

There was no objection.

Mr. THOMAS. Mr. Speaker, I yield 3 minutes to gentleman from Virginia (Mr. BLILEY), chairman of the Committee on Commerce.

Mr. BLILEY. Mr. Speaker, I thank the gentleman from California (Mr. THOMAS) for yielding me this time.

Mr. Speaker, I rise today in support of H.R. 3075, the Medicare, Medicaid and S-CHIP Balanced Budget Refinement Act of 1999.

Two years ago, we made some very important changes to the Medicare and Medicaid programs when we passed the Balanced Budget Act. The Medicare program was facing bankruptcy. The changes we made are keeping this vital program for our Nation's seniors alive.

In addition, we created the State Children's Health Insurance Program, otherwise known as S-CHIP, to provide health coverage for millions of low-income, uninsured American children. It was historic legislation and I am very proud of it.

Today we are considering a bill that will refine some of the policies put into effect by BBA. In the two years since we passed the BBA, we have heard that some of the changes we made went a little too far and some health providers have felt some hardship. Today we are going back to make a few corrections.

Under our bill, the seniors will receive the health care they deserve. We put needed dollars into the system to ensure patient access and care to hospitals, skilled nursing facilities and other care.

I want to highlight some of the more important pieces of this bill.

First, we provide additional funding for hospital outpatient departments. This includes more funds for small rural hospitals and for patients who receive cancer treatments, those most in need of assistance. We cannot allow these hospitals to close their doors.

Additionally, this bill provides an additional \$3.5 billion for the Medicare+Choice program. This vital program gives seniors the opportunity to choose a private health plan rather than the traditional Medicare program.

I am also proud to have strengthened this bill by adding \$200 million to pay for immunosuppressive drugs. Medicare currently only covers these drugs for 36 months. This bill takes a first step at addressing that issue and allows us to provide for coverage for needy organ transplant patients. Access to these drugs can literally make the difference between life and death.

We also help our Nation's community health centers and rural health clinics by ensuring they receive the funding they need to provide care to millions of low income and uninsured Americans. Our bill authorizes States to create new payment systems for community health centers and rural clinics.

Finally, our bill puts more funds into the S-CHIP program. We created the S-CHIP program in 1997 to provide health insurance to our Nation's children, and it has been an enormous success.

Mr. Speaker, I am proud of the work the committee has put into this product. It is a good bill and deserves the support of all of our colleagues.

HON. BILL ARCHER,

Chairman, Committee on Ways and Means, Washington, DC.

DEAR BILL: I am writing regarding H.R. 3075, the Medicare Balanced Budget Refinement Act of 1999. As you know, the Committee on Commerce is an additional committee of jurisdiction for the bill, and I understand that the version of that bill will be considered under the suspension calendar will contain a number of Medicaid provisions which fall within my Committee's exclusive jurisdiction.

However, in light of your willingness to work with me on those provisions within the Commerce Committee's jurisdiction, I will not exercise the Committee on Commerce's right to act on the legislation. By agreeing to waive its consideration of the bill, however, the Commerce Committee does not waive its jurisdiction over H.R. 3075. In addition, the Commerce Committee reserves its authority to seek conferees on any provisions of the bill that are within its jurisdiction during any House-Senate conference that may be convened on this legislation or similar legislation. I ask that you support our request in this regard.

I ask that you include a copy of this letter and your response in the RECORD during consideration of the bill on the House floor. Thank you for your consideration and assistance. I remain,

Sincerely,

TOM BLILEY, *Chairman.*

Mr. STARK. Mr. Speaker, I yield 1½ minutes to the gentleman from Washington (Mr. McDERMOTT).

Mr. McDERMOTT. Mr. Speaker, there will not be half a dozen votes against this pathetic piece of legislation. I sat on the Medicare Commission for a year and in the committee for 10 months, and we never had a proposal for a bipartisan overhaul, which everybody knows we should do. We did not even consider the President's proposal to extend from 65 down to 55, at no cost to the government, health insurance for people in the workforce. Now, if one wants to have access, that is the best way to get it.

We had nothing in here to talk about whether or not we were going to extend the life of Medicare. The President offered 15 percent of the surplus and said let us extend the life. We never had a discussion about that in the committee.

Finally, and worst of all, there is not one single thing done for senior citizens on their prescription drugs.

Now, everybody sitting on this floor is going to go home to their district and they are going to explain to their constituents why it is they have a drug benefit. We all have one through our health plan, that if we have a prescription we pay \$12. I pay \$12. Everybody pays \$12 in this body. But my mother and my aunts and my uncles and all my constituents and the constituents of all of us pay retail. Now that is a disgrace.

This piece of legislation is worthless, but we have no choice. They gave us no choice.

Mr. BROWN of Ohio. Mr. Speaker, I yield myself 1 minute.

Mr. Speaker, I rise in support of H.R. 3075, but I rise with a great deal of disappointment that this bill falls far, far short of what this House should do. Today we are not considering prescription drug coverage when 75 percent of our elderly have inadequate or non-existent prescription drug coverage. We are not modernizing Medicare. We are not repealing therapy caps, caps which have harmed thousands of our elderly.

Too many seniors are spending into poverty to pay for prescription drugs. Yet, all the majority is doing is tinkering at the edges of the Medicare payment system. When is this Congress going to get serious about modernizing Medicare? When is this Congress going to take action based on the best interests of Medicare enrollees? When is this Congress going to get serious about the Patients' Bill of Rights? And when is this Congress going to provide prescription drugs for this Nation's elderly?

If Republicans remain in the majority, Mr. Speaker, the answer unfortunately is do not hold your breath.

Mr. THOMAS. Mr. Speaker, it is now my pleasure to yield 2 minutes to the gentleman from Florida (Mr. BILIRAKIS), chairman of the Subcommittee on Health of the Committee on Commerce.

Mr. BILIRAKIS. Mr. Speaker, in early 1997, a Medicare trustees' annual report confirmed that the Medicare hospital insurance trust fund would exhaust its resources faster than previously anticipated. The part B trust fund was in similar straits.

Its board of trustees issued its own report warning that prompt, effective and decisive action is necessary. And so the Congress addressed this problem with BBA 1997, as we so fondly refer to it.

BBA 1997 was the Balanced Budget Act of 1997. It saved Medicare. It did something that the prior Congresses had not done. It saved Medicare for an additional 14 years until the year 2015.

It represented the most comprehensive Medicare reform since the program's establishment in 1965. It made many changes, expanding Medicare's coverage of preventive benefits. It hadn't been done before. Providing additional choices for seniors through the Medicare+ program; implementing new programs to combat fraud, waste and abuse; and establishing new initiatives and modernizing and strengthen the Medicare speed for service payment system.

□ 1100

But it also established new payment provisions, bold steps to control Medicare spending by changing the financial incentives inherent in payment methods that, prior to the BBA, did not reward providers for delivering care efficiently.

Unfortunately, as quite often happens, there are unintended consequences; and, consequently, a lot of the reimbursements we have determined now have not been adequate. So we tried to address this with the BBA fixes.

I would say to this Congress through the Speaker that, as far as the Committee on Commerce was concerned, I cannot speak for the Committee on Ways and Means, although I am sure the same thing happened there, as far as the Committee on Commerce is concerned, the majority staff and the minority staffs worked many, many hours over many, many days, sitting with HCFA, I might add, trying to work things out. Things seem to have been going along really well. Many of the ideas that the minority had are incorporated in this particular BBA 1997 fix.

I ask for support for this legislation.

Mr. STARK. Mr. Speaker, I yield myself 30 seconds. I do so just to challenge my Republican colleagues who are afraid today that they would have to vote on a drug benefit, but to remind the public that the gentleman from Pennsylvania (Mr. ENGLISH), the gentlewoman from Connecticut (Mrs. JOHNSON), the gentleman from Arizona (Mr. HAYWORTH), and the gentleman from Florida (Mr. SHAW), who are all sitting here voted to deny seniors in

their districts a discount on prescription drugs at no cost to the Federal Government.

I hope that they will explain to the seniors whose benefits are being reduced why they did that and why they are afraid to see it come up today and vote for it or against it in an up forward manner.

Mr. BROWN of Ohio. Mr. Speaker, I yield 1½ minutes to the gentleman from Michigan (Mr. DINGELL), ranking member of the Committee on Commerce.

Mr. DINGELL. Mr. Speaker, what are we doing here in such haste and why? There has been no consultation, no attention to the regular and orderly process. Most Members have not got the vaguest idea what we are doing here.

This is a subject which would enable us to function in an intelligent fashion, using the ordinary processes of the House to discuss, to have an opportunity to come to agreement, and to do something which can and should be bipartisan in a bipartisan fashion.

The bill, on the other hand, is rushed to the floor without any particular attention, without any consultation, not addressing the problems, and, interestingly enough, if we look at it, we find that the bill is not paid for, probably is going to jeopardize Medicare and Social Security and their trust funds, and it is going to ignore the opportunity to do many things which we could have done.

It is not going to pay for most of the benefits, although most Members here are probably going to vote for it, including myself, understanding full well that we have not done the job that we should, not knowing what should be done, having disregarded the regular and orderly process of the House.

More importantly, we are going to proceed to move forward, ignoring the opportunity to craft a bill of which we could all, first of all, know what we are doing, and, second of all, a bill in which we could genuinely be proud.

We also have an opportunity here to craft a piece of legislation which is not going to hold in it a large number of surprises and perhaps even poison pills. The result of what we are doing today is bad process and is going to probably result in imperfect legislation. It holds within its bounds sure surprises and very little opportunity to address really important problems like the balanced budget and protecting and preserving Medicare and Social Security.

Mr. Speaker, I am pleased to see that the Republican leadership is finally getting down to the business of rectifying some of the consequences of the Balanced Budget Act. Like many others here, I am very concerned about its effects on beneficiaries and providers.

Regrettably, I am also concerned today by the process. We are voting on a bill that can be and should be bipartisan . . . that is the product of partisan efforts. This is a matter of

great importance to the 38 million Americans covered by Medicare, yet we have had less than one day to examine this bill. This is a matter that can and should be the subject of more careful and thoughtful but still expeditious process.

Our Republican friends made a great deal about the need to protect the Social Security surplus, but the bill they are offering is not paid for. Preliminary estimates show this bill to cost almost \$12 billion—unpaid for, the bill will shorten the life of the Medicare Trust Fund and increase premiums to seniors. Apparently, fiscal responsibility only suits the Republican party when it is convenient.

I am also concerned that we have not done enough. The relief for Medicare patients who need physical therapy is inadequate. The relief for Medicare patients in rural or cancer hospitals is not adequate. And, from what I understand, the Hospital Outpatient policy may be unworkable.

A number of Democrats sent a letter to the Speaker yesterday, concerned that we have not done enough to provide relief, asking for the opportunity to offer a paid-for amendment to this bill. Our request was denied.

This bill leaves out what is perhaps the most important relief that Congress could offer to Medicare beneficiaries—relief from the high cost of prescription drugs. Seniors should not have to choose between food and needed medicines. Yet, the Speaker would not let us even offer our amendment that would have made prescription drugs more affordable for seniors.

This bill provides much needed relief for the Community Health Centers which are critical to providing care to underserved areas. But I am dismayed to see that the bill could not find the money to address the needs of low-income women with breast cancer. But the Republican bill is able to provide more than one billion dollars to HMOs—the same HMOs that HCFA, the IG, and the GAO have noted are already being overpaid.

Mr. Speaker, I have a great number of concerns about this bill. Not only with what is in it, but what is not. I am also concerned about the process and the fact this bill is not paid for. The bill is a small step in the direction of ensuring that seniors continue to have access to the same high quality care in Medicare that they have come to depend on, but there are clearly areas that need more help.

HOUSE OF REPRESENTATIVES,
Washington, DC, November 4, 1999.

HON. DENNIS HASTERT,
Speaker of the U.S. House of Representatives,
The Capitol, Washington, DC.

DEAR MR. SPEAKER: We are writing to ask that you not bring the Medicare Balanced Budget Act legislation (HR 3075 as amended in negotiations with Commerce Committee Republicans) to the floor under suspension of the rules, but instead provide a rule permitting Democratic amendments and a motion to recommit. Because Democrats were not included in the negotiations between the Ways and Means and Commerce Committee Republican members, it is particularly important that we be offered the opportunity for floor amendments.

While the Republican bills that have been introduced provide a great deal of needed relief, we believe that—

(1) some additional relief to providers,

(2) some beneficiary improvements (in particular help with the high cost of pharmaceuticals), and

(3) some alternative policies are desperately needed.

The amendments we propose would provide an additional \$2.4 billion in paid-for relief, with some going to beneficiaries in lower pharmaceutical prices and other program improvements. Our amendments would also eliminate several policies in the Republican bill which the Administration has identified as unworkable or which would hurt Medicare beneficiaries.

As fiscally responsible Democrats, we are concerned that the Republican bill is not paid for, and we urge you to find a way to pay for it, rather than further spending Social Security surpluses. For example, because it is not currently paid for, the Ways and Means bill (HR 3075) shortens the solvency of the Medicare Part A Trust Fund by at least a year, and increases Part B premiums for seniors.

Therefore, to avoid this problem, we pay for the additional relief offered by our amendments. Thus we do not hurt Medicare's solvency. The \$2.4 billion in relief over five years is paid for by \$2.4 billion in Medicare savings from the President's budget proposal of last January. These savings come from Medicare anti-fraud, waste, and abuse proposals.

PROVIDING NEEDED ADDITIONAL RELIEF

The \$2.4 billion provides important, much needed additional relief to: beneficiaries to meet the cost of fighting cancer and the high costs of pharmaceutical insurance,¹ teaching hospitals, safety net hospitals, which have the lowest overall operating margins, rural hospitals, which have the lowest Medicare margins, skilled nursing homes, home health agencies which are serving the sickest patients, a more rational rehabilitation cap program that will help our most severely disabled stroke patients and amputees, help for hospice agencies facing sky-rocketing pharmaceutical costs for end-of-life painkillers, and the Medicaid and Children's Health Insurance Program, to help the providers serving the low income and to help Puerto Rico and the Possessions with more adequate payment rates.

This additional relief will further ensure that Medicare beneficiaries are buffered from the cuts in the 1997 BBA and will allow Medicare beneficiaries to continue to receive high quality care.

The attached memo describes these amendments in more detail.

HELP SENIORS WITH THE HIGH COST OF PHARMACEUTICALS

We believe we need to help all Medicare beneficiaries with a prescription drug insurance benefit, but that is a larger issue that cannot be addressed in this limited BBA corrections legislation. We hope, Mr. Speaker, that you will make this a priority issue for the Second Session of this Congress.

In the meantime, we do believe that this bill gives us the one opportunity this year to help seniors with the exorbitant cost of prescription drugs. We propose an amendment which was offered in the Ways and Means Committee by Rep. Karen Thurman (and supported by all the Democratic members of

¹We assume that the bill the Majority brings to the floor will include an expansion of Medicare's coverage of immuno-suppressive drugs, so that transplant patients do not suffer organ rejection. If this provision is not included, we ask permission to include it and pay for it with additional antifraud and abuse provisions.

the Committee) that makes the Allen-Turner-Waxman-Berry pharmaceutical discount bill (HR 664) germane to Medicare. Basically, the amendment says that if a drug manufacturer wants to sell pharmaceuticals to a hospital participating in Medicare, it must also make available to pharmacies for sale to seniors drugs at the best available price for which they offer that drug. By some estimates, this type of program could lower drug costs to seniors by as much as 40%.

If we can't pass a major Medicare drug reform bill this fall, we can at least give seniors a chance for the discounts available to large buyers.

PREVENTING BAD POLICIES

If the Majority bill includes certain provisions, we ask that the rule governing debate permits us to strike those anti-beneficiary and anti-consumer provisions:

Specifically, we are concerned that the Administration has warned that the hospital out-patient department (HOPD) provisions of the Ways and Means bill are so complicated that they will delay the start of HOPD Prospective Payment (PPS) by at least a year. Such a delay in the PPS will cost beneficiaries about \$1.4 billion, with patients' share of total HOPD payments running about 50%. We would move to strike the House HOPD provisions in favor of the Senate's more administrable proposals, but keep the amount of relief to hospitals and patients at the House level.

Second, if the Majority bill includes the Commerce Republicans' provision giving "deemed status" to HMOs, we would strike that provision. An overwhelming number of House members have just voted in favor of higher quality in managed care plans. Therefore, we find it incredible that the majority may be proposing an amendment to the BBA which would weaken our ability to ensure quality by turning over approval of these plans to participate in Medicare to private groups which are often dominated by the very industry they are supposed to be regulating. If such "deemed status" language is included, we will seek to strike it in order to protect beneficiaries.

Third, as mentioned above, we propose to strike the unworkable \$1500 limit on rehabilitation caps for 2 years while the Secretary develops a rational therapy payment plan. This is the same approach as taken by the Senate Finance Committee.

In conclusion, our beneficiaries and providers need the improvements made by the Democratic amendment. We urge you to make it in order. Thank you for your consideration.

Sincerely,
Charles B. Rangel and others.

Issue Area	In addition to HR 3075, a \$2.4 billion paid-for package (dollars expressed as additions to costs in HR 3075)
Hospitals	Freeze indirect medical education cut for 1 year more than HR 3075 (\$0.2). Freeze disproportionate share hospital cuts for 1 year more than HR 3075 (\$0). Carve out DSH payments from payments to M+C plans. Moves about \$1 billion per year to the nation's safety net hospitals; is not in HR 3075 (\$0).
Rural Hospitals	Tanner Amendment to protect rural and cancer hospitals against outpatient department PPS cuts (HR 3075 phases in cuts to these hospitals, still leaving huge payment reductions) (\$0.2).
\$1,500 Therapy Caps ..	Strike HR 3075 limits by suspending caps for 2 years while a new, more rational system is developed (net \$0).
Community Health Centers & Rural CHCs	Establish a PPS system which protects CHCs against State Medicaid cuts (\$0.2).
Nursing Homes	Raise HR 3075's payment to high acuity cases from 10% to 30% (\$0.1).

Issue Area	In addition to HR 3075, a \$2.4 billion paid-for package (dollars expressed as additions to costs in HR 3075)
Physicians	Raise HR 3075's nursing home inflation adjustment from 0.8% in FY01 to 1% (\$0.1) and authorize extra payments for his cost of living in Hawaii and Alaska. Study of why payment rates in certain States and Puerto Rico are low.
Home Health	Provide \$250 million "outlier" pool for home health agencies that treat tough cases (\$0.3) HR 1917, by Rep. Jim McGovern and 102 cosponsors.
Hospice	Eliminate 1% cut in FY 01 and 02 (\$0.2)
Medicaid	Help for Medicaid DSH formula errors in NM, DC, MN, and WY (\$0.2). Premanent fix for CA Medicaid DSH problem \$0. Help families not lose Medicaid coverage as a result of delinking of welfare and Medicaid eligibility (\$0.2).
CHIPs	Increase CHIPs amount for Possessions and provide technical fix to CHIPs formula (\$0.1).
Beneficiary Improvements.	Immuno-suppressive drugs, cover without a time limit (\$0.3). Allow States to require M+C plans to cover certain benefits (like MA used to do with Rx) (\$0). Allow people abandoned by M+C plans to buy a medi-gap policy which covers Rx (\$0). Coverage of cancer treatment for low-income women (\$0.3) HR 1070, by Rep. Eshoo and Lazio and 271 cusponsors.
Pay-fors	3 Medicare items from President's budget: mental health partial hospitalization reform, Medicare Secondary Payer data match, and pay for outpatient drugs at 83% of average wholesale price. (\$4.4).

Mr. THOMAS. Mr. Speaker, we appreciate the support of the gentleman from Michigan (Mr. DINGELL), the ranking member of the Committee on Commerce.

Mr. Speaker, it is my pleasure to yield 2 minutes to the gentlewoman from Connecticut (Mrs. JOHNSON), a member of the Subcommittee on Health who, without all of her hours of work, this bill would not have been possible.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I thank the gentleman from California for yielding me this time.

I, as many others in this body, have spent hours and hours sitting in the nursing homes, the hospitals, the home health agencies of my district, studying the problems that Medicare has caused them. The goal of this bill is to save those community-based providers in the small towns of America, in the small cities.

Frankly, I think it is utterly irresponsible for my colleagues on the other side of the aisle to try to focus on an expansion of Medicare benefits, which we believe needs to be done, before we have saved the system.

This bill is about fixing Medicare. We fixed it in 1997. We slowed an 11 percent rate of growth in Medicare to 5.5 percent. Unfortunately, because our estimates were off, and the administration has chosen to implement that bill in a harsh fashion, we must come back today and add money back in.

I am very proud, and I commend the gentleman from California (Mr. THOMAS) and the staff for the detailed way they have added money back in at critical points and provided much greater flexibility so our institutions can evolve to offer the quality care our seniors need throughout America, through this legislation.

I am proud because it retains our commitment to slowing the rate of

growth in Medicare so it will be sustainable. But it puts the money back in that our community providers desperately need.

I am very proud of the detailed way in which it addresses the problems in the nursing homes and in the home health agencies and the hospitals, not just so that people will be there to give the care, but so that the medically complex patient, the person whose costs are very high, whose medical problems are very complex will get the care they need.

I regret to say the administration provided no detailed proposals, and the Democrats on the committee provided no detailed proposals until the day of the mark-up. Only the chairman has provided a comprehensive approach. So while there are other processes that would be fruitful, the product we have before us is outstanding. I urge my colleagues to support it.

I want to thank Chairman THOMAS and the Health Subcommittee staff for their hard work on bringing this legislation to the floor.

My work on this issue started back in January when I visited all the hospitals in my district and several nursing homes and home health agencies.

The resounding message from those who provide the life-saving health services throughout my district was that the Balanced Budget Act had reached way beyond congressional intent and was threatening the very existence of our efficient, high quality community health care providers.

Most importantly, this legislation will help ensure that critically ill patients get access to Medicare services and that our health care providers will continue to be able to serve the communities that support them.

This legislation today is in direct response to the concerns I heard from community-based nursing homes in my district that are having a hard time caring for medically complex patients and managing the increased administrative costs of the new prospective payment system. I spent long hours talking with Patricia Walden and Carol Barno at the Southington Care Center, Sister Deborah and Sister Honorata at Monsignor Bojnowski Manor, and John Horstman at Geer Nursing and Rehabilitation Center.

This legislation also responds to the concerns that I hear from teaching hospitals in my district, Larry Tanner at New Britain General Hospital, Dr. Peter Dekkers at the University of Connecticut Health Center and David D'Eramo at St. Francis Hospital. It is also in response to small community providers, Rosanne Griswold at Charlotte Hungerford Hospital, Tom Kennedy at Bristol Hospital and Michael Gallacher at Sharon Hospital.

Finally, this legislation addresses the concerns of the 6th district's caring, efficient home health providers, like Ellen Rothberg at VNA Health Care, MaryJane Corn at the VNA of Central Connecticut and Anne Dolson at the Greater Bristol VNA. These providers helped me understand the enormous complexity of the interim payment system and the difficulty they were having in providing services to the sickest seniors.

In 1997 Congress adopted the most significant reforms to Medicare since the program began. The reforms were absolutely necessary because the program was galloping toward bankruptcy. Already in 1997, it was paying out more for services than it collected in payroll taxes and premiums. Medicare spending was exploding, especially in the areas of home health and skilled nursing facility costs, and as it reached the unsustainable level of 11% growth per year, the BBA reforms were adopted to cut this growth rate in half—from 11% to 5.5%; a modest and responsible goal.

Today's legislation is essential because the impact of the BBA—both legislative and because of the way the Administration has chose to implement it—is much more significant than Congress intended. The BBA was projected to save \$106 billion over 5 years. The real savings that will be achieved are about \$100 billion above that. While the goal was to slow the rate of growth to 5.5%, growth has dropped to less than 2% per year, though the number of seniors and of frail elderly continues to grow.

Mr. Speaker, this bill makes the critical adjustments necessary to assure the ability of our community hospitals, home health care agencies, and nursing homes to provide the high quality care Medicare is required to provide to our senior citizens. Equally important, this bill assures the care needed by critically ill seniors with complex, high-cost medical problems.

I urge support of this important legislation.

Mr. STARK. Mr. Speaker, noting that the gentlewoman from Connecticut (Mrs. JOHNSON) did not respond to the question of why she voted to deny seniors a medical drug benefit, I yield 1½ minutes to the gentleman from Wisconsin (Mr. KLECZKA).

Mr. KLECZKA. Mr. Speaker, 2 years ago, the Medicare Trust Fund was projected to become insolvent by year 2001. To address this problem, as we were told, Congress passed the Balanced Budget Act of 1997.

In March of this year, it was estimated that the Medicare Trust Fund would be solvent until year 2015. This dramatic improvement is largely due to changes in reimbursements paid to health care providers made by the BBA.

While the BBA can be credited with increasing the solvency of the trust fund, providers have expressed concern that the cuts had hurt that ability to care for patients. We have all heard about stroke victims unable to get rehabilitation services they need. We have all heard about hospitals unable to find nursing homes to care for ventilator patients. Some of the most vulnerable patients in the Medicare program have been the hardest hit by these changes.

The legislation before us today takes important steps to address these problems. It provides more money for therapy services. It increases reimbursement to nursing homes who care for medically complex patients. It also includes funds for hospitals, home health agencies, and Medicare health maintenance

organizations. These changes help ensure that the Medicare program will continue to meet the commitment and provide quality care to our Nation's seniors.

The Medicare Refinements Act before us today maintains the delicate balance between the fiscal concerns of the providers and the long-term stability of the Medicare program for generations to come.

Mr. Speaker, I urge all my colleagues to support this necessary legislation.

Mr. BROWN of Ohio. Mr. Speaker, may I inquire how much time remains for each of us.

The SPEAKER pro tempore (Mr. LAHOOD). The gentleman from Ohio (Mr. BROWN) has 5½ minutes remaining. The gentleman from California (Mr. STARK) has 4½ minutes remaining. The gentleman from California (Mr. THOMAS) has 10 minutes remaining.

Mr. BROWN of Ohio. Mr. Speaker, I yield such time as he may consume to the gentleman from Maine (Mr. BALDACCIO).

Mr. BALDACCIO. Mr. Speaker, I thank the gentleman from Ohio for this courtesy. I rise in support of the legislation as a beginning to build on down the road for future changes.

Mr. Speaker, I support this very important legislation which will correct some of the unintended consequences of the Balanced Budget Act of 1997 cuts on Medicare reimbursements. Along with the assurances from the President that further alterations can be made administratively, I hope that health care providers, particular those in rural areas such as my own, will be afforded relief so that services to seniors will not be diminished. With the implementation of BBA Medicare cuts, Maine hospitals alone will lose \$338 million over 5 years. This legislation provides us with the first step towards restoring some of these deep cuts.

Implementation of the BBA and a slowing in the growth in spending by Medicare has ensured that the solvency of the Medicare Trust Fund is extended another seven years, until 2015. In fact, there was no growth in spending in the Medicare program for the first quarter of this year. This is good news and provides us with the flexibility to improve some of the harmful provisions which threaten care to seniors.

Rural areas, in particular, have suffered under the BBA. As a member of the Rural Health Care Coalition, I was very pleased to see portions of the Triple A bill, H.R. 1344, included in H.R. 3075. I thank Chairman THOMAS for his attention to the special needs of rural areas. A good portion of this bill is dedicated to allowing for more flexibility for rural health institutions. These facilities are the backbone of care in Maine, and their survival is of primary importance to me.

One area which has been of particular concern to me has been the very harmful effects of the BBA on the home health industry. In Maine, agencies are under significant financial stress. The burden of my home health agencies have been asked to bear is extreme, especially when considering that the losses are spread among only 40 providers in the state.

On a nationwide scale, the Department of Health and Human Services recently released a study which shows that the very sickest of seniors are having difficulty accessing home health care. I am encouraged by the direction this legislation takes to address the most harmful BBA provisions regarding home health care.

Another rural concern is the future implementation of the outpatient Prospective Payment System. By HCFA's own admission in the May 7 published rule, rural hospitals will take the biggest hit in reimbursements from the outpatient PPS. The total reduction in the first year for all institutions will be \$900 million, or a 5.7% average reduction per facility. The outlier adjustment is a good beginning to addressing this issue, though much more work must be done to ensure hospitals can meet the burdens of such cuts.

One final issue I would like to touch on is the reimbursement for hospitals training physicians, especially in rural areas, where there remain significant physician shortages. I am pleased to see that a portion of my GME technical corrections legislation, H.R. 1222, was included in the BBA Refinement Act. In particular, the adjustments allowed for upwards to 30% growth in resident limits and the inclusion of rural training tracks recognize the need for increased flexibility for rural areas to address physicians shortages are extremely positive steps. However, there exists a significant provision of H.R. 1222 which have been left out of this bill. Numerous hospitals have had their residency limits lowered because the BBA fails to count all of a programs' residents. For example, a resident who was on medical leave in 1996 or who was training in another facility cannot be counted because he or she was not physically "in the hospital." Thus, many hospitals are facing an artificially low cap that does not reflect the true number of residents enrolled. This provision is contained in the Senate version of the BBA corrections bill, and I hope that conferees will adopt the entire language of the bill H.R. 1222 in the conference report.

Finally, I must voice my concern with one provision of H.R. 3075 which would alter the Direct GME payments. Unlike the other provisions of this bill, the alteration in determining the Direct GME payments to facilities does not correct a harmful BBA provision. It is unclear to me why this provision was included in H.R. 3075, and I am very wary of the shifting of resources that will result from some hospitals to others. I hope that conferees do not include this provision, as it does not have a place in this corrective legislation, there has been no opportunity to debate this new adjustment, nor is it clear how specific institutions will fare under the adjusted DGME payments.

Mr. Speaker, the corrections contained in H.R. 3075 are moderate, but essential to rural health care providers who serve the elderly. Through technical refinements we are beginning the process to ensure providers are reimbursed fairly for the services they furnish Medicare beneficiaries. I trust that we will continue to rework these reimbursement levels, through future Medicare reform legislation, in order to maintain the best and most efficient health care to our seniors.

Mr. BROWN of Ohio. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. WAXMAN).

Mr. WAXMAN. Mr. Speaker, in 1997, we knew there was concern about the long-term financial health of Medicare, because we knew the baby boom generation would soon become eligible for the program. But what did we do? We slashed Medicare payments to providers of care far beyond what was sensible—not to use that money for Medicare, but in order to take it and use it for tax cuts. Now we are faced with the consequences of that action.

But today we are attempting to remedy some of the effects of that law by a process that is just as hasty and imperfect.

And so we do not know if we are really addressing the problems satisfactorily. What we do know is we did not do anything in this Congress nor in this bill to assure the viability of the Medicare program as the President proposed to do. We are certainly not doing anything to address the needs of the seniors on Medicare to provide prescription drugs for them.

This is both unfair and irresponsible. We are not dealing with some small program that has limited impact. What we do will affect millions of Medicare beneficiaries and virtually all health providers in this country—teaching hospitals, home health providers, rural and inner city institutions—all of them are affected.

Of course I will vote for this bill because it is the only choice before us, and because we clearly need to remedy some of the most severe problems caused by the Balanced Budget Act of 1997.

But this process is wrong.

The Republican majority has denied us the opportunity to provide help for Medicare beneficiaries to secure more affordable drugs. We could and should be voting today to stop the discrimination our seniors face when they are charged prices frequently more than a hundred percent greater than HMOs or favored buyers secure.

My Government Reform staff has conducted more than 140 surveys in Members' districts throughout the country, and we have found this price discrimination against seniors over and over again. They pay more than our neighbors in Canada, they pay more than the Federal government, they pay more than HMOs—and they pay much more than they can afford.

We need to add a prescription drug benefit to Medicare for all beneficiaries. But until we do, we at least have to stop the price discrimination against seniors. This bill should have provided the opportunity to do so.

Why is the majority blocking the effort to offer an amendment to do that and help seniors everywhere? I ask my Republican colleagues: what are they afraid of? Are they afraid to let Medicare beneficiaries know where they stand on drug company price discrimination against seniors?

Medicare beneficiaries and providers deserve better than the hasty and limited action we take today.

Mr. THOMAS. Mr. Speaker, it is my pleasure to yield such time as he may

consume to the gentleman from Florida (Mr. CANADY).

Mr. CANADY of Florida. Mr. Speaker, I rise in strong support of this important legislation.

In addition to making adjustments in Medicare payment policies instituted by the Balanced Budget Act of 1997, this bill addresses two issues of particular concern to me and to the 12th District of Florida.

Since 1996 I have been working to draw attention to what I believe is an arbitrary provision in the Medicare statute that provides for beneficiaries with organ transplants to receive immunosuppressive drugs for only 36 months. The policy—which was originally brought to my attention by a constituent—is amazingly short-sighted since organ recipients need these prohibitively expensive but essential anti-rejection drugs for an unlimited period of time. If transplant patients do not have access to these drugs and maintain a proper dosage regimen, they will ultimately reject their organ and potentially lose their life. Ironically, Medicare policy does cover dialysis, re-transplantation, and the hospitalization and medical costs associated with organ rejection—each of which are more costly than the average cost of immunosuppressive drugs for one year. With the strong support and assistance of my colleague from Florida, KAREN THURMAN, and interested groups such as the National Kidney Foundation, I introduced the Immunosuppressive Drug coverage Extension Act earlier this year. Since its introduction, 263 of my colleagues from both sides of the aisle have cosponsored it. I am very grateful to see that the Medicare package before us today includes a provision that, while not identical to my legislation, is an effort to improve upon Medicare's current immunosuppressive drug coverage policy. H.R. 3075 includes \$200 million over the next five years to provide additional drug coverage to beneficiaries who have exhausted their original 36 months of coverage.

While I am convinced that extending beneficiary entitlement to the drugs without imposing a capped dollar amount is appropriate, I appreciate the committees' concerns that more definitive data and cost analysis is needed before taking a more permanent step. To the chairmen of the House health care committees and to the cosponsors of my bill and on behalf of thousands of organ recipients, I want to say thank you for recognizing the need to improve Medicare's existing policy in this area.

Secondly, since early 1998, I have been extremely concerned about the exodus of managed care plans from the Medicare program. In Polk County, in my district, all four operating managed care plans pulled up stakes effective in 1999, suddenly leaving approximately 6,000 beneficiaries without their managed care plan. Ninety-three other counties in the U.S. were also left with no plans. Insurers pointed to low reimbursement rates and provisions of the Balanced Budget Act of 1997—the very law Congress intended to expand beneficiary choice—as the reason for numerous departures from counties around the country. While some counties enjoy extremely high payment rates and the presence of several managed care plans, others (like Polk

have a disproportionately low payment rate and no managed care plans. It doesn't take much examination to see that this is patently unfair. The Congress has an obligation to answer to the over 60,000 beneficiaries nationwide who, after 1998, were left with no managed care plans to choose from; to the approximately 350,000 others whose plan choices were reduced; and to the thousands of beneficiaries in over 2,000 counties who didn't even have a managed care choice in 1998 in the first place.

I am pleased to see several provisions included in the Medicare bill before us today that are aimed at the inequity I've described. The bill is a very positive development. The provisions to ease burdensome requirements and deadlines imposed on managed care plans, and particularly the language to give incentives to plans to enter counties left with no managed care choices, promise greater equity for all Medicare beneficiaries.

Mr. THOMAS. Mr. Speaker, it is my pleasure to yield 1 minute to the gentlewoman from Washington (Ms. DUNN), a member of the Committee on Ways and Means and someone who supplied a very important component to this bill.

Ms. DUNN. Mr. Speaker, as we continue to make major progress in reforming programs to make sure there is greater access in health care, we want to also make sure that nobody falls through the cracks.

So that is why I rise in enthusiastic support today for this bill to provide essential relief to seniors that are affected by unintended reductions in Medicare under the BBA.

I want to thank the gentleman from California (Chairman THOMAS) for his willingness to work with me on several provisions that are important for women's health and to the pace of medical innovation.

First, this bill doubles the reimbursement for Pap smears. This reimbursement rate has not been increased in over a decade. It really is essential to maintain access to one of the most important preventive measures for detecting cervical cancer.

Secondly, the bill extends Pap smear reimbursements to automated screening technologies. These are important innovations in health care that will make it possible to identify cervical cancer at an early stage and with greater accuracy.

Mr. Speaker, providing incentives to protect the health of women as they grow older is one of the most important public policy decisions we can make. This bill recognizes that fact and goes a long way toward making innovative new treatments available to women.

Mr. STARK. Mr. Speaker, noting that the gentlewoman from Washington (Ms. DUNN), the previous speaker, had joined with Messrs. ENGLISH, SHAW, and HAYWORTH in voting to deny seniors a free drug benefit reduction, I yield 1½ minutes to the gentleman from Maryland (Mr. CARDIN).

Mr. CARDIN. Mr. Speaker, let me thank the gentleman from California for yielding me this time.

Mr. Speaker, the purpose of this bill is to make certain adjustments to the 1997 Balanced Budget Act. I applaud the chairman of the subcommittee for bringing out a bill that deals with that.

We have projected Medicare savings in 1997 over 5 years of \$115 billion. In reality, it is going to be closer to \$200 billion. This bill contains some very important improvements in the Medicare system that will deal with the \$1,500 therapy cap right now which is denying many of our seniors necessary rehabilitative care.

It will extend the municipal health demonstration project that affects thousands of seniors. It will provide help for frail elderly and those high acuity nursing home patients. It will help us deal with the Medicare Plus choice problems particularly in rural areas of getting more HMO participation.

But, Mr. Speaker, let me say that this is a very important bill that I hope will pass overwhelmingly on the floor, but there is more that we need to do. As has been pointed out, we need Medicare reform, including prescription drug benefits. We need to deal with a stable funding source for graduate medical education in inflation. I know many people share that thought.

We need to take a look at high acuity patients, particularly from long-term care and the special needs of psychiatric hospitals.

I congratulate all those who are responsible for bringing forward this bill. Let us pass it, and then let us work on the other reforms that are necessary in order to provide the best possible care to our seniors.

Mr. Speaker, I rise in support of the important Medicare bill before us today. In taking the important step of refining many of the Balanced Budget Act's Medicare provisions, Congress is acknowledging what so many seniors and health care providers have known for a long time now: that the 105th Congress made several mistakes in crafting Medicare reforms back in 1997. Some of the changes we made restructured the risk contracting program, others were designed to reduce provider reimbursement levels in several areas. In both categories, the consequences have been far different from what we in this body intended or expected.

In 1997, the Congressional Budget Office estimated the Medicare reductions at \$115 billion over five years. Since that time, we have seen evidence that the reductions are closer to \$200 billion. The effect of this difference on the accessibility and quality of care for our seniors transcends budget numbers, however.

This bill, the Balanced Budget Refinement Act, makes important restorations in several key areas that will help our seniors secure the medical care they need. It adjusts payments for skilled nursing facilities so that the most frail nursing home patients can receive additional payments for the ancillary services they

require; it helps alleviate the arbitrary caps placed on outpatient therapy services, which now prevent one of six patients from receiving the care they need; it extends the Municipal Health Services Project for one year, and it provides very important relief for seniors who rely on home health services. I am also very pleased that this bill extends coverage of immunosuppressive drugs for transplant patients who are now subject to a three-year limit for these life-saving therapies.

This bill also provides incentives for Medicare+Choice plans to participate in lower-cost areas. The Medicare+Choice program was designed to expand the private health plan options available to our seniors. But two years after BBA's passage, seniors' options have diminished rather than increased as many rural areas have lost their Medicare HMOs and even in higher cost urban areas, plans are reducing benefits and raising premium charges. In some states, there has never been a managed care option for seniors. Most health plans cite low payment rates as the reason for their lack of participation. This bill offers bonus payments to plans that are willing to enter markets where there is no Medicare HMO option today.

There are additional areas that still must be addressed. I support the creation of an all-payer graduate medical education trust fund that will save Medicare more than \$1 billion annually, while providing a steady funding source for the training of our Nation's medical professionals. My proposal for BME replaces the current outdated payment structure for residents with a fair national standard based on actual resident wages. As the dire financial situation of academic medical centers worsens, I hope we can reorganize the need to stabilize their financial condition. We can act to shore up these institutions and ensure the continuation of the high-quality medical workforce we enjoy today.

I also support restoration of the cuts BBA made to hospice care, which is an essential part of our effort to provide comprehensive medical treatment to the Nation's elderly and disabled. I support providing adequate payments for all frail patients in nursing homes, including rehabilitation categories whose costs will continue to be inadequately reimbursed even after passage of this bill. And, I support the creation of a drug benefit for fee-for-service Medicare that provides all beneficiaries, not just those with access to an HMO, with coverage for outpatient prescription drugs. These are key issues that Congress will need to be addressed further next year.

Earlier this year, I urged Congress and the Administration to join in a united effort to address these matters. I am proud that Congress has taken this crucial step today and I also applaud the Administration for working with Congress and moving to take the administrative measures that are within its power. I urge my colleagues to support this bill and help us move forward to restore crucial health services to America's Medicare beneficiaries.

Mr. BROWN of Ohio. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. DEUTSCH).

Mr. DEUTSCH. Mr. Speaker, let us remember specifically why we are here. We are here because we made mistakes,

but we made mistakes with the Republican majority in terms of some of the draconian cuts that they were attempting.

We still do not deal with the fundamental issues. We do not deal with the fundamental issues that literally thousands of Americans are, in fact, being permanently damaged because they have reached therapy caps in terms of stroke victims who will remain paralyzed forever because of the inaction in this Congress that remains in this bill.

But let us talk about what we are not doing. What we are not doing is we are not facing any of the real fundamental issues facing health care in America. My colleagues in the majority are afraid of those issues.

There is a procedural game that is being played today, which is a suspension vote, which rejects the ability of the minority to do a motion to recommend that would probably overwhelmingly pass in this Chamber on prescription drug coverage for Medicare. My colleagues on the other side are afraid of that vote. They are afraid of giving the American people what they need and they deserve. They are afraid of fundamental change in the Medicare system. They are afraid of the Patients' Bill of Rights bill. They are afraid of putting the sponsor of that bill on the conference committee.

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Mr. THOMAS. Mr. Speaker, I yield 1 minute to the gentleman from Louisiana (Mr. MCCREY), a member of the Subcommittee on Health of the Committee on Ways and Means, again without whose tireless work this bill would not be possible.

Mr. MCCREY. Mr. Speaker, I thank the gentleman for yielding me this time. A few moments ago our colleague, the gentleman from California (Mr. WAXMAN), was on the floor and said that the cuts in the BBA were irresponsible. Well, they certainly have gone further than most of us would have liked, but the fact is those cuts, that legislation, was a joint effort between Democrats and Republicans, the White House and the Congress, so we ought not be down here denigrating anybody for the good faith effort that was entered into to try to save the Medicare system.

We now know that some mistakes were made; that some of the cuts went too far. That is the purpose of this legislation on the floor today, and we have worked together again, Democrats and Republicans, to try to repair that damage in the most responsible way.

What is irresponsible, though, is to stand up and call for free drugs, free prescription drugs. Americans, senior Americans, know that drugs are not free. Prescription drugs are not free, and we ought not promise something that is impossible. We ought to be responsible about crafting a Medicare

program that, yes, includes a prescription drug program but not to stand up here and say, let us vote for free prescription drugs. That is irresponsible.

Mr. STARK. Mr. Speaker, I yield 1½ minutes to the gentlewoman from Florida (Mrs. THURMAN), the author of the amendment, that would have given free or discounted prescription drugs, not free, free to the government, but a deduction or a reduction in the cost to the seniors.

I would note, Mr. Speaker, that the previous speaker, the gentleman from Louisiana (Mr. MCCREARY), also voted to deny the seniors in his district a discount on prescription drugs at no cost to the government.

Mrs. THURMAN. Mr. Speaker, I thank the gentleman for yielding me this time, and I appreciate his remarks. I too want to reiterate that was a discount, not free, and it would have been just like we do with Medicaid and VA.

And I want to bring to the attention here today that just yesterday there was a report that was released that actually said that drugs have gone up 25 percent, which is two times the inflation. So many of these drugs have continued to rise for no apparent reason.

I do want to say, though, that I am pleased in some respects, would have liked to have done a little bit more, obviously, but I am somewhat happy with the IME, the DSH, we have done some things in here for skilled nursing facilities, and I hope that we will concur with the Senate on the hospice issue.

I want to take a moment to thank all the members of the committee who listened to my plea and who have helped me with the anti-rejection drug issue that is in here. My colleagues will realize, once we get some of this other report back, once we start spending this money, that this will save lives. It was good common sense. It will save money to our Medicare system. And I also want to say we did the right thing when we did the composite rate on dialysis.

I do want to suggest, though, that I hope in this coming year that we can truly sit down on an issue that is so important, especially after the report that came out yesterday, that we really have got to do something on. Because the other issue that was brought out that was an advertisement by PhRMA which said, look at all of these wonderful drugs we are doing. They cannot afford them.

Mr. BROWN of Ohio. Mr. Speaker, I yield such time as he may consume to the gentleman from Texas (Mr. GREEN), a fellow member of the Subcommittee on Health.

Mr. GREEN of Texas. Mr. Speaker, I thank the gentleman for yielding me this time.

I am pleased to support H.R. 3075, the Medicare, Medicaid and State Childrens Health Insurance Program Refinement Act of 1999.

This bill takes an important first step towards ensuring that cancer patients have access to the best medical treatments available.

Under the BBA of 1997, the Health Care Financing Administration was directed to develop a hospital outpatient prospective payment system (PPS). Under their original proposal, reimbursements for cancer drugs would have been dangerously low—potentially denying Medicare patients access to the most effective treatments.

However, under H.R. 3075, our nation's seniors with cancer will be protected because our nations cancer hospital's, including MD Anderson in Houston, will be exempt from the PPS for two years.

This additional time will give the medical community and Members of Congress time to evaluate the plan based on actual practices in other hospitals across the country.

Moreover, because HCFA has recognized the flaws in their original proposal, they have committed to redevelop the PPS to better reflect the needs of Medicare patients everywhere. According to HCFA, they are preparing to substantially increase the number of payment categories for cancer drugs, which will better reflect the high cost of innovative treatments and new drug therapies.

This bill is better than nothing—but leaves a lot of issues neglected including senior citizen prescription medication needs and making medicine better serve the needs of today's and tomorrow's senior citizens.

Today represents the way this process should work—Congress and the Administration working together to meet the needs of the American people.

Mr. BROWN of Ohio. Mr. Speaker, I yield 1 minute to the gentleman from New York (Mr. ENGEL).

Mr. THOMAS. Mr. Speaker, I yield 15 seconds to the gentleman from New York (Mr. ENGEL).

Mr. ENGEL. Mr. Speaker, if this were only about fixing Medicare, it would be fine, but a provision that was entered into this bill wrecks havoc with teaching hospitals.

This proposal results in no savings but would shift millions of direct medical education dollars between hospitals, with no consideration as to the financial needs of a hospital or the type of patient they serve. As a result, \$250 million in Medicare funds will be transferred from 400 teaching hospitals across the country to 600 others. This will actually cost \$300 million extra.

Now, BBA relief legislation was supposed to restore Medicare cuts to hospitals, not initiate new cuts to hospitals. That is what it does to a major teaching hospital in my district, and that is what it does across the country. This affects Democrats, Republicans, people representing all different places across the country. This provision should not be in here.

I know my friend from California (Mr. THOMAS) put in the provision because it helps his district, but it should not be done this way. There should not be winners and losers here, and the payment should not be made at the national rate.

Mr. Speaker, I provide for the RECORD a letter addressed to the Chairman of the Subcommittee on Health of the Committee on Ways and Means from one of our colleagues, the gentleman from Georgia (Mr. KINGSTON) dated November 3, 1999, and signed by numerous other colleagues.

HOUSE OF REPRESENTATIVES,
Washington, DC, November 3, 1999.

Hon. WILLIAM M. THOMAS,
Chairman, Ways and Means Subcommittee on Health, Washington, DC.

DEAR CHAIRMAN THOMAS: We are very concerned about two provisions in the House Balanced Budget Act (BBA) Relief package. We fervently request that these provisions be changed because of their serious, disproportionately harmful effects on smaller teaching hospitals.

Specifically, the Indirect Medical Education payment freeze proposal and the per resident averaging provision for Graduate Medical Education would reduce reimbursements for hospitals in our districts by millions of dollars per year. It is ironic that a bill designed to provide relief to hospitals hurt more by BBA than projected would, in fact, inflict even deeper harm.

As you know, H.R. 3075 contains a provision that would change the Medicare per Resident Direct Medical Education payment from a hospital-specific rate to an amount based on a national average per resident. This provision penalizes smaller teaching hospital programs because the fixed costs of operating a fully accredited residency program is spread over a smaller number of residents. It rewards programs that train large numbers of residents, regardless of community need. We further question its need, as it is budget-neutral at the national level—it simply shifts funding from smaller programs to the larger programs.

Unfortunately, the second provision is even more harmful. The House bill, unlike the Senate, freezes the relief rate from BBA reductions in IME at six percent for one year, then decreases the rate to 5.5 percent. Proceeding further with this proposal will result in multi-million dollar penalties for hospitals across the country. We ask that the House bill be modified to raise the IME relief from 6.0 to 6.5 percent.

Furthermore, we strongly oppose retaining a provision for per resident averaging and ask that it be eliminated in the House bill before it is brought to the floor or via a manager's amendment during floor consideration.

Thank you very much for your serious consideration of these concerns. We must ensure that legislation intending to provide relief for hospitals does so fairly for all facilities and avoids inflicting additional harm.

Sincerely,

Jack Kingston, Nathan Deal, Mac Collins, Charles Norwood, Jim Talent, Sherwood Boehlert, David Vitter, Lee Terry, Jim DeMint, Sue Myrick, Jack Quinn, Todd Tiahart, Pete King, Judy Biggert, Billy Tauzin, Robert Ehrlich, Jr., Connie Morella

Mr. KINGSTON. Mr. Speaker, will the gentleman yield?

Mr. ENGEL. I yield to the gentleman from Georgia.

Mr. KINGSTON. Mr. Speaker, I thank the gentlemen from New York and California, and I want to say this is a bipartisan problem.

We do thank the gentleman from California for trying to correct some of

the problems with the BBA, but, on the other hand, it creates a new problem with the indirect medical education reimbursements and it changes the formula to base it on a national average per residence, which in some areas causes great losses of money.

Mr. THOMAS. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. SHAW), the chairman of the Subcommittee on Social Security of the Committee on Ways and Means, who represents the district with the greatest number of seniors in the United States.

Mr. SHAW. Mr. Speaker, today I rise, as I think every Member of the House on both sides of the aisle does, in strong support of H.R. 3075, the Medicare Balanced Budget Refinement Act of 1999. This is a bill that is of critical importance to the citizens of my district, my State, and, indeed, all across the United States.

I would like to commend the chairman of the Subcommittee on Health, the gentleman from California (Mr. THOMAS), and the gentleman from Texas (Mr. ARCHER), chairman of the full Committee on Ways and Means, for expediting this effort to restore desperately needed funds to Medicare providers, who have been caring for Medicare patients day in and day out, often for Medicare payments that are not adequate to cover the cost of providing these services.

In my district, for example, the Sylvester Cancer Hospital is currently losing approximately \$700,000 a year caring for Medicare cancer patients and hospices which cares for the most vulnerable terminally ill Medicare patients are unable to provide newest medications to comfort these patients under the current Medicare reimbursement level.

I have been hearing from many, many concerned citizens—nursing homes, physical therapists, home health providers, physicians and hospitals regarding the importance of acting quickly to restore some of the 1997 BBA cuts that are already detrimentally impacting patient care. I thank my good friends the Health Subcommittee Chairman BILL THOMAS and Full Committee Chairman BILL ARCHER for moving this important Medicare rescue bill so quickly. I urge my colleagues to unanimously support H.R. 3075—it doesn't provide all the Medicare fixes that are needed—but begins to address the most urgent needs immediately.

Mr. Speaker, there are many things we have to do next year and work on, one is the question of drugs, and we will certainly look forward to working, hopefully in cooperation with the minority, in order to come up with a good bill to give our seniors further relief.

Mr. THOMAS. Mr. Speaker, I yield 1½ minutes to the gentleman from Iowa (Mr. NUSSLE), a member of the Committee on Ways and Means and someone who has worked on this bill especially for rural hospitals.

Mr. NUSSLE. Mr. Speaker, I thank the gentleman for yielding me this time.

I guess I should not be surprised that there are some who run to the floor today and try to make political issues for the next campaign. None of us should be surprised by that because it has been done so many times in the past. Whether it is prescription drugs, no, there is no debate today on that issue. There should be. Should it be on Medicare reform? You bet. HMO reform? We have had it, and we are going to have more debate. All of that debate needs to occur.

But while some want to preserve those issues for a campaign, my hospitals are ready to close. Because this is the most important issue in health care that we face this year. We cannot wait while Members cut 30-second spots for their campaigns and let my hospitals close. Because I tell my colleagues that if my hospital closes, my seniors, my neighbors and I do not have health care.

So while my colleagues on the other side want to fiddle around, those who have come down here to do just that, our hospitals across the country are in jeopardy of closing. So I would ask those individuals on the other side to stop the politics and let us pass this bill.

And I would end my debate by just suggesting that the rural health care portions of this bill are going so far in order to make us whole over the 1997 cuts, cuts that were not meant to have the kind of impact that they have had, and I commend the committee for doing the reform.

Mr. THOMAS. Mr. Speaker, I yield 1 minute to the gentleman from Arizona (Mr. HAYWORTH), a member of the Committee on Ways and Means.

Mr. HAYWORTH. Mr. Speaker, I thank the gentleman for yielding me this time, the chairman of the Subcommittee on Health, and I would echo the comments of my good friend, the gentleman from Iowa (Mr. NUSSLE), and simply say that for rural hospitals this refining piece of legislation is absolutely important.

I would agree with the portion of the statement of the gentlewoman from Florida that when it comes to immunosuppressive drugs for transplant patients, this legislation is vitally important. When it comes to teaching hospitals, this legislation is vitally important.

When it comes to accountability in the legislative branch, and let us be honest about the budget negotiations in 1997, many of these provisions were not advocated by either the majority or the minority here but at the other end of Pennsylvania Avenue. When we choose to correct, we are being responsive to our constituents.

I welcome constructive comments. We will save the politicking for a cam-

paign. Today we do the people's business, restoring rural health care, restoring home health care, expanding immunosuppressive drugs and making a difference with a prescription for success for health care and the American people.

Mr. BROWN of Ohio. Mr. Speaker, I yield 1¼ minutes to the gentleman from Massachusetts (Mr. MARKEY).

Mr. MARKEY. Mr. Speaker, this bill is inadequate. The Republicans have been standing on the floor for the last month holding up a penny saying, oh, people are not willing to cut a penny out of the entire Federal budget, although it would affect, ironically, many of the programs that they now are out on the floor saying they care so much about.

But in 1997 they led the effort to cut Medicare by what they said was going to be \$110 billion. It has wound up now at \$210 billion and, at the same time, they had a tax break out here on the floor for the wealthiest Americans for \$275 billion over 10 years. Now that was a nice package in 1997. A tax break of \$275 billion, that is the law for the wealthiest in America; cut Medicare by \$200 billion, just over 5 years, and then come back in 2 years and say, look at the great surplus, look where it came from.

What do they say to the people on Medicare? We are going to give back a nickel out of that \$200 billion cut in Medicare. To the hospitals, to the home health servers, to the communities across the country, to the people who are sick in our country, and old, they get back a nickel. And what do they do with the rest of the surplus? Oh, they have a new idea, an \$800 billion tax break for the wealthiest in America over the next 10 years.

So who is funding this huge tax break idea, the money that goes back to the communities, actually to the wealthy under their plan? The people who are funding it are people who are in nursing homes. The people who are funding it are people who they cut viciously, this program. Hospitals and nursing homes are hemorrhaging and they want to put a Band-Aid on it today.

Mr. THOMAS. Mr. Speaker, I yield such time as he may consume to the gentleman from Wisconsin (Mr. RYAN).

Mr. RYAN of Wisconsin. Mr. Speaker, I rise in support of the bill.

Mr. Speaker, this bill is vital to the successful continuation of Medicare as we know it. This bill restores some of the changes that were made to the Medicare program back in 1997 in the Balanced Budget Act.

In the district I serve, several Medicare+Choice providers announced that they would terminate services for seniors. The beneficiaries were understandably devastated. I held a town hall meeting in August of this year to bring together the health plans, HCFA and Medicare beneficiaries. The response was overwhelming.

Some of the beneficiaries decided they were not going to lose their managed care coverage without a fight. Joyce Scantling, of Racine, WI has been leading this fight and has worked tirelessly with 50 or 60 other beneficiaries to rally their support around Medicare legislation to fix the reimbursement rates. I hold in my hand thousands of signatures of Wisconsin seniors who have contacted me in support of providing a fix to Medicare and in support of protecting their choices under Medicare.

This bill restores funding for Medicare+Choice providers, as well as hospitals, home health care providers, and skilled nursing facilities. It protects the benefits of Medicare beneficiaries like Joyce Scantling into the future.

Mr. Speaker, I believe the current situation with Medicare in this country is unacceptable. Wisconsin and other rural states do not receive the same reimbursements as the rest of the country; as a result of this disparity, seniors in these areas are not entitled to the same services as seniors in places like Florida or Texas. Some of these areas do not even have a Medicare+Choice option because they cannot make it work with the low reimbursement rates that are offered in those areas. Seniors in my state should not be entitled to a lower level of service than seniors in other parts of the country.

My ultimate goal is to equalize reimbursement rates nationwide to ensure that all seniors, regardless of where they live, would be entitled to a choice in Medicare, a choice that would give them the services they are entitled to. However, in the meantime, I believe this legislation provides the next best alternative because it targets resources where they are needed, such as my home state of Wisconsin.

To this end, I applaud passage of this legislation because I believe it will bring Wisconsin closer to receiving fair and equitable reimbursements for medical services; this cause is not yet complete, however it is a step in the right direction. I will continue to fight to ensure fair medical coverage for seniors in all parts of this country.

Mr. THOMAS. Mr. Speaker, I yield myself 1½ minutes.

Contrast the speech we just heard on the floor with the statement from the White House. Chris Jennings, who is the White House health person, said recently, "We were partners with the Congress when we passed the Balanced Budget Act, and we are going to be partners when we address the rough edges of that law."

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I have been pleased with Members on both sides of the aisle in terms of their understanding of just what this bill is. It is a refinement bill. It is not a reform bill. We still need to address prescription drugs. But Members need to remember that the 1997 act created the bipartisan Medicare Commission.

On that Commission, the public and the private members agreed, the Senate and the House Members agreed, Democrats and Republicans agreed. We had 10 votes. We needed 11. The President had four appointees. Not one of

the President's appointees supported the reform package, which would have integrated prescription drugs into that program.

In the recent tax bill, there was a tax deduction for prescription drugs. The President vetoed that plan.

We stand ready to sit down tomorrow with the President and any Democrats who work in a positive way to deal with integrating prescription drugs into Medicare. It needs to be done. But this very narrow, very shallow canoe cannot support that kind of an issue today. It is a refinement bill.

I am very pleased with the comments of the Members who understand our objective today. This is a modest change. We will continue.

Mr. STARK. Mr. Speaker, I yield such time as he may consume to the gentleman from Rhode Island (Mr. KENNEDY).

Mr. KENNEDY of Rhode Island. Mr. Speaker, I oppose this bill because it shortens the solvency and the life of Medicare.

H.R. 3075 increases payments to Medicare providers by approximately \$11.5 billion over five years. But it is a flawed and irresponsible bill.

It was brought up without the Democrats having any chance to negotiate with the Republicans.

We were not allowed any Democratic amendments, including a substitute, which we specifically requested.

There has been no consultation with Democrats—it is being brought up hastily.

It is being brought up under the suspension of the rules.

The Republican bill is not paid for. Because it is not paid for the bill shortens the solvency of the Medicare Part A trust fund by at least a year and increases Part B premiums for seniors. The Republican bill will shorten the life of the Medicare Trust Fund.

A democratic amendment if offered would have paid for the 2.7 billion that would have been offset.

The bill will reduce medicare payments to teaching hospitals. It will transfer \$250 million in Medicare funds from 400 teaching hospitals. It will initiate new cuts against teaching hospitals.

It does not include language to help seniors with the high cost of drugs.

It does not have the Senate language to strike the \$1,500 limit on rehabilitation caps and therapies. This is a provision that nursing homes need desperately.

It includes "deemed status" for HMO's; this provision will weaken our ability to insure quality in HMO's that participate in Medicare.

Mr. STARK. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the gentleman from Rhode Island (Mr. KENNEDY) said it quite eloquently. This bill is not paid for. It spends Social Security surplus, shortens the life of the Medicare trust fund, and does not deal with, as the committee had an opportunity to deal with, providing a discount, a discount of 25 to 50 percent off prescription drugs.

I would remind people in the Florida area that the gentleman from Florida (Mr. SHAW) voted against people getting that discount on their prescription drugs at a time when the managed care plans in his area are reducing the prescription drug benefits to seniors, as did the gentleman from Pennsylvania (Mr. ENGLISH), as did the gentleman from Arizona (Mr. HAYWORTH). They voted to deny seniors a savings of 25 to 50 percent at no cost to the Federal Government.

They intend to support the pharmaceutical industry, whose huge political contributions are funding the Republican campaigns. Make no doubt about it, they yield to the big men and they will not help the seniors who are struggling every day to pay for the prescription drug benefits which the Republicans have repeatedly denied. They refused to have hearings, and they refused to vote for reasonable legislation.

They are on the record. Let them deny it. Let them go home and explain to their seniors why they are being destituted because they cannot get prescription drugs at a reasonable price.

Vote against the bill in protest.

Mr. BROWN of Ohio. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, no one from the Ways and Means majority has answered why they voted against prescription drug discounts.

We have legislation before this Congress to cut the cost of prescription drugs. Yet Republicans will not give us a vote or allow us to debate on the floor any of the legislation we have to provide discounts while Americans pay two times and three times and four times for prescription drugs what people in other countries pay. Remember, 50 percent of all research and development for prescription drugs in this country is paid for by taxpayers. Yet American consumers, America's elderly pay twice as much or three times as much as consumers all over the world in England and France and everywhere else in the world.

This bill is okay, Mr. Speaker. We help providers. But most importantly, we should pass a patients' bill of rights. We should pass prescription drug coverage and prescription drug discounts for America's seniors.

Mr. THOMAS. Mr. Speaker, I yield such time as he may consume to the gentleman from Florida (Mr. FOLEY), a member of the committee.

Mr. FOLEY. Mr. Speaker, I rise in support of the bill.

Mr. Speaker, I am pleased that my colleagues and I on the Ways and Means Committee were able to craft a bill that addresses some of the problems the have arisen through the implementation of the Balanced Budget Act.

I have heard from nursing homes, home health agencies, HMOs, hospital administrators, doctors and nurses, and other health care providers about their difficulties giving

seniors on Medicare adequate care under new and sometimes unrealistic financial constraints.

I have also heard from many of my constituents on Medicare who are frustrated and scared by some of the problems that the BBA has created.

I am happy that we can give back some of the resources that Medicare patients desperately need.

I would like to comment on some of the provisions in the bill;

OUTPATIENT PPS

I am pleased that we can help hospitals, and specifically hospital outpatient departments, by including a provision that is similar to the bill I introduced—the Hospital Outpatient Preservation Act.

This provision gives hospitals a more gradual transition to the prospective payment system. I hope this will help them to continue offering services that are better provided in an outpatient settings—services like chemotherapy and psychiatric counseling—so that patients can return more quickly to the comfort of their homes.

MEDICARE+CHOICE RISK ADJUSTER

I was very concerned to read remarks made by the President, expressing his opposition to restoring HCFA's cuts to Medicare managed care companies.

I have 12,500 seniors who are losing their HMO at the end of this year and I know that I'm not the only member who has had this experience. Many seniors will have to go back to fee-for-service because they don't have another HMO in their country.

Most of my constituents are pleased with their HMO. These plans provide prescription drug coverage and other much-needed services that traditional Medicare does not cover.

But these companies are struggling with the high cost of caring for Medicare patients in areas where their reimbursements are not high enough—especially rural areas.

When we passed the BBA and started Medicare+Choice, we intended this to be a first step in modernizing the Medicare system. If HMOs—that had previously been successful in the Medicare system—cannot survive under the new reimbursements, how can other types of health plans compete?

This bill contains provisions which will encourage HMOs to enter areas where none exist.

I want to guarantee that we get HMOs into new areas, but also that we keep them there and keep them in areas where they are already operating.

This must be an ongoing process. We must look at reimbursement rates for rural areas where the cost of health care is high but the availability is low.

We must look at the rates for plans who are treating very sick patients.

We must ensure that HCFA is paying these HMOs fairly and not cutting more money from them than Congress intended based on its own motives of those of the Administration.

IMMUNOSUPPRESSIVE DRUG COVERAGE

Finally, I am pleased to see the inclusion of immunosuppressive drug coverage offered by two of my colleagues from Florida, Congressman CANADY and Congresswoman THURMAN.

It defies logic for Medicare to pay for transplant surgery for a Medicare recipient, then cut off the drugs that they need to survive this surgery after only three years.

Receiving a transplant is a tremendous gift—a chance for a new life. This chance should not be wasted by arbitrary limits on drug coverage.

I am glad that we have showed compassion in extending these drug benefits.

CONCLUSION

I hope that the President is quick to sign this bill into law so that seniors continue to receive the care they need.

While more fundamental reform in Medicare is necessary, it is important to preserve the services of the current system until this is achieved.

Mr. THOMAS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, first of all, again I want to thank all of the Members who worked across the aisle in a bipartisan fashion to fashion this refinement bill. I want to thank the staff. It is always difficult when we are attempting to provide assistance and it is an unlimited resource.

I want to underscore, this bill is paid for by on-budget surplus. One movie role most Members of Congress would not have to audition for was the scene in *Oliver* when he holds his porridge bowl up and says, "More, please." It is always "more, please."

But this is a refinement, not a reform. As the Members on both sides of the aisle have indicated, there needs to be adjustments.

As a matter of fact, the President of the United States, in a letter dated October 19, said, "We believe that our administrative actions can complement legislative modifications to refine BBA payment policies. These legislative modifications should be targeted to address unintended consequences of the BBA that can expect to adversely affect beneficiary access to quality care."

He did not say do a prescription drug program. He did not say rewrite the program. He said refine it where those areas have unintended consequences. That is exactly what this bill does. That is the intention and purpose of the bill.

It just seems to me this is a modest effort, it is a meaningful effort. I would urge those who continue to say they want to really deal with prescription drugs to sit down with us tomorrow and deal with prescription drugs the only responsible way. That is an integrated prescription drug program for all our seniors, not an add-on, not a tack-on, not something that uses gimmicks like formulas or numbers, but a prescription drug program that integrates health care delivery with numerical prescription drugs.

That is what seniors deserve. That is what we offered that the President refused to participate in and the Medicare Commission. They could have de-

ducted the cost of those in the tax bill that he vetoed. But we stand ready tomorrow to sit down and work on this important problem.

Today, let us make those adjustments that the President said were needed in areas that we had not fully understood at the time we passed the bill needed to be changed.

Mr. Speaker, let me conclude that more than three dozen organizations, including the American Hospital Association, the American Medical Association, more than two dozen specialty medical groups including the American Geriatrics Society are in support of this. It seems to me that this modest adjustment needs to go forward.

I thank all of those Democrats who spoke harshly but who will, of course, vote for the bill. I urge all to vote for the bill.

Mr. UNDERWOOD. Mr. Speaker, I'm speaking today in support of H.R. 3075: The Medicare Balanced Budget Refinement Act of 1999. This act provides for increased funding for the State Children's Health Insurance Program which provides much needed health insurance coverage for low-income children.

The SCHIP is targeted at those uninsured children who live in families with income 2-times below the poverty line. This program is authorized to match state spending for child health initiatives, including Guam.

This bill modifies the SCHIP allotment formula to provide states with a more stable financing mechanism. But, more importantly, H.R. 3075 corrects and under-representation of territory population that was reflected in the original formula established by the Balance Budget Act of 1997.

Under this new provision, H.R. 3075 provides for increased allotments for territories which typically receive a pittance of what most states are allocated. This bill will authorize an additional \$34.2 million for each of Fiscal Years 2000–2001, \$25.2 million for each of Fiscal Years 2002–2004; \$34.2 million for each of Fiscal Years 2005–2006 and \$40 million for FY 2007 for commonwealths and territories to correct the disparity created as a result in the original formula.

This is an important victory for the territories and commonwealths because no American child ought to be left behind no matter where they live. I am very pleased that uninsured children who live in Guam, the other territories and commonwealths will receive medical insurance that is much needed in the islands.

I would like to take this opportunity to commend my colleague, the gentleman from Puerto Rico, Mr. CARLOS ROMERO-BARCELÓ, who worked tirelessly to ensure that the territories and commonwealths were fairly represented in this measure. Therefore, I stand in support of H.R. 3075.

Mr. MURTHA. Mr. Speaker, I want to acknowledge the hard work on both sides of the aisle and both ends of Pennsylvania Avenue that went into the arduous task of balancing the budget and arriving at the 1997 Balanced Budget Agreement.

However, two years later, I think it is eminently clear that our Senior Citizens, as well as all medical patients and health care providers cannot sustain the cuts that were made

in Medicare and so I applaud the efforts of the committees of jurisdiction in moving this BBA 'refinement' bill before adjourning for the year. It will restore some of those cuts and give the hospitals and home health providers some hope and some breathing room for the short term. There are a lot of people, I think, who won't be laid off for Christmas because of this bill.

This 11.5 billion-dollar Medicare reimbursement adjustment bill marks a major step forward in our necessary commitment to provide the care needed throughout our health care system. The improvement in reimbursements to hospitals, home health agencies, rehabilitation services, and nursing homes give a huge boost to the commitment by our health care professionals to provide the full, quality care we all want to see.

However, from my continuing conversations with health care professionals, I think we also need to recognize that as strong of a step forward as this bill is, it is not the last word. We're going to have to keep working toward HMO reform, prescription drug coverage, and expanding the number of people with health care coverage and further adjustments in reimbursement rates.

During this period of a sustained health economy, we need to understand that it is not acceptable to have people out there not getting the health care they need.

I have kept in constant touch with the hospital people, the home health care people, the ambulance people and of course, patients—especially the elderly—in my district during this long period of severe belt-tightening, consolidation, layoffs and downsizing that have significantly harmed the quality of health care service in rural Pennsylvania. There is no question the impact was much more severe than was foreseen.

So, while there is no doubt that this bill is a key to alleviating the crushing, and I think to a large extent unexpected, slashing of revenues that have caused even small rural hospitals' budgets to drop millions of dollars each in just a few years, the struggle to maintain adequate health care funding is not over and I will press very hard to make sure we'll be addressing this issue again in the very near term.

Mr. STENHOLM. Mr. Speaker, I am pleased that the House of Representatives has recognized the need for considering legislation to address the concerns of many of my constituents regarding the impact of the medical payment reductions included in the Balanced Budget Act of 1997 (BBA). The BBA included provisions which were intended to preserve the solvency and integrity of the Medicare program for future generations. Unfortunately, some of the provisions of the BBA have resulted in unintended consequences as many health care providers have indicated that the payment reductions go too far. This is particularly problematic in rural areas where health care providers have always had to do more with less.

Along with my colleagues in the House Rural Health Care Coalition, I have been working to encourage the Congressional Leadership to consider legislation which would help rural health care providers. We introduced the Triple A Rural Health Improvement Act as a

basis for these discussions, and I am pleased to see that some of the important rural health provisions from our bill have been included in the legislation we are considering today. In particular, this bill contains provisions which should help our rural hospitals, nursing homes, home health care agencies, rural health clinics, community health centers, and other health care providers.

This bill contains provisions intended to protect low-volume, rural hospitals from the disproportionate impact of the hospital outpatient prospective payment system, creates an alternative payment system for community health centers and rural health clinics, strengthens the Medicare Rural Hospital Flexibility/Critical Access Hospital Program, expands Graduate Medical Education opportunities in rural settings, and permits rural hospitals in urban-defined counties to be recognized as rural for purposes of Medicare reimbursement.

The legislation we are considering today is a step in the right direction; however, it is only a first step. We have much more work to be done in order to ensure that rural Americans have access to quality, affordable health care services, and to preserve the solvency of the Medicare program for current and future generations.

Mr. CALVERT. Mr. Speaker, my district in Riverside County depends on a number of facilities to provide quality health care to its residents. Many of these facilities have been hit hard by the restrictions that were imposed after enactment of the Balanced Budget Act. This legislation would increase reimbursements to Skilled Nursing Facilities with patients that have medically complex conditions, provide flexibility in staffing and procurement priorities at rural hospitals, ensure the availability of home health care, and restore funding lost from some of the BBA reforms. With these new provisions, we will be able to continue to reap the benefit of the savings provided by the BBA reforms without driving critical healthcare facilities out of business and deteriorating our healthcare infrastructure.

I support this important bill and would have voted for the bill. Unfortunately, I have conflicting responsibilities in my congressional district. Specifically, I have been asked to participate in the dedication of the National Medal of Honor Memorial at Riverside National Cemetery. While I regret having to miss this vote, I look forward to honoring the recipients of the Medal of Honor at this dedication. We enjoy freedom and liberty today because of their dedication and sacrifice for our country.

Mrs. CHRISTENSEN. Mr. Speaker, I rise today in strong opposition to the fact that this very important bill to my constituents and to many senior Americans across the country is being brought to the floor under the suspension of the rules without any opportunity for members to amend the bill.

Mr. Speaker, all of us will agree that the cuts in Medicare that were made under the Balanced Budget Act of 1997 went too far. Literally thousands of seniors have lost or are about to lose the opportunity to receive vital care in hospitals, nursing homes and home health care facilities.

In my own district, we only have two facilities that provide long term care for the elderly. As a result, of the Balanced Budget Act cuts

in Medicare, both Mentor Clinical Services and Sea View Health Care Services have been tethering on the brink of financial collapse because of the inadequate reimbursement rate that the Act provided.

Mr. Speaker, the bill before us today is a start in remedying the damage that was done to our seniors two years but it doesn't go far enough. The minority should be allowed to offer our amendment to provide additional relief. I urge my colleagues on the other side of the aisle to reconsider their refusal to allow amendments. This is a good bill but it doesn't go far enough.

Mr. RILEY. Mr. Speaker, this legislation is certainly a step in the right direction, and that's good, but it simply doesn't solve all the problems facing America's hospitals, especially those out in our rural areas. Now, if you take a closer look, you'll see that most of these changes only delay the problems, they don't solve them. However, they do buy us some time, and if we use that time wisely, we can find a permanent fix.

Like me, I'm sure all of you have heard a lot about this from your constituents, and rightly so. Only half of the Medicare savings plan has taken effect, but already we're seeing some serious problems with it—funding for home health care isn't enough, it's getting harder to recruit physicians, ambulance services are losing money and we're even having trouble funding transportation services for people physically unable to drive to their doctors' appointments. Now that's not right. We can do better.

So I do support this legislation today. As I said, it's a step in the right direction. However, I strongly urge my colleagues to stay the course and help us find a permanent solution to this very serious problem before it's too late.

Mrs. LOWEY. Mr. Speaker, I rise in reluctant opposition to H.R. 3075. I have been calling all year for this House to address the already-staggering burdens that our health care providers are coping with from the cuts mandated by the Balanced Budget Act of 1997. In fact, I introduced legislation with my colleague JACK QUINN to do just that.

I wanted very much to support this legislation. Hospitals in New York have faced significant operating losses and deficits, and they still have \$2.6 billion in BBA cuts ahead of them. Thousands of employees have been laid off in an attempt to avoid damaging quality health care services. Even with significant cuts in personnel, many hospitals are hemorrhaging money. The plight of our hospitals, particularly teaching and safety net hospitals, is especially grim.

These premier educational and research institutions have been caught between their traditional mission of serving the less fortunate while educating new generations of physicians and competing in the managed care marketplace. Many states, including California, Pennsylvania, Massachusetts and New York, have heard from hospitals reeling from the impact of substantial cuts.

Our hospitals desperately need some relief. But this bill undercuts New York hospitals. It contains policy changes to the Graduate Medical Education program that would take GME dollars away from New York and other states'

institutions, and redistribute it to other states. This is unfair and it is punitive, and it certainly does not belong in a bill intended to help struggling hospitals.

I hope that these damaging GME provisions will be removed as negotiations proceed with the Senate and the White House. My colleagues, we need BBA relief desperately—but it must be fair. I will oppose the bill as it is written, and will work with my colleagues to make sure this bill truly provides relief to our health care institutions.

Mr. SMITH of Washington. Mr. Speaker, I rise today in strong support of H.R. 3075, the bill to revise changes made to Medicare payments as a result of the Balanced Budget Act of 1997.

I strongly support this step forward in making the necessary adjustments to select changes made by the Balanced Budget Act. These changes called for a reduction in Medicare spending of \$116 billion over five years, but cuts have actually been closer to \$200 million, according to estimates. These reductions are primarily in Medicare reimbursement rates—the amount hospitals and health care providers are reimbursed by the Federal Government for treating Medicare patients. As a result, many health care organizations are becoming unwilling or unable to provide care to Medicare patients.

I am concerned that the Congress made in 1997 are beginning to impact seniors whose health care services are affected by the cuts. Seniors who rely on Medicare for their health care coverage are losing access to vital services. This legislation is an important first step in fixing some of the problems and help ensure that seniors are getting the health care they need.

What's more, the reimbursement rate cuts by the Balanced Budget Act disproportionately affected Washington state. Washington was one of the most efficient states with regards to waste in the Medicare program, the cuts did not properly account for the differences, and treated each state equally. This bill makes a few steps forward in address this problem.

I urge my colleagues to support this important step forward in making needed changes to our Medicare program.

Mr. BENTSEN. Mr. Speaker, I rise in strong support of H.R. 3075, a bill refining the Medicare provisions of the Balanced Budget Act of 1997. This is a good bill, and with a few corrections in conference can become an even better bill.

When the Congress passed the BBA in 1997, we were unaware of the impact the Medicare provisions would have on Medicare providers, specifically the nation's teaching hospitals. As the BBA has been implemented, the reductions in Medicare have been far greater than we had proposed or anticipated. Therefore, it is appropriate for us to revisit this provision of BBA and not allow unintended consequences to adversely affect our nation's medical education and teaching hospitals including those in my district in Texas.

I am pleased that the bill includes provisions which are similar to legislation which I have introduced as it relates to medical residency funding and allied health services funding. Specifically, the bill includes two provisions affecting the wage base for medical residents.

Earlier this year, a study conducted by the New England Journal of Medicine determined that the existing Graduate Medical Education system grossly distorted payments to medical residents in different regions of the country. For instance, the study found that residents in New York were paid seven times the rate as residents at Memorial-Hermann Hospital in my district under the old formula. The bill before us today includes a provision from legislation introduced by Mr. CARDIN of Maryland and myself to equalize such payments based upon regional wage indices.

I am also pleased that the bill includes a provision from a bill introduced by Mr. CRANE of Illinois and myself which would provide for Medicare managed care companies to pay for allied health and skilled nursing graduate medical education at our nation's teaching hospitals. Unfortunately, the bill nets out such payments at \$60 million per year from the physician portion of GME and I am hopeful that this can be corrected in conference with the Senate.

Finally, this bill corrects reductions in Indirect Medical Education funding and increases funding for Skilled Nursing Facilities. This bill also addressed problems related to the outpatient PPS for cancer hospitals by exempting such hospitals for two years and does not increase beneficiary copayments. And the bill provides a temporary two year pass through for orphan drugs, cancer drugs, and new drugs and devices which for many patients may be their only hope. The bill also makes needed corrections in the home health care provisions of the BBA and begins to address the physical and speech therapy caps. And, the bill extends coverage for immunosuppressive drugs until October 1, 2004 and increases the payment rate for pap smears, requiring the Secretary of HHS to review payment rates periodically.

Mr. Speaker, this is a good bill which with a few minor corrections in conference can become an even better bill and I urge my colleagues to support its passage.

Mr. SANDLIN. Mr. Speaker, I rise in strong support of H.R. 3075, the Medicare Balanced Budget Refinements Act. H.R. 3075 provides much needed relief for nearly all health care sectors suffering from the unintended consequences of the 1997 Balanced Budget Act. Providing this relief is a bipartisan priority and warrants no less than our immediate attention.

Health care providers in the First Congressional District of Texas have been hit exceptionally hard by the BBA changes. Medicare issues are particularly important to East Texas and other rural areas around this country. With the Medicare population making up over 18% of the rural population, rural hospitals depend more on Medicare reimbursements than their urban counterparts. I have worked hard to make sure rural health care receives the special attention it deserves in this debate. I am pleased that many of my priorities for rural health care relief were adopted by the committee in writing this bill. While the bill may not be everything I had wanted, it is certainly a first step in the right direction.

In particular, I am pleased the bill includes some rural specific provisions to help maintain access to small rural hospitals. The bill permits rural hospitals with fewer than 50 beds to

apply for grants of up to \$50,000 to meet the costs associated with implementing new prospective payment systems. The Medicare Dependent Hospital Program, established to assist small rural hospitals that are not classified as sole community hospitals and that treat relatively high proportions of Medicare patients, also is extended through fiscal year 2005 in this bill. In addition, provisions to strengthen the Critical Access Hospital Program are included as well. These hospitals are small, rural, limited service hospitals that are geographically remote, rural nonprofit, or public hospitals that are certified by states as a necessary provider. These sources of health care are critical to my constituents and will benefit from the enactment of H.R. 3075.

Mr. Speaker, while I am satisfied with many of the bill's provisions, it does not go far enough in several areas. First, H.R. 3075 does help home health care providers by delaying the 15% reduction until one year after implementation of the PPS. However, I urge my colleagues to include language in the conference bill that would continue Periodic Interim Payments to assist small agencies with cash flow problems. The other body has included language in its bill that would preserve this system for a year after imposition of the PPS. I strongly support this provision and urge its inclusion in the final bill.

I also support efforts to provide more relief for nursing homes. This bill only addresses payment problems for these facilities through a six-month fix. This is insufficient assistance and will not give nursing homes enough time to adjust to the PPS. I hope this provision will be extended in the final product as well.

Although H.R. 3075 falls short in these areas, as well as in the area of prescription drugs where there is a total lack of language to help our seniors, I believe it is essential to pass this legislation as a first step toward reform. I will continue to fight for more improvements to Medicare as we enter the new year, but I urge all of my colleagues to vote today for this overdue relief.

Mr. TERRY. Mr. Speaker, I support H.R. 3075, the Medicare Balanced Budget Refinement Act, even though I have some reservation about a few of its provisions.

When I visited my Omaha district over the past year, I frequently met with Medicare beneficiaries, hospital administrators and representatives of other health care providers. The stories and data they provided me about some of the adverse impacts of the Balanced Budget Act of 1997 (BBA), including restrictions on services to patients, were compelling.

I share the information I received during these visits with Chairman THOMAS of the Subcommittee on Health of the Ways and Means Committee. I told him that Medicare benefits must meet the needs of our growing senior population, and services provided through Medicare must be fairly reimbursed.

I am pleased that this legislation is responsive to Nebraskans' concerns. This is well-planned, comprehensive reform legislation that addresses the needs of both retirees and health care institutions involved in Medicare. It also respects the importance of maintaining Medicare's long-term financial solvency.

I do not agree with all of the provisions in this bill that affect teaching hospitals. Specifically, the Indirect Medical Education payment

freeze proposal and the per resident averaging provision for Graduate Medical Education would have a mixed impact on hospitals. Some smaller teaching hospitals will lose considerable resources they need to train our future doctors.

I also do not agree with how the Health Care Financing Administration (HCFA) has imposed restrictions on Medicare providers that have gone well beyond the requirements of the Balanced Budget Act. Restrictions adopted administratively will reduce Medicare spending by an estimated \$80 billion more over the life of the BBA than was anticipated by Congress. I have joined a number of my colleagues in protesting HCFA's over-reaching regulations.

I also believe that HCFA should be more aggressive in eliminating the billions of dollars of waste and abuse that it acknowledges occur every year. I am familiar with the practices of many private insurers headquartered in the Midwest who have used private recovery services in a successful effort to identify improper payments. HCFA use of a similar approach could save billions. As a member of the Government Reform Committee concerned about waste in government programs, I will continue to encourage HCFA to adopt more such private sector business practices, even if only on a trial basis.

Mr. Speaker, despite my reservations, I support H.R. 3075 and urge its approval.

Mr. RAMSTAD. Mr. Speaker, I rise today in strong support of this critically important legislation.

When we passed the Balanced Budget Act of 1997, we expected savings to be accrued to the system. While GAO and MedPAC report that there has been no loss in access to services for seniors, we have heard from providers across the country that some of these changes have significantly impacted providers, and that relief is necessary. Relief is particularly needed since the Administration is draining close to an additional \$100 billion out of the system—something which no Member of this House ever envisioned!

I would like to take a moment to highlight some of the important provisions included in H.R. 3075. There are a number of very important sections addressing payments to hospitals, all of which I support. I greatly appreciate the inclusion of a technical "fix" for Minnesota's Medicaid Disproportionate Share Hospital (DSH) problem and improvements to funding for graduate medical education.

Hospitals and patients will also be helped through the provisions to create an "outlier" adjustment for high-acuity patients. And, as Chair of the Medical Technology Caucus, I know hospitals and patients will benefit from the new adjusted payments for innovative medical devices, drugs and biologicals in the hospital outpatient prospective payment system.

I also support the provisions in the bill which will impact Skilled Nursing Facilities (SNF's) by addressing the costs for caring for medically-complex patients and those who need prosthetic devices, chemotherapy drugs and ambulance and emergency services. I know many therapy providers in my state appreciate the adjustments to the outpatient rehabilitation limits.

Being from Minnesota, which has experienced egregiously low payments due to our

ability to provide quality care efficiently, I am particularly supportive of the efforts in the bill to boost Medicare+Choice payments. And, until we can reform the system and significantly improve the funding formula so more Minnesotans have the opportunity to participate in Medicare+Choice, I appreciate the two year extension of the cost contract plans.

I also strongly support the provisions in the bill to ensure frail, elderly seniors will continue to enjoy the services they receive through EverCare and similar programs. EverCare is an effective health care option for the frail elderly living in nursing homes, and along with critical report language that will accompany the bill, this mention of EverCare will stand as a reminder to HCFA to make accommodations necessary for ensuring that frail elderly seniors have continued access to the special, intensive care EverCare provides.

Similarly, I support the section of the bill that extends the life of the Community Nursing Organization demonstration projects for another two years and requires the Administration to submit a comprehensive report on the effectiveness of these programs.

Lastly, I support the provisions in the bill to limit the Administration's use of the Inherent Reasonableness (IR) authority. I am hopeful they will send a strong signal to HCFA to curtail its abusive use of the authority until we have a chance to review GAO's upcoming report on it.

This bill includes significant relief that will help ensure access to care for American seniors. I strongly urge my colleagues to vote for this critically important legislation!

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise in support of H.R. 3075, the Medicare Balanced Budget Refinement Act. H.R. 3075 increase payments to Medicare providers by approximately \$11.5 billion over five years and addresses lawmaker and health care provider concerns that reforms made in the 1997 Balanced Budget Act adversely affects access to health care services for Medicare beneficiaries.

Like many of my colleagues, I have been contacted by several health care providers in my district who were concerned about the cuts in the Balanced Budget Act of 1997. Although everyone supported a balanced budget agreement, no one intended for the consequences to adversely affect the health care system.

The 1997 BBA made comprehensive reforms to Medicare that included expanding Medicare's coverage of preventive benefits; providing additional choice for seniors; implementing new tools to combat waste, fraud, and abuse; and establishing new initiatives to strengthen Medicare's fee-for-service payment system.

Although these reforms were necessary to control Medicare spending, some of the effects have resulted in providers not receiving their reimbursements in an efficient manner. This bill seeks to resolve some of these issues.

This bill provides hospitals with greater flexibility to participate in Medicare as critical access or sole community hospitals and includes a number of provisions designed to strengthen and increase flexibility for critical access hospitals. It also eases the financial burden on hospitals that care for a disproportionate share of low-income individuals.

This bill includes measures designed to ensure the availability of home care services. It also increases payments for medically complex skilled nursing facility patients and adopts a more equitable structure for direct Graduate Medical Education payments to teaching hospitals nationwide.

H.R. 3075 makes a number of changes to the Medicaid program, including authorizing states to create a new payment system for community health centers and rural clinics that recognize the cost of providing health coverage in rural and underserved areas.

I support this bill and I urge my colleagues to support it as well.

Mr. MCGOVERN. Mr. Speaker, I rise today in support of providing relief to America's home health patients, to those people living in nursing homes and those people that use our teaching and community hospitals. In 1997, I voted against the Balanced Budget Act because it would cut \$115 billion out of Medicare. However, these cuts were much worse than anticipated and they are projected to get worse.

Today we are debating H.R. 3075, a bill to give some money back to those health care delivery systems that were hit so hard by the BBA. The specifics of these cuts are staggering. Hospitals in Massachusetts are projected to lose \$1.7 billion over five years. However, almost 90% of the cuts have yet to take place. Community hospitals operating margins will decrease 42% from 1997 to 2001. This means that each hospital is reimbursed less per patient than it costs them to treat each patient. The BBA also set an arbitrary reimbursement cap for rehabilitation therapy. We have heard anecdotal stories for three years about how patients are reaching their rehabilitation caps after a few months. Once these caps are reached, the patient cannot continue to receive rehabilitation therapy that is reimbursed by Medicare. Once again, the patient suffers because of these arbitrary caps. And home health agencies are also hurt by the BBA cuts. Twenty agencies in Massachusetts have closed their doors since 1997 and are losing \$160 million annually. The end result of these cuts—the hospital, nursing home and home health cuts—is that services for patients decrease.

While I will vote for this bill, the process under which this bill has been brought to the floor disheartens me and I am distressed that the bill is so limited in scope. We should be debating the merits of this bill under the normal rules of the House, not under suspension. We should be able to debate specific amendments. For example, I introduced a bill—along with Congressmen BOB WEYGAND, TOM COBURN and VAN HILLEARY—to provide supplemental funding for home health agencies that treat outliers, or the costliest and sickest patients that can still receive home health care. Because of the way this bill was brought to the floor, this House is prohibited from debating other, meritorious BBA-fix proposals.

I am somewhat encouraged by the ability of the majority party, and in particular the Chairman of the Ways and Means Subcommittee on Health, to admit their mistakes and work to rescind some of these irresponsible Medicare cuts. However, we can do more. I urge my colleagues to vote yes for this bill but to work

the leadership of the House, the Senate and the President to provide more relief for the Medicare patients who are hurting because of these irresponsible cuts.

Mr. SHAYS. Mr. Speaker, as an original co-sponsor of H.R. 3075, the Medicare Balanced Budget Refinement Act, I rise in strong support of its passage today.

Our seniors, hospitals and providers have spoken in a loud, clear voice. Today we have the opportunity to answer their calls for relief by dedicating \$11.5 billion over the next five years to strengthening Medicare for all seniors.

The Medicare Balanced Budget Refinement Act, introduced by Representative BILL THOMAS of California, makes a number of important adjustments to the Balanced Budget Act of 1997 (BBA 97) designed to ensure seniors have access to the care they need.

H.R. 3075 eases the financial burden on hospitals that care for a disproportionate share of low-income individuals, and includes measures to ease the transition for outpatient hospitals switching to the new payment system established by BBA 97. In addition, the bill includes a number of provisions to ensure the availability of home health services, increases payments for medically complex skilled nursing facility patients, and creates separate therapy caps for physical and speech therapy on a per-facility rather than a per-beneficiary basis.

In 1997, we passed the Balanced Budget Agreement (BBA 97) which was an important first step in placing Medicare on firm financial footing while giving seniors options in how they receive care.

BBA 97 was more successful at slowing the growth of Medicare than even Congress envisioned when we passed the legislation in 1997. In 1998, the growth of Medicare spending slowed sharply, and outlays for the program actually declined by 2 percent during the first six months of fiscal year 1999—representing the first spending decrease in the program's history.

We need to pass H.R. 3075 to ensure our success in slowing the growth of Medicare does not come at the expense of our seniors' health.

Mr. Speaker, I urge my colleagues on both sides of the aisle to support H.R. 3075, a vital, common-sense piece of legislation.

Mr. ADERHOLT. Mr. Speaker, I would like to lend my support to H.R. 3075, the Medicare Balanced Budget Refinement Act. This bill represents an important first step in strengthening the long-term future of the Medicare program.

The hospitals in my district are in serious financial trouble. These hospitals, as well as all of the others in Alabama are struggling to make up shortfalls in the millions of dollars, but they refuse to compromise the quality of care they provide. The provisions of this legislation help rural hospitals, and I am supporting the bill, but it is only a first step.

Balancing the budget is important, but we need to periodically examine the effects of previous legislation. Now, the evidence is pouring in from all over the country: we need immediate relief in the form of this bill and we must take an even deeper look early next year.

Thank you Congressman THOMAS for recognizing the enormity of the consequences. Let's pass this legislation today and come back in January prepared to find a permanent solution to this health care crisis.

The SPEAKER pro tempore (Mr. LAHOOD). The question is on the motion offered by the gentleman from Texas (Mr. ARCHER) that the House suspend the rules and pass the bill, H.R. 3075, as amended.

The question was taken.

Mr. THOMAS. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 388, nays 25, not voting 20, as follows:

[Roll No. 573]

YEAS—388

Abercrombie	Chambliss	Frelinghuysen
Aderholt	Chenoweth-Hage	Frost
Allen	Clayton	Galleghy
Andrews	Clement	Ganske
Archer	Clyburn	Gejdenson
Armey	Coble	Gekas
Bachus	Coburn	Gephardt
Baird	Collins	Gibbons
Baker	Combust	Gilchrest
Baldacci	Condit	Gillmor
Baldwin	Conyers	Gilman
Ballenger	Cook	Gonzalez
Barcia	Cooksey	Goode
Barr	Costello	Goodlatte
Barrett (NE)	Cox	Goodling
Barrett (WI)	Crane	Gordon
Bartlett	Cubin	Goss
Barton	Cummings	Graham
Bass	Cunningham	Granger
Bateman	Danner	Green (TX)
Becerra	Davis (FL)	Green (WI)
Bentsen	Davis (IL)	Greenwood
Berkley	Davis (VA)	Gutierrez
Berman	Deal	Gutknecht
Berry	DeFazio	Hall (OH)
Biggert	DeGette	Hall (TX)
Bilbray	Delahunt	Hansen
Billrakis	DeLauro	Hastings (FL)
Bishop	DeLay	Hayes
Blagojevich	DeMint	Hayworth
Billey	Deutsch	Hefley
Blumenauer	Diaz-Balart	Herger
Blunt	Dicks	Hill (IN)
Boehlert	Dingell	Hill (MT)
Boehner	Dixon	Hilleary
Bonilla	Dooley	Hilliard
Bonior	Doolittle	Hinojosa
Bono	Doyle	Hobson
Borski	Dreier	Hoefel
Boswell	Duncan	Hoekstra
Boucher	Dunn	Holden
Boyd	Edwards	Holt
Brady (PA)	Ehlers	Hooley
Brady (TX)	Ehrlich	Horn
Brown (FL)	Emerson	Hostettler
Brown (OH)	English	Houghton
Bryant	Eshoo	Hoyer
Burr	Etheridge	Hulshof
Burton	Evans	Hunter
Buyer	Everett	Hutchinson
Callahan	Ewing	Hyde
Camp	Farr	Inslee
Campbell	Fattah	Isakson
Canady	Filner	Istook
Cannon	Fletcher	Jackson (IL)
Capps	Foley	Jackson-Lee
Capuano	Ford	(TX)
Cardin	Fossella	Jefferson
Carson	Fowler	Jenkins
Castle	Frank (MA)	John
Chabot	Franks (NJ)	Johnson (CT)

Johnson, E. B.	Nethercutt	Shuster
Jones (NC)	Ney	Simpson
Jones (OH)	Northup	Sisisky
Kaptur	Nussle	Skeen
Kasich	Oberstar	Skeltton
Kelly	Obey	Smith (MI)
Kildee	Olver	Smith (NJ)
Kilpatrick	Ortiz	Smith (TX)
Kind (WI)	Ose	Smith (WA)
King (NY)	Oxley	Snyder
Kingston	Packard	Souder
Kleczka	Pallone	Spence
Knollenberg	Pascrell	Spratt
Kolbe	Pastor	Stabenow
Kuykendall	Pease	Stearns
LaFalce	Pelosi	Stenholm
LaHood	Pryce (OH)	Strickland
Lampson	Peterson (MN)	Stump
Lantos	Peterson (PA)	Stupak
Largent	Petri	Sununu
Larson	Phelps	Sweeney
Latham	Pickering	Talent
LaTourette	Pickett	Tancredo
Lazio	Pitts	Tanner
Leach	Pombo	Tauscher
Lee	Pomeroy	Tauzin
Levin	Porter	Taylor (MS)
Lewis (CA)	Portman	Terry
Lewis (GA)	Price (NC)	Thomas
Lewis (KY)	Pryce (OH)	Thompson (CA)
Lipinski	Quinn	Thompson (MS)
LoBiondo	Radanovich	Thornberry
Lofgren	Rahall	Thune
Lucas (KY)	Ramstad	Thurman
Lucas (OK)	Rangel	Tiahrt
Luther	Regula	Tierney
Maloney (CT)	Reynolds	Toomey
Manzullo	Riley	Traficant
Mascara	Rivers	Turner
Matsui	Roemer	Udall (CO)
McCarthy (NY)	Rogan	Udall (NM)
McCollum	Rogers	Upton
McCrery	Rohrabacher	Velazquez
McGovern	Ros-Lehtinen	Vento
McHugh	Rothman	Visclosky
McIntosh	Roukema	Vitter
McIntyre	Roybal-Allard	Walden
McKeon	Royce	Walsh
McKinney	Rush	Wamp
McNulty	Ryan (WI)	Waters
Meeke (FL)	Ryan (KS)	Watkins
Meeke (NY)	Sabo	Watt (NC)
Menendez	Salmon	Watts (OK)
Metcalf	Sanchez	Waxman
Millerder-	Sanders	Weldon (FL)
McDonald	Sandin	Weldon (PA)
Miller (FL)	Sawyer	Weller
Miller, Gary	Saxton	Wexler
Minge	Schaffer	Weygand
Mink	Schakowsky	Whitfield
Moakley	Scott	Wicker
Moore	Sensenbrenner	Wilson
Moran (KS)	Sessions	Wise
Moran (VA)	Shadegg	Wolf
Morella	Shaw	Woolsey
Murtha	Shays	Wu
Myrick	Sherman	Wynn
Napolitano	Sherwood	Young (AK)
Neal	Shimkus	Young (FL)
	Shows	

NAYS—25

Ackerman	Kucinich	Payne
Coyne	Lowey	Sanford
Crowley	Maloney (NY)	Serrano
Doggett	Markey	Slaughter
Engel	McDermott	Stark
Forbes	Miller, George	Towns
Hinchev	Nadler	Weiner
Kennedy	Owens	
Klink	Paul	

NOT VOTING—20

Bereuter	Kanjorski	Mollohan
Calvert	Linder	Norwood
Clay	Martinez	Reyes
Cramer	McCarthy (MO)	Rodriguez
Dickey	McInnis	Scarborough
Hastings (WA)	Meehan	Taylor (NC)
Johnson, Sam	Mica	

□ 1200

Mr. KLINK and Mr. TOWNS changed their vote from "yea" to "nay."

Mr. RUSH changed his vote from "nay" to "yea."

So (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

The result of the vote was announced as above recorded.

The title of the bill was amended so as to read: "A bill to amend titles XVIII, XIX, and XXI of the Social Security Act to make corrections and refinements in the medicare, medicaid, and State children's health insurance programs, as revised by the Balanced Budget Act of 1997."

A motion to reconsider was laid on the table.

Stated for:

Ms. MCCARTHY of Missouri. Mr. Speaker, during rollcall vote No. 573, on H.R. 3075, I was unavoidably detained. Had I been present, I would have voted "yes."

Mr. MICA. Mr. Speaker, on rollcall No. 573, I was unavoidably detained. Had I been present, I would have voted "yea."

LEGISLATIVE PROGRAM

(Mr. BONIOR asked and was given permission to address the House for 1 minute.)

Mr. BONIOR. Mr. Speaker, I rise for the purpose of inquiring from the majority leader the schedule for the remainder of the week and for next week.

Mr. ARMEY. Mr. Speaker, will the gentleman yield?

Mr. BONIOR. I yield to the gentleman from Texas.

Mr. ARMEY. Mr. Speaker, I am pleased to announce that we have completed legislative business for the week. I thank all my colleagues for their hard work and patience this past week as we labored to wrap up the legislative session.

The House will next meet on Monday November 8 at 12:30 p.m. for morning hour, and at 2 o'clock p.m. for legislative business. We will consider a number of bills under suspension of the rules, a list of which will be distributed to Members' offices later today. On Monday we do not expect recorded votes until 6 o'clock p.m.

On Tuesday, November 9, the House will take up H.R. 3073, the Fathers Count Act of 1999, and H.R. 1714, the Electronic Signatures in Global National Commerce Act, both subject to a rule. We are also likely to consider a number of bills under suspension of the rules and any appropriations business ready for consideration.

Mr. Speaker, authorizing committees are hard at work wrapping up key bills with their Senate counterparts, so we expect a number of conference reports next week, including H.R. 1554, the Satellite Home Viewer Act, H.R. 100, the FAA Reauthorization Act, H.R. 1555, the Intelligence Authorization Act for Fiscal Year 2000, and H.R. 1180, the Work Incentives Improvement Act of 1999.

Mr. Speaker, the House will also pass a rule allowing suspensions on any day of the week, provided there are two hours of prior notification to the House. We will, of course, consult the minority leader should we add suspensions to Wednesday's schedule.

Mr. Speaker, we are obviously making good progress on our appropriations business. The continuing resolution passed by the Congress this week will be in effect until November 10, and we are all working hard to finish our business by that date. I will, of course, try to keep Members apprised of any scheduling changes as soon as we have that information.

Mr. Speaker, with that I want to thank the gentleman for yielding.

Mr. BONIOR. I thank my colleague for his information. We can assume late evenings until we finish, is that a relatively accurate assessment of where we are in the process, until we finish this session?

Mr. ARMEY. Yes, I think Members should understand that we will be coming back Monday night; we would be working Monday night, Tuesday, and hoping to finish on Wednesday. All the conferees on the various appropriations bills are going to be working over the weekend and working hard. So we should expect to see long days, perhaps periods where we go into recess subject to the call of the Chair.

These are frustrating times, but they are times where once the logistical work of moving paperwork and these things are fulfilled, and with any good fortune and good work and the continued cooperation across the aisle and across the long corridor, hopefully we can meet our objective to complete our work by Wednesday, sometime in the evening.

Mr. BONIOR. I thank the gentleman.

PERMISSION TO FILE CONFERENCE REPORT ON H.R. 1555, INTELLIGENCE AUTHORIZATION ACT FOR FISCAL YEAR 2000

Mr. GUTKNECHT. Mr. Speaker, I ask unanimous consent that the managers on the part of the House have until midnight tonight to file a conference report to accompany the bill, H.R. 1555, the Intelligence Authorization Act for Fiscal Year 2000.

The SPEAKER pro tempore (Mr. LAHOOD). Is there objection to the request of the gentleman from Minnesota?

There was no objection.

ADJOURNMENT TO MONDAY, NOVEMBER 8, 1999

Mr. GUTKNECHT. Mr. Speaker, I ask unanimous consent that when the House adjourns today, it adjourn to meet at 12:30 p.m. on Monday next for morning hour debates.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Minnesota?

There was no objection.

DISPENSING WITH CALENDAR WEDNESDAY BUSINESS ON WEDNESDAY NEXT

Mr. GUTKNECHT. Mr. Speaker, I ask unanimous consent that the business in order under the Calendar Wednesday rule be dispensed with on Wednesday next.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Minnesota?

There was no objection.

SPECIAL ORDERS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 1999, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

CRITICS QUESTION USEC'S REQUEST FOR \$200 MILLION

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Ohio (Mr. STRICKLAND) is recognized for 5 minutes.

Mr. STRICKLAND. Mr. Speaker, I rise today to speak about an issue that is of great importance to our Nation and I believe to our Nation's national security.

A few months ago we chose unwisely, I believe, to privatize the uranium enrichment industry, taking this from a government-owned and operated industry and turning it over to the private sector.

Now, the Government supposedly received about \$1.9 billion from the sale of this industry, but immediately after privatization, or shortly after privatization, we forced the taxpayers to spend \$325 million to keep a deal with the Russians, enabling us to bring materiel from their dismantled warheads into our country. This private industry is now asking for an additional \$200 million bailout from this Congress and from the taxpayer.

Jonathan Riskind, who writes for the Columbus Dispatch, has recently authored an article on this privatization arrangement and the request for \$200 million, and I would like to share some of the comments that were contained in Mr. Riskind's Columbus Dispatch article.

He begins by saying the Federal corporation that was created to cut the costs of running Southern Ohio's uranium enrichment plant wants a \$200 million bailout from the taxpayer. Critics, ranging from lawmakers to arms control experts, say the request is further evidence, further evidence, that officials made a bad decision in privatizing the United States Enrichment Corporation.

At its plants in Piketon, Ohio, and in Paducah, Kentucky, USEC converts