105TH CONGRESS
1st Session

COMMITTEE PRINT

S. PRT.
105–29

BUDGET RECONCILIATION RECOMMENDATIONS OF THE COMMITTEE ON FINANCE

(Spending Provisions)

AS SUBMITTED TO THE COMMITTEE ON THE BUDGET PURSUANT TO H. CON. RES. 84

COMMITTEE ON FINANCE
UNITED STATES SENATE

WILLIAM V. ROTH, JR., *Chairman*

JUNE 1997

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1997

41–420—CC

S.362-20

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-055188-9

COMMITTEE ON FINANCE

WILLIAM V. ROTH, JR., Delaware, *Chairman*

JOHN H. CHAFEE, Rhode Island
CHARLES E. GRASSLEY, Iowa
ORRIN G. HATCH, Utah
ALFONSE M. D'AMATO, New York
FRANK H. MURKOWSKI, Alaska
DON NICKLES, Oklahoma
PHIL GRAMM, Texas
TRENT LOTT, Mississippi
JAMES M. JEFFORDS, Vermont
CONNIE MACK, Florida

DANIEL PATRICK MOYNIHAN, New York
MAX BAUCUS, Montana
JOHN D. ROCKEFELLER IV, West Virginia
JOHN BREAUX, Louisiana
KENT CONRAD, North Dakota
BOB GRAHAM, Florida
CAROL MOSELEY-BRAUN, Illinois
RICHARD H. BRYAN, Nevada
J. ROBERT KERREY, Nebraska

LINDY L. PAULL, *Staff Director and Chief Counsel*
MARK A. PATTERSON, *Minority Staff Director and Chief Counsel*

PREFACE

The Congressional Budget Resolution for Fiscal Year 1998 (H. Con. Res. 84) as adopted by the full Senate on June 5, 1997 sets forth the congressional budget for the United States Government for fiscal years 1999, 2000, 2001, and 2002. The resolution also instructs Senate and House committees to develop legislation that achieves the levels of deficit reduction established by the resolution. These "budget reconciliation" recommendations of the various committees are submitted to the Committees on the Budget and assembled into a bill which is considered by each House.

H. Con. Res. 84 instructs the Committee on Finance to report reconciliation recommendations sufficient to reduce the growth in direct spending for programs within the jurisdiction of the Committee by $40.911 billion in Fiscal Year 2002, and $100.646 billion for the period of 1998 through 2002. On June 18, 1997, the Committee on Finance reported spending recommendations to the Committee on the Budget by a unanimous vote of 20 to 0.

CONTENTS

TITLE V—COMMITTEE ON FINANCE

DIVISION 1—MEDICARE

Subtitle A—Medicare Choice Program

Subtitle B—Prevention Initiatives

TITLE V—FINANCE COMMITTEE

DIVISION 1—MEDICARE

Subtitle A—Medicare Choice Program

CHAPTER 1—ESTABLISHMENT OF MEDICARE CHOICE

MEDICARE CHOICE PROGRAM

MEDICARE HEALTH PLAN OPTIONS

Present Law

Medicare beneficiaries have two basic coverage options. They may elect to obtain services through the traditional fee-for-service system under which program payments are made for each service rendered, or Medicare beneficiaries may enroll in a managed care organization that has a contract with the Health Care Financing Administration (HCFA).

There are two types of contracts: cost and risk. Under cost contracts, Medicare arranges to reimburse the organization in a different way for Medicare covered services but essentially pays the same amount as it would under the Medicare fee-for-service program. The Committee is not proposing to change the Medicare HMO cost contracting program. Therefore, the following description of current law for Medicare payments to HMOs refers only to Medicare risk contracts.

Organizations eligible to contract with HCFA on a risk basis must be organized under State laws and be either:

1. A Federally qualified health maintenance organization (HMO) as defined by section 1310(d) of the Public Health Service Act; or

2. An organization called a "competitive medical plan" (CMP) that meets the following requirements:

a. Provides at least the following services to its enrollees:

(1) Physician services;

(2) Inpatient hospital services;

(3) Laboratory, x-ray, emergency, and preventive services; and

(4) Out-of-area coverage.

b. Is compensated on a periodic, capitated basis without regard to the volume of services provided to members.

c. Physician services are provided by physicians on salary or through contracts with individual physicians or groups of physicians.

d. Assumes full financial risk on a prospective basis for the provision of health care services, except the organization may insure for:

(1) Services exceeding $5,000 per member per year;

(2) Services provided to members by providers outside the network;

(3) Not more than 90 percent of costs which exceed 115 percent of income in a fiscal year; and

(4) Make arrangements with other providers to accept all or part of the risk.

e. Meets solvency standards satisfactory to the Secretary.

For Medicare purposes, the requirements for HMOs and CMPs are essentially identical. For simplicity, the term "Medicare HMO" is used in this document to refer to both HMOs and CMPs that have Medicare risk contracts.

ELIGIBILITY

Present Law

Any person entitled to coverage under Medicare Part A and enrolled under Medicare Part B, or enrolled under Medicare Part B only, except persons with end-stage renal disease, is eligible to enroll in a Medicare HMO that serves the geographic area in which the person resides. A Medicare beneficiary developing end-stage renal disease after having enrolled in a Medicare HMO may continue enrollment in that Medicare HMO.

ELECTION AND ENROLLMENT

Present Law

Persons are automatically enrolled in the Medicare fee-for-service system when they first become eligible for Medicare. Once enrolled in the Medicare program, persons wishing to enroll in a Medicare HMO must do so directly through the Medicare HMO.

Each Medicare HMO is required to have at least a 30 day annual open enrollment period for Medicare beneficiaries. Open enrollment periods are not coordinated. Secretary may waive open enrollment under certain conditions. Medicare HMOs must accept persons on a first-come basis up to plan capacity.

DISENROLLMENT

Present Law

Medicare beneficiaries enrolled in Medicare HMOs may disenroll at any time and return to the regular Medicare program or switch to another Medicare HMO at the time of that Medicare HMO's open enrollment period.

INFORMATION

Present Law

Information on Medicare HMOs must be obtained from the Medicare HMOs directly. The Health Care Financing Administration

(HCFA) does not distribute any specific information on Medicare HMO options to Medicare beneficiaries.

Medicare HMOs are required to make available to enrollees at the time of enrollment, and at least annually thereafter, the following information:

1. The enrollee's rights to benefits from the organization;
2. The restrictions on Medicare payment for services furnished to the enrollee by other than the Medicare HMO's providers;
3. Out-of-area coverage provided by the Medicare HMO;
4. Coverage of emergency services and urgently needed care;
5. Appeal rights of enrollees; and
6. Notice that the Medicare HMO is authorized by law to terminate or refuse to renew its Medicare contract, and, therefore, may terminate or refuse to renew the enrollment of Medicare individuals.

MARKETING

Present Law

Medicare HMOs must submit any brochures, application forms, and promotional or informational material to the Secretary for approval 45 days before distribution of the material.

BENEFITS

Present Law

Medicare HMOs are required to provide all services and items covered by Part A and Part B of the Medicare program. Beneficiaries must receive all Medicare covered services from the HMO's providers, except in emergencies or unless the plan has an approved point-of-service option which allows some out of service use.

Medicare HMOs may adopt cost-sharing requirements that are different from the cost-sharing requirements in the Medicare program. However, the average total amount of cost-sharing per enrollee may not exceed the average total amount of cost-sharing per enrollee in the fee-for-service Medicare program.

Medicare HMOs may offer additional benefits. The additional benefits may be included in the basic package of benefits offered by the HMO, subject to the approval of HCFA. Or, additional supplemental benefits may be offered for an additional, separate premium payment. The same supplemental benefit options must be offered to all of the HMO's Medicare enrollees and premiums for supplemental benefits may not exceed what the Medicare HMO would have charged for the same set of services in the private market.

Medicare HMOs are required to include additional benefits in their basic benefit package to the extent that the HMO achieves a "savings" from Medicare. The "savings" is the amount by which the capitated payment from Medicare exceeds the estimated rate the HMO would charge for coverage in the private market (called the adjusted community rate, or ACR). The additional benefits may be in the form of:

1. Reduced cost sharing;
2. Expanded scope of benefits; or

3. Reduction in the premium charged to the beneficiary by the Medicare HMO.

Instead of offering additional benefits up to the full value of their "savings," Medicare HMOs may elect to have a portion of their "savings" placed in a benefit stabilization fund. This fund enables Medicare HMOs to continue to offer the same benefit package from year to year without concern about the degree of annual fluctuation in the Medicare payment amount.

BENEFICIARY PROTECTIONS AND HEALTH PLAN STANDARDS

Present Law

Quality assurance. Medicare HMOs are required to have an ongoing quality assurance program. Medicare HMOs are also required to contract with Medicare Peer Review Organizations (PROs) for external quality oversight.

Capacity and enrollment. Medicare HMOs must have at least 5,000 enrollees, unless the HMO serves a primarily rural area (specified in regulation as 1,500 enrollees).

50/50 Rule. No more than 50 percent of a Medicare HMO's enrollment may be Medicare or Medicaid beneficiaries (called the "50/50" rule). Medicare HMOs serving areas where more than 50 percent of the population qualifies for Medicare or Medicaid may receive a waiver of this rule.

Access. An HMO must make all Medicare covered services and all other services contracted for available and accessible within its service area, with reasonable promptness and in a manner that assures continuity of care. Urgent care must be available and accessible 24 hours a day and 7 days a week.

Emergency Services. Medicare HMOs must also pay for emergency services provided by nonaffiliated providers when it is not reasonable, given the circumstances, to obtain the services through the Medicare HMO.

Consumer Protections. Medicare HMOs may not disenroll or refuse to re-enroll a beneficiary because of health status or need for health care services.

Medicare HMOs must have meaningful grievance and procedures for the resolution of individual enrollee complaints. An enrollees who is dissatisfied with the outcome of the grievance procedure has the right to a hearing before the Secretary if the amount involved is greater than $100. If the amount is greater than $1,000, either the enrollee or the Medicare HMO may seek judicial review.

Medicare HMOs must also inform beneficiaries of the rights to appeal and of HCFA's appeals process.

Physician Incentive Policies. A Medicare HMO may not adopt physician compensation policies that may directly or indirectly have the effect of reducing or limiting services to a specific enrollee.

Contract Termination. A Medicare HMO terminating its contract with HCFA must arrange for supplementary coverage for its Medicare enrollees for the duration of any preexisting condition exclusion under the enrollee's successor coverage for the lesser of 6 months or the duration of the exclusion period.

If a Medicare HMO terminates its Medicare contract, other Medicare HMOs serving the same service area must hold a 30 day open

enrollment period for persons enrolled under the terminated contract.

MEDICARE PAYMENTS TO HMOS

Present Law

Medicare HMOs are paid a single monthly capitation payment issued by Medicare for each enrolled beneficiary. In order to determine appropriate payments to HMOs, two key numbers are calculated: the adjusted average per capita cost, or AAPCC, and the adjusted community rate, the ACR.

The AAPCC is Medicare's estimate of the average per capita amount it would spend for a given beneficiary (classified by certain demographic characteristics and county of residence) who obtained services on the usual fee-for-service basis. Separate AAPCCs are established for enrollees on the basis of age, disability status, and other classes determined by the Secretary (which, by regulation, includes sex, whether they are in a nursing home or other institution, and whether they are also eligible for Medicaid) and the county of their residence. These AAPCC values are calculated in four basic steps:

1. Medicare national average calendar year per capita costs are projected for the future year under consideration. These numbers are known as the U.S. per capita costs (USPCCs). USPCCs are developed separately for Parts A and B of Medicare, and for costs incurred by the aged, disabled, and those with ESRD in those two parts of the program.
2. Geographic adjustment factors that reflect the historical relationship between each county's and the Nation's per capita costs are used to convert the national average per capita costs to the county level.
3. Expected Medicare per capita costs for the county are adjusted to a fee-for-service basis by removing both reimbursement and enrollment attributable to Medicare beneficiaries in prepaid plans.
4. The recalculated county per capita cost is converted into rates that vary according to the demographic variables enumerated above: age, sex, institutional status, and Medicaid status.

For each Medicare beneficiary enrolled in a Medicare HMO, Medicare will pay the Medicare HMO 95 percent of the rate corresponding to the demographic class to which the beneficiary belongs.

The ACR is an estimate of what each Medicare HMO would charge comparable private enrollees for the set of benefits the Medicare HMO will be furnishing to Medicare beneficiaries under its contract. The starting point for this estimate is the community rate that the HMO actually charges its non-Medicare enrollees. This figure is then adjusted to reflect differences between the scope of benefits covered under Medicare and those offered under private contracts, as well as expected differences in the use of services by Medicare enrollees as compared to other HMO members. The ACR is an estimated market price for those services and may include allowances for reserve funds or profits.

The degree to which the average Medicare payment rate to a Medicare HMO exceeds the Medicare HMO's ACR is the "savings" amount available to provide additional benefits to Medicare enrollees, beyond the basic services covered by Medicare.

PREMIUMS

Present Law

Section 1876 provides for requirements relating to benefits, payment to the plans by Medicare, and payments to the plans by beneficiaries. A Medicare beneficiary enrolled in an HMO/CMP is entitled to receive all services and supplies covered under Medicare Parts A and B (or Part B only, if only enrolled in Part B). These services must be provided directly by the organization or under arrangements with the organization. Enrollees in risk-based organizations are required to receive all services from the HMO/CMP except in emergencies.

In general, HMOs/CMPs offer benefits in addition to those provided under Medicare's benefit package. In certain cases, the beneficiary has the option of selecting the additional benefits, while in other cases some or all of the supplementary benefits are mandatory.

Some entities may require members to accept additional benefits (and pay extra for them in some cases). These required additional services may be approved by the Secretary if it is determined that the provision of such additional services will not discourage enrollment in the organization by other Medicare beneficiaries.

The amount an HMO/CMP may charge for additional benefits is based on a comparison of the entity's adjusted community rate (ACR, essentially the estimated market price) for the Medicare package and the average of the Medicare per capita payment rate. A risk-based organization is required to offer "additional benefits" at no additional charge if the organization achieves a savings from Medicare. This "savings" occurs if the ACR for the Medicare package is less than the average of the per capita Medicare payment rates. The difference between the two is the amount available to pay additional benefits to enrollees. These may include types of services not covered, such as outpatient prescription drugs, or waivers of coverage limits, such as Medicare's lifetime limit on reserve days for inpatient hospital care. The organization might also waive some or all of the Medicare's cost-sharing requirements.

The entity may elect to have a portion of its "savings" placed in a benefit stabilization fund. The purpose of this fund is to permit the entity to continue to offer the same set of benefits in future years even if the revenues available to finance those benefits diminish. Any amounts not provided as additional benefits or placed in a stabilization fund would be offset by a reduction in Medicare's payment rate.

If the difference between the average Medicare payment rate and the adjusted ACR is insufficient to cover the cost of additional benefits, the HMO/CMP may charge a supplemental premium or impose additional cost-sharing charges. If, on the other hand, the HMO does not offer additional benefits equal in value to the difference between the ACR and the average Medicare payment, the

Medicare payments are reduced until the average payment is equal to the sum of the ACR and the value of the additional benefits.

For the basic Medicare covered services, premiums and the projected average amount of any other cost-sharing may not exceed what would have been paid by the average enrollee under Medicare rules if she or he had not joined the HMO. For supplementary services, premiums and projected average cost-sharing may not exceed what the HMO would have charged for the same set of services in the private market.

ORGANIZATIONAL AND FINANCIAL REQUIREMENTS

Present Law

Under section 1876 of the Social Security Act, Medicare specifies requirements to be met by an organization seeking to become a managed care contractor with Medicare. In general, these include the following: (1) the entity must be organized under the laws of the State and be a Federally qualified HMO or a competitive medical plan (CMP) which is an organization that meets specified requirements (it provides physician, inpatient, laboratory, and other services, and provides out-of-area coverage); (2) the organization is paid a predetermined amount without regard to the frequency, extent, or kind of services actually delivered to a member; (3) the entity provides physicians' services primarily through physicians who are either employees or partners of the organization or through contracts with individual physicians or physician groups; (4) the entity assumes full financial risk on a prospective basis for the provision of covered services, except that it may obtain stop-loss coverage and other insurance for catastrophic and other specified costs; and (5) the entity has made adequate protection against the risk of insolvency.

Provider Sponsored Organizations (PSOs) that are not organized under the laws of a state and are neither a Federally qualified HMO or CMP are not eligible to contract with Medicare under the risk contract program. A PSO is a term generally used to describe a cooperative venture of a group of providers who control its health service delivery and financial arrangements.

CONTRACTS, ADMINISTRATION AND ENFORCEMENT

Present Law

Contracts with Medicare HMOs are for one year, and may be made automatically renewable. However, the contract may be terminated by the Secretary at any time (after reasonable notice and opportunity for a hearing) if the organization no longer meets the requirements for Medicare HMOs. The Secretary also has authority to impose certain lesser sanctions, including suspension of enrollment or payment and imposition of civil monetary penalties. These sanctions may be applied for denial of medically necessary services, overcharging, enrollment violations, misrepresentation, failure to pay promptly for services, or employment of providers barred from Medicare participation.

The Secretary transmits to each Medicare beneficiary's selected plan a payment amount equal to the pertinent Medicare payment

amount for that individual in that payment area. Payments occur in advance and on a monthly basis.

Payments to plans are made with funds withdrawn from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The allocation from each fund is determined each year by the Secretary, based on the relative weight that benefits from each fund contribute to the determination of the Medicare payment amounts.

Reasons for Change

The existing Medicare HMO risk contracting program has enjoyed only limited success for a number of reasons. First of all, there has been no assertive effort by the Health Care Financing Administration to inform Medicare beneficiaries of the option of enrolling in a Medicare HMO and encourage them to do so.

Second, the current Medicare risk-contracting program is, for the most part, limited to closed panel health maintenance organizations and does not allow Medicare beneficiaries a choice of the full range of health plan options currently available to the non-Medicare population.

The greatest impediment to increased enrollment in Medicare HMO plans is the existing methodology for computing the amount that the Medicare program pays for enrollees in Medicare HMOs. The payments, which are the direct result of per capita spending in an area by the traditional Medicare program, vary greatly from county to county.

For example, in 1995, monthly payment amounts range across counties from $221 per month to $767 per month. Not surprisingly, most Medicare HMO activity is concentrated in high-payment areas.

Using the county as the geographic area also causes volatility of Medicare payment rates from year to year, especially in sparsely populated counties. Such unpredictable payment rates discourages HMOs from offering plans in many market areas.

Lastly, the Medicare program is not realizing any financial benefits from the enrollment of Medicare beneficiaries in private health maintenance organizations. The Medicare risk contracting program is structured so that any savings achieved by enrollment in private health plans are returned to the beneficiaries in the form of additional benefits.

Committee Provision

A new "Medicare Choice" program is created. Medicare Choice builds on the existing Medicare program which allows health maintenance organizations (HMOs) to enter into risk contracts with the Health Care Financing Administration. Under Medicare Choice, Medicare beneficiaries will have the opportunity to choose from a variety of private health plan options the health care plan that best suits their needs and preferences.

MEDICARE CHOICE PLAN OPTIONS

Medicare beneficiaries will be given the option of enrolling in the traditional fee-for-service Medicare program or enrolling in a Medicare Choice plan available in the area of their residence.

The types of health plans that may be available as Medicare Choice plans include:

(1) *Fee-for-service* indemnity health plans which pay providers on the basis of a privately determined fee schedule;

(2) *Preferred provider organizations (PPOs)* which offer enrollees the option to use providers with whom discounts have been negotiated;

(3) *Point-of-service plans (PoS)* which give beneficiaries in a coordinated care plan the option of using out-of-network providers;

(4) *Provider sponsored organization (PSOs)* plans, which are plans formed by affiliated providers and which enroll and treat beneficiaries for a capitated payment;

(5) *Health maintenance organizations (HMOs)* which are tightly closed networks of contracted or salaried providers which coordinate care and provide health services for a capitated payment;

(6) *Medical savings accounts (MSAs)* combined with high deductible health plans. (A limited option for a maximum of 100,000 Medicare beneficiaries and only from 1999 to 2002.); and

(7) Any other types of health plans that meet the standards required of Medicare Choice health plans.

ELIGIBILITY

Any person entitled to coverage under Medicare Part A and enrolled in Medicare Part B, is eligible to enroll in a Medicare Choice plan that serves the geographic area in which the person resides, except persons with end-stage renal disease (ESRD). However, a Medicare beneficiary developing end-stage renal disease after having enrolled in a Medicare Choice plan may continue enrollment in that Medicare Choice plan.

ELECTION AND ENROLLMENT

The Medicare Choice plans will be responsible for enrolling individuals. Plans must hold open enrollment during the month of November and during other specified times including when beneficiaries in the plan's area becomes newly eligible for Medicare, and when another plan's contract in the area is terminated. In addition to these specified times, plans may be open for enrollment at any other time. If an individual does not make an election upon initial enrollment, that individual will be deemed to have chosen the traditional fee-for-service Medicare plan.

Guaranteed Renewal. Medicare Choice plan sponsors may not cancel or refuse to renew a beneficiary except in cases of fraud or non-payment of premium amounts due the plan.

DISENROLLMENT

As under current law, Medicare enrollees will be able to disenroll from a Medicare Choice plan and enroll in another Medicare Choice plan or revert to the traditional Medicare program at any time. A beneficiary's disenrollment and reenrollment will become effective on the first day of the month following their notification to disenroll. There will be an exception for MSA plan holders who will only be able to enroll and disenroll in an MSA plan during the coordinated enrollment period and during certain other periods such as when a plan's contract is terminated or when the beneficiary moves out of the area served by the plan.

INFORMATION

Information to be distributed by the Secretary. The Secretary of HHS is responsible for developing informational materials that include (1) General information about Medicare choice plans and (2) information describing and comparing the Medicare Choice plans available in each area. The materials will be mailed to each Medicare beneficiary no later than 15 days prior to the annual coordinated information period. And no later than 30 days prior to a beneficiary becoming eligible for Medicare. The Secretary of HHS may contract with private organizations to develop and distribute the informational materials. The Secretary will coordinate with the States, to the extent possible, in developing and disseminating any information that is provided to beneficiaries.

General Information. The general information distributed by the Secretary will include at minimum (1) The Medicare Part B premium rate for the upcoming calendar year (paid by all Medicare beneficiaries with Part B benefits); (2) instructions on how to enroll in a Medicare choice plan; (3) enrollees' rights and responsibilities in a Medicare Choice Plan, including appeal and grievance rights; (4) notice that Medicare Choice plan sponsors are authorized by law to terminate or refuse to renew their Medicare contracts, and, therefore, may terminate or refuse to renew the enrollment of Medicare individuals.

Comparative Information. The comparative informational material distributed by the Secretary will be in a standardized chart-like format, written in the most easily understandable manner possible, and include the information described below as well as any other information the Secretary determines is necessary to assist Medicare beneficiaries in selection of a Medicare Choice plan. The Secretary will develop this information in consultation with outside organizations, including groups representing the elderly, eligible organizations under this section, providers of services, and physicians and other health care professionals. The comparative information will be of a similar level of specificity as the information distributed by the Office of Personnel Management for the Federal Employees Health Benefits Program (FEHBP).

The comparative informational materials will contain at a minimum for each plan in the area:

(1) A description of the plan's covered items and services, including those that are in addition to those provided in the government-run Medicare fee-for-service plan;

(2) Supplemental benefits offered by the plan and premiums associated with such supplemental benefits;

(3) All cost-sharing amounts including premiums, deductibles, coinsurance, or any monetary limits on benefits;

(4) Special cost sharing and balance billing rules for medical savings account plans and private fee-for-service plans;

(5) Quality indicators for the traditional Medicare program and each of the Medicare Choice plans, including disenrollment rates for the previous two fiscal years (excluding disenrollment due to death or moving outside a plan's service area) enrollee satisfaction rates, and health outcomes information;

(6) The plans' service areas;

(7) The extent to which beneficiaries may select the provider of their choice, including providers both within the network and outside the network (if the plan allows out-of-network services);

(8) An indication of beneficiaries' exposure to balance billing and the restrictions on payment for services furnished to the enrollee by other than the Medicare Choice plan's participating providers; and

(9) An overall summary description on how participating plan physicians are compensated.

MARKETING

Medicare Choice plans may prepare and distribute marketing materials and pursue marketing strategies so long as they accurately describe the benefits available from the plan in comparison to the traditional Medicare program. Marketing will be pursued in a manner not intended to violate the antidiscrimination requirements. Marketing materials will not contain false or materially misleading information, and will conform to all other applicable fair marketing and advertising standards and requirements.

Medicare Choice plan sponsors must submit any brochures, application forms, and promotional or informational material to the Secretary for review. Materials not disapproved by the Secretary within 45 days may be distributed. Marketing materials reviewed and not disapproved in one HHS regional office will be deemed approved for use in all other areas where the Medicare Choice plan is offered.

BENEFITS

Benefits and Cost-Sharing. All Medicare Choice plans, other than medical savings account plans, must offer, at a minimum, coverage for the same items and services as the traditional Medicare program. Medicare Choice plans may require cost-sharing that is different from the cost-sharing requirements in the Medicare program. However, the average total amount of cost-sharing per enrollee for Medicare covered items and services in a Medicare Choice plan may not exceed the average total amount of cost-sharing per enrollee in the traditional Medicare program. MSA plans and fee-

for-service plans will be exempted from these cost-sharing requirements.

Additional Basic Benefits. Medicare Choice plans may include additional benefits as part of their basic benefit package offered to Medicare enrollees and included in the basic premium price.

Supplemental Benefits. Medicare Choice plans may offer optional, supplemental benefits to Medicare Choice plan enrollees for an additional premium. The supplemental benefits may be marketed and sold by the Medicare Choice plan separate from the Medicare Choice enrollment process. However, if the supplemental benefits are offered only to enrollees in the sponsor's Medicare Choice plan(s) the same supplemental benefit options must be offered to all of the Medicare Choice plan sponsor's Medicare enrollees for the same premium amount.

National Coverage Determinations. If the Secretary of HHS makes a national coverage determination that will result in added costs for Medicare Choice plans, the Medicare Choice plans are not responsible for assuming responsibility for such coverage until the beginning of the next contract year. Medicare Choice plan enrollees may obtain any new benefits on a fee-for-service basis until the new coverage requirement goes into effect at the beginning of the next contract year.

Hospitalized at Time of Disenrollment. In the case of a Medicare beneficiary who is hospitalized at the time of enrollment or disenrollment from a Medicare Choice plan, responsibility for payment for the hospitalization is determined by the status of coverage at the time of admission to the hospital.

Medicare as Secondary Payor. Medicare Choice plans may recover payment for services provided to a plan enrollee which qualify for coverage under workers compensation, automobile, or other insurance policies of an enrollee.

BENEFICIARY PROTECTIONS AND HEALTH PLAN STANDARDS

Beneficiary Antidiscrimination. Medicare Choice plan sponsors may not discriminate against individuals on the basis of health status or anticipated need for health services during the enrollment, disenrollment, or provision of services.

Balance Billing. Current law balance billing restrictions will apply to all Medicare Choice plans except Medical Savings Account Plans and Fee-for-Service plans.

Information to be distributed by the Medicare Choice Plan upon enrollment.

(1) Benefits offered including exclusions from coverage;

(2) The number, mix, and distribution of participating providers;

(3) Out-of-area coverage;

(4) Optional supplemental coverage including the premium price for optional supplemental benefits;

(5) Prior authorization rules;

(6) Plan grievance and appeals procedures, including both general Medicare procedures and plan-specific procedures;

(7) Coverage of emergency services and urgently needed care;

(8) A description of the organization's quality assurance program;

(9) The organization's coverage of out-of-network services (if any); and

(10) The plan's service area.

In addition to the above material specified to be distributed by the Medicare Choice plan, all Medicare Choice plans must have available to distribute, at the request of any eligible Medicare beneficiary, the comparative and general information developed and distributed by the Secretary.

Also, at the request of a beneficiary, plans must provide information on utilization review procedures.

Access to Services and Specialists. Medicare Choice plans must make all Medicare covered services and all other services contracted for available and accessible within their service areas, with reasonable promptness and in a manner that assures continuity of care. All Medicare Choice plans must provide access to the appropriate providers, including specialists credentialed by the Medicare Choice plan sponsor, for all medically necessary treatment and services.

Emergency Services. Urgent care must be available and accessible 24 hours a day and 7 days a week. Medicare Choice plans must also pay for emergency services provided by nonaffiliated providers when a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

Post-Stabilization Guidelines. A plan must comply with guidelines to be issued by the Secretary regarding post-stabilization care. These guidelines shall provide that a provider of emergency service shall make a documented good faith effort to contact the plan in a timely fashion from the point at which the individual is stabilized to request approval for medically necessary post-stabilization care. The plan shall respond in a timely fashion with a decision as to whether the services will be authorized. If a request is denied, the plan shall, upon request from the treating physician, arrange for a physician who is authorized by the plan to review the denial to communicate directly with the treating physician.

In the case of emergency services or urgent care provided outside of the Medicare Choice plan's service area to an enrollee of a Medicare Choice plan which utilizes an integrated network of providers, the provider will accept as payment in full from the Medicare Choice plan the amount that would be payable to the provider, under the Medicare program and from the individual enrolled in Medicare, if the individual were not enrolled in the Medicare Choice plan.

Ongoing Quality Assurance Program. Each Medicare Choice plan sponsor must have arrangements for an ongoing quality assurance program, including review by an external organization. The program must:

(1) Stress health outcomes;

(2) Provide written protocols for utilization review;

(3) Provide review by physicians and other health care professionals of the process followed in the provision of health services;

(4) Monitor and evaluate high volume and high risk services;

(5) Evaluate the continuity of care enrollees receive;

(6) Have mechanisms to identify underutilization and overutilization of services;

(7) Alter practice parameters after identifying areas for improvement;

(8) Take actions to improve quality;

(9) Make available information on quality and outcomes to facilitate beneficiary comparisons;

(10) Be evaluated on an ongoing basis as to its effectiveness;

(11) Include measures of consumer satisfaction; and

(12) Provide the Secretary with such access to information collection as may be appropriate to monitor and ensure the quality of care provided under this part.

Independent Accrediting Organizations. Medicare Choice plan sponsors will be accredited for meeting quality standards established by the Secretary of HHS. Medicare Choice plans accredited by external independent accrediting organizations, recognized by the Secretary of HHS as establishing standards at least as stringent as Medicare standards, will be "deemed" accredited for Medicare purposes.

Coverage Determinations. A Medicare Choice organization would be required to make determinations regarding authorization requests for nonemergency care on a timely basis. Appeals of denials would generally have to be decided within 30 days of receiving medical information, but not later than 60 days after the coverage determination. Physicians would be the only individuals permitted to make decisions to deny coverage based on medical necessity. Appeals of determinations involving a life-threatening or emergency situation would have to be made in an expedited manner and within 72 hours of denial.

Grievance and Appeals Procedures. Medicare Choice plan sponsors must have meaningful grievance procedures for the resolution of individual enrollee complaints. An enrollee who is dissatisfied with the outcome of the grievance procedure has the right to appeal through a hearing before the Secretary if the amount involved is greater than $100. If the amount is greater than $1,000, either the enrollee or the Medicare Choice plan sponsor may seek judicial review.

Independent Review of Certain Coverage Denials. The Secretary will contract with an independent, outside entity to review and resolve reconsiderations that affirm denial of coverage.

Confidentiality and Accuracy of Enrollee Records. A plan must have procedures to maintain accurate medical records, safeguard the privacy of the individuals' records, and make these records accessible to beneficiaries.

Ability to Service Enrollment. Medicare Choice plans must demonstrate the capacity to adequately serve their expected enrollment of Medicare beneficiaries.

50/50 Rule. During 1998, Medicare Choice plans must maintain at least as many commercial enrollees at any time as Medicare en-

rollees. (Medicare Choice plans will be relieved of the requirement to maintain a commercial enrollment equal to or greater than its enrollment of both Medicare and Medicaid enrollees.) This requirement may be waived if the Secretary determines that the plan meets all other beneficiary protections and quality standards. Beginning January of 1999, the 50/50 requirement will be repealed.

Rural access. If the Medicare Choice plan restricts coverage to services provided by a network of providers, primary care services in rural areas must be available within 30 minutes or 30 miles from an enrollee's place of residence. The Secretary may make exceptions to this standard on a case-by-case basis.

Advance Directives. A Medicare Choice plan must maintain written policies and procedures respecting advance directives. Nothing in this section will be construed to require the provision of information regarding assisted suicide, euthanasia, or mercy killing.

Physician Incentive Plans. Medicare Choice plans may not operate physician incentive plans as an inducement for physicians to reduce or limit medically necessary services.

Provider Antidiscrimination. A Medicare Choice plan may not discriminate in participation, reimbursement or indemnification against a provider who is acting within the scope of his or her license or certification under applicable state law, solely based on such license or certification of the provider. This provision is not intended to prevent a plan from matching the number and type of health care providers to the needs of the plan's members or establish any other measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

PAYMENTS TO MEDICARE CHOICE ORGANIZATIONS

A Medicare payment amount will be established for each Medicare payment area (by county) within the United States. The same Medicare payment amount will apply to each Medicare beneficiary eligible for coverage within a Medicare payment area. The Medicare payment rates will be based on the current Medicare HMO payment methods with adjustments made so that the variation in Medicare payment amounts across geographic areas are reasonable.

A base Medicare payment amount will be established for each Medicare payment area. The link between traditional Medicare fee-for-service spending and the Medicare payment amounts will be broken. The base Medicare payment amount for an area will be determined through adjustments over 5 years.

Beginning in 1998, plans are to be paid the greatest of:

(1) A blended local/national rate (initially based on 1997 rates), updated by the nominal per capita growth in the gross domestic product (GDP) plus .5 percentage points;

(2) A minimum payment amount of up to 85% of the national average payment (to be determined annually depending on enrollment and other factors), for U.S. territories the minimum payment amount will equal 150% of the 1997 payment;

(3) 100 percent of the plan's 1997 payment.

Blended local/national rate. Blending of local and national rates will be phased in over five years beginning in 1998. Local rates of 90% in 1998, 80% in 1999, 70% in 2000, 60% in 2001, and 50% in

2002 will be blended with national rates of 10% in 1998, 20% in 1999, 30% in 2000, 40% in 2001, and 50% in 2002.

GME/DSH Payments. 100 percent of the amount of payments for indirect medical education, graduate medical education (GME), and disproportionate share (DSH) will be carved out of local rates over a four year period (1998–2001). Hospitals will be allowed to submit a Medicare claim for each Medicare Choice enrollee and receive the amount of medical education and DSH payments they would otherwise receive for a patient enrolled in traditional Medicare. During the first 3 years, payments will be proportionate to the amount of the carve out.

Risk Adjustment. In making payments to Medicare Choice plans on behalf of Medicare beneficiaries, the Medicare payment amount will be adjusted by the Secretary to reflect demographic and health status factors applicable to the beneficiary.

Payments to Medicare Choice plans will also be adjusted for new enrollees by 5 percent for beneficiaries in their first year of enrollment, and then 4 percent, 3 percent, 2 percent and 1 percent in their second, third, fourth, and fifth years of enrollment respectively. Payments for beneficiaries who "age-in" to a Medicare Choice plan—i.e. beneficiaries who are already enrolled in a risk plan with a Medicare Choice contract upon turning 65 would not be subjected to this adjustment if the enrollee remained with the same sponsoring organization. New Medicare Choice plans in any county where the Medicare Choice payment is below the national average Medicare Choice payment will be exempt from the new enrollee adjustment during the 12 months after they enroll their first Medicare Choice beneficiary. The new enrollee adjustment would be discontinued when the Secretary has fully implemented a risk adjustment methodology that accounts for variations in per capita costs based on health status and which has been evaluated as effective by an independent actuary of the actuarial soundness of the risk adjuster.

Encounter Data Collection. The Secretary will require Medicare Choice organizations (and risk-contract plans) to submit, for periods beginning on or after January 1, 1998, data physician visits, nursing home days, home health visits, hospital inpatient days, and rehabilitation services.

Study on Input Price Adjustments. With the Medicare Payment Advisory Commission, the Secretary shall study appropriate input price adjustments for applying national rates to local areas—including the Medicare hospital wage index and the actual case mix of a geographic region. Recommendations shall be submitted in a report to Congress.

Payment areas with highly variable rates. In the case of a Medicare Choice payment area for which the AAPCC for 1997 varies by more than 20% from such rate for 1996, the Secretary, where appropriate, could substitute for the 1997 rate a rate that is more representative of the cost of the enrollees in the area.

Request for alternate Medicare Choice payment area. Upon request of a state for a contract year (beginning after 1998) made at least 7 months before the beginning of the year, the Secretary would redefine Medicare Choice payment areas in the state to: (1) a single statewide Medicare Choice payment area; (2) a metropoli-

tan system (described in the provision); or (3) a single Medicare Choice payment area consolidating noncontiguous counties (or equivalent areas) within a state. This adjustment would be effective for payments for months beginning with January of the year following the year in which the request was received. The Secretary would be required to make an adjustment to payment areas in the state to ensure budget neutrality.

Analysis of Payment Variation. The Secretary will conduct an analysis, based on the developments in the Medicare Choice program up to December 31, 2000, of the variation in Medicare payment amounts, taking into consideration measurable input cost differences, and the degree to which Medicare Choice payment amounts have enhanced or limited beneficiary choice of health plans in areas. The Secretary would report the findings to the appropriate committees of the Congress, and the public, not later than December 31, 2002.

PREMIUMS

Annual filing by Plan. Each Medicare Choice organization would be required annually to file with the Secretary the amount of the monthly premium for coverage under each of the plans it would be offering in each payment area, and the enrollment capacity in relation to the plan in each such area.

Monthly Amount. The monthly premium charged for a plan offered in a payment area would equal 1/12 of the amount (if any) by which the premium exceeded the Medicare Choice capitation rate. The organization would have to permit monthly payment of premiums.

Uniform Plan Premium. Premiums could not vary among individuals who resided in the same payment area.

Limitation on Cost Sharing. In no case could the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled with a Medicare Choice plan with respect to required benefits exceed the actuarial value of the deductibles, coinsurance, and copayments applicable in Medicare FFS. This provision would not apply to an MSA plan or a private fee-for-service plan. If the Secretary determined that adequate data were not available to determine the actuarial value of the cost-sharing elements of the plan, the Secretary could determine the amount.

Requirement for Additional Benefits. The extent to which a Medicare Choice plan (other than a MSA plan) would have to provide additional benefits would depend on whether the plan's adjusted community rate (ACR) was lower than its average capitation payments. The ACR would mean, at the election of the Medicare Choice organization, either: (I) the rate of payment for services which the Secretary annually determined would apply to the individuals electing a Medicare Choice plan if the payment were determined under a community rating system, or (ii) the portion of the weighted aggregate premium which the Secretary annually estimated would apply to the individual but adjusted for differences between the utilization of individuals under Medicare and the utilization of other enrollees (or through another specified manner). For PSOs, the ACR could be computed using data in the general com-

mercial marketplace or (during a transition period) based on the costs incurred by the organization in providing such a plan.

If the actuarial value of the benefits under the Medicare Choice plan (as determined based upon the ACR) for individuals was less than the average of the capitation payments made to the organization for the plan at the beginning of a contract year, the organization would have to provide additional benefits in a value which was at least as much as the amount by which the capitation payment exceeded the ACR. These benefits would have to be uniform for all enrollees in a plan area. (The excess amount could, however, be lower if the organization elected to withhold some of it for a stabilization fund.) A Medicare Choice organization could provide additional benefits (over and above those required to be added as a result of the excess payment), and could impose a premium for such additional benefits. A Medicare Choice organization could not provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

Periodic Auditing. The Secretary would be required to provide annually for the auditing of the financial records (including data relating to utilization and computation of the ACR) of at least one-third of the Medicare Choice organizations offering Medicare Choice plans. The General Accounting Office would be required to monitor such auditing activities.

Prohibition of State Imposition of Premium Taxes. No state could impose a premium tax or similar tax on the premiums of Medicare Choice plans or the offering of such plans.

ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR MEDICARE CHOICE ORGANIZATIONS

State Licensure. Organizations eligible to contract with the Secretary of Health and Human Services (HHS) to offer Medicare Choice plans must be organized and licensed under state laws applicable to entities bearing risk for the provision of health services, by each state in which they wish to enroll Medicare beneficiaries.

Solvency Standards. Eligible Medicare Choice plan sponsoring organizations must meet solvency requirements satisfactory to the Secretary of HHS. Organizations licensed in states recognized by the Secretary of HHS as requiring solvency standards at least as stringent as those required by Medicare will be deemed to meet Medicare Choice plan solvency requirements.

Exceptions for Provider Sponsored Organizations (PSOs). To help facilitate the availability of Medicare Choice plans throughout the United States, a waiver process to temporarily certify PSOs to enroll Medicare beneficiaries without a state license is established.

Prior to January 1, 2001, PSOs would be granted a waiver which would allow them to contract directly with HCFA for Medicare enrollees without first obtaining a state license.

The Federal waiver would allow PSOs to circumvent the solvency requirements of the State, but other State requirements, including the State's patient protection standards, would be imposed upon the PSO through the Medicare Choice contracting process. The Secretary will enter into agreements with States to ensure adequate enforcement of State non-solvency standards. If the Secretary is notified by the State that the PSO is not in compliance, and the Sec-

retary agrees that the PSO is not in compliance, the Secretary will terminate the PSO's Medicare Choice. Before termination of contract, the PSO must be allowed 60 days to reach compliance.

A PSO's Federal waiver will be effective until the State in which the PSO is located receives Federal certification that the State's solvency requirements for PSOs are identical to the Federal government's solvency standards for PSOs.

Federal solvency standards for PSOs will be developed through a negotiated rule-making process taking into consideration risk based capital standards developed by the National Association of Insurance Commissioners. The target publishing date of the interim rule on Medicare Choice solvency requirements for PSOs is April 1, 1998. The rule will be effective immediately on an interim basis. The final rule will be published not later than April 1, 1999.

Beginning January 1, 2001, PSOs will be required to have state licenses to enroll Medicare beneficiaries.

The Secretary is required to report to Congress evaluating the temporary certification process by December 31, 1998. The report will include an analysis of state efforts to adopt regulatory standards that take into account health plan sponsors that provide services directly to enrollees through affiliated providers.

A PSO is defined as a locally, organized and operated entity that provides a substantial proportion of services directly through affiliated providers, and that is organized to deliver a spectrum of health care services. A provider is affiliated if through contract, ownership or otherwise (1) one provider, directly or indirectly, is controlled by, or is under common control with the other; (2) both providers are part of a controlled group of corporations; (3) each provider is a participant in a lawful combination under which the providers share substantial financial risk in connection with the PSO's operations; or (4) both providers are part of an affiliated service group.

Assume Full Risk. All Medicare Choice plan sponsoring organizations must assume full financial risk (except, at the election of the organization, hospice care) on a prospective basis for the provision of health care services, except the organization may insure or make arrangements for stop-loss coverage for costs exceeding an amount established by regulation and adjusted annually based on the consumer price index; services provided to members by providers outside of the organization; and for not more than 90 percent of costs which exceed 115 percent of income in a fiscal year. An organization may also make arrangements with providers to assume all or part of the risk on a prospective basis for the provision of basic health services.

Establishment of Other Standards and Interim Standards. The Secretary would be required to establish by regulation other standards for Medicare Choice organizations and plans consistent with this act. By January 1, 1998, the Secretary would be required to issue interim standards based on currently applicable standards for Medicare HMOs/CMPs. The new standards established under this provision would supersede any state law or regulation with respect to Medicare Choice plans offered by Medicare contractors to the extent that such state law or regulations was inconsistent with such standards.

CONTRACTS/ADMINISTRATION AND ENFORCEMENT

The Secretary will enter into a contract with every organization eligible to offer a Medicare Choice plan and certified by the Secretary as meeting Medicare Choice plan standards. The contracts may be made automatically renewable.

Minimum Enrollment. A Medicare Choice organization must have a minimum of 1,500 commercial enrollees, or no less than 500 commercial enrollees in rural areas. Provider sponsored organizations can include as commercial enrollees those individuals for whom the organization has assumed financial risk. This requirement will be waived for the first two years of a Medicare Choice contract.

Payments to Plans. The Secretary will transmit to each Medicare beneficiary's selected Medicare Choice plan a payment amount equal to the pertinent adjusted Medicare payment amount for that individual in that Medicare payment area. Payments will occur in advance and on a monthly basis, except in the case of an MSA plan which will be paid on an annual basis with the remainder of the premium being deposited into the holder's Medicare Choice Medical Savings Account on an annual basis. Monthly Medicare Choice payments for October 1, 2001 would be paid on the last business day of September, 2001.

Trust Fund Allocation. Payments to plans will be made with funds withdrawn from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The allocation from each fund will be determined each year by the Secretary of HHS, based on the relative weight that benefits from each fund contribute to the determination of the Medicare payment amounts.

Right to Inspect and Audit. The Medicare Choice contract will provide that the Secretary, or the Secretary's designee, will have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the contract; the facilities of the plan's sponsor; and the books and records of the plan sponsor that pertain to the ability of the sponsor to bear responsibility for potential financial losses. The Secretary will also require a Medicare Choice plan sponsor to provide notice to enrollees in the event of termination of the plan's contract and include in the notice a description of each enrollee's options for obtaining benefits.

Rate Disclosure. Each Medicare Choice plan must submit to the Secretary of HHS a table of its rates for all actuarial categories of beneficiaries prior to contract approval by the Secretary.

Risk of Insolvency. Medicare Choice plan sponsors must make adequate provision against the risk of insolvency, including provisions to prevent the plan's enrollees from being held liable to any person or entity for the plan sponsor's debts in the event of the plan sponsor's insolvency.

User Fees. The Secretary may require plans to share in the cost of disseminating information to beneficiaries.

Plan Service Areas. Medicare Choice plan service areas must correspond to Medicare payment areas. The Secretary of HHS may waive this requirement and approve service areas that are smaller

than Medicare payment areas if the Secretary determines that the service areas are not defined so as to discriminate against any population.

Beneficiary Protection upon Contract Termination. A Medicare Choice plan terminating its contract with the Secretary of HHS must arrange for supplementary coverage for its Medicare enrollees for the duration of any preexisting condition exclusion under the enrollee's successor coverage for the lesser of 6 months or the duration of the exclusion period.

Prompt Payment. Medicare Choice plan sponsors must provide prompt payment for covered items and services to providers who are not under contract with the plan. If the Medicare Choice plan sponsor does not provide prompt payment, the Secretary may pay such providers directly and deduct the payment amount from the payments made to the Medicare Choice plan.

Intermediate Sanctions. The Secretary of HHS may impose certain lesser intermediate sanctions, including suspension of enrollment or payment and imposition of civil monetary penalties. These sanctions may be applied for denial of medically necessary services, overcharging, enrollment violations, misrepresentation, failure to pay promptly for services, or employment of providers barred from Medicare participation.

Contract Termination and Due Process. A contract may be terminated by the Secretary of HHS at any time if the organization no longer meets the Medicare Choice plan requirements. Prior to terminating a contract for non-compliance on a Medicare Choice plan sponsor, the Secretary will provide the Medicare Choice plan sponsor with the opportunity to develop and implement a corrective action plan. The Secretary must also provide the Medicare Choice plan sponsor with the opportunity for a hearing, including the opportunity to appeal an initial decision, before terminating the contract.

Previous Termination. The Secretary may not enter into a contract with a Medicare Choice plan sponsor if a previous contract with the plan sponsor was terminated within the previous five years, except in circumstances that warrant special consideration.

OTHER PROVISIONS

Restrictions on Enrollment for Certain Medicare Choice Plans. A Medicare Choice religious fraternal benefit society plan could restrict enrollment to individuals who are members of the church, convention, or group with which the society is affiliated. A Medicare Choice religious fraternal benefit society plan would be a Medicare Choice plan that (i) is offered by a religious fraternal benefit society only to members of the church, convention, or affiliated group, and (ii) permits all members to enroll without regard to health status-related factors. This provision could not be construed as waiving plan requirements for financial solvency. In developing solvency standards, the Secretary would take into account open contract and assessment features characteristic of fraternal insurance certificates. Under regulations, the Secretary would provide for adjustments to payment amounts under section 1854 to assure an appropriate payment level, taking account of the actuarial characteristics of the individuals enrolled in such a plan.

A religious fraternal benefit society is an organization that (i) is exempt from Federal income taxation under section 501(c)(8) of the Internal Revenue Code; (ii) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches; (iii) offers, in addition to a Medicare Choice religious fraternal benefit society plan, at least the same level of health coverage to individuals entitled to Medicare benefits who are members of such church, convention, or group; and (iv) does not impose any limitation on membership in the society based on any health status-related factor.

TRANSITION RULES

Existing Medicare HMO risk-contract plans are pre-approved as Medicare Choice plans and have up to three years to meet any new or different standards.

The Secretary would be prohibited from entering into, renewing, or continuing any risk-sharing contract under section 1876 for any contract year beginning on or after the date Medicare Choice standards are first established for Medicare Choice organizations that are insurers or HMOs. If the organization had a contract in effect on that date, the prohibition would be effective one year later. The Secretary could not enter into, renew, or continue a risk-sharing contract for any contract year beginning on or after January 1, 2000. An individual who is enrolled in Medicare part B only and also in an organization with a risk-sharing contract on December 31, 1998 could continue enrollment in accordance with regulations issued not later than July 1, 1998.

CHAPTER 2—PROVISIONS RELATING TO MEDICARE SUPPLEMENTAL INSURANCE

PORTABILITY AND OTHER CHANGES

Present Law

1. *Medigap Portability.* Medicare beneficiaries have a 6-month open enrollment period to purchase a Medigap insurance policy when they first turn 65. During this open enrollment period, medical underwriting (i.e. requiring a beneficiary to pass a physical exam in order to be able to purchase insurance) is prohibited. After this initial 6-month open enrollment period seniors maybe unable to purchase a Medigap policy if they are forced to change their Medigap insurer or if their employer stops providing retiree health benefits.

2. *Preexisting Condition Limitations.* A 6 month pre-existing condition limitation is currently allowed during the initial open enrollment period available to beneficiaries when they first become eligible for Medicare benefits.

3. *Medigap for the Medicare Disabled.* The 6 month open enrollment period available to Medicare beneficiaries to purchase a Medigap insurance policy without any medical underwriting applies only to beneficiaries turning 65 years old.

4. *Standard Benefit Packages.* Current law requires that all Medigap policies conform with one of ten authorized standard policies. These standard policies range from very basic cost sharing

coverage to very rich cost sharing plus coverage plus coverage of extra benefits.

Reason for Change

When a Medicare beneficiary decides to leave the traditional Medicare program to try a Medicare Choice plan, they no longer need their supplemental coverage (Medigap) policy because most (if not all) Medicare Choice plans will cover the "gaps" that traditional Medicare does not cover. However, Medicare beneficiaries who want to try a Medicare Choice plan may be discouraged from doing so because once they give up their Medigap policy to enroll in a Medicare Choice plan, they may never be able to purchase that policy at the same price again if they should decide to return to traditional Medicare. This is because their guaranteed issue period expired six months after becoming eligible for Medicare at age 65.

In addition, the 10 standardized Medigap policies all include first dollar coverage which creates an incentive for over-utilization of Medicare services. A Medigap policy option with a high deductible and lower premiums may help to reduce incentives for overutilization of Medicare services.

Committee Provision

Current Medigap Laws will be amended as follows:

1. *Portability.* Medigap insurers would be required to sell a Medigap insurance policy without underwriting during a 63 day period if:

(a) an individual covered under a Medigap policy, discontinues that policy to enroll in a Medicare Choice plan or a Medicare Select plan and then decides—before the end of their first 12 months of their first enrollment—to return to the traditional Medicare program;

(b) an individual enrolls in a Medicare Choice plan upon turning 65 and then decides—before the end of their first 12 months—to disenroll and enroll in the traditional Medicare program;

(c) an individual loses their employer sponsored retiree health benefits,

(d) an individual insured by a Medigap plan, a Medicare Choice plan, or a Medicare Select plan moves outside the state in which the insurer is licensed, moves outside the plan's or the insurer's service area, or the insurer or health plan goes out of business or withdraws from the market; or has its Medicare contract terminated.

(Note. In the case of a beneficiary who previously owned a Medigap policy, that individual would not be guaranteed issued a Medigap plan with benefits which are greater than those contained in the individual's previous policy.)

2. *Pre-existing Condition Exclusions.* Medigap insurers will no longer be allowed to impose pre-existing condition exclusions during guaranteed issue periods (i.e. during first 6 months of Medicare eligibility, and during the new guaranteed issue periods listed above under portability.)

3. *Guarantee issue for the Disabled.* Provides a one time open enrollment period for disabled Medicare beneficiaries during the six month period after they first become eligible for Medicare.

4. *New Medigap High Deductible Option.* The 10 standard Medigap policies will be amended to allow an optional high deductible feature. Under this provision, a State must choose one or more of the current 10 Medigap standard policies and authorize the sale of those policies with an optional high deductible feature. The new products will be authorized to have an annual $1,500 deductible before the policy begins paying benefits.

Effective Date

January 1, 1998.

CHAPTER3—PACE PROGRAM

Present Law

OBRA 86 required the Secretary to grant waivers of certain Medicare and Medicaid requirements to not more than 10 public or non-profit private community-based organizations to provide health and long-term care services on a capitated basis to frail elderly persons at risk of institutionalization. These projects, known as the Programs of All Inclusive Care for the Elderly, or PACE projects, were intended to determine whether an earlier demonstration program, ON LOK, could be replicated across the country. OBRA 90 expanded the number of organizations eligible for waivers to 15.

Committee Provision

The provision would repeal current ON LOK and PACE project demonstration waiver authority and establish in Medicare law PACE as a permanent benefit category eligible for coverage and reimbursement under the Medicare program. PACE providers would offer comprehensive health care services to eligible individuals in accordance with a PACE program agreement and regulations. In general, PACE providers would be public or private nonprofit entities, except for entities (up to 10) participating in a demonstration to test the operation of a PACE program by private, for-profit entities.

CHAPTER 4—DEMONSTRATIONS

MEDICARE MEDICAL SAVINGS ACCOUNT DEMONSTRATION

Present Law

Medical Savings Accounts are not currently an option for Medicare beneficiaries.

Reason for Change

The intention of this act is to give Medicare beneficiaries the same choices for health care delivery as the private sector currently has, including Medical Savings Accounts. In addition, Medical Savings Accounts coupled with high-deductible insurance policies dis-

courage over-utilization of health care items and services and therefore help to slow the growth in health care spending.

Committee Provision

Medicare beneficiaries will be able to elect as a Medicare Choice option, a medical savings account high deductible insurance policy in combination with a medical savings account. The high deductible insurance policy must provide reimbursement for at least the items and services covered under Medicare Parts A and B—but only after the enrollee incurs countable expenses equal to the amount of an annual deductible of not more than $2,250 and not less than $1,500 in 1999, updated annually by an inflation factor.

To the extent an individual chooses such a plan, the Secretary of Health and Human Services would pay the premium of the high deductible insurance policy and also make an annual contribution to the beneficiary's medical savings account equal to the difference between the premium of the insurance policy and the Medicare Choice capitation rate in the beneficiary's county. Only contributions by the Secretary of Health and Human Services could be made to a Medicare Choice MSA and such contributions would not be included in the taxable income of the Medicare Choice MSA holder.

Contributions to the enrollee's MSA can be used by the enrollee to pay for any medical care they choose. Withdrawals from Medicare Choice MSAs are excludable from taxable income if used for qualified medical expenses regardless of whether an account holder is enrolled in an MSA Plan at the time of the distribution. Withdrawals for purposes other than qualified medical expenses are includable in taxable income. An additional tax of 50% of the amount includible in taxable income applies to the extent total distributions for purposes other than qualified medical expenses in a taxable year exceed the amount by which the value of the MSA (as of December 31 of the preceding taxable year) exceeds 60 percent of the MSA plan's deductible.

Any MSA plan purchased by a Medicare beneficiary must include a cap on out-of-pocket costs of $3,000.

The demonstration will be limited to the first 100,000 Medicare beneficiaries who enroll and new enrollments will not be permitted after January 1, 2003.

An exception to the enrollment and date limits listed above will be made for individuals who already have tax-deductible MSAs upon turning 65. These individuals will be permitted to retain qualified MSAs under Medicare Choice without respect to this demonstration's limit on enrollment or sunset date.

Effective Date

January 1, 1998.

COMPETITIVE PRICING DEMONSTRATION FOR MEDICARE CHOICE

Present Law

Under section 402 of the Social Security Amendments of 1967 (P.L. 90–248, 42 U.S.C. 1395b–1), the Secretary is authorized to de-

velop and engage in experiments and demonstration projects for specified purposes, including to determine whether, and if so, which changes in methods of payment or reimbursement for Medicare services, including a change to methods based on negotiated rates, would have the effect of increasing the efficiency and economy of such health services.

Reason for Change

Under the authority described above, HCFA is currently seeking to demonstrate the application of competitive pricing as a method for establishing payments for risk contract HMOs in the Denver area. HCFA's actions have been challenged in the courts.

Committee Provision

An Office of Competition would be established within the Department of Health of Human Services to negotiate with plans and administer the competitive pricing process.

Plans would submit a premium amount based on core benefit package which must include benefits currently provided under Medicare A & B plus prescription drugs. The Office of Competition would calculate the weighted average premium—90% would be paid by Medicare and 10% by the enrollee. Plans would be allowed to offer two standardized supplemental benefit packages to be included in the comparative information given to beneficiaries.

The Secretary must establish a technical advisory group in each demonstration site that includes plan representatives, beneficiaries, employers and providers. The Secretary must meet with the technical advisory group at least monthly beginning six months prior to the demonstration and regularly throughout the implementation period.

Standardized Medicare payment amount (government contribution)

Not later than June 1 of each year, the Office of Competition would solicit premium bids on a core package of standardized benefits.

The government contribution would be set at the weighted average of the premium bids. The Office of Competition would have the authority to negotiate with plans to adjust their premium bids to ensure that the standardized Medicare payment amount would never be greater than per capita fee- for-service spending in that area.

The Office of Competition would negotiate with plans to ensure that premiums are actuarially sound and fair and do not foster adverse selection.

The standardized Medicare payment amount would be adjusted upward or downward at the time the beneficiary enrolls in the plan according to their health status. The beneficiary's share of the premium would be based on the standardized Medicare payment amount regardless of the risk adjustment made to the amount the plan is paid.

Enrollees cost-sharing

Beneficiaries would be required to pay a minimum of 10% of the premium. If seniors choose a plan that costs less than the standardized Medicare payment amount, their premium will be lower. If seniors choose a plan that costs more than the federal payment, they will have to pay the difference.

Transition/Phase-in

Beginning on January 1, 1999, this competitive pricing model would be tested as a demonstration in 10 urban areas with less than 25% Medicare HMO penetration and 3 rural markets. By December 31, 2001, the Secretary will evaluate the demonstration project. The President will make a legislative recommendation to Congress on whether the method of paying plans as tested in the demonstration project should be extended to the entire Medicare population.

Effective Date

Payment under the demonstration will begin on January 1, 1999. The demonstration will last no longer than December 31, 2002. The Office of Competition will be established upon enactment.

MEDICARE ENROLLMENT DEMONSTRATION

Present Law

HMOs with Medicare contracts may directly market to and enroll Medicare beneficiaries.

Reason for Change

There is some evidence that allowing plans to conduct their own enrollment operations may lead to greater risk selection (i.e. "cherry picking" healthier beneficiaries). One possible solution to this would be to require all beneficiaries to enroll through HCFA. However a preferred option would be to requiring plans to contract with a private third party enroller approved by the Secretary.

Committee Provision

The Secretary is authorized to conduct a demonstration for using a third-party contractor to conduct the Medicare Choice plan enrollment and disenrollment functions in an area. Such demonstration shall be conducted separately from the Medicare competitive pricing demonstrations. In conducting the demonstrations the Secretary must:

1. Consult with affected parties on the design of the demonstration, selection criteria for the third party contractor, and the establishment of performance standards
2. Establish performance standards relative to accuracy and timeliness. Should the third-party broker not comply with these standards, the enrollment and disenrollment functions would immediately revert to the Medicare Choice plans.
3. In the case of a dispute between the Secretary and the Medicare Choice plans in the demonstration regarding compli-

ance with the standards, the plans shall conduct these functions.

EXTENSION AND EXPANSION OF SOCIAL HMO DEMONSTRATION

Present Law

The Deficit Reduction Act of 1984 required the Secretary to grant 3-year waivers for demonstrations of social health maintenance organizations (SHMOs) which provide integrated health and long-term care services on a prepaid capitation basis. The waivers have been extended on several occasions since then and a second generation of projects was authorized by OBRA 90.

Committee Provision

The provision would require the Secretary to extend waivers for SHMOs through December 31, 2000, and to submit a final report on the projects by March 31, 2001. The limit on the number of persons served per site would be expanded from 12,000 to 36,000. The Secretary also would be required to submit to Congress by January 1, 1999, a plan, including an appropriate transition, for the integration of health plans offered by first and second generation SHMOs and similar plans into the Medicare Choice program. The report on the plan would be required to include recommendations on appropriate payment levels for SHMO plans, including an analysis of the extent to which it is appropriate to apply the Medicare Choice risk adjustment factors to SHMO populations.

COMMUNITY NURSING ORGANIZATION DEMONSTRATION PROJECTS

Present Law

OBRA 87 required the Secretary to conduct demonstration projects to test a prepaid capitated, nurse-managed system of care. Covered services include home health care, durable medical equipment, and certain ambulatory care services. Four sites (Mahomet, Illinois; Tucson, Arizona; New York, New York; and St. Paul, Minnesota) were awarded contracts in September, 1992, and represent a mix of urban and rural sites and different types of health provider, including a home health agency, a hospital-based system, and a large multi-specialty clinic. The community nursing organization (CNO) sites completed development activities and implemented the demonstration in January 1994, with service delivery beginning February 1994.

Committee Provision

The provision would extend the CNO demonstration for an additional period of 2 years, and the deadline for the report on the results of the demonstration would be not later than 6 months before the end of the extension.

MEDICARE COORDINATED CARE DEMONSTRATION

Present Law

No provision.

Reason for Change

A study sponsored by the Physician Payment Review Commission (PPRC) concluded that "an effective case management program could help Medicare patients who are chronically ill or who are facing costly, complex treatment options. Based on experience of private payers, these Medicare patients would receive more appropriate medical care and Medicare would experience lower claims cost relative to the current program, which lacks a coordination of care function."

Committee Provision

The Secretary would be required to establish a demonstration program to evaluate methods such as case management and other models of coordinated care that improve the quality of care and reduce Medicare expenditures for beneficiaries with chronic illnesses enrolled in traditional Medicare.

The Secretary would be required to examine best practices in the private sector for coordinating care for individuals with chronic illnesses for one year and, using the results of the evaluation, establish at least nine demonstration projects (6 urban and 3 rural) within 24 months of the date of enactment.

Not later than two years after implementation, the Secretary would be required to evaluate the demonstrations and submit a report to Congress. The evaluation would have to address, at a minimum, the cost-effectiveness of the demonstration projects, quality of care received by beneficiaries, beneficiary satisfaction, and provider satisfaction. If the evaluation showed the demonstration project to either reduce Medicare expenditures or to not increase Medicare expenditures while increasing the quality of care received by beneficiaries and increasing beneficiary satisfaction, the Secretary would continue the project in the demonstration sites, and could expand the number of demonstration sites to implement the program nationally. The Secretary would be required to submit a report to Congress every two years for as long as the demonstration project continued.

In carrying out the demonstration projects, the Secretary would be required to provide that the aggregate payments in Medicare be no greater than what such payments would have been if the demonstration projects had not been implemented. Such sums as necessary would be authorized to be appropriated for the purpose of evaluating and reporting on the demonstrations.

MEDICARE SUBVENTION DEMONSTRATION PROJECT

Present Law

Under current law, Medicare is prohibited from reimbursing for any services provided by a Federal health care provider, unless the provider is determined by the Secretary of Health and Human Services to be providing services to the public generally as a community institution or agency or is operated by the Indian Health Service. In addition, Medicare is prohibited from making payment to any Federal health care provider who is obligated by law or contract to render services at the public expense.

Reasons for Change

The Committee provision is intended to provide for greater access by Medicare-eligible military retirees to military treatment facilities (MTFs) operated by the Department of Defense, and greater access by veterans to medical centers operated by the Department of Veterans Affairs.

Committee Provision

The Committee provision would establish two, three-year demonstration projects under which Medicare would reimburse the Department of Defense and the Department of Veterans Affairs for medical care provided to Medicare-eligible military retirees and veterans, respectively. The Secretary of Health and Human Services would enter into agreements with the Secretary of Defense and the Secretary of Veterans Affairs on the specifications of each demonstration project; these agreements would be transmitted to Congress prior to operation of the demonstration projects. Both demonstration projects permit Medicare payment for services on a fee-for-service basis and as a capitated payment for services provided in managed care organizations operated by each department. The Medicare outlays for both demonstrations are capped, and both departments would be required to maintain current levels of efforts.

Effective Date

January 1, 1998.

CHAPTER 5: COMMISSIONS

ESTABLISHMENT OF THE NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE

Present Law

No provision.

Reasons for Change

In 1995, expenditures out of the Hospital Insurance (HI or Part A) Trust Fund exceeded all sources of revenues into the Trust Fund. The Medicare Trustees predict in their 1997 annual report that in 2001 Medicare will out-spend its revenues and spend down its current surplus, becoming insolvent with a $23.4 billion shortfall. This shortfall grows rapidly to over *one half trillion dollars* in 2007. And, this is before the baby-boomers begin to retire in 2010.

In the long-term, demographic trends will continue to increase financial pressure on the HI Trust Fund, challenging its ability to maintain our promise to beneficiaries. Today, there are less than 40 million Americans who qualify to receive Medicare. By the year 2010, the number will be approaching 50 million, and by 2020, it will be over 60 million. While these numbers are increasing, the number of workers supporting retirees will decrease. Today, there are almost four workers per retiree, but in 2030 there will be only about two per retiree.

The National Bipartisan Commission on the Future of Medicare will serve as an essential catalyst, and ultimately lead to a solution that will preserve and protect the Medicare program for current beneficiaries, their children, grandchildren, and great-grandchildren.

Committee Provision

The National Bipartisan Commission on the Future of Medicare will be established to:

1. review and analyze the long-term financial condition of both Medicare Trust Funds;
2. identify problems that threaten the financial integrity of both the Hospital Insurance (HI) and the Supplementary Medical Insurance (SMI) Trust Funds;
3. analyze potential solutions that ensure the financial integrity and the provision of appropriate benefits including the extent to which current Medicare update indexes do not accurately reflect inflation;
4. make recommendations to restore solvency of the HI Trust Fund and the financial integrity of the SMI Trust Fund through the year 2030;
5. make recommendations for establishing the appropriate financial structure of the program as a whole;
6. make recommendations for establishing the appropriate balance of benefits covered and beneficiary contributions;
7. make recommendations for the time periods during which the Commission's recommendations should be implemented;
8. make recommendations regarding the financing of graduate medical education (GME), including consideration of alternative broad-based sources of funding for such education and funding for institutions not currently eligible for Medicare GME support that conduct approved graduate medical residencies, such as children's hospitals;
9. make recommendations on the feasibility of allowing individuals between the age of 62 and Medicare eligibility age to buy into the Medicare program; and
10. make recommendations on the impact of chronic disease and disability trends on future costs and quality of services under the current benefit, financing, and delivery system structure of the Medicare program.

The Commission will consist of 15 members, appointed in the following manner:

3 by the President;

6 by the House of Representatives (not more than 4 from the same political party);

6 by the Senate (not more than 4 from the same political party); and

the Chairman will be designated by the joint agreement of the Speaker of the House of Representatives and the Majority Leader of the Senate.

Members of the Commission may be appointed from both the public and private sector.

The Commission must submit a report to the President and Congress no later than 12 months from the date of enactment.

The Commission terminates 30 days after the report is submitted.

Funding is authorized to be appropriated from both Medicare Trust Funds.

Effective Date

Upon enactment.

MEDICARE PAYMENT REVIEW COMMISSION

Current Law

The Prospective Payment Assessment Commission was established by Congress through the Social Security Act Amendments of 1983 (P.L. 98–21). The Commission is charged with reporting each year its recommendation of an update factor for PPS payment rates and for other changes in reimbursement policy. It is also required each year to submit a report to Congress which provides background information on trends in health care delivery and financing. The Physician Payment Review Commission was established by the Congress through the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99–272). It was charged with advising and making recommendations to the Congress on methods to reform payment to physicians under the Medicare program. In subsequent laws, Congress mandated additional responsibilities relating to the Medicare and Medicaid programs as well as the health care system more generally.

The law specified that both Commissions were to be appointed by the Director of the Office of Technology Assessment and funded through appropriations from the Medicare trust funds. In 1995, the Office of Technology Assessment was abolished. In May 1997, P.L.105–13 was enacted; this legislation extended the terms of those Commission members whose terms were slated to expire in 1997 to May 1, 1998.

Reason for Change

Both the ProPAC, which is responsible for hospital and health facilities payment policy, and the PPRC, which is responsible for physician payment policy and other Part B issues, have assumed critically important roles in assisting Congress with oversight and policy making for the Medicare program. However, with fee-for-service payment policy becoming relatively mature after years of refinement, Congress will require guidance in the future primarily in the Medicare Choice area. This area will require evaluation and oversight best suited for a single commission which can view the Medicare program in terms of an integrated totality between Parts A and B.

Committee Provision

The Medicare Payment Review Commission will be formed to replace the Physician Payment Review Commission and the Prospective Payment Assessment Commission. The new Medicare Payment Review Commission (MPRC) will submit an annual report to Con-

gress containing an examination of issues affecting the Medicare program.

The Commission will review, and make recommendations to Congress concerning, payment policies under both the Medicare Choice program and the Medicare fee-for-service program.

Membership

The Commission will be composed of 15 members appointed by the Comptroller General. The members will include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of services, and other related fields. The membership will also include representatives of consumers and the elderly.

TAX TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS

Present Law

To qualify as a charitable tax-exempt organization described in Internal Revenue Code (the "Code") section 501(c)(3), and organization must be organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster international sports competition, or for the prevention of cruelty to children or animals. Although section 501(c)(3) does not specifically mention furnishing medical care and operating a nonprofit hospital, such activities have long been considered to further charitable purposes, provided that the organization benefits the community as a whole.

No part of the net earnings of a 501(c)(3) organization may inure to the benefit of any private shareholder or individual. No substantial part of the activities of a 501(c)(3) organization may consist of carrying on propaganda, or otherwise attempting to influence legislation, and such organization may not participate in, or intervene in, any political campaign on behalf of (or in opposition to) any candidate for public office. In addition, under section 501(m), an organization described in section 501(c)(3) or 501(c)(4) is exempt from tax only if no substantial part of its activities consists of providing commercial-type insurance.

A tax-exempt organization may, subject to certain limitations, enter into a joint venture or partnership with a for-profit organization without affecting its tax-exempt status. Under current ruling practice, the IRS examines the facts and circumstances of each arrangement to determine (1) whether the venture itself and the participation of the tax-exempt organization therein furthers a charitable purpose, and (2) whether the sharing of profits and losses or other aspects of the arrangement entail improper private inurement or more than incidental private benefit.

Committee Provision

The proposal would provide that an organization shall not fail to be treated as organized and operated exclusively for a charitable purpose for purposes of Code section 501(c)(3) solely because a hos-

pital which is owned and operated by such organization participates in a provider-sponsored organization ("PSO") (as defined in section 1845(a)(1) of the Social Security Act), whether or not such PSO is exempt from tax. Thus, participation by a hospital in a PSO (whether taxable or tax-exempt) would be deemed to satisfy the first part of the inquiry under current IRS ruling practice.

The proposal would not change present-law restrictions on private inurement and private benefit. However, the proposal would provide that any person with a material financial interest in such a PSO shall be treated as a private shareholder or individual with respect to the hospital for purposes of applying the private inurement prohibition in Code section 501(c)(3). Accordingly, the facts and circumstances of each PSO arrangement would be evaluated to determine whether the arrangement entails impermissible private inurement or more than incidental private benefit (e.g., where there is a disproportionate allocation of profits and losses to the non-exempt partners, the tax-exempt partner provides property or services to the joint venture at less than fair market value, or a non-exempt partner receives more than reasonable compensation for the sale of property or services to the joint venture).

The proposal would not change present-law restrictions on lobbying and political activities. In addition, restrictions of Code section 501(m) on the provision of commercial-type insurance would continue to apply.

Subtitle B—Prevention Initiatives

ENHANCED COVERAGE FOR MAMMOGRAPHY SERVICES

Present Law

Under current law, Medicare provides coverage for screening mammograms. The frequency of coverage depends on the age and risk factors of the woman. For women ages 35–39, one test is authorized. For women ages 40–49, one mammogram is covered every 24 months, except an annual test is authorized for women at high risk for breast cancer. Annual mammograms are covered for women ages 50–64. For women aged 65 and over, Medicare covers one mammogram every 24 months. Medicare's Part B deductible and Part B coinsurance apply for these services.

Reasons for Change

The Committee provision would expand Medicare's coverage rules for mammograms.

Committee Provision

The Committee provision would authorize annual mammograms for all women ages 40 and over, and waive co-insurance payments for beneficiaries.

Effective Date

January 1, 1998.

NEW COVERAGE FOR COLORECTAL SCREENING

Present Law

Medicare does not cover colorectal cancer screening procedures. Such services are only covered as diagnostic services.

Reasons for Change

The Committee proposal would establish a new screening benefit for Medicare beneficiaries.

Committee Provision

The Committee provision would authorize coverage of colorectal cancer screening tests, and provide the Secretary, after consultation with appropriate organizations, to determine which screening procedures shall be reimbursed, payment amounts or limits for each procedure, and the frequency of each procedure, with consideration for risk factors. The Committee provision would direct the Secretary to promulgate the regulation three months following date of enactment. The Committee notes the Administration's Medicare reform proposal contained a provision to provide coverage of preventive colorectal screening. The Committee expects that this provision will be implemented expeditiously.

Effective Date

January 1, 1998.

DIABETES SELF-MANAGEMENT BENEFIT

Present Law

Medicare covers home blood glucose monitors and associated testing strips for certain diabetes patients. Home blood glucose monitors enable diabetics to measure their blood glucose levels and then alter their diets or insulin dosages to ensure that they are maintaining an adequate blood glucose level. Home glucose monitors and testing strips are covered under Medicare's durable medical equipment benefit. Coverage of home blood glucose monitors is currently limited to certain diabetics, formerly referred to as Type I diabetics, where: (1) the patient is an insulin-treated diabetic; (2) the patient is capable of being trained to use the monitor in an appropriate manner, or, in some cases, another responsible person is capable of being trained to use the equipment and monitor the patient to assure that the intended effect is achieved; and (3) the device is designed for home rather than clinical use.

Reasons for Change

The Committee provision provides for improved diabetes management benefits.

Committee Provision

The Committee provision would include among Medicare's covered benefits diabetes outpatient self-management training services. These services would include educational and training services

furnished to an individual with diabetes by or under arrangements with a certified provider in an outpatient setting meeting certain quality standards. These services would be covered only if the physician who is managing the individual's diabetic condition certifies that the services are needed under a comprehensive plan of care to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual's condition.

Certified providers for these purposes would be defined as physicians or other individuals or entities that, in addition to providing diabetes outpatient self-management training services, provide other items or services reimbursed by Medicare. Providers would have to meet quality standards established by the Secretary. They would be deemed to have met the Secretary's standards if they meet standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards of the Board, or if they are recognized by an organization representing persons with diabetes as meeting standards for furnishing such services.

In establishing payment amounts for diabetes outpatient self-management training provided by physicians and determining the relative value for these services, the Secretary would be required to consult with appropriate organizations, including organizations representing persons or Medicare beneficiaries with diabetes.

In addition, the provision would extend Medicare coverage of blood glucose monitors and testing strips to Type II diabetics and without regard to a person's use of insulin (as determined under standards established by the Secretary in consultation with appropriate organizations). The provision would also reduce the national payment limit for testing strips by 10 percent beginning in 1998.

The Secretary, in consultation with appropriate organizations, would be required to establish outcome measures for purposes of evaluating the improvement of the health status of Medicare beneficiaries with diabetes. The Secretary would also be required to submit recommendations to Congress from time to time on modifications to coverage of services for these beneficiaries.

Effective Date

January 1, 1998.

COVERAGE OF BONE MASS MEASUREMENTS

Present Law

Medicare does not have a uniform national policy for coverage of bone mass measurement.

Reason for Change

Many Medicare coverage decisions are made locally by individual carriers, that is, contractors to the Medicare program who process claims for payment for Part B items and services. There is no consistent national policy regarding payment for bone mass measurement. Early detection of bone mass loss is important for women at high risk of developing osteoporosis.

Committee Provision

The Committee provision would authorize coverage of bone mass measurement for the following high-risk individuals: an estrogen-deficient woman at clinical risk for osteoporosis; an individual with vertebral abnormalities; an individual receiving long-term glucocorticoid steroid therapy, an individual with primary hyperparathyroidism, and an individual being monitored to assess osteoporosis drug therapy.

Effective Date

January 1, 1998.

Subtitle C—Rural Initiatives

Present Law

The Medicare program includes a number of provisions to help rural seniors receive health services and for Medicare to pay fairly in rural areas.

Athough the standardized amount under the Medicare Prospective Payment System (PPS) paid to hospitals is the same whether they are rural or urban, there are adjustments to that base payment that are lower for rural areas reflecting the lower cost of health care in rural America. The wage index, for example, in a rural area is often significantly lower than in an urban area.

Certain rural hospitals do receive improved payments over other rural hospitals, or, they can also have greater flexibility than urban hospitals in their delivery of care. The following are some of the special rural hospital designations:

1. Sole Community Hospitals (SCH): geographically isolated hospitals that represent the only readily available source of inpatient care in an area. SCHs are paid the highest of three amounts: (1) payment based on hospital-specific costs in 1982, updated to the current year; (2) payment based on hospital-specific costs in 1987, updated to the current year; or (3) the PPS payment for the hospital. About 60% of SCHs currently receive payment based on their hospital-specific base year costs (about 728 hospitals are SCHs).

2. (Expired provision) Small rural Medicare Dependent hospitals (MDHs): the designation of Medicare dependent, small rural hospitals expired on September 30, 1994. These hospitals were reimbursed on the same basis as sole community hospitals. MDHs were hospitals with 100 beds or less located in a rural area and that had more that 60% of its inpatient days attributable to Medicare (in FY 1994, about 390 hospitals were MDHs). Since the provision expired, these hospitals have been receiving PPS payments.

3. Rural Referral Centers (RRCs): relatively large rural hospitals with at least 275 beds or that meet specific criteria indicating that they receive a high referral from other hospitals. (about 130 hospitals are designated RRCs).

4. Limited-Service Hospitals: under current law, there are several demonstration projects that are in place allowing hospitals in rural communities greater flexibility in delivering

care. There is also a grant program to help states coordinate the type of care delivered among limited service hospitals.

a. Rural Health Care Transition Act: up to $50,000 per year available to nonprofit acute care hospitals in rural areas with less than 100 beds. The grants can be used for improvement of outpatient or emergency services, recruitment of health professionals, or development of alternative delivery systems (the program is extended through FY 1997. In FY 1995, grants were made to 129 facilities in 44 states).

b. Medical Assistance Facility (MAF) Demonstration: only in the State of Montana, a category of facilities in remote rural areas that do not qualify as full-service hospitals but provide emergency services and short-term inpatient care. Funding is through July 1, 2000.

c. Essential Access Community Hospitals Demonstration Projects (EACH/RPCH): Provides $25 million per year in grants to establish rural networks for EACH/RPCHs. RPCHs are facilities in rural areas that do not qualify as full-service hospitals but provide temporary inpatient care to patients requiring stabilization prior to discharge or transfer to another hospital. EACHs provide emergency and medical backup services to RPCHs participating in the network (7 states: WV, CA, CO, KS, NY, NC, and SD are participating in the demonstration program).

5. Rural Health Clinics (RHCs). The RHC program provides Medicare and Medicaid reimbursement to health clinics in underserved rural communities. Medicare reimburses RHCs on the basis of their actual costs for providing care. Once certified as an RHC, a clinic remains eligible for cost reimbursement indefinitely, even if the area it serves no longer qualifies as rural or underserved.

6. Telemedicine. Under a Health Care Financing Administration (HCFA) demonstration, Medicare began reimbursing telemedicine services in 1996 at five sites in four states—North Carolina, West Virginia, Iowa and Georgia. HCFA is analyzing the demonstration to determine which telemedicine services should be covered and how. Outside of the demonstration project, Medicare reimburses only for certain physician services. HCFA does not have the authority to reimburse all physician consultations made with the use of telemedicine. Medicare requires a face-to-face encounter in order to cover consultation services, unless standard medical practice does not require face-to-face contact as in the case of radiology.

Reasons for Change

Rural providers are often financially dependent on Medicare payments. The provisions assist rural areas to continue to provide high quality, cost effective access to health services.

Since the Medicare physician fee schedules were established in 1989, the number of clinics participating in the RHC program has grown by over 30 percent a year to nearly 3,000. According to a November, 1996 Government Accounting Office (GAO) report, contrary to its original purpose, the RHC program is generally not focused on serving Medicare and Medicaid populations having dif-

ficulty obtaining primary care in isolated rural areas. Rather, the payments are being provided to RHCs that are financially viable clinics in suburban areas. Most RHCs are conversions of existing physician practices that generally do not need the RHC program payments to expand care to underserved portions of the area's population. According to GAO, at many of the RHCs, their providers receive extraordinarily high reimbursement for patient visits, as much as $214 for each patient visit at one clinic compared with an average of $37 received by providers on the Medicare fee schedule.

Committee Provision

The following rural provisions are included in the Chairman's Mark:

1. A fourth reimbursement option is made available to Sole Community Providers; it allows SCHs to choose an alternative target amount based on costs in FY 1994 or FY 1995.

2. The Medicare Dependent Hospital (MDH) program will be reinstated effective for cost reporting periods on or after October 1, 1997. The same program with the expired provisions setting out the criteria of rural hospitals with 100 or less beds and 60 percent of discharges or patient days will be used to identify eligible hospitals. MDHs will receive Medicare payment based on the expired provisions payment arrangement.

3. A new Medicare rural hospital flexibility program will be available to all states. (a) $25 million per year in FY 1998–2002 is authorized for grants available to states seeking to establish a network of access to health care services in rural communities. (b) The provision also creates a new single designation for small rural limited-service hospitals known as Critical Access Hospitals (CAHs). These hospitals must be state certified, more than 35 miles from another hospital, make available 24 hour emergency care services, and can have up to 15 acute care inpatient beds (swing beds are permitted) for providing care not to exceed 96 hours (unless inclement weather or other emergency conditions).

Payment for inpatient and outpatient services provided at CAHs will be made on the basis of reasonable costs of providing such services. Such payment will also continue for designated EACH, RPCH hospitals in effect on September 30, 1997, as well as for the MAF demonstration program.

4. Rural Referral Centers (RRCs) can apply to the Medicare Geographic Classification Review Board to be reclassified for purposes of a wage index adjustment. RRCs could apply without having to meet the wage threshold requiring that the hospital's average hourly wage (AHW) is at least 108% of the statewide rural AHW. The Secretary shall make the adjustment required to allow the change in wage indexes to occur in a budget neutral manner. In addition, any hospital designated as a RRC since fiscal year 1991 is permanently grandfathered.

5. Rural Health Clinics (RHCs). (a) Extends per-visit payment limits applicable to independent rural health clinics to provider-based clinic (with the exception of clinics based in small rural hospitals with less than 50 beds). (b) Requires clinics have a quality assurance and performance program as spec-

ified by the Secretary. (c) Limits the nurse practitioner/physician assistant (NP/PA) waiver to clinics already certified as RHCs. Clinics seeking initial certification will be required to meet the NP/PA staffing requirement. (d) Requires triennial recertification of RHCs: (i) the Secretary must certify that there are insufficient numbers of needed health care practitioners in the clinic's area; (ii) clinics that no longer meet the shortage area requirement will be permitted to retain their designation only if the Secretary determines that they are essential to the delivery of primary care services that would otherwise be unavailable in the area; and (iii) rural health clinics currently owned and operated by PA's will be grandfathered through 2002.

6. Medicare reimbursement for telehealth services in underserved rural areas.

a. The provision requires HCFA to reimburse for telehealth services in underserved rural areas, using the health professional shortage area (HPSA) designation. Reimbursement methodology would (i) provide a bundled payment to be shared between the referring and consulting health care provider that would be no greater than the standard amount paid to the consulting health care provider according to HCFA's current fee schedule for face-to-face encounters, and (ii) prohibit any reimbursement for line charges or other facility fees. The Secretary would also be required to study the possibility for reimbursement for homebound or nursing home-bound seniors.

b. The provision also authorizes $27 million for a 5-year telemedicine demonstration project for high-capacity computing and advanced networks.

The Committee is concerned that HCFA is not fully utilizing existing HCFA telemedicine demonstration projects. The Committee intends that HCFA provide full Medicare payments to all sites and providers affiliated with existing HCFA demonstration projects, regardless of whether the telemedicine equipment at those sites was purchased with HCFA funds or from other federal, state, or private funds.

The Committee is also concerned that the current Medicare telemedicine demonstration does not include rural sites in the Western United States. Therefore, the Committee strongly recommends HCFA extend the demonstration to at least three additional sites located in rural regions of the Western United States. HCFA should use all sites and providers affiliated with the demonstration as well as other willing telemedicine providers within all participating states. To get a cross-sampling of rural Western sites, the following criteria should be met:

The first site—(1) is recognized by its state government as the primary telemedicine project of the state; (2) consists of a consortium of both public and private academic institutions, military establishments, health care providers, telecommunication carriers and Native organizations; (3) is in existence for at least three years; (4) attempts to unite health care facilities throughout the state; (5) exists in a state with communities and Native villages not

accessible by roads due to extremes in geography and climate; and (6) exists in a state containing significant Native population.

The second site—(1) is located in a frontier state with an at least two existing telehealth networks that emphasizes mental health care specialty services; (2) has prior experience working with other third-party payers both public and not-for-profit; and (3) has an existing state-wide network of telehealth sites.

The third site—(1) is located in a Northern Plains state serving a predominantly rural population; (2) offers a full range of specialty health care services; (3) includes at least one network with an emphasis on geriatric and long-term care; and (4) works with at least one mid-level practitioner to provide emergency care services.

Effective Date

All provisions are effective in fiscal year 1998. The MDH program expires on September 30, 2002.

Subtitle D—Anti-Fraud and Abuse Provisions and Improvements in Protecting Program Integrity

CHAPTER 1—REVISIONS TO SANCTIONS FOR FRAUD AND ABUSE

AUTHORITY TO REFUSE TO ENTER INTO MEDICARE AGREEMENTS WITH INDIVIDUALS OR ENTITIES CONVICTED OF FELONIES

Present Law

Section 1866 of the Social Security Act sets forth certain conditions under which providers may become qualified to participate in the Medicare program. The Secretary may refuse to enter into an agreement with a provider, or may refuse to renew or may terminate such an agreement, if the Secretary determines that the provider has failed to comply with provisions of the agreement, other applicable Medicare requirements and regulations, or if the provider has been excluded from participation in a health care program under section 1128 or 1128A of the Social Security Act. Section 1842 of the Social Security Act permits physicians and suppliers to enter into agreements with the Secretary under which they become "participating" physicians or suppliers under the Medicare program.

Reasons for Change

This provision would help protect against fraud and abuse in the Medicare program.

Committee Provision

The provision would add a new section giving the Secretary authority to refuse to enter into an agreement, or refuse to renew or terminate an agreement, with a provider if the provider has been convicted of a felony under federal or state law for an offense which the Secretary determines is inconsistent with the best interests of program beneficiaries. This authority would extend to the Secretary's agreements with physicians or suppliers who become "par-

ticipating" physicians or suppliers under the Medicare program. Similar provisions would apply to the Medicaid program.

Effective Date

On enactment.

EXCLUSION OF ENTITY CONTROLLED BY FAMILY MEMBER OF A SANCTIONED INDIVIDUAL

Present Law

Section 1128 of the Social Security Act authorizes the Secretary of HHS to impose mandatory and permissive exclusions of individuals and entities from participation in the Medicare program, Medicaid program and programs receiving funds under the Title V Maternal and Child Health Services Block Grant, or the Title XX Social Services Block Grant. The Secretary may exclude any entity which the Secretary determines has a person with a direct or indirect ownership or control interest of 5 percent or more in the entity or who is an officer, director, agent, or managing employee of the entity, where that person has been convicted of a specified criminal offense, or against whom a civil monetary penalty has been assessed, or who has been excluded from participation under Medicare or a state health care program. The Committee expects the Secretary to examine the facts and circumstances of each case carefully before applying this penalty.

Reasons for Change

This provision would help protect against fraud and abuse in the Federal programs.

Committee Provision

The provision would specify that if a person transfers an ownership or control interest in an entity to an immediate family member or to a member of the household of the person in anticipation of, or following, a conviction, assessment or exclusion against the person, that the entity may be excluded from participation in Federal health care programs on the basis of that transfer. The terms "immediate family member" and "member of the household" are defined in this section.

ADDITIONAL AUTHORITY TO IMPOSE CIVIL MONEY PENALTIES

Present Law

Section 1128A of the Social Security Act sets forth a list of fraudulent activities relating to claims submitted for payments for items of services under a Federal health care program. Civil money penalties of up to $10,000 for each item or service may be assessed. In addition, the Secretary of HHS (or head of the department or agency for the Federal health care program involved) may also exclude the person involved in the fraudulent activity from participation in a Federal health care program, defined as any program providing health benefits, whether directly or otherwise, which is funded directly, in whole or in part, by the United States Govern-

ment (other than the Federal Employees Health Benefits Program). Violations of the anti-kickback statute (sec. 1128B of the Social Security Act) are punishable only as criminal matters.

Reason for Change

The provisions providing for a civil monetary penalty for either contracting with an excluded individual or furnishing items or services ordered by an excluded individual are intended to close loopholes in current law identified by the Inspector General of the Department of Health and Human Services by which individuals excluded from Federal health care programs continue to participate. The anti-kickback civil monetary penalty would provide an intermediate sanction, where such violations under current law may only be prosecuted as criminal offenses.

Committee Provision

The provision would add a new civil money penalty for cases in which a person contracts with an excluded provider for the provision of health care items or services, where the person knows or should know that the provider has been excluded from participation in a Federal health care program. A civil money penalty is also added for cases in which a person provides a service ordered or prescribed by an excluded provider, where that person knows or should know that the provider has been excluded from participation in a Federal health care program. Lastly, a civil monetary penalty is provided for violations of the anti-kickback statute.

The Committee notes that the two new civil monetary penalties for arranging or contracting with an excluded individual, or for providing items or services ordered or prescribed by an excluded individual, do not place an affirmative responsibility on a provider or supplier to determine the excluded status of any individual. Rather, only if a provider or supplier knows or should know of an individual's excluded status, that is, information has come to the attention of a provider or supplier regarding the excluded status of an individual and the provider or supplier acts with deliberate ignorance or reckless disregard of the individual's excluded status, the provider or supplier may be liable for a civil monetary penalty.

Effective Date

On enactment.

CHAPTER 2—IMPROVEMENTS IN PROTECTING PROGRAM INTERGRITY

DISCLOSURE OF INFORMATION, SURETY BONDS, AND ACCREDITATION

Present Law

Section 1834(a) of the Social Security Act establishes requirements for payments under Medicare for covered items defined as durable medical equipment. Home health agencies are required, under Section 1861(o) of the Social Security Act, to meet specified conditions in order to provide health care services under Medicare, including requirements, set by the Secretary, relating to bonding or

establishing of escrow accounts, as the Secretary finds necessary for the effective and efficient operation of the Medicare program.

Reasons for Change

This provision would help protect against fraud and abuse in the Medicare program.

Committee Provision

The provision would require that suppliers of durable medical equipment provide the Secretary with full and complete information as to persons with an ownership or control interest in the supplier, or in any subcontractor in which the supplier has a direct or indirect 5 percent or more ownership interest, other information concerning such ownership or control, and a surety bond for at least $50,000. Home health agencies, comprehensive outpatient rehabilitation facilities, and rehabilitation agencies would also be required to provide a surety bond for at least $50,000. The Secretary may impose the surety bond requirement which applies to durable medical equipment suppliers to home health agencies, suppliers of ambulance services, and certain clinics that furnish medical and other health services (other than physicians" services).

The amendments with respect to suppliers of durable medical equipment would apply to equipment furnished on or after January 1, 1998. The amendments with respect to home health agencies would apply to services furnished on or after such date, and the Secretary of Health and Human Services (HHS) is directed to modify participation agreements with home health agencies to provide for implementation of these amendments on a timely basis. The amendments with respect to ambulance services, certain clinics, comprehensive outpatient rehabilitation facilities, and rehabilitation agencies would take effect on the date of enactment of this Act.

The Committee provision would also authorize the Secretary to require durable medical equipment suppliers to be accredited or to meet equivalent standards.

Effective Date

Various dates.

PROVISION OF CERTAIN IDENTIFICATION NUMBERS

Present Law

Section 1124 of the Social Security Act requires that entities participating in Medicare, Medicaid and the Maternal and Child Health Block Grant programs (including providers, clinical laboratories, renal disease facilities, health maintenance organizations, carriers and fiscal intermediaries), provide certain information regarding the identity of each person with an ownership or control interest in the entity, or in any subcontractor in which the entity has a direct or indirect 5 percent or more ownership interest. Section 1124A of the Social Security Act requires that providers under Part B of Medicare also provide information regarding persons with ownership or control interest in a provider, or in any subcontractor

in which the provider has a direct or indirect 5 percent or more ownership interest.

Reasons for Change

This provision would help protect against fraud and abuse in the Medicare program.

Committee Provision

The provision would require that all Medicare providers supply the Secretary with both the employer identification number and social security account number of each disclosing entity, each person with an ownership or control interest, and any subcontractor in which the entity has a direct or indirect 5 percent or more ownership interest. The Secretary of Health and Human Services (HHS) is directed to transmit to the Commissioner of Social Security information concerning each social security account number and to the Secretary of the Treasury information concerning each employer identification number supplied to the Secretary for verification of such information. The Secretary would reimburse the Commissioner and the Secretary of the Treasury for costs incurred in performing the verification services required by this provision. The Secretary of HHS would report to Congress on the steps taken to assure confidentiality of social security numbers to be provided to the Secretary under this section. This section's reporting requirements would then become effective 90 days after submission of the Secretary's report to Congress on confidentiality of social security numbers.

Effective Date

Generally on enactment.

IMPROVEMENT OF EXCLUSION AUTHORITY AND NON–DISCHARGEABILITY OF CERTAIN DEBTS

Present Law

Under the Bankruptcy Code, a provider can assert that any civil monetary penalty due to the Medicare program is discharged and does not survive the bankruptcy proceeding. Current law provides for various causes of exclusion from the Medicare program. However, several bankruptcy courts have held that a provider may not be excluded from Medicare during the pendency of a bankruptcy proceeding because of the court's automatic stay.

Reasons for Change

Current law supports and sustains Medicare fraud and abuse by permitting providers to escape sanctions through the Bankruptcy Code.

Committee Provision

The Committee provision would amend the Social Security Act to specify that any overpayment determined to have occurred due to fraud and civil monetary penalty amounts are not dischargeable

under the Bankruptcy Code and that a bankruptcy court cannot bar exclusions from the Medicare program.

Effective Date

On enactment.

IMPROVEMENTS IN PAYMENT METHODOLOGY

Present Law

Under Part B, Medicare continues to pay for certain items or services on basis of reasonable charges. Such items or services include parenteral and enteral nutrition, dialysis equipment, certain medical supplies, and therapeutic shoes. The Secretary has a limited "inherent reasonableness" authority under Part B to adjust the amounts Medicare pays for any item or service that are either grossly excessive or deficient.

Reasons for Change

Replacing reasonable charge methodologies with fee schedules would provide less variability and more appropriate payment for those items or services paid according to reasonable charges, and give providers more predictability of payment and promote greater efficiency in providing items and services. Improved flexibility in the application of the Secretary's inherent reasonableness authority would help ensure that Medicare pays an appropriate amount for medical items and services.

Committee Provision

The Committee provision would permit the Secretary to replace reasonable charge methodologies by fee schedules. The Committee provision would also provide the Secretary with greater flexibility to determine the appropriateness of payment amounts under Part B (excluding physician services) and adjust payment amounts accordingly.

Effective Date

On enactment.

REQUIREMENT TO FURNISH DIAGNOSTIC INFORMATION

Present Law

Diagnostic test and durable medical equipment providers may be required by the Secretary to provide certain diagnostic information with submission of a claim for payment. However, that information may be available only to the ordering physician or other health care practitioner.

Reason for Change

Diagnostic test and durable medical equipment providers often do not have diagnostic information readily to them, thereby delaying submission of claims for payments or, in the absence of such information, resulting in a rejection of a claim for payment. Lack

of diagnostic information can also impede certain program integrity activities.

Committee Provision

The Committee provision would require physician and other health care practitioners to provide diagnostic information when ordering an item or service from a diagnostic test or durable medical equipment supplier.

Effective Date

January 1, 1998.

REPORT BY GENERAL ACCOUNTING OFFICE ON OPERATION OF FRAUD AND ABUSE CONTROL PROGRAM

Present Law

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) required a report by the General Accounting Office (GAO) not later than January 1, 2000, 2002, and 2004, on the operation of a new Medicare fraud and abuse control program designed to improve investigation and prosecution of fraud against the Medicare program.

Reason for Change

An earlier GAO report would be useful in providing an independent assessment of progress in combating fraud and abuse in the Medicare program.

Committee Provision

The Committee provision would require the first GAO report no later than June 1, 1998.

Effective Date

On enactment.

COMPETITIVE BIDDING AUTHORITY FOR PART B SERVICES

Present Law

Medicare does not use competitive bidding for the selection of providers authorized to provide covered services to beneficiaries.

Reasons for Change

Medicare has the potential of achieving greater value in both price and quality for covered Part B medical items and services with the additional flexibility provided by competitive bidding. Both the General Accounting Office (GAO) and the Inspector General of the Department of Health and Human Services report that private payers using competitive acquisition strategies pay significantly less than Medicare for certain items. Competitive bidding may also increase quality because Medicare currently does not evaluate medical items and services for quality, but quality would

be one factor the Secretary would be required to consider in a competitive acquisition process.

Committee Provision

The Committee provision would provide the Secretary with the authority to acquire Part B covered medical items and services (except physician services) through a competitive bidding process.

The Secretary would establish competitive acquisition areas for contract awards for specific items and services. The Secretary may limit the number of contractors in a competitive acquisition to the number needed to meet projected demand for items and services covered under the contracts. Additionally, the Secretary may not award a contract unless the Secretary finds the entity meets quality standards specified by the Secretary.

Generally, the Secretary would be limited in the amount of payment for an item or services to the amount otherwise payable under an applicable fee schedule, unless the Secretary determines an additional amount is warranted by reason of technological innovation, quality improvement, or similar reasons specified by the Secretary.

In using this broad, new authority, the Committee encourages the Secretary to carefully consider any effects on beneficiary choice and on rural areas.

Effective Date

January 1, 1998.

CHAPTER 3—CLARIFICATIONS AND TECHNICAL CHANGES

OTHER FRAUD AND ABUSE RELATED PROVISIONS

Present Law

Section 1128A of the Social Security Act provides for civil monetary penalties for offering inducements to any individual enrolled in a Federal health plan to order or receive any service from a particular provider. Section 1128D provides for safe harbors, advisory opinions, and fraud alerts as guidance regarding application of health care fraud and abuse sanctions. Section 1128E of the Social Security Act directs the Secretary of HHS to establish a national health care fraud and abuse data collection program for the reporting of final adverse actions against health care providers, suppliers, or practitioners.

Reasons for Change

The Committee provision provides for certain technical corrections and improvements to the anti-fraud and abuse provisions enacted as part of the Health Insurance Portability and Accountability Act of 1996 ("HIPPA").

Committee Provision

The Committee provision would make certain technical changes in provisions added by the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"). In addition, the Committee pro-

vision would clarify that Medicare SELECT insurance contracts do not violate section 1128A, as amended by HIPPA, and clarify the application of waivers provided under 1128B(b)(3) to section 1128A(i)(6).

The Committee provision would also provide that mandatory and permissive exclusions under section 1128 apply to any Federal health care program, defined as any program providing health benefits, whether directly or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program).

The Committee provision would provide for a civil money penalty of up to $25,000 to be imposed against a health plan that fails to report information on an adverse action required to be reported under the health care fraud and abuse data collection program established under HIPPA. The Committee provision would require the Secretary to publicize those government agencies which fail to report information on adverse actions as required.

The application of exclusion authority under section 1128 of the Social Security Act to federal programs would be effective on the date of enactment of this Act. The sanction provision for failure to report adverse action information as required under Section 1128E of the Social Security Act would apply to failures occurring on or after the date of the enactment of this Act. The other amendments made by this section would be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996.

Effective Date

Generally on enactment.

Subtitle E—Prospective Payment Systems

CHAPTER 1—PROVISIONS RELATING TO PART A

LONG-TERM CARE AND REHABILITATION HOSPITALS (AND UNITS)

Present Law

Rehabilitation and long-term care hospitals are two of the categories of hospitals not paid by the Medicare Prospective Payment System (PPS). These hospitals receive Medicare cost-based payments with special rules. For a complete explanation of these payments, please refer to the section titled "PPS-Exempt Hospital Payments" in Subtitle F—Provisions Relating to Part A.

Reasons for Change

TEFRA payments are not suited, nor were they intended, to be applied over the long run. The Prospective Payment Assessment Commission (ProPAC) recommends replacing current TEFRA payments with a case-mix adjusted prospective payment system that would provide incentives for controlling costs.

Committee Provision

(a) For rehabilitation hospitals and distinct-part units, the Secretary shall establish a case-mix adjusted Prospective Payment System (PPS), effective Fiscal Year 2001. Data will be collected from all facilities necessary for administering and evaluating such a system. The case-mix adjuster may reflect a patient classification system which assigns patients to groups primarily on the basis of functional status, modified by age and diagnosis.

(b) For long-term care hospitals, the Secretary shall collect data in order to eventually establish a case-mix adjusted PPS. The Secretary shall develop a proposal for an adequate patient classification system which reflects the differences in patient resource use and costs among long-term care hospitals. The Secretary shall collect relevant data necessary for developing, administering, and evaluating such a system. The Secretary shall submit recommendations to the Congress no later than October 1, 1999.

CHAPTER 2—PROVISIONS RELATING TO PART B

Subchapter A—Payment for Hospital Outpatient Department Services

ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS (FDO) FOR CERTAIN OUTPATIENT HOSPITAL SERVICES

Present Law

Medicare payments for hospital outpatient ambulatory surgery, radiology, and other diagnostic services equals the lesser of: (1) the lower of a hospital's reasonable costs or its customary charges, net of deductible and coinsurance amounts, or (2) a blended amount comprised of a cost portion and a fee schedule portion, net of beneficiary cost-sharing. The cost portion of the blend is based on the lower of the hospital's costs or charges, net of beneficiary cost sharing, and the fee schedule portion is based, in part, on ambulatory surgery center payment rates or the rates for radiology and diagnostic services in other settings, net of beneficiary coinsurance. For cost reporting periods beginning on or after January 1, 1991, the hospital cost portion and the ASC cost portion are 42 percent and 58 percent, respectively.

A hospital may bill a beneficiary for the coinsurance amount owed for the outpatient service provided. The beneficiary coinsurance is based on 20 percent of the hospital's submitted charges for the outpatient service, whereas Medicare usually pays based on the blend of the hospital's costs and the amount paid in other settings for the same service. This results in an anomaly whereby the amount a beneficiary pays in coinsurance does not equal 20 percent of the program's payment and does not result in a dollar-for-dollar decrease in Medicare program payments.

Reasons for Change

There is a flaw in the payment formula for certain hospital outpatient department services. As a result, Medicare overpays for

such services because a beneficiary's coinsurance payments are not properly credited to reduce Medicare's allowed payment amounts.

Committee Provision

The provision would require that beneficiary coinsurance amounts be deducted after the reimbursement calculation for hospital outpatient services, so that Medicare payments would reflect the full amount of the beneficiary coinsurance. Medicare's payment for hospital outpatient services would equal the blended amount less any amount the hospital may charge the beneficiary as coinsurance for services furnished during portions of cost reporting periods occurring on or after October 1, 1997.

Effective Date

October 1, 1997.

EXTENSION OF REDUCTIONS IN PAYMENTS FOR COSTS OF HOSPITAL OUTPATIENT SERVICES

Present Law

a. Reduction in Payments for Capital-Related Costs.—Hospitals receive payments for Medicare's share of capital costs associated with outpatient departments. The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) extended a 10-percent reduction in payments for the capital costs of outpatient departments through FY 1998.

b. Reduction in Payments for Non-Capital-Related Costs.—Certain hospital outpatient services are paid on the basis of reasonable costs. OBRA 93 extended a 5.8-percent reduction for those services paid on a cost-related basis through FY 1998.

Reasons for Change

The Committee provision would establish more appropriate growth in payments.

Committee Provision

a. Reduction in Payments for Capital-Related Costs.—The provision would extend the 10-percent reduction in payments for outpatient capital through FY 1999 and during FY 2000 before January 1, 2000.

b. Reduction in Payments for Non-Capital-Related Costs.—The 5.8-percent reduction for outpatient services paid on a cost basis would be extended through FY 1999 and during FY 2000 before January 1, 2000.

Effective Date

On enactment.

PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Present Law

Medicare payments for hospital outpatient ambulatory surgery, radiology, and other diagnostic services equals the lesser of: (1) the lower of a hospital's reasonable costs or its customary charges, net of deductible and coinsurance amounts, or (2) a blended amount comprised of a cost portion and a fee schedule portion, net of beneficiary cost-sharing. The cost portion of the blend is based on the lower of the hospital's costs or charges, net of beneficiary cost sharing, and the fee schedule portion is based, in part, on ambulatory surgery center payment rates or the rates for radiology and diagnostic services in other settings, net of beneficiary coinsurance. For cost reporting periods beginning on or after January 1, 1991, the hospital cost portion and the ASC cost portion are 42 percent and 58 percent, respectively.

Reasons for Change

The current payment methodology for hospital outpatient department services is complicated and confusing, and a prospective payment system would simplify determination of payment amounts. Moreover, the current payment methodology results in beneficiaries bearing an increasing percentage of the cost of many hospital outpatient department services.

Committee Provision

The Committee provision would require the Secretary of Health and Human Services (HHS) to establish a prospective payment system for covered hospital outpatient department (OPD) services beginning in 1999. The Secretary would be required to develop a classification system for covered OPD services, such that services classified within each group would be comparable clinically and with respect to the use of resources. The Secretary would be required to establish relative payment rates for covered OPD services using 1997 hospital claims and cost report data, and determine projections of the frequency of utilization of each such service or group of services in 1999. The Secretary would be required to determine a wage adjustment factor to adjust the portions of payment attributable to labor-related costs for relative geographic differences in labor and labor-related costs that would be applied in a budget neutral manner. The Secretary would be required to establish other adjustments as necessary to ensure equitable payments under the system. The Secretary would also be required to develop a method for controlling unnecessary increases in the volume of covered OPD services.

For 1999, the Secretary would be required to establish a conversion factor for determining the Medicare OPD fee payment amounts for each covered OPD service (or group of services) furnished in 1999 so that the sum of the products of the Medicare OPD fee payment amounts and the frequencies for each service or group would be required to equal the total amounts estimated by the Secretary that would be paid for OPD services in 1999. In sub-

sequent years, the Secretary would be required to establish a conversion factor for covered OPD services furnished in an amount equal to the conversion factor established for 1999 and applicable to services furnished in the previous year increased by the OPD payment increase factor. The increase factor would be equal to the hospital market basket (MB) percentage increase plus 3.5 percentage points.

Hospitals OPD copayments would be limited to 20 percent of the national median of the charges for the service (or services within the group) furnished in 1997 updated to 1999 using the Secretary's estimate of charge growth during this period. The Secretary would be required to establish rules for the establishment of a copayment amount for a covered OPD service not furnished during 1997, based on its classification within a group of such services.

The Secretary would be required to establish a procedure under which a hospital, before the beginning of a year (starting with 1999), could elect to reduce the copayment amount for some or all covered OPD services to an amount that is not less than 25 percent of the Medicare OPD fee schedule amount for the service involved, adjusted for relative differences in labor costs and other factors. A reduced copayment amount could not be further reduced or increased during the year involved, and hospitals could disseminate information on the reduction of copayment amount.

The Secretary would be authorized periodically to review and revise the groups, relative payment weights, and the wage and other adjustments to take into account changes in medical practice, medical technology, the addition of new services new cost data, and other relevant information. Any adjustments made by the Secretary would be made in a budget neutral manner. If the Secretary determined that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary would be authorized to adjust the update to the conversion factor otherwise applicable in a subsequent year.

The Committee provision would provide that the copayment for covered OPD services would be determined by the provisions of this bill instead of the standard 20-percent coinsurance other Part B services. The Committee provision would prohibit administrative or judicial review of the prospective payment system. The Committee provision would also provide for conforming amendments regarding approved ambulatory surgical center procedures performed in hospital OPDs, for radiology and other diagnostic procedures, and for other hospital outpatient services.

The Committee provision would become effective for hospitals described in section 1886(d)(l)(B)(v) of the Social Security Act, beginning on January 1, 2000, and the Secretary would have the authority to establish a separate conversion factor for such hospitals.

Effective Date

Generally January 1, 1999.

Subchapter B—Ambulance Services

PAYMENTS FOR AMBULANCE SERVICES

Present Law

Payment for ambulance services provided by freestanding suppliers is based on reasonable charge screens developed by individual carriers based on local billings. Hospital or other provider-based ambulance services are paid on a reasonable cost basis; payment cannot exceed what would be paid to a freestanding supplier. Annual updates in payments for ambulances services are provided in regulation.

Reasons for Change

The Committee provision would establish an improved payment methodology for ambulance services.

Committee Provision

The Committee provision would specify payment rules for ambulance services for FY 1998 through FY 2002. For ambulance services paid on a reasonable cost basis, the annual increase in the costs recognized as reasonable would be limited to the percentage increase in the consumer price index reduced for FY 1998 by 1 percent. Similarly, for ambulance services furnished on a reasonable charge basis, the annual increase in the charges recognized as reasonable would be limited to the percentage increase in the consumer price index reduced for FY 1998 by 1 percent.

The Committee provision would require the Secretary to establish a fee schedule for ambulance services through a negotiated rule-making process no later than January 1, 1999. In establishing the fee schedule, the Secretary would be required to: (1) establish mechanisms to control Medicare expenditure increases; (2) establish definitions for services; (3) consider appropriate regional and operational differences; (4) consider adjustments to payment rates to account for inflation and other relevant factors; and (5) phase-in the application of the payment rates in an efficient and fair manner. The Secretary would be required to assure that payments in FY 1999 under the fee schedule did not exceed the aggregate amount of payments which would have been made in the absence of the fee schedule. The annual increase in the payment amounts in each subsequent year would be limited to the increase in the consumer price index minus 1 percentage point. Medicare payments would equal 80 percent of the lesser of the fee schedule amount or the actual charge.

The Committee provision would authorize payment for advanced life support (ALS) services provided by paramedic intercept service providers in rural areas. The ALS services would be provided as part of a two-tiered system in conjunction with one or more volunteer ambulance services. The volunteer ambulance service involved must be certified as qualified to provide the service, have a contractual agreement with the volunteer ambulance service providing the additional ALS intercept service, provide only basic life support services at the time of the intercept, and be prohibited by state law

from billing for services. The ALS service provider must be certified to provide the services and bill all recipients (not just Medicare beneficiaries) for ALS intercept services.

Effective Date

On enactment.

CHAPTER 3—PROVISIONS RELATING TO PARTS A AND B

Subchapter A—Payments to Skilled Nursing Facilities

PAYMENTS TO NURSING HOMES

Present Law

Medicare pays skilled nursing facilities (SNFs) on a per day basis for reasonable costs, subject to per day cost limits. The limits are applied to the per day routine service costs only (nursing, room and board, administrative, and other overhead) of a facility. Routine cost limits are updated annually by the skilled nursing home market basket. OBRA 93 eliminated the annual market basket update for SNF limits for cost reporting periods beginning in FY 1994 and FY 1995.

Non-routine costs, such as therapy services (e.g., physical therapy, occupational therapy, and speech therapy services) are paid according to reasonable costs. There are no cost limits for non-routine costs. Medicare pays, under Part A and Part B, a variety of providers (i.e., nursing homes for facility-based therapists, independent therapists, therapy companies) for non-routine services.

Freestanding SNF routine cost limits are set at 112 percent of the mean per day routine costs. Hospital-based SNF routine cost limits are set at the limit for freestanding SNFs, plus 50 percent of the difference between the freestanding limit and 112 percent of the mean per day routine service costs of hospital-based SNFs.

Payments for ancillary service and capital costs are unlimited, since both are paid on the basis of reasonable costs and neither are subject to limits.

New providers are exempt from Medicare's routine cost limits for about their first three years of operation. During this period they receive full cost reimbursement for all routine services, as well as ancillary and capital costs.

Under certain circumstances, Medicare permits exceptions payments for facilities that exceed their cost limits.

Low volume SNFs (less than 1500 SNF days per year) may choose to be paid on a prospective payment basis at 105 percent of the mean. Low volume SNFs did not receive inflation updates for 1994 and 1995 prospective rates.

There are no requirements for SNFs to monitor or bill for any Part B service delivered to a beneficiary when a Medicare beneficiary is residing at a SNF outside of the 100 days covered by Medicare.

To research and develop a prospective payment system for SNF care, HCFA since 1984 has been sponsoring research on a patient classification system for Medicare SNF patients. Specifically, HCFA has sought to adapt to Medicare patients a classification

system known as the Resource Utilization Groups (RUGs), which was developed originally for a Medicaid nursing home population and which used primarily functional disability scores for classifying patients. The version of RUGs that HCFA is currently testing for application to Medicare is known as RUGs–III is being tested in six states (Kansas, Maine, Mississippi, New York, South Dakota, and Texas). HCFA anticipates that 1,000 SNFs will be participating in the demonstration by the time enrollment closes in 1997.

Reasons for Change

Medicare payments for skilled nursing facilities (SNF) grew over 28 percent for 1994–1995 according to CBO. Spending growth of nursing home care is unsustainable in the Medicare program. Providers are paid based on costs subject to certain limits for routine services, with no limits for non- routine services. Providers have no incentives to keep the cost growth of non-routine services low.

Committee Provision

The proposal extends the FY 1997 routine cost limits until a new Prospective Payment System (PPS) is established on July 1, 1998:

(a) The Secretary shall determine the standard federal payment rates for the SNF PPS based on cost reports beginning in fiscal year 1995, excluding cost reports from new SNFs exempted from cost limits, and excluding exceptions payments made to SNFs. The Secretary shall trend the rate forward by the market basket index of minus one percentage point for fiscal years 1996, 1997, and 1998.

The standard federal payment rates shall be based on the average cost of SNF services and determined on a per diem basis with regional variation. The labor portion of the standard federal payment will be adjusted by an appropriate wage index.

The standard federal payment rates will be adjusted to account for case-mix based on a resident classification system which reflects the relative resource needs of caring for different types of patients. The Secretary shall collect resident assessment data and other data in order to develop the case-mix adjuster.

The standard federal payment rates will be updated annually by the market basket after fiscal year 1998.

During the four year transition to a fully prospective system, a SNF's payment shall be based on a blend of the federal payment rate and the facility's specific rate. The facility specific rate will include all costs of skilled nursing services (including routine costs, ancillary costs, capital related costs, and all Part B services which will be covered under the new PPS) and will be based on the most recent settled cost report available, updated annually. For SNFs participating in the RUGS–III demonstration project, their base year facility specific rate will be equal to their 1997 RUG rate.

The Secretary will have the authority to develop normative standards based on program data which reflects the overall practices of SNFs for comparable cases. The Secretary may adjust payments when a variation from the standards cannot be justified.

As was the case for the development of the Medicare hospital PPS and physician payment reform, certain administrative or judi-

cial review will not be permitted for the establishment of the SNF PPS. Administrative or judicial review will not be permitted for the determination of the federal per diem rates, including the computation of the standardized per diem rates and adjustments for case-mix; and for the transition for low-volume SNFs and rural hospitals providing SNF care with inpatient beds.

(b) SNFs will be required to consolidate all bills to Medicare for all Part B services used by Medicare patients (with the exception of physician services). Payments for Part B services would have to be made to the facility. The Secretary is required to use applicable Part B payment methodologies in developing fee schedules for items and services subject to consolidated billing. The Secretary shall rely on new salary equivalency guidelines for physical therapy, occupational therapy, respiratory therapy, and speech language pathology in determining reasonable costs for such services.

(c) New provider exemptions are eliminated for cost reporting periods beginning on or after July 1, 1998.

(d) The Secretary shall conform payments to low volume nursing homes with the policies in these provisions.

Effective Date

The new payment system will be effective July 1, 1998.

Subchapter B—Home Health Services and Benefits

PAYMENT FOR HOME HEALTH SERVICES

Present Law

Home health care services are primarily nursing services (e.g., cleaning and dressing a wound) or therapies (e.g., physical therapy) provided by a nurse or other health care worker in the home.

There are no cost sharing requirements for beneficiaries for home health services.

Medicare pays home health agencies the lower of their costs or a limit; there are no exemptions for new entrants. The limits are based on 112 percent of the average cost per visit for free-standing agencies for each of the six types of visits.

Medicare's home health policies do not specify the duration of a visit.

While the limits are computed at the service level, they are applied to aggregate agency costs. That is, an aggregate cost limit is set for each agency that equals the limit for each type of service multiplied by the number of visits of each type provided by that agency. There is an adjustment made to payments to reflect the regional variation of wages which is the same as the local hospital wage index.

In OBRA 93, the per visit cost limits for home care were frozen for two years. The freeze meant that the cost limits set in 1993 could not be adjusted in 1994 and 1995 for inflation or wage cost increases. Cost limits were then recalculated for cost reporting periods beginning on or after July 1, 1996.

Home health agencies can have their cost reimbursement payments paid to them from Medicare through periodic interim payments (PIPs). These lump sum payments are made several times

a year based on anticipated costs incurred in order to help agencies with their cash flow. PIP payments are reconciled at the end of the cost reporting year between the Health Care Financing Administration and the agency.

Reasons for Change

Medicare home health service utilization and costs are growing at an unsustainable rate for the Medicare program. ProPAC reports that from 1980-1994, persons using the home care benefit grew from 26 to 88 persons per 1,000 Medicare enrollees and from an average of 23 visits to an average of 65 visits per person using the home care benefit. From 1988 to 1996, Medicare's payments for home health services increased 37% on average every year.

Medicare's current cost-based payment system for home care provides no incentive for providers or patients to be cost conscious.

Committee Provision

The provision requires the Secretary to establish a prospective payment system (PPS) for home health services and implement the system in FY 2000. Until the new PPS is in effect, an interim payment system will be in place.

1. Interim payment for home health services for FY 1998–1999. Reduces per visit cost limits to 105% of the national median of labor-related and nonlabor costs for freestanding home health agencies beginning in FY 1998. Home health agencies will be paid the lesser of: (a) their actual costs; (b) the per visit limits; or (c) a new agency-specific per beneficiary annual limit calculated from 1994 reasonable costs, updated by the home health market basket.

The Secretary is required to expand research on a PPS for home health that ties prospective payments to a unit of service, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of variance in cost.

2. To establish the PPS, the Secretary will compute a standard prospective payment amount that will initially be based on the most current audited cost report data available to the Secretary. For FY 2000, payment amounts under the prospective system will be computed in such a way that total payments equal amounts that would have been paid had the system not been in effect, but would also reflect a 15% reduction in cost limits and per beneficiary limits in effect September 30, 1999. Payment amounts will 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. The new payment system will take into account regional differences or differences based on whether or not services are provided in an area. Beginning FY 2001, standard prospective payment amounts will be updated by the home health market basket index.

3. With the implementation of the home health PPS, as was the case for the development of the Medicare hospital PPS and physician payment reform, certain administrative or judicial review will not be permitted. Administrative or judicial review will not be permitted for the establishment of the computation of the initial standard payment amounts and case-mix adjustments; the transi-

tion period (if any) for the prospective system; and the amount or types of exceptions to the prospective payment amounts.

4. Beginning in FY 1998, payment for home health services will be based on the location of where home health services are furnished.

5. Periodic interim payments are eliminated October 1, 1999 with the implementation of the home health care PPS.

HOME HEALTH BENEFITS

Present Law

Payment for home health care is made from the Part A trust fund for all home health services except for those provided to individuals enrolled under Part B, but not entitled to receive benefits under Part A. Only about 1% of home health services are reimbursed under Part B.

Eligibility and reimbursement policies are identical for home health services under Parts A and B. Although the original 1965 home health care benefit required coinsurance, there currently is no coinsurance requirement and home health services are not counted towards the Part B deductible. The Part B deductible applies to all Medicare Part B benefits excluding home health care. All part B benefits, including current Part B home health care are included in the calculation of the Part B premium.

Once beneficiaries qualify for the home health benefit, the program covers part-time or intermittent nursing care provided by or under the supervision of a registered nurse and part-time or intermittent home health aide services, among other services. Coverage guidelines issued by HCFA have defined part-time and intermittent.

In order to be eligible for home health care, a Medicare beneficiary must be confined to his or her home. The law specifies that this "homebound" requirement is met when the beneficiary has a condition that restricts the ability of the individual to leave home, except with the assistance of another individual or with the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. The law further specifies that while an individual does not have to be bedridden to be considered confined to home, the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, and that absences from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment.

A Medicare beneficiary who is "homebound" is entitled to an unlimited number of home-based part-time nursing visits provided by or under the supervision of a nurse.

Reasons for Change

The Medicare Hospital Insurance (HI or Part A) Trust Fund will be insolvent in 2001. The rapid and unsustainable level of growth in home health care has contributed significantly to the Trust Fund's impending fiscal straights. Redefining the home health ben-

efit to a predominantly Medicare Supplemental Medical Insurance (SMI or Part B) Trust Fund benefit will help clarify and rationalize the current unlimited, and undefined aspects of the home health benefit.

Committee Provision

(a) Beginning in 1998, the home health benefit will be redefined. The Part A benefit will be limited to 100 visits that follow a 3 day hospital stay, and the Part B benefit will include all other home health visits.

(b) Beginning in 1998, the new Part B home health benefit will be paid partly from the Part A Trust Fund for a seven year phase-in period. For example, the newly defined Part B home health benefit will be paid 14% (1/7) from Part B and 86% (6/7) from Part A in FY 1998. The next year, payment will be 28% (2/7) from Part B and 72% (5/7)from Part A, etc. The amount paid from Part B will be included in the Part B premium calculation each year, as is all other Part B spending.

(c) Consistent with other Part B services, cost-sharing is established for Part B home health services at $5 per visit, billable on a monthly basis, capped at an annual amount equal to the annual hospital deductible.

(d) Effective for services furnished on or after October 1, 1997, the provision defines part-time and intermittent skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of qualifying for Medicare's home health benefit because of a need for intermittent skilled nursing care, "intermittent" would mean skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day of skilled nursing and home health aide services combined for periods of 21 days or less (with extensions for exceptional circumstances when the need for additional care is finite and predictable).

(e) The Secretary shall conduct a study on the criteria that should be applied with regards to the determination of whether an individual is considered homebound for purposes of receiving the home health benefit. The Secretary shall report to Congress with specific recommendations no later than October 1, 1998.

(f) The Medicare Explanation of Benefits notice will include home health care benefits provided and billed for.

(g) Seamless administration of the home health benefit is assured by (i) allowing beneficiaries the same appeals rights either under Part A or Part B ($100 in benefits must be in dispute), and (ii) requiring fiscal intermediaries to administer claims for all home health benefits.

Subtitle F—Provisions Relating to Part A

PPS HOSPITAL PAYMENT UPDATE

Present Law

Since 1983, Medicare has paid hospitals for most inpatient services with a fixed, predetermined amount according to patient diagnosis. The payment system is called the Medicare Prospective Payment System (PPS).

Medicare's PPS payments are updated each year for inflation. The inflation update is based on the projected increase in "market basket index" (MB), which estimates the prices of the goods and services hospitals buy to provide care.

Since fiscal year (FY) 1986, Congress has repeatedly set the update factor at a level below the MB. In OBRA 1993, the update was set at:

1. FY 1994—Rural hospitals: MB minus .55 percentage points. Urban hospitals: MB minus 2.5 percentage points.
2. FY 1995—Rural hospitals: inflation update necessary to eliminate the rural/urban differential. Urban hospitals: MB minus 2.5 percentage points.
3. FY 1996—MB minus 2 percentage points.
4. FY 1997—MB minus 0.5 percentage points.
5. FY 1998 and later years—Equal to the MB with no reductions.

Reasons for Change

In recent years, hospitals' cost growth has slowed while operating margins have improved to record levels. According to the Prospective Payment Assessment Commission (ProPAC), in FY 1995 the average hospital Medicare PPS margin was 10%, and is anticipated to be about 12% in FY 1996, 14% in FY 1997, and 17% in FY 1998. The healthy operating margins reflect the difference between Medicare payments and the increasing efficiency attributed to the amount and timing of services furnished during inpatient stays. While margins have continued to improve, estimates of the proportion of hospitals with negative Medicare PPS margins has continued to decline. According to ProPAC, in FY 1995 34% of all hospitals had a negative Medicare PPS margin, the decline is anticipated to continue through next year to 19% of all hospitals.

ProPAC recommends a zero update for the FY 1998 PPS update in order to adjust for increasing efficiencies reflected in hospitals' declining costs. ProPAC believes a zero update would allow hospitals to continue furnishing quality care to Medicare beneficiaries while simultaneously fulfilling Medicare's responsibility to act as a prudent purchaser.

Hospital payments should be placed on a calendar year cycle because of the interaction with Regulatory Reform which will continue to delay the timely implementation of the hospital updates. Regulatory Reform requires that "major" rules have a 60 day waiting period from the date the final rule is issued to the date of implementation. The Office of Management and Budget (OMB) determined that the September 1996 interim final rule for Prospective Payment System (PPS) regulations including all Medicare hospital

payments constituted a "major rule." As a "major rule", the fiscal year 1997 PPS regulations could not be implemented for 60 days which would have caused a 30 day delay beyond the October 1st date Medicare usually provides hospitals with their annual payment inflation update. The Regulatory Reform bill was signed into law in March of 1996, and the Administration had ample time to notify agencies regarding compliance. The delay in payments could have been avoided had HCFA issued final regulations 60 days in advance of the October 1st date.

Although Congress intervened to permit the regulations to go into effect in a timely manner, it appears that the Health Care Financing Administration has not altered the timing of the development of the PPS regulations which will again lead to a delay in implementation of the regulations beyond the October 1st implementation date. In order to avert a perennial delay in the implementation of the PPS regulations, the implementation date should be moved to a calendar year cycle, which will correspond to the same timing for annual updates for physicians and most other Medicare Part B services.

Committee Provision

Establishes a calendar year cycle for all hospital PPS payments. Hospital payments for fiscal year 1997 are continued until January 1, 1998, the first calendar year update. The annual market basket update for hospitals will equal MB minus 2.5 percentage points in CY 1998, and MB minus 1 percentage point for each calendar year, 1999-2002.

Effective Date

For discharges on or after October 1, 1997.

CAPITAL PAYMENTS FOR PPS HOSPITALS

Present Law

Hospital capital expenses (the costs of building or acquiring facilities and major equipment) are paid for under the Prospective Payment System (PPS).

Until fiscal year 1992, Medicare payments for capital costs were based on each hospital's actual expenses, subject to statutory percentage reductions. A 10-year transition to fully prospective payments began in FY 1992, during which capital payments are paid prospectively based on average capital costs per case in FY 1989, updated for inflation and other cost changes.

From FY 1992 through FY 1995, the Health Care Financing Administration (HCFA) updated base payment rates using a moving average of capital cost increases in previous years. During this period, Congress required HCFA to adjust the payment rates in each year in a budget neutral manner so that anticipated aggregate capital payments would equal 90 percent of anticipated aggregate costs. This provision expired on September 30, 1995, resulting in a 22.6 percent increase in the Federal capital payment rate for FY 1996.

The Secretary implements the capital provisions by regulation. Currently, there is no separate payment for property tax related capital costs. Medicare provides for a special exceptions process for certain major capital projects.

Reasons for Change

Hospital inpatient capital payments grew 22.6 percent per discharge in FY 1996 due to expiring statutory provisions. According to HCFA, overall payments per discharge in FY 1997 are expected to increase to 27.7% above what they would have been had the budget neutrality provision not expired in FY 1996. In addition, ProPAC has stated that data indicate that the original base calculation for capital payments was overstated.

Under current law, payments for transitional capital were reduced from 85% to 70% as an attempt to contain Medicare costs. Several hospitals across the country began construction or renovation projects and raised capital under the old rules for Medicare capital costs, but under current law are required to pay off their debts under the new (lower) Medicare capital reimbursement rates.

Committee Provision

For discharges occurring on or after October 1, 1998 the Committee provision reinstates the original OBRA 1990 budget neutrality requirement (extended in OBRA 1993 for fiscal years 1994 and 1995) through fiscal years 1998-2002 so that aggregate capital payments each year equal 90 percent of what payments would be under reasonable cost payments.

The provision amends the exceptions process provided in federal regulation to include as eligible for an exception hospitals located in an urban area, with over 300 beds, and without regard to whether a hospital qualifies for additional disproportionate share hospital (DSH) payment amounts. The provision amends the project size requirement to require that a hospital's project costs must be at least 150% of its operating costs during the first 12-month cost reporting period beginning on or after October 1, 1991. The provision requires the minimum payment level for qualifying hospitals be equal to 85%. The provision requires that a hospital be considered to meet the requirement that the capital project involved be completed no later than the end of the hospital's last cost reporting period beginning before October 1, 2001, if: (1) the hospital had obtained a certificate of need for the project approved by the state or local planning authority by September 1, 1995, and (2) by September 1, 1995, the hospital has expended on the project at least $750,000 or 10% of the estimated cost of the project. The provision also requires that the additional payment that would otherwise be payable for the cost reporting period will be reduced by the amount (if any) by which the hospital's current year Medicare capital payments (excluding the hospital's capital-related DSH payments) exceeds the hospital's capital costs for such year.

The provision requires the Secretary to implement the provision in a budget neutral manner not to exceed $50 million per year to ensure that the provision will not result in an increase in the total amount that would have otherwise been paid. The provision re-

quires the Secretary to publish annually (beginning in 1999) in the Federal Register a description of the distributional impact of the application of this capital exception on hospitals which receive and do not receive a capital exception payment. The provision also provides a conforming amendment that requires the provision of capital exception payments.

Effective Date

Discharges occurring on or after October 1, 1997.

PPS-EXEMPT HOSPITAL PAYMENTS

Present Law

Not all hospitals paid by Medicare are paid by the Prospective Payment System (PPS). There are a number of special categories of hospitals that Medicare pays based on the hospitals' costs. These five types of hospitals are:

1. Rehabilitation hospitals/rehabilitation units of hospitals treat patients with injuries or conditions who require extensive hospital-based therapy and who can withstand at least 3 hours of therapy per day (i.e., a patient in need of therapy must be healthy enough to tolerate the minimum therapy required);
2. Psychiatric hospitals/psychiatric units of hospitals (e.g., patients with severe mental illnesses that require hospital stays);
3. Long-term care hospitals treat patients who on average, require, 25 days or more of hospital care;
4. Cancer hospitals limited by law in OBRA 1989 as determined at that time by the National Cancer Institute as research-based cancer hospitals; and
5. Pediatric hospitals.

Medicare will reimburse for only two of these types of facilities as distinct-part units within an acute care hospital. A PPS hospital can establish psychiatric or rehabilitation "distinct units" or wings, and the host hospital receives a separate reimbursement for patients undergoing treatment in those wings. A hospital may not create a PPS-exempt long-term care unit, it must completely separate the two forms of care so that the long-term care hospital is a "hospital within a hospital."

These types of hospitals are excluded by law from Medicare's PPS payments (PPS-exempt) and are paid on the basis of reasonable costs, subject to limits in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) rate of increase limits. The rate of increase limits are called "TEFRA limits".

TEFRA payments for inpatient operating costs are based on each provider's current Medicare allowable costs per discharge or a target amount. A hospital's target amount is based on its inpatient operating costs per discharge in a base year, trended to the current year by an annual update factor. While payments must be for covered services, a new facility seeking to establish its TEFRA base-year ceiling is exempted from any limit.

A facility with Medicare-allowable inpatient operating costs less than its ceiling (its target amount times the number of discharges) receives its costs plus an additional amount, known as the "bonus"

payment, that is equal to half the difference between its ceiling and costs or 5 percent of its ceiling, whichever is less.

A facility with Medicare-allowable inpatient operating costs above its ceiling receives a "relief" payment equal to its ceiling plus either 50 percent of the difference between its costs and ceiling or 10 percent of its ceiling, whichever is less.

There are additional payments made for exceptions.

OBRA 93 provided for an update factor to the TEFRA limits that range from zero to market basket minus 1.0 percentage point for fiscal years 1994–1997. A hospital with operating costs in FY 1990 that exceeded its TEFRA target amount by 10 percent or more receives a full MB update, with partial reductions applied to hospitals near the threshold.

PPS-exempt hospitals are paid for the reasonable costs of capital.

Reasons for Change

TEFRA payments rely on historical costs to set target amounts that systematically reward certain facilities and penalize others.

Newly certified facilities have no incentives under Medicare to restrain their costs. In fact, they have an incentive to come into TEFRA with high base year costs per case, thereby establishing a high target amount. These newly certified facilities are then essentially guaranteed cost reimbursement for their high costs, as long as they stay below their target amounts. According to ProPAC, in 1995, target amounts for Rehabilitation hospitals and units varied from a target amount of $8,585 representing the 10th percentile, to $95,930 maximum target amount paid to a hospital or unit for essentially the same discharge. For long-term care hospitals, in 1995, $4,612 represented the 10th percentile target amount, $84,995 the maximum target amount. The very wide divergence in payments per discharge can not be justified for either of these types of hospitals, other than the incentives rooted in a cost-based reimbursement system.

Fueled by the TEFRA payment incentives, the number of PPS-exempt providers has grown rapidly since 1990, especially rehabilitation facilities and long-term care hospitals. Although the total number of facilities remains small, few other provider groups can match the growth seen in rehabilitation facilities and long-term care hospitals.

The number of rehabilitation hospitals and units combined increased 26% from 1990 to 1995. The number of long-term care hospitals grew by 105% over that same period.

Committee Provision

(a) The update will vary for hospitals above and below their target amounts for fiscal years 1998-2002. For hospitals (1) with costs that exceed their target amounts in fiscal year 1995 by 10 percent or more, the update will equal the market basket; (2) that exceed their target, but by less than 10%, the update factor is the market basket minus .25 percentage points for each percentage point by which costs are less than 10% over the target, but it shall not be less than zero; (3) that are either at their target, or below (but not below 2/3 of the target amount for the hospital) the update factor

would be the market basket minus 1.5 percentage points, but in no case less than zero; or (4) that do not exceed 2/3 of their target amount, the update factor would be 0.

(b) Hospital capital payments for PPS-exempt hospitals are reduced by 15 percent for FY 1998–2002 (cancer and children's hospitals are exempted).

(c) Bonus payments are reduced to the lesser of:

(1) 10% of (the TARGET amount minus COSTS), or

(2) 1% of COSTS.

(d) Relief payments are altered so that they apply only to those facilities in greatest need (with costs that are at least 10% above their target).

(e) Target amounts are adjusted for existing rehabilitation hospitals, long-term care hospitals, and psychiatric hospitals. Hospitals with low target amounts will be adjusted so that they will not be less than 50 percent of the national average, and the maximum amount reimbursed will be limited to the 90th percentile of each category of hospitals' target amounts.

Establishes new payment criteria for start-up facilities, so that target amounts do not exceed 130 percent of the national average. The Secretary shall calculate new provider base target amounts for each facility type using data from all providers within each category modified by geographic location, size, and patient characteristics that are related to resource use.

(f) Permanently grandfathers long-term care hospitals that were established within a hospital prior to September 30, 1995.

(g) Establishes a new category of PPS-exempt hospitals. Non-research cancer hospitals that were qualified as long-term care hospitals between 1991 and 1995 may qualify under the new designation. At least 50% of their discharges must be cancer related.

(h) Makes technical correction for a National Cancer Institute designated comprehensive cancer center.

Effective Date

Cost reports beginning on or after October 1, 1998.

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

Present Law

Under Medicare's Prospective Payment System (PPS), an extra payment is made for certain hospitals that serve a disproportionate share of low-income patients.

The amount of the extra DSH payment for each hospital is based on a formula that considers certain hospital and patient factors. The factors considered in determining whether a hospital qualifies for a DSH payment adjustment include the number of beds, the disproportionate patient percentage, and the hospital's location. A hospital's disproportionate patient percentage is the sum of (1) the total number of inpatient days attributable to Federal Supplemental Security Income (SSI) beneficiaries divided by the total number of Medicare patient days, and (2) the number of Medicaid patient days divided by total patient days, expressed as a percentage. A hospital is classified as a DSH under any of the following circumstances:

(1) If its disproportionate patient percentage equals or exceeds:

(a) 15 percent for an urban hospital with 100 or more beds, or a rural hospital with 500 or more beds (the latter is set by regulation);

(b) 30 percent for a rural hospital with more than 100 beds and fewer than 500 beds or is classified as a sole community hospital;

(c) 40 percent for an urban hospital with fewer than 100 beds; or

(d) 45 percent for a rural hospital with 100 or fewer beds, or

(2) if it is located in an urban area, has 100 or more beds, and can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to indigent payments. (This provision is intended to help hospitals in States that fund care for low-income patients through direct grants rather than expanded Medicaid programs.)

For a hospital qualifying on the basis of (1)(a) above, if its disproportionate patient percentage is greater than 20.2 percent, the applicable PPS payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage. If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is equal to: 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage. If the hospital qualifies as a DSH on the basis of (1)(b), the payment adjustment factor is determined as follows:

(a) if the hospital is classified as a rural referral center, the payment adjustment factor is 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent;

(b) if the hospital is a sole community hospital (SCH) the adjustment factor is 10 percent;

(c) if the hospital is classified as both a rural referral center and a SCH, the adjustment factor is the greater of 10 percent or 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent; and

(d) if the hospital is not classified as either a SCH or a rural referral center, the payment adjustment factor is 4 percent.

If the hospital qualifies on the basis of (1)(c), the adjustment factor is equal to 5 percent. If the hospital qualifies on the basis of (1)(d), the adjustment factor is 4 percent. If the hospital qualifies on the basis of (2) above, the payment adjustment factor is 35 percent.

Reasons for Change

It is more difficult for rural hospitals to qualify for Medicare DSH payments because the threshold is much higher for rural than urban hospitals, even if they treat the same number of low-income individuals. The Prospective Payment Assessment Commission (ProPAC) supports applying a uniform threshold to all hospitals.

ProPAC also recommends that Medicare DSH payments should reflect the additional costs of services provided to low-income groups in both inpatient and outpatient settings, and uninsured and underinsured patients as reflected by uncompensated and charity care.

According to ProPAC, DSH payments have grown rapidly since fiscal year 1989, increasing almost fourfold from $1.1 billion to $4.3 billion in 1996. This acceleration is largely due to legislative changes that raised the DSH payment rate for some hospitals.

Committee Provision

From October 1, 1997 to January 1, 1999, apply current formula with a 4% reduction in the DSH adjustment. This will reduce DSH payments to hospitals by 4%.

For Calendar Years 1999–2002, the Secretary will continue to apply an additional 4% reduction in the DSH payment adjustment.

On January 1, 1999, the Secretary must establish a new formula that takes into account Medicaid, Medicare SSI, and uncompensated/charity care. This new formula will have one threshold for all hospitals. In each year, the Secretary must implement the new formula in a budget neutral manner in order to achieve the same savings that would have been achieved with the old formula under the provisions above.

Effective Date

Cost reporting periods beginning on or after October 1, 1997.

CAPITAL ASSETS SALE EQUAL TO BOOK VALUE

Present Law

Medicare provides for establishing an appropriate allowance for depreciation and for interest on capital indebtedness and a return on equity capital when a hospital or skilled nursing facility has undergone a change of ownership. The valuation of the asset is the lesser of the allowable acquisition costs of the asset to the owner of record, or the acquisition cost of such asset to the new owner.

Reasons for Change

There is increasing evidence that intangible losses that do not have any true value associated to them are being included in the sale of facilities because Medicare will currently reimburse for these "paper" losses.

Committee Provision

Establishes the value of a capital asset at the time of change of ownership at the book value of the asset. The Committee provision also applies this valuation to providers of services other than hospitals and skilled nursing facilities, and eliminates return on equity.

Effective Date

After the third month beginning after the date of enactment of this Act.

GRADUATE MEDICAL EDUCATION PAYMENTS

Present Law

Since the inception of the Medicare program in 1965, Medicare has reimbursed teaching hospitals for certain costs associated with approved graduate medical education (GME) programs. GME is a period of clinical education of physicians after graduation from medical school. Physicians-in-training are called "interns" or "residents." Since enactment of the hospital prospective payment system (PPS) in the early 1980's, Medicare has made two specific GME payments to teaching hospitals: direct and indirect medical education payments.

(a) Direct Medical Education (DME) Payments.—DME payments reimburse a teaching hospital for the costs of a resident's salary, benefits, and certain overhead associated with operating a teaching program. The DME payment is calculated as the product of three factors: (1) The adjusted number of full-time residents; (2) the Medicare patient load of the hospital (the fraction of the hospital's total number of inpatient days the Medicare beneficiaries represent); and an amount per resident (which reflects each teaching hospital's allowed DME costs per resident in 1984 adjusted for inflation).

(b) Indirect Medical Education (IME) Payments.—IME payments reimburse teaching hospitals for certain other costs associated with physician training, such as the additional tests or procedures that may be ordered by a resident. For IME, Medicare pays teaching hospitals an additional percentage of each Medicare beneficiary's hospital bill by increasing the diagnosis-related group (DRG) payment by approximately 7.7 percent for each 10 percent increment in a hospital's ratio of interns and residents to hospital beds.

(c) Direct and Indirect Medical Education Payments for Managed Care Organizations.—Teaching hospitals do not receive a direct payment from Medicare for either DME and IME payments for beneficiaries enrolled in HMOs. Instead, such payments are included in the monthly amount Medicare pays to HMOs.

Reason for Change

(a) Direct Medical Education (DME) Payments.—The number of U.S. medical school graduates filling residency positions in teaching hospitals has remained relatively constant, while the total number of resident positions have grown sharply in recent years. Expert testimony has suggested that Medicare's unlimited reimbursement of additional resident positions has substantially fueled this growth, and contributed to a generally acknowledged surplus in the physician workforce. However, it is also believed rural areas have physician shortages, in part because residency programs are rarely located in rural areas which would create ties and attachments to rural communities.

(b) Indirect Medical Education (IME) Payments.—The Prospective Payment Assessment Commission (ProPAC) has advised Con-

gress that Medicare is paying more than Medicare's share of hospitals' costs for IME, and that this amount should be reduced. In addition, current law limits ME payments to hospital departments, which provides a disincentive to train residents in ambulatory care settings where medical care is increasingly provided.

(c) Direct and Indirect Medical Education Payments for Managed Care Organizations.—At present, there is no assurance that the portion of the monthly Medicare payment to HMOs attributed to direct and indirect medical education is actually paid to teaching hospitals. Moreover, payment of graduate medical education subsidies by Medicare directly to teaching hospitals for HMO enrollees would permit teaching hospitals to be more competitive in negotiating rates with HMOs and other managed care organizations.

Committee Provision

(a) Direct Medical Education (DME) Payments.—The Committee provision would provide that the number of allopathic and osteopathic interns and residents reimbursed by Medicare could not exceed the number of interns and residents reported on a hospital's cost report for the period ending December 31, 1996. Subject to this limit, for cost reporting periods beginning on or after October 1, 1997, the Committee provision provides for calculating the number of FTEs as the average of the cost period and the preceding cost period; for each subsequent year, the cost period and the two preceding cost periods. The Committee provision also would permit DME payments to Federally qualified health centers (FQHCs) and rural health clinics (RHCs) with approved medical residency training programs.

(b) Indirect Medical Education (IME) Payments.—The Committee provision would reduce the additional payment adjustment for IME from 7.7 percent for each 10 percent increment in the ratio of interns and residents to beds to:

1. Fiscal year 1998: 7.0 percent, and
2. Fiscal year 1999: 6.5 percent,
3. Fiscal year 2000: 6.0 percent,
4. Fiscal year 2001: 5.5 percent and after, for each 10 percent increment in the ratio of interns/residents to beds.

For purposes of computing the intern-and-resident to bed ratio, the Committee would limit the number of interns and residents to the total number of residents and interns in a hospital or non-hospital setting reported on the hospital's cost report for the period ending December 31, 1996. This provision would be effective for discharges occurring after October 1, 1997. Subject to this limit, for hospital's first cost-reporting period beginning on or after October 1, 1997, the number of FTE residents and interns for payment purposes would equal the average of the actual FTE resident and intern count for the cost reporting period and the preceding year's cost reporting period. For the cost reporting period beginning October 1, 1998, and each subsequent cost reporting period, subject to certain limits, the total number of FTE residents and interns for payment purposes would equal the average of the actual FTE resident count for the cost reporting period and the preceding two year's cost reporting periods.

The Committee provision would permit that time spent by an intern or resident in patient care activities under an approved medical residency training program at a non-hospital setting shall be counted towards FTEs if the hospitals incurs all or substantially all the costs for training in that setting.

(c) Direct and Indirect Medical Education Payments for Medicare Choice Organizations.—The Committee provision would provide that care provided by teaching hospitals to Medicare beneficiaries enrolled in managed care organizations would be recognized in the formulas for direct and indirect graduate medical education payments in proportion to the annual carve out of such amounts from payments to Medicare Choice organizations.

(d) Other Provisions.—The Committee provision would authorize the Secretary to approve DME and IME payments to facilities which had not previously had a Medicare approved graduate medical education program and to annually increase such payments for a period of no more than 5 years, and to increase such payments to facilities with programs less than 5 years old for a period of 5 years following establishment of the program. The Secretary would be limited by the difference in number of positions reimbursed or counted in the current calendar year and the previous calendar year. The Secretary shall give special consideration to facilities that meet rural underserved needs.

The Committee provision would also authorize the Secretary to establish consortia demonstration projects which demonstrate innovative graduate medical education and payment methods. The purposes of the consortia demonstration projects are varied, such as encouraging the participation of payers, public and private, to further supplement Medicare's funding for the extra costs associated with graduate medical education. The Committee encourages the Secretary to give special consideration to applications for consortia demonstration projects that emphasize rural primary care with training experience in community-based settings; geriatrics; participation by other payers that supplements Medicare funding for graduate medical education, and the use of telehealth and computer technologies to supervise and support residents in community-based training settings.

Effective Date

Cost reporting periods beginning on or after October 1, 1997.

ELIMINATE ADD-ONS FOR OUTLIERS (DSH AND GME)

Present Law

Medicare provides outlier payments to hospitals that are intended to protect them from the risk of large financial losses associated with cases having exceptionally high costs or unusually long hospital stays.

Outlier payments are meant to be self-funded as a percentage of all hospital payments. Every year, the Secretary of Health and Human Services establishes an outlier payment funding pool of 5% to 6% of all the anticipated hospital payments for that year.

Beginning in FY 1998, the length of stay outlier policy will terminate, and hospitals will receive outlier payments only for very high

cost cases. For each diagnosis related group (DRG), a specific dollar loss threshold is set, and outlier payments are calculated based on the amount by which a hospital's costs exceed this loss threshold. For teaching and disproportionate share hospitals, however, their estimated cost for each case is reduced by the amount of the hospital's IME and DSH payment adjustments. The amount by which the estimated cost exceeds the outlier threshold thus is less for a case treated at a teaching or disproportionate share hospital, resulting in lower outlier payments. The lower outlier payment amount is then increased by the hospital's IME and DSH adjustments, but this generally is not enough to offset the loss in outlier payments resulting from the reduced cost estimate for the case.

Reasons for Change

Teaching and DSH adjustments are now made on top of the DRG plus the outlier payment which means the Medicare program is spending more on IME and DSH for outlier cases than is warranted.

Committee Provision

Changes the ways that IME and DSH payments are calculated for cost outlier cases. The IME and DSH adjustments will be made to the base payment amount, not to the outlier portion of a hospital's payment. The provision would result in teaching and disproportionate share hospitals being treated like all other hospitals in the calculation of outlier payment amounts. Their estimated costs per case would not be reduced by their IME and DSH payments, and an additional IME or DSH adjustment would not be added to these payments.

Effective Date

The provision would apply to discharges occurring after September 30, 1997.

TREATMENT OF TRANSFER CASES

Present Law

Medicare adjusts its payment to a hospital which has transferred a patient to another hospital. In these cases, the diagnosis related group (DRG) payment to the hospital "sending" a patient to a second hospital is reduced because the "sending" hospital did not complete the term of care for the patient.

In a transfer situation, full payment is made for a patient's stay to the second hospital which completes the patient's hospital care and then discharges the patient. The "sending" hospital is paid a per diem rate for each day of the stay; total per diem payments are not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

This transfer policy is only applicable when an acute care hospital transfers a patient to another acute care hospital.

Reasons for Change

Present law does not apply to patients discharged from a hospital to a skilled nursing facility, home health agency or to a Prospective Payment System-exempted (PPS-exempt) hospital or distinct unit. The Committee provision will curb the current "double dipping" trend of hospitals moving Medicare patients early on in their course of treatment to an alternative health care setting (often a separate wing or floor of the same facility) while still receiving the full hospital DRG payment.

Committee Provision

Discharges from an acute care hospital to a PPS-exempt hospital or unit, a skilled nursing facility, (after April, 1998, discharges to home health care), will be considered "transfers" for payment purposes.

BAD EBT

Present Law

Certain hospital and other provider bad debts are reimbursed by Medicare on an allowable cost basis. To be qualified for reimbursement, the debt must be related to covered services and derived from deductible and coinsurance amounts left unpaid by Medicare beneficiaries. The provider must be able to establish that reasonable collection efforts were made and that sound business judgement established that there was no likelihood of recovery at any time in the future.

Reasons for Change

The payment of hospitals' Medicare-related bad debt is a legacy of hospital cost-based reimbursement. Under the current prospective payment system, bad debts should be considered a cost of doing business. Providers under Part B of the Medicare program are not reimbursed for bad debt.

Committee Provision

Reduces bad debt payments to providers by 25 percent for cost reporting periods beginning during FY 1998; 40 percent for cost reporting periods beginning in FY 1999; and 50 percent for subsequent cost reporting periods.

FLOOR ON AREA WAGE INDEX

Present Law

As part of the methodology for determining payments to hospitals under the Medicare prospective payment system (PPS), the Secretary is required to adjust a portion of the standardized amounts for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average wage level.

Reason for Change

Insures that the wage index in urban areas is at least equal to that of rural areas in a state.

Committee Provision

For discharges occurring on or after October 1, 1997, the area wage index applicable for any hospital which is located in an urban area can not be less than the average of the area wage indices applicable to hospitals located in rural areas in the state in which the hospital is located. The Secretary is required to make any adjustments in the wage index in a budget neutral manner.

INCREASE BASE PAYMENT RATE TO PUERTO RICO

Present Law

Hospitals in Puerto Rico are paid in a similar manner to hospitals paid on the United States mainland, however, they are paid a much lower amount. The lower payments are largely attributed to the dramatically lower prevailing wage in Puerto Rico. For hospital capital payments, Puerto Rico receives a special payment for capital which is lower than what most hospitals on the US mainland receive.

—Puerto Rico hospital payments are based on a different standardized amount. The Puerto Rican standardized amount is a blend of 75% of the local average cost of treating a patient in Puerto Rico and 25% of a national amount (this is not the same as the national standardized amount).

Reasons for Change

In 1995, Puerto Rico's urban hospitals had an average inpatient PPS margin of −4%, while mainland United States hospitals had an average 10.7% margin.

Committee Provision

Increases payments to Puerto Rico's hospitals by altering the blended formula for the standardized amount from the 75% local rate, 25% Federal rate to a 50%/50% blend.

PERMANENT EXTENSION OF HEMOPHILIA PASS-THROUGH

Present Law

Medicare made additional payments for the costs of administering blood clotting factor to Medicare beneficiaries with hemophilia admitted for hospital stays where the clotting factor was furnished between June 19, 1990 and September 30, 1994.

Reasons for Change

Due to increases in the cost of clotting factor resulting from the increase in AIDs prevalence in the blood supply, in 1989, Congress changed the way Medicare paid for inpatient costs of clotting factor by providing an add-on to the PPS payment rates. This change was

initially limited to 18 months and then subsequently extended through FY 1994.

Committee Provision

Permanently reinstates Medicare's additional payments for the costs of administering blood clotting factor to Medicare beneficiaries with hemophilia admitted forhospital stays where the clotting factor was furnished. Reaches back to September 30, 1994, and makes the provision permanent.

PAYMENTS FOR HOSPICE SERVICES

Present Law

Medicare covers hospice care for terminally ill beneficiaries with a life expectancy of 6 months or less. Persons electing Medicare's hospice benefit are covered for four benefit periods: two 90-day periods, a subsequent 30-day period, and a final period of unlimited duration.

At the beginning of the first 90-day period when a Medicare beneficiary elects hospice, both the individual's attending physician and the hospice physician must certify in writing that the beneficiary is terminally ill not later than 2 days after hospice is initiated (or, verbally not later than 2 days after care is initiated and in writing not later than 8 days after care has begun).

Medicare covers hospice care, in lieu of most other Medicare benefits. Payment for hospice care is based on one of four prospectively determined rates, which correspond to four different levels of care, each day a beneficiary is under the care of the hospice. The four categories are routine home care, continuous home care, inpatient respite care, and general inpatient care. The prospective payment rates are updated annually by the hospital market basket index (MB).

Hospice services are defined in Medicare statute to include nursing care; physical and occupational therapy and speech language pathology services; medical social services; home health aide services; medical supplies (including drugs and biologicals) and medical appliances; physician services; short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management); and counseling. Beneficiaries electing hospice waive coverage to most Medicare services when the services they need are not related to the terminal illness.

Medicare law requires that hospices routinely provide directly substantially all of certain specified services, often referred to as core services. Physician services are among these core services. HCFA has defined "directly" to require that services be provided by hospice employees.

Hospices generally bill Medicare on the basis of location of the home office, rather than where service is actually delivered.

Medicare law provides financial relief to beneficiaries and providers for certain services for which Medicare payment would otherwise be denied. Medicare payment under this "limitation of liability" provision is dependent on a finding that the beneficiary did not know and could not reasonably have been expected to know that

services would not be covered on one of several bases (but not on the determination that an individual is not terminally ill).

Reasons for Change

The hospice benefit should be altered to better reflect the needs of the terminally ill. The current benefit should be changed to provide hospices greater flexibility to deliver services, as well as clearer guidelines for patient certification. Patients who enroll in hospice care, yet who are not deemed to be terminally ill should not be penalized.

Committee Provision

(a) Hospice benefit periods will be restructured to include two 90 day periods, followed by an unlimited number of 60 day periods. The medical director of the hospice will have to recertify at the beginning of the 60 day periods that the beneficiary is terminally ill. The provision will also allow greater flexibility in items and services provided in hospice care as long as they are part of the patient's plan of care. Hospices will be allowed to contract with physicians. Certain staffing requirements will be waived for rural hospices. Eliminates the specific time frame physicians must complete certification forms in order to admit a patient to hospice care.

(b) Requires payment for hospice care furnished in an individual's home be based on the geographic location of the home.

(c) Places limitations on hospice care liability for individuals who are not in fact terminally ill. Provides that Medicare beneficiaries do not have to pay for hospice care based on an incorrect diagnosis of terminal illness if the beneficiary did not know, and could not reasonable have been expected to know, that the diagnosis was in error. As is the case under current practice for other situations involving waiver of liability, a beneficiary has a favorable presumption of ignorance, while a provider of services does not.

Effective Date

Cost reporting periods beginning on or after October 1, 1997.

RELIGIOUS, NON-MEDICAL SERVICES

Present Law

Since Medicare was first enacted, the program has covered the services furnished by Christian Science sanatoria under Part A of the program. In order to be a covered provider, the institution must be listed and certified by the First Church of Christ Scientist, of Boston, Massachusetts. A certified sanatorium qualifies as both a hospital and as a skilled nursing facility. Under Medicare, two separate types of benefits are payable: services received in an inpatient Christian Science sanatorium and extended care services in a sanatorium. Section 1861(e)(9) of the Social Security Act includes a Christian Science sanatorium in the definition of a hospital; 1861(y) defines extended care in a Christian Science skilled nursing facility. Under the Medicaid program, states have the option of covering services provided by Christian Scientist sanatoria and extended care facilities.

Reasons for Change

The need for clarification of how the statute treats religious, nonmedical institutions became evident after the current statutory provisions were successfully challenged in a Minnesota District Court which held that they violate the Establishment Clause of the Constitution as an impermissible sectarian preference. The Court's decision enjoined the Secretary from further implementation of the law, but the injunction was stayed until August.

Committee Provision

This provision replaces existing law and provides for reimbursement of nursing services to individuals who decline to accept medical care due to sincerely held religious beliefs. The provision requires the Health Care Financing Administration (HCFA) to develop conditions of participation for religious, nonmedical institutions and to require that such conditions are met. The provision requires that HCFA develop the conditions of participation in a manner that will not exceed $20 million per year.

Subtitle G—Provisions Relating to Part B Only

CHAPTER 1—PAYMENTS FOR PHYSICIANS AND OTHER HEALTH CARE PROVIDERS

PAYMENTS FOR PHYSICIAN'S SERVICES

Present Law

(a) Physician Fee Schedule.—Medicare pays for over 7,000 physician services according to a fee schedule. The Medicare physician fee schedule uses two formulas: (1) one to calculate the fee for each service; and (2) another to annually revise or "update" the fees.

Under the fee schedule, each physician service is assigned relative value units (RVUs) that reflect three factors: physician work, practice expenses (i.e., office costs), and malpractice insurance costs. The RVUs for each service are adjusted for geographic variations in the costs of practicing medicine.

To determine the Medicare fee payment for a physician service, the adjusted RVUs for that service are multiplied by a dollar amount called a "conversion factor." There are currently three conversion factors, for (1) surgical services; (2) primary care services; and (3) other nonsurgical services. In 1997, the conversion factors were: $40.96 for surgical services; $35.77 for primary care services; and $33.85 for other nonsurgical services.

Each year, unless Congress otherwise provides, a default formula is used to update each conversion factor. The default update is the sum of the Medicare Economic Index (MEI) (a measure of inflation) and a volume performance adjustment. If the volume performance adjustment is less than MEI, the update is positive; if less than MEI, the update is negative.

The volume performance adjustment is intended to reward restraint in increases in the quantity of physician services provided to beneficiaries (so-called volume and intensity of services), and is a comparison of actual physician spending in a base period with an

expenditure goal known as the Medicare Volume Performance Standard (MVPS). MVPS is calculated from changes in volume and intensity of services and certain other factors, based on data from the second-preceding fiscal year (e.g., 1995 data would be used to determine the 1997 update). The MVPS derived from this calculation is subject to a reduction known as the "performance standard factor." The MVPS has a lower limit of MEI minus five percentage points.

Anesthesia services are reimbursed according to a separate fee schedule, although that fee schedule also uses RVUs and a conversion factor. The anesthesia services conversion factor was $16.68 in 1997.

(b) Resource-Based Methodology for Practice Expenses.—Currently, practice expenses (i.e., the costs of running a doctor's office) are based on charges to the Medicare program before the enactment of the physician fee schedule in 1989, not the resources actually used in providing each physician service. However, a resource-based methodology for practice expenses was intended by the Omnibus Reconciliation Act of 1989 (OBRA 1989), which established the physician fee schedule. In the Social Security Act Amendments of 1994, Congress instructed the Secretary of Health and Human Services to implement a resource- based methodology for practice expenses, to be implemented in 1998.

Reasons for Change

(a) Physician Fee Schedule.—The Committee provision provides for a single conversion factor. A single conversion factor restores the integrity of the fee schedule. When the fee schedule was established, it was intended that each RVU should be worth the same amount across all physicians' services, and not by the category of physician service (i.e., surgical services, primary care services, and other non-surgical services). However, under current law, physician services assigned the same number of RVUs may be paid differing amounts. The Committee provision corrects this distortion of the physician fee schedule. A single conversion factor has been recommended by the Physician Payment Review Commission.

(b) Resource-Based Methodology for Practice Expenses.—The resource-based practice expense methodology is expected to result in enhanced reimbursement for physician services provided in an office setting with undervalued office costs, and reduced reimbursement for services provided in a hospital or other health care facility (such as surgical procedures) with overvalued costs. To allow this redistribution to proceed in an orderly fashion, the Committee provision would provide for an extended transition period for implementation of the resource-based methodology for practice expenses.

Committee Provision

(a) Physician Fee Schedule.—The Committee bill would provide for the establishment of a single conversion factor, rather than three conversion factors, effective January 1, 1998. The provision would set the single conversion factor for 1998 at the 1997 primary care conversion factor, updated to 1998 by the Secretary's estimate

of the weighted average of the three separate updates that would occur in the absence of the legislation.

The Committee bill would modify the default update formula, effective for calendar year 1997. The update would equal the product of MEI and the update adjustment factor. The update adjustment factor would match spending on physician services to a cumulative sustainable growth rate. By November of each year, the Secretary will calculate the update adjustment factor for the succeeding year on the basis of a comparison between cumulative target spending (cumulated from annual sustainable growth rate calculations) and cumulative actual spending from a base year of July 1996 to June 1997. The annual sustainable growth rate would be calculated with the same factors as the current Medicare Volume Performance Standard (MVPS), except the factor of growth in historical volume and intensity of physician services is replaced with projected annual growth in real Gross Domestic Product (GDP) and the performance standard factor is eliminated.

The update would be subject to upper and lower bounds. The update could be no greater than approximately MEI plus three percentage points, or less than MEI minus seven percentage points.

The Committee provision specify that the conversion factor for anesthesia services would equal 46 percent of the conversion factor established for other services for 1998.

(b) Resource-Based Methodology for Practice Expenses.—The Committee provision would provide a one-year delay in the implementation of the proposed rule for a resource-based methodology for practice expenses by the Health Care Financing Administration (HCFA) and a subsequent phase in of a rule over a subsequent three-year period, from January 1, 1999 through January 1, 2001. For 1998, the Committee bill would establish a special rule by which approximately 10 percent of the amount of money expected to be redistributed under practice expense reform would be subtracted from the practice expenses of physician services where practice RVUs exceed work RVUs by 110 percent and added to the practice expenses of primary care services provided in a physician's office which have been determined to have been historically underpaid. Full implementation of practice expense reform would occur no later than 2001, with implementation in equal yearly proportions over this period.

The Committee is aware and concerned that many issues have been raised about the resource-based practice expense methodology proposed by HCFA. To provide for an independent and objective review of these issues, the Committee provision would provide for a study within 6 months by the General Accounting Office. The GAO study is intended to be a thorough examination of the proposed rule on practice expenses. As part of this examination, the Committee expects that GAO will consult with organizations representing physicians and to address the issue of beneficiary access to medical services. The Committee provision would also direct the Secretary to solicit the individual views of physicians in the practice of surgical and non-surgical specialties, physicians in academic practice, and other appropriate experts. The Committee provision would direct the Secretary to report to the appropriate committees of jurisdiction the results of these consultations.

The Committee expects the Secretary to carefully review both the GAO report and the information provided by the individual physicians and other experts. The Committee intends to review these reports carefully as well. If the Secretary determines that insufficient data exists to support the proposed rule, or finds other serious problems with the proposed rule, the Committee expects the Secretary to collect new data or take such other actions needed to correct any deficiencies, including a new study, before proceeding to a final rulemaking. In general, any new data collection or other action to correct deficiencies shall include the following: (1) direct and indirect cost accounting according to standard accounting principles; (2) physician associated costs of non-physician staff, personnel, equipment and supplies used by a physician in the delivery of patient related service, regardless of site; and (3) inclusion of appropriate physician practices relevant to the provision of services to Medicare beneficiaries.

Effective Date

Generally January 1, 1998.

INCREASED MEDICARE REIMBURSEMENT FOR NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS, AND PHYSICIAN ASSISTANTS

Present Law

(a) Payments for Nurse Practitioners and Clinical Nurse Specialists.—Separate payments are made for nurse practitioner (NP) services provided in collaboration with a physician, which are furnished in a nursing facility. Such payments equal 85 percent of the physician fee schedule amount. Nurse practitioners and clinical nurse specialists (CNSs) are paid directly for services provided in collaboration with a physician in a rural area. Payment equals 75 percent of the physician fee schedule amount for services furnished in a hospital and 85 percent of the fee schedule amount for other services.

(b) Payments for Physician Assistants.—Separate payments are made for physician assistant (PA) services when provided under the supervision of a physician: (1) in a hospital, skilled nursing or nursing facility, (2) as an assistant at surgery, or (3) in a rural area designated as a health professional shortage area.

Reasons for Change

Expanded reimbursement of nurse practitioners, clinical nurse specialists, and physician assistants would enhance the availability of care in rural areas and of primary care services to Medicare beneficiaries generally.

Committee Provision

(a) Payments for Nurse Practitioners and Clinical Nurse Specialists.—The provision would remove the restriction on settings. It would also provide that payment for NP and CNS services could only be made if no facility or other provider charges are paid in connection with the service. Payment would equal 80 percent of the lesser of either the actual charge or 85 percent of the fee schedule

amount for the same service if provided by a physician. For assistant-at-surgery services, payment would equal 80 percent of the lesser of either the actual charge or 85 percent of the amount that would be recognized for a physician serving as an assistant at surgery. The provision would authorize direct payment for NP and CNS services.

The provision would clarify that a clinical nurse specialist is a registered nurse licensed to practice in the state and who holds a master's degree in a defined clinical area of nursing from an accredited educational institution.

(b) Payments for Physician Assistants.—The Committee provision would remove the restriction on settings. The Committee provision would also provide that payment for PA services could only be made if no facility or other provider charges are paid in connection with the service. Payment would equal 80 percent of the lesser of either the actual charge or 85 percent of the fee schedule amount for the same service if provided by a physician. For assistant-at-surgery services, payment would equal 80 percent of the lesser of either the actual charge or 85 percent of the amount that would be recognized for a physician serving as an assistant at surgery. The provision would further provide that the PA could be in an independent contractor relationship with the physician. Employer status would be determined in accordance with state law.

Effective Date

January 1, 1998.

CHIROPRACTIC SERVICES DEMONSTRATION PROJECT

Present Law

Medicare covers chiropractic services involving manual manipulation of the spine to correct a subluxation demonstrated to exist by X-ray. Medicare regulations prohibit payment for the X-ray either if performed by a chiropractor or ordered by a chiropractor.

Reason for Change

Current policy on coverage of services provided by chiropractors was enacted 20 years ago and does not reflect current subsequent developments in recognition of the value of chiropractic services. This demonstration will provide additional information on the cost effectiveness of services provided by chiropractors.

Committee Provision

The Committee provision would direct the Secretary to establish a two-year demonstration project, beginning not later than one year after enactment, to examine methods under which access to chiropractic services by Medicare beneficiaries might be expanded on a cost-effective basis.

The Secretary would conduct a demonstration with at least the following elements: (1) the effect of allowing doctors of chiropractic to order and be reimbursed for x-rays; (2) the effect of removing the x-ray requirement; (3) the effect of allowing chiropractors, within the scope of their licensure, to provide physicians services to bene-

ficiaries; and (4) the cost effectiveness of allowing beneficiaries who are enrolled with a risk-based HMO to have direct access to chiropractors. Direct access would be defined as the ability of a beneficiary to go directly to a chiropractor without prior approval from a physician or other gatekeeper.

The Committee provision would require that each of the demonstration elements to be examined in three or more rural areas, in three or more urban areas, and in three or more areas having a shortage of primary medical care professionals. The Secretary, in designing and conducting the demonstration, would be required to consult, on an ongoing basis, with chiropractors, organizations representing chiropractors, and representatives of Medicare beneficiary groups. The provision would require the Secretary to examine the direct access element described above with at least 10 Medicare HMOs that have voluntarily elected to participate in the demonstration; these HMOs would be eligible to receive a small incentive payment.

The Secretary would be required to evaluate whether beneficiaries who use chiropractic services use fewer Medicare services overall, the overall costs effects of increased access to chiropractors, and beneficiary satisfaction with chiropractic services. The Secretary would be required to submit a preliminary report to Congress within two years of enactment and a final report by January 1, 2001 together with recommendations on each of the four elements noted above. The Secretary would be required to include specific legislative proposals for those items that the Secretary has found to be cost effective.

As soon as possible after submission of the final report, the Secretary would begin payment for elements of the demonstration project proven cost effective for the Medicare program.

Effective Date

January 1, 1998.

CHAPTER 2—OTHER PAYMENT PROVISIONS

PAYMENTS FOR CLINICAL LABORATORY DIAGNOSTIC SERVICES

Present Law

Since 1984, Medicare payments for clinical laboratory services have been made on the basis of local fee schedules established in areas designated by the Secretary. Beginning in 1986, the fee for each laboratory service has been limited by a national cap amount, which is based on the median of all local fees established for that laboratory test during a base year. The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) mandated a reduction in the national cap amounts in 1996 to 76 percent of the median fee amount paid for each service in a base year.

Current law provides that fee schedule amounts for laboratory services are updated each January 1 by the decrease or increase in the consumer price index for urban consumers (CPI–U). OBRA 93 eliminated this update for 1994 and 1995.

Reasons for Change

The Committee provision would establish more appropriate growth in payments.

Committee Provision

The Committee provision would reduce the inflation updates by two percentage points each year from January 1, 1998, through December 31, 2002. It would also lower the cap from 76 percent of the median to 74 percent of the median beginning in 1998.

The Committee provision directs the Secretary of Health and Human Services to request the Institute of Medicine to conduct a study on Medicare Part B payments for clinical laboratory services, including the relationship between Medicare payments for laboratory services and access by beneficiaries to high quality services and new test procedures.

Effective Date

January 1, 1998.

IMPROVING PROGRAM INTEGRITY AND CONSISTENCY IN THE CLINICAL LABORATORY DIAGNOSTIC SERVICES BENEFIT

Present Law

Claims for payment for clinical laboratory diagnostic services, as other claims for payment under Medicare Part B, are processed by carriers, which are by statute health insurance companies under contract to the Health Care Financing Administration to conduct claims processing and certain program integrity activities. Carriers have a limited authority to establish coverage and payment rules.

Reasons for Change

The Committee provision would provide for improved program integrity in the administration of the laboratory services benefit

Committee Provision

The Committee provision would require the Secretary to divide the country into no more than 5 regions and designate a single carrier for each region to process laboratory claims no later than January 1, 1999. One of the carriers would be selected as a central statistical resource. The assignment of claims to a particular carrier would be based on whether the carrier serves the geographic area where the specimen was collected or other method selected by the Secretary.

The Committee provision would require the Secretary, by July 1, 1998, to adopt uniform coverage, administration, and payment policies for lab tests using a negotiated rule-making process. The policies would be designed to promote uniformity and program integrity and reduce administrative burdens with respect to clinical diagnostic laboratory tests.

The Committee provision would provide that during the period prior to the implementation of uniform policies, carriers could implement new local requirements under certain circumstances.

The provision would permit the use of interim regional policies where a uniform national policy had not been established. The Secretary would establish a process under which designated carriers could collectively develop and implement interim national standards for up to 2 years.

The Secretary would be required to conduct a review, at least every 2 years, of uniform national standards. The review would consider whether to incorporate or supersede interim regional or national policies.

With regard to the implementation of new requirements in the period prior to the adoption of uniform policies, and the development of interim regional and interim national standards, carriers must provide advance notice to interested parties and allow a 45 day period for parties to submit comments on proposed modifications.

The Committee provision would require the inclusion of a laboratory representative on carrier advisory committees. The Secretary would be required to consider nominations submitted by national and local organizations representing independent clinical labs.

This Committee provision would exempt independent physician offices until the Secretary could provide that such offices would not be unduly burdened by billing responsibilities with more than one carrier.

Effective Date

Generally on enactment.

DURABLE MEDICAL EQUIPMENT

Present Law

The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) established six categories of durable medical equipment for purposes of determining fee schedules and making payments. Among these categories are home oxygen equipment, which is reimbursed on a regionally adjusted monthly payment amount. Fee schedule amounts for durable medical equipment are updated annually for inflation.

Reasons for Change

Although the Committee bill would reduce the growth in expenditures on durable medical equipment, spending in this area is expected to remain among the fastest growing areas in the Medicare program. In the category of home oxygen equipment, the General Accounting Office has reported that a Medicare substantially overpays for home oxygen equipment compared to the Veteran's Administration, even when differences between the two programs are considered.

Committee Provision

The Committee provision would reduce the update by two percentage points for all categories of DME, including orthotics and prosthetics and parenteral and enteral nutrients, supplies, and

equipment, each year from January 1, 1998, through January 1, 2002.

The Committee provision would provide for the monthly payment amount for home oxygen services to be reduced 25 percent in 1998 and an additional 12.5 percent in 1999. The Committee provision would authorize the Secretary to create classes of oxygen equipment with differing payments, so long as there is no net increase in payments for home oxygen equipment. The Committee provision would also direct the Secretary to establish service standards and accreditation requirements for home oxygen providers. The Committee provision would direct the General Accounting Office to report within six months of enactment of this Act on access to home oxygen equipment, and direct the Secretary to arrange with peer review organizations established under section 1154 of the Social Security Act to evaluate access and quality of home oxygen equipment following enactment of this act. In addition, the Committee provision would require the Secretary to conduct a demonstration project of competitive bidding for home oxygen equipment.

The Committee provision would permit beneficiaries to purchase upgraded or enhanced durable medical equipment (DME) in a simpler fashion. A DME supplier would be permitted to bill the Medicare program for the basic DME item, and receive an additional payment from the beneficiary for the amount of the difference between the Medicare payment and the cost of the enhanced item. The Committee provision provides for the promulgation by the Secretary of consumer protection regulations, at which time this provision becomes effective.

Effective Date

Generally January 1, 1998.

UPDATES FOR AMBULATORY SURGICAL SERVICES

Present Law

Under current law, payments to ambulatory surgical centers are made on the basis of prospectively determined rates, determined by the Secretary for each covered procedure. Payments are updated annually for inflation.

Committee Provision

The Committee bill would reduce updates for payments to ambulatory surgical centers by two percentage points each year for 1998 through 2002.

Effective Date

January 1, 1998.

PAYMENTS FOR OUTPATIENT PRESCRIPTION DRUGS

Present Law

Under current law, Medicare provides a very limited outpatient prescription drug benefit (however, Medicare generally pays for drugs provided to a beneficiary while in a hospital). With some ex-

ceptions, Medicare pays only for outpatient drugs that cannot be "self-administered"—for example, drugs that must be administered directly by a physician in his office, such as intravenous drugs for cancer therapy; or require specialized equipment in the home, such as infusion therapy.

Reasons for Change

Medicare pays "reasonable charges" for outpatient drugs, which in practice is the manufacturers' recommended price. The Inspector General of the Department of Health and Human Services has found that Medicare pays substantially more than most other payers for prescription drugs.

Committee Provision

The Committee provision would specify that in any case where payment is not made on a cost or prospective payment basis, the payment could not exceed 95 percent of the average wholesale price, as specified by the Secretary. In any case, the amount payable for any drug or biological shall not exceed the amount paid on May 1, 1997, increased annually by consumer price index.

The Secretary would be required to conduct such studies or surveys to determine the average wholesale price or other appropriate price of outpatient prescription drugs and report to Congress within six months following the date of enactment. If the Secretary further adjusts the payment amounts for outpatient prescription drugs, the Secretary is authorized to pay a dispensing fee to pharmacies.

Effective Date

On enactment.

CHAPTER 3—PART B PREMIUM AND RELATED PROVISIONS

PART B PREMIUM

Present Law

Part B of Medicare is a voluntary program for which beneficiaries pay a monthly premium. When Medicare was established in 1965, the Part B monthly premium was set at an amount to cover one-half of the Part B program costs, with the remainder of funding from general revenues.

Under current law, Part B monthly premiums are required to cover 25 percent of Part B program costs. However, this provision expires effective for calendar year 1999. For subsequent years, increases in the Part B premium are limited to the cost-of-living adjustment for Social Security beneficiaries.

Reasons for Change

The Committee provision would establish the policy that Part B premiums permanently cover 25 percent of Part B spending.

Committee Provision

The Committee provision would establish permanently Part B monthly premiums in law at 25 percent of Part B program costs.

Effective Date

January 1, 1998.

INCOME-RELATED PART B DEDUCTIBLE

Present Law

Part B of Medicare is a voluntary program. Beneficiaries enrolled in Part B must pay the first $100 each year of the costs of Part B covered services. This deductible amount is the same for all beneficiaries regardless of income. The deductible amount has been increased only three times since the inception of the Medicare program: from 1966 to 1972 the deductible was $50; from 1973 to 1981, $60; and from 1982 to 1990, $75.

Reasons for Change

There are many beneficiaries who can afford to pay more of Part B program costs, and taxpayers should not be asked to subsidize these beneficiaries. Moreover, a higher deductible would make beneficiaries more conscious of the costs of medical care, and encourage more prudent purchasing by beneficiaries of medical services. Savings from this provision would be applied to improving the financial status of the Part A (Hospital Insurance) Trust Fund.

Committee Provision

The Committee provision would provide for an income-related Part B deductible for individuals with incomes over $50,000 and couples with incomes over $75,000. The Committee provision would increase the amount of the deductible over the current law amount of $100 by an amount equal to the amount Part B premiums would be increased if there were a straight line phase out of the Federal subsidy (currently 75 percent) for the Part B premium. For individuals, this phase out would occur over the income range of $50,000 to $100,000; for couples, $75,000 to $125,000.

The Committee provision would require the Secretary to make an initial determination of the amount of an individual's adjusted gross income (AGI) by September 1 for the forthcoming year, and notify each beneficiary subject to an increased deductible. The beneficiary would have a 30-day period to provide information on the beneficiary's anticipated AGI and the Secretary would adjust the deductible amount. If it is subsequently determined that a beneficiary's deductible amount was too high and the beneficiary paid too much for medical services, the Secretary would provide for repayment of the difference. If the deductible amount was too low, and the beneficiary paid too little for medical services, the Secretary would seek recovery from the beneficiary.

For beneficiaries enrolled in Medicare Choice organizations, the Secretary would reduce the monthly payment by an amount the Secretary determines (on the basis of actuarial value) to be the

equivalent amount of the increase in the deductible for a beneficiary. The Committee provision would allow Medicare Choice organizations to recoup the amount of any payment reduction from a beneficiary.

The Committee provision would require the Secretary to transfer amounts equal to the reduction in payments under this provision to the Part A (Hospital Insurance) Trust Fund.

Effective Date

January 1, 1998.

Subtitle H—Provisions Relating to Parts A and B

CHAPTER 1—SECONDARY PAYOR PROVISIONS

SECONDARY PAYOR PROVISIONS

Present Law

(a) Secondary Payer Extensions.—Generally, Medicare is the "primary payer," that is, Medicare pays medical claims first, with an individual's private or other public insurance only responsible for claims not covered by Medicare. For certain Medicare beneficiaries, however, the beneficiary's employer's health insurance plan pays medical bills first (so-called "primary payer"), with Medicare paying for any gaps in coverage within Medicare's coverage limits (Medicare is the "secondary payer"). Medicare is the secondary payer to certain employer group health plans for: (1) aged beneficiaries (age 65 and over); (2) disabled beneficiaries, and (3) beneficiaries with end-stage renal disease (ESRD) during the first 18 months of a beneficiary's entitlement to Medicare on the basis of ESRD.

The Medicare secondary payer provision regarding aged beneficiaries is permanent law. The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) extended the law making Medicare the secondary payer for disabled and ESRD beneficiaries through October 1, 1998.

(b) Data Match Program.—The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) authorized a "data match" program to identify potential secondary payer situations. Medicare beneficiaries are matched against data collected by Internal Revenue Service and the Social Security Administration to identify cases in which a working beneficiary (or working spouse) may have employer-based health insurance coverage. Cases of incorrect Medicare payments are identified and recoveries of payments are sought. The authority for this program expires on September 30, 1998.

(c) Recovery of Payments.—In many cases where Medicare secondary payer recoveries are sought, claims have never been filed with the primary payer. Identification of potential recoveries under the data match process typically takes several years—considerably in excess of the period many health plans allow for claims filing. A 1994 appeals court decision held that HCFA could not recover overpayments without regard to an insurance plan's filing requirements. A 1994 appeals court decision held that HCFA could not recover from third party administrators of self-insured plans.

Reasons for Change

The Committee provision would provide for improved operation of the secondary payer program.

Committee Provision

The Committee provision would:

(a) Make permanent law that Medicare is the secondary payer for disabled beneficiaries who have employer-provided health insurance; and make permanent law and extend to 30 months the period of time employer health insurance is the primary payer for ESRD beneficiaries;

(b) Make the data match program authority permanent law; and

(c) Specify that the U.S. could seek to recover payments if the request for payments was submitted to the entity required or responsible to pay within three years from the date the item or service was furnished. This provision would apply notwithstanding any other claims filing time limits that may apply under an employer group health plan. The provision would apply to items and services furnished after 1990. The provision should not be construed as permitting any waiver of the 3-year requirement in the case of items and services furnished more than 3 years before enactment.

The provision would permit recovery from third party administrators of primary plans. However, recovery would not be permitted where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

The provision would clarify that the beneficiary is not liable in Medicare secondary payer recovery cases unless the benefits were paid directly to the beneficiary.

Effective Date

Generally on enactment.

CHAPTER 2—OTHER PROVISIONS

CONFORMING AGE FOR ELIGIBILITY UNDER MEDICARE TO RETIREMENT AGE FOR SOCIAL SECURITY BENEFITS

Present Law

In 1983, Congress raised the eligibility age for Social Security old-age cash benefits from age 65 to age 67, to be phased in over a transition period from 2003 to 2027. However, under current law, the age of entitlement for Medicare remains unchanged at age 65.

Reasons for Change

The Committee provision will establish a consistent national policy on eligibility for both Social Security old-age pension benefits and Medicare. Although this provision will not produce any savings that apply to the Committee's reconciliation instructions, this provision will improve the long-term solvency of the Hospital Insurance (Part A) Trust Fund.

Committee Provision

The Committee provision amends the relevant sections of the Social Security Act to raise the age of eligibility for Medicare benefits from age 65 to age 67 over the years 2003 to 2027 in the same increments as for Social Security old-age pensions as detailed in section 216(l)(1)) of the Social Security Act.

INCREASE CERTIFICATION PERIOD FOR ORGAN PROCUREMENT ORGANIZATIONS

Present Law

Section 1138(b) of the Social Security Act requires that the Secretary can make Medicare and Medicaid payments for organ procurement costs to organ procurement organizations (OPOs) operating under Section 371 of the Public Health Service Act, or having been certified or recertified by the Secretary within the previous 2 years as meeting certain requirements.

Reasons for Change

OPOs compete during recertification periods for service areas. This competition involves massive data gathering and contracting for legal services in order to justify service areas.

Committee Provision

The provision would amend current law to provide OPOs three years between certifications or recertifications if the Secretary deems the organizations as having a good record in meeting standards to be a qualified OPO.

DIVISION 2—MEDICAID AND CHILDREN'S HEALTH INSURANCE INITIATIVES

Subtitle I—Medicaid

CHAPTER 1—MEDICAID SAVINGS

Subchapter A—Managed Care Reforms

STATE OPTION FOR MANDATORY MANAGED CARE

Present Law

To control costs and improve the quality of care, states are increasingly delivering services to their Medicaid populations through Health Maintenance Organizations (HMOs) and other managed care arrangements. Medicaid programs use three main types of managed care arrangements. These vary according to the comprehensiveness of the services they provide and the degree to which they accept risk, and include Primary Care Case Management (PCCM), fully capitated Health Maintenance Organizations (HMOs) and Health Insuring Organizations (HIOs), and partially capitated Pre-Paid Health Plans (PHPs). Under PCCM a Medicaid beneficiary selects, or is assigned to a single primary care provider, which provides or arranges for all covered services and is reimbursed on a fee-for-service basis in addition to receiving a small monthly "management" fee. Fully capitated plans contract on a risk basis to provide beneficiaries with a comprehensive set of covered services in return for a monthly capitation payment. Partially capitated plans provide a less than comprehensive set of services on a risk basis; services not included in the contract are reimbursed on a fee-for-service basis. Under fully and partially capitated managed care arrangements, beneficiaries have a regular source of coordinated care and states have predictable, controlled spending per beneficiary. This is in contrast to the traditional fee-for-service arrangements used by Medicaid beneficiaries where Medicaid pays for each service used.

The Medicaid statute contains several provisions that limit a state's ability to use managed care, including the freedom of choice, statewideness, and comparability requirements. These require that beneficiaries be free to receive services from the provider of their choice and that all covered benefits in a state plan be available throughout the state. States can bypass these requirements by establishing voluntary fully- or partially-capitated managed care plans. States are not, however, authorized to establish voluntary primary care case management (PCCM) programs. Voluntary managed care plans must meet other requirements that govern how Medicaid managed care plans operate. These include rules about solvency, enrollment practices, procedures for protecting bene-

ficiaries' rights, and contracting arrangements of managed care plans.

As a proxy for quality, current law requires that plans limit their enrollment of Medicaid and Medicare beneficiaries to no more than 75% of total enrollment (known as the "75/25 rule'). Publicly owned contracting plan, plans with more than 25,000 enrollees that serve a designated "medically underserved" area and that previously participated in an approved demonstration project, or plans that have had a Medicaid contract for less than three years may obtain a waiver of this requirement if they are making continuous and reasonable efforts to comply with the 75% limit. In addition, for some HMOs, the 75/25 rule has been bypassed through state demonstration waivers or through specific federal legislation. Beneficiaries must be permitted to disenroll from a managed care plan without cause during the first month of enrollment and may disenroll at any time for cause. Enrollees may be locked into the same plan for up to six months if the plan is a federally qualified (HMO). States may also guarantee eligibility for up to six months for persons enrolled in federally qualified HMOs. States may not restrict access to family planning services under managed care.

To mandate that a beneficiary enroll in a managed care entity, to operate a PCCM program, or to limit managed care services to a specific population or geographic area, a state must first obtain a waiver of the freedom-of-choice provision of Medicaid law. These renewable waivers, as authorized under section 1915(b) of Medicaid law, are initially good for two years. Most states have received waivers of federal law to implement managed care programs.

Reasons for Change

The Committee provision permits states to mandate enrollment of individuals in managed care plans without the need for waivers.

Committee Provision

The provision would give states the option of providing benefits through a managed care entity, including a PCCM program, without requiring a 1915(b) waiver of the statewideness, comparability, and freedom of choice requirements. States would be allowed to require that individuals eligible for medical assistance under the state plan enroll in a capitated managed care plan or with a primary care case manager. The provision would also eliminate the 75/25 rule effective June 20, 1997. Individuals who are "dually eligible" for Medicare and Medicaid and "special needs" children cannot be required to enroll in managed care, but may do so on a voluntary basis.

Present Law

All state contracts with a managed care organization must receive prior approval from the Secretary if expenditures are expected to be over $100,000.

Committee Provision

The provision would raise the threshold for federal review of managed care contracts from $100,000 to $1,000,000.

Present Law

In order to operate a PCCM system, states must obtain a waiver of the freedom-of-choice provision of Medicaid law. The waiver allows states to restrict the provider from whom a beneficiary can obtain services. Except in the case of an emergency, the beneficiary may obtain other services, such as specialty physician and hospital care, only with the authorization of the primary care provider. The aim of the program is to reduce the use of unnecessary services and provide better overall coordination of beneficiaries' care.

Reasons for Change

The Committee provision would establish rules for using primary care case management.

Committee Provision

The provision establishes a definition of PCCM, sets contractual requirements for PCCM arrangements, adds PCCM services to the list of Medicaid covered services, and repeals waiver authorization for PCCM.

"Primary Care Case Manager" means a provider that has entered into a primary case management contract with the state agency and that is a physician, a physician group practice, or an entity employing or having other arrangements with physicians who provide case management services or, at state option, a nurse practitioner, a certified nurse-midwife, or a physician assistant.

States would be permitted to mandate enrollment in PCCM or other managed care arrangements if a Medicaid beneficiary had a choice of at least two entities or managers and other conditions were met. States would be permitted to require beneficiaries to remain in a managed care arrangement for up to six months; states would also be permitted to guarantee six months of eligibility for enrollees. Prior to establishing a mandatory managed care requirement, a state would be required to provide for public notice and comment.

The payment limit and actuarial soundness standards would be modified to require that capitated payment amounts be set at rates that have been determined, by an actuary meeting the standards of qualification and practice established by the Actuarial Standards Board, to be sufficient and not excessive with respect to the estimated costs of services provided.

Present Law

The Medicaid statute includes a number of provisions intended to improve quality of care in prepaid programs and to protect beneficiaries. States are required to obtain an independent assessment of the quality of services furnished by contracting HMOs and prepaid health plans (those offering a non-comprehensive set of services under partial capitation), using either a utilization and quality

control peer review organization (PRO) under contract to the Secretary or another independent accrediting body. In addition, states are prohibited from contracting with an organization which is managed or controlled by, or has a significant subcontractual relationship with, individuals or entities potentially excludable from participating in Medicaid or Medicare. States are required to collect sufficient data on HMO enrollees" encounters with physicians to identify the physicians furnishing services to Medicaid beneficiaries. As a proxy for quality, federal law requires that less than 75% of a managed care organization's enrollment must be Medicaid and Medicare beneficiaries. For some HMOs, the 75/25 rule has been bypassed through state demonstration waivers or through specific federal legislation. Some HMOs are federally qualified—determined by the Secretary to meet standards set forth in title XIII of the Public Health Service Act that includes quality standards.

Reasons for Change

The Committee provision establishes quality standards including consumer protections.

Committee Provision

The provision would require the state agency to develop and implement a quality assessment and improvement strategy consistent with standards that the Secretary shall monitor. These shall include standards for access to care so that covered services are available within reasonable time frames and in a manner that ensures continuity of care and adequate primary care and specialized services capacity. Procedures for monitoring and evaluating the quality and appropriateness of care and services to beneficiaries shall include requirements for provision of quality assurance data to the state using the data and information that the Secretary shall specify with respect to entities contracting under section 1876 or alternative data requirements approved by the Secretary; regular and periodic examination of the scope and content of the quality improvement strategy; and other aspects of care and service directly related to the improvement of quality of care including grievance procedures and marketing and information standards. Each year the Secretary shall conduct validation surveys of managed care organizations serving Medicaid beneficiaries to assure the quality and completeness of data reporting.

Entities entering into such agreements shall be required to submit to the state agency information that demonstrates improvement in the care delivered to members; to maintain an internal quality assurance program consistent with standards the Secretary shall establish in regulations; to provide effective procedures for hearing and resolving grievances between the entity and its members; and that adequate provision is made with respect to the solvency, financial reporting, and avoidance of waste, fraud, and abuse by those entities.

The PCCM contract shall provide for reasonable and adequate hours of operation including 24-hour availability of information, referral, and treatment with respect to medical emergencies; restriction of enrollment to individuals residing sufficiently near a service

delivery site of the entity to be able to reach that site within a reasonable time using available and affordable modes of transportation; employment of, or contracts or other arrangements with sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care; prohibition on discrimination on the basis of health status or requirements for health services in enrollment, disenrollment, and reenrollment; and the right to terminate enrollment at any time for cause. In assuring beneficiaries' access to emergency care, the "prudent layperson" standard shall apply.

Managed care plans would be required to pay affiliated providers in a timely manner for items and services provided to Medicaid beneficiaries. Payments to federally qualified health centers and rural health centers must be made on a cost basis comparable to what other providers are paid.

If a state uses an enrollment broker, the broker must be independent of any MCO or PCCM that provides coverage to Medicaid beneficiaries in that state.

Subchapter B—Management Flexibility Reforms

ELIMINATION OF BOREN AMENDMENT REQUIREMENTS FOR PROVIDER PAYMENT RATES

Present Law

The Boren amendments require states to pay hospitals, nursing facilities, and intermediate care facilities for the mentally retarded (ICFs/MR) rates that are "reasonable and adequate" to cover the costs which must be incurred by "efficiently and economically operated facilities." In several states, providers and provider organizations challenged state policies in federal courts alleging that the state's procedures for reimbursement violated requirements of the Boren amendments. Following a Supreme Court decision that the amendments created enforceable rights for providers, a number of courts found that state systems failed to meet the test of "reasonableness" and some states had to increase payments to these providers.

Reasons for Change

The Committee provision would repeal the "Boren Amendment" provisions.

Committee Provision

The provision would repeal the present law provisions for payments for hospital services, nursing facilities services, services of intermediate care facilities for the mentally retarded and home and community-based services. States would provide for a public notice process for reimbursement methodology and proposed payment rates for these institutional providers. Providers, beneficiaries, and their representatives, and other concerned individuals are to be given an opportunity to review proposed payment rates and the methodologies underlying the establishment of such rates. Such no-

tice shall describe how the rate-setting methods used by the states will affect access to services, quality of services and safety of beneficiaries. Final payment rates, the methodologies underlying the establishments of such rates, and justifications for such rates that may take into account public comments received by the state (if any) shall be published in 1 or more daily newspapers of general circulation in the state or in any publication used by the state to publish state statutes or rules.

Not later than four years after enactment of this act, the Secretary shall study the effect on access to services, the quality of services, and the safety of beneficiaries and submit a report to Congress with conclusions from the study, together with any recommendations.

MEDICAID PAYMENT RATES FOR QUALIFIED MEDICARE BENEFICIARIES

Present Law

State Medicaid programs are required to pay Medicare cost-sharing charges for individuals who are beneficiaries under both Medicaid and Medicare (dual eligibles) and for qualified Medicare beneficiaries (QMBs). QMBs are individuals who have incomes not over 100% of the poverty level and who meet specified resources standards. The amount of required payment has been the subject of some controversy.

State Medicaid programs frequently have lower payment rates for services than the rates that would be paid under Medicare. Program guidelines permit states to either (1) pay the full Medicare deductible and coinsurance amounts or (2) pay cost-sharing charges only to the extent that the Medicare provider has not received the full Medicaid rate for an item or service. Some courts have forced state Medicaid programs to reimburse Medicare providers to the full Medicare allowable rates for services provided to QMBs and dually eligible individuals.

Reasons for Change

The Committee provision would clarify that state Medicaid programs could limit Medicare cost-sharing to amounts that do not exceed Medicaid payment rates.

Committee Provision

A state is not required to provide any payment for any expenses incurred relating to payment for a coinsurance or copayment for Medicare cost-sharing if the amount of the payment under title XVIII for the service exceeds the payment amount that otherwise would be made under the state plan. The amount of payment made under title XVIII plus the amount of payment (if any) under the state plan shall be considered to be payment in full for the service, the beneficiary shall not have any legal liability to make payment to the provider for the service, and any lawful sanction that may be imposed upon a provider for excess charges under this title or title XVIII shall apply to the imposition of any charge on the individual in such case. This shall not be construed as preventing pay-

ment of any Medicare cost-sharing by a Medicare supplemental policy on behalf of an individual.

NO WAIVER REQUIRED FOR PROVIDER SELECTIVITY

Present Law

Generally, Medicaid beneficiaries have freedom of choice of providers; they may obtain services from any person, institution, or organization that undertakes to provide the services and is qualified to perform the service. States may, under specified conditions, purchase laboratory services or medical devices through special arrangements such as a competitive bidding process. Otherwise, to restrict the providers from which a beneficiary may obtain services, a state must obtain a waiver of the freedom of choice requirement.

Committee Provision

States would be permitted to enter into exclusive contracts with selected providers at negotiated rates without the need for a waiver.

Subchapter C—Reduction of Disproportionate Share Hospital Payments

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

Present Law

States are required to make adjustments to the payment rates of certain hospitals that treat large numbers of low income and Medicaid patients. The law sets minimum standards by which a hospital may qualify as a disproportionate share (DSH) hospital, and minimum payments to be made to those hospitals. States are generally free to exceed federal minimums in both designation and payments up to certain ceilings. Each year states are designated as either "high" DSH states or "low" DSH states based on the percentage of total medical assistance payments for DSH adjustments in the prior year. States making DSH payments in excess of 12% of medical assistance are designated "high" DSH and those paying less than 12% of medical assistance for DSH are designated as low DSH. Total disproportionate share payments to each state are limited to a published allotment amount that can be no more than 12% of medical assistance payments in states designated as "low" DSH states, and in states designated as "high" DSH states the amount of payments in 1992. Payments to individual hospitals may be no more than the cost of care provided to Medicaid recipients and individuals who have no health insurance or other third-party coverage for services during the year (net of non-disproportionate share Medicaid payments and other payments by uninsured individuals). A hospital may not be designated as a DSH hospital by a state unless it serves a minimum of 1% Medicaid clients among their caseload.

Reasons for Change

Although the history of the DSH program dates back to 1981 as part of the "Boren amendment" reforms, the cost of DSH payments did not become significant until 1990. Between 1990 and 1995, federal and state DSH payments grew from $960 million to $19 billion or 1,879 percent. While DSH growth has moderated, both the HCFA actuaries and CBO analysts believe that DSH spending will again accelerate.

While other methods of leveraging federal dollars appear to have been somewhat abated, some states have dramatically increased federal funding by making claims for services in mental health facilities.

Committee Provision

This provision would lower the DSH allotments by imposing freezes, making graduated proportional reductions, and reducing payments by amounts claimed for mental health services.

States would be restricted in providing DSH payments to Institutes for Mental Diseases (IMDs).

DSH allotments for each state for years after 2002 would be equal to the allotment for the previous year multiplied by the percentage change in the consumer price index for medical services.

A state must develop and report to the Secretary a methodology for prioritizing payments to disproportionate share hospitals, including children's hospitals, on the basis of the proportion of low-income and Medicaid patients served by such hospitals. The state shall provide an annual report to the Secretary describing the disproportionate share payments to high-volume disproportionate share hospitals.

CHAPTER 2—EXPANSION OF MEDICAID ELIGIBILITY

STATE OPTION TO PERMIT WORKERS WITH DISABILITIES TO BUY INTO MEDICAID

Present Law

States must continue Medicaid coverage for "qualified severely impaired individuals under the age of 65." These are disabled and blind individuals whose earnings reach or exceed the SSI benefit standard. (The current law threshold for earnings is $1,053 per month.) This special eligibility status applies as long as the individual (1) continues to be blind or have a disabling impairment; (2) except for earnings, continues to meet all the other requirements for SSI eligibility; (3) would be seriously inhibited from continuing or obtaining employment if Medicaid eligibility were to end; and (4) has earnings that are not sufficient to provide a reasonable equivalent of benefits from SSI, state supplementary payments (if provided), Medicaid, and publicly funded attendant care that would have been available in the absence of those earnings. To implement the fourth criterion, the Social Security Administration compares the individual's gross earnings to a "threshold" amount that represents average expenditures for Medicaid benefits for disabled SSI cash recipients in the individual's state of residence.

Committee Provision

States would have the option of allowing disabled SSI beneficiaries with incomes up to 250% of poverty to "buy into" Medicaid by paying a premium. Premium levels would be on a sliding scale, based on the individual's income as determined by the state.

12 MONTH CONTINUOUS ELIGIBILITY FOR CHILDREN

Committee Provision

At the option of the state, the state may provide that a child may be eligible for benefits for 12 months' continuous coverage.

CHAPTER 3—PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

ESTABLISHMENT OF PACE PROGRAM AS MEDICAID STATE OPTION

Present Law

OBRA 86 required the Secretary to grant waivers of certain Medicare and Medicaid requirements to not more than 10 public or non-profit private community-based organizations to provide health and long-term care services on a capitated basis to frail elderly persons at risk of institutionalization. These projects, known as the Programs of All Inclusive Care for the Elderly, or PACE projects, were intended to determine whether an earlier demonstration program, ON LOK, could be replicated across the country. OBRA 90 expanded the number of organizations eligible for waivers to 15.

Committee Provision

States would be permitted to offer PACE to Medicaid beneficiaries who were also eligible for Medicaid. The PACE provision is described in Medicare.

CHAPTER 4—MANAGEMENT AND PROGRAM REFORMS

ELIMINATION OF REQUIREMENT TO PAY FOR PRIVATE INSURANCE

Present Law

States are required to identify cases in which it would be cost-effective to enroll a Medicaid-eligible individual in a private insurance plan and, as a condition of eligibility, require the individual to enroll in the plan.

Committee Provision

Identification and enrollment requirements would be eliminated. States would continue to have the option of purchasing private insurance.

ELIMINATION OF OBSTETRICAL AND PEDIATRIC PAYMENT RATE REQUIREMENTS

Present Law

States are required to assure adequate payment levels for obstetrical and pediatric services. For this purpose, states must provide annual reports to the Secretary on their payment rates for these services.

Committee Provision

These reporting requirements would be eliminated.

PHYSICIAN QUALIFICATION REQUIREMENTS

Present Law

Medicaid law establishes special minimum qualifications for a physician who furnishes services to a child under age 21 or to a pregnant woman.

Committee Provision

The current law provision would be repealed.

EXPANDED COST-SHARING REQUIREMENTS

Present Law

States are permitted to impose nominal cost-sharing charges with certain exceptions. No charges may be imposed on services that are provided to children under age 18; related to pregnancy; provided to inpatients in hospitals, nursing facilities, ICFs/MR, or other medical institution if the patients are required to spend all their income for medical expenses except for the amount exempted for personal needs; or on services that are emergency, family planning, or hospice services. States may not impose cost-sharing charges on categorically needy enrollees in health maintenance organizations.

Reasons for Change

Personal responsibility when participating in any public benefit program is vital and should be encouraged. Cost-sharing is an important method used to encourage use of primary and preventive care and discourage unnecessary or less economical care. Cost-sharing may discourage inappropriate use of services through inappropriate health care settings.

As Medicaid coverage is extended to families which are not below the poverty level, cost-sharing can have a positive affect on participation. The Committee received testimony that cost-sharing helps overcome the stigma of Medicaid as a welfare program and increases the use of preventive services.

Committee Provision

States would be permitted to impose limited cost-sharing on services provided to individuals whom federal law does not require the

state to cover. No additional cost-sharing would be allowed for individuals who are required to be covered under federal law except as allowed under current law or any waiver granted to any state. States would be permitted to impose nominal copayments on HMO enrollees as allowed in fee-for-service.

If any charges are imposed under the state plan for cost-sharing, such cost-sharing shall be pursuant to a public schedule and reflect economic factors, employment status, and family size. Total cost-sharing for a family with income less than 150 percent of the federal poverty level is subject to an annual limit of 3 percent of gross earnings less child care expenses. Total cost-sharing for a family with income greater than 150 percent but less than 200 percent of the poverty level is subject to an annual limit of 5 percent of gross earnings less child care expenses. Existing waivers, if any, which have been approved by the Secretary and may allow for greater cost-sharing are not subject to this limit.

Cost-sharing includes copayments, deductibles, coinsurance, enrollment fees, premiums, and other charges for the provision of health care goods and services.

Cost-sharing charges cannot be counted as state expenditures for purposes of matching requirements.

PENALTY FOR FRAUDULENT ELIGIBILITY

Present Law

A person who knowingly and willfully disposes of assets, including transfers to certain trusts, in order to obtain Medicaid eligibility for nursing home care is liable for a criminal fine and/or imprisonment, if the disposition of assets results in a period of ineligibility for such Medicaid benefits.

Committee Provision

The provision would provide that a person who for a fee assists an individual to dispose of assets in order to obtain Medicaid eligibility for nursing home care would be subject to criminal liability if the individual disposes of assets and a period of ineligibility is imposed against such individual.

ELIMINATION OF WASTE, FRAUD, AND ABUSE

Committee Provision

The Committee provides a number of reforms to eliminate waste, fraud, and abuse in the Medicaid program including a ban on spending for nonhealth related items not covered in the state plan. It requires disclosure of information and surety bond requirements for suppliers of durable medical equipment and home health agencies. The intent of the surety bond requirement is to prevent fraudulent providers and suppliers from entering the Medicaid program. Surety bonds should not be used to discriminate against minority providers and suppliers.

STUDY ON EPSDT BENEFITS

Present Law

States are required to provide early and periodic screening, diagnostic, and treatment services (EPSDT) to Medicaid beneficiaries under age 21. Such services include screening, vision, dental, hearing services. A state is required to provide other necessary health care services to correct or ameliorate defects and conditions discovered by the screening services, whether or not the services are covered under the state's Medicaid plan.

Committee Provision

Not later than one year after enactment, the Secretary, in consultation with governors, state Medicaid and maternal and child health director, the Institute of Medicine, beneficiaries and their representatives, and the American Academy of Pediatrics, would be required to provide for a study on EPSDT benefits.

CHAPTER 5—MISCELLANEOUS

INCREASED FMAPS

District of Columbia

Present Law

Under Medicaid law, the District of Columbia is treated as a state. Each state is required to pay 40% of the non-federal share of Medicaid expenditures. Under this rule, a state can require local jurisdictions to share in Medicaid costs. Each state must, however, assure that the lack of adequate funds from local sources will not result in diminished services in the state.

The federal government shares in the cost of Medicaid items and services according to a statutory formula designed to pay a higher matching percentage to states with lower per capita incomes relative to the national average per capita income. The federal share of a state's expenditures for Medicaid items and services is called the federal medical assistance percentage (FMAP). The law establishes a minimum FMAP of 50% and a maximum of 83%. For the District and 11 states, the FMAP is 50%.

Reasons for Change

The Committee will temporarily increase the federal share of the District's Medicaid program.

Committee Provision

The FMAP for the District would be increased to 60% for each of the fiscal years 1998–2000.

Alaska

Present Law

The federal government shares in the cost of Medicaid items and services according to a statutory formula designed to pay a higher

matching percentage to states with lower per capita incomes relative to the national average per capita income. The federal share is called the federal medical assistance percentage (FMAP). The law establishes a minimum FMAP of 50% and a maximum of 83% though currently, the highest match rate is 79%. For Alaska, 10 other states, and the District of Columbia, the match rate is 50%.

Committee Provision

The FMAP for Alaska would be increased to 59.8% for each of fiscal years 1998–2000. This increase would be offset by a decrease in the proposed FMAP increase for the District of Columbia (to 60%).

Reasons for Change

Alaska has higher costs of living. The national average FMAP is 59.8%.

INCREASE IN PAYMENT CAPS FOR TERRITORIES

Present Law

For the commonwealths and territories, the federal matching rate is 50 percent. The total amount which may be made is capped at annual maximum fixed amounts beginning in FY 1994 as specified in section 1108 of the Social Security Act. The limits are increased annually by the percentage increase in the medical care component of the consumer price index.

Puerto Rico: $116,500,000 in FY 1994, rounded to the nearest $100,000. Virgin Islands: $3,837,000, rounded to the nearest $10,000.

Guam: $3,685,000, rounded to the nearest $10,000.

Northern Mariana Islands: $1,100,000, rounded to the nearest $10,000. American Samoa: $2,140,000, rounded to the nearest $10,000.

Reasons for Change

The Committee provision will raise the current Medicaid caps on the territories.

Committee Provision

For FY 1998 and each fiscal year thereafter, the caps are raised and indexed from the FY 1997 levels for the commonwealths and territories by the following amounts:

Puerto Rico: $30 million.
Virgin Islands: $750,000.
Guam: $750,000.
Northern Mariana Islands: $500,000.
American Samoa: $500,000.

The 50 percent match rate and indexing under current law are maintained.

COMMUNITY-BASED MENTAL HEALTH SERVICES

Committee Provision

The Committee provides a definition for outpatient and intensive community-based mental health services to include psychiatric rehabilitation, day treatment, intensive in-home services for children, assertive community treatment, therapeutic out-of-home placements (excluding room and board), clinic services, partial hospitalization, and targeted case management.

OPTIONAL MEDICAID COVERAGE OF CERTAIN CDC-SCREENED BREAST CANCER PATIENTS

Present Law

Medicaid covers medically necessary services for beneficiaries who meet the program's categorical and financial requirements. The Centers for Disease Control and Prevention screens uninsured women for breast cancer.

Reasons for Change

Uninsured women diagnosed with cancer have difficulty obtaining appropriate and timely treatment.

Committee Provision

Medicaid eligibility standards would be expanded to include women who are under age 65, who have been diagnosed with breast cancer, and who have no health insurance coverage.

TREATMENT OF STATE TAXES IMPOSED ON CERTAIN HOSPITALS THAT PROVIDE FREE CARE

Present Law

States may not claim for federal matching payments state spending generated from provider-related donations or health care taxes that are not broad based. Health care provider-specific taxes are not considered broad-based and, thus, may not be used to claim federal matching payments for Medicaid spending.

Committee Provision

This provision would amend the definition of the term "broad-based health care related tax" to specify that taxes that exclude hospitals which are exempt from taxation under Section 501(c)(3) of the Internal Revenue code and do not accept Medicaid or Medicare reimbursement would qualify for federal matching payments if used as state Medicaid spending. The provision would also prohibit states from claiming federal matching payments for state spending generated form health care taxes applied to these facilities.

TREATMENT OF VETERANS' PENSIONS UNDER MEDICAID

Present Law

Generally, Medicaid beneficiaries in nursing homes contribute most of their incomes to the cost of care except for an allowance for a dependent in the community. Medicaid law requires that at least $30 per month be reserved from an institutionalized recipient's income as a personal allowance for items and services not included in the institution's charges. By law, Veterans" Administration pension payments to a Medicaid beneficiary who is in a nursing home are limited to $90 per month and the full amount of the payment (except for a dependent allowance) is protected for personal needs. This statutory provision expires Sept. 30, 1997.

Committee Provision

The amendment would allow State Veterans Homes to collect from Medicaid eligible veteran residents amounts in excess of $90.00 per month to defray the cost of care, but excluding amounts of income attributable to a dependent.

EFFECTIVE DATE

Committee Provision

Except as otherwise specifically provided, the provisions of and amendments by this subtitle shall apply on and after October 1, 1997. There is an extension for state law amendment for a state that has a two-year legislative session.

Subtitle J—Children's Health Insurance Initiatives

ESTABLISHMENT OF CHILDREN'S HEALTH INSURANCE INITIATIVES

Present Law

Medicaid, Title XIX of the Social Security Act, provides almost 21 million children with health coverage. States choosing to participate in the Medicaid program are required to cover children in families who would have qualified to receive AFDC under the program rules in effect on August 22, 1996; children under age 6 in families with income below 133% of the federal poverty level; and children under age 14 in families with income below 100% of the federal poverty level. Coverage for children between the ages of 14 and 18 and in families with income below 100% of the federal poverty level is being phased-in through 2002. States also have the option to cover other categories of low-income children under Medicaid and many have done so. The costs of providing Medicaid coverage are shared by the states and the federal government. The federal share is determined by a formula that takes into account the average per capita income in the state relative to the national average. States with lower per capita incomes have higher federal matching rates. These federal matching rates range from a floor of 50% to almost 80%. All 50 states currently participate in Medicaid.

The Maternal and Child Health Block Grant is authorized under Title V of the Social Security Act to improve the health of all moth-

ers and children consistent with the goals established under the Public Health Service Act. The program makes block grants to states to enable them to coordinate programs, develop systems, and provide a broad range of direct health services. The major component of the MCH block grant requires states to contribute $3 for every $4 of federal block grant funds collected.

Committee Provision

The provision would establish a new title of the Social Security Act, Title XXI, Child Health Insurance Initiatives. The new title would provide an entitlement to states for funds for 1998 through 2007 to expand access to health insurance for eligible children. Participating states would be required to extend Medicaid coverage to children under age 19 in families with income below 100% of the federal poverty level and to assure that funds provided under this section cover low-income children before covering higher income children. Total funding authorized and appropriated under this provision would be $2.5 billion in 1998, $3.2 billion in 1999, $3.2 billion in 2000, $3.2 billion in 2001, $3.9 billion in 2002, and for each of the fiscal years 2003 through 2007, $4.58 billion and would be available without fiscal year limitation. Participating states would choose whether to receive their allotted funds through Medicaid or another program meeting the requirement of Title XXI and would be required to use 1% of their allotted funds for Medicaid outreach and public awareness campaigns to encourage employers to provide health insurance for children.

States participating in Title XXI would be required to submit to the Secretary, no later than March 31 of any fiscal year (or, in the case of fiscal year 1998, October 1, 1997), an outline that identifies which option the State intends to use to provide coverage under this section (Medicaid or other qualified program), describes how such coverage shall be provided, and includes other information as the Secretary may require. The outline would also include: (a) the eligibility standards for the program, (b) the methodologies to be used to determine eligibility, (c) the procedures to be used to ensure only eligible children receive benefits and that the establishment of a program under this section does not reduce the number of children who currently have insurance coverage, and (d) a description of how the state would ensure that Indians are served by a program under this title.

The funds would be distributed in the following manner. States would receive 1% of their allotted funds prior to the beginning of the fiscal year for the purpose of conducting outreach activities. During the year, the states would receive quarterly payments in an amount equal to the Federal Medicaid medical assistance percentage of the cost of providing health insurance coverage for an eligible low-income child and any applicable bonuses based on estimates by the states. The Secretary could increase or reduce payments as necessary to adjust for any overpayment or underpayment for prior quarters.

The remaining child health allotment funds would be divided into two pools: a basic allotment pool and a new coverage incentive pool. In 1998, the basic allotment pool would be comprised of 85% of funds remaining after subtracting the costs of the Medicaid ex-

pansions for children under age 19, the Medicaid 12 months continuous eligibility option and the increase in enrollment as a result of the 1% outreach requirement from total authorized funds. The remaining funds would become the new coverage incentive pool. For years thereafter, the Secretary would make annual adjustments to the size of the two pools in order to provide sufficient basic allotments and new coverage incentives.

A set aside of .25% of the basic allotment pool would be established for the territories. The rest of the basic allotment pool would be allotted to each state based on the average percentage of all children in families with income below 200% of poverty that reside in the state during the three fiscal years beginning on October 1, 1992 (as reported in the Current Population Surveys of March 1994, 1995 and 1996). Amounts allotted to a state would be available the state for a period of three years beginning with the fiscal year for which the allotment made.

States would be eligible for bonus payments for the number of low income children covered under either Medicaid or other state-run health insurance programs who are not in a required Medicaid coverage group during 1996 in an amount equal to 5% of the cost of providing health insurance coverage. This 5% bonus would come from the state's basic allotment pool. Performance bonus payments in an amount of 10% of the cost of providing health insurance coverage for newly covered children in excess of those covered in 1996 would also be available with funds coming from the new coverage incentive pool.

States extending coverage for previously uninsured children could purchase employer-sponsored health insurance on behalf of eligible children or provide for insurance through other plans. If a state chooses to provide health insurance under plans other than employer-sponsored plan, it must provide for health insurance coverage that is at least the actuarial equivalent of those provided under the Federal Employees Health Benefits Program plans as provided in that state and must be certified by the Secretary as meeting this standard.

Total amounts paid to a state under this title would not be allowed to exceed 85% of the total cost of a state program conducted under this title. Funds under the non-Medicaid option could be used to subsidize the payment of employee contributions for health insurance for a dependent child under an employer sponsored plan or to provide an FEHBP equivalent plan.

States would not be eligible to receive funds under this title unless, in fiscal year 1998, state spending on children's health care is no less than the amounts spent in 1996. For years thereafter, states spending on children's health care must be no less than such spending in 1996 increased by a Medicaid child population growth factor as determined by the Secretary.

Funds may not be used to cover the costs of abortions except in cases of rape or incest or when necessary to save the women's life. No more than 10% of funds under this title would be allowed for the administrative costs of the program.

Provisions of Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, prohibiting the receipt of

public benefits for certain legal immigrants for a period of five years, would not be applied to benefits provided under this section.

Under this program the Secretary would not approve any amount in excess of a state's allotment and would make adjustments in the federal share of the costs to ensure the caps are not exceeded. The title would not establish an entitlement for individuals to any health insurance or assistance or services provided by a state program. A state would be allowed to adjust the applicable eligibility criteria or other program characteristics if the state determines that funds allotted are not sufficient to provide health insurance coverage for all low-income children.

The following sections of Title XI would apply to States' Child Health Assistance Insurance Programs as they do under Title XIX: Section 1116 relating to administrative and judicial review, Section 1124 relating to disclosure of ownership and related information, Section 1126 relating to disclosure of information about certain convicted individuals, Section 1128A relating to criminal penalties for certain additional charges, Section 1128B(d) relating to criminal penalties, and Section 1132 relating to periods within which claims must be filed, Section 1902(a)(4)(C) relating to conflict of interest standards, Section 1903(e) relating to limitations on payment, Section 1903(w) relating to limitations on provider taxes and donations, Section 1905(a)(B) relating to exclusion of care or services for individuals under the age of 65 in IMDs from the definition of medical assistance, Section 1921 relating to state licensure, Sections 1902(a)(25), 1912(a)(1)(A), and 1903(o) relating to third party liability.

Participating states would be required to provide an annual assessment of the operation of the program funded under this title that includes a description of the progress made in providing health insurance coverage for low income children. The Secretary would be required to submit to Congress an annual report and evaluation of the State programs based on the annual assessment and would include any conclusions and recommendations the Secretary considers appropriate.

Effective Date

October 1, 1997.

DIVISION 3—INCOME SECURITY AND OTHER PROVISIONS

Subtitle K—Income Security, Welfare-To-Work Grant Program, and Other Provisions

CHAPTER 1—INCOME SECURITY

SSI ELIGIBILITY FOR ALIENS RECEIVING SSI ON AUGUST 22, 1996

Present Law

SSI. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193) bars most "qualified aliens" from Supplemental Security Income (SSI) for the Aged, Blind, and Disabled (sec. 402(a)). Current recipients must be screened for continuing eligibility during a 1-year period after enactment of the welfare law (i.e., by August 22, 1997). The pending Fiscal Year 1997 supplemental appropriations bill would extend this date until September 30, 1997.

Medicaid. States may exclude "qualified aliens" who entered the United States before enactment of the welfare law (August 22, 1996) from Medicaid beginning January 1, 1997 (sec. 402(b)). Additionally, to the extent that legal immigrants" receipt of Medicaid is based only on their eligibility for SSI, some will lose Medicaid because of their ineligibility for SSI.

Definitions and exemptions. "Qualified aliens" are defined by P.L. 104–193 (as amended by P.L. 104–208) as aliens admitted for legal permanent residence (i.e., immigrants), refugees, aliens paroled into the United States for at least 1 year, aliens granted asylum or related relief, and certain abused spouses and children.

Certain "qualified aliens" are exempted from the SSI bar and the State option to deny Medicaid, as well as from certain other restrictions. These groups include: (1) refugees for 5 years after admission and asylees 5 years after obtaining asylum; (2) aliens who have worked, or may be credited with, 40 "qualifying quarters." As defined by P.L. 104–193, a "qualifying quarter" is a 3-month work period with sufficient income to qualify as a social security quarter and, with respect to periods beginning after 1996, during which the worker did not receive Federal means-based assistance (Sec. 435). The "qualifying quarter" test takes into account work performed by the alien, the alien's parent while the alien was under age 18, and the alien's spouse (provided the alien remains married to the spouse or the spouse is deceased); and (3) veterans, active duty members of the armed forces, and their spouses and unmarried dependent children.

Committee Provision

Legal noncitizens who were receiving SSI benefits on August 22, 1996 (the date of enactment of the welfare reform law) would remain eligible for SSI, despite underlying restrictions in the Personal Responsibility and Work Opportunity Act. This section also specifies that Cuban and Haitian entrants are to be considered qualified aliens, thereby continuing the SSI and Medicaid eligibility of those who were receiving SSI benefits on August 22, 1996.

Effective Date

August 22, 1996.

EXTENSION OF ELIGIBILITY PERIOD FOR REFUGEES AND CERTAIN OTHER QUALIFIED ALIENS FROM 5 TO 7 YEARS FOR SSI AND MEDICAID

Present Law

Current law provides a 5-year exemption from: (1) the bar against SSI and Food Stamps; and (2) the provision allowing States to deny "qualified aliens" access to Medicaid, TANF, and Social Services Block Grant for three groups of aliens admitted for humanitarian reasons. These groups are: (1) refugees, for 5 years after entry; (2) asylees, for 5 years after being granted asylum; and (3) aliens whose deportation is withheld on the grounds of likely persecution upon return, for 5 years after such withholding.

Reasons for Change

The Committee proposal would extend the 5 year exemption period to allow sufficient time to assimilate into the country.

Committee Provision

This change would lengthen the period during which welfare eligibility is guaranteed to refugees, asylees, and aliens whose deportation has been withheld from 5 years to 7 years. Cuban and Haitian entrants would also be covered by this provision.

Effective Date

August 22, 1996.

SSI ELIGIBILITY FOR PERMANENT RESIDENT ALIENS WHO ARE MEMBERS OF AN INDIAN TRIBE

Committee Provision

Restrictions on SSI eligibility under welfare reform do not apply to permanent resident aliens who are members of an Indian tribe.

SSI ELIGIBILITY FOR DISABLED LEGAL ALIENS IN THE UNITED STATES ON AUGUST 22, 1996

Committee Provision

Disabled legal aliens residing in the United States on August 22, 1996 will be eligible for SSI benefits if they apply for such benefits on or before September 30, 1997.

EXEMPTION FROM RESTRICTION ON SSI PROGRAM PARTICIPATION BY CERTAIN RECIPIENTS ELIGIBLE ON THE BASIS OF VERY OLD APPLICATIONS

Committee Provision

Restrictions on SSI benefits shall not apply to any individual who is receiving benefits under such program after July 1996 on the basis of an application filed before January 1, 1979 and with respect to whom the Commissioner of Social Security lacks clear and convincing evidence that such individual is an alien ineligible for such benefits.

REINSTATEMENT OF ELIGIBILITY FOR BENEFITS

Committee Provision

This provision reinstates the linkage between SSI benefits and Medicaid.

EXEMPTION FOR CHILDREN WHO ARE LEGAL ALIENS FROM 5-YEAR BAN ON MEDICAID ELIGIBILITY

Committee Provision

The limitation on Medicaid eligibility shall not apply to any alien lawfully residing in any state who has not attained the age of 19 but only with respect to such alien's eligibility for medical assistance under a state plan.

EFFECTIVE DATE

Committee Provision

The amendments made by this chapter shall take effect as if they were included in the enactment of title IV of the Personal Responsibility and Work Opportunity Act of 1996.

CHAPTER 2—WELFARE-TO-WORK GRANT PROGRAM

ESTABLISH "WELFARE TO WORK" GRANTS

Present Law

The law combines recent Federal funding levels for three repealed programs (AFDC, Emergency Assistance, and JOBS) into a single block grant ($16.5 billion annually through Fiscal Year 2002). Each State is entitled to the sum it received for these programs in a recent year, but no part of the TANF grant is earmarked for any program component, such as benefits or work programs. The law also provides an average of $2.3 billion annually in a child care block grant.

Reasons for Change

The Committee proposal will establish a new "Welfare to Work" grant program.

Committee Provision

After reserving 1 percent of each year's appropriation for Indian tribes and .5 percent for evaluation by the Secretary of HHS, the remainder of each year's appropriation is divided into two grant funds. The first fund is used for grants to states and is allocated by a formula based equally on each state's share of the national poor population, unemployed workers, and adults receiving assistance under the Temporary Assistance for Needy Families block grant. There will be a small state minimum of 0.5 percent. The second fund is used to support proposals submitted by political subdivisions of states that are determined by the Secretary of Health and Human Services to hold promise for helping long-term welfare recipients enter the workforce.

Formula grants from the first fund are to be provided to States for the purpose of initiating projects that aim to place long-term welfare recipients in the workforce. Governors must distribute at least 85 percent of the state allotment to local jurisdictions within the state in which poverty and unemployment rates are above the state average. These funds must be distributed in accord with a formula devised by the governor that bases at least 50 percent of its allocation weight on poverty and may also include two additional factors, welfare recipients who have received benefits for 30 or more months and unemployment. Any local jurisdiction that, under this formula, would be allotted less than $100,000 will not receive any funds; these funds will instead revert to the governor. Governors may use up to 15 percent of the state allocation, plus any amounts remitted from local jurisdictions that would be allotted less than $100,000, to fund projects designed to help long-term recipients enter the workforce.

Competitive grants are awarded in FY 1998 and FY 2000, although approved projects can receive funds from the Secretary every year and have 3 years to spend funds once obligated, on the basis of the likelihood that program applicants can successfully make long-term placements of welfare-dependent individuals into the workforce. The Secretary must select projects that show promise in: (1) expanding the base of knowledge about welfare-to-work programs for the least job ready; (2) moving the least job ready recipients into the labor force; and (3) moving the least job ready recipients into the labor force even in labor markets that have a shortage of low-skill jobs. Other factors the Secretary, at her discretion, may use to select projects include: history of success in moving individuals with multiple barriers into work; evidence of ability to leverage private, State, and local resources; use of State and local resources that exceed the required match; plans to coordinate with other organizations at the local and State level; and use of current or former welfare recipients as mentors, case managers, or service providers. Any political subdivision of a state may apply for funds. Not less than 30 percent shall be awarded to rural areas. The Secretary cannot award grants unless the TANF agency has approved the grant application. Further, the Secretary must terminate funds for a project upon a determination that the TANF agency is not adhering to the agreement. Awards to each project must be based on the Secretary's determination of the amount needed for

the project to be successful. Allowable activities include job creation, on-the-job training, contracts with public or private providers of employment services, job vouchers, and job support services. The Secretary must include several required outcome measures in the evaluation study and must report on program outcomes to Congress in 1999 and 2001.

Funds under both the competitive grants and the formula grants can be spent only for job creation through public or private sector employment wage subsidies, on-the-job training, contracts with public or private providers of readiness, placement, and post-employment services, job vouchers for placement, readiness, and post-employment services, and job support services (not including child care) if such services are not otherwise available. Any entity receiving funds under either grant must expend at least 90 percent of the money on recipients who have received benefits for at least 30 months, who suffer from multiple barriers to employment, or are within 12 months of a mandatory time limit on benefits. States must provide a 33 percent match of federal funds and must comply with the 75 percent maintenance of effort requirements in TANF.

The Secretary shall also reserve $100 million to add to the "High Performance Bonus" amount in FY 2003 for states which are most successful in increasing the earnings of long-term welfare recipients or of those who are at risk of long-term welfare dependency.

Funds available under this program are $.75 billion for fiscal year 1998, $1.15 billion for fiscal year 1999, and $1.0 billion for fiscal year 2000. The Secretary must include several specific measures, such as success in job placements, in her evaluation of the program. In addition, the Secretary must submit a progress report to Congress in 1999 and a final report in 2001.

Effective Date

Date of enactment (funds are available beginning in fiscal year 1998).

NONDISPLACEMENT IN WORKER ACTIVITIES

Present Law

A TANF recipient may fill a vacant employment position. However, no adult in a work activity that is funded in whole or in part by federal funds shall be employed or assigned when another person is on layoff from the same or any substantially equivalent job; or if the employer has ended the employment of any regular employee or otherwise caused an involuntary reduction of his workforce in order to fill the vacancy so created with a TANF recipient. These provisions shall not preempt or supersede any state or local law that provides greater protection against displacement.

Committee Provision

A participant in a work activity pursuant to this section shall not displace (including a partial displacement, such as a reduction in the hours of nonovertime work, wages, or employment benefits) any individual who, as of the date of the participation, is an employee.

A participant in a work activity shall not be employed in a job when any other individual is on layoff from the same or any substantially equivalent job; when the employer has terminated the employment of any regular employee or otherwise reduced the workforce of the employer with the intention of filling the vacancy so created with the participant; or which is created in a promotional line that will infringe in any way upon the promotional opportunities of employed individuals.

ENROLLMENT FLEXIBILITY

Present Law

The Secretary is provided with authority to waive provisions of law, with authority to approve a variety of demonstration projects, and with authority to enter into contracts with entities other than public entities.

Reasons for Change

The Committee provision would encourage innovation in enrolling individuals for a variety of federal, state, and local benefit programs for which they may be eligible.

Committee Provision

A state plan to consolidate and automate the administration of low-income benefit programs, including Medicaid and to competitively contract for the administration of such programs that was submitted to the Secretary of Health and Human Services prior to June 1, 1997 shall be deemed by the Secretary to be approved.

The state is required to take necessary steps to safeguard the privacy, confidentiality, and protections of individuals provided under law. The state is required to take necessary steps to provide that all protections for individuals seeking benefits including appeals and grievances as provided by law are ensured.

CLARIFICATION OF A STATE'S ABILITY TO SANCTION AN INDIVIDUAL RECEIVING ASSISTANCE UNDER TANF FOR NONCOMPLIANCE

Present Law

The Personal Responsibility and Work Opportunity Reconciliation Act provides that states may penalize welfare recipients by reduction of benefits. For example, the PRWO provides that states shall not be prohibited from sanctioning welfare recipients who test positive for use of controlled substances. Further, if a parent fails to cooperate in establishing paternity or in establishing, modifying, or enforcing a child support order, and the individual does not qualify for a good cause exception, the state must reduce the family's benefit by at least 25 percent and may reduce it to zero.

Reasons for Change

The Administration has interpreted the Fair Labor Standards Act as applying to workfare programs under the TANF law. This interpretation will require that workfare participants receive a benefit that at least equals the federal minimum wage rate multiplied

by their required hours of work. Reduction in the benefit of a workfare participant for noncompliance with program rules might violate the federal minimum wage.

Committee Provision

The amendment provides that, notwithstanding any minimum wage requirement, states will not be prohibited from sanctioning a workfare participant for noncompliance even if that sanction reduces the benefit below the minimum wage equivalent.

CHAPTER 3—UNEMPLOYMENT COMPENSATION

INCREASE IN FEDERAL UNEMPLOYMENT ACCOUNT CEILING AND SPECIAL DISTRIBUTION TO STATES FROM THE UNEMPLOYMENT TRUST FUND

Present Law

FUTA taxes are credited to Federal accounts in the Unemployment Trust Fund in proportions that are set by statute. Funds are held in reserve in these accounts to provide Federal spending authority for certain purposes. The Employment Security Administration Account (ESAA) funds Federal and State administration of the UI program. The Extended Unemployment Compensation Account (EUCA) finances the Federal share of extended UI benefits. The Federal Unemployment Account (FUA) provides authority for loans to States with insolvent UI benefit accounts. Each of these accounts has a statutory ceiling. ESAA's balance after the end of a fiscal year is reduced to 40% of the prior-year appropriation from ESAA. Excess funds are transferred to EUCA and/or FUA. The ceilings on EUCA and FUA are set as a percent of total wages in employment covered by UI. The current ceilings are 0.5% of wages for EUCA and 0.25% of wages for FUA. If all three accounts reach their ceilings, excess funds are distributed among the 53 State benefit accounts in the Unemployment Trust Fund, after repayment of any outstanding general revenue advances to FUA and EUCA. These transfers to the State accounts are termed "Reed Act transfers" after the name of the legislation that authorized this use of excess FUTA funds. The Department of Labor projects that Reed Act transfers will be triggered beginning in Fiscal Year 2000 under present law.

Reasons for Change

The Committee provision would increase the Federal Unemployment Account ceiling from 0.25 percent to 0.50 percent of covered wages.

Committee Provision

The provision would double the Federal Unemployment Account ceiling from 0.25 percent to 0.50 percent of covered wages, effective at the beginning of fiscal year 2002. In addition, for each of fiscal years 2000, 2001, and 2002, if Federal account ceilings are reached, an annual total of no more than $100 million in Reed Act transfers are to be made from Federal UI accounts to State accounts for use

by States in administering their UI programs. (Annual amounts in excess of $100 million are to accrue to the Federal Unemployment Account, notwithstanding the continued 0.25 percent ceiling). Funds are to be distributed among the States in the same manner as administrative funds from the Federal account are allocated.

Effective Date

The increase in the Federal Unemployment Account ceiling is to occur on October 1, 2001; special distributions are made beginning in fiscal year 2000, based on account balances at the end of the preceding fiscal year.

CLARIFYING PROVISION RELATING TO BASE PERIODS

Present Law

Federal law establishes broad guidelines for the operation of State unemployment insurance (UI) programs but leaves most of the details of eligibility and benefits to State determination. One of these general Federal guidelines calls for States to use administrative methods that ensure full payment of UI benefits "when due." All States meet this requirement with program rules that the U.S. Department of Labor has found to be in compliance. In complying with the "when due" clause, States must decide what "base period" to use in measuring a claimant's wage history for the purpose of determining individual eligibility and benefit entitlement. States have generally used a base period consisting of the first 4 of the last 5 completed calendar quarters. However, several States that use this base period also use an "alternative base period," usually the last 4 completed calendar quarters. This alternative base period is used for claimants who are found to be ineligible because their earnings were too low in the regular base period. Although current State base periods have Department of Labor approval, a Federal court in Illinois, in the case of *Pennington* v. *Doherty,* ruled that the State of Illinois is not in compliance with the "when due" clause because it could use a more recent base period, which would benefit a significant number of claimants. This case may be appealed further. If left standing, it will apply only to three States: Illinois, Indiana, and Wisconsin. However, similar suits have been filed in other States, and they could lead to a de facto national rules change based on judicial action.

Reasons for Change

The Committee provision clarifies that states have full discretion in setting their own unemployment insurance base periods for determining eligibility for unemployment insurance benefits.

Committee Provision

The provision reinforces current policy by affirming that States have complete authority to set their own base periods used in determining individuals' eligibility for unemployment insurance benefits. According to the Congressional Budget Office, failing to make this change could result in 41 States being required to adopt alternative base periods at a cost of $400 million annually in added UI

benefits plus increased administrative costs. CBO assumes that States would increase their revenue collections (by raising payroll taxes) to cover any increase in benefit outlays.

Effective Date

This section shall apply for purposes of any period beginning before, on, or after the date of enactment of this Act.

TREATMENT OF CERTAIN SERVICES PERFORMED BY INMATES

Present Law

Federal law requires UI coverage for most nongovernmental employment, and employers have to pay taxes under the Federal Unemployment Tax Act (FUTA) for their employees. Federal law also requires state UI programs to cover jobs in state and local government agencies. Each governmental employer reimburses the state UI program for the cost of any unemployment benefits paid to its workers.

Federal law does except certain employment from this mandatory coverage. One exception permits states to exclude from coverage services performed for a governmental agency by inmates of custodial or penal institutions. However, any work performed by inmates by private employers through work-release programs or other cooperative arrangements between prison authorities and private employers does not come under this exception. Further, there is no exception to FUTA coverage of private employers for jobs held by inmates of penal institutions. Thus, it is possible for a prison inmate on work-release to earn UI coverage that may be used to claim UI benefits, if the inmate, when released, is unemployed and available for work.

Reasons for Change

The Committee provision exempts services performed by inmates who participate in prison work programs from unemployment taxes and benefits.

Committee Provisions

The Committee provision will prevent the payment of unemployment compensation benefits to former prisoners who became "unemployed" when they were released and were no longer participating in a prison work program. Inmates who provide services directly to the prison are already exempt from unemployment taxes. This would extend the same treatment to inmates who participate in other work programs while in prison.

Subtitle M—Welfare Reform Technical Corrections

WELFARE REFORM TECHNICAL CORRECTIONS

Reasons for Change

The Committee provision makes approximately 200 technical and conforming amendments to the "Personal Responsibility and Work Opportunity Act of 1996," (P.L. 104–193).

Committee Provision

The Committee adopts H.R. 1048, the "Welfare Reform Technical Corrections Act of 1997," as amended by deleting all provisions relating to Title II of the Social Security Act. It is further amended by the following provision to remove teen parents attending school from the limit on vocational education.

REMOVE TEEN PARENTS ATTENDING SCHOOL FROM THE LIMIT ON VOCATIONAL EDUCATION

Present Law

The law restricts to 20 percent the proportion of persons in all families and in two-parent families who may be treated as engaged in work for a month by reason of participating in vocational educational training, or if single teenage household heads without a high school diploma, by reason of satisfactory attendance at secondary school or participation in education directly related to employment. The law also requires all unmarried parents under age 18 who did not complete high school to participate in education as a condition of eligibility for TANF.

Reasons for Change

In some states the number of teen parents who must attend school in order to receive TANF is so large that the state's ability to use vocational education training is significantly reduced. Further, states want the additional flexibility to promote vocational education for adults as a means of promoting eventual self-sufficiency.

Committee Provision

Remove single heads of household under age 20 from the calculation of the limit on the number of persons that are permitted to meet the work requirement through vocational educational activity.

DIVISION 4—EARNED INCOME CREDIT AND OTHER PROVISIONS

Subtitle L—Earned Income and Other Provisions

CHAPTER 1—EARNED INCOME CREDIT

DESCRIPTION OF EARNED INCOME CREDIT PROVISIONS

Present Law

In general

Certain eligible low-income workers are entitled to claim a refundable earned income credit (EIC) (sec. 32 of the Internal Revenue Code of 1986 ("Code")). A refundable credit is a credit that not only reduces an individual's tax liability but allows refunds to the individual in excess of income tax liability. The amount of the credit an eligible individual may claim depends upon whether the individual has one, more than one, or no qualifying children, and is determined by multiplying the credit rate by the individual's earned income up to an earned income amount. (Note: In the case of a married individual who files a joint return with his or her spouse, the income for purposes of these tests is the combined income of the couple.)

The maximum amount of the credit is the product of the credit rate and the earned income amount. The credit is reduced by the amount of alternative minimum tax ("AMT") the taxpayer owes for the year. The EIC is phased out above certain income levels. For individuals with earned income or modified adjusted gross income ("modified AGI"), in excess of the beginning of the phaseout range, the maximum credit amount is reduced by the phaseout rate multiplied by the amount of earned income (or modified AGI, if greater) in excess of the beginning of the phaseout range.

For individuals with earned income (or modified AGI, if greater) in excess of the end of the phaseout range, no credit is allowed. Modified AGI means AGI, but for this purpose does not include the following amounts: (1) net capital losses (if greater than zero); (2) net losses from trusts and estates; (3) net losses from nonbusiness rents and royalties; and (4) 50 percent of the net losses from business, computed separately with respect to sole proprietorships (other than in farming), sole proprietorships in farming, and other businesses. Amounts attributable to a business that consists of the performance of services by the taxpayer as an employee are not taken into account for purposes of (4).

The parameters for the EIC for 1997 are given in the following table:

EARNED INCOME CREDIT PARAMETERS (1997)

	Two or more qualifying children	One qualifying child	No qualifying children
Credit rate (percent)	40.00	34.00	7.65
Earned income amount	$9,140	$6,500	$4,340
Maximum credit	$3,656	$2,210	$332
Phaseout begins	$11,930	$11,930	$5,430
Phaseout rate (percent)	21.06	15.98	7.65
Phaseout ends	$29,290	$25,760	$9,770

Under present law, an individual is not eligible for the earned income credit if the aggregate amount of "disqualified income" of the taxpayer for the taxable year exceeds $2,250. Disqualified income is the sum of: (1) interest (taxable and tax-exempt); (2) dividends; (3) net rent and royalty income (if greater than zero); (4) capital gain net income; and (5) net passive income (if greater than zero) that is not self-employment income. The $2,250 threshold is indexed for inflation.

The earned income amount and the phaseout amount are indexed for inflation.

Earned income

Under present law, earned income means the sum of (1) wages, salaries, tips, and other employee compensation, and (2) the amount of the taxpayer's net earnings from self employment for the taxable year, determined without regard to the deduction for one-half of the taxpayer's self-employment taxes (Code sec. 164(f)). For purposes of this definition, earned income is computed without regard to any community property laws, pension and annuity payments are not treated as earned income, certain amounts relating to nonresident aliens are disregarded, and no amount received by inmates for services in penal institutions is treated as earned income.

Eligible individual

Under present law, an individual is an eligible individual entitled to claim the EIC for a year if

(1) the individual has a qualifying child for the taxable year, or

(2) the individual does not have a qualifying child, but satisfies the following requirements:

(i) the individual's principal place of abode is in the United States for more than ½ of the year,

(ii) the individual (or, if the individual is married, either the individual or the individual's spouse) has attained age 25, but has not attained age 65 before the close of the year, and

(iii) the individual is not a dependent for whom a dependency exemption is allowed on another taxpayer's return for a taxable year beginning in the same calendar year as the taxable year of the individual.

An individual is not an eligible individual for the year if the individual (1) is a qualifying child of another taxpayer, (2) claims any

exclusion from income under Code section 911 for citizens or residents living abroad, (3) is a nonresident alien individual for any portion of the year unless the individual is treated as a U.S. resident for the year under Code section 6013, or (4) does not include the individual's taxpayer identification number ("TIN") or the individual's spouse's TIN on the tax return.

Qualifying child

A qualifying child must meet a relationship test, an age test, an identification test, and a residence test. Under the relationship and age tests, an individual is eligible for the EIC with respect to another person only if that other person: (1) is a son, daughter, or adopted child (or a descendent of a son, daughter, or adopted child); a stepson or stepdaughter; or a foster child of the taxpayer (a foster child is defined as a person whom the individual cares for as the individual's child; it is not necessary to have a placement through a foster care agency); and (2) is under the age of 19 at the close of the taxable year (or is under the age of 24 at the end of the taxable year and was a full-time student during the taxable year), or is permanently and totally disabled. Also, if the qualifying child is married at the close of the year, the individual may claim the EIC for that child only if the individual may also claim that child as a dependent.

To satisfy the identification test, an individual must include on their tax return the name, age, and TIN of each qualifying child.

The residence test requires that a qualifying child must have the same principal place of abode as the taxpayer for more than one-half of the taxable year (for the entire taxable year in the case of a foster child), and that this principal place of abode must be located in the United States. For purposes of determining whether a qualifying child meets the residence test, the principal place of abode shall be treated as in the United States for any period during which a member of the Armed Forces is stationed outside the United States while serving on extended active duty.

Advance payment

An individual with qualifying children may elect to receive the credit on an advance basis by furnishing an advance payment certificate to his or her employer. For such an individual, the employer makes an advance payment of the credit at the time wages are paid. The amount of advance payment allowable in a taxable year is limited to 60 percent of the maximum credit available to an individual with one qualifying child.

TIN requirement

Under present law, for purposes of determining who is an eligible individual and who is a qualifying child, a TIN means a social security number issued to an individual by the Social Security Administration other than a social security number issued pursuant to clause (II) (or that portion of clause (III) that relates to clause (II)) of section 205(c)(2)(B)(i) of the Social Security Act relating to the issuance of a Social Security number to an individual applying for or receiving Federally funded benefits.

Mathematical or clerical errors

The IRS may summarily assess additional tax due as a result of a mathematical or clerical error without sending the taxpayer a notice of deficiency and giving the taxpayer an opportunity to petition the Tax Court. If an individual fails to provide a correct TIN, such omission is treated as a mathematical or clerical error. Also, if an individual who claims the EIC with respect to net earnings from self employment fails to pay the proper amount of self-employment tax on such net earnings, the failure is treated as a mathematical or clerical error for purposes of the amount of EIC claimed.

Where the IRS uses the summary assessment procedure for mathematical or clerical errors, the taxpayer must be given an explanation of the asserted error and a period of 60 days to request that the IRS abate its assessment. The IRS may not proceed to collect the amount of the assessment until the taxpayer has agreed to it or has allowed the 60-day period for objecting to expire. If the taxpayer files a request for abatement of the assessment specified in the notice, the IRS must abate the assessment. Any reassessment of the abated amount is subject to the ordinary deficiency procedures.

The request for abatement of the assessment is the only procedure a taxpayer may use prior to paying the assessed amount in order to contest an assessment arising out of a mathematical or clerical error. Once the assessment is satisfied, however, the taxpayer may file a claim for refund if he or she believes the assessment was made in error.

Committee Provisions

A. Deny EIC Eligibility for Prior Acts of Recklessness or Fraud

Present Law

The accuracy-related penalty, which is imposed at a rate of 20 percent, applies to the portion of any underpayment that is attributable to (1) negligence, (2) any substantial understatement of income tax, (3) any substantial valuation overstatement, (4) any substantial overstatement of pension liabilities, or (5) any substantial estate or gift tax valuation understatement (sec. 6662). Negligence includes any careless, reckless, or intentional disregard of rules or regulations, as well as any failure to make a reasonable attempt to comply with the provisions of the Code.

The fraud penalty, which is imposed at a rate of 75 percent, applies to the portion of any underpayment that is attributable to fraud (sec. 6663).

Neither the accuracy-related penalty nor the fraud penalty is imposed with respect to any portion of an underpayment if it is shown that there was a reasonable cause for that portion and that the taxpayer acted in good faith with respect to that portion.

Reasons for Change

The Committee believes that taxpayers who fraudulently claim the EIC or recklessly or intentionally disregard EIC rules or regulations should be penalized for doing so.

Committee Proposal

A taxpayer who fraudulently claims the EIC would be ineligible to claim the EIC for a subsequent period of 10 years. In addition, a taxpayer who erroneously claims the EIC due to reckless or intentional disregard of rules or regulations would be ineligible to claim the EIC for a subsequent period of two years. These sanctions would be in addition to any other penalty imposed under present law. The determination of fraud or of reckless or intentional disregard of rules or regulations would be made in a deficiency proceeding (which would provide for judicial review).

Effective Date

The proposal would be effective for taxable years beginning after December 31, 1996.

B. Recertification Required When Taxpayer Found to be Ineligible for EIC in Past

Present Law

If an individual fails to provide a correct TIN and claims the EIC, such omission is treated as a mathematical or clerical error. Also, if an individual who claims the EIC with respect to net earnings from self employment fails to pay the proper amount of self-employment tax on such net earnings, the failure is treated as a mathematical or clerical error for purposes of the amount of EIC claimed. Generally, taxpayers have 60 days in which they can either provide a correct TIN or request that the IRS follow the current-law deficiency procedures. If a taxpayer fails to respond within this period, he or she must file an amended return with a correct TIN or clarify that any self-employment tax has been paid in order to obtain the EIC originally claimed.

The IRS must follow deficiency procedures when investigating other types of questionable EIC claims. Under these procedures, contact letters are first sent to the taxpayer. If the necessary information is not provided by the taxpayer, a statutory notice of deficiency is sent by certified mail, notifying the taxpayer that the adjustment will be assessed unless the taxpayer files a petition in Tax Court within 90 days. If a petition is not filed within that time and there is no other response to the statutory notice, the assessment is made and the EIC is denied.

Reasons for Change

The Committee believes that the requirement of additional information to determine EIC eligibility is prudent for taxpayers who have incorrectly claimed the EIC in the past.

Committee Proposal

A taxpayer who has been denied the EIC as a result of deficiency procedures would be ineligible to claim the EIC in subsequent years unless evidence of eligibility for the credit is provided by the taxpayer. To demonstrate current eligibility, the taxpayer would be required to meet evidentiary requirements established by the Sec-

retary of the Treasury. Failure to provide this information when claiming the EIC would be treated as a mathematical or clerical error. If a taxpayer is recertified as eligible for the credit, the taxpayer would not be required to provide this information in the future unless the IRS again denies the EIC as a result of a deficiency procedure. Ineligibility for the EIC under the proposal would be subject to review by the courts.

Effective Date

The proposal would be effective for taxable years beginning after December 31, 1996.

C. Due Diligence Requirements for Paid Preparers

Present Law

There are several penalties that apply in the case of an understatement of tax that is caused by an income tax return preparer. First, if any part of an understatement of tax on a return or claim for refund is attributable to a position for which there was not a realistic possibility of being sustained on its merits and if any person who is an income tax return preparer with respect to such return or claim for refund knew (or reasonably should have known) of such position and such position was not disclosed or was frivolous, then that return preparer is subject to a penalty of $250 with respect to that return or claim (sec. 6694(a)). The penalty is not imposed if there is reasonable cause for the understatement and the return preparer acted in good faith.

In addition, if any part of an understatement of tax on a return or claim for refund is attributable to a willful attempt by an income tax return preparer to understate the tax liability of another person or to any reckless or intentional disregard of rules or regulations by an income tax return preparer, then the income tax return preparer is subject to a penalty of $1,000 with respect to that return or claim (sec. 6694(b)).

Also, a penalty for aiding and abetting the understatement of tax liability is imposed in cases where any person aids, assists in, procures, or advises with respect to the preparation or presentation of any portion of a return or other document if (1) the person knows or has reason to believe that the return or other document will be used in connection with any material matter arising under the tax laws, and (2) the person knows that if the portion of the return or other document were so used, an understatement of the tax liability of another person would result (sec. 6701).

Additional penalties are imposed on return preparers with respect to each failure to (1) furnish a copy of a return or claim for refund to the taxpayer, (2) sign the return or claim for refund, (3) furnish his or her identifying number, (4) retain a copy or list of the returns prepared, and (5) file a correct information return (sec. 6695). The penalty is $50 for each failure and the total penalties imposed for any single type of failure for any calendar year are limited to $25,000.

Reasons for Change

The Committee believes that more thorough efforts by return preparers are important to improving EIC compliance.

Committee Proposal

Return preparers would be required to fulfill certain due diligence requirements with respect to returns they prepare claiming the EIC. The penalty for failure to meet these requirements is $100. This penalty would be in addition to any other penalty imposed under present law.

Effective Date

The proposal would be effective for taxable years beginning after December 31, 1996.

CHAPTER 2—INCREASE IN THE PUBLIC DEBT

STATUTORY DEBT LIMIT INCREASE

In addition to the spending and revenue reconciliation bills, the Senate Finance Committee has been reconciled with increasing the statutory limit on the public debt to $5.950 trillion. The current debt ceiling of $5.5 trillion is expected to be reached in early 1998. The Chairman's mark includes the required increase to $5.950 trillion.

It is assumed that the $5.950 trillion limit will be sufficient to allow the government to operate until sometime in late 1999. The debt limit bill has been included in the spending reconciliation instructions to the Finance Committee.

CHAPTER 3—MISCELLANEOUS

REGARDING THE ACCURACY OF THE CONSUMER PRICE INDEX (CPI)

Inclusion of S. Res. 50 into the Chairman's mark. S. Res. 50 expresses the Sense of the Senate that the current CPI does not accurately reflect true changes in the cost of living. It refers to the Boskin Commission report which concluded that the Consumer Price Index overstates the cost of living in the U.S. by 1.1 percentage points.

> *"Resolved,* That it is the sense of the Senate that all cost-of-living adjustments required by statute should accurately reflect the best available estimate of changes in the cost of living."

TITLE V—COMMITTEE ON FINANCE

SEC. 5000. AMENDMENTS TO SOCIAL SECURITY ACT AND REFERENCES TO OBRA; TABLE OF CONTENTS OF TITLE.

(a) 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.

(b) REFERENCES TO OBRA.—In this title, the terms "OBRA–1986", "OBRA–1987", "OBRA–1989", "OBRA–1990", and "OBRA–1993" refer to the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509), the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203), the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239), the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508), and the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), respectively.

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

DIVISION 1—MEDICARE

Subtitle A—Medicare Choice Program

CHAPTER 1—MEDICARE CHOICE PROGRAM

Subchapter A—Medicare Choice Program

SEC. 5001. ESTABLISHMENT OF MEDICARE CHOICE PROGRAM.

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

"PART C—MEDICARE CHOICE PROGRAM

"ELIGIBILITY, ELECTION, AND ENROLLMENT

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

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

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

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

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

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

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

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

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

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

"(F) COMBINATION OF MSA PLAN AND CONTRIBUTIONS TO MEDICARE CHOICE MSA.—An MSA plan, as defined in section 1859(b)(3), and a contribution into a Medicare Choice medical savings account (MSA).

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

"(3) MEDICARE CHOICE ELIGIBLE INDIVIDUAL.—

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

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

"(b) SPECIAL RULES.—

"(1) RESIDENCE REQUIREMENT.—

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

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

"(2) SPECIAL RULE FOR CERTAIN INDIVIDUALS COVERED UNDER FEHBP OR ELIGIBLE FOR VETERANS OR MILITARY HEALTH BENEFITS, VETERANS.—

"(A) FEHBP.—An individual who is enrolled in a health benefit plan under chapter 89 of title 5, United States Code, is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

"(B) VA AND DOD.—The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of title 10, United States Code, or under chapter 17 of title 38 of such Code.

"(3) LIMITATION ON ELIGIBILITY OF QUALIFIED MEDICARE BENEFICIARIES AND OTHER MEDICAID BENEFICIARIES TO ENROLL IN AN MSA PLAN.—An individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)), a qualified disabled and working individual (described in section 1905(s)), an individual described in section 1902(a)(10)(E)(iii), or otherwise entitled to medicare cost-sharing under a State plan under title XIX is not eligible to enroll in an MSA plan.

"(4) COVERAGE UNDER MSA PLANS ON A DEMONSTRATION BASIS.—

"(A) IN GENERAL.—An individual is not eligible to enroll in an MSA plan under this part—

"(i) on or after January 1, 2003, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

"(ii) as of any date if the number of such individuals so enrolled as of such date has reached 100,000.

Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

"(B) EVALUATION.—The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under this part on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds under this title.

"(C) REPORTS.—The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B). The Secretary shall submit such a report, by not later than March 1, 2002, on whether the time limitation under subparagraph (A)(i) should be extended or removed and whether to change the numerical limitation under subparagraph (A)(ii).

"(c) PROCESS FOR EXERCISING CHOICE.—

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

"(2) COORDINATION THROUGH MEDICARE CHOICE ORGANIZATIONS.—

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

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

"(3) DEFAULT.—

"(A) INITIAL ELECTION.—

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

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

such plan or plans as the Secretary identifies under such procedures).

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

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

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

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

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

"(2) PROVISION OF NOTICE.—

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

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

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

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

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

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

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

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

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

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

"(i) covered items and services,

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

"(iii) any beneficiary liability for balance billing.

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

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

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

"(E) INFORMATION ON MEDIGAP AND MEDICARE SELECT.—A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1882 and provisions relating to medicare select policies described in section 1882(t).

"(F) POTENTIAL FOR CONTRACT TERMINATION.—The fact that a Medicare Choice organization may terminate or refuse to renew its contract under this part and the effect the termination or nonrenewal of its contract may have on individuals enrolled with the Medicare Choice plan under this part.

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

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

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

"(ii) any beneficiary cost sharing,

"(iii) any maximum limitations on out-of-pocket expenses, and

"(iv) in the case of an MSA plan, differences in cost sharing and balance billing under such a plan compared to under other Medicare Choice plans.

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

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

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

"(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the

previous 2 years (excluding disenrollment due to death or moving outside the plan's service area),

"(ii) information on medicare enrollee satisfaction,

"(iii) information on health outcomes,

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

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

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

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

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

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

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

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

"(e) COVERAGE ELECTION PERIODS.—

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

"(2) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—Subject to paragraph (5), a Medicare Choice eligible individual may change the election under subsection (a)(1) at any time, except that such individual may only enroll in a Medicare

Choice plan which has an open enrollment period in effect at that time.

"(3) ANNUAL, COORDINATED ELECTION PERIOD.—

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

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

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

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

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

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

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

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

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

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

"(5) SPECIAL RULES FOR MSA PLANS.—Notwithstanding the preceding provisions of this subsection, an individual—

"(A) may elect an MSA plan only during—

"(i) an initial open enrollment period described in paragraph (1), or

"(ii) an annual, coordinated election period described in paragraph (3)(B), and

"(B) may not discontinue an election of an MSA plan except during the periods described in subparagraph (A) and under paragraph (4).

"(6) OPEN ENROLLMENT PERIODS.—A Medicare Choice organization—

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

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

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

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

"(2) DURING CONTINUOUS OPEN ENROLLMENT PERIODS.—An election or change of coverage made under subsection (e)(2) shall take effect with the first day of the first calendar month following the date on which the election is made.

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

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

"(g) GUARANTEED ISSUE AND RENEWAL.—

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

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

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

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

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

"(3) LIMITATION ON TERMINATION OF ELECTION.—

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

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

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

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

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

"(C) CONSEQUENCE OF TERMINATION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

"BENEFITS AND BENEFICIARY PROTECTIONS

"SEC. 1852. (a) BASIC BENEFITS.—

"(1) IN GENERAL.—Except as provided in section 1859(b)(3) for MSA plans, each Medicare Choice plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

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

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

"(2) SUPPLEMENTAL BENEFITS.—

"(A) BENEFITS INCLUDED SUBJECT TO SECRETARY'S APPROVAL.—Each Medicare Choice organization may provide to individuals enrolled under this part (without affording those individuals an option to decline the coverage) supplemental health care benefits that the Secretary may ap-

prove. The Secretary shall approve any such supplemental benefits unless the Secretary determines that including such supplemental benefits would substantially discourage enrollment by Medicare Choice eligible individuals with the organization.

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

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

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

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

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

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

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

"(b) ANTIDISCRIMINATION.—

"(1) BENEFICIARIES.—

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

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

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

"(c) DISCLOSURE REQUIREMENTS.—

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

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

"(B) BENEFITS.—Benefits offered under the plan, including information described in section 1851(d)(3)(A) and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other Medicare Choice plans.

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

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

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

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

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

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

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

"(i) whether the supplemental benefits are optional,

"(ii) the supplemental benefits covered, and

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

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

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

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

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

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

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

"(B) Information on utilization review procedures.

"(d) ACCESS TO SERVICES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(ii) serious impairment to bodily functions, or

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

"(e) QUALITY ASSURANCE PROGRAM.—

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

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

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

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

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

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

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

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

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

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

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

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

"(K) include measures of consumer satisfaction; and

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

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

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

"(5) TREATMENT OF ACCREDITATION.—The Secretary shall provide that a Medicare Choice organization is deemed to meet requirements of paragraphs (1) and (2) of this subsection and subsection (h) (relating to confidentiality and accuracy of enrollee records) if the organization is accredited (and periodically reaccredited) by a private organization under a process

that the Secretary has determined assures that the organization, as a condition of accreditation, applies and enforces standards with respect to the requirements involved that are no less stringent than the standards established under section 1856 to carry out the respective requirements.

"(f) COVERAGE DETERMINATIONS.—

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

"(2) RECONSIDERATIONS.—

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

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

"(g) GRIEVANCES AND APPEALS.—

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

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

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

"(4) EXPEDITED DETERMINATIONS AND RECONSIDERATIONS.—

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

"(B) ORGANIZATION PROCEDURES.—

"(i) IN GENERAL.—The Medicare Choice organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of normal time frames for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

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

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

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

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

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

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

"(j) RULES REGARDING PHYSICIAN PARTICIPATION.—

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

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

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

"(C) providing a process within the organization for appealing such adverse decisions, including the presen-

tation of information and views of the physician regarding such decision.

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

"(3) LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.—

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

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

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

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

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

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

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

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

"PAYMENTS TO MEDICARE CHOICE ORGANIZATIONS

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

"(1) MONTHLY PAYMENTS.—

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

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

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

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

"(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

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

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

"(3) ESTABLISHMENT OF RISK ADJUSTMENT FACTORS.—

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

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

"(4) INTERIM RISK ADJUSTMENT.—

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

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

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

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

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

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

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

"Months enrolled in HMOs:	Applicable percentage:
1–12	5
13–24	4
25–36	3
37–48	2
49–60	1.

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

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

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

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

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

"(b) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—

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

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

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

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

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

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

"(1) IN GENERAL.—For purposes of this part, each annual Medicare Choice capitation rate, for a Medicare Choice payment area for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraphs (A), (B), or (C):

"(A) BLENDED CAPITATION RATE.—The sum of—

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

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

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

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

"(i) For 1998, $4,200 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area).

"(ii) For each subsequent year, 101 percent of the amount in effect under this subparagraph for the previous year.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(i) In 1999, 50 percent.

"(ii) In 2000, 75 percent.

"(iii) In 2001, 100 percent.

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

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

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

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

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

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

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

such subparagraphs and such other adjustment factor) if the area-specific percentage under paragraph (1) for the year had been 100 percent and the national percentage had been 0 percent.

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

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

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

"(B) 0.5 percentage points.

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

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

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

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

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

"(B) LIMITATION ON INCREASE IN MINIMUM AMOUNT.—The Secretary shall not under subparagraph (A)(ii) increase the minimum amount under paragraph (1)(B) to an amount that is greater than the amount the Secretary estimates will result in increased payments under such paragraph equal to the decrease in payments by reason of the redetermination under subparagraph (A)(i).

"(9) STUDY OF LOCAL PRICE INDICATORS.—The Secretary and the Medicare Payment Advisory Commission shall each conduct a study with respect to appropriate measures for ad-

justing the annual Medicare Choice capitation rates determined under this section to reflect local price indicators, including the medicare hospital wage index and the case-mix of a geographic region. The Secretary and the Advisory Commission shall report the results of such study to the appropriate committees of Congress, including recommendations (if any) for legislation.

"(d) MEDICARE CHOICE PAYMENT AREA DEFINED.—

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

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

"(3) GEOGRAPHIC ADJUSTMENT.—

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

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

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

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

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

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

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

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

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

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

"(e) SPECIAL RULES FOR INDIVIDUALS ELECTING MSA PLANS.—

"(1) IN GENERAL.—If the amount of the monthly premium for an MSA plan for a Medicare Choice payment area for a year is less than 1/12 of the annual Medicare Choice capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a Medicare Choice MSA established (and, if applicable, designated) by the individual under paragraph (2).

"(2) ESTABLISHMENT AND DESIGNATION OF MEDICARE CHOICE MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) on behalf of an individual for a month unless the individual—

"(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a Medicare Choice MSA (as defined in section 138(b)(2) of the Internal Revenue Code of 1986), and

"(B) if the individual has established more than one such Medicare Choice MSA, has designated one of such accounts as the individual's Medicare Choice MSA for purposes of this part.

Under rules under this section, such an individual may change the designation of such account under subparagraph (B) for purposes of this part.

"(3) LUMP-SUM DEPOSIT OF MEDICAL SAVINGS ACCOUNT CONTRIBUTION.—In the case of an individual electing an MSA plan effective beginning with a month in a year, the amount of the contribution to the Medicare Choice MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

"(4) SPECIAL RULE FOR APPLICABLE ENROLLEE.—In the case of an enrollee in a MSA plan for any month who is an applicable enrollee for such month under section 1853(a)(4)(B), the amount of the deposit under paragraph (1) for such month shall be reduced by the applicable percentage (as defined in section 1853(a)(4)(C)) of the amount of such deposit (determined without regard to this paragraph).

"(f) PAYMENTS FROM TRUST FUND.—The payment to a Medicare Choice organization under this section for individuals enrolled under this part with the organization and payments to a Medicare Choice MSA under subsection (e)(1)(B) shall be made from the Fed-

eral Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this title. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001. Monthly payments otherwise payable under this section for October 2006 shall be paid on the first business day of October 2006.

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

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

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

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

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

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

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

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

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

"PREMIUMS

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

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

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

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

"(2) TERMINOLOGY.—In this part—

"(A) the term 'monthly premium' means, with respect to a Medicare Choice plan offered by a Medicare Choice or-

ganization, the monthly premium filed under paragraph (1), not taking into account the amount of any payment made toward the premium under section 1853; and

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

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

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

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

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

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

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

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

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

"(3) EXCEPTION FOR MSA PLANS AND UNRESTRICTED FEE-FOR-SERVICE PLANS.—Paragraphs (1) and (2) do not apply to an MSA plan or an unrestricted fee-for-service plan.

"(4) DETERMINATION ON OTHER BASIS.—If the Secretary determines that adequate data are not available to determine the

actuarial value under paragraph (1)(A) or (2), the Secretary may determine such amount with respect to all individuals in the Medicare Choice payment area, the State, or in the United States, eligible to enroll in the Medicare Choice plan involved under this part or on the basis of other appropriate data.

"(f) REQUIREMENT FOR ADDITIONAL BENEFITS.—

"(1) REQUIREMENT.—

"(A) IN GENERAL.—Each Medicare Choice organization (in relation to a Medicare Choice plan it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits (as the organization may specify) in a value which is at least equal to the adjusted excess amount (as defined in subparagraph (C)).

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

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

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

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

"(D) NO APPLICATION TO MSA PLANS.—Subparagraph (A) shall not apply to an MSA plan.

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

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

"(2) STABILIZATION FUND.—A Medicare Choice organization may provide that a part of the value of an excess amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of

the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the Medicare Choice plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

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

"(4) ADJUSTED COMMUNITY RATE.—

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

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

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

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

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

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

troller General shall monitor auditing activities conducted under this subsection.

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

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

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

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

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

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

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

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

"(B) TREATMENT OF WAIVER.—

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

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

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

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

"(I) December 31, 2000; or

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

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

"(D) ENFORCEMENT OF STATE STANDARDS.—

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

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

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

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

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

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

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

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

"(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity re-

quired their provision before they could be secured through the organization,

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

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

For purposes of paragraph (1), the applicable amount for 1998 is the amount established by the Secretary, and for 1999 and any succeeding year is the amount in effect for the previous year increased by the percentage change in the Consumer Price Index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

"(d) CERTIFICATION OF PROVISION AGAINST RISK OF INSOLVENCY FOR PSOs.—

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

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

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

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

"(e) PROVIDER-SPONSORED ORGANIZATION DEFINED.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"ESTABLISHMENT OF STANDARDS

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

"(1) ESTABLISHMENT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(b) ESTABLISHMENT OF OTHER STANDARDS.—

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

"(2) USE OF CURRENT STANDARDS.—Consistent with the requirements of this part, standards established under this subsection shall be based on standards established under section 1876 to carry out analogous provisions of such section.

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

Such interim standards shall not apply after the date standards are established under the preceding provisions of this subsection.

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

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

"CONTRACTS WITH MEDICARE CHOICE ORGANIZATIONS

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

"(b) MINIMUM ENROLLMENT REQUIREMENTS.—

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

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

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

"(c) CONTRACT PERIOD AND EFFECTIVENESS.—

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

"(2) TERMINATION AUTHORITY.—In accordance with procedures established under subsection (h), the Secretary may at any time terminate any such contract, or may impose the intermediate sanctions described in an applicable paragraph of

subsection (g)(3) on the Medicare Choice organization, if the Secretary determines that the organization—

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

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

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

"(3) EFFECTIVE DATE OF CONTRACTS.—The effective date of any contract executed pursuant to this section shall be specified in the contract, except that in no case shall a contract under this section which provides for coverage under an MSA plan be effective before January 1999 with respect to such coverage.

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

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

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

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

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

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

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

"(3) DISCLOSURE.—

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

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

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

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

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

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

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

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

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

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

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

"(I) is an officer or director;

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

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

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

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

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

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

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

"(e) ADDITIONAL CONTRACT TERMS.—

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

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

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

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

"(1) REQUIREMENT.—A contract under this part shall require a Medicare Choice organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to individuals pursuant to the contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

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

"(g) INTERMEDIATE SANCTIONS.—

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

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

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

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

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

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

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

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

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

"(G) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services;

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2).

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

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

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

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

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

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

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

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

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

"(h) PROCEDURES FOR TERMINATION.—

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

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

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

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

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

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

"DEFINITIONS; MISCELLANEOUS PROVISIONS

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

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

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

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

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

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

"(3) MSA PLAN.—

"(A) IN GENERAL.—The term 'MSA plan' means a Medicare Choice plan that—

"(i) provides reimbursement for at least the items and services described in section 1852(a)(1) in a year but only after the enrollee incurs countable expenses (as specified under the plan) equal to the amount of an annual deductible (described in subparagraph (B));

"(ii) counts as such expenses (for purposes of such deductible) at least all amounts that would have been payable under parts A and B, and that would have been payable by the enrollee as deductibles, coinsurance, or copayments, if the enrollee had elected to receive benefits through the provisions of such parts;

"(iii) subject to clause (iv), provides, after such deductible is met for a year and for all subsequent expenses for items and services referred to in clause (i) in the year, for a level of reimbursement that is not less than—

"(I) 100 percent of such expenses, or

"(II) 100 percent of the amounts that would have been paid (without regard to any deductibles or coinsurance) under parts A and B with respect to such expenses,

whichever is less; and

"(iv) provides that the annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed the amount in effect under section 220(c)(2)(A)(iii)(I) of the Internal Revenue Code of 1986 for the year.

"(B) DEDUCTIBLE.—The amount of annual deductible under an MSA plan shall not be less than or more than the amounts in excess under section 220(c)(2)(A)(i) of the Internal Revenue Code of 1986 for the year.

"(c) OTHER REFERENCES TO OTHER TERMS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) in paragraph (1)—

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

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

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

(3) by adding at the end the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) in paragraph (1)—

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

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

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

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

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

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

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

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

(f) ADDITIONAL CONFORMING CHANGES.—

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

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

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

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

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

SEC. 5003. CONFORMING CHANGES IN MEDIGAP PROGRAM.

(a) CONFORMING AMENDMENTS TO MEDICARE CHOICE CHANGES.—

(1) IN GENERAL.—Section 1882(d)(3)(A)(i) (42 U.S.C. 1395ss(d)(3)(A)(i)) is amended—

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

(B) in subclause (II)—

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

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

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

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

(b) ADDITIONAL RULES RELATING TO INDIVIDUALS ENROLLED IN MSA PLANS.—Section 1882 (42 U.S.C. 1395ss) is further amended by adding at the end the following new subsection:

"(u)(1) It is unlawful for a person to sell or issue a policy described in paragraph (2) to an individual with knowledge that the individual has in effect under section 1851 an election of an MSA plan.

"(2) A policy described in this subparagraph is a health insurance policy that provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the MSA plan.".

Subchapter B—Special Rules for Medicare Choice Medical Savings Accounts

SEC. 5006. MEDICARE CHOICE MSA.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to amounts specifically excluded from gross income) is amended by redesignating section 138 as section 139 and by inserting after section 137 the following new section:

"SEC. 138. MEDICARE CHOICE MSA.

"(a) EXCLUSION.—Gross income shall not include any payment to the Medicare Choice MSA of an individual by the Secretary of Health and Human Services under part C of title XVIII of the Social Security Act.

"(b) MEDICARE CHOICE MSA.—For purposes of this section, the term 'Medicare Choice MSA' means a medical savings account (as defined in section 220(d))—

"(1) which is designated as a Medicare Choice MSA,

"(2) with respect to which no contribution may be made other than—

"(A) a contribution made by the Secretary of Health and Human Services pursuant to part C of title XVIII of the Social Security Act, or

"(B) a trustee-to-trustee transfer described in subsection (c)(4),

"(3) the governing instrument of which provides that trustee-to-trustee transfers described in subsection (c)(4) may be made to and from such account, and

"(4) which is established in connection with an MSA plan described in section 1859(b)(3) of the Social Security Act.

"(c) SPECIAL RULES FOR DISTRIBUTIONS.—

"(1) DISTRIBUTIONS FOR QUALIFIED MEDICAL EXPENSES.—In applying section 220 to a Medicare Choice MSA—

"(A) qualified medical expenses shall not include amounts paid for medical care for any individual other than the account holder, and

"(B) section 220(d)(2)(C) shall not apply.

"(2) PENALTY FOR DISTRIBUTIONS FROM MEDICARE CHOICE MSA NOT USED FOR QUALIFIED MEDICAL EXPENSES IF MINIMUM BALANCE NOT MAINTAINED.—

"(A) IN GENERAL.—The tax imposed by this chapter for any taxable year in which there is a payment or distribution from a Medicare Choice MSA which is not used exclusively to pay the qualified medical expenses of the account holder shall be increased by 50 percent of the excess (if any) of—

"(i) the amount of such payment or distribution, over

"(ii) the excess (if any) of—

"(I) the fair market value of the assets in such MSA as of the close of the calendar year preceding the calendar year in which the taxable year begins, over

"(II) an amount equal to 60 percent of the deductible under the Medicare Choice MSA plan covering the account holder as of January 1 of the calendar year in which the taxable year begins.

Section 220(f)(2) shall not apply to any payment or distribution from a Medicare Choice MSA.

"(B) EXCEPTIONS.—Subparagraph (A) shall not apply if the payment or distribution is made on or after the date the account holder—

"(i) becomes disabled within the meaning of section 72(m)(7), or

"(ii) dies.

"(C) SPECIAL RULES.—For purposes of subparagraph (A)—

"(i) all Medicare Choice MSAs of the account holder shall be treated as 1 account,

"(ii) all payments and distributions not used exclusively to pay the qualified medical expenses of the account holder during any taxable year shall be treated as 1 distribution, and

"(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

"(3) WITHDRAWAL OF ERRONEOUS CONTRIBUTIONS.—Section 220(f)(2) and paragraph (2) of this subsection shall not apply to any payment or distribution from a Medicare Choice MSA to the Secretary of Health and Human Services of an erroneous contribution to such MSA and of the net income attributable to such contribution.

"(4) TRUSTEE-TO-TRUSTEE TRANSFERS.—Section 220(f)(2) and paragraph (2) of this subsection shall not apply to any trustee-to-trustee transfer from a Medicare Choice MSA of an account holder to another Medicare Choice MSA of such account holder.

"(d) SPECIAL RULES FOR TREATMENT OF ACCOUNT AFTER DEATH OF ACCOUNT HOLDER.—In applying section 220(f)(8)(A) to an account which was a Medicare Choice MSA of a decedent, the rules of section 220(f) shall apply in lieu of the rules of subsection (c) of

this section with respect to the spouse as the account holder of such Medicare Choice MSA.

"(e) REPORTS.—In the case of a Medicare Choice MSA, the report under section 220(h)—

"(1) shall include the fair market value of the assets in such Medicare Choice MSA as of the close of each calendar year, and

"(2) shall be furnished to the account holder—

"(A) not later than January 31 of the calendar year following the calendar year to which such reports relate, and

"(B) in such manner as the Secretary prescribes in such regulations.

"(f) COORDINATION WITH LIMITATION ON NUMBER OF TAXPAYERS HAVING MEDICAL SAVINGS ACCOUNTS.—Subsection (i) of section 220 shall not apply to an individual with respect to a Medicare Choice MSA, and Medicare Choice MSA's shall not be taken into account in determining whether the numerical limitations under section 220(j) are exceeded.".

(b) TECHNICAL AMENDMENTS.—

(1) The last sentence of section 4973(d) of such Code is amended by inserting "or section 138(c)(3)" after "section 220(f)(3)".

(2) Subsection (b) of section 220 of such Code is amended by adding at the end the following new paragraph:

"(7) MEDICARE ELIGIBLE INDIVIDUALS.—The limitation under this subsection for any month with respect to an individual shall be zero for the first month such individual is entitled to benefits under title XVIII of the Social Security Act and for each month thereafter.".

(3) The table of sections for part III of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

"Sec. 138. Medicare Choice MSA.

"Sec. 139. Cross references to other Acts.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1998.

CHAPTER 2—INTEGRATED LONG-TERM CARE PROGRAMS

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

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

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

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

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

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

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

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

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

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

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

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

"(B) COMPREHENSIVE BENEFITS.—The program provides comprehensive health care services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

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

"(3) PACE PROVIDER DEFINED.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(9) TRIAL PERIOD DEFINED.—

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

"(B) TREATMENT OF ENTITIES PREVIOUSLY OPERATING PACE DEMONSTRATION WAIVER PROGRAMS.—Each contract year (including a year occurring before the effective date of

this section) during which an entity has operated a PACE demonstration waiver program shall be counted under subparagraph (A) as a contract year during which the entity operated a PACE program as a PACE provider under a PACE program agreement.

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

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

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

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

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

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

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

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

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

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

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

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

"(c) ELIGIBILITY DETERMINATIONS.—

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

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

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

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

"(3) ANNUAL ELIGIBILITY RECERTIFICATIONS.—

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

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

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

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

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

"(1) IN GENERAL.—In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the Secretary shall make prospective monthly payments of a capitation amount for

each PACE program eligible individual enrolled under the agreement under this section in the same manner and from the same sources as payments are made to an eligible organization under a risk-sharing contract under section 1876. Such payments shall be subject to adjustment in the manner described in section 1876(a)(1)(E).

"(2) CAPITATION AMOUNT.—The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be based upon payment rates established under section 1876 for risk-sharing contracts and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. Such amount under such an agreement shall be computed in a manner so that the total payment level for all PACE program eligible individuals enrolled under a program is less than the projected payment under this title for a comparable population not enrolled under a PACE program.

"(e) PACE PROGRAM AGREEMENT.—

"(1) REQUIREMENT.—

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

"(B) NUMERICAL LIMITATION.—

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

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

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

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

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

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

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

"(2) SERVICE AREA AND ELIGIBILITY.—

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

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

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

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

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

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

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

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

"(A) DATA COLLECTION.—

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

"(I) collect data;

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

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

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

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

"(4) OVERSIGHT.—

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

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

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

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

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

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

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

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

"(5) TERMINATION OF PACE PROVIDER AGREEMENTS.—

"(A) IN GENERAL.—Under regulations—

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

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

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

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

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

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

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

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

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

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

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

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

"(iii) Terminate such agreement.

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

"(7) PROCEDURES FOR TERMINATION OR IMPOSITION OF SANCTIONS.—Under regulations, the provisions of section 1376(i)(9) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and an eligible organization under section 1876.

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

"(f) REGULATIONS.—

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

"(2) USE OF PACE PROTOCOL.—

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

"(B) FLEXIBILITY.—In order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use nonstaff physicians according to State licensing law requirements) under this section and section 1932, the Secretary (in close consultation with State administering agencies) may modify or waive provisions of the PACE protocol so long as any such modification or waiver is not inconsistent with and would not impair the essential elements, objectives, and requirements of this section, but may not modify or waive any of the following provisions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(2) SIMILAR TERMS AND CONDITIONS.—

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

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

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

SEC. 5012. EFFECTIVE DATE; TRANSITION.

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

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

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

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

(B) in paragraph (2)—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) DELAY IN APPLICATION.—

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

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

SEC. 5013. STUDY AND REPORTS.

(a) STUDY.—

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

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

(b) REPORT.—

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

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

(A) The number of covered lives enrolled with entities operating under demonstration project waivers under sec-

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

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

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

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

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

Subchapter B—Social Health Maintenance Organizations

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

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

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

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

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

(c) REPORT ON INTEGRATION AND TRANSITION.—

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

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

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

Subchapter C—Other Programs

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

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

CHAPTER 3—COMMISSIONS

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

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

(b) FINDINGS.—Congress finds that—

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

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

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

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

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

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

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

(2) identify problems that threaten the financial integrity of the Federal Hospital Insurance Trust Fund and the Federal

Supplementary Medical Insurance Trust Fund established under that title (42 U.S.C. 1395i, 1395t);

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

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

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

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

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

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

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

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

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

(d) MEMBERSHIP.—

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

(A) three shall be appointed by the President;

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

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

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

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

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

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

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

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

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

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

(e) STAFF AND SUPPORT SERVICES.—

(1) EXECUTIVE DIRECTOR.—

(A) APPOINTMENT.—The Chairperson shall appoint an executive director of the Commission.

(B) COMPENSATION.—The executive director shall be paid the rate of basic pay for level V of the Executive Schedule.

(2) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director considers appropriate.

(3) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

(4) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(5) STAFF OF FEDERAL AGENCIES.—Upon the request of the Commission, the head of any Federal agency may detail any of the personnel of such agency to the Commission to assist in carrying out the duties of the Commission.

(6) OTHER RESOURCES.—The Commission shall have reasonable access to materials, resources, statistical data, and other information from the Library of Congress and agencies and elected representatives of the executive and legislative branches of the Federal Government. The Chairperson of the Commission shall make requests for such access in writing when necessary.

(7) PHYSICAL FACILITIES.—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

(f) POWERS OF COMMISSION.—

(1) HEARINGS.—The Commission may conduct public hearings or forums at the discretion of the Commission, at any time and place the Commission is able to secure facilities and witnesses, for the purpose of carrying out the duties of the Commission.

(2) GIFTS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(3) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as other Federal agencies.

(g) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Commission shall submit a report to the President and Congress which shall contain a detailed statement of the recommendations, findings, and conclusions of the Commission.

(h) TERMINATION.—The Commission shall terminate on the date which is 30 days after the date the Commission submits its report to the President and to Congress under subsection (g).

(i) FUNDING.—There is authorized to be appropriated to the Commission such sums as are necessary to carry out the purposes of this section. Sums appropriated under this subsection shall be paid equally from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t).

SEC. 5022. MEDICARE PAYMENT ADVISORY COMMISSION.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1804 the following new section:

"MEDICARE PAYMENT ADVISORY COMMISSION

"SEC. 1805. (a) ESTABLISHMENT.—There is hereby established the Medicare Payment Advisory Commission (in this section referred to as the 'Commission').

"(b) DUTIES.—

"(1) REVIEW OF PAYMENT POLICIES AND ANNUAL REPORTS.—The Commission shall—

"(A) review payment policies under this title, including the topics described in paragraph (2);

"(B) make recommendations to Congress concerning such payment policies;

"(C) by not later than March 1 of each year (beginning with 1998), submit a report to Congress containing the results of such reviews and its recommendations concerning such policies; and

"(D) by not later than June 1 of each year (beginning with 1998), submit a report to Congress containing an ex-

amination of issues affecting the medicare program, including the implications of changes in health care delivery in the United States and in the market for health care services on the medicare program.

"(2) SPECIFIC TOPICS TO BE REVIEWED.—

"(A) MEDICARE CHOICE PROGRAM.—Specifically, the Commission shall review, with respect to the Medicare Choice program under part C, the following:

"(i) The methodology for making payment to plans under such program, including the making of differential payments and the distribution of differential updates among different payment areas.

"(ii) The mechanisms used to adjust payments for risk and the need to adjust such mechanisms to take into account health status of beneficiaries.

"(iii) The implications of risk selection both among Medicare Choice organizations and between the Medicare Choice option and the traditional medicare fee-for-service option.

"(iv) The development and implementation of mechanisms to assure the quality of care for those enrolled with Medicare Choice organizations.

"(v) The impact of the Medicare Choice program on access to care for medicare beneficiaries.

"(vi) Other major issues in implementation and further development of the Medicare Choice program.

"(B) TRADITIONAL MEDICARE FEE-FOR-SERVICE SYSTEM.—Specifically, the Commission shall review payment policies under parts A and B, including—

"(i) the factors affecting expenditures for services in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees,

"(ii) payment methodologies, and

"(iii) their relationship to access and quality of care for medicare beneficiaries.

"(C) INTERACTION OF MEDICARE PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—Specifically, the Commission shall review the effect of payment policies under this title on the delivery of health care services other than under this title and assess the implications of changes in health care delivery in the United States and in the general market for health care services on the medicare program.

"(3) COMMENTS ON CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to payment policies under this title, the Secretary shall transmit a copy of the report to the Commission. The Commission shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Commission deems appropriate.

"(4) AGENDA AND ADDITIONAL REVIEWS.—The Commission shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding the Commission's agenda and progress towards achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title as may be requested by such chairmen and members and as the Commission deems appropriate.

"(5) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

"(6) APPROPRIATE COMMITTEES OF CONGRESS.—For purposes of this section, the term 'appropriate committees of Congress' means the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate.

"(c) MEMBERSHIP.—

"(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members appointed by the Comptroller General.

"(2) QUALIFICATIONS.—

"(A) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

"(B) INCLUSION.—The membership of the Commission shall include (but not be limited to) physicians and other health professionals, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

"(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under this title shall not constitute a majority of the membership of the Commission.

"(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

"(3) TERMS.—

"(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that the Comptroller

General shall designate staggered terms for the members first appointed.

"(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

"(4) COMPENSATION.—While serving on the business of the Commission (including traveltime), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

"(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment.

"(6) MEETINGS.—The Commission shall meet at the call of the Chairman.

"(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General deems necessary to assure the efficient administration of the Commission, the Commission may—

"(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

"(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

"(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

"(4) make advance, progress, and other payments which relate to the work of the Commission;

"(5) provide transportation and subsistence for persons serving without compensation; and

"(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

"(e) POWERS.—

"(1) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

"(2) DATA COLLECTION.—In order to carry out its functions, the Commission shall—

"(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

"(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and

"(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

"(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data of the Commission, immediately upon request.

"(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General.

"(f) AUTHORIZATION OF APPROPRIATIONS.—

"(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

"(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Sixty percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.".

(b) ABOLITION OF PROPAC AND PPRC.—

(1) PROPAC.—

(A) IN GENERAL.—Section 1886(e) (42 U.S.C. 1395ww(e)) is amended—

(i) by striking paragraphs (2) and (6); and

(ii) in paragraph (3), by striking "(A) The Commission" and all that follows through "(B)".

(B) CONFORMING AMENDMENT.—Section 1862 (42 U.S.C. 1395y) is amended by striking "Prospective Payment Assessment Commission" each place it appears in subsection (a)(1)(D) and subsection (i) and inserting "Medicare Payment Advisory Commission".

(2) PPRC.—

(A) IN GENERAL.—Title XVIII is amended by striking section 1845 (42 U.S.C. 1395w–1).

(B) ELIMINATION OF CERTAIN REPORTS.—Section 1848 (42 U.S.C. 1395w–4) is amended—

(i) by striking subparagraph (F) of subsection (d)(2),

(ii) by striking subparagraph (B) of subsection (f)(1), and

(iii) in subsection (f)(3), by striking "Physician Payment Review Commission,".

(C) CONFORMING AMENDMENTS.—Section 1848 (42 U.S.C. 1395w–4) is amended by striking "Physician Payment Review Commission" and inserting "Medicare Payment Advisory Commission" each place it appears in subsections (c)(2)(B)(iii), (g)(6)(C), and (g)(7)(C).

(c) EFFECTIVE DATE; TRANSITION.—

(1) IN GENERAL.—The Comptroller General shall first provide for appointment of members to the Medicare Payment Advisory Commission (in this subsection referred to as "MedPAC") by not later than September 30, 1997.

(2) TRANSITION.—As quickly as possible after the date a majority of members of MedPAC are first appointed, the Comptroller General, in consultation with the Prospective Payment Assessment Commission (in this subsection referred to as "ProPAC") and the Physician Payment Review Commission (in this subsection referred to as "PPRC"), shall provide for the termination of the ProPAC and the PPRC. As of the date of termination of the respective Commissions, the amendments made by paragraphs (1) and (2), respectively, of subsection (b) become effective. The Comptroller General, to the extent feasible, shall provide for the transfer to the MedPAC of assets and staff of the ProPAC and the PPRC, without any loss of benefits or seniority by virtue of such transfers. Fund balances available to the ProPAC or the PPRC for any period shall be available to the MedPAC for such period for like purposes.

(3) CONTINUING RESPONSIBILITY FOR REPORTS.—The MedPAC shall be responsible for the preparation and submission of reports required by law to be submitted (and which have not been submitted by the date of establishment of the MedPAC) by the ProPAC and the PPRC, and, for this purpose, any reference in law to either such Commission is deemed, after the appointment of the MedPAC, to refer to the MedPAC.

CHAPTER 4—MEDIGAP PROTECTIONS

SEC. 5031. MEDIGAP PROTECTIONS.

(a) GUARANTEEING ISSUE WITHOUT PREEXISTING CONDITIONS FOR CONTINUOUSLY COVERED INDIVIDUALS.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(1) in paragraph (3), by striking "paragraphs (1) and (2)" and inserting "this subsection",

(2) by redesignating paragraph (3) as paragraph (4), and

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

"(3)(A) The issuer of a medicare supplemental policy—

"(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (C) that is offered and is available for issuance to new enrollees by such issuer;

"(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

"(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such subparagraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

"(B) An individual described in this subparagraph is an individual described in any of the following clauses:

"(i) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under this title and the plan terminates or ceases to provide all such supplemental health benefits to the individual.

"(ii) The individual is enrolled with a Medicare Choice organization under a Medicare Choice plan under part C, and there are circumstances permitting discontinuance of the individual's election of the plan under section 1851(e)(4).

"(iii) The individual is enrolled with an eligible organization under a contract under section 1876, a similar organization operating under demonstration project authority, with an organization under an agreement under section 1833(a)(1)(A), or with an organization under a policy described in subsection (t), and such enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under section 1851(c)(4) and, in the case of a policy described in subsection (t), there is no provision under applicable State law for the continuation of coverage under such policy.

"(iv) The individual is enrolled under a medicare supplemental policy under this section and such enrollment ceases because—

"(I) of the bankruptcy or insolvency of the issuer or because of other involuntary termination of coverage or enrollment under such policy and there is no provision under applicable State law for the continuation of such coverage;

"(II) the issuer of the policy substantially violated a material provision of the policy; or

"(III) the issuer (or an agent or other entity acting on the issuer's behalf) materially misrepresented the policy's provisions in marketing the policy to the individual.

"(v) The individual—

"(I) was enrolled under a medicare supplemental policy under this section,

"(II) subsequently terminates such enrollment and enrolls, for the first time, with any Medicare Choice organi-

zation under a Medicare Choice plan under part C, any eligible organization under a contract under section 1876, any similar organization operating under demonstration project authority, any organization under an agreement under section 1833(a)(1)(A), or any policy described in subsection (t), and

"(III) the subsequent enrollment under subclause (II) is terminated by the enrollee during the first 12 months of such enrollment.

"(vi) The individual, upon first becoming eligible for medicare at age 65, enrolls in a Medicare Choice plan and within 12 months of such enrollment, disenrolls from such plan.

"(C)(i) Subject to clauses (ii), a medicare supplemental policy described in this subparagraph is a policy the benefits under which are comparable or lessor in relation to the benefits under the plan, policy, or contract described in the applicable clause of subparagraph (B).

"(ii) Only for purposes of an individual described in subparagraph (B)(vi), a medicare supplemental policy described in this subparagraph shall include any medicare supplemental policy.

"(D) At the time of an event described in subparagraph (B) because of which an individual ceases enrollment or loses coverage or benefits under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, the insurer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the rights of the individual, and obligations of issuers of medicare supplemental policies, under subparagraph (A).".

(b) LIMITATION ON IMPOSITION OF PREEXISTING CONDITION EXCLUSION DURING INITIAL OPEN ENROLLMENT PERIOD.—Section 1882(s)(2) (42 U.S.C. 1395ss(s)(2)) is amended—

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

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

"(D) In the case of a policy issued during the 6-month period described in subparagraph (A) to an individual who is 65 years of age or older as of the date of issuance and who as of the date of the application for enrollment has a continuous period of creditable coverage (as defined in section 2701(c) of the Public Health Service Act) of—

"(i) at least 6 months, the policy may not exclude benefits based on a pre-existing condition; or

"(ii) less than 6 months, if the policy excludes benefits based on a preexisting condition, the policy shall reduce the period of any preexisting condition exclusion by the aggregate of the periods of creditable coverage (if any, as so defined) applicable to the individual as of the enrollment date.

The Secretary shall specify the manner of the reduction under clause (ii), based upon the rules used by the Secretary in carrying out section 2701(a)(3) of such Act.".

(c) EXTENDING 6-MONTH INITIAL ENROLLMENT PERIOD TO NON-ELDERLY MEDICARE BENEFICIARIES.—Section 1882(s)(2)(A)(ii) of (42 U.S.C. 1395ss(s)(2)(A)) is amended by striking "is submitted" and all that follows and inserting the following: "is submitted—

"(I) before the end of the 6-month period beginning with the first month as of the first day on which the individual is 65 years of age or older and is enrolled for benefits under part B; and

"(II) at the time the individual first becomes eligible for benefits under part A pursuant to section 226(b) and is enrolled for benefits under part B, before the end of the 6-month period beginning with the first month as of the first day on which the individual is so eligible and so enrolled.".

(d) EFFECTIVE DATES.—

(1) GUARANTEED ISSUE.—The amendment made by subsection (a) shall take effect on July 1, 1998.

(2) LIMIT ON PREEXISTING CONDITION EXCLUSIONS.—The amendment made by subsection (b) shall apply to policies issued on or after July 1, 1998.

(3) NON-ELDERLY MEDICARE BENEFICIARIES.—The amendment made by subsection (c) shall apply to policies issued on or after July 1, 1998.

(e) TRANSITION PROVISIONS.—

(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section, the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act due solely to failure to make such change until the date specified in paragraph (4).

(2) NAIC STANDARDS.—If, within 9 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (in this subsection referred to as the "NAIC") modifies its NAIC Model regulation relating to section 1882 of the Social Security Act (referred to in such section as the 1991 NAIC Model Regulation, as modified pursuant to section 171(m)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432) and as modified pursuant to section 1882(d)(3)(A)(vi)(IV) of the Social Security Act, as added by section 271(a) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191) to conform to the amendments made by this section, such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate Regulation for the purposes of such section.

(4) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or

(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section, but

(ii) having a legislature which is not scheduled to meet in 1999 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after July 1, 1999. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 5032. ADDITION OF HIGH DEDUCTIBLE MEDIGAP POLICY.

(a) IN GENERAL.—Section 1882(p) (42 U.S.C. 1395ss(p)) is amended by adding at the end the following:

"(11)(A) On and after the date specified in subparagraph (C)—

"(i) each State with an approved regulatory program, and

"(ii) in the case of a State without an approved regulatory program, the Secretary,

shall, in addition to the 10 policies allowed under paragraph (2)(C), allow at least 1 other policy described in subparagraph (B).

"(B)(i) A policy is described in this subparagraph if it consists of—

"(I) one of the 10 benefit packages described in paragraph (2)(C), and

"(II) a high deductible feature.

"(ii) For purposes of clause (i), a high deductible feature is one which requires the beneficiary of the policy to pay annual out-of-pocket expenses (other than premiums) of $1,500 before the policy begins payment of benefits.

"(C)(i) Subject to clause (ii), the date described in this subparagraph is one year after the date of the enactment of this paragraph.

"(ii) In the case of a State which the Secretary identifies as—

"(I) requiring State legislation (other than legislation appropriating funds) in order to meet the requirements of this paragraph, but

"(II) having a legislature which is not scheduled to meet in 1997 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1998. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.".

(b) CONFORMING AMENDMENT.—Section 1882(p)(2)(C) (42 U.S.C. 1395ss(p)(2)(C)) is amended by inserting "or (11)" after "paragraph (4)(B)".

CHAPTER 5—DEMONSTRATIONS

Subchapter A—Medicare Choice Competitive Pricing Demonstration Project

SEC. 5041. MEDICARE CHOICE COMPETITIVE PRICING DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services (in this subchapter referred to as the "Secretary") shall, beginning January 1, 1999, conduct demonstration projects in applicable areas (in this section referred to as the "project") for the purpose of—

(1) applying a pricing methodology for payments to Medicare Choice organizations under part C of title XVIII of the Social Security Act (as amended by section 5001 of this Act) that uses the competitive market approach described in section 5042;

(2) applying a benefit structure and beneficiary premium structure described in section 5043; and

(3) evaluating the effects of the methodology and structures described in the preceding paragraphs on medicare fee-for-service spending under parts A and B of the Social Security Act in the project area.

(b) APPLICABLE AREA DEFINED.—

(1) IN GENERAL.—In subsection (a), the term "applicable area" means, as determined by the Secretary—

(A) 10 urban areas with respect to which less than 25 percent of medicare beneficiaries are enrolled with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm); and

(B) 3 rural areas not described in paragraph (1).

(2) TREATMENT AS MEDICARE CHOICE PAYMENT AREA.—For purposes of this subchapter and part C of title XVIII of the Social Security Act, any applicable area shall be treated as a Medicare Choice payment area (hereinafter referred to as the "applicable Medicare Choice payment area").

(c) TECHNICAL ADVISORY GROUP.—Upon the selection of an area for inclusion in the project, the Secretary shall appoint a technical advisory group, composed of representatives of Medicare Choice organizations, medicare beneficiaries, employers, and other persons in the area affected by the project who have technical expertise relative to the design and implementation of the project to advise the Secretary concerning how the project will be implemented in the area.

(d) EVALUATION.—

(1) IN GENERAL.—Not later than December 31, 2001, the Secretary shall submit to the President a report regarding the demonstration projects conducted under this section.

(2) CONTENTS OF REPORT.—The report described in paragraph (1) shall include the following:

(A) A description of the demonstration projects conducted under this section.

(B) An evaluation of the effectiveness of the demonstration projects conducted under this section and any legislative recommendations determined appropriate by the Secretary.

(C) Any other information regarding the demonstration projects conducted under this section that the Secretary determines to be appropriate.

(D) An evaluation as to whether the method of payment under section 5042 which was used in the demonstration projects for payment to Medicare Choice plans should be extended to the entire medicare population and if such evaluation determines that such method should not be extended, legislative recommendations to modify such method so that it may be applied to the entire medicare population.

(3) SUBMISSION TO CONGRESS.—The President shall submit the report under paragraph (2) to the Congress and if the President determines appropriate, any legislative recommendations for extending the project to the entire medicare population.

(e) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of titles XI, XVIII, and XIX of the Social Security Act (42 U.S.C. 1301 et seq., 1395 et seq., 1396 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

SEC. 5042. DETERMINATION OF ANNUAL MEDICARE CHOICE CAPITATION RATES.

(a) IN GENERAL.—In the case of an applicable Medicare Choice payment area within which a project is being conducted under section 5041, the annual Medicare Choice capitation rate under part C of title XVIII of the Social Security Act for Medicare Choice plans within such area shall be the standardized payment amount determined under this section rather than the amount determined under section 1853 of such Act.

(b) DETERMINATION OF STANDARDIZED PAYMENT AMOUNT.—

(1) SUBMISSION AND CHARGING OF PREMIUMS.—

(A) IN GENERAL.—Not later than June 1 of each calendar year, each Medicare Choice organization offering one or more Medicare Choice plans in an applicable Medicare Choice payment area shall file with the Secretary, in a form and manner and at a time specified by the Secretary, a bid which contains the amount of the monthly premium for coverage under each such Medicare Choice plan.

(B) UNIFORM PREMIUM.—The premiums charged by a Medicare Choice plan sponsor under this part may not

vary among individuals who reside in the same applicable Medicare Choice payment area.

(C) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each Medicare Choice organization shall permit the payment of premiums on a monthly basis.

(2) ANNOUNCEMENT OF STANDARDIZED PAYMENT AMOUNT.—

(A) AUTHORITY TO NEGOTIATE.—After bids are submitted under paragraph (1), the Secretary may negotiate with Medicare Choice organizations in order to modify such bids if the Secretary determined that the bids do not provide enough revenues to ensure the plan's actuarial soundness, are too high relative to the applicable Medicare Choice payment area, foster adverse selection, or otherwise require renegotiation under this paragraph.

(B) IN GENERAL.—Not later than July 31 of each calendar year (beginning with 1998), the Secretary shall determine, and announce in a manner intended to provide notice to interested parties, a standardized payment amount determined in accordance with this paragraph for the following calendar year for each applicable Medicare Choice payment area.

(3) CALCULATION OF PAYMENT AMOUNTS.—

(A) IN GENERAL.—The standardized payment amount for a calendar year after 1998 for any applicable Medicare Choice payment area shall be equal to the maximum premium determined for such area under subparagraph (B).

(B) MAXIMUM PREMIUM.—The maximum premium for any applicable Medicare Choice payment area shall be equal to the amount determined under subparagraph (C) for the payment area, but in no case shall such amount be greater than the sum of—

(i) the average per capita amount, as determined by the Secretary as appropriate for the population eligible to enroll in Medicare Choice plans in such payment area, for such calendar year that the Secretary would have expended for an individual in such payment area enrolled under the medicare fee-for-service program under parts A and B, plus

(ii) the amount equal to the actuarial value of deductibles, coinsurance, and copayments charged an individual for services provided under the medicare fee-for-service program (as determined by the Secretary).

(C) DETERMINATION OF AMOUNT.—

(i) IN GENERAL.—The Secretary shall determine for each applicable Medicare Choice payment area for each calendar year an amount equal to the average of the bids (weighted based on capacity) submitted to the Secretary under paragraph (1)(A) for that payment area.

(ii) DISREGARD CERTAIN PLANS.—In determining the amount under clause (i), the Secretary may disregard any plan that the Secretary determines would

unreasonably distort the amount determined under such subparagraph.

(4) ADJUSTMENTS FOR PAYMENTS TO PLAN SPONSORS.—

(A) IN GENERAL.—For purposes of determining the amount of payment under part C of title XVIII of the Social Security Act to a Medicare Choice organization with respect to any Medicare Choice eligible individual enrolled in a Medicare Choice plan of the sponsor, the standardized payment amount for the applicable Medicare Choice payment area and the premium charged by the plan sponsor shall be adjusted with respect to such individual for such risk factors as age, disability status, gender, institutional status, health status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

(B) RECOMMENDATIONS.—

(i) IN GENERAL.—In addition to any other duties required by law, the Physician Payment Review Commission and the Prospective Payment Assessment Commission (or their successors) shall each develop recommendations on—

(I) the risk factors that the Secretary should use in adjusting the standardized payment amount and premium under subparagraph (A), and

(II) the methodology that the Secretary should use in determining the risk factors to be used in adjusting the standardized payment amount and premium under subparagraph (A).

(ii) TIME.—The recommendations described in clause (i) shall be developed not later than January 1, 1999.

(iii) ANNUAL REPORT.—The Physician Payment Review Commission and the Prospective Payment Assessment Commission (or their successors) shall include the recommendations described in clause (i) in their respective annual reports to Congress.

(c) PAYMENTS TO PLAN SPONSORS.—

(1) MONTHLY PAYMENTS.—

(A) IN GENERAL.—Subject to paragraph (4), for each individual enrolled with a plan under this subchapter, the Secretary shall make monthly payments in advance to the Medicare Choice organization of the Medicare Choice plan with which the individual is enrolled in an amount equal to 1/12 of the amount determined under paragraph (2).

(B) RETROACTIVE ADJUSTMENTS.—The amount of payment under this paragraph may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

(2) AMOUNT OF PAYMENT TO MEDICARE CHOICE PLANS.—The amount determined under this paragraph with respect to any individual shall be equal to the sum of—

(A) the lesser of—

(i) the standardized payment amount for the applicable Medicare Choice payment area, as adjusted for such individual under subsection (a)(4), or

(ii) the premium charged by the plan for such individual, as adjusted for such individual under section (a)(4), minus

(B) the amount such individual paid to the plan pursuant to section 5043 (relating to 10 percent of the premium).

(3) PAYMENTS FROM TRUST FUNDS.—The payment to a Medicare Choice organization or to a Medicare Choice account under this section for a medicare-eligible individual shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under parts A and B are representative of the actuarial value of the total benefits under this part.

(4) LIMITATION ON AMOUNTS AN OUT-OF-PLAN PHYSICIAN OR OTHER ENTITY MAY COLLECT.—A physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this subchapter with a Medicare Choice organization shall accept as payment in full for services that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a Medicare Choice organization under this part) also applies with respect to an individual so enrolled.

(d) OFFICE OF COMPETITION.—

(1) ESTABLISHMENT.—There is established within the Department of Health and Human Services an office to be known as the 'Office of Competition'.

(2) DIRECTOR.—The Secretary shall appoint the Director of the Office of Competition.

(3) DUTIES.—

(A) IN GENERAL.—The Director shall administer this subchapter and so much of part C of title XVIII of the Social Security Act as relates to this subchapter.

(B) TRANSFER AUTHORITY.—The Secretary shall transfer such personnel, administrative support systems, assets, records, funds, and other resources in the Health Care Financing Administration to the Office of Competition as are used in the administration of section 1876 and as may be required to implement the provisions of this part promptly and efficiently.

(4) USE OF NON-FEDERAL ENTITIES.—The Secretary shall, to the maximum extent feasible, enter into contracts with ap-

propriate non-Federal entities to carry out activities under this subchapter.

SEC. 5043. BENEFITS AND BENEFICIARY PREMIUMS.

(a) BENEFITS PROVIDED TO INDIVIDUALS.—

(1) BASIC BENEFIT PLAN.—Each Medicare Choice plan in an applicable Medicare Choice payment area shall provide to members enrolled under this subchapter, through providers and other persons that meet the applicable requirements of title XVIII of the Social Security Act and part A of title XI of such Act—

(A) those items and services covered under parts A and B of title XVIII of such Act which are available to individuals residing in such area, subject to nominal copayments as determined by the Secretary,

(B) prescription drugs, subject to such limits as established by the Secretary, and

(C) additional health services as the Secretary may approve.

(2) SUPPLEMENTAL BENEFITS.—

(A) IN GENERAL.—Each Medicare Choice plan may offer any of the optional supplemental benefit plans described in subparagraph (B) to an individual enrolled in the basic benefit plan offered by such organization under this subchapter for an additional premium amount. If the supplemental benefits are offered only to individuals enrolled in the sponsor's plan under this subchapter, the additional premium amount shall be the same for all enrolled individuals in the applicable Medicare Choice payment area. Such benefits may be marketed and sold by the Medicare Choice organization outside of the enrollment process described in part C of title XVIII of the Social Security Act.

(B) OPTIONAL SUPPLEMENTAL BENEFIT PLANS DESCRIBED.—The Secretary shall provide for 2 optional supplemental benefit plans. Such plans shall include such standardized items and services that the Secretary determines must be provided to enrollees of such plans described in order to offer the plans to Medicare Choice eligible individuals.

(C) LIMITATION.—A Medicare Choice organization may not offer an optional benefit plan to a Medicare Choice eligible individual unless such individual is enrolled in a basic benefit plan offered by such organization.

(D) LIMITATION ON PREMIUM.—If a Medicare Choice organization provides to individuals enrolled in a Medicare Choice plan supplemental benefits described in subparagraph (A), the sum of—

(i) the annual premiums for such benefits, plus

(ii) the actuarial value of any deductibles, coinsurance, and copayments charged with respect to such benefits for the year,

shall not exceed the amount that would have been charged for a plan in the applicable Medicare Choice payment area which is not a Medicare Choice plan (adjusted in such manner as the Secretary may prescribe to reflect that only

medicare beneficiaries are enrolled in such plan). The Secretary shall negotiate the limitation under this subparagraph with each plan to which this paragraph applies.

(3) OTHER RULES.—Rules similar to rules of paragraphs (3) and (4) of section 1852 of the Social Security Act (relating to national coverage determinations and secondary payor provisions) shall apply for purposes of this subchapter.

(b) PREMIUM REQUIREMENTS FOR BENEFICIARIES.—

(1) PREMIUM DIFFERENTIALS.—If a Medicare Choice eligible individual enrolls in a Medicare Choice plan under this subchapter, the individual shall be required to pay—

(A) 10 percent of the plan's premium;

(B) if the premium of the plan is higher than the standardized payment amount (as determined under section 5042), 100 percent of such difference; and

(C) an amount equal to cost-sharing under the medicare fee-for-service program, except that such amount shall not exceed the actuarial value of the deductibles and coinsurance under such program less the actual value of nominal copayments for benefits under such plan for basic benefits described in subsection (a)(1).

(2) PART B PREMIUM.—An individual enrolled in a Medicare Choice plan under this subchapter shall not be required to pay the premium amount (determined under section 1839 of the Social Security Act) under part B of title XVIII of such Act for so long as such individual is so enrolled.

Subchapter B—Other Projects

SEC. 5045. MEDICARE ENROLLMENT DEMONSTRATION PROJECT.

(a) DEMONSTRATION PROJECT.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall implement a demonstration project (in this section referred to as the "project") for the purpose of evaluating the use of a third-party contractor to conduct the Medicare Choice plan enrollment and disenrollment functions, as described in part C of the Social Security Act (as added by section 5001 of this Act), in an area.

(2) CONSULTATION.—Before implementing the project under this section, the Secretary shall consult with affected parties on—

(A) the design of the project;

(B) the selection criteria for the third-party contractor; and

(C) the establishment of performance standards, as described in paragraph (3).

(3) PERFORMANCE STANDARDS.—

(A) IN GENERAL.—The Secretary shall establish performance standards for the accuracy and timeliness of the Medicare Choice plan enrollment and disenrollment functions performed by the third-party contractor.

(B) NONCOMPLIANCE.—If the Secretary determines that a third-party contractor is out of compliance with the performance standards established under subparagraph

(A), such enrollment and disenrollment functions shall be performed by the Medicare Choice plan until the Secretary appoints a new third-party contractor.

(C) DISPUTE.—In the event that there is a dispute between the Secretary and a Medicare Choice plan regarding whether or not the third-party contractor is in compliance with the performance standards, such enrollment and disenrollment functions shall be performed by the Medicare Choice plan.

(b) REPORT TO CONGRESS.—The Secretary shall periodically report to Congress on the progress of the project conducted pursuant to this section.

(c) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of part C of the Social Security Act (as amended by section 5001 of this Act) to such extent and for such period as the Secretary determines is necessary to conduct the project.

(d) DURATION.—A demonstration project under this section shall be conducted for a 3-year period.

(e) SEPARATE FROM OTHER DEMONSTRATION PROJECTS.—A project implemented by the Secretary under this section shall not be conducted in conjunction with any other demonstration project.

SEC. 5046. MEDICARE COORDINATED CARE DEMONSTRATION PROJECT.

(a) DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct demonstration projects for the purpose of evaluating methods, such as case management and other models of coordinated care, that—

(A) improve the quality of items and services provided to target individuals; and

(B) reduce expenditures under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for items and services provided to target individuals.

(2) TARGET INDIVIDUAL DEFINED.—In this section, the term "target individual" means an individual that has a chronic illness, as defined and identified by the Secretary, and is enrolled under the fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.).

(b) PROGRAM DESIGN.—

(1) INITIAL DESIGN.—The Secretary shall evaluate best practices in the private sector of methods of coordinated care for a period of 1 year and design the demonstration project based on such evaluation.

(2) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of enactment of this Act, the Secretary shall implement at least 9 demonstration projects, including—

(A) 6 projects in urban areas; and

(B) 3 projects in rural areas.

(3) EXPANSION OF PROJECTS; IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—

(A) EXPANSION OF PROJECTS.—If the initial report under subsection (c) contains an evaluation that demonstration projects—

(i) reduce expenditures under the medicare program; or

(ii) do not increase expenditures under the medicare program and increase the quality of health care services provided to target individuals and satisfaction of beneficiaries and health care providers;

the Secretary shall continue the existing demonstration projects and may expand the number of demonstration projects.

(B) IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—If a report under subsection (c) contains an evaluation as described in subparagraph (A), the Secretary may issue regulations to implement, on a permanent basis, the components of the demonstration project that are beneficial to the medicare program.

(c) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 2 years after the Secretary implements the initial demonstration projects under this section, and biannually thereafter, the Secretary shall submit to Congress a report regarding the demonstration projects conducted under this section.

(2) CONTENTS OF REPORT.—The report in paragraph (1) shall include the following:

(A) A description of the demonstration projects conducted under this section.

(B) An evaluation of—

(i) the cost-effectiveness of the demonstration projects;

(ii) the quality of the health care services provided to target individuals under the demonstration projects; and

(iii) beneficiary and health care provider satisfaction under the demonstration project.

(C) Any other information regarding the demonstration projects conducted under this section that the Secretary determines to be appropriate.

(d) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of titles XI, XVIII, and XIX of the Social Security Act (42 U.S.C. 1301 et seq., 1395 et seq., 1396 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(e) FUNDING.—

(1) DEMONSTRATION PROJECTS.—

(A) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t), in such proportions as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration projects under this section.

(B) LIMITATION.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration projects under this section were not implemented.

(2) EVALUATION AND REPORT.—There are authorized to be appropriated such sums as are necessary for the purpose of developing and submitting the report to Congress under subsection (c).

SEC. 5047. ESTABLISHMENT OF MEDICARE REIMBURSEMENT DEMONSTRATION PROJECTS.

Title XVIII (42 U.S.C. 1395 et seq.) (as amended by section 5343) is amended by adding at the end the following:

"MEDICARE SUBVENTION DEMONSTRATION PROJECT FOR VETERANS

"SEC. 1896. (a) DEFINITIONS.—In this section:

"(1) ADMINISTERING SECRETARIES.—The term 'administering Secretaries' means the Secretary and the Secretary of Veterans Affairs acting jointly.

"(2) DEMONSTRATION PROJECT; PROJECT.—The terms 'demonstration project' and 'project' mean the demonstration project carried out under this section.

"(3) MILITARY RETIREE.—The term 'military retiree' means a member or former member of the Armed Forces who is entitled to retired pay.

"(4) TARGETED MEDICARE-ELIGIBLE VETERAN.—The term 'targeted medicare-eligible veteran' means an individual who—

"(A) is a veteran (as defined in section 101(2) of title 38, United States Code) and is described in section 1710(a)(3) of title 38, United States Code; and

"(B) is entitled to benefits under part A of this title and is enrolled under part B of this title.

"(5) TRUST FUNDS.—The term 'trust funds' means the Federal Hospital Insurance Trust Fund established in section 1817 and the Federal Supplementary Medical Insurance Trust Fund established in section 1841.

"(b) DEMONSTRATION PROJECT.—

"(1) IN GENERAL.—

"(A) ESTABLISHMENT.—The administering Secretaries are authorized to establish a demonstration project (under an agreement entered into by the administering Secretaries) under which the Secretary shall reimburse the Secretary of Veterans Affairs, from the trust funds, for medicare health care services furnished to certain targeted medicare-eligible veterans.

"(B) AGREEMENT.—The agreement entered into under subparagraph (A) shall include at a minimum—

"(i) a description of the benefits to be provided to the participants of the demonstration project established under this section;

"(ii) a description of the eligibility rules for participation in the demonstration project, including any cri-

teria established under subsection (c) and any cost sharing under subsection (d);

"(iii) a description of how the demonstration project will satisfy the requirements under this title;

"(iv) a description of the sites selected under paragraph (2);

"(v) a description of how reimbursement and maintenance of effort requirements under subsection (l) will be implemented in the demonstration project; and

"(vi) a statement that the Secretary shall have access to all data of the Department of Veterans Affairs that the Secretary determines is necessary to conduct independent estimates and audits of the maintenance of effort requirement, the annual reconciliation, and related matters required under the demonstration project.

"(2) NUMBER OF SITES.—The administering Secretaries shall establish a plan for the selection of up to 12 medical centers under the jurisdiction of the Secretary of Veterans Affairs and located in geographically dispersed locations to participate in the project.

"(3) GENERAL CRITERIA.—The selection plan shall favor selection of those medical centers that are suited to serve targeted medicare-eligible individuals because—

"(A) there is a high potential demand by targeted medicare-eligible veterans for their services;

"(B) they have sufficient capability in billing and accounting to participate;

"(C) they have favorable indicators of quality of care, including patient satisfaction;

"(D) they deliver a range of services required by targeted medicare-eligible veterans; and

"(E) they meet other relevant factors identified in the plan.

"(4) MEDICAL CENTER NEAR CLOSED BASE.—The administering Secretaries shall endeavor to include at least 1 medical center that is in the same catchment area as a military medical facility which was closed pursuant to either of the following laws:

"(A) The Defense Base Closure and Realignment Act of 1990.

"(B) Title II of the Defense Authorization Amendments and Base Closure and Realignment Act.

"(5) RESTRICTION.—No new facilities will be built or expanded with funds from the demonstration project.

"(6) DURATION.—The administering Secretaries shall conduct the demonstration project during the 3-year period beginning on January 1, 1998.

"(c) VOLUNTARY PARTICIPATION.—Participation of targeted medicare-eligible veterans in the demonstration project shall be voluntary, subject to the capacity of participating medical centers and the funding limitations specified in subsection (l), and shall be subject to such terms and conditions as the administering Secretar-

ies may establish. In the case of a demonstration project at a medical center described in subsection (b)(3), targeted medicare-eligible veterans who are military retirees shall be given preference in participating in the project.

"(d) COST SHARING.—The Secretary of Veterans Affairs may establish cost-sharing requirements for veterans participating in the demonstration project. If such cost sharing requirements are established, those requirements shall be the same as the requirements that apply to targeted medicare-eligible patients at nongovernmental facilities.

"(e) CREDITING OF PAYMENTS.—A payment received by the Secretary of Veterans Affairs under the demonstration project shall be credited to the applicable Department of Veterans Affairs medical appropriation and (within that appropriation) to funds that have been allotted to the medical center that furnished the services for which the payment is made. Any such payment received during a fiscal year for services provided during a prior fiscal year may be obligated by the Secretary of Veterans Affairs during the fiscal year during which the payment is received.

"(f) AUTHORITY TO WAIVE CERTAIN MEDICARE REQUIREMENTS.—The Secretary may, to the extent necessary to carry out the demonstration project, waive any requirement under this title. If the Secretary waives any such requirement, the Secretary shall include a description of such waiver in the agreement described in subsection (b)(1)(B).

"(g) INSPECTOR GENERAL.—Nothing in the agreement entered into under subsection (b) shall limit the Inspector General of the Department of Health and Human Services from investigating any matters regarding the expenditure of funds under this title for the demonstration project, including compliance with the provisions of this title and all other relevant laws.

"(h) REPORT.—At least 30 days prior to the commencement of the demonstration project, the administering Secretaries shall submit a copy of the agreement entered into under subsection (b) to the committees of jurisdiction in Congress.

"(i) MANAGED HEALTH CARE PLANS.—(1) In carrying out the demonstration project, the Secretary of Veterans Affairs may establish and operate managed health care plans.

"(2) Any such plan shall be operated by or through a Department of Veterans Affairs medical center or group of medical centers and may include the provision of health care services through other facilities under the jurisdiction of the Secretary of Veterans Affairs as well as public and private entities under arrangements made between the Department and the other public or private entity concerned. Any such managed health care plan shall be established and operated in conformance with standards prescribed by the administering Secretaries.

"(3) The administering Secretaries shall prescribe the minimum health care benefits to be provided under such a plan to veterans enrolled in the plan. Those benefits shall include at least all health care services covered under the medicare program under this title.

"(4) The establishment of a managed health care plan under this section shall be counted as the selection of a medical center

for purposes of applying the numerical limitation under subsection (b)(1).

"(j) MEDICAL CENTER REQUIREMENTS.—The Secretary of Veterans Affairs may establish a managed health care plan using 1 or more medical centers and other facilities only after the Secretary of Veterans Affairs submits to Congress a report setting forth a plan for the use of such centers and facilities. The plan may not be implemented until the Secretary of Veterans Affairs has received from the Inspector General of the Department of Veterans Affairs, and has forwarded to Congress, certification of each of the following:

"(1) The cost accounting system of the Veterans Health Administration (known as the Decision Support System) is operational and is providing reliable cost information on care delivered on an inpatient and outpatient basis at such centers and facilities.

"(2) The centers and facilities have operated in conformity with the eligibility reform amendments made by title I of the Veterans Health Care Act of 1996 for not less than 3 months.

"(3) The centers and facilities have developed a credible plan (on the basis of market surveys, data from the Decision Support System, actuarial analysis, and other appropriate methods and taking into account the level of payment under subsection (l) and the costs of providing covered services at the centers and facilities) to minimize, to the extent feasible, the risk that appropriated funds allocated to the centers and facilities will be required to meet the centers' and facilities' obligation to targeted medicare-eligible veterans under the demonstration project.

"(4) The centers and facilities collectively have available capacity to provide the contracted benefits package to a sufficient number of targeted medicare-eligible veterans.

"(5) The entity administering the health plan has sufficient systems and safeguards in place to minimize any risk that instituting the managed care model will result in reducing the quality of care delivered to enrollees in the demonstration project or to other veterans receiving care under paragraphs subsection (1) or (2) of section 1710(a) of title 38, United States Code.

"(k) RESERVES.—The Secretary of Veterans Affairs shall maintain such reserves as may be necessary to ensure against the risk that appropriated funds, allocated to medical centers and facilities participating in the demonstration project through a managed health care plan under this section, will be required to meet the obligations of those medical centers and facilities to targeted medicare-eligible veterans.

"(l) PAYMENTS BASED ON REGULAR MEDICARE PAYMENT RATES.—

"(1) PAYMENTS.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall reimburse the Secretary of Veterans Affairs for services provided under the demonstration project at the following rates:

"(i) NONCAPITATION.—Except as provided in clause (ii) and subject to subparagraphs (B)(i) and (D), at a rate equal to 95 percent of the amounts that otherwise would be payable under this title on a noncapitated basis for such services if the medical center were not a Federal medical center, were participating in the program, and imposed charges for such services.

"(ii) CAPITATION.—Subject to subparagraphs (B)(ii) and (D), in the case of services provided to an enrollee under a managed health care plan established under subsection (i), at a rate equal to 95 percent of the amount paid to a Medicare Choice organization under part C with respect to such an enrollee.

In cases in which a payment amount may not otherwise be readily computed, the Secretaries shall establish rules for computing equivalent or comparable payment amounts.

"(B) EXCLUSION OF CERTAIN AMOUNTS.—

"(i) NONCAPITATION.—In computing the amount of payment under subparagraph (A)(i), the following shall be excluded:

(i) DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT.—Any amount attributable to an adjustment under subsection (d)(5)(F) of section 1886 of the Social Security Act (42 U.S.C. 1395ww).

(ii) DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.—Any amount attributable to a payment under subsection (h) of such section.

(iii) PERCENTAGE OF INDIRECT MEDICAL EDUCATION ADJUSTMENT.—40 percent of any amount attributable to the adjustment under subsection (d)(5)(B) of such section.

(iv) PERCENTAGE OF CAPITAL PAYMENTS.—67 percent of any amounts attributable to payments for capital-related costs under subsection (g) of such section.

"(ii) CAPITATION.—In the case of years before 2001, in computing the amount of payment under subparagraph (A)(ii), the payment rate shall be computed as though the amounts excluded under clause (i) had been excluded in the determination of the amount paid to a Medicare Choice organization under part C with respect to an enrollee.

"(C) PERIODIC PAYMENTS FROM MEDICARE TRUST FUNDS.—Payments under this subsection shall be made—

"(i) on a periodic basis consistent with the periodicity of payments under this title; and

"(ii) in appropriate part, as determined by the Secretary, from the trust funds.

"(D) ANNUAL LIMIT ON MEDICARE PAYMENTS.—The amount paid to the Department of Veterans Affairs under this subsection for any year for the demonstration project may not exceed $50,000,000.

"(2) REDUCTION IN PAYMENT FOR VA FAILURE TO MAINTAIN EFFORT.—

"(A) IN GENERAL.—In order to avoid shifting onto the medicare program under this title costs previously assumed by the Department of Veterans Affairs for the provision of medicare-covered services to targeted medicare-eligible veterans, the payment amount under this subsection for the project for a fiscal year shall be reduced by the amount (if any) by which—

"(i) the amount of the VA effort level for targeted veterans (as defined in subparagraph (B)) for the fiscal year ending in such year, is less than

"(ii) the amount of the VA effort level for targeted veterans for fiscal year 1997.

"(B) VA EFFORT LEVEL FOR TARGETED VETERANS DEFINED.—For purposes of subparagraph (A), the term 'VA effort level for targeted veterans' means, for a fiscal year, the amount, as estimated by the administering Secretaries, that would have been expended under the medicare program under this title for VA-provided medicare-covered services for targeted veterans (as defined in subparagraph (C)) for that fiscal year if benefits were available under the medicare program for those services. Such amount does not include expenditures attributable to services for which reimbursement is made under the demonstration project.

"(C) VA-PROVIDED MEDICARE-COVERED SERVICES FOR TARGETED VETERANS.—For purposes of subparagraph (B), the term 'VA-provided medicare-covered services for targeted veterans' means, for a fiscal year, items and services—

"(i) that are provided during the fiscal year by the Department of Veterans Affairs to targeted medicare-eligible veterans;

"(ii) that constitute hospital care and medical services under chapter 17 of title 38, United States Code; and

"(iii) for which benefits would be available under the medicare program under this title if they were provided other than by a Federal provider of services that does not charge for those services.

"(3) ASSURING NO INCREASE IN COST TO MEDICARE PROGRAM.—

"(A) MONITORING EFFECT OF DEMONSTRATION PROGRAM ON COSTS TO MEDICARE PROGRAM.—

"(i) IN GENERAL.—The Secretaries, in consultation with the Comptroller General, shall closely monitor the expenditures made under the medicare program for targeted medicare-eligible veterans during the period of the demonstration project compared to the expenditures that would have been made for such veterans during that period if the demonstration project had not been conducted.

"(ii) ANNUAL REPORT BY THE COMPTROLLER GENERAL.—Not later than December 31 of each year during which the demonstration project is conducted, the Comptroller General shall submit to the Secretaries

and the appropriate committees of Congress a report on the extent, if any, to which the costs of the Secretary under the medicare program under this title increased during the preceding fiscal year as a result of the demonstration project.

"(B) REQUIRED RESPONSE IN CASE OF INCREASE IN COSTS.—

"(i) IN GENERAL.—If the administering Secretaries find, based on subparagraph (A), that the expenditures under the medicare program under this title increased (or are expected to increase) during a fiscal year because of the demonstration project, the administering Secretaries shall take such steps as may be needed—

"(I) to recoup for the medicare program the amount of such increase in expenditures; and

"(II) to prevent any such increase in the future.

"(ii) STEPS.—Such steps—

"(I) under clause (i)(I) shall include payment of the amount of such increased expenditures by the Secretary of Veterans Affairs from the current medical care appropriation of the Department of Veterans Affairs to the trust funds; and

"(II) under clause (i)(II) shall include suspending or terminating the demonstration project (in whole or in part) or lowering the amount of payment under paragraph (1)(A).

"(m) EVALUATION AND REPORTS.—

"(1) INDEPENDENT EVALUATION.—The administering Secretaries shall arrange for an independent entity with expertise in the evaluation of health services to conduct an evaluation of the demonstration project. The entity shall submit annual reports on the demonstration project to the administering Secretaries and to the committees of jurisdiction in the Congress. The first report shall be submitted not later than 12 months after the date on which the demonstration project begins operation, and the final report not later than 3½ years after that date. The evaluation and reports shall include an assessment, based on the agreement entered into under subsection (b), of the following:

"(A) The cost to the Department of Veterans Affairs of providing care to veterans under the project.

"(B) Compliance of participating medical centers with applicable measures of quality of care, compared to such compliance for other medicare-participating medical centers.

"(C) A comparison of the costs of medical centers' participation in the program with the reimbursements provided for services of such medical centers.

"(D) Any savings or costs to the medicare program under this title from the project.

"(E) Any change in access to care or quality of care for targeted medicare-eligible veterans participating in the project.

"(F) Any effect of the project on the access to care and quality of care for targeted medicare-eligible veterans not participating in the project and other veterans not participating in the project.

"(G) The provision of services under managed health care plans under subsection (l), including the circumstances (if any) under which the Secretary of Veterans Affairs uses reserves described in subsection (k) and the Secretary of Veterans Affairs' response to such circumstances (including the termination of managed health care plans requiring the use of such reserves).

"(H) Any effect that the demonstration project has on the enrollment in Medicare Choice organizations under part C of this title in the established site areas.

"(2) REPORT ON EXTENSION AND EXPANSION OF DEMONSTRATION PROJECT.—Not later than six months after the date of the submission of the penultimate report under paragraph (1), the administering Secretaries shall submit to Congress a report containing their recommendation as to—

"(A) whether to extend the demonstration project or make the project permanent;

"(B) whether to expand the project to cover additional sites and areas and to increase the maximum amount of reimbursement (or the maximum amount of reimbursement permitted for managed health care plans under this section) under the project in any year; and

"(C) whether the terms and conditions of the project should be continued (or modified) if the project is extended or expanded.

"MEDICARE SUBVENTION DEMONSTRATION PROJECT FOR MILITARY RETIREES

"SEC. 1897. (a) DEFINITIONS.—In this section:

"(1) ADMINISTERING SECRETARIES.—The term 'administering Secretaries' means the Secretary and the Secretary of Defense acting jointly.

"(2) DEMONSTRATION PROJECT; PROJECT.—The terms 'demonstration project' and 'project' mean the demonstration project carried out under this section.

"(3) DESIGNATED PROVIDER.—The term 'designated provider' has the meaning given that term in section 721(5) of the National Defense Authorization Act For Fiscal Year 1997 (Public Law 104–201; 110 Stat. 2593; 10 U.S.C. 1073 note).

"(4) MEDICARE-ELIGIBLE MILITARY RETIREE OR DEPENDENT.—The term 'medicare-eligible military retiree or dependent' means an individual described in section 1074(b) or 1076(b) of title 10, United States Code, who—

"(A) would be eligible for health benefits under section 1086 of such title by reason of subsection (c)(1) of such section 1086 but for the operation of subsection (d) of such section 1086;

"(B)(i) is entitled to benefits under part A of this title; and

"(ii) if the individual was entitled to such benefits before July 1, 1996, received health care items or services from a health care facility of the uniformed services before that date, but after becoming entitled to benefits under part A of this title;

"(C) is enrolled for benefits under part B of this title; and

"(D) has attained age 65.

"(5) MEDICARE HEALTH CARE SERVICES.—The term 'medicare health care services' means items or services covered under part A or B of this title.

"(6) MILITARY TREATMENT FACILITY.—The term 'military treatment facility' means a facility referred to in section 1074(a) of title 10, United States Code.

"(7) TRICARE.—The term 'TRICARE' has the same meaning as the term 'TRICARE program' under section 711 of the National Defense Authorization Act for Fiscal Year 1996 (10 U.S.C. 1073 note).

"(5) TRUST FUNDS.—The term 'trust funds' means the Federal Hospital Insurance Trust Fund established in section 1817 and the Federal Supplementary Medical Insurance Trust Fund established in section 1841.

"(b) DEMONSTRATION PROJECT.—

"(1) IN GENERAL.—

"(A) ESTABLISHMENT.—The administering Secretaries are authorized to establish a demonstration project (under an agreement entered into by the administering Secretaries) under which the Secretary shall reimburse the Secretary of Defense, from the trust funds, for medicare health care services furnished to certain medicare-eligible military retirees or dependents.

"(B) AGREEMENT.—The agreement entered into under subparagraph (A) shall include at a minimum—

"(i) a description of the benefits to be provided to the participants of the demonstration project established under this section;

"(ii) a description of the eligibility rules for participation in the demonstration project, including any cost sharing requirements established under subsection (h);

"(iii) a description of how the demonstration project will satisfy the requirements under this title;

"(iv) a description of the sites selected under paragraph (2);

"(v) a description of how reimbursement and maintenance of effort requirements under subsection (j) will be implemented in the demonstration project; and

"(vi) a statement that the Secretary shall have access to all data of the Department of Defense that the Secretary determines is necessary to conduct independent estimates and audits of the maintenance of effort requirement, the annual reconciliation, and related matters required under the demonstration project.

"(2) IN GENERAL.—The project established under this section shall be conducted in no more than 6 sites, designated jointly by the administering Secretaries after review of all TRICARE regions.

"(3) RESTRICTION.—No new military treatment facilities will be built or expanded with funds from the demonstration project.

"(4) DURATION.—The administering Secretaries shall conduct the demonstration project during the 3-year period beginning on January 1, 1998.

"(c) CREDITING OF PAYMENTS.—A payment received by the Secretary of Defense under the demonstration project shall be credited to the applicable Department of Defense medical appropriation and (within that appropriation). Any such payment received during a fiscal year for services provided during a prior fiscal year may be obligated by the Secretary of Defense during the fiscal year during which the payment is received.

"(d) AUTHORITY TO WAIVE CERTAIN MEDICARE REQUIREMENTS.—The Secretary may, to the extent necessary to carry out the demonstration project, waive any requirement under this title. If the Secretary waives any such requirement, the Secretary shall include a description of such waiver in the agreement described in subsection (b).

"(e) INSPECTOR GENERAL.—Nothing in the agreement entered into under subsection (b) shall limit the Inspector General of the Department of Health and Human Services from investigating any matters regarding the expenditure of funds under this title for the demonstration project, including compliance with the provisions of this title and all other relevant laws.

"(f) REPORT.—At least 30 days prior to the commencement of the demonstration project, the administering Secretaries shall submit a copy of the agreement entered into under subsection (b) to the committees of jurisdiction in Congress.

"(g) VOLUNTARY PARTICIPATION.—Participation of medicare-eligible military retirees or dependents in the demonstration project shall be voluntary, subject to the capacity of participating military treatment facilities and designated providers and the funding limitations specified in subsection (j), and shall be subject to such terms and conditions as the administering Secretaries may establish.

"(h) COST-SHARING BY DEMONSTRATION ENROLLEES.—The Secretary of Defense may establish cost-sharing requirements for medicare-eligible military retirees and dependents who enroll in the demonstration project consistent with part C of this title.

"(i) TRICARE HEALTH CARE PLANS.—

"(1) TRICARE PROGRAM ENROLLMENT FEE WAIVER.—The Secretary of Defense shall waive the enrollment fee applicable to any medicare-eligible military retiree or dependent enrolled in the managed care option of the TRICARE program for any period for which reimbursement is made under this section with respect to such retiree or dependent.

"(2) MODIFICATION OF TRICARE CONTRACTS.—In carrying out the demonstration project, the Secretary of Defense is authorized to amend existing TRICARE contracts in order to pro-

vide the medicare health care services to the medicare-eligible military retirees and dependents enrolled in the demonstration project.

"(3) HEALTH CARE BENEFITS.—The administering Secretaries shall prescribe the minimum health care benefits to be provided under such a plan to medicare-eligible military retirees or dependents enrolled in the plan. Those benefits shall include at least all medicare health care services covered under this title.

"(j) PAYMENTS BASED ON REGULAR MEDICARE PAYMENT RATES.—

"(1) PAYMENTS.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall reimburse the Secretary of Defense for services provided under the demonstration project at the following rates:

"(i) NONCAPITATION.—Except as provided in clause (ii) and subject to subparagraphs (B)(i) and (D), at a rate equal to 95 percent of the amounts that otherwise would be payable under this title on a noncapitated basis for such services if the military treatment facility or designated provider were not a Federal medical center, were participating in the program, and imposed charges for such services.

"(ii) CAPITATION.—Subject to subparagraphs (B)(ii) and (D), in the case of services provided to an enrollee under a managed health care plan established under subsection (i), at a rate equal to 95 percent of the amount paid to a Medicare Choice organization under part C with respect to such an enrollee.

In cases in which a payment amount may not otherwise be readily computed, the Secretaries shall establish rules for computing equivalent or comparable payment amounts.

"(B) EXCLUSION OF CERTAIN AMOUNTS.—

"(i) NONCAPITATION.—In computing the amount of payment under subparagraph (A)(i), the following shall be excluded:

"(I) SPECIAL PAYMENTS.—Any amount attributable to an adjustment under subparagraphs (B) and (F) of section 1886(d)(5) and subsection (h) of such section.

"(II) PERCENTAGE OF CAPITAL PAYMENTS.—An amount determined by the administering Secretaries for amounts attributable to payments for capital-related costs under subsection (g) of such section.

"(ii) CAPITATION.—In the case of years before 2001, in computing the amount of payment under subparagraph (A)(ii), the payment rate shall be computed as though the amounts excluded under clause (i) had been excluded in the determination of the amount paid to a Medicare Choice organization under part C with respect to an enrollee.

"(C) PERIODIC PAYMENTS FROM MEDICARE TRUST FUNDS.—Payments under this subsection shall be made—

"(i) on a periodic basis consistent with the periodicity of payments under this title; and

"(ii) in appropriate part, as determined by the Secretary, from the trust funds.

"(D) CAP ON AMOUNT.—The aggregate amount to be reimbursed under this paragraph pursuant to the agreement entered into between the administering Secretaries under subsection (b) shall not exceed a total of—

"(i) $55,000,000 for calendar year 1998;

"(ii) $65,000,000 for calendar year 1999; and

"(iii) $75,000,000 for calendar year 2000.

"(2) ASSURING NO INCREASE IN COST TO MEDICARE PROGRAM.—

"(A) MONITORING EFFECT OF DEMONSTRATION PROGRAM ON COSTS TO MEDICARE PROGRAM.—

"(i) IN GENERAL.—The Secretaries, in consultation with the Comptroller General, shall closely monitor the expenditures made under the medicare program for medicare-eligible military retirees or dependents during the period of the demonstration project compared to the expenditures that would have been made for such medicare-eligible military retirees or dependents during that period if the demonstration project had not been conducted. The agreement entered into by the administering Secretaries under subsection (b) shall require any participating military treatment facility to maintain the level of effort for space available care to medicare-eligible military retirees or dependents.

"(ii) ANNUAL REPORT BY THE COMPTROLLER GENERAL.—Not later than December 31 of each year during which the demonstration project is conducted, the Comptroller General shall submit to the Secretaries and the appropriate committees of Congress a report on the extent, if any, to which the costs of the Secretary under the medicare program under this title increased during the preceding fiscal year as a result of the demonstration project.

"(B) REQUIRED RESPONSE IN CASE OF INCREASE IN COSTS.—

"(i) IN GENERAL.—If the administering Secretaries find, based on subparagraph (A), that the expenditures under the medicare program under this title increased (or are expected to increase) during a fiscal year because of the demonstration project, the administering Secretaries shall take such steps as may be needed—

"(I) to recoup for the medicare program the amount of such increase in expenditures; and

"(II) to prevent any such increase in the future.

"(ii) STEPS.—Such steps—

"(I) under clause (i)(I) shall include payment of the amount of such increased expenditures by the Secretary of Defense from the current medical care appropriation of the Department of Defense to the trust funds; and

"(II) under clause (i)(II) shall include suspending or terminating the demonstration project (in whole or in part) or lowering the amount of payment under paragraph (1)(A).

"(k) EVALUATION AND REPORTS.—

"(1) INDEPENDENT EVALUATION.—The administering Secretaries shall arrange for an independent entity with expertise in the evaluation of health services to conduct an evaluation of the demonstration project. The entity shall submit annual reports on the demonstration project to the administering Secretaries and to the committees of jurisdiction in the Congress. The first report shall be submitted not later than 12 months after the date on which the demonstration project begins operation, and the final report not later than 3½ years after that date. The evaluation and reports shall include an assessment, based on the agreement entered into under subsection (b), of the following:

"(A) The number of medicare-eligible military retirees and dependents opting to participate in the demonstration project instead of receiving health benefits through another health insurance plan (including benefits under this title).

"(B) Compliance by the Department of Defense with the requirements under this title.

"(C) The cost to the Department of Defense of providing care to medicare-eligible military retirees and dependents under the demonstration project.

"(D) Compliance by the Department of Defense with the standards of quality required of entities that furnish medicare health care services.

"(E) An analysis of whether, and in what manner, easier access to the uniformed services treatment system affects the number of medicare-eligible military retirees and dependents receiving medicare health care services.

"(F) Any savings or costs to the medicare program under this title resulting from the demonstration project.

"(G) An assessment of the access to care and quality of care for medicare-eligible military retirees and dependents under the demonstration project.

"(H) Any impact of the demonstration project on the access to care for medicare-eligible military retirees and dependents who did not enroll in the demonstration project and for other individuals entitled to benefits under this title.

"(I) Any impact of the demonstration project on private health care providers.

"(J) Any impact of the demonstration project on access to care for active duty military personnel and their dependents.

"(K) A list of the health insurance plans and programs that were the primary payers for medicare-eligible military retirees and dependents during the year prior to their participation in the demonstration project and the distribution of their previous enrollment in such plans and programs.

"(L) An identification of cost-shifting (if any) between the medicare program under this title and the Defense health program as a result of the demonstration project and a description of the nature of any such cost-shifting.

"(M) An analysis of how the demonstration project affects the overall accessibility of the uniformed services treatment system and the amount of space available for point-of-service care, and a description of the unintended effects (if any) upon the normal treatment priority system.

"(N) A description of the difficulties (if any) experienced by the Department of Defense in managing the demonstration project.

"(O) A description of the effects of the demonstration project on military treatment facility readiness and training and the probable effects of the project on overall Department of Defense medical readiness and training.

"(P) A description of the effects that the demonstration project, if permanent, would be expected to have on the overall budget of the Defense health program, the budgets of individual military treatment facilities and designated providers, and on the budget of the medicare program under this title.

"(Q) An analysis of whether the demonstration project affects the cost to the Department of Defense of prescription drugs or the accessibility, availability, and cost of such drugs to demonstration program beneficiaries.

"(R) Any additional elements specified in the agreement entered into under subsection (b).

"(2) REPORT ON EXTENSION AND EXPANSION OF DEMONSTRATION PROJECT.—Not later than six months after the date of the submission of the penultimate report under paragraph (1), the administering Secretaries shall submit to Congress a report containing their recommendation as to—

"(A) whether to extend the demonstration project or make the project permanent;

"(B) whether to expand the project to cover additional sites and areas and to increase the maximum amount of reimbursement (or the maximum amount of reimbursement permitted for managed health care plans under this section) under the project in any year; and

"(C) whether the terms and conditions of the project should be continued (or modified) if the project is extended or expanded.".

CHAPTER 6—TAX TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS

SEC. 5049. TAX TREATMENT OF HOSPITALS WHICH PARTICIPATE IN PROVIDER-SPONSORED ORGANIZATIONS.

(a) IN GENERAL.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

"(o) TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS.—An organization shall not fail to be treated as organized and operated exclusively for a charitable purpose for purposes of subsection (c)(3) solely because a hospital which is owned and operated by such organization participates in a provider-sponsored organization (as defined in section 1853(e) of the Social Security Act), whether or not the provider-sponsored organization is exempt from tax. For purposes of subsection (c)(3), any person with a material financial interest in such a provider-sponsored organization shall be treated as a private shareholder or individual with respect to the hospital.".

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

Subtitle B—Prevention Initiatives

SEC. 5101. ANNUAL SCREENING MAMMOGRAPHY FOR WOMEN OVER AGE 39.

(a) IN GENERAL.—Section 1834(c)(2)(A) (42 U.S.C. 1395m(c)(2)(A)) is amended by striking clauses (iii), (iv), and (v) and inserting the following:

"(iii) in the case of a woman over 39 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed."

(b) WAIVER OF COINSURANCE.—

(1) IN GENERAL.—Section 1834(c)(1)(C) (42 U.S.C. 1395m(c)(1)(C)) is amended by striking "80 percent of".

(2) WAIVER OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—The third sentence of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting after "1861(s)(10)(A)" the following: ", with respect to screening mammography (as defined in section 1861(jj),".

(c) EFFECTIVE DATE.—The amendments made by subsection (a) apply to items and services furnished on or after January 1, 1998.

SEC. 5102. COVERAGE OF COLORECTAL SCREENING.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) in subsection (s)(2)—

(A) by striking "and" at the end of subparagraphs (N) and (O); and

(B) by inserting after subparagraph (O) the following:

"(P) colorectal cancer screening tests (as defined in subsection (oo)); and"; and

(2) by adding at the end the following:

"Colorectal Cancer Screening Test

"(oo)(1)(A) The term 'colorectal cancer screening test' means a procedure furnished to an individual that the Secretary prescribes in regulations as appropriate for the purpose of early detection of colorectal cancer, taking into account availability, effectiveness, costs, changes in technology and standards of medical practice, and such other factors as the Secretary considers appropriate.

"(B) The Secretary shall consult with appropriate organizations in prescribing regulations under subparagraph (A).".

(b) FREQUENCY AND PAYMENT LIMITS.—Section 1834 (42 U.S.C. 1395m) is amended by inserting after subsection (c) the following new subsection:

"(d) FREQUENCY AND PAYMENT LIMITS FOR COLORECTAL CANCER SCREENING TESTS.—

"(1) IN GENERAL.—The Secretary shall prescribe regulations that—

"(A) establish frequency limits for colorectal cancer screening tests that take into account the risk status of an individual and that are consistent with frequency limits for similar or related services; and

"(B) establish payment limits (including limits on charges of nonparticipating physicians) for colorectal cancer screening tests that are consistent with payment limits for similar or related services.

"(2) REVISIONS.—The Secretary shall periodically review and, to the extent the Secretary considers appropriate, revise the frequency and payment limits established under paragraph (1).

"(3) FACTORS TO DETERMINE INDIVIDUALS AT RISK.—In establishing criteria for determining whether an individual is at risk for purposes of this subsection, the Secretary shall take into consideration family history, prior experience of cancer, a history of chronic digestive disease condition, and the presence of any appropriate recognized gene markers for colorectal cancer.

"(4) CONSULTATION.—In establishing and revising frequency and payment limits under this subsection, the Secretary shall consult with appropriate organizations."

(c) CONFORMING AMENDMENTS.—(1) Paragraphs (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended by inserting "or section 1834(d)" after "subsection (h)(1)".

(2) Section 1833(h)(1)(A) (42 U.S.C. 1395l(h)(1)(A)) is amended by striking "The Secretary" and inserting "Subject to section 1834(d), the Secretary".

(3) Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (E), by striking "and" at the end,

(ii) in subparagraph (F), by striking the semicolon at the end and inserting ", and", and

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

"(G) in the case of colorectal cancer screening tests, which are performed more frequently than is covered under section 1834(d);"; and

(B) in paragraph (7), by striking "paragraph (1)(B) or under paragraph (1)(F)" and inserting "subparagraph (B), (F), or (G) of paragraph (1)".

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

(2) REGULATIONS.—The Secretary of Health and Human Services shall issue final regulations described in sections 1861(oo) and 1834(d) of the Social Security Act (as added by this section) within 3 months after the date of enactment of this Act.

SEC. 5103. DIABETES SCREENING TESTS.

(a) DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES.—

(1) IN GENERAL.—Section 1861(s) (42 U.S.C. 1395x(s)), as amended by section 5102, is amended—

(A) in subsection (s)(2)—

(i) by striking "and" at the end of subparagraph (P);

(ii) by inserting "and" at the end of subparagraph (Q); and

(iii) by adding at the end the following:

"(R) diabetes outpatient self-management training services (as defined in subsection (pp));", and

(B) by adding at the end the following:

"Diabetes Outpatient Self-Management Training Services

"(pp)(1) The term 'diabetes outpatient self-management training services' means educational and training services furnished to an individual with diabetes by a certified provider (as described in paragraph (2)(A)) in an outpatient setting by an individual or entity that meets the quality standards described in paragraph (2)(B), but only if the physician who is managing the individual's diabetic condition certifies that the services are needed under a comprehensive plan of care related to the individual's diabetic condition to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual's condition.

"(2) In paragraph (1)—

"(A) a 'certified provider' is a physician, or other individual or entity designated by the Secretary, that, in addition to providing diabetes outpatient self-management training services, provides other items or services for which payment may be made under this title; and

"(B) a physician, or other such individual or entity, meets the quality standards described in this subparagraph if the physician, or individual or entity, meets quality standards established by the Secretary, except that the physician, or other

individual or entity, shall be deemed to have met such standards if the physician or other individual or entity—

"(i) meets applicable standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards by such Board, or

"(ii) is recognized by an organization that represents individuals (including individuals under this title) with diabetes as meeting standards for furnishing the services."

(2) CONSULTATION WITH ORGANIZATIONS IN ESTABLISHING PAYMENT AMOUNTS FOR SERVICES PROVIDED BY PHYSICIANS.—In establishing payment amounts under section 1848 of the Social Security Act for physicians' services consisting of diabetes outpatient self-management training services, the Secretary of Health and Human Services shall consult with appropriate organizations, including such organizations representing individuals or medicare beneficiaries with diabetes, in determining the relative value for such services under section 1848(c)(2) of such Act.

(b) BLOOD-TESTING STRIPS FOR INDIVIDUALS WITH DIABETES.—

(1) INCLUDING STRIPS AND MONITORS AS DURABLE MEDICAL EQUIPMENT.—The first sentence of section 1861(n) (42 U.S.C. 1395x(n)) is amended by inserting before the semicolon the following: ", and includes blood-testing strips and blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individual's use of insulin (as determined under standards established by the Secretary in consultation with the appropriate organizations)".

(2) 10 PERCENT REDUCTION IN PAYMENTS FOR TESTING STRIPS.—Section 1834(a)(2)(B)(iv) (42 U.S.C. 1395m(a)(2)(B)(iv)) is amended by adding before the period the following: "(reduced by 10 percent, in the case of a blood glucose testing strip furnished after 1997 for an individual with diabetes)".

(c) ESTABLISHMENT OF OUTCOME MEASURES FOR BENEFICIARIES WITH DIABETES.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with appropriate organizations, shall establish outcome measures, including glysolated hemoglobin (past 90-day average blood sugar levels), for purposes of evaluating the improvement of the health status of medicare beneficiaries with diabetes mellitus.

(2) RECOMMENDATIONS FOR MODIFICATIONS TO SCREENING BENEFITS.—Taking into account information on the health status of medicare beneficiaries with diabetes mellitus as measured under the outcome measures established under subparagraph (A), the Secretary shall from time to time submit recommendations to Congress regarding modifications to the coverage of services for such beneficiaries under the medicare program.

(d) EFFECTIVE DATE.—The amendments made by this section apply to items and services furnished on or after January 1, 1998.

SEC. 5104. COVERAGE OF BONE MASS MEASUREMENTS.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) in subsection (s)—

(A) in paragraph (12)(C), by striking "and" at the end;

(B) by striking the period at the end of paragraph (14) and inserting "; and";

(C) by redesignating paragraphs (15) and (16) as paragraphs (16) and (17), respectively; and

(D) by inserting after paragraph (14) the following:

"(15) bone mass measurement (as defined in subsection (oo))."; and

(2) by inserting after subsection (pp), as added by section 5103, the following:

"Bone Mass Measurement

"(gg)(1) The term 'bone mass measurement' means a radiologic or radioscopic procedure or other Food and Drug Administration approved technology performed on a qualified individual (as defined in paragraph (2)) for the purpose of identifying bone mass, detecting bone loss, or determining bone quality, and includes a physician's interpretation of the results of the procedure.

"(2) For purposes of paragraph (1), the term 'qualified individual' means an individual who is (in accordance with regulations prescribed by the Secretary)—

"(A) an estrogen-deficient woman at clinical risk for osteoporosis and who is considering treatment;

"(B) an individual with vertebral abnormalities;

"(C) an individual receiving long-term glucocorticoid steroid therapy;

"(D) an individual with primary hyperparathyroidism; or

"(E) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.".

(b) CONFORMING AMENDMENTS.—Sections 1864(a), 1865(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) (42 U.S.C. 1395aa(a), 1395bb(a), 1396a(a)(9)(C), and 1396n(a)(1)(B)(ii)(I)) are amended by striking "paragraphs (15) and (16)" each place such term appears and inserting "paragraphs (16) and (17)".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to bone mass measurements performed on or after January 1, 1998.

Subtitle C—Rural Initiatives

SEC. 5151. SOLE COMMUNITY HOSPITALS.

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

(1) in clause (i), by redesignating subclauses (I) and (II) as items (aa) and (bb), respectively;

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

(3) by striking "(C) In" and inserting "(C)(i) Subject to clause (ii), in"; and

(4) by striking the last sentence and inserting the following:

"(ii)(I) There shall be substituted for the base cost reporting period described in clause (i)(I) a hospital's cost reporting period (if

any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

"(II) Beginning with discharges occurring in fiscal year 1998, there shall be substituted for the base cost reporting period described in clause (i)(I) either—

"(aa) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital's cost reporting period (if any) beginning during fiscal year 1994 increased (in a compounded manner) by the applicable percentage increases applied to the hospital under this paragraph for discharges occurring in fiscal years 1995, 1996, 1997, and 1998, or

"(bb) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital's cost reporting period (if any) beginning during fiscal year 1995 increased (in a compounded manner) by the applicable percentage increase applied to the hospital under this paragraph for discharges occurring in fiscal years 1995, 1996, 1997, and 1998,

if such substitution results in an increase in the target amount for the hospital.".

SEC. 5152. MEDICARE-DEPENDENT, SMALL RURAL HOSPITAL PAYMENT EXTENSION.

(a) SPECIAL TREATMENT EXTENDED.—

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

(A) in clause (i), by striking "October 1, 1994," and inserting "October 1, 1994, or beginning on or after October 1, 1997, and before October 1, 2001,"; and

(B) in clause (ii)(II), by striking "October 1, 1994," and inserting "October 1, 1994, or beginning on or after October 1, 1997, and before October 1, 2001,".

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

(A) in the matter preceding clause (i), by striking "September 30, 1994," and inserting "September 30, 1994, and for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2001,";

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

(C) in clause (iii), by striking the period at the end and inserting ", and"; and

(D) by adding after clause (iii) the following new clause:

"(iv) with respect to discharges occurring during fiscal year 1998 through fiscal year 2000, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).".

(3) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of OBRA–93 (42 U.S.C. 1395ww note) is amended by striking "or fiscal year 1994" and inserting ", fiscal year 1994, fiscal year 1998, fiscal year 1999, or fiscal year 2000".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to discharges occurring on or after October 1, 1997.

SEC. 5153. MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.

(a) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.—Section 1820 (42 U.S.C. 1395i–4) is amended to read as follows:

"MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

"SEC. 1820. (a) ESTABLISHMENT.—Any State that submits an application in accordance with subsection (b) may establish a medicare rural hospital flexibility program described in subsection (c).

"(b) APPLICATION.—A State may establish a medicare rural hospital flexibility program described in subsection (c) if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing—

"(1) assurances that the State—

"(A) has developed, or is in the process of developing, a State rural health care plan that—

"(i) provides for the creation of 1 or more rural health networks (as defined in subsection (d)) in the State;

"(ii) promotes regionalization of rural health services in the State; and

"(iii) improves access to hospital and other health services for rural residents of the State; and

"(B) has developed the rural health care plan described in subparagraph (A) in consultation with the hospital association of the State, rural hospitals located in the State, and the State Office of Rural Health (or, in the case of a State in the process of developing such plan, that assures the Secretary that the State will consult with its State hospital association, rural hospitals located in the State, and the State Office of Rural Health in developing such plan);

"(2) assurances that the State has designated (consistent with the rural health care plan described in paragraph (1)(A)), or is in the process of so designating, rural nonprofit or public hospitals or facilities located in the State as critical access hospitals; and

"(3) such other information and assurances as the Secretary may require.

"(c) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM DESCRIBED.—

"(1) IN GENERAL.—A State that has submitted an application in accordance with subsection (b), may establish a medicare rural hospital flexibility program that provides that—

"(A) the State shall develop at least 1 rural health network (as defined in subsection (d)) in the State; and

"(B) at least 1 facility in the State shall be designated as a critical access hospital in accordance with paragraph (2).

"(2) STATE DESIGNATION OF FACILITIES.—

"(A) IN GENERAL.—A State may designate 1 or more facilities as a critical access hospital in accordance with subparagraph (B).

"(B) CRITERIA FOR DESIGNATION AS CRITICAL ACCESS HOSPITAL.—A State may designate a facility as a critical access hospital if the facility—

"(i) is a nonprofit or public hospital and is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D)) that—

"(I) is located more than a 35-mile drive from a hospital, or another facility described in this subsection; or

"(II) is certified by the State as being a necessary provider of health care services to residents in the area;

"(ii) makes available 24-hour emergency care services that a State determines are necessary for ensuring access to emergency care services in each area served by a critical access hospital;

"(iii) provides not more than 15 acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period not to exceed 96 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions), except that a peer review organization or equivalent entity may, on request, waive the 96-hour restriction on a case-by-case basis;

"(iv) meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

"(I) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open and fully staffed, except insofar as the facility is required to make available emergency care services as determined under clause (ii) and must have nursing services available on a 24-hour basis, but need not otherwise staff the facility except when an inpatient is present;

"(II) the facility may provide any services otherwise required to be provided by a full-time, on site dietitian, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, off site basis under arrangements as defined in section 1861(w)(1); and

"(III) the inpatient care described in clause (iii) may be provided by a physician's assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who need not be present in the facility; and

"(v) meets the requirements of section 1861(aa)(2)(I).

"(d) DEFINITION OF RURAL HEALTH NETWORK.—

"(1) IN GENERAL.—In this section, the term 'rural health network' means, with respect to a State, an organization consisting of—

"(A) at least 1 facility that the State has designated or plans to designate as a critical access hospital; and

"(B) at least 1 hospital that furnishes acute care services.

"(2) AGREEMENTS.—

"(A) IN GENERAL.—Each critical access hospital that is a member of a rural health network shall have an agreement with respect to each item described in subparagraph (B) with at least 1 hospital that is a member of the network.

"(B) ITEMS DESCRIBED.—The items described in this subparagraph are the following:

"(i) Patient referral and transfer.

"(ii) The development and use of communications systems including (where feasible)—

"(I) telemetry systems; and

"(II) systems for electronic sharing of patient data.

"(iii) The provision of emergency and non-emergency transportation among the facility and the hospital.

"(C) CREDENTIALING AND QUALITY ASSURANCE.—Each critical access hospital that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least—

"(i) 1 hospital that is a member of the network;

"(ii) 1 peer review organization or equivalent entity; or

"(iii) 1 other appropriate and qualified entity identified in the State rural health care plan.

"(e) CERTIFICATION BY THE SECRETARY.—The Secretary shall certify a facility as a critical access hospital if the facility—

"(1) is located in a State that has established a medicare rural hospital flexibility program in accordance with subsection (c);

"(2) is designated as a critical access hospital by the State in which it is located; and

"(3) meets such other criteria as the Secretary may require.

"(f) PERMITTING MAINTENANCE OF SWING BEDS.—Nothing in this section shall be construed to prohibit a critical access hospital from entering into an agreement with the Secretary under section 1883 under which the facility's inpatient hospital facilities are used for the furnishing of extended care services.

"(g) GRANTS.—

"(1) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.—The Secretary may award grants to States that have submitted applications in accordance with subsection (b) for—

"(A) engaging in activities relating to planning and implementing a rural health care plan;

"(B) engaging in activities relating to planning and implementing rural health networks; and

"(C) designating facilities as critical access hospitals.

"(2) RURAL EMERGENCY MEDICAL SERVICES.—

"(A) IN GENERAL.—The Secretary may award grants to States that have submitted applications in accordance with subparagraph (B) for the establishment or expansion of a program for the provision of rural emergency medical services.

"(B) APPLICATION.—An application is in accordance with this subparagraph if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing the assurances described in subparagraphs (A)(ii), (A)(iii), and (B) of subsection (b)(1) and paragraph (3) of that subsection.

"(h) GRANDFATHERING OF CERTAIN FACILITIES.—

"(1) IN GENERAL.—Any medical assistance facility operating in Montana and any rural primary care hospital designated by the Secretary under this section prior to the date of the enactment of the Balanced Budget Act of 1997 shall be deemed to have been certified by the Secretary under subsection (e) as a critical access hospital if such facility or hospital is otherwise eligible to be designated by the State as a critical access hospital under subsection (c).

"(2) CONTINUATION OF MEDICAL ASSISTANCE FACILITY AND RURAL PRIMARY CARE HOSPITAL TERMS.—Notwithstanding any other provision of this title, with respect to any medical assistance facility or rural primary care hospital described in paragraph (1), any reference in this title to a 'critical access hospital' shall be deemed to be a reference to a 'medical assistance facility' or 'rural primary care hospital'.

"(i) WAIVER OF CONFLICTING PART A PROVISIONS.—The Secretary is authorized to waive such provisions of this part and part D as are necessary to conduct the program established under this section.

"(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for making grants to all States under subsection (g), $25,000,000 in each of the fiscal years 1998 through 2002.".

(b) REPORT ON ALTERNATIVE TO 96-HOUR RULE.—Not later than January 1, 1998, the Administrator of the Health Care Financing Administration shall submit to Congress a report on the feasibility of, and administrative requirements necessary to establish an alternative for certain medical diagnoses (as determined by the Administrator) to the 96-hour limitation for inpatient care in critical access hospitals required by section 1820(c)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395i–4), as added by subsection (a) of this section.

(c) CONFORMING AMENDMENTS RELATING TO RURAL PRIMARY CARE HOSPITALS AND CRITICAL ACCESS HOSPITALS.—

(1) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) and title XVIII of that Act (42 U.S.C. 1395 et seq.) are each amended by striking "rural primary care" each place it appears and inserting "critical access".

(2) DEFINITIONS.—Section 1861(mm) of the Social Security Act (42 U.S.C. 1395x(mm)) is amended to read as follows:

"CRITICAL ACCESS HOSPITAL; CRITICAL ACCESS HOSPITAL SERVICES

"(mm)(1) The term 'critical access hospital' means a facility certified by the Secretary as a critical access hospital under section 1820(e).

"(2) The term 'inpatient critical access hospital services' means items and services, furnished to an inpatient of a critical access hospital by such facility, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.

"(3) The term 'outpatient critical access hospital services' means medical and other health services furnished by a critical access hospital on an outpatient basis.".

(3) PART A PAYMENT.—Section 1814 of the Social Security Act (42 U.S.C. 1395f) is amended—

(A) in subsection (a)(8), by striking "72" and inserting "96"; and

(B) by amending subsection (*l*) to read as follows:

"Payment for Inpatient Critical Access Hospital Services

"(*l*) The amount of payment under this part for inpatient critical access hospital services is the reasonable costs of the critical access hospital in providing such services.".

(4) PAYMENT CONTINUED TO DESIGNATED EACHS.—Section 1886(d)(5)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(D)) is amended—

(A) in clause (iii)(III), by inserting "as in effect on September 30, 1997" before the period at the end; and

(B) in clause (v)—

(i) by inserting "as in effect on September 30, 1997" after "1820(i)(1)"; and

(ii) by striking "1820(g)" and inserting "1820(d)".

(5) PART B PAYMENT.—Section 1834(g) of the Social Security Act (42 U.S.C. 1395m(g)) is amended to read as follows:

"(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—The amount of payment under this part for outpatient critical access hospital services is the reasonable costs of the critical access hospital in providing such services.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 1997.

SEC. 5154. PROHIBITING DENIAL OF REQUEST BY RURAL REFERRAL CENTERS FOR RECLASSIFICATION ON BASIS OF COMPARABILITY OF WAGES.

(a) IN GENERAL.—Section 1886(d)(10)(D) (42 U.S.C. 1395ww(d)(10)(D)) is amended—

(1) by redesignating clause (iii) as clause (iv); and

(2) by inserting after clause (ii) the following new clause:

"(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which has ever been classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average

hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.".

(b) CONTINUING TREATMENT OF PREVIOUSLY DESIGNATED CENTERS.—

(1) IN GENERAL.—Any hospital classified as a rural referral center by the Secretary of Health and Human Services under section 1886(d)(5)(C) of the Social Security Act for fiscal year 1991 shall be classified as such a rural referral center for fiscal year 1998 and each subsequent fiscal year.

(2) BUDGET NEUTRALITY.—The provisions of section 1886(d)(8)(D) of the Social Security Act shall apply to reclassifications made pursuant to paragraph (1) in the same manner as such provisions apply to a reclassification under section 1886(d)(10) of such Act.

SEC. 5155. RURAL HEALTH CLINIC SERVICES.

(a) PER-VISIT PAYMENT LIMITS FOR PROVIDER-BASED CLINICS.—

(1) EXTENSION OF LIMIT.—

(A) IN GENERAL.—The matter in section 1833(f) (42 U.S.C. 1395l(f)) preceding paragraph (1) is amended by striking "independent rural health clinics" and inserting "rural health clinics (other than such clinics in rural hospitals with less than 50 beds)".

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) applies to services furnished after 1997.

(2) TECHNICAL CLARIFICATION.—Section 1833(f)(1) (42 U.S.C. 1395l(f)(1)) is amended by inserting "per visit" after "$46".

(b) ASSURANCE OF QUALITY SERVICES.—

(1) IN GENERAL.—Subparagraph (I) of the first sentence of section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended to read as follows:

"(I) has a quality assessment and performance improvement program, and appropriate procedures for review of utilization of clinic services, as the Secretary may specify,".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 1998.

(c) WAIVER OF CERTAIN STAFFING REQUIREMENTS LIMITED TO CLINICS IN PROGRAM.—

(1) IN GENERAL.—Section 1861(aa)(7)(B)) (42 U.S.C. 1395x(aa)(7)(B)) is amended by inserting before the period ", or if the facility has not yet been determined to meet the requirements (including subparagraph (J) of the first sentence of paragraph (2)) of a rural health clinic.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) applies to waiver requests made after 1997.

(d) REFINEMENT OF SHORTAGE AREA REQUIREMENTS.—

(1) DESIGNATION REVIEWED TRIENNIALLY.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended in the second sentence, in the matter in clause (i) preceding subclause (I)—

(A) by striking "and that is designated" and inserting "and that, within the previous 3-year period, has been designated"; and

(B) by striking "or that is designated" and inserting "or designated".

(2) AREA MUST HAVE SHORTAGE OF HEALTH CARE PRACTITIONERS.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)), as amended by paragraph (1), is further amended in the second sentence, in the matter in clause (i) preceding subclause (I)—

(A) by striking the comma after "personal health services"; and

(B) by inserting "and in which there are insufficient numbers of needed health care practitioners (as determined by the Secretary)," after "Bureau of the Census)".

(3) PREVIOUSLY QUALIFYING CLINICS GRANDFATHERED ONLY TO PREVENT SHORTAGE.—

(A) IN GENERAL.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended in the third sentence by inserting before the period "if it is determined, in accordance with criteria established by the Secretary in regulations, to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic".

(B) PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT SERVICES.—

(i) IN GENERAL.—With respect to any regulations issued to implement section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) (as amended by subparagraph (A)), the Secretary of Health and Human Services shall include in such regulations provisions providing for the direct payment to the physician assistant for any physician assistant services as described in clause (ii).

(ii) SERVICES DESCRIBED.—Services described in this clause are physician assistant services provided at a rural health clinic that is principally owned, as determined by the Secretary, by a physician assistant—

(I) as of the date of enactment of this Act; and

(II) continuously from such date through the date on which such services are provided.

(iii) SUNSET.—The provisions of this subparagraph shall not apply after January 1, 2003.

(4) EFFECTIVE DATES; IMPLEMENTING REGULATIONS.—

(A) IN GENERAL.—Except as otherwise provided, the amendments made by the preceding paragraphs take effect on January 1 of the first calendar year beginning at least 1 month after enactment of this Act.

(B) CURRENT RURAL HEALTH CLINICS.—The amendments made by the preceding paragraphs take effect, with respect to entities that are rural health clinics under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) on the date of enactment of this Act, on January 1 of the second calendar year following the calendar year specified in subparagraph (A).

(C) GRANDFATHERED CLINICS.—

(i) IN GENERAL.—The amendment made by paragraph (3) shall take effect on the effective date of regulations issued by the Secretary under clause (ii).

(ii) REGULATIONS.—The Secretary shall issue final regulations implementing paragraph (3) that shall take effect no later than January 1 of the third calendar year beginning at least 1 month after the date of enactment of this Act.

SEC. 5156. MEDICARE REIMBURSEMENT FOR TELEHEALTH SERVICES.

(a) IN GENERAL.—Not later than July 1, 1998, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall make payments from the Federal Supplementary Medical Insurance Trust Fund under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) in accordance with the methodology described in subsection (b) for professional consultation via telecommunications systems with a health care provider furnishing a service for which payment may be made under such part to a beneficiary under the medicare program residing in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) that is designated as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)), notwithstanding that the individual health care provider providing the professional consultation is not at the same location as the health care provider furnishing the service to that beneficiary.

(b) METHODOLOGY FOR DETERMINING AMOUNT OF PAYMENTS.—Taking into account the findings of the report required under section 192 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 1988), the findings of the report required under paragraph (c), and any other findings related to the clinical efficacy and cost-effectiveness of telehealth applications, the Secretary shall establish a methodology for determining the amount of payments made under subsection (a) within the following parameters:

(1) The payment shall include a bundled payment to be shared between the referring health care provider and the consulting health care provider. The amount of such bundled payment shall not be greater than the current fee schedule of the consulting health care provider for the health care services provided.

(2) The payment shall not include any reimbursement for any line charges or any facility fees.

(c) SUPPLEMENTAL REPORT.—Not later than January 1, 1998, the Secretary shall submit a report to Congress which shall contain a detailed analysis of—

(1) how telemedicine and telehealth systems are expanding access to health care services;

(2) the clinical efficacy and cost-effectiveness of telemedicine and telehealth applications;

(3) the quality of telemedicine and telehealth services delivered; and

(4) the reasonable cost of telecommunications charges incurred in practicing telemedicine and telehealth in rural, frontier, and underserved areas.

(d) EXPANSION OF TELEHEALTH SERVICES FOR CERTAIN MEDICARE BENEFICIARIES.—

(1) IN GENERAL.—Not later than January 1, 1999, the Secretary shall submit a report to Congress that examines the possibility of making payments from the Federal Supplementary Medical Insurance Trust Fund under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) for professional consultation via telecommunications systems with a health care provider furnishing a service for which payment may be made under such part to a beneficiary described in paragraph (2), notwithstanding that the individual health care provider providing the professional consultation is not at the same location as the health care provider furnishing the service to that beneficiary.

(2) BENEFICIARY DESCRIBED.—A beneficiary described in this paragraph is a beneficiary under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) who does not reside in a rural area (as so defined) that is designated as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)), who is homebound or nursing homebound, and for whom being transferred for health care services imposes a serious hardship.

(3) REPORT.—The report described in paragraph (1) shall contain a detailed statement of the potential costs to the medicare program of making the payments described in that paragraph using various reimbursement schemes.

SEC. 5157. TELEMEDICINE, INFORMATICS, AND EDUCATION DEMONSTRATION PROJECT.

(a) PURPOSE AND AUTHORIZATION.—

(1) IN GENERAL.—Not later than 9 months after the date of enactment of this section, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct a demonstration project described in paragraph (2).

(2) DESCRIPTION OF PROJECT.—The demonstration project described in this paragraph is a single demonstration project to study the use of eligible health care provider telemedicine networks to implement high-capacity computing and advanced networks to improve primary care (and prevent health care complications), improve access to specialty care, and provide educational and training support to rural practitioners.

(3) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of titles XI, XVIII, and XIX of the Social Security Act (42 U.S.C. 1301 et seq., 1395 et seq., 1396 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct the demonstration project.

(4) DURATION OF PROJECT.—The project shall be conducted for a 5-year period.

(b) OBJECTIVES OF PROJECT.—The objectives of the demonstration project conducted under this section shall include the following:

(1) The improvement of patient access to primary and specialty care and the reduction of inappropriate hospital visits in

order to improve patient quality-of-life and reduce overall health care costs.

(2) The development of a curriculum to train and development of standards for required credentials and licensure of health professionals (particularly primary care health professionals) in the use of medical informatics and telecommunications.

(3) The demonstration of the application of advanced technologies such as video-conferencing from a patient's home and remote monitoring of a patient's medical condition.

(4) The development of standards in the application of telemedicine and medical informatics.

(5) The development of a model for cost-effective delivery of primary and related care in both a managed care environment and in a fee-for-service environment.

(c) ELIGIBLE HEALTH CARE PROVIDER TELEMEDICINE NETWORK DEFINED.—In this section, the term "eligible health care provider telemedicine network" means a consortium that—

(1) includes—

(A) at least 1 tertiary care hospital with an existing telemedicine network with an existing relationship with a medical school; and

(B) not more than 6 facilities, including at least 3 rural referral centers, in rural areas; and

(2) meets the following requirements:

(A) The consortium is located in a region that is predominantly rural.

(B) The consortium submits to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the use the consortium would make of any amounts received under the demonstration project and the source and amount of non-Federal funds used in the project.

(C) The consortium guarantees that it will be responsible for payment for all costs of the project that are not paid under this section and that the maximum amount of payment that may be made to the consortium under this section shall not exceed the amount specified in subsection (d)(3).

(d) COVERAGE AS MEDICARE PART B SERVICES.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, services for medicare beneficiaries furnished under the demonstration project shall be considered to be services covered under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j).

(2) PAYMENTS.—

(A) IN GENERAL.—Subject to paragraph (3), payment for services provided under this section shall be made at a rate of 50 percent of the costs that are reasonable and related to the provision of such services. In computing such costs, the Secretary shall include costs described in subparagraph (B), but may not include costs described in subparagraph (C).

(B) COSTS THAT MAY BE INCLUDED.—The costs described in this subparagraph are the permissible costs (as recognized by the Secretary) for the following:

(i) The acquisition of telemedicine equipment for use in patients' homes (but only in the case of patients located in medically underserved areas).

(ii) Curriculum development and training of health professionals in medical informatics and telemedicine.

(iii) Payment of telecommunications costs including salaries, maintenance of equipment, and costs of telecommunications between patients' homes and the eligible network and between the network and other entities under the arrangements described in subsection (c).

(iv) Payments to practitioners and providers under the medicare programs.

(C) OTHER COSTS.—The costs described in this subparagraph include the following:

(i) The purchase or installation of transmission equipment (other than such equipment used by health professionals to deliver medical informatics services under the project).

(ii) The establishment or operation of a telecommunications common carrier network.

(iii) Construction that is limited to minor renovations related to the installation of equipment.

(3) LIMITATION AND FUNDS.—The Secretary shall make the payments under the demonstration project conducted under this section from the Federal Supplementary Medical Insurance Trust Fund, established under section 1841 of the Social Security Act (42 U.S.C. 1395t), except that the total amount of the payments that may be made by the Secretary under this section shall not exceed $27,000,000.

Subtitle D—Anti-Fraud and Abuse Provisions and Improvements in Protecting Program Integrity

CHAPTER 1—REVISIONS TO SANCTIONS FOR FRAUD AND ABUSE

SEC. 5201. AUTHORITY TO REFUSE TO ENTER INTO MEDICARE AGREEMENTS WITH INDIVIDUALS OR ENTITIES CONVICTED OF FELONIES.

(a) MEDICARE PART A.—Section 1866(b)(2) (42 U.S.C. 1395cc(b)(2)) is amended—

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

(2) in subparagraph (C), by striking the period at the end and inserting ", or"; and

(3) by adding at the end the following:

"(D) has ascertained that the provider has been convicted of a felony under Federal or State law for an offense

that the Secretary determines is inconsistent with the best interests of program beneficiaries.".

(b) MEDICARE PART B.—Section 1842 (42 U.S.C. 1395u) is amended by adding at the end the following:

"(s) The Secretary may refuse to enter into an agreement with a physician or supplier under subsection (h), or may terminate or refuse to renew such agreement, in the event that such physician or supplier has been convicted of a felony under Federal or State law for an offense which the Secretary determines is inconsistent with the best interests of program beneficiaries.".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and apply to the entry and renewal of contracts on or after such date.

SEC. 5202. EXCLUSION OF ENTITY CONTROLLED BY FAMILY MEMBER OF A SANCTIONED INDIVIDUAL.

(a) IN GENERAL.—Section 1128 (42 U.S.C. 1320a–7) is amended—

(1) in subsection (b)(8)(A)—

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

(B) in clause (ii), by striking the dash at the end and inserting "; or"; and

(C) by inserting after clause (ii) the following:

"(iii) who was described in clause (i) but is no longer so described because of a transfer of ownership or control interest, in anticipation of (or following) a conviction, assessment, or exclusion described in subparagraph (B) against the person, to an immediate family member (as defined in subsection (j)(1)) or a member of the household of the person (as defined in subsection (j)(2)) who continues to maintain an interest described in such clause—"; and

(2) by adding at the end the following:

"(j) DEFINITION OF IMMEDIATE FAMILY MEMBER AND MEMBER OF HOUSEHOLD.—For purposes of subsection (b)(8)(A)(iii):

"(1) The term 'immediate family member' means, with respect to a person—

"(A) the husband or wife of the person;

"(B) the natural or adoptive parent, child, or sibling of the person;

"(C) the stepparent, stepchild, stepbrother, or stepsister of the person;

"(D) the father-, mother-, daughter-, son-, brother-, or sister-in-law of the person;

"(E) the grandparent or grandchild of the person; and

"(F) the spouse of a grandparent or grandchild of the person.

"(2) The term 'member of the household' means, with respect to any person, any individual sharing a common abode as part of a single family unit with the person, including domestic employees and others who live together as a family unit, but not including a roomer or boarder.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date that is 45 days after the date of the enactment of this Act.

SEC. 5203. IMPOSITION OF CIVIL MONEY PENALTIES.

(a) CIVIL MONEY PENALTIES FOR PERSONS THAT CONTRACT WITH EXCLUDED INDIVIDUALS.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(1) in paragraph (4), by striking "or" at the end;

(2) in paragraph (5), by adding "or" at the end; and

(3) by inserting after paragraph (5) the following:

"(6) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in section 1128B(f)), for the provision of items or services for which payment may be made under such a program;".

(b) CIVIL MONEY PENALTIES FOR SERVICES ORDERED OR PRESCRIBED BY AN EXCLUDED INDIVIDUAL OR ENTITY.—Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1)) is amended—

(1) in subparagraph (D)—

(A) by inserting ", ordered, or prescribed by such person" after "other item or service furnished";

(B) by inserting "(pursuant to this title or title XVIII)" after "period in which the person was excluded";

(C) by striking "pursuant to a determination by the Secretary" and all that follows through "the provisions of section 1842(j)(2)"; and

(D) by striking "or" at the end;

(2) by redesignating subparagraph (E) as subparagraph (F); and

(3) by inserting after subparagraph (D) the following:

"(E) is for a medical or other item or service ordered or prescribed by a person excluded pursuant to this title or title XVIII from the program under which the claim was made, and the person furnishing such item or service knows or should know of such exclusion, or".

(c) CIVIL MONEY PENALTIES FOR KICKBACKS.—

(1) PERMITTING SECRETARY TO IMPOSE CIVIL MONEY PENALTY.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by subsection (a), is amended—

(A) in paragraph (5), by striking "or" at the end;

(B) in paragraph (6), by adding "or" at the end; and

(C) by adding after paragraph (6) the following:

"(7) commits an act described in paragraph (1) or (2) of section 1128B(b);".

(2) DESCRIPTION OF CIVIL MONEY PENALTY APPLICABLE.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by paragraph (1), is amended in the matter following paragraph (7)—

(A) by striking "occurs)." and inserting "occurs; or in cases under paragraph (7), $50,000 for each such act).";

and

(B) by inserting after "of such claim" the following: "(or, in cases under paragraph (7), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose)".

(d) EFFECTIVE DATES.—

(1) CONTRACTS WITH EXCLUDED PERSONS.—The amendments made by subsection (a) shall apply to arrangements and contracts entered into after the date of the enactment of this Act.

(2) SERVICES ORDERED OR PRESCRIBED.—The amendments made by subsection (b) shall apply to items and services furnished, ordered, or prescribed after the date of the enactment of this Act.

(3) KICKBACKS.—The amendments made by subsection (c) shall apply to acts taken after the date of the enactment of this Act.

CHAPTER 2—IMPROVEMENTS IN PROTECTING PROGRAM INTEGRITY

SEC. 5211. DISCLOSURE OF INFORMATION, SURETY BONDS, AND ACCREDITATION.

(a) DISCLOSURE OF INFORMATION, SURETY BOND, AND ACCREDITATION REQUIREMENT FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by inserting after paragraph (15) the following:

"(16) DISCLOSURE OF INFORMATION, SURETY BOND, AND ACCREDITATION.—The Secretary shall not provide for the issuance (or renewal) of a provider number for a supplier of durable medical equipment, for purposes of payment under this part for durable medical equipment furnished by the supplier, unless the supplier provides the Secretary on a continuing basis—

"(A) with—

"(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1124(a)(3)) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest; and

"(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1124(a)(2)) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity;

"(B) with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000; and

"(C) at the discretion of the Secretary, with evidence of compliance with the applicable conditions or requirements of this title through an accreditation survey conducted by a national accreditation body under section 1865(b).

The Secretary may waive the requirement of a bond under subparagraph (B) in the case of a supplier that provides a comparable surety bond under State law.".

(b) SURETY BOND REQUIREMENT FOR HOME HEALTH AGENCIES.—

(1) IN GENERAL.—Section 1861(o) (42 U.S.C. 1395x(o)) is amended—

(A) in paragraph (7), by inserting "and including providing the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000" after "financial security of the program"; and

(B) by adding at the end the following: "The Secretary may waive the requirement of a surety bond under paragraph (7) in the case of an agency or organization that provides a comparable surety bond under State law."

(2) CONFORMING AMENDMENTS.—Section 1861(v)(1)(H) (42 U.S.C. 1395x(v)(1)(H)) is amended—

(A) in clause (i), by striking "the financial security requirement" and inserting "the financial security and surety bond requirements"; and

(B) in clause (ii), by striking "the financial security requirement described in subsection (o)(7) applies" and inserting "the financial security and surety bond requirements described in subsection (o)(7) apply".

(3) REFERENCE TO CURRENT DISCLOSURE REQUIREMENT.—For additional provisions requiring home health agencies to disclose information on ownership and control interests, see section 1124 of the Social Security Act (42 U.S.C. 1320a–3).

(c) AUTHORIZING APPLICATION OF DISCLOSURE AND SURETY BOND REQUIREMENTS TO AMBULANCE SERVICES AND CERTAIN CLINICS.—Section 1834(a)(16) (42 U.S.C. 1395m(a)(16)), as added by subsection (a), is amended by adding at the end the following flush sentence:

The Secretary, in the Secretary's discretion, may impose the requirements of the previous sentence with respect to some or all classes of suppliers of ambulance services described in section 1861(s)(7) and clinics that furnish medical and other health services (other than physicians' services) under this part.".

(d) APPLICATION TO COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORFS).—Section 1861(cc)(2) (42 U.S.C. 1395x(cc)(2)) is amended—

(1) in subparagraph (I), by inserting before the period at the end the following: "and providing the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000"; and

(2) by adding at the end the following flush sentence:

"The Secretary may waive the requirement of a bond under subparagraph (I) in the case of a facility that provides a comparable surety bond under State law.".

(e) APPLICATION TO REHABILITATION AGENCIES.—Section 1861(p) (42 U.S.C. 1395x(p)) is amended—

(1) in paragraph (4)(A)(v), by inserting after "as the Secretary may find necessary," the following: "and provides the Secretary, to the extent required by the Secretary, on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000,", and

(2) by adding at the end the following: "The Secretary may waive the requirement of a bond under paragraph (4)(A)(v) in the case of a clinic or agency that provides a comparable surety bond under State law.".

(f) EFFECTIVE DATES.—

(1) SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.—The amendment made by subsection (a) shall apply to suppliers of durable medical equipment with respect to such equipment furnished on or after January 1, 1998.

(2) HOME HEALTH AGENCIES.—The amendments made by subsection (b) shall apply to home health agencies with respect to services furnished on or after January 1, 1998. The Secretary of Health and Human Services shall modify participation agreements under section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) with respect to home health agencies to provide for implementation of such amendments on a timely basis.

(3) OTHER AMENDMENTS.—The amendments made by subsections (c) through (e) shall take effect on the date of the enactment of this Act and may be applied with respect to items and services furnished on or after the date specified in paragraph (1).

SEC. 5212. PROVISION OF CERTAIN IDENTIFICATION NUMBERS.

(a) REQUIREMENTS TO DISCLOSE EMPLOYER IDENTIFICATION NUMBERS (EINS) AND SOCIAL SECURITY ACCOUNT NUMBERS (SSNS).—Section 1124(a)(1) (42 U.S.C. 1320a–3(a)(1)) is amended by inserting before the period at the end the following: "and supply the Secretary with the both the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing entity, each person with an ownership or control interest (as defined in subsection (a)(3)), and any subcontractor in which the entity directly or indirectly has a 5 percent or more ownership interest".

(b) OTHER MEDICARE PROVIDERS.—Section 1124A (42 U.S.C. 1320a–3a) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking "and" at the end;

(B) in paragraph (2), by striking the period at the end and inserting "; and"; and

(C) by adding at the end the following:

"(3) including the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing part B provider and any person, managing employee, or other entity identified or described under paragraph (1) or (2).."; and

(2) in subsection (c)(1), by inserting "(or, for purposes of subsection (a)(3), any entity receiving payment)" after "on an assignment-related basis".

(c) VERIFICATION BY SOCIAL SECURITY ADMINISTRATION (SSA).—Section 1124A (42 U.S.C. 1320a–3a), as amended by subsection (b), is amended—

(1) by redesignating subsection (c) as subsection (d); and

(2) by inserting after subsection (b) the following:

"(c) VERIFICATION.—

"(1) TRANSMITTAL BY HHS.—The Secretary shall transmit—

"(A) to the Commissioner of Social Security information concerning each social security account number (assigned under section 205(c)(2)(B)), and

"(B) to the Secretary of the Treasury information concerning each employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986),

supplied to the Secretary pursuant to subsection (a)(3) or section 1124(c) to the extent necessary for verification of such information in accordance with paragraph (2).

"(2) VERIFICATION.—The Commissioner of Social Security and the Secretary of the Treasury shall verify the accuracy of, or correct, the information supplied by the Secretary to such official pursuant to paragraph (1), and shall report such verifications or corrections to the Secretary.

"(3) FEES FOR VERIFICATION.—The Secretary shall reimburse the Commissioner and Secretary of the Treasury, at a rate negotiated between the Secretary and such official, for the costs incurred by such official in performing the verification and correction services described in this subsection.".

(d) REPORT.—The Secretary of Health and Human Services shall submit to Congress a report on steps the Secretary has taken to assure the confidentiality of social security account numbers that will be provided to the Secretary under the amendments made by this section.

(e) EFFECTIVE DATES.—

(1) DISCLOSURE REQUIREMENTS.—The amendment made by subsection (a) shall apply to the application of conditions of participation, and entering into and renewal of contracts and agreements, occurring more than 90 days after the date of submission of the report under subsection (d).

(2) OTHER PROVIDERS.—The amendments made by subsection (b) shall apply to payment for items and services furnished more than 90 days after the date of submission of such report.

SEC. 5213. APPLICATION OF CERTAIN PROVISIONS OF THE BANKRUPTCY CODE.

(a) RESTRICTED APPLICABILITY OF BANKRUPTCY STAY, DISCHARGE, AND PREFERENTIAL TRANSFER PROVISIONS TO MEDICARE AND MEDICAID DEBTS.—Part A of title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1143 the following:

"APPLICATION OF CERTAIN PROVISIONS OF THE BANKRUPTCY CODE

"SEC. 1144. (a) MEDICARE AND MEDICAID-RELATED ACTIONS NOT STAYED BY BANKRUPTCY PROCEEDINGS.—The commencement or continuation of any action against a debtor under this title or title XVIII or XIX (other than an action with respect to health care services for the debtor under title XVIII), including any action or proceeding to exclude or suspend the debtor from program participation, assess civil money penalties, recoup or set off overpay-

ments, or deny or suspend payment of claims shall not be subject to the provisions of section 362(a) of title 11, United States Code.

"(b) CERTAIN MEDICARE- AND MEDICAID-RELATED DEBT NOT DISCHARGEABLE IN BANKRUPTCY.—A debt owed to the United States or to a State for an overpayment under title XVIII or XIX (other than an overpayment for health care services for the debtor under title XVIII) resulting from the fraudulent actions of the debtor, or for a penalty, fine, or assessment under this title or title XVIII or XIX, shall not be dischargeable under any provision of title 11, United States Code.

"(c) REPAYMENT OF CERTAIN DEBTS CONSIDERED FINAL.—Payments made to repay a debt to the United States or to a State with respect to items or services provided, or claims for payment made, under title XVIII or XIX (including repayment of an overpayment (other than an overpayment for health care services for the debtor under title XVIII) resulting from the fraudulent actions of the debtor), or to pay a penalty, fine, or assessment under this title or title XVIII or XIX, shall be considered final and not preferential transfers under section 547 of title 11, United States Code.".

(b) MEDICARE RULES APPLICABLE TO BANKRUPTCY PROCEEDINGS.—Title XVIII (42 U.S.C. 1395 et seq.) is amended by adding at the end the following:

"APPLICATION OF PROVISIONS OF THE BANKRUPTCY CODE

"SEC. 1894. (a) USE OF MEDICARE STANDARDS AND PROCEDURES.—Notwithstanding any provision of title 11, United States Code, or any other provision of law, in the case of claims by a debtor in bankruptcy for payment under this title, the determination of whether the claim is allowable and of the amount payable, shall be made in accordance with the provisions of this title and title XI and implementing regulations.

"(b) NOTICE TO CREDITOR OF BANKRUPTCY PETITIONER.—In the case of a debt owed to the United States with respect to items or services provided, or claims for payment made, under this title (including a debt arising from an overpayment or a penalty, fine, or assessment under title XI or this title), the notices to the creditor of bankruptcy petitions, proceedings, and relief required under title 11, United States Code (including under section 342 of that title and section 2002(j) of the Federal Rules of Bankruptcy Procedure), shall be given to the Secretary. Provision of such notice to a fiscal agent of the Secretary shall not be considered to satisfy this requirement.

"(c) TURNOVER OF PROPERTY TO THE BANKRUPTCY ESTATE.—For purposes of section 542(b) of title 11, United States Code, a claim for payment under this title shall not be considered to be a matured debt payable to the estate of a debtor until such claim has been allowed by the Secretary in accordance with procedures under this title.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to bankruptcy petitions filed after the date of the enactment of this Act.

SEC. 5214. REPLACEMENT OF REASONABLE CHARGE METHODOLOGY BY FEE SCHEDULES.

(a) IN GENERAL.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended in the matter preceding subparagraph (A) by striking "the reasonable charges for the services" and inserting "the lesser of the actual charges for the services and the amounts determined by the applicable fee schedules developed by the Secretary for the particular services".

(b) CONFORMING AMENDMENTS.—

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

(A) in subparagraph (A), by striking "reasonable charges for" and inserting "payment bases otherwise applicable to";

(B) in subparagraph (B), by striking "reasonable charges" and inserting "fee schedule amounts"; and

(C) by inserting after subparagraph (F) the following: "(G) with respect to services described in clause (i) or (ii) of section 1861(s)(2)(K) (relating to physician assistants and nurse practitioners), the amounts paid shall be 80 percent of the lesser of the actual charge for the services and the applicable amount determined under subclause (I) or (II) of section 1842(b)(12)(A)(ii),".

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

(A) in subparagraph (B), in the matter preceding clause (i), by striking "(C), (D)," and inserting "(D)"; and

(B) by striking subparagraph (C).

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

(A) in paragraph (3)—

(i) by striking subparagraph (B); and

(ii) by striking "(3)(A)" and inserting "(3)"; and

(B) by striking paragraph (6).

(4) Section 1834(a)(10)(B) (42 U.S.C. 1395m(a)(10)(B)) is amended by striking "paragraphs (8) and (9)" and all that follows through "section 1848(i)(3)." and inserting "section 1842(b)(8) to covered items and suppliers of such items and payments under this subsection as such provisions would otherwise apply to physicians' services and physicians.".

(5) Section 1834(g)(1)(A)(ii) (42 U.S.C. 1395m(g)(1)(A)(ii)) is amended in the heading by striking "REASONABLE CHARGES FOR PROFESSIONAL" and inserting "PROFESSIONAL".

(6) Section 1842(a) (42 U.S.C. 1395u(a)) is amended—

(A) in the matter preceding paragraph (1), by striking "reasonable charge" and inserting "fee schedule"; and

(B) in paragraph (1)(A), by striking "reasonable charge" and inserting "other".

(7) Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(A) in subparagraph (B)—

(i) in the matter preceding clause (i), by striking "where payment" and all that follows through "made—" and inserting "where payment under this part for a service is on a basis other than a cost basis, such payment will (except as otherwise provided in section 1870(f)) be made—"; and

(ii) by striking clause (ii)(I) and inserting the following: "(I) the amount determined by the applicable payment basis under this part is the full charge for the service,"; and

(B) by striking the second, third, fourth, fifth, sixth, eighth, and ninth sentences.

(8) Section 1842(b)(4) (42 U.S.C. 1395u(b)(4)) is amended to read as follows:

"(4) In the case of an enteral or parenteral pump that is furnished on a rental basis during a period of medical need—

"(A) monthly rental payments shall not be made under this part for more than 15 months during that period, and

"(B) after monthly rental payments have been made for 15 months during that period, payment under this part shall be made for maintenance and servicing of the pump in amounts that the Secretary determines to be reasonable and necessary to ensure the proper operation of the pump.".

(9) Section 6112(b) (42 U.S.C. 1395m note; Public Law 101-239) of OBRA—1989 is repealed.

(10) Section 1842(b)(7) (42 U.S.C. 1395u(b)(7)) is amended—

(A) in subparagraph (D)(i), in the matter preceding subclause (I), by striking ", to the extent that such payment is otherwise allowed under this paragraph,";

(B) in subparagraph (D)(ii), by striking "subparagraph" and inserting "paragraph";

(C) by striking "(7)(A) In the case of" and all that follows through subparagraph (C);

(D) by striking "(D)(i)" and inserting "(7)(A)";

(E) by redesignating clauses (ii) and (iii) as subparagraphs (B) and (C), respectively; and

(F) by redesignating subclauses (I), (II), and (III) of subparagraph (A) (as redesignated by subparagraph (D) of this paragraph) as clauses (i), (ii), and (iii), respectively.

(11) Section 1842(b)(9) (42 U.S.C. 1395u(b)(9)) is repealed.

(12) Section 1842(b)(10) (42 U.S.C. 1395u(b)(10)) is repealed.

(13) Section 1842(b)(11) (42 U.S.C. 1395u(b)(11)) is amended—

(A) by striking subparagraphs (B) through (D);

(B) by striking "(11)(A)" and inserting "(11)"; and

(C) by redesignating clauses (i) and (ii) as subparagraphs (A) and (B), respectively.

(14) Section 1842(b)(12)(A)(ii) (42 U.S.C. 1395u(b)(12)(A)(ii)) is amended—

(A) in the matter preceding subclause (I), by striking "prevailing charges determined under paragraph (3)" and inserting "the amounts determined under section 1833(a)(1)(G)"; and

(B) in subclause (II), by striking "prevailing charge rate" and all that follows up to the period and inserting "fee schedule amount specified in section 1848 for such services performed by physicians".

(15) Paragraphs (14) through (17) of section 1842(b) (42 U.S.C. 1395u(b)) are repealed.

(16) Section 1842(b) (42 U.S.C. 1395u(b)) is amended—

(A) in paragraph (18)(A), by striking "reasonable charge or"; and

(B) by redesignating paragraph (18) as paragraph (14).

(17) Section 1842(j)(1) (42 U.S.C. 1395u(j)) is amended to read as follows:

"(j)(1) See subsections (k), (l), (m), (n), and (p) as to the cases in which sanctions may be applied under paragraph (2).".

(18) Section 1842(j)(4) (42 U.S.C. 1395u(j)(4)) is amended by striking "under paragraph (1)".

(19) Section 1842(n)(1)(A) (42 U.S.C. 1395u(n)(1)(A)) is amended by striking "reasonable charge (or other applicable limit)" and inserting "other applicable limit".

(20) Section 1842(q) (42 U.S.C. 1395u(q)) is amended—

(A) by striking paragraph (1)(B); and

(B) by striking "(q)(1)(A)" and inserting "(q)(1)".

(21) Section 1845(b)(1) (42 U.S.C. 1395w–1(b)(1)) is amended by striking "adjustments to the reasonable charge levels for physicians' services recognized under section 1842(b) and".

(22) Section 1848(i)(3) (42 U.S.C. 1395w–4(i)(3)) is repealed.

(23) Section 1866(a)(2)(A)(ii) (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by striking "reasonable charges" and all that follows through "provider)" and inserting "amount customarily charged for the items and services by the provider".

(24) Section 1881(b)(3)(A) (42 U.S.C. 1395rr(b)(3)(A)) is amended by striking "a reasonable charge" and all that follows through "section 1848)" and inserting "the basis described in section 1848".

(25) Section 9340 of OBRA—1986 (42 U.S.C. 1395u note; Public Law 99-509) is repealed.

(c) EFFECTIVE DATES.—The amendments made by this section to the extent such amendments substitute fee schedules for reasonable charges, shall apply to particular services as of the date specified by the Secretary of Health and Human Services.

(d) INITIAL BUDGET NEUTRALITY.—The Secretary, in developing a fee schedule for particular services (under the amendments made by this section), shall set amounts for the first year period to which the fee schedule applies at a level so that the total payments under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for those services for that year period shall be approximately equal to the estimated total payments if those amendments had not been made.

SEC. 5215. APPLICATION OF INHERENT REASONABLENESS TO ALL PART B SERVICES OTHER THAN PHYSICIANS' SERVICES.

(a) IN GENERAL.—Section 1842(b)(8) (42 U.S.C. 1395u(b)(8)) is amended to read as follows:

"(8) The Secretary shall describe by regulation the factors to be used in determining the cases (of particular items or services) in which the application of this part (other than to physicians' services paid under section 1848) results in the determination of an amount that, because of its being grossly excessive or grossly defi-

cient, is not inherently reasonable, and provide in those cases for the factors to be considered in establishing an amount that is realistic and equitable.".

(b) CONFORMING AMENDMENT.—Section 1834(a)(10) (42 U.S.C. 1395m(a)(10)(B)) is amended—

(1) by striking subparagraph (B); and

(2) by redesignating subparagraph (C) as subparagraph (B).

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

SEC. 5216. REQUIREMENT TO FURNISH DIAGNOSTIC INFORMATION.

(a) INCLUSION OF NON-PHYSICIAN PRACTITIONERS IN REQUIREMENT TO PROVIDE DIAGNOSTIC CODES FOR PHYSICIAN SERVICES.—Paragraphs (1) and (2) of section 1842(p) (42 U.S.C. 1395u(p)) are each amended by inserting "or practitioner specified in subsection (b)(18)(C)" after " by a physician".

(b) REQUIREMENT TO PROVIDE DIAGNOSTIC INFORMATION WHEN ORDERING CERTAIN ITEMS OR SERVICES FURNISHED BY ANOTHER ENTITY.—Section 1842(p) (42 U.S.C. 1395u(p)), is amended by adding at the end the following:

"(4) In the case of an item or service defined in paragraph (3), (6), (8), or (9) of subsection 1861(s) ordered by a physician or a practitioner specified in subsection (b)(18)(C), but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 5217. REPORT BY GAO ON OPERATION OF FRAUD AND ABUSE CONTROL PROGRAM.

Section 1817(k)(6) (42 U.S.C. 1395i(k)(6)) is amended by inserting "June 1, 1998, and" after "Not later than".

SEC. 5218. COMPETITIVE BIDDING.

(a) GENERAL RULE.—Part B of title XVIII (42 U.S.C. 1395j et seq.) is amended by inserting after section 1846 the following:

"SEC. 1847. COMPETITIVE ACQUISITION OF ITEMS AND SERVICES.

"(a) ESTABLISHMENT OF BIDDING AREAS.—

"(1) IN GENERAL.—The Secretary shall establish competitive acquisition areas for contract award purposes for the furnishing under this part after 1997 of the items and services described in subsection (c). The Secretary may establish different competitive acquisition areas under this subsection for different classes of items and services.

"(2) CRITERIA FOR ESTABLISHMENT.—The competitive acquisition areas established under paragraph (1) shall be chosen based on the availability and accessibility of entities able to furnish items and services, and the probable savings to be realized by the use of competitive bidding in the furnishing of items and services in the area.

"(b) AWARDING OF CONTRACTS IN AREAS.—

"(1) IN GENERAL.—The Secretary shall conduct a competition among individuals and entities supplying items and services described in subsection (c) for each competitive acquisition area established under subsection (a) for each class of items and services.

"(2) CONDITIONS FOR AWARDING CONTRACT.—The Secretary may not award a contract to any entity under the competition conducted pursuant to paragraph (1) to furnish an item or service unless the Secretary finds that the entity meets quality standards specified by the Secretary, and subject to paragraph (3), that the total amounts to be paid under the contract are expected to be less than the total amounts that would otherwise be paid.

"(3) LIMIT ON AMOUNT OF PAYMENT.—The Secretary may not under a contract awarded under this section provide for payment for an item or service in an amount in excess of the applicable fee schedule under this part for similar or related items or services. The preceding sentence shall not apply if the Secretary determines that an amount in excess of such amount is warranted by reason of technological innovation, quality improvement, or similar reasons, except that the total amount paid under the contract shall not exceed the limit under paragraph (2).

"(4) CONTENTS OF CONTRACT.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

"(5) LIMIT ON NUMBER OF CONTRACTORS.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts.

"(c) SERVICES DESCRIBED.—The items and services to which this section applies are all items and services covered under this part (except for physician services as defined by 1861(r)) that the Secretary may specify.".

(b) ITEMS AND SERVICES TO BE FURNISHED ONLY THROUGH COMPETITIVE ACQUISITION.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) by striking "or" at the end of paragraph (14),

(2) by striking the period at the end of paragraph (15) and inserting "; or", and

(3) by inserting after paragraph (15) the following:

"(16) where the expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1847(a)) by an entity other than an entity with which the Secretary has entered into a contract under section 1847(b) for the furnishing of such an item or service in that area, unless the Secretary finds that the expenses were incurred in a case of urgent need, or in other circumstances specified by the Secretary.".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) apply to items and services furnished after December 31, 1997.

CHAPTER 3—CLARIFICATIONS AND TECHNICAL CHANGES

SEC. 5221. OTHER FRAUD AND ABUSE RELATED PROVISIONS.

(a) REFERENCE CORRECTION.—(1) Section 1128D(b)(2)(D) (42 U.S.C. 1320a–7d(b)(2)(D)), as added by section 205 of the Health Insurance Portability and Accountability Act of 1996, is amended by striking "1128B(b)" and inserting "1128A(b)".

(2) Section 1128E(g)(3)(C) (42 U.S.C. 1320a–7e(g)(3)(C)) is amended by striking "Veterans' Administration" and inserting "Department of Veterans Affairs".

(b) LANGUAGE IN DEFINITION OF CONVICTION.—Section 1128E(g)(5) (42 U.S.C. 1320a–7e(g)(5)), as inserted by section 221(a) of the Health Insurance Portability and Accountability Act of 1996, is amended by striking "paragraph (4)" and inserting "paragraphs (1) through (4)".

(c) IMPLEMENTATION OF EXCLUSIONS.—Section 1128 (42 U.S.C. 1320a–7) is amended—

(1) in subsection (a), by striking "any program under title XVIII and shall direct that the following individuals and entities be excluded from participation in any State health care program (as defined in subsection (h))" and inserting "any Federal health care program (as defined in section 1128B(f))"; and

(2) in subsection (b), by striking "any program under title XVIII and may direct that the following individuals and entities be excluded from participation in any State health care program" and inserting "any Federal health care program (as defined in section 1128B(f))".

(d) SANCTIONS FOR FAILURE TO REPORT.—Section 1128E(b) (42 U.S.C. 1320a–7e(b)), as inserted by section 221(a) of the Health Insurance Portability and Accountability Act of 1996, is amended by adding at the end the following:

"(6) SANCTIONS FOR FAILURE TO REPORT.—

"(A) HEALTH PLANS.—Any health plan that fails to report information on an adverse action required to be reported under this subsection shall be subject to a civil money penalty of not more than $25,000 for each such adverse action not reported. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

"(B) GOVERNMENTAL AGENCIES.—The Secretary shall provide for a publication of a public report that identifies those Government agencies that have failed to report information on adverse actions as required to be reported under this subsection.".

(e) CLARIFICATION OF TREATMENT OF CERTAIN WAIVERS AND PAYMENTS OF PREMIUMS.—

(1) Section 1128A(i)(6) (42 U.S.C. 1320a–7a(i)(6)) is amended—

(A) in subparagraph (A)(iii)—

(i) in subclause (I), by adding "or" at the end;

(ii) in subclause (II), by striking "or" at the end; and

(iii) by striking subclause (III);

(B) by redesignating subparagraphs (B) and (C) as subparagraphs (C) and (D); and

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

"(B) any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;".

(2) Section 1128A(i)(6) (42 U.S.C. 1320a–7a(i)(6)), is amended—

(A) in subparagraph (C), as redesignated by paragraph (1), by striking "or" at the end;

(B) in subparagraph (D), as so redesignated, by striking the period at the end and inserting "; or"; and

(C) by adding at the end the following:

"(D) the waiver of deductible and coinsurance amounts pursuant to medicare supplemental policies under section 1882(t).".

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in this subsection, the amendments made by this section shall be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996.

(2) FEDERAL HEALTH PROGRAM.—The amendments made by subsection (c) shall take effect on the date of the enactment of this Act.

(3) SANCTION FOR FAILURE TO REPORT.—The amendment made by subsection (d) shall apply to failures occurring on or after the date of the enactment of this Act.

(4) CLARIFICATION.—The amendments made by subsection (e)(2) shall take effect on the date of the enactment of this Act.

Subtitle E—Prospective Payment Systems

CHAPTER 1—PROVISIONS RELATING TO PART A

SEC. 5301. PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION HOSPITAL SERVICES.

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

"(j) PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION SERVICES.—

"(1) PAYMENT DURING TRANSITION PERIOD.—

"(A) IN GENERAL.—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation hospital or a rehabilitation unit (in this subsection referred to as a 'rehabilitation facility'), in a cost reporting period beginning on or after October 1, 2000, and before October 1, 2003, is equal to the sum of—

"(i) the TEFRA percentage (as defined in subparagraph (C)) of the amount that would have been paid under part A of this title with respect to such costs if this subsection did not apply, and

"(ii) the prospective payment percentage (as defined in subparagraph (C)) of the product of (I) the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs, and (II) the number of such payment units occurring in the cost reporting period.

"(B) FULLY IMPLEMENTED SYSTEM.—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation facility for a payment unit in a cost reporting period beginning on or after October 1, 2003, is equal to the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs.

"(C) TEFRA AND PROSPECTIVE PAYMENT PERCENTAGES SPECIFIED.—For purposes of subparagraph (A), for a cost reporting period beginning—

"(i) on or after October 1, 2000, and before October 1, 2001, the 'TEFRA percentage' is 75 percent and the 'prospective payment percentage' is 25 percent;

"(ii) on or after October 1, 2001, and before October 1, 2002, the 'TEFRA percentage' is 50 percent and the 'prospective payment percentage' is 50 percent; and

"(iii) on or after October 1, 2002, and before October 1, 2003, the 'TEFRA percentage' is 25 percent and the 'prospective payment percentage' is 75 percent.

"(D) PAYMENT UNIT.—For purposes of this subsection, the term 'payment unit' means a discharge, day of inpatient hospital services, or other unit of payment defined by the Secretary.

"(2) PATIENT CASE MIX GROUPS.—

"(A) ESTABLISHMENT.—The Secretary shall establish—

"(i) classes of patients of rehabilitation facilities (each in this subsection referred to as a 'case mix group'), based on such factors as the Secretary deems appropriate, which may include impairment, age, related prior hospitalization, comorbidities, and functional capability of the patient; and

"(ii) a method of classifying specific patients in rehabilitation facilities within these groups.

"(B) WEIGHTING FACTORS.—For each case mix group the Secretary shall assign an appropriate weighting which reflects the relative facility resources used with respect to patients classified within that group compared to patients classified within other groups.

"(C) ADJUSTMENTS FOR CASE MIX.—

"(i) IN GENERAL.—The Secretary shall from time to time adjust the classifications and weighting factors established under this paragraph as appropriate to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment is made under this title, and other factors which may af-

fect the relative use of resources. Such adjustments shall be made in a manner so that changes in aggregate payments under the classification system are a result of real changes and are not a result of changes in coding that are unrelated to real changes in case mix.

"(ii) ADJUSTMENT.—Insofar as the Secretary determines that such adjustments for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under the classification system during the fiscal year that are a result of changes in the coding or classification of patients that do not reflect real changes in case mix, the Secretary shall adjust the per payment unit payment rate for subsequent years so as to discount the effect of such coding or classification changes.

"(D) DATA COLLECTION.—The Secretary is authorized to require rehabilitation facilities that provide inpatient hospital services to submit such data as the Secretary deems necessary to establish and administer the prospective payment system under this subsection.

"(3) PAYMENT RATE.—

"(A) IN GENERAL.—The Secretary shall determine a prospective payment rate for each payment unit for which such rehabilitation facility is entitled to receive payment under this title. Subject to subparagraph (B), such rate for payment units occurring during a fiscal year shall be based on the average payment per payment unit under this title for inpatient operating and capital costs of rehabilitation facilities using the most recent data available (as estimated by the Secretary as of the date of establishment of the system) adjusted—

"(i) by updating such per-payment-unit amount to the fiscal year involved by the weighted average of the applicable percentage increases provided under subsection (b)(3)(B)(ii) (for cost reporting periods beginning during the fiscal year) covering the period from the midpoint of the period for such data through the midpoint of fiscal year 2000 and by an increase factor (described in subparagraph (C)) specified by the Secretary for subsequent fiscal years up to the fiscal year involved;

"(ii) by reducing such rates by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on prospective payment amounts which are additional payments described in paragraph (4) (relating to outlier and related payments) or paragraph (7);

"(iii) for variations among rehabilitation facilities by area under paragraph (6);

"(iv) by the weighting factors established under paragraph (2)(B); and

"(v) by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

"(B) BUDGET NEUTRAL RATES.—The Secretary shall establish the prospective payment amounts under this subsection for payment units during fiscal years 2001 through 2004 at levels such that, in the Secretary's estimation, the amount of total payments under this subsection for such fiscal years (including any payment adjustments pursuant to paragraph (7)) shall be equal to 99 percent of the amount of payments that would have been made under this title during the fiscal years for operating and capital costs of rehabilitation facilities had this subsection not been enacted. In establishing such payment amounts, the Secretary shall consider the effects of the prospective payment system established under this subsection on the total number of payment units from rehabilitation facilities and other factors described in subparagraph (A).

"(C) INCREASE FACTOR.—For purposes of this subsection for payment units in each fiscal year (beginning with fiscal year 2001), the Secretary shall establish an increase factor. Such factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under this subsection, which may be the market basket percentage increase described in subsection (b)(3)(B)(iii).

"(4) OUTLIER AND SPECIAL PAYMENTS.—

"(A) OUTLIERS.—

"(i) IN GENERAL.—The Secretary may provide for an additional payment to a rehabilitation facility for patients in a case mix group, based upon the patient being classified as an outlier based on an unusual length of stay, costs, or other factors specified by the Secretary.

"(ii) PAYMENT BASED ON MARGINAL COST OF CARE.—The amount of such additional payment under clause (i) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable under clause (i).

"(iii) TOTAL PAYMENTS.—The total amount of the additional payments made under this subparagraph for payment units in a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on prospective payment rates for payment units in that year.

"(B) ADJUSTMENT.—The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of rehabilitation facilities located in Alaska and Hawaii.

"(5) PUBLICATION.—The Secretary shall provide for publication in the Federal Register, on or before September 1 before each fiscal year (beginning with fiscal year 2001, of the classi-

fication and weighting factors for case mix groups under paragraph (2) for such fiscal year and a description of the methodology and data used in computing the prospective payment rates under this subsection for that fiscal year.

"(6) AREA WAGE ADJUSTMENT.—The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under paragraph (3) for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. Not later than October 1, 2001 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under this paragraph for a fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.

"(7) ADDITIONAL ADJUSTMENTS.—The Secretary may provide by regulation for—

"(A) an additional payment to take into account indirect costs of medical education and the special circumstances of hospitals that serve a significantly disproportionate number of low-income patients in a manner similar to that provided under subparagraphs (B) and (F), respectively, of subsection (d)(5); and

"(B) such other exceptions and adjustments to payment amounts under this subsection in a manner similar to that provided under subsection (d)(5)(I) in relation to payments under subsection (d).

"(8) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the establishment of—

"(A) case mix groups, of the methodology for the classification of patients within such groups, and of the appropriate weighting factors thereof under paragraph (2),

"(B) the prospective payment rates under paragraph (3),

"(C) outlier and special payments under paragraph (4),

"(D) area wage adjustments under paragraph (6), and

"(E) additional adjustments under paragraph (7).".

(b) CONFORMING AMENDMENTS.—Section 1886(b) (42 U.S.C. 1395ww(b)) is amended—

(1) in paragraph (1), by inserting "and other than a rehabilitation facility described in subsection (j)(1)" after "subsection (d)(1)(B)", and

(2) in paragraph (3)(B)(i), by inserting "and subsection (j)" after "For purposes of subsection (d)".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning on or after October

1, 2000, except that the Secretary of Health and Human Services may require the submission of data under section 1886(j)(2)(D) of the Social Security Act (as added by subsection (a)) on and after the date of the enactment of this section.

SEC. 5302. STUDY AND REPORT ON PAYMENTS FOR LONG-TERM CARE HOSPITALS.

(a) STUDY.—The Secretary of Health and Human Services shall—

(1) collect data to develop, establish, administer and evaluate a case-mix adjusted prospective payment system for hospitals described in section 1886(d)(1)(B)(iv) (42 U.S.C. 1395ww(d)(1)(B)(iv)); and

(2) develop a legislative proposal for establishing and administering such a payment system that includes an adequate patient classification system that reflects the differences in patient resource use and costs among such hospitals.

(b) REPORT.—Not later than October 1, 1999, the Secretary of Health and Human Services shall submit the proposal described in subsection (a)(2) to the appropriate committees of Congress.

CHAPTER 2—PROVISIONS RELATING TO PART B

Subchapter A—Payment for Hospital Outpatient Department Services

SEC. 5311. ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS (FDO) FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.

(a) ELIMINATION OF FDO FOR AMBULATORY SURGICAL CENTER PROCEDURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C. 1395l(i)(3)(B)(i)(II)) is amended—

(1) by striking "of 80 percent"; and

(2) by striking the period at the end and inserting the following: ", less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).".

(b) ELIMINATION OF FDO FOR RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i) (42 U.S.C. 1395l(n)(1)(B)(i)) is amended—

(1) by striking "of 80 percent", and

(2) by inserting before the period at the end the following: ", less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A)".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished during portions of cost reporting periods occurring on or after October 1, 1997.

SEC. 5312. EXTENSION OF REDUCTIONS IN PAYMENTS FOR COSTS OF HOSPITAL OUTPATIENT SERVICES.

(a) REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS.—Section 1861(v)(1)(S)(ii)(I) (42 U.S.C. 1395x(v)(1)(S)(ii)(I)) is amended by striking "through 1998" and inserting "through 1999 and during fiscal year 2000 before January 1, 2000".

(b) REDUCTION IN PAYMENTS FOR OTHER COSTS.—Section 1861(v)(1)(S)(ii)(II) (42 U.S.C. 1395x(v)(1)(S)(ii)(II)) is amended by striking "through 1998" and inserting "through 1999 and during fiscal year 2000 before January 1, 2000".

SEC. 5313. PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

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

"(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

"(1) IN GENERAL.—With respect to hospital outpatient services designated by the Secretary (in this section referred to as 'covered OPD services') and furnished during a year beginning with 1999, the amount of payment under this part shall be determined under a prospective payment system established by the Secretary in accordance with this subsection.

"(2) SYSTEM REQUIREMENTS.—Under the payment system—

"(A) the Secretary shall develop a classification system for covered OPD services;

"(B) the Secretary may establish groups of covered OPD services, within the classification system described in subparagraph (A), so that services classified within each group are comparable clinically and with respect to the use of resources;

"(C) the Secretary shall, using data on claims from 1997 and using data from the most recent available cost reports, establish relative payment weights for covered OPD services (and any groups of such services described in subparagraph (B)) based on median hospital costs and shall determine projections of the frequency of utilization of each such service (or group of services) in 1999;

"(D) the Secretary shall determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner;

"(E) the Secretary shall establish other adjustments as determined to be necessary to ensure equitable payments, such as outlier adjustments or adjustments for certain classes of hospitals; and

"(F) the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services.

"(3) CALCULATION OF BASE AMOUNTS.—

"(A) AGGREGATE AMOUNTS THAT WOULD BE PAYABLE IF DEDUCTIBLES WERE DISREGARDED.—The Secretary shall estimate the total amounts that would be payable from the Trust Fund under this part for covered OPD services in 1999, determined without regard to this subsection, as though the deductible under section 1833(b) did not apply, and as though the coinsurance described in section 1866(a)(2)(A)(ii) (as in effect before the date of the enactment of this subsection) continued to apply.

"(B) UNADJUSTED COPAYMENT AMOUNT.—

"(i) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the 'unadjusted copayment amount' applicable to a covered OPD service (or group of such services) is 20 percent of the national median

of the charges for the service (or services within the group) furnished during 1997, updated to 1999 using the Secretary's estimate of charge growth during the period.

"(ii) ADJUSTMENTS WHEN FULLY PHASED IN.—If the pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year would be equal to or exceed 80 percent, then the unadjusted copayment amount shall be 25 percent of amount determined under subparagraph (D)(i).

"(iii) RULES FOR NEW SERVICES.—The Secretary shall establish rules for establishment of an unadjusted copayment amount for a covered OPD service not furnished during 1997, based upon its classification within a group of such services.

"(C) CALCULATION OF CONVERSION FACTORS.—

"(i) FOR 1999.—

"(I) IN GENERAL.—The Secretary shall establish a 1999 conversion factor for determining the medicare pre-deductible OPD fee payment amounts for each covered OPD service (or group of such services) furnished in 1999. Such conversion factor shall be established—

"(aa) on the basis of the weights and frequencies described in paragraph (2)(C), and

"(bb) in such manner that the sum of the products determined under subclause (II) for each service or group equals the total project amount described in subparagraph (A).

"(II) PRODUCT.—The Secretary shall determine for each service or group the product of the medicare pre-deductible OPD fee payment amount (taking into account appropriate adjustments described in paragraphs (2)(D) and (2)(E)) and the frequencies for such service or group.

"(ii) SUBSEQUENT YEARS.—Subject to paragraph (8)(B), the Secretary shall establish a conversion factor for covered OPD services furnished in subsequent years in an amount equal to the conversion factor established under this subparagraph and applicable to such services furnished in the previous year increased by the OPD payment increase factor specified under clause (iii) for the year involved.

"(iii) OPD PAYMENT INCREASE FACTOR.—For purposes of this subparagraph, the 'OPD payment increase factor' for services furnished in a year is equal to the sum of—

"(I) the market basket percentage increase applicable under section 1886(b)(3)(B)(iii) to hospital discharges occurring during the fiscal year ending in such year, plus

"(II) in the case of a covered OPD service (or group of such services) furnished in a year in which the pre-deductible payment percentage

would not exceed 80 percent, 3.5 percentage points.

In applying the previous sentence for years beginning with 2000, the Secretary may substitute for the market basket percentage increase under subclause (I) an annual percentage increase that is computed and applied with respect to covered OPD services furnished in a year in the same manner as the market basket percentage increase is determined and applied to inpatient hospital services for discharges occurring in a fiscal year.

"(D) PRE-DEDUCTIBLE PAYMENT PERCENTAGE.—The pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year is equal to the ratio of—

"(i) the conversion factor established under subparagraph (C) for the year, multiplied by the weighting factor established under paragraph (2)(C) for the service (or group), to

"(ii) the sum of the amount determined under clause (i) and the unadjusted copayment amount determined under subparagraph (B) for such service or group.

"(E) CALCULATION OF MEDICARE OPD FEE SCHEDULE AMOUNTS.—The Secretary shall compute a medicare OPD fee schedule amount for each covered OPD service (or group of such services) furnished in a year, in an amount equal to the product of—

"(i) the conversion factor computed under subparagraph (C) for the year, and

"(ii) the relative payment weight (determined under paragraph (2)(C)) for the service or group.

"(4) MEDICARE PAYMENT AMOUNT.—The amount of payment made from the Trust Fund under this part for a covered OPD service (and such services classified within a group) furnished in a year is determined as follows:

"(A) FEE SCHEDULE AND COPAYMENT AMOUNT.—Add (i) the medicare OPD fee schedule amount (computed under paragraph (3)(E)) for the service or group and year, and (ii) the unadjusted copayment amount (determined under paragraph (3)(B)) for the service or group.

"(B) SUBTRACT APPLICABLE DEDUCTIBLE.—Reduce the sum under subparagraph (A) by the amount of the deductible under section 1833(b), to the extent applicable.

"(C) APPLY PAYMENT PROPORTION TO REMAINDER.—Multiply the amount determined under subparagraph (B) by the pre-deductible payment percentage (as determined under paragraph (3)(D)) for the service or group and year involved.

"(D) LABOR-RELATED ADJUSTMENT.—The amount of payment is the product determined under subparagraph (C) with the labor-related portion of such product adjusted for relative differences in the cost of labor and other fac-

tors determined by the Secretary, as computed under paragraph (2)(D).

"(5) COPAYMENT AMOUNT.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the copayment amount under this subsection is determined as follows:

"(i) UNADJUSTED COPAYMENT.—Compute the amount by which the amount described in paragraph (4)(B) exceeds the amount of payment determined under paragraph (4)(C).

"(ii) LABOR ADJUSTMENT.—The copayment amount is the difference determined under clause (i) with the labor-related portion of such difference adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraphs (2)(D). The adjustment under this clause shall be made in a manner that does not result in any change in the aggregate copayments made in any year if the adjustment had not been made.

"(B) ELECTION TO OFFER REDUCED COPAYMENT AMOUNT.—The Secretary shall establish a procedure under which a hospital, before the beginning of a year (beginning with 1999), may elect to reduce the copayment amount otherwise established under subparagraph (A) for some or all covered OPD services to an amount that is not less than 25 percent of the medicare OPD fee schedule amount (computed under paragraph (3)(E)) for the service involved, adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under subparagraphs (D) and (E) of paragraph (2). Under such procedures, such reduced copayment amount may not be further reduced or increased during the year involved and the hospital may disseminate information on the reduction of copayment amount effected under this subparagraph.

"(C) NO IMPACT ON DEDUCTIBLES.—Nothing in this paragraph shall be construed as affecting a hospital's authority to waive the charging of a deductible under section 1833(b).

"(6) PERIODIC REVIEW AND ADJUSTMENTS COMPONENTS OF PROSPECTIVE PAYMENT SYSTEM.—

"(A) PERIODIC REVIEW.—The Secretary may periodically review and revise the groups, the relative payment weights, and the wage and other adjustments described in paragraph (2) to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

"(B) BUDGET NEUTRALITY ADJUSTMENT.—If the Secretary makes adjustments under subparagraph (A), then the adjustments for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expendi-

tures under this part that would have been made if the adjustments had not been made.

"(C) UPDATE FACTOR.—If the Secretary determines under methodologies described in subparagraph (2)(F) that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary may appropriately adjust the update to the conversion factor otherwise applicable in a subsequent year.

"(7) SPECIAL RULE FOR AMBULANCE SERVICES.—The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in the matter in subsection (a)(1) preceding subparagraph (A).

"(8) SPECIAL RULES FOR CERTAIN HOSPITALS.—In the case of hospitals described in section 1886(d)(1)(B)(v)—

"(A) the system under this subsection shall not apply to covered OPD services furnished before January 1, 2000; and

"(B) the Secretary may establish a separate conversion factor for such services in a manner that specifically takes into account the unique costs incurred by such hospitals by virtue of their patient population and service intensity.

"(9) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

"(A) the development of the classification system under paragraph (2), including the establishment of groups and relative payment weights for covered OPD services, of wage adjustment factors, other adjustments, and methods described in paragraph (2)(F);

"(B) the calculation of base amounts under paragraph (3);

"(C) periodic adjustments made under paragraph (6); and

"(D) the establishment of a separate conversion factor under paragraph (8)(B).".

(b) COINSURANCE.—Section 1866(a)(2)(A)(ii) (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by adding at the end the following: "In the case of items and services for which payment is made under part B under the prospective payment system established under section 1833(t), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1833(t)(5).".

(c) TREATMENT OF REDUCTION IN COPAYMENT AMOUNT.—Section 1128A(i)(6) (42 U.S.C. 1320a–7a(i)(6)) is amended—

(1) by striking "or" at the end of subparagraph (B),

(2) by striking the period at the end of subparagraph (C) and inserting "; or", and

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

"(D) a reduction in the copayment amount for covered OPD services under section 1833(t)(5)(B).".

(d) CONFORMING AMENDMENTS.—

(1) APPROVED ASC PROCEDURES PERFORMED IN HOSPITAL OUTPATIENT DEPARTMENTS.—

(A)(i) Section 1833(i)(3)(A) (42 U.S.C. 13951(i)(3)(A)) is amended—

(I) by inserting "before January 1, 1999" after "furnished", and

(II) by striking "in a cost reporting period".

(ii) The amendment made by clause (i) shall apply to services furnished on or after January 1, 1999.

(B) Section 1833(a)(4) (42 U.S.C. 13951(a)(4)) is amended by inserting "or subsection (t)" before the semicolon.

(2) RADIOLOGY AND OTHER DIAGNOSTIC PROCEDURES.—

(A) Section 1833(n)(1)(A) (42 U.S.C. 1395l(n)(1)(A)) is amended by inserting "and before January 1, 1999" after "October 1, 1988," and after "October 1, 1989,".

(B) Section 1833(a)(2)(E) (42 U.S.C. 1395l(a)(2)(E)) is amended by inserting "or , for services or procedures performed on or after January 1, 1999, subsection (t)" before the semicolon.

(3) OTHER HOSPITAL OUTPATIENT SERVICES.—Section 1833(a)(2)(B) (42 U.S.C. 1395l(a)(2)(B)) is amended—

(A) in clause (i), by inserting "furnished before January 1, 1999," after "(i)",

(B) in clause (ii), by inserting "before January 1, 1999," after "furnished",

(C) by redesignating clause (iii) as clause (iv), and

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

"(iii) if such services are furnished on or after January 1, 1999, the amount determined under subsection (t), or".

Subchapter B—Ambulance Services

SEC. 5321. PAYMENTS FOR AMBULANCE SERVICES.

(a) INTERIM REDUCTIONS.—

(1) PAYMENTS DETERMINED ON REASONABLE COST BASIS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

"(V) In determining the reasonable cost of ambulance services (as described in subsection (s)(7)) provided during a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2002), the Secretary shall not recognize any costs in excess of costs recognized as reasonable for ambulance services provided during the previous fiscal year (after application of this subparagraph), increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the fiscal year involved reduced in the case of fiscal year 1998 by 1.0 percentage point."

(2) PAYMENTS DETERMINED ON REASONABLE CHARGE BASIS.—Section 1842(b) (42 U.S.C. 1395u(b)) is amended by adding at the end the following new paragraph:

"(19) For purposes of section 1833(a)(1), the reasonable charge for ambulance services (as described in section 1861(s)(7)) provided

during a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2002) may not exceed the reasonable charge for such services provided during the previous fiscal year (after application of this paragraph), increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved reduced in the case of fiscal year 1998 by 1.0 percentage point."

(b) ESTABLISHMENT OF PROSPECTIVE FEE SCHEDULE.—

(1) PAYMENT IN ACCORDANCE WITH FEE SCHEDULE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking "and (P)" and inserting "(P)"; and

(B) by striking the semicolon at the end and inserting the following: ", and (Q) with respect to ambulance service, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary under section 1834(k);".

(2) ESTABLISHMENT OF SCHEDULE.—Section 1834 (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

"(k) ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.—

"(1) IN GENERAL.—The Secretary shall establish a fee schedule for payment for ambulance services under this part through a negotiated rulemaking process described in title 5, United States Code, and in accordance with the requirements of this subsection.

"(2) CONSIDERATIONS.—In establishing such fee schedule, the Secretary shall—

"(A) establish mechanisms to control increases in expenditures for ambulance services under this part;

"(B) establish definitions for ambulance services which link payments to the type of services provided;

"(C) consider appropriate regional and operational differences;

"(D) consider adjustments to payment rates to account for inflation and other relevant factors; and

"(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner.

"(3) SAVINGS.—In establishing such fee schedule, the Secretary shall—

"(A) ensure that the aggregate amount of payments made for ambulance services under this part during 1999 does not exceed the aggregate amount of payments which would have been made for such services under this part during such year if the amendments made by section 5321 of the Balanced Budget Act of 1997 had not been made; and

"(B) set the payment amounts provided under the fee schedule for services furnished in 2000 and each subsequent year at amounts equal to the payment amounts under the fee schedule for service furnished during the previous year, increased by the percentage increase in the

consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced (but not below zero) by 1.0 percentage points.

"(4) CONSULTATION.—In establishing the fee schedule for ambulance services under this subsection, the Secretary shall consult with various national organizations representing individuals and entities who furnish and regulate ambulance services and share with such organizations relevant data in establishing such schedule.

"(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of the amounts established under the fee schedule for ambulance services under this subsection, including matters described in paragraph (2).

"(6) RESTRAINT ON BILLING.—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to ambulance services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).".

(3) EFFECTIVE DATE.—The amendments made by this section apply to ambulance services furnished on or after January 1, 1999.

(c) AUTHORIZING PAYMENT FOR PARAMEDIC INTERCEPT SERVICE PROVIDERS IN RURAL COMMUNITIES.—In promulgating regulations to carry out section 1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7)) with respect to the coverage of ambulance service, the Secretary of Health and Human Services may include coverage of advanced life support services (in this subsection referred to as "ALS intercept services") provided by a paramedic intercept service provider in a rural area if the following conditions are met:

(1) The ALS intercept services are provided under a contract with one or more volunteer ambulance services and are medically necessary based on the health condition of the individual being transported.

(2) The volunteer ambulance service involved—

(A) is certified as qualified to provide ambulance service for purposes of such section,

(B) provides only basic life support services at the time of the intercept, and

(C) is prohibited by State law from billing for any services.

(3) The entity supplying the ALS intercept services—

(A) is certified as qualified to provide such services under the medicare program under title XVIII of the Social Security Act, and

(B) bills all recipients who receive ALS intercept services from the entity, regardless of whether or not such recipients are medicare beneficiaries.

CHAPTER 3—PROVISIONS RELATING TO PARTS A AND B

Subchapter A—Payments to Skilled Nursing Facilities

SEC. 5331. BASING UPDATES TO PER DIEM LIMITS EFFECTIVE FOR FISCAL YEAR 1998 ON COST LIMITS EFFECTIVE FOR FISCAL YEAR 1997.

The last sentence of section 1888(a) (42 U.S.C. 1395yy(a)) is amended by striking "subsection" the last place it appears and all that follows and inserting "subsection, except that the limits effective for cost reporting periods beginning on or after October 1, 1997, shall be based on the limits effective for cost reporting periods beginning on or after October 1, 1996, increased by the skilled nursing facility market basket index to account for inflation and adjusted to account for the most recent changes in metropolitan statistical areas and wage index data.".

SEC. 5332. PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITY SERVICES.

(a) IN GENERAL.—Section 1888 (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

"(e) PROSPECTIVE PAYMENT.—

"(1) PAYMENT PROVISION.—Notwithstanding any other provision of this title, subject to paragraph (7), the amount of the payment for all costs (as defined in paragraph (2)(B)) of covered skilled nursing facility services (as defined in paragraph (2)(A)) for each day of such services furnished—

"(A) in a cost reporting period during the transition period (as defined in paragraph (2)(E)), is equal to the sum of—

"(i) the non-Federal percentage of the facility-specific per diem rate (computed under paragraph (3)), and

"(ii) the Federal percentage of the adjusted Federal per diem rate (determined under paragraph (4)) applicable to the facility; and

"(B) after the transition period is equal to the adjusted Federal per diem rate applicable to the facility.

"(2) DEFINITIONS.—For purposes of this subsection:

"(A) COVERED SKILLED NURSING FACILITY SERVICES.—

"(i) IN GENERAL.—The term 'covered skilled nursing facility services'—

"(I) means post-hospital extended care services as defined in section 1861(i) for which benefits are provided under part A; and

"(II) includes all items and services (other than services described in clause (ii)) for which payment may be made under part B and which are furnished to an individual who is a resident of a skilled nursing facility during the period in which the individual is provided covered post-hospital extended care services.

"(ii) SERVICES EXCLUDED.—Services described in this clause are physicians' services, services described by clauses (i) through (iii) of section 1861(s)(2)(K), certified nurse-midwife services, qualified psychologist

services, services of a certified registered nurse anesthetist, items and services described in subparagraphs in (F) and (O) of section 1861(s)(2), and, only with respect to services furnished during 1998, the transportation costs of electrocardiogram equipment for electrocardiogram tests services (HCPCS Code R0076). Services described in this clause do not include any physical, occupational, or speech-language therapy services regardless of whether or not the services are furnished by, or under the supervision of, a physician or other health care professional.

"(B) ALL COSTS.—The term 'all costs' means routine service costs, ancillary costs, and capital-related costs of covered skilled nursing facility services, but does not include costs associated with approved educational activities.

"(C) NON-FEDERAL PERCENTAGE; FEDERAL PERCENTAGE.—For—

"(i) the first cost reporting period (as defined in subparagraph (D)) of a facility, the 'non-Federal percentage' is 75 percent and the 'Federal percentage' is 25 percent;

"(ii) the next cost reporting period of such facility, the 'non-Federal percentage' is 50 percent and the 'Federal percentage' is 50 percent; and

"(iii) the subsequent cost reporting period of such facility, the 'non-Federal percentage' is 25 percent and the 'Federal percentage' is 75 percent.

"(D) FIRST COST REPORTING PERIOD.—The term 'first cost reporting period' means, with respect to a skilled nursing facility, the first cost reporting period of the facility beginning on or after October 1, 1998.

"(E) TRANSITION PERIOD.—

"(i) IN GENERAL.—The term 'transition period' means, with respect to a skilled nursing facility, the 3 cost reporting periods of the facility beginning with the first cost reporting period.

"(ii) TREATMENT OF NEW SKILLED NURSING FACILITIES.—In the case of a skilled nursing facility that does not have a settled cost report for a cost reporting period before July 1, 1998, payment for such services shall be made under this subsection as if all services were furnished after the transition period.

"(3) DETERMINATION OF FACILITY SPECIFIC PER DIEM RATES.—The Secretary shall determine a facility-specific per diem rate for each skilled nursing facility for a cost reporting period as follows:

"(A) DETERMINING BASE PAYMENTS.—The Secretary shall determine, on a per diem basis, the total of—

"(i) the allowable costs of extended care services for the facility for cost reporting periods beginning in 1995 with appropriate adjustments (as determined by the Secretary) to non-settled cost reports, and

"(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable

deductibles, coinsurance and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during such period to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

"(B) UPDATE TO COST REPORTING PERIODS THROUGH 1998.—The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase.

"(C) UPDATING TO APPLICABLE COST REPORTING PERIOD.—The Secretary shall further update such amount for each cost reporting period beginning with the first cost reporting period and up to and including the cost reporting period involved by a factor equal to the skilled nursing facility market basket percentage increase.

"(D) CERTAIN DEMONSTRATION PROJECTS.—In the case of a facility participating in the Nursing Home Case-Mix and Quality Demonstration (RUGS-III), the Secretary shall determine the facility specific per diem rate for any year after 1997 by computing the base period payments by using the RUGS-III rate received by the facility for 1997, increased by a factor equal to the skilled nursing facility market basket percentage increase.

"(4) FEDERAL PER DIEM RATE.—

"(A) DETERMINATION OF HISTORICAL PER DIEM FOR FACILITIES.—For each skilled nursing facility that received payments for post-hospital extended care services during a cost reporting period beginning in fiscal year 1995 and that was subject to (and not exempted from) the per diem limits referred to in paragraph (1) or (2) of subsection (a) (and facilities described in subsection (d)), the Secretary shall estimate, on a per diem basis for such cost reporting period, the total of—

"(i) subject to subparagraph (I), the allowable costs of extended care services for the facility for cost reporting periods beginning in 1995 with appropriate adjustments (as determined by the Secretary) to nonsettled cost reports, and

"(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during such period to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

"(B) UPDATE TO COST REPORTING PERIODS THROUGH 1998.—The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the cost reporting period described in subparagraph

(A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase reduced (on an annualized basis) by 1 percentage point.

"(C) COMPUTATION OF STANDARDIZED PER DIEM RATE.—The Secretary shall standardize the amount updated under subparagraph (B) for each facility by—

"(i) adjusting for variations among facility by area in the average facility wage level per diem, and

"(ii) adjusting for variations in case mix per diem among facilities.

"(D) COMPUTATION OF WEIGHTED AVERAGE PER DIEM RATE.—The Secretary shall compute a weighted average per diem rate by computing an average of the standardized amounts computed under subparagraph (C), weighted for each facility by the number of days of extended care services furnished during the cost reporting period referred to in subparagraph (A). The Secretary may compute and apply such average separately for facilities located in urban and rural areas (as defined in section 1886(d)(2)(D)).

"(E) UPDATING.—

"(i) FISCAL YEAR 1999.—For fiscal year 1999, the Secretary shall compute for each skilled nursing facility an unadjusted Federal per diem rate equal to the weighted average per diem rate computed under subparagraph (D) and applicable to the facility increased by skilled nursing facility market basket percentage change for the fiscal year involved.

"(ii) SUBSEQUENT FISCAL YEARS.—For each subsequent fiscal year the Secretary shall compute for each skilled nursing facility an unadjusted Federal per diem rate equal to the Federal per diem rate computed under this subparagraph for the previous fiscal year and applicable to the facility increased by the skilled nursing facility market basket percentage change for the fiscal year involved.

"(F) ADJUSTMENT FOR CASE MIX CREEP.—Insofar as the Secretary determines that such adjustments under subparagraph (G)(i) for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in the coding or classification of residents that do not reflect real changes in case mix, the Secretary may adjust unadjusted Federal per diem rates for subsequent years so as to discount the effect of such coding or classification changes.

"(G) APPLICATION TO SPECIFIC FACILITIES.—The Secretary shall compute for each skilled nursing facility for each fiscal year (beginning with fiscal year 1998) an adjusted Federal per diem rate equal to the unadjusted Federal per diem rate determined under subparagraph (E), as adjusted under subparagraph (F), and as further adjusted as follows:

"(i) ADJUSTMENT FOR CASE MIX.—The Secretary shall provide for an appropriate adjustment to account for case mix. Such adjustment shall be based on a resident classification system, established by the Secretary, that accounts for the relative resource utilization of different patient types. The case mix adjustment shall be based on resident assessment data and other data that the Secretary considers appropriate.

"(ii) ADJUSTMENT FOR GEOGRAPHIC VARIATIONS IN LABOR COSTS.—The Secretary shall adjust the portion of such per diem rate attributable to wages and wage-related costs for the area in which the facility is located compared to the national average of such costs using an appropriate wage index as determined by the Secretary. Such adjustment shall be done in a manner that does not result in aggregate payments under this subsection that are greater or less than those that would otherwise be made if such adjustment had not been made.

"(H) PUBLICATION OF INFORMATION ON PER DIEM RATES.—The Secretary shall provide for publication in the Federal Register, before the July 1 preceding each fiscal year (beginning with fiscal year 1999), of—

"(i) the unadjusted Federal per diem rates to be applied to days of covered skilled nursing facility services furnished during the fiscal year,

"(ii) the case mix classification system to be applied under subparagraph (G)(i) with respect to such services during the fiscal year, and

"(iii) the factors to be applied in making the area wage adjustment under subparagraph (G)(ii) with respect to such services.

"(I) EXCLUSION OF EXCEPTION PAYMENTS FROM DETERMINATION OF HISTORICAL PER DIEM.—In determining allowable costs under subparagraph (A)(i), the Secretary shall not take into account any payments described in subsection (c).

"(5) SKILLED NURSING FACILITY MARKET BASKET INDEX, PERCENTAGE, AND HISTORICAL TREND FACTOR.—For purposes of this subsection:

"(A) SKILLED NURSING FACILITY MARKET BASKET INDEX.—The Secretary shall establish a skilled nursing facility market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered skilled nursing facility services.

"(B) SKILLED NURSING FACILITY MARKET BASKET PERCENTAGE.—The term 'skilled nursing facility market basket percentage' means, for a fiscal year or other annual period and as calculated by the Secretary, the percentage change in the skilled nursing facility market basket index (established under subparagraph (A)) from the midpoint of the prior fiscal year (or period) to the midpoint of the fiscal year (or other period) involved.

"(6) SUBMISSION OF RESIDENT ASSESSMENT DATA.—A skilled nursing facility shall provide the Secretary, in a manner and within the timeframes prescribed by the Secretary, the resident assessment data necessary to develop and implement the rates under this subsection. For purposes of meeting such requirement, a skilled nursing facility may submit the resident assessment data required under section 1819(b)(3), using the standard instrument designated by the State under section 1819(e)(5).

"(7) TRANSITION FOR MEDICARE SWING BED HOSPITALS.—

"(A) IN GENERAL.—The Secretary shall determine an appropriate manner in which to apply this subsection to the facilities described in subparagraph (B), taking into account the purposes of this subsection, and shall provide that at the end of the transition period (as defined in paragraph (2)(E)) such facilities shall be paid only under this subsection. Payment shall not be made under this subsection to such facilities for cost reporting periods beginning before such date (not earlier than July 1, 1999) as the Secretary specifies.

"(B) FACILITIES DESCRIBED.—The facilities described in this subparagraph are facilities that have in effect an agreement described in section 1883, for which payment is made for the furnishing of extended care services on a reasonable cost basis under section 1814(l) (as in effect on and after such date).

"(8) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

"(A) the establishment of Federal per diem rates under paragraph (4), including the computation of the standardized per diem rates under paragraph (4)(C), adjustments and corrections for case mix under paragraphs (4)(F) and (4)(G)(i), and adjustments for variations in labor-related costs under paragraph (4)(G)(ii); and

"(B) the establishment of transitional amounts under paragraph (7).".

(b) CONSOLIDATED BILLING.—

(1) FOR SNF SERVICES.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) by striking "or" at the end of paragraph (15),

(B) by striking the period at the end of paragraph (16) and inserting "; or", and

(C) by inserting after paragraph (16) the following new paragraph:

"(17) which are covered skilled nursing facility services described in section 1888(e)(2)(A)(i)(II) and which are furnished to an individual who is a resident of a skilled nursing facility by an entity other than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the skilled nursing facility, or such services are furnished by a physician described in section 1861(r)(1).".

(2) REQUIRING PAYMENT FOR ALL PART B ITEMS AND SERVICES TO BE MADE TO FACILITY.—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended—

(A) by striking "and (D)" and inserting "(D)"; and

(B) by striking the period at the end and inserting the following: ", and (E) in the case of an item or service (other than services described in section 1888(e)(2)(A)(ii)) furnished to an individual who (at the time the item or service is furnished) is a resident of a skilled nursing facility, payment shall be made to the facility (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).".

(3) PAYMENT RULES.—Section 1888(e) (42 U.S.C. 1395yy(e)), as added by subsection (a), is amended by adding at the end the following:

"(9) PAYMENT FOR CERTAIN SERVICES.—

"(A) IN GENERAL.—In the case of an item or service furnished by a skilled nursing facility (or by others under arrangement with them made by a skilled nursing facility or under any other contracting or consulting arrangement or otherwise) for which payment would otherwise (but for this paragraph) be made under part B in an amount determined in accordance with section 1833(a)(2)(B), the amount of the payment under such part shall be based on the part B methodology applicable to the item or service, except that for items and services that would be included in a facility's cost report if not for this section, the facility may continue to use a cost report for reimbursement purposes until the prospective payment system established under this section is implemented.

"(B) THERAPY AND PATHOLOGY SERVICES.—Payment for physical therapy, occupational therapy, respiratory therapy, and speech language pathology services shall reflect new salary equivalency guidelines calculated pursuant to section 1861(v)(5) when finalized through the regulatory process.

"(10) REQUIRED CODING.—No payment may be made under part B for items and services (other than services described in paragraph (2)(A)(ii)) furnished to an individual who is a resident of a skilled nursing facility unless the claim for such payment includes a code (or codes) under a uniform coding system specified by the Secretary that identifies the items or services delivered.".

(4) CONFORMING AMENDMENTS.—

(A) Section 1819(b)(3)(C)(i) (42 U.S.C. 1395i–3(b)(3)(C)(i)) is amended by striking "Such" and inserting "Subject to the timeframes prescribed by the Secretary under section 1888(t)(6), such".

(B) Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)) is amended by striking "(2);" and inserting "(2) and section 1842(b)(6)(E);".

(C) Section 1833(a)(2)(B) (42 U.S.C. 1395l(a)(2)(B)) is amended by inserting "or section 1888(e)(9)" after "section 1886".

(D) Section 1861(h) (42 U.S.C 1395x(h)) is amended—

(i) in the opening paragraph, by striking "paragraphs (3) and (6)" and inserting "paragraphs (3), (6), and (7)", and

(ii) in paragraph (7), after "skilled nursing facilities", by inserting ", or by others under arrangements with them made by the facility".

(E) Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)) is amended—

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

(ii) by inserting "(i)" after "(H)", and

(iii) by adding after clause (i), as so redesignated, the following new clause:

"(ii) in the case of skilled nursing facilities which provide covered skilled nursing facility services—

"(I) that are furnished to an individual who is a resident of the skilled nursing facility, and

"(II) for which the individual is entitled to have payment made under this title,

to have items and services (other than services described in section 1888(e)(2)(A)(ii)) furnished by the skilled nursing facility or otherwise under arrangements (as defined in section 1861(w)(1)) made by the skilled nursing facility,".

(c) MEDICAL REVIEW PROCESS.—In order to ensure that medicare beneficiaries are furnished appropriate services in skilled nursing facilities, the Secretary of Health and Human Services shall establish and implement a thorough medical review process to examine the effects of the amendments made by this section on the quality of covered skilled nursing facility services furnished to medicare beneficiaries. In developing such a medical review process, the Secretary shall place a particular emphasis on the quality of non-routine covered services and physicians' services for which payment is made under title XVIII of the Social Security Act for which payment is made under section 1848 of such Act.

(d) EFFECTIVE DATE.—The amendments made by this section are effective for cost reporting periods beginning on or after July 1, 1998; except that the amendments made by subsection (b) shall apply to items and services furnished on or after July 1, 1998.

Subchapter B—Home Health Services and Benefits

PART I—PAYMENTS FOR HOME HEALTH SERVICES

SEC. 5341. RECAPTURING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES FOR HOME HEALTH SERVICES.

(a) BASING UPDATES TO PER VISIT COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the end the following:

"(iv) In establishing limits under this subparagraph for cost reporting periods beginning after September 30, 1997, the Secretary shall not take into account any changes in the home health market basket, as determined by the Secretary, with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.".

(b) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by subsection (a) in making any exemptions and exceptions pursuant to section 1861(v)(1)(L)(ii) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(ii)).

SEC. 5342. INTERIM PAYMENTS FOR HOME HEALTH SERVICES.

(a) REDUCTIONS IN COST LIMITS.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) by moving the indentation of subclauses (I) through (III) 2-ems to the left;

(2) in subclause (I), by inserting "of the mean of the labor-related and nonlabor per visit costs for freestanding home health agencies" before the comma at the end;

(3) in subclause (II), by striking ", or" and inserting "of such mean,";

(4) in subclause (III)—

(A) by inserting "and before October 1, 1997," after "July 1, 1987", and

(B) by striking the period at the end and inserting "of such mean, or"; and

(5) by striking the matter following subclause (III) and inserting the following:

"(IV) October 1, 1997, 105 percent of the median of the labor-related and nonlabor per visit costs for freestanding home health agencies.".

(b) DELAY IN UPDATES.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by inserting ", or on or after July 1, 1997, and before October 1, 1997" after "July 1, 1996".

(c) ADDITIONS TO COST LIMITS.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)), as amended by section 5341(a), is amended by adding at the end the following:

"(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the Secretary shall provide for an interim system of limits. Payment shall be the lower of—

"(I) costs determined under the preceding provisions of this subparagraph, or

"(II) an agency-specific per beneficiary annual limitation calculated from the agency's 12-month cost reporting period ending on or after January 1, 1994, and on or before December 31, 1994, based on reasonable costs (including nonroutine medical supplies), updated by the home health market basket index.

The per beneficiary limitation in subclause (II) shall be multiplied by the agency's unduplicated census count of patients (entitled to benefits under this title) for the cost reporting period subject to the limitation to determine the aggregate agency-specific per beneficiary limitation.

"(vi) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the following rules apply:

"(I) For new providers and those providers without a 12-month cost reporting period ending in calendar year 1994, the per beneficiary limitation shall be equal to the median of these limits (or the Secretary's best estimates thereof) applied to other home health agencies as determined by the Secretary. A home health agency that has altered its corporate structure or name shall not be considered a new provider for this purpose.

"(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitations shall be prorated among the agencies.".

(d) DEVELOPMENT OF CASE MIX SYSTEM.—The Secretary of Health and Human Services shall expand research on a prospective payment system for home health agencies under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) that ties prospective payments to a unit of service, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of the variances in costs.

(e) SUBMISSION OF DATA FOR CASE MIX SYSTEM.—Effective for cost reporting periods beginning on or after October 1, 1997, the Secretary of Health and Human Services may require all home health agencies to submit additional information that the Secretary considers necessary for the development of a reliable case mix system.

SEC. 5343. PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 5011, is amended by adding at the end the following new section:

"PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

"SEC. 1895. (a) IN GENERAL.—Notwithstanding section 1861(v), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 1999, for payments for home health services in accordance with a prospective payment system established by the Secretary under this section.

"(b) SYSTEM OF PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.—

"(1) IN GENERAL.—The Secretary shall establish under this subsection a prospective payment system for payment for all costs of home health services. Under the system under this subsection all services covered and paid on a reasonable cost basis under the medicare home health benefit as of the date of the enactment of the this section, including medical supplies, shall be paid for on the basis of a prospective payment amount determined under this subsection and applicable to the services involved. In implementing the system, the Secretary may provide for a transition (of not longer than 4 years) during which a portion of such payment is based on agency-specific costs, but only if such transition does not result in aggregate payments under this title that exceed the aggregate payments that would be made if such a transition did not occur.

"(2) UNIT OF PAYMENT.—In defining a prospective payment amount under the system under this subsection, the Secretary shall consider an appropriate unit of service and the number, type, and duration of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

"(3) PAYMENT BASIS.—

"(A) INITIAL BASIS.—

"(i) IN GENERAL.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts). Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for fiscal year 2000 shall be equal to the total amount that would have been made if the system had not been in effect but if the reduction in limits described in clause (ii) had been in effect. Such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

"(ii) REDUCTION.—The reduction described in this clause is a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L), as those limits are in effect on September 30, 1999.

"(B) ANNUAL UPDATE.—

"(i) IN GENERAL.—The standard prospective payment amount (or amounts) shall be adjusted for each fiscal year (beginning with fiscal year 2001) in a prospective manner specified by the Secretary by the home health market basket percentage increase applicable to the fiscal year involved.

"(ii) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE.—For purposes of this subsection, the term 'home health market basket percentage increase' means, with respect to a fiscal year, a percentage (estimated by the Secretary before the beginning of the fiscal year) determined and applied with respect to the mix of goods and services included in home health services in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to the mix of goods and services comprising inpatient hospital services for the fiscal year.

"(C) ADJUSTMENT FOR OUTLIERS.—The Secretary shall reduce the standard prospective payment amount (or

amounts) under this paragraph applicable to home health services furnished during a period by such proportion as will result in an aggregate reduction in payments for the period equal to the aggregate increase in payments resulting from the application of paragraph (5) (relating to outliers).

"(4) PAYMENT COMPUTATION.—

"(A) IN GENERAL.—The payment amount for a unit of home health services shall be the applicable standard prospective payment amount adjusted as follows:

"(i) CASE MIX ADJUSTMENT.—The amount shall be adjusted by an appropriate case mix adjustment factor (established under subparagraph (B)).

"(ii) AREA WAGE ADJUSTMENT.—The portion of such amount that the Secretary estimates to be attributable to wages and wage-related costs shall be adjusted for geographic differences in such costs by an area wage adjustment factor (established under subparagraph (C)) for the area in which the services are furnished or such other area as the Secretary may specify.

"(B) ESTABLISHMENT OF CASE MIX ADJUSTMENT FACTORS.—The Secretary shall establish appropriate case mix adjustment factors for home health services in a manner that explains a significant amount of the variation in cost among different units of services.

"(C) ESTABLISHMENT OF AREA WAGE ADJUSTMENT FACTORS.—The Secretary shall establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services in a geographic area compared to the national average applicable level. Such factors may be the factors used by the Secretary for purposes of section 1886(d)(3)(E).

"(5) OUTLIERS.—The Secretary may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year.

"(6) PRORATION OF PROSPECTIVE PAYMENT AMOUNTS.—If a beneficiary elects to transfer to, or receive services from, another home health agency within the period covered by the prospective payment amount, the payment shall be prorated between the home health agencies involved.

"(c) REQUIREMENTS FOR PAYMENT INFORMATION.—With respect to home health services furnished on or after October 1, 1998, no claim for such a service may be paid under this title unless—

"(1) the claim has the unique identifier for the physician who prescribed the services or made the certification described in section 1814(a)(2) or 1835(a)(2)(A); and

"(2) in the case of a service visit described in paragraph (1), (2), (3), or (4) of section 1861(m), the claim has information (coded in an appropriate manner) on the length of time of the service visit, as measured in 15 minute increments.

"(d) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

"(1) the establishment of a transition period under subsection (b)(1);

"(2) the definition and application of payment units under subsection (b)(2);

"(3) the computation of initial standard prospective payment amounts under subsection (b)(3)(A) (including the reduction described in clause (ii) of such subsection);

"(4) the adjustment for outliers under subsection (b)(3)(C);

"(5) case mix and area wage adjustments under subsection (b)(4);

"(6) any adjustments for outliers under subsection (b)(5); and

"(7) the amounts or types of exceptions or adjustments under subsection (b)(7).".

(b) ELIMINATION OF PERIODIC INTERIM PAYMENTS FOR HOME HEALTH AGENCIES.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(1) by inserting "and" at the end of subparagraph (C),

(2) by striking subparagraph (D), and

(3) by redesignating subparagraph (E) as subparagraph (D).

(c) CONFORMING AMENDMENTS.—

(1) PAYMENTS UNDER PART A.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended in the matter preceding paragraph (1) by striking "and 1886" and inserting "1886, and 1895".

(2) TREATMENT OF ITEMS AND SERVICES PAID UNDER PART B.—

(A) PAYMENTS UNDER PART B.—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended—

(i) by amending subparagraph (A) to read as follows:

"(A) with respect to home health services (other than a covered osteoporosis drug) (as defined in section 1861(kk)), the amount determined under the prospective payment system under section 1895;";

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

(iii) by adding "and" at the end of subparagraph (F); and

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

"(G) with respect to items and services described in section 1861(s)(10)(A), the lesser of—

"(i) the reasonable cost of such services, as determined under section 1861(v), or

"(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);".

(B) REQUIRING PAYMENT FOR ALL ITEMS AND SERVICES TO BE MADE TO AGENCY.—

(i) IN GENERAL.—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) (as amended by section 5332(b)(2)) is amended—

(I) by striking "and (E)" and inserting "(E)"; and

(II) by striking the period at the end and inserting the following: ", and (F) in the case of home health services furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or when any other contracting or consulting arrangement, or otherwise).".

(ii) CONFORMING AMENDMENT.—Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)) (as amended by section 5332(b)(4)(B)) is amended by striking "section 1842(b)(6)(E);" and inserting "subparagraphs (E) and (F) of section 1842(b)(6);".

(C) EXCLUSIONS FROM COVERAGE.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 5332(b)(1), is amended—

(i) by striking "or" at the end of paragraph (16);

(ii) by striking the period at the end of paragraph (17) and inserting "or"; and

(iii) by inserting after paragraph (17) the following:

"(18) where such expenses are for home health services furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency.".

(d) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 1999.

(e) CONTINGENCY.—If the Secretary of Health and Human Services for any reason does not establish and implement the prospective payment system for home health services described in section 1895(b) of the Social Security Act (as added by subsection (a)) for cost reporting periods described in subsection (d), for such cost reporting periods the Secretary shall provide for a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L) of such Act, as those limits would otherwise be in effect on September 30, 1999.

SEC. 5344. PAYMENT BASED ON LOCATION WHERE HOME HEALTH SERVICE IS FURNISHED.

(a) CONDITIONS OF PARTICIPATION.—Section 1891 (42 U.S.C. 1395bbb) is amended by adding at the end the following:

"(g) PAYMENT ON BASIS OF LOCATION OF SERVICE.—A home health agency shall submit claims for payment for home health services under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.".

(b) WAGE ADJUSTMENT.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking "agency is located" and inserting "service is furnished".

(c) EFFECTIVE DATE.—The amendments made by this section apply to cost reporting periods beginning on or after October 1, 1997.

PART II—HOME HEALTH BENEFITS

SEC. 5361. MODIFICATION OF PART A HOME HEALTH BENEFIT FOR INDIVIDUALS ENROLLED UNDER PART B.

(a) IN GENERAL.—Section 1812 (42 U.S.C. 1395d) is amended—

(1) in subsection (a)(3), by striking "home health services" and inserting "for individuals not enrolled in part B, home health services, and for individuals so enrolled, part A home health services (as defined in subsection (g))";

(2) by redesignating subsection (g) as subsection (h); and

(3) by inserting after subsection (f) the following new subsection:

"(g)(1) For purposes of this section, the term 'part A home health services' means—

"(A) for services furnished during each year beginning with 1998 and ending with 2003, home health services subject to the transition reduction applied under paragraph (2)(C) for services furnished during the year, and

"(B) for services furnished on or after January 1, 2004, post-institutional home health services for up to 100 visits during a home health spell of illness.

"(2) For purposes of paragraph (1)(A), the Secretary shall specify, before the beginning of each year beginning with 1998 and ending with 2003, a transition reduction in the home health services benefit under this part as follows:

"(A) The Secretary first shall estimate the amount of payments that would have been made under this part for home health services furnished during the year if—

"(i) part A home health services were all home health services, and

"(ii) part A home health services were limited to services described in paragraph (1)(B).

"(B)(i) The Secretary next shall compute a transfer reduction amount equal to the appropriate proportion (specified under clause (ii)) of the amount by which the amount estimated under subparagraph (A)(i) for the year exceeds the amount estimated under subparagraph (A)(ii) for the year.

"(ii) For purposes of clause (i), the 'appropriate proportion' is equal to—

"(I) 1/7 for 1998,
"(II) 2/7 for 1999,
"(III) 3/7 for 2000,
"(IV) 4/7 for 2001,
"(V) 5/7 for 2002, and
"(V) 6/7 for 2003.

"(C) The Secretary shall establish a transition reduction by specifying such a visit limit (during a home health spell of illness) or such a post-institutional limitation on home health services furnished under this part during the year as the Secretary estimates will result in a reduction in the amount of payments that would otherwise be made under this part for home health services furnished during the year equal to the transfer amount computed under subparagraph (B)(i) for the year.

"(3) Payment under this part for home health services furnished an individual enrolled under part B—

"(A) during a year beginning with 1998 and ending with 2003, may not be made for services that are not within the visit limit or other limitation specified by the Secretary under the transition reduction under paragraph (3)(C) for services furnished during the year; or

"(B) on or after January 1, 2004, may not be made for home health services that are not post-institutional home health services or for post-institutional furnished to the individual after such services have been furnished to the individual for a total of 100 visits during a home health spell of illness.".

(b) POST-INSTITUTIONAL HOME HEALTH SERVICES DEFINED.—Section 1861 (42 U.S.C. 1395x), as amended by sections 5102(a) and 5103(a), is amended by adding at the end the following:

"Post-Institutional Home Health Services; Home Health Spell of Illness

"(qq)(1) The term 'post-institutional home health services' means home health services furnished to an individual—

"(A) after discharge from a hospital or rural primary care hospital in which the individual was an inpatient for not less than 3 consecutive days before such discharge if such home health services were initiated within 14 days after the date of such discharge; or

"(B) after discharge from a skilled nursing facility in which the individual was provided post-hospital extended care services if such home health services were initiated within 14 days after the date of such discharge.

"(2) The term 'home health spell of illness' with respect to any individual means a period of consecutive days—

"(A) beginning with the first day (not included in a previous home health spell of illness) (i) on which such individual is furnished post-institutional home health services, and (ii) which occurs in a month for which the individual is entitled to benefits under part A, and

"(B) ending with the close of the first period of 60 consecutive days thereafter on each of which the individual is neither

an inpatient of a hospital or rural primary care hospital nor an inpatient of a facility described in section 1819(a)(1) or subsection (y)(1) nor provided home health services.".

(c) MAINTAINING APPEAL RIGHTS FOR HOME HEALTH SERVICES.—Section 1869(b)(2)(B) (42 U.S.C. 1395ff(b)(2)(B)) is amended by inserting "(or $100 in the case of home health services)" after "$500".

(d) MAINTAINING SEAMLESS ADMINISTRATION THROUGH FISCAL INTERMEDIARIES.—Section 1842(b)(2) (42 U.S.C. 1395u(b)(2)) is amended by adding at the end the following:

"(E) With respect to the payment of claims for home health services under this part that, but for the amendments made by section 5361, would be payable under part A instead of under this part, the Secretary shall continue administration of such claims through fiscal intermediaries under section 1816.".

(e) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after January 1, 1998. For the purpose of applying such amendments, any home health spell of illness that began, but did not end, before such date shall be considered to have begun as of such date.

SEC. 5362. IMPOSITION OF $5 COPAYMENT FOR PART B HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1833(a)(2)(A) (42 U.S.C. 1395l(a)(2)(A)) (as amended by section 5343(c)(2)) is amended by striking "1895" and inserting "1895, less a copayment amount equal to $5 per visit, not to exceed a total annual copayment amount equal to the inpatient hospital deductible determined under section 1813 for the calendar year in which such service is furnished".

(b) PROVIDER CHARGES.—Section 1866(a)(2)(A)(i) (42 U.S.C. 1395cc(a)(2)(A)(i)) is amended—

(1) by striking "deduction or coinsurance" and inserting "deduction, coinsurance, or copayment"; and

(2) by striking "section 1833(b)" and inserting "subsection (a)(2)(A) or (b) of section 1833".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 1997.

SEC. 5363. CLARIFICATION OF PART-TIME OR INTERMITTENT NURSING CARE.

(a) IN GENERAL.—Section 1861(m) (42 U.S.C. 1395x(m)) is amended by adding at the end the following: "For purposes of paragraphs (1) and (4), the term 'part-time or intermittent services' means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of sections 1814(a)(2)(C) and 1835(a)(2)(A), 'intermittent' means skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to services furnished on or after October 1, 1997.

SEC. 5364. STUDY ON DEFINITION OF HOMEBOUND.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the criteria that should be applied, and the method of applying such criteria, in the determination of whether an individual is homebound for purposes of qualifying for receipt of benefits for home health services under the medicare program. Such criteria shall include the extent and circumstances under which a person may be absent from the home but nonetheless qualify.

(b) REPORT.—Not later than October 1, 1998, the Secretary shall submit a report to the Congress on the study conducted under subsection (a). The report shall include specific recommendations on such criteria and methods.

SEC. 5365. NORMATIVE STANDARDS FOR HOME HEALTH CLAIMS DENIALS.

(a) IN GENERAL.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by section 5102(c), is amended—

(1) by striking "and" at the end of subparagraph (F),

(2) by striking the semicolon at the end of subparagraph (G) and inserting ", and", and

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

"(H) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation;".

(b) NOTIFICATION.—The Secretary of Health and Human Services may establish a process for notifying a physician in cases in which the number of home health service visits furnished under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) pursuant to a prescription or certification of the physician significantly exceeds such threshold (or thresholds) as the Secretary specifies. The Secretary may adjust such threshold to reflect demonstrated differences in the need for home health services among different beneficiaries.

(c) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after October 1, 1997.

SEC. 5366. INCLUSION OF COST OF SERVICE IN EXPLANATION OF MEDICARE BENEFITS.

(a) IN GENERAL.—Section 1842(h)(7) of the Social Security Act (42 U.S.C. 1395u(h)(7)) is amended—

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

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

(3) by adding at the end the following:

"(E) in the case of home health services furnished to an individual enrolled under this part, the total amount that the home health agency or other provider of such services billed for such services.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to explanation of benefits provided on and after October 1, 1997.

Subtitle F—Provisions Relating to Part A

CHAPTER 1—PAYMENT OF PPS HOSPITALS

SEC. 5401. PPS HOSPITAL PAYMENT UPDATE.

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

(1) in subclause (XII)—

(A) by inserting "and the period beginning on October 1, 1997, and ending on December 31, 1997," after "fiscal year 1997,"; and

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

(2) by striking subclause (XIII) and inserting the following:

"(XIII) for calendar year 1998 for hospitals in all areas, the market basket percentage increase minus 2.5 percentage points,

"(XIV) for calendar years 1999 through 2002 for hospitals in all areas, the market basket percentage increase minus 1.0 percentage points, and

"(XV) for calendar year 2003 and each subsequent calendar year for hospitals in all areas, the market basket percentage increase.".

(b) RULE OF CONSTRUCTION.—Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

"(j) PPS CALENDAR YEAR PAYMENTS.—Notwithstanding any other provision of this title, any updates or payment amounts determined under this section shall on and after December 31, 1998, take effect and be applied on a calendar year basis. With respect to any cost reporting periods that relate to any such updates or payment amounts, the Secretary shall revise such cost reporting periods to ensure that on and after December 31, 1998, such cost reporting periods relate to updates and payment amounts made under this section on a calendar year basis in the same manner as such cost reporting periods applied to updates and payment amounts under this section on the day before the date of enactment of this subsection.".

SEC. 5402. CAPITAL PAYMENTS FOR PPS HOSPITALS.

(a) MAINTAINING SAVINGS FROM TEMPORARY REDUCTION IN PPS CAPITAL RATES.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following: "In addition to the reduction described in the preceding sentence, for discharges occurring on or after October 1, 1997, the Secretary shall apply the budget neutrality adjustment factor used to determine the Federal capital payment rate in effect on September 30, 1995 (as described in section 412.352 of title 42 of the Code of Federal Regulations), to (i) the unadjusted standard Federal capital payment rate (as described in section 412.308(c) of that title, as in effect on September 30, 1997), and (ii) the unadjusted hospital-specific rate (as described in section 412.328(e)(1) of that title, as in effect on September 30, 1997).".

(b) SYSTEM EXCEPTION PAYMENTS FOR TRANSITIONAL CAPITAL.—

(1) IN GENERAL.—Section 1886(g)(l) (42 U.S.C. 1395ww(g)(1)) is amended—

(A) by redesignating subparagraph (C) as subparagraph (F), and

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

"(C) The exceptions under the system provided by the Secretary under subparagraph (B)(iii) shall include the provision of exception payments under the special exceptions process provided under section 412.348(g) of title 42, Code of Federal Regulations (as in effect on September 1, 1995), except that the Secretary shall revise such process, effective for discharges occurring after September 30, 1997, as follows:

"(i) Eligible hospital requirements, as described in section 412.348(g)(1) of title 42, Code of Federal Regulations, shall apply except that subparagraph (ii) shall be revised to require that hospitals located in an urban area with at least 300 beds shall be eligible under such process and that such a hospital shall be eligible without regard to its disproportionate patient percentage under subsection (d)(5)(F) or whether it qualifies for additional payment amounts under such subsection.

"(ii) Project size requirements, as described in section 412.348(g)(5) of title 42, Code of Federal Regulations, shall apply except that subparagraph (ii) shall be revised to require that the project costs of a hospital are at least 150 percent of its operating cost during the first 12 month cost reporting period beginning on or after October 1, 1991.

"(iii) The minimum payment level for qualifying hospitals shall be 85 percent.

"(iv) A hospital shall be considered to meet the requirement that it complete the project involved no later than the end of the last cost reporting period of the hospital beginning before October 1, 2001, if—

"(I) the hospital has obtained a certificate of need for the project approved by the State or a local planning authority by September 1, 1995; and

"(II) by September 1, 1995, the hospital has expended on the project at least $750,000 or 10 percent of the estimated cost of the project.

"(v) Offsetting amounts, as described in section 412.348(g)(8)(ii) of title 42, Code of Federal Regulations, shall apply except that subparagraph (B) of such section shall be revised to require that the additional payment that would otherwise be payable for the cost reporting period shall be reduced by the amount (if any) by which the hospital's current year medicare capital payments (excluding, if applicable, 75 percent of the hospital's capital-related disproportionate share payments) exceeds its medicare capital costs for such year.

"(D)(i) The Secretary shall reduce the Federal capital and hospital rates up to $50,000,000 for a calendar year to ensure that the application of subparagraph (C) does not result in an increase in the total amount that would have been paid under this subsection in the fiscal year if such subparagraph did not apply.

"(ii) Payments made pursuant to the application of subparagraph (C) shall not be considered for purposes of calculating total estimated payments under section 412.348(h), Title 42, Code of Federal Regulations.

"(E) The Secretary shall provide for publication in the Federal Register each year (beginning with 1999) of a description of the distributional impact of the application of subparagraph (C) on hospitals which receive, and do not receive, an exception payment under such subparagraph.".

(2) CONFORMING AMENDMENT.—Section 1886(g)(1)(B)(iii) (42 U.S.C. 1395ww(g)(1)(B)(iii)) is amended by striking "may provide" and inserting "shall provide (in accordance with subparagraph (C))".

CHAPTER 2—PAYMENT OF PPS EXEMPT HOSPITALS

SEC. 5421. PAYMENT UPDATE.

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

(1) in clause (ii)—

(A) by striking "and" at the end of subclause (V);

(B) by redesignating subclause (VI) as subclause (VIII); and

(C) by inserting after subclause (V), the following subclauses:

"(VI) for fiscal year 1998, is 0 percent;

"(VII) for fiscal years 1999 through 2002, is the applicable update factor specified under clause (vi) for the fiscal year; and"; and

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

"(vi) For purposes of clause (ii)(VII) for a fiscal year, if a hospital's allowable operating costs of inpatient hospital services recognized under this title for the most recent cost reporting period for which information is available—

"(I) is equal to, or exceeds, 110 percent of the hospital's target amount (as determined under subparagraph (A)) for such cost reporting period, the applicable update factor specified under this clause is the market basket percentage;

"(II) exceeds 100 percent, but is less than 110 percent, of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 0.25 percentage points for each percentage point by which such allowable operating costs (expressed as a percentage of such target amount) is less than 110 percent of such target amount;

"(III) is equal to, or less than 100 percent, but exceeds ⅔ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 1.5 percentage points; or

"(IV) does not exceed ⅔ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent.".

(b) NO EFFECT OF PAYMENT REDUCTION ON EXCEPTIONS AND ADJUSTMENTS.—Section 1886(b)(4)(A)(ii) (42 U.S.C. 1395ww(b)(4)(A)(ii)) is amended by adding at the end the following new sentence: "In making such reductions, the Secretary shall treat the applicable update factor described in paragraph (3)(B)(vi) for a fiscal year as being equal to the market basket percentage for that year.".

SEC. 5422. REDUCTIONS TO CAPITAL PAYMENTS FOR CERTAIN PPS-EXEMPT HOSPITALS AND UNITS.

Section 1886(g) (42 U.S.C. 1395ww(g)) is amended by adding at the end the following new paragraph:

"(4) In determining the amount of the payments that are attributable to portions of cost reporting periods occurring during fiscal years 1998 through 2002 and that may be made under this title with respect to capital-related costs of inpatient hospital services of a hospital which is described in clause (i), (ii), or (iv) of subsection (d)(1)(B) or a unit described in the matter after clause (v) of such subsection, the Secretary shall reduce the amounts of such payments otherwise determined under this title by 15 percent.".

SEC. 5423. CAP ON TEFRA LIMITS.

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

(1) in subparagraph (A) by striking "subparagraphs (C), (D), and (E)" and inserting "subparagraph (C) and succeeding subparagraphs", and

(2) by adding at the end the following:

"(F)(i) In the case of a hospital or unit that is within a class of hospital described in clause (ii), for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002, such target amount may not be greater than the 90th percentile of the target amounts for such hospitals within such class for cost reporting periods beginning during that fiscal year.

"(ii) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

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

"(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

"(III) Hospitals described in clause (iv) of such subsection.".

SEC. 5424. CHANGE IN BONUS AND RELIEF PAYMENTS.

(a) CHANGE IN BONUS PAYMENT.—Section 1886(b)(1)(A) (42 U.S.C. 1395ww(b)(1)(A)) is amended by striking all that follows "plus—" and inserting the following:

"(i) 10 percent of the amount by which the target amount exceeds the amount of the operating costs, or

"(ii) 1 percent of the operating costs,

whichever is less;".

(b) CHANGE IN RELIEF PAYMENTS.—Section 1886(b)(1) (42 U.S.C. 1395ww(b)(1)) is amended—

(1) in subparagraph (B)—

(A) by striking "greater than the target amount" and inserting "greater than 110 percent of the target amount",

(B) by striking "exceed the target amount" and inserting "exceed 110 percent of the target amount",

(C) by striking "10 percent" and inserting "20 percent", and

(D) by redesignating such subparagraph as subparagraph (C); and

(2) by inserting after subparagraph (A) the following new subparagraph:

"(B) are greater than the target amount but do not exceed 110 percent of the target amount, the amount of the payment with respect to those operating costs payable under part A on a per discharge basis shall equal the target amount; or".

SEC. 5425. TARGET AMOUNTS FOR REHABILITATION HOSPITALS, LONG-TERM CARE HOSPITALS, AND PSYCHIATRIC HOSPITALS.

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

(1) in subparagraph (A), in the matter preceding clause (i), by striking "and (E)" and inserting "(E), (F), and (G)"; and

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

"(F) In the case of a rehabilitation hospital (or unit thereof) (as described in clause (ii) of subsection (d)(1)(B)), for cost reporting periods beginning on or after October 1, 1997—

"(i) in the case of a hospital which first receives payments under this section before October 1, 1997, the target amount determined under subparagraph (A) for such hospital or unit for a cost reporting period beginning during a fiscal year shall not be less than 50 percent of the national mean of the target amounts determined under such subparagraph for all such hospitals for cost reporting periods beginning during such fiscal year (determined without regard to this subparagraph); and

"(ii) in the case of a hospital which first receives payments under this section on or after October 1, 1997, such target amount may not be greater than 130 percent of the national mean of the target amounts for such hospitals (and units thereof) for cost reporting periods beginning during fiscal year 1991.

"(G) In the case of a hospital which has an average inpatient length of stay of greater than 25 days (as described in clause (iv) of subsection (d)(1)(B)), for cost reporting periods beginning on or after October 1, 1997—

"(i) in the case of a hospital which first receives payments under this section as a hospital that is not a subsection (d) hospital or a subsection (d) Puerto Rico hospital before October 1, 1997, the target amount determined under subparagraph (A) for such hospital for a cost reporting period beginning during a fiscal year shall not be less than 50 percent of the national mean of the target amounts determined under such subparagraph for all such hospitals for cost reporting periods begin-

ning during such fiscal year (determined without regard to this subparagraph); and

"(ii) in the case of any other hospital which first receives payment under this section on or after October 1, 1997, such target amount may not be greater than 130 percent of such national mean of the target amounts for such hospitals for cost reporting periods beginning during fiscal year 1991.

"(H) In the case of a psychiatric hospital (as defined in section 1861(f)), for cost reporting periods beginning on or after October 1, 1997—

"(i) in the case of a hospital which first receives payments under this section before October 1, 1997, the target amount determined under subparagraph (A) for such hospital for a cost reporting period beginning during a fiscal year shall not be less than 50 percent of the national mean of the target amounts determined under such subparagraph for all such hospitals for cost reporting periods beginning during such fiscal year (determined without regard to this subparagraph); and

"(ii) in the case of any other hospital which first receives payment under this section on or after October 1, 1997, such target amount may not be greater than 130 percent of such national mean of the target amounts for such hospitals for cost reporting periods beginning during fiscal year 1991.".

SEC. 5426. TREATMENT OF CERTAIN LONG-TERM CARE HOSPITALS LOCATED WITHIN OTHER HOSPITALS.

(a) IN GENERAL.—Section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended by adding at the end the following new sentence: "A hospital that was classified by the Secretary on or before September 30, 1995, as a hospital described in clause (iv) shall continue to be so classified notwithstanding that it is located in the same building as, or on the same campus as, another hospital.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to discharges occurring on or after October 1, 1995.

SEC. 5427. ELIMINATION OF EXEMPTIONS; REPORT ON EXCEPTIONS AND ADJUSTMENTS.

(a) ELIMINATION OF EXEMPTIONS.—

(1) IN GENERAL.—Section 1886(b)(4)(A)(i) (42 U.S.C. 1395ww(b)(4)(A)(i)) is amended by striking "exemption from, or an exception and adjustment to," and inserting "an exception and adjustment to" each place it appears.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to hospitals that first qualify as a hospital described in clause (i), (ii), or (iv) of section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) on or after October 1, 1997.

(b) REPORT.—The Secretary of Health and Human Services shall publish annually in the Federal Register a report describing the total amount of payments made to hospitals by reason of section 1886(b)(4) of the Social Security Act (42 U.S.C. 1395ww(b)(4)), as amended by subsection (a), for cost reporting periods ending during the previous fiscal year.

SEC. 5428. TECHNICAL CORRECTION RELATING TO SUBSECTION (d) HOSPITALS.

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

(1) in subparagraph (B)(v)—

(A) by inserting "(I)" after "(v)"; and

(B) by striking the semicolon at the end and inserting ", or"; and

(C) by adding at the end the following:

"(II) a hospital that—

"(aa) was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, or is able to demonstrate, for any six-month period, that at least 50 percent of its total discharges have a principal diagnosis that reflects a finding of neoplastic disease, as defined in subparagraph (E);

"(bb) applied on or before December 31, 1990, for classification as a hospital involved extensively in treatment for or research on cancer under this clause (as in effect on the day before the date of the enactment of this subclause), but was not approved for such classification; and

"(cc) is located in a State which, as of December 19, 1989, was not operating a demonstration project under section 1814(b);"; and

(2) by adding at the end the following:

"(E) For purposes of subparagraph (B)(v)(II)(aa), the term 'principal diagnosis that reflects a finding of neoplastic disease' means the condition established after study to be chiefly responsible for occasioning the admission of a patient to a hospital, except that only discharges with ICD–9–CM principal diagnosis codes of 140 through 239, V58.0, V58.1, V66.1, or 990 will be considered to reflect such a principal diagnosis.".

(b) PAYMENTS.—Any classification by reason of section 1886(d)(1)(B)(v)(II) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(v)(II)) (as added by subsection (a)) shall apply to all cost reporting periods beginning on or after January 1, 1991. Any payments owed to a hospital as a result of such section (as so amended) shall be made expeditiously, but in no event later than 1 year after the date of enactment of this Act.

SEC. 5429. CERTAIN CANCER HOSPITALS.

(a) IN GENERAL.—Section 1886(d)(1) (42 U.S.C. 1395ww(d)(1)), as amended by section 5428, is amended—

(1) in subparagraph (B)(v), by striking the semicolon at the end of subclause (II)(cc) and inserting the following: ", or", and by adding at the end the following:

"(III) a hospital—

"(aa) that was classified under subsection (iv) beginning on or before December 31, 1990, and through December 31, 1995; and

"(bb) throughout the period described in item (aa) and currently has greater than 49 percent of its total patient discharges with a principal diagnosis that reflects a finding of neoplastic disease;"; and

(2) by adding at the end the following:

"(F) In the case of a hospital that is classified under subparagraph (B)(v)(III), no rebasing is permitted by such hospital and such hospital shall use the base period in effect at the time of such hospital's December 31, 1995, cost report.".

CHAPTER 3—GRADUATE MEDICAL EDUCATION PAYMENTS

Subchapter A—Direct Medical Education

SEC. 5441. LIMITATION ON NUMBER OF RESIDENTS AND ROLLING AVERAGE FTE COUNT.

Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended by adding after subparagraph (E) the following:

"(F) LIMITATION ON NUMBER OF RESIDENTS IN ALLOPATHIC AND OSTEOPATHIC MEDICINE.—Except as provided in subparagraph (H), such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number of full-time equivalent residents with respect to such programs for the hospital's most recent cost reporting period ending on or before December 31, 1996.

"(G) COUNTING INTERNS AND RESIDENTS FOR 1998 AND SUBSEQUENT YEARS.—

"(i) IN GENERAL.—For cost reporting periods beginning on or after October 1, 1997, subject to the limit described in subparagraph (F) and except as provided in subparagraph (H), the total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.

"(ii) ADJUSTMENT FOR SHORT PERIODS.—If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent resident counts pursuant to clause (ii) are based on the equivalent of full twelve-month cost reporting periods.

"(iii) TRANSITION RULE FOR 1998.—In the case of a hospital's first cost reporting period beginning on or after October 1, 1997, clause (i) shall be applied by using the average for such period and the preceding cost reporting period.

"(H) SPECIAL RULES FOR NEW FACILITIES.—

"(i) IN GENERAL.—If a hospital is an applicable facility under clause (iii) for any year with respect to

any approved medical residency training program described in subsection (h)—

"(I) subject to the applicable annual limit under clause (ii), the Secretary may provide an additional amount of full-time equivalent residents which may be taken into account with respect to such program under subparagraph (F) for cost reporting periods beginning during such year, and

"(II) the averaging rules under subparagraph (G) shall not apply for such year.

"(ii) APPLICABLE ANNUAL LIMIT.—The total of additional full-time equivalent residents which the Secretary may authorize under clause (i) for all applicable facilities for any year shall not exceed the amount which would result in the number of full-time equivalent residents with respect to approved medical residency training programs in the fields of allopathic and osteopathic medicine for all hospitals exceeding such number for the preceding year. In allocating such additional residents, the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

"(iii) APPLICABLE FACILITY.—For purposes of this subparagraph, a hospital shall be treated as an applicable facility with respect to an approved medical residency training program only during the first 5 years during which such program is in existence. A hospital shall not be treated as such a facility if the 5-year period described in the preceding sentence ended on or before December 31, 1996.

"(iv) COORDINATION WITH LIMIT.—For purposes of applying subparagraph (F), the number of full-time equivalent residents of an applicable facility with respect to any approved medical residency training program in the fields of allopathic and osteopathic medicine for the facility's most recent cost reporting period ending on or before December 31, 1996, shall be increased by the number of such residents allocated to such facility under clause (i)."

SEC. 5442. PERMITTING PAYMENT TO NONHOSPITAL PROVIDERS.

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

"(j) PAYMENT TO NONHOSPITAL PROVIDERS.—

"(1) IN GENERAL.—For cost reporting periods beginning on or after October 1, 1997, the Secretary may establish rules for payment to qualified nonhospital providers for their direct costs of medical education, if those costs are incurred in the operation of an approved medical residency training program described in subsection (h). Such rules shall specify the amounts, form, and manner in which payments will be made and the portion of such payments that will be made from each of the trust funds under this title.

"(2) QUALIFIED NONHOSPITAL PROVIDERS.—For purposes of this subsection, the term 'qualified nonhospital providers' means—

"(A) a federally qualified health center, as defined in section 1861(aa)(4);

"(B) a rural health clinic, as defined in section 1861(aa)(2); and

"(C) such other providers (other than hospitals) as the Secretary determines to be appropriate."

(b) PROHIBITION ON DOUBLE PAYMENTS.—Section 1886(h)(3)(B) (42 U.S.C. 1395ww(h)(3)(B)) is amended by adding at the end the following:

"The Secretary shall reduce the aggregate approved amount to the extent payment is made under subsection (j) for residents included in the hospital's count of full-time equivalent residents."

Subchapter B—Indirect Medical Education

SEC. 5446. INDIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.

(a) MULTIYEAR TRANSITION REGARDING PERCENTAGES.—

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

"(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to
c × (((1+r) to the nth power) − 1), where 'r' is the ratio of the hospital's full-time equivalent interns and residents to beds and 'n' equals .405. For discharges occurring—

"(I) on or after May 1, 1986, and before October 1, 1997, 'c' is equal to 1.89;

"(II) during fiscal year 1998, 'c' is equal to 1.72;

"(III) during fiscal year 1999, 'c' is equal to 1.6;

"(IV) during fiscal year 2000, 'c' is equal to 1.47; and

"(V) on or after October 1, 2000, 'c' is equal to 1.35."

(2) NO RESTANDARDIZATION OF PAYMENT AMOUNTS REQUIRED.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by adding at the end the following: "except that the Secretary shall not take into account any reduction in the amount of additional payments under paragraph (5)(B)(ii) resulting from the amendment made by section 5446(a)(1) of the Balanced Budget Act of 1997,".

(b) LIMITATION.—

(1) IN GENERAL.—Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding after clause (iv) the following:

"(v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full-time equivalent interns and residents in either a hospital or nonhospital setting may not exceed the number of such full-time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996.

"(vi) For purposes of clause (ii)—

"(I) 'r' may not exceed the ratio of the number of interns and residents as determined under clause (v) with respect to the hospital for its most recent cost reporting period ending on or before December 31, 1996, to the hospital's available beds (as defined by the Secretary) during that cost reporting period, and

"(II) for the hospital's cost reporting periods beginning on or after October 1, 1997, subject to the limits described in clauses (iv) and (v), the total number of full-time equivalent residents for payment purposes shall equal the average of the actual full-time equivalent resident count for the cost reporting period and the preceding two cost reporting periods.

In the case of the first cost reporting period beginning on or after October 1, 1997, subclause (II) shall be applied by using the average for such period and the preceding cost reporting period.

"(vii)(I) If a hospital is an applicable facility under subclause (III) for any year with respect to any approved medical residency training program described in subsection (h)—

"(aa) subject to the applicable annual limit under subclause (II), the Secretary may provide an additional amount of full-time equivalent interns and residents which may be taken into account with respect to such program under clauses (v) and (vi) for cost reporting periods beginning during such year, and

"(bb) the averaging rules under clause (vi)(II) shall not apply for such year.

"(II) The total of additional full-time equivalent interns and residents which the Secretary may authorize under subclause (I) for all applicable facilities for any year shall not exceed the amount which would result in the number of full-time equivalent interns or residents for all hospitals exceeding such number for the preceding year. In allocating such additional residents, the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

"(III) For purposes of this clause, a hospital shall be treated as an applicable facility with respect to an approved medical residency training program only during the first 5 years during which such program is in existence. A hospital shall not be treated as such a facility if the 5-year period described in the preceding sentence ended on or before December 31, 1996.

"(IV) For purposes of applying clause (v), the number of full-time equivalent residents of an applicable facility with respect to any approved medical residency training program for the facility's most recent cost reporting period ending on or before December 31, 1996, shall be increased by the number of such residents allocated to such facility under subclause (I).

"(viii) If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent residency count pursuant to subclause (II) of clause (vi) is based on the equivalent of full twelve-month cost reporting periods."

(2) PAYMENT FOR INTERNS AND RESIDENTS PROVIDING OFF-SITE SERVICES.—Section 1886(d)(5)(B)(iv) (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended to read as follows:

"(iv) Effective for discharges occurring on or after October 1, 1997, all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting."

Subchapter C—Graduate Medical Education Payments for Managed Care Enrollees

SEC. 5451. DIRECT AND INDIRECT MEDICAL EDUCATION PAYMENTS TO HOSPITALS FOR MANAGED CARE ENROLLEES.

(a) PAYMENTS TO HOSPITALS FOR DIRECT COSTS OF GRADUATE MEDICAL EDUCATION.—Section 1886(h)(3) (42 U.S.C. 1395ww(h)(3)) is amended by adding after subparagraph (C) the following:

"(D) PAYMENT FOR MEDICARE CHOICE ENROLLEES.—

"(i) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount under this subsection for services furnished to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 and who are entitled to part A or with a Medicare Choice organization under part C. The amount of such a payment shall equal the applicable percentage of the product of—

"(I) the aggregate approved amount (as defined in subparagraph (B)) for that period; and

"(II) the fraction of the total number of inpatient-bed days (as established by the Secretary) during the period which are attributable to such enrolled individuals.

"(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the applicable percentage is—

"(I) 25 percent in 1998,

"(II) 50 percent in 1999,

"(III) 75 percent in 2000, and

"(IV) 100 percent in 2001 and subsequent years.

"(iii) SPECIAL RULE FOR HOSPITALS UNDER REIMBURSEMENT SYSTEM.—The Secretary shall establish rules for the application of this subparagraph to a hospital reimbursed under a reimbursement system authorized under section 1814(b)(3) in the same manner

as it would apply to the hospital if it were not reimbursed under such section."

(b) PAYMENT TO HOSPITALS OF INDIRECT MEDICAL EDUCATION COSTS.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following:

"(11) ADDITIONAL PAYMENTS FOR MANAGED CARE SAVINGS.—

"(A) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital (or any hospital reimbursed under a reimbursement system authorized under section 1814(b)(3)) that has an approved medical residency training program.

"(B) APPLICABLE DISCHARGE.—For purposes of this paragraph, the term 'applicable discharge' means the discharge of any individual who is enrolled under a risk-sharing contract with an eligible organization under section 1876 and who is entitled to benefits under part A or any individual who is enrolled with a Medicare Choice organization under part C.

"(C) DETERMINATION OF AMOUNT.—The amount of the payment under this paragraph with respect to any applicable discharge shall be equal to the applicable percentage (as defined in subsection (h)(3)(D)(ii)) of the estimated average per discharge amount that would otherwise have been paid under paragraph (1)(A) if the individuals had not been enrolled as described in subparagraph (B)."

SEC. 5452. DEMONSTRATION PROJECT ON USE OF CONSORTIA.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish a demonstration project under which, instead of making payments to teaching hospitals pursuant to section 1886(h) of the Social Security Act, the Secretary shall make payments under this section to each consortium that meets the requirements of subsection (b).

(b) QUALIFYING CONSORTIA.—For purposes of subsection (a), a consortium meets the requirements of this subsection if the consortium is in compliance with the following:

(1) The consortium consists of an approved medical residency training program in a teaching hospital and one or more of the following entities:

(A) A school of allopathic medicine or osteopathic medicine.

(B) Another teaching hospital, which may be a children's hospital.

(C) Another approved medical residency training program.

(D) A federally qualified health center.

(E) A medical group practice.

(F) A managed care entity.

(G) An entity furnishing outpatient services.

(I) Such other entity as the Secretary determines to be appropriate.

(2) The members of the consortium have agreed to participate in the programs of graduate medical education that are operated by the entities in the consortium.

(3) With respect to the receipt by the consortium of payments made pursuant to this section, the members of the consortium have agreed on a method for allocating the payments among the members.

(4) The consortium meets such additional requirements as the Secretary may establish.

(c) AMOUNT AND SOURCE OF PAYMENT.—The total of payments to a qualifying consortium for a fiscal year pursuant to subsection (a) shall not exceed the amount that would have been paid under section 1886(h) of the Social Security Act for the teaching hospital (or hospitals) in the consortium. Such payments shall be made in such proportion from each of the trust funds established under title XVIII of such Act as the Secretary specifies.

CHAPTER 4—OTHER HOSPITAL PAYMENTS

SEC. 5461. DISPROPORTIONATE SHARE PAYMENTS TO HOSPITALS FOR MANAGED CARE AND MEDICARE CHOICE ENROLLEES.

Section 1886(d) (42 U.S.C. 1395ww(d)) (as amended by section 5451) is amended by adding at the end the following:

"(12) ADDITIONAL PAYMENTS FOR MANAGED CARE AND MEDICARE CHOICE SAVINGS.—

"(A) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each applicable discharge of—

(i) any subsection (d) hospital that is a disproportionate share hospital (as described in paragraph (5)(F)(i)); or

(ii) any hospital reimbursed under a reimbursement system authorized under section 1814(b)(3)) if such hospital would qualify as a disproportionate share hospital were it not so reimbursed.

"(B) APPLICABLE DISCHARGE.—For purposes of this paragraph, the term 'applicable discharge' means the discharge of any individual who is enrolled under a risk-sharing contract with an eligible organization under section 1876 and who is entitled to benefits under part A or any individual who is enrolled with a Medicare Choice organization under part C.

"(C) DETERMINATION OF AMOUNT.—The amount of the payment under this paragraph with respect to any applicable discharge shall be equal to the applicable percentage (as defined in subsection (h)(3)(D)(ii)) of the estimated average per discharge amount that would otherwise have been paid under paragraph (1)(A) if the individuals had not been enrolled as described in subparagraph (B).".

SEC. 5462. REFORM OF DISPROPORTIONATE SHARE PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS.

(a) IN GENERAL.—Section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (i), by inserting "and before December 31, 1998," after "May, 1, 1986,";

(2) in clause (ii), by striking "The amount" and inserting "Subject to clauses (ix) and (x), the amount"; and

(3) by adding at the end the following:

"(ix) In the case of discharges occurring on or after October 1, 1997, and before December 31, 1998, the additional payment amount otherwise determined under clause (ii) shall be reduced by 4 percent.

"(x)(I) In the case of discharges occurring during calendar years 1999 and succeeding calendar years, the additional payment amount shall be determined in accordance with the formula established under subclause (II).

"(II) Not later than January 1, 1999, the Secretary shall establish a formula for determining additional payment amounts under this subparagraph. In determining such formula the Secretary shall—

"(aa) establish a single threshold for costs incurred by hospitals in serving low-income patients,

"(bb) consider the costs described in subclause (III), and

"(cc) ensure that such formula complies with the requirement described in subclause (IV).

"(III) The costs described in this subclause are as follows:

"(aa) The costs incurred by the hospital during a period (as determined by the Secretary) of furnishing inpatient and outpatient hospital services to individuals who are entitled to benefits under part A of this title and are entitled to supplemental security income benefits under title XVI (excluding any supplementation of those benefits by a State under section 1616).

"(bb) The costs incurred by the hospital during a period (as so determined) of furnishing inpatient and outpatient hospital services to individuals who are eligible for medical assistance under the State plan under title XIX and are not entitled to benefits under part A of this title (including individuals enrolled in a health maintenance organization (as defined in section 1903(m)(1)(A)) or any other managed care plan under such title, individuals who are eligible for medical assistance under such title pursuant to a waiver approved by the Secretary under section 1115, and individuals who are eligible for medical assistance under the State plan under title XIX (regardless of whether the State has provided reimbursement for any such assistance provided under such title)).

"(cc) The costs incurred by the hospital during a period (as so determined) of furnishing inpatient and outpatient hospital services to individuals who are not described in item (aa) or (bb) and who do not have health insurance coverage (or any other source of third party payment for such services) and for which the hospital did not receive compensation.

"(IV)(aa) The requirement described in this subclause is that for each calendar year for which the formula established

under this clause applies, the additional payment amount determined for such calendar year under such formula shall not exceed an amount equal to the additional payment amount that, in the absence of such formula, would have been determined under this subparagraph, reduced by the applicable percentage for such calendar year.

"(bb) For purposes of subclause (aa), the applicable percentage for—

"(AA) calendar year 1999 is 8 percent;

"(BB) calendar year 2000 is 12 percent;

"(CC) calendar year 2001 is 16 percent;

"(DD) calendar year 2002 is 20 percent;

"(EE) calendar year 2003 and subsequent calendar years, is 0 percent".

(b) DATA COLLECTION.—

(1) IN GENERAL.—In developing the formula under section 1886(g)(5)(F)(x) of the Social Security Act (42 U.S.C. 1395ww(g)(5)(F)(x)), as added by subsection (a), and in implementing the provisions of and amendments made by this section, the Secretary of Health and Human Services may require any subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) receiving additional payments by reason of section 1886(d)(5)(F) of that Act (42 U.S.C. 1395ww(d)(5)(F)) (as amended by subsection (a) of this section) to submit to the Secretary any information that the Secretary determines is necessary to implement the provisions of and amendments made by this section.

(2) FAILURE TO COMPLY.—Any subsection (d) hospital (as so defined) that fails to submit to the Secretary of Health and Human Services any information requested under paragraph (1), shall be deemed ineligible for an additional payment amount under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) (as amended by subsection (a) of this section).

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to discharges occurring on and after October 1, 1997.

SEC. 5463. MEDICARE CAPITAL ASSET SALES PRICE EQUAL TO BOOK VALUE.

(a) IN GENERAL.—Section 1861(v)(1)(O) (42 U.S.C. 1395x(v)(1)(O)) is amended—

(1) in clause (i)—

(A) by striking "and (if applicable) a return on equity capital";

(B) by striking "hospital or skilled nursing facility" and inserting "provider of services";

(C) by striking "clause (iv)" and inserting "clause (iii)"; and

(D) by striking "the lesser of the allowable acquisition cost" and all that follows and inserting "the historical cost of the asset, as recognized under this title, less depreciation allowed, to the owner of record as of the date of enactment of the Balanced Budget Act of 1997 (or, in the case of an asset not in existence as of that date, the first owner of record of the asset after that date).";

(2) by striking clause (ii); and

(3) by redesignating clauses (iii) and (iv) as clauses (ii) and (iii), respectively.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to changes of ownership that occur after the third month beginning after the date of enactment of this section.

SEC. 5464. ELIMINATION OF IME AND DSH PAYMENTS ATTRIBUTABLE TO OUTLIER PAYMENTS.

(a) INDIRECT MEDICAL EDUCATION.—Section 1886(d)(5)(B)(i)(I) (42 U.S.C. 1395ww(d)(5)(B)(i)(I)) is amended by inserting ", for cases qualifying for additional payment under subparagraph (A)(i)," before "the amount paid to the hospital under subparagraph (A)".

(b) DISPROPORTIONATE SHARE ADJUSTMENTS.—Section 1886(d)(5)(F)(ii)(I) (42 U.S.C. 1395ww(d)(5)(F)(ii)(I)) is amended by inserting ", for cases qualifying for additional payment under subparagraph (A)(i)," before "the amount paid to the hospital under subparagraph (A)".

(c) COST OUTLIER PAYMENTS.—Section 1886(d)(5)(A)(ii) (42 U.S.C. 1395ww(d)(5)(A)(ii)) is amended by striking "exceed the applicable DRG prospective payment rate" and inserting "exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under subparagraphs (B) and (F) of subsection (d)(5)".

(d) EFFECTIVE DATE.—The amendments made by this section apply to discharges occurring after September 30, 1997.

SEC. 5465. TREATMENT OF TRANSFER CASES.

(a) TRANSFERS TO PPS EXEMPT HOSPITALS AND SKILLED NURSING FACILITIES.—Section 1886(d)(5)(I) (42 U.S.C. 1395ww(d)(5)(I)) is amended by adding at the end the following new clause:

"(iii) In carrying out this subparagraph, the Secretary shall treat the term 'transfer case' as including the case of an individual who, upon discharge from a subsection (d) hospital—

"(I) is admitted as an inpatient to a hospital or hospital unit that is not a subsection (d) hospital for the receipt of inpatient hospital services; or

"(II) is admitted to a skilled nursing facility or facility described in section 1861(y)(1) for the receipt of extended care services.".

(b) TRANSFERS FOR PURPOSES OF HOME HEALTH SERVICES.—Section 1886(d)(5)(I) (42 U.S.C. 1395ww(d)(5)(I)), as amended by subsection (a), is amended—

(1) in clause (iii), by striking the period at the end and inserting "; or" and

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

"(III) receives home health services from a home health agency, if such services directly relate to the condition or diagnosis for which such individual received inpatient hospital services from the subsection (d) hospital, and if such services are provided within an appropriate period as determined by the Secretary in regulations promulgated not later than April 1, 1998.".

(c) EFFECTIVE DATES.—

(1) The amendment made by subsection (a) shall apply with respect to discharges occurring on or after October 1, 1997.

(2) The amendment made by subsection (b) shall apply with respect to discharges occurring on or after April 1, 1998.

SEC. 5466. REDUCTIONS IN PAYMENTS FOR ENROLLEE BAD DEBT.

Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

"(T) In determining such reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs which are attributable to the deductibles and coinsurance amounts under this title shall be reduced—

"(i) for cost reporting periods beginning on or after October 1, 1997 and on or before December 31, 1998, by 25 percent of such amount otherwise allowable,

"(ii) for cost reporting periods beginning during calendar year 1999, by 40 percent of such amount otherwise allowable, and

"(iii) for cost reporting periods beginning during a subsequent calendar year, by 50 percent of such amount otherwise allowable.".

SEC. 5467. FLOOR ON AREA WAGE INDEX.

(a) IN GENERAL.—For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)) may not be less than the average of the area wage indices applicable under such section to hospitals located in rural areas in the State in which the hospital is located.

(b) IMPLEMENTATION.—The Secretary of Health and Human Services shall adjust the area wage indices referred to in subsection (a) for hospitals not described in such subsection in a manner which assures that the aggregate payments made under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) in a fiscal year for the operating costs of inpatient hospital services are not greater or less than those which would have been made in the year if this section did not apply.

SEC. 4568. INCREASE BASE PAYMENT RATE TO PUERTO RICO HOSPITALS.

Section 1886(d)(9)(A) (42 U.S.C. 1395ww(d)(9)(A)) is amended—

(1) in the matter preceding clause (i), by striking "in a fiscal year beginning on or after October 1, 1987,",

(2) in clause (i), by striking "75 percent" and inserting "for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)", and

(3) in clause (ii), by striking "25 percent" and inserting "for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987 and September 30, 1997, 25 percent)".

SEC. 5469. PERMANENT EXTENSION OF HEMOPHILIA PASS-THROUGH.

Effective October 1, 1997, section 6011(d) of OBRA–1989 (as amended by section 13505 of OBRA–1993) is amended by striking "and shall expire September 30, 1994".

SEC. 5470. COVERAGE OF SERVICES IN RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONS UNDER THE MEDICARE AND MEDICAID PROGRAMS.

(a) MEDICARE COVERAGE.—

(1) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) (as amended by section 5361) is amended—

(1) in the sixth sentence of subsection (e)—

(A) by striking "includes" and all that follows up to "but only" and inserting "includes a religious nonmedical health care institution (as defined in subsection (rr)(1)),", and

(B) by inserting "consistent with section 1821" before the period;

(2) in subsection (y)—

(A) by amending the heading to read as follows:

"Extended Care in Religious Nonmedical Health Care Institutions",

(B) in paragraph (1), by striking "includes" and all that follows up to "but only" and inserting "includes a religious nonmedical health care institution (as defined in subsection (rr)(1))," , and

(C) by inserting "consistent with section 1821" before the period; and

(3) by adding at the end the following:

"Religious Nonmedical Health Care Institution

"(rr)(1) The term 'religious nonmedical health care institution' means an institution that—

"(A) is described in subsection (c)(3) of section 501 of the Internal Revenue Code of 1986 and is exempt from taxes under subsection (a) of such section;

"(B) is lawfully operated under all applicable Federal, State, and local laws and regulations;

"(C) provides only nonmedical nursing items and services exclusively to patients who choose to rely solely upon a religious method of healing and for whom the acceptance of medical health services would be inconsistent with their religious beliefs;

"(D) provides such nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of such patients;

"(E) provides such nonmedical items and services to inpatients on a 24-hour basis;

"(F) on the basis of its religious beliefs, does not provide through its personnel or otherwise medical items and services (including any medical screening, examination, diagnosis, prognosis, treatment, or the administration of drugs) for its patients;

"(G) is not a part of, or owned by, or under common ownership with, or affiliated through ownership with, a health care facility that provides medical services;

"(H) has in effect a utilization review plan which—

"(i) provides for the review of admissions to the institution, of the duration of stays therein, of cases of continuous extended duration, and of the items and services furnished by the institution,

"(ii) requires that such reviews be made by an appropriate committee of the institution that includes the individuals responsible for overall administration and for supervision of nursing personnel at the institution,

"(iii) provides that records be maintained of the meetings, decisions, and actions of such committee, and

"(iv) meets such other requirements as the Secretary finds necessary to establish an effective utilization review plan;

"(I) provides the Secretary with such information as the Secretary may require to implement section 1821, to monitor quality of care, and to provide for coverage determinations; and

"(J) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

"(2) If the Secretary finds that the accreditation of an institution by a State, regional, or national agency or association provides reasonable assurances that any or all of the requirements of paragraph (1) are met or exceeded, the Secretary shall, to the extent the Secretary deems it appropriate, treat such institution as meeting the condition or conditions with respect to which the Secretary made such finding.

"(3)(A)(i) In administering this subsection and section 1821, the Secretary shall not require any patient of a religious nonmedical health care institution to undergo any medical screening, examination, diagnosis, prognosis, or treatment or to accept any other medical health care service, if such patient (or legal representative of the patient) objects thereto on religious grounds.

"(ii) Clause (i) shall not be construed as preventing the Secretary from requiring under section 1821(a)(2) the provision of sufficient information regarding an individual's condition as a condition for receipt of benefits under part A for services provided in such an institution.

"(B)(i) In administering this subsection and section 1821, the Secretary shall not subject a religious nonmedical health care institution to any medical supervision, regulation, or control, insofar as such supervision, regulation, or control would be contrary to the religious beliefs observed by the institution.

"(ii) Clause (i) shall not be construed as preventing the Secretary from reviewing items and services billed by the institution to the extent the Secretary determines such review to be necessary to determine whether such items and services were not covered under part A, are excessive, or are fraudulent.".

(2) CONDITIONS OF COVERAGE.—Part A of title XVIII of the Social Security Act is amended by adding at the end the following new section:

"CONDITIONS FOR COVERAGE OF RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONAL SERVICES

"SEC. 1821. (a) IN GENERAL.—Subject to subsections (c) and (d), payment under this part may be made for inpatient hospital services or post-hospital extended care services furnished an individual in a religious nonmedical health care institution only if—

"(1) the individual has an election in effect for such benefits under subsection (b); and

"(2) the individual has a condition such that the individual would qualify for benefits under this part for inpatient hospital services or extended care services, respectively, if the individual were an inpatient or resident in a hospital or skilled nursing facility that was not such an institution.

"(b) ELECTION.—

"(1) IN GENERAL.—An individual may make an election under this subsection in a form and manner specified by the Secretary consistent with this subsection. Unless otherwise provided, such an election shall take effect immediately upon its execution. Such an election, once made, shall continue in effect until revoked.

"(2) FORM.—The election form under this subsection shall include the following:

"(A) A statement, signed by the individual (or such individual's legal representative), that—

"(i) the individual is conscientiously opposed to acceptance of nonexcepted medical treatment; and

"(ii) the individual's acceptance of nonexcepted medical treatment would be inconsistent with the individual's sincere religious beliefs.

"(B) A statement that the receipt of non-excepted medical services shall constitute a revocation of the election and may limit further receipt of services described in subsection (a).

"(3) REVOCATION.—An election under this subsection by an individual may be revoked in a form and manner specified by the Secretary and shall be deemed to be revoked if the individual receives medicare reimbursable non-excepted medical treatment, regardless of whether or not benefits for such treatment are provided under this title.

"(4) LIMITATION ON SUBSEQUENT ELECTIONS.—Once an individual's election under this subsection has been made and revoked twice—

"(A) the next election may not become effective until the date that is 1 year after the date of most recent previous revocation, and

"(B) any succeeding election may not become effective until the date that is 5 years after the date of the most recent previous revocation.

"(5) EXCEPTED MEDICAL TREATMENT.—For purposes of this subsection:

"(A) EXCEPTED MEDICAL TREATMENT.—The term 'excepted medical treatment' means medical care or treatment (including medical and other health services)—

"(i) for the setting of fractured bones,

"(ii) received involuntarily, or

"(iii) required under Federal or State law or law of a political subdivision of a State.

"(B) NON-EXCEPTED MEDICAL TREATMENT.—The term 'nonexcepted medical treatment' means medical care or treatment (including medical and other health services) other than excepted medical treatment.

"(c) MONITORING AND SAFEGUARD AGAINST EXCESSIVE EXPENDITURES.—

"(1) ESTIMATE OF EXPENDITURES.—Before the beginning of each fiscal year (beginning with fiscal year 2000), the Secretary shall estimate the level of expenditures under this part for services described in subsection (a)for that fiscal year.

"(2) ADJUSTMENT IN PAYMENTS.—

"(A) PROPORTIONAL ADJUSTMENT.—If the Secretary determines that the level estimated under paragraph (1) for a fiscal year will exceed the trigger level (as defined in subparagraph (C)) for that fiscal year, the Secretary shall, subject to subparagraph (B), provide for such a proportional reduction in payment amounts under this part for services described in subsection (a) for the fiscal year involved as will assure that such level (taking into account any adjustment under subparagraph (B)) does not exceed the trigger level for that fiscal year.

"(B) ALTERNATIVE ADJUSTMENTS.—The Secretary may, instead of making some or all of the reduction described in subparagraph (A), impose such other conditions or limitations with respect to the coverage of covered services (including limitations on new elections of coverage and new facilities) as may be appropriate to reduce the level of expenditures described in paragraph (1) to the trigger level.

"(C) TRIGGER LEVEL.—For purposes of this subsection, subject to adjustment under paragraph (3)(B), the 'trigger level' for—

"(i) fiscal year 1998, is $20,000,000, or

"(ii) a succeeding fiscal year is the amount specified under this subparagraph for the previous fiscal year increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with July preceding the beginning of the fiscal year.

"(D) PROHIBITION OF ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the estimation of expenditures under subparagraph (A) or the application of reduction amounts under subparagraph (B).

"(E) EFFECT ON BILLING.—Notwithstanding any other provision of this title, in the case of a reduction in payment provided under this subsection for services of a reli-

gious nonmedical health care institution provided to an individual, the amount that the institution is otherwise permitted to charge the individual for such services is increased by the amount of such reduction.

"(3) MONITORING EXPENDITURE LEVEL.—

"(A) IN GENERAL.—The Secretary shall monitor the expenditure level described in paragraph (2)(A) for each fiscal year (beginning with fiscal year 1999).

"(B) ADJUSTMENT IN TRIGGER LEVEL.—If the Secretary determines that such level for a fiscal year exceeded, or was less than, the trigger level for that fiscal year, then the trigger level for the succeeding fiscal year shall be reduced, or increased, respectively, by the amount of such excess or deficit.

"(d) SUNSET.—If the Secretary determines that the level of expenditures described in subsection (c)(1) for 3 consecutive fiscal years (with the first such year being not earlier than fiscal year 2002) exceeds the trigger level for such expenditures for such years (as determined under subsection (c)(2)), benefits shall be paid under this part for services described in subsection (a) and furnished on or after the first January 1 that occurs after such 3 consecutive years only with respect to an individual who has an election in effect under subsection (b) as of such January 1 and only during the duration of such election.

"(e) ANNUAL REPORT.—At the beginning of each fiscal year (beginning with fiscal year 1999), the Secretary shall submit to the Committees on Ways and Means of the House of Representatives and the Committee on Finance of the Senate an annual report on coverage and expenditures for services described in subsection (a) under this part and under State plans under title XIX. Such report shall include—

"(1) level of expenditures described in subsection (c)(1) for the previous fiscal year and estimated for the fiscal year involved;

"(2) trends in such level; and

"(3) facts and circumstances of any significant change in such level from the level in previous fiscal years.".

(b) MEDICAID.—

(1) The third sentence of section 1902(a) of such Act (42 U.S.C. 1396a(a)) is amended by striking all that follows "shall not apply" and inserting "to a religious nonmedical health care institution (as defined in section 1861(rr)(1)).".

(2) Section 1908(e)(1) of such Act (42 U.S.C. 1396g–1(e)(1)) is amended by striking all that follows "does not include" and inserting "a religious nonmedical health care institution (as defined in section 1861(rr)(1)).".

(c) CONFORMING AMENDMENTS.—

(1) Section 1122(h) of such Act (42 U.S.C. 1320a–1(h)) is amended by striking all that follows "shall not apply to" and inserting "a religious nonmedical health care institution (as defined in section 1861(rr)(1)).".

(2) Section 1162 of such Act (42 U.S.C. 1320c–11) is amended—

(A) by amending the heading to read as follows:

"EXEMPTIONS FOR RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONS"; and

(B) by striking all that follows "shall not apply with respect to a" and inserting "religious nonmedical health care institution (as defined in section 1861(rr)(1)).".

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date. By not later than July 1, 1998, the Secretary of Health and Human Services shall first issue regulations to carry out such amendments. Such regulations may be issued so they are effective on an interim basis pending notice and opportunity for public comment. For periods before the effective date of such regulations, such regulations shall recognize elections entered into in good faith in order to comply with the requirements of section 1821(b) of the Social Security Act.

CHAPTER 5—PAYMENTS FOR HOSPICE SERVICES

SEC. 5481. PAYMENT FOR HOME HOSPICE CARE BASED ON LOCATION WHERE CARE IS FURNISHED.

(a) IN GENERAL.—Section 1814(i)(2) (42 U.S.C. 1395f(i)(2)) is amended by adding at the end the following:

"(D) A hospice program shall submit claims for payment for hospice care furnished in an individual's home under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to cost reporting periods beginning on or after October 1, 1997.

SEC. 5482. HOSPICE CARE BENEFITS PERIODS.

(a) RESTRUCTURING OF BENEFIT PERIOD.—Section 1812 (42 U.S.C. 1395d) is amended in subsections (a)(4) and (d)(1), by striking ", a subsequent period of 30 days, and a subsequent extension period" and inserting "and an unlimited number of subsequent periods of 60 days each".

(b) CONFORMING AMENDMENTS.—(1) Section 1812 (42 U.S.C. 1395d) is amended in subsection (d)(2)(B) by striking "90- or 30-day period or a subsequent extension period" and inserting "90-day period or a subsequent 60-day period".

(2) Section 1814(a)(7)(A) (42 U.S.C. 1395f(a)(7)(A)) is amended—

(A) in clause (i), by inserting "and" at the end;

(B) in clause (ii)—

(i) by striking "30-day" and inserting "60-day"; and

(ii) by striking ", and" at the end and inserting a period; and

(C) by striking clause (iii).

SEC. 5483. OTHER ITEMS AND SERVICES INCLUDED IN HOSPICE CARE.

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

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

(2) in subparagraph (H), by striking the period at the end and inserting ", and"; and

(3) by inserting after subparagraph (H) the following:

"(I) any other item or service which is specified in the plan and for which payment may otherwise be made under this title.".

SEC. 5484. CONTRACTING WITH INDEPENDENT PHYSICIANS OR PHYSICIAN GROUPS FOR HOSPICE CARE SERVICES PERMITTED.

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

(1) in subparagraph (A)(ii)(I), by striking "(F),"; and

(2) in subparagraph (B)(i), by inserting "or, in the case of a physician described in subclause (I), under contract with" after "employed by".

SEC. 5485. WAIVER OF CERTAIN STAFFING REQUIREMENTS FOR HOSPICE CARE PROGRAMS IN NON-URBANIZED AREAS.

Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended—

(1) in subparagraph (B), by inserting "or (C)" after "subparagraph (A)" each place it appears; and

(2) by adding at the end the following:

"(C) The Secretary may waive the requirements of paragraph clauses (i) and (ii) of paragraph (2)(A) for an agency or organization with respect to the services described in paragraph (1)(B) and, with respect to dietary counseling, paragraph (1)(H), if such agency or organization—

"(i) is located in an area which is not an urbanized area (as defined by the Bureau of the Census), and

"(ii) demonstrates to the satisfaction of the Secretary that the agency or organization has been unable, despite diligent efforts, to recruit appropriate personnel.".

SEC. 5486. LIMITATION ON LIABILITY OF BENEFICIARIES FOR CERTAIN HOSPICE COVERAGE DENIALS.

Section 1879 (42 U.S.C. 1395pp) is amended—

(1) in subsection (a), in the matter following paragraph (2), by inserting "and except as provided in subsection (i)," after "to the extent permitted by this title,";

(2) in subsection (g)—

(A) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and indenting such subparagraphs appropriately;

(B) by striking "is," and inserting "is—";

(C) by making the remaining text of subsection (g) (as amended) that follows "is—" a new paragraph (1) and indenting that paragraph appropriately;

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

(E) by adding at the end the following:

"(2) with respect to the provision of hospice care to an individual, a determination that the individual is not terminally ill."; and

(3) by adding at the end the following:

"(i) In any case involving a coverage denial with respect to hospice care described in subsection (g)(2), only the individual that received such care shall, notwithstanding such determination, be indemnified for any payments that the individual made to a provider

or other person for such care that would, but for such denial, otherwise be paid to the individual under part A or B of this title.".

SEC. 5487. EXTENDING THE PERIOD FOR PHYSICIAN CERTIFICATION OF AN INDIVIDUAL'S TERMINAL ILLNESS.

Section 1814(a)(7)(A)(i) (42 U.S.C. 1395f(a)(7)(A)(i)) is amended, in the matter following subclause (II), by striking ", not later than 2 days after hospice care is initiated (or, if each certify verbally not later than 2 days after hospice care is initiated, not later than 8 days after such care is initiated)" and inserting "at the beginning of the period".

SEC. 5488. EFFECTIVE DATE.

Except as otherwise provided in this chapter, the amendments made by this chapter apply to benefits provided on or after the date of the enactment of this chapter, regardless of whether or not an individual has made an election under section 1812(d) of the Social Security Act (42 U.S.C. 1395d(d)) before such date.

Subtitle G—Provisions Relating to Part B Only

CHAPTER 1—PAYMENTS FOR PHYSICIANS AND OTHER HEALTH CARE PROVIDERS

SEC. 5501. ESTABLISHMENT OF SINGLE CONVERSION FACTOR FOR 1998.

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

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The conversion factor for each year shall be the conversion factor established under this subsection for the previous year, adjusted by the update established under paragraph (3) for the year involved.

"(B) SPECIAL RULE FOR 1998.—The single conversion factor for 1998 shall be the conversion factor for primary care services for 1997, increased by the Secretary's estimate of the weighted average of the 3 separate updates that would otherwise occur but for the enactment of chapter 1 of subtitle G of title V of the Balanced Budget Act of 1997.

"(C) PUBLICATION.—The Secretary shall, during the last 15 days of October of each year, publish the conversion factor which will apply to physicians' services for the following year and the update determined under paragraph (3) for such year."

(b) CONFORMING AMENDMENT.—Section 1848(i)(1)(C) (42 U.S.C. 1395w–4(i)(1)(C)) is amended by striking "conversion factors" and inserting "the conversion factor".

SEC. 5502. ESTABLISHING UPDATE TO CONVERSION FACTOR TO MATCH SPENDING UNDER SUSTAINABLE GROWTH RATE.

(a) UPDATE.—

(1) IN GENERAL.—Section 1848(d)(3) (42 U.S.C. 1395w–4(d)(3)) is amended to read as follows:

"(3) UPDATE.—

"(A) IN GENERAL.—Unless otherwise provided by law, subject to subparagraph (D) and the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii), the update to the single conversion factor established in paragraph (1)(B) for a year beginning with 1999 is equal to the product of—

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

"(ii) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100),

minus 1 and multiplied by 100.

"(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), the 'update adjustment factor' for a year is equal to the quotient (as estimated by the Secretary) of—

"(i) the difference between (I) the sum of the allowed expenditures for physicians' services (as determined under subparagraph (C)) for the period beginning July 1, 1997, and ending on June 30 of the year involved, and (II) the amount of actual expenditures for physicians' services furnished during the period beginning July 1, 1997, and ending on June 30 of the preceding year; divided by

"(ii) the actual expenditures for physicians' services for the 12-month period ending on June 30 of the preceding year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

"(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph, the allowed expenditures for physicians' services for the 12-month period ending with June 30 of—

"(i) 1997 is equal to the actual expenditures for physicians' services furnished during such 12-month period, as estimated by the Secretary; or

"(ii) a subsequent year is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

"(D) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

"(i) greater than 100 times the following amount: (1.03 + (MEI percentage/100)) - 1; or

"(ii) less than 100 times the following amount: (0.93 + (MEI percentage/100)) -1,

where 'MEI percentage' means the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.".

(b) ELIMINATION OF REPORT.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended by striking paragraph (2).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to the update for years beginning with 1999.

SEC. 5503. REPLACEMENT OF VOLUME PERFORMANCE STANDARD WITH SUSTAINABLE GROWTH RATE.

(a) IN GENERAL.—Section 1848(f) (42 U.S.C. 1395w–4(f)) is amended by striking paragraphs (2) through (5) and inserting the following:

"(2) SPECIFICATION OF GROWTH RATE.—The sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998) shall be equal to the product of—

"(A) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services in the fiscal year involved,

"(B) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than Medicare Choice plan enrollees) from the previous fiscal year to the fiscal year involved,

"(C) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous fiscal year to the fiscal year involved, and

"(D) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the fiscal year (compared with the previous fiscal year) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services resulting from changes in the update to the conversion factor under subsection (d)(3), minus 1 and multiplied by 100.

"(3) DEFINITIONS.—In this subsection:

"(A) SERVICES INCLUDED IN PHYSICIANS' SERVICES.—The term 'physicians' services' includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare Choice plan enrollee.

"(B) MEDICARE CHOICE PLAN ENROLLEE.—The term 'Medicare Choice plan enrollee' means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a Medicare Choice plan offered under part C, and also includes an individual who is receiving benefits under this part through enrollment with an eligible organization with a risk-sharing contract under section 1876.".

(b) CONFORMING AMENDMENTS.—So much of section 1848(f) (42 U.S.C. 1395w–4(f)) as precedes paragraph (2) is amended to read as follows:

"(f) SUSTAINABLE GROWTH RATE.—

"(1) PUBLICATION.—The Secretary shall cause to have published in the Federal Register the sustainable growth rate for each fiscal year beginning with fiscal year 1998. Such publication shall occur in the last 15 days of October of the year in which the fiscal year begins, except that such rate for fiscal year 1998 shall be published not later than January 1, 1998."

SEC. 5504. PAYMENT RULES FOR ANESTHESIA SERVICES.

(a) IN GENERAL.—Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)), as amended by section 5501, is amended—

(A) in subparagraph (B), striking "The single" and inserting "Except as provided in subparagraph (C), the single";

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

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

"(C) SPECIAL RULES FOR ANESTHESIA SERVICES.—The separate conversion factor for anesthesia services for a year shall be equal to 46 percent of the single conversion factor established for other physicians' services, except as adjusted for changes in work, practice expense, or malpractice relative value units.".

(b) CLASSIFICATION OF ANESTHESIA SERVICES.—The first sentence of section 1848(j)(1) (42 U.S.C. 1395w–4(j)(1)) is amended—

(1) by striking "and including anesthesia services"; and

(2) by inserting before the period the following: "(including anesthesia services)".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1998.

SEC. 5505. IMPLEMENTATION OF RESOURCE-BASED PHYSICIAN PRACTICE EXPENSE.

(a) ADJUSTMENTS TO RELATIVE VALUE UNITS FOR 1998.—Section 1848(c)(2) (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraph:

"(G) ADJUSTMENTS IN RELATIVE VALUE UNITS FOR 1998.—

"(i) IN GENERAL.—The Secretary shall—

"(I) reduce the practice expense relative value units applied to any services described in clause (ii) furnished in 1998 to a number equal to 110 percent of the number of work relative value units, and

"(II) increase the practice expense relative value units for primary care services provided in an office setting during 1998 by a uniform percentage which the Secretary estimates will result in an aggregate increase in payments for such services equal to the aggregate decrease in payments by reason of subclause (I).

"(ii) SERVICES COVERED.—For purposes of clause (i), the services described in this clause are physicians' services that are not described in clause (iii) and for which—

"(I) there are work relative value units, and

"(II) the number of practice expense relative value units (determined for 1998) exceeds 110 percent of the number of work relative value units (determined for such year).

"(iii) EXCLUDED SERVICES.—For purposes of clause (ii), the services described in this clause are services which the Secretary determines at least 75 percent of which are provided under this title in an office setting."

(b) PHASED-IN IMPLEMENTATION.—Section 1848(c)(2) (42 U.S.C. 1395w–4(c)(2)), as amended by subsection (a), is amended—

(1) in subparagraph (C)(ii), in the matter following subclause (II), by inserting ", to the extent provided under subparagraph (H)," after "based", and

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

"(H) TRANSITIONAL RULE FOR RESOURCE-BASED PRACTICE EXPENSE UNITS.—In applying subparagraph (C)(ii) for 1998, 1999, 2000, and any subsequent year, the number of units under such subparagraph shall be based 75 percent, 50 percent, 25 percent, and 0 percent, respectively, on the practice expense relative value units in effect in 1997 (or the Secretary's imputation of such units for new or revised codes) and the remainder on the relative value expense resources involved in furnishing the service."

(c) REVIEW BY COMPTROLLER GENERAL.—The Comptroller General of the United States shall review and evaluate the proposed rule on resource-based methodology for practice expenses issued by the Health Care Financing Administration. The Comptroller General shall, within 6 months of the date of the enactment of this Act, report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate the results of its evaluation, including an analysis of—

(1) the adequacy of the data used in preparing the rule,

(2) categories of allowable costs,

(3) methods for allocating direct and indirect expenses,

(4) the potential impact of the rule on beneficiary access to services, and

(5) any other matters related to the appropriateness of resource-based methodology for practice expenses.

The Comptroller General shall consult with representatives of physicians' organizations with respect to matters of both data and methodology.

(d) CONSULTATION.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall assemble a group of physicians with expertise in both surgical and nonsurgical areas (including primary care physicians and academics), accounting experts, and the chair of the Prospective Payment Review Commission (or its successor) to solicit their individual views on whether sufficient data exist to allow the Health Care Financing Administration to proceed with implementation of the rule described in subsection (c). After hearing the views of individual members of the group, the Secretary shall determine whether sufficient data exists to

proceed with practice expense relative value determination and shall report on such views of the individual members to the committees described in subsection (c), including any recommendations for modifying such rule.

(2) ACTION.—If the Secretary determines under paragraph (1) that insufficient data exists or that the rule described in subsection (c) needs to be revised, the Secretary shall provide for additional data collection and such other actions to correct any deficiencies.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to years beginning on and after January 1, 1998.

SEC. 5506. INCREASED MEDICARE REIMBURSEMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.

(a) REMOVAL OF RESTRICTIONS ON SETTINGS.—

(1) IN GENERAL.—Clause (ii) of section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended to read as follows:

"(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services;".

(2) CONFORMING AMENDMENTS.—(A) Section 1861(s)(2)(K) of such Act (42 U.S.C. 1395x(s)(2)(K)) is further amended—

(i) in clause (i), by inserting "and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service; and" after "are performed,"; and

(ii) by striking clauses (iii) and (iv).

(B) Section 1861(b)(4) (42 U.S.C. 1395x(b)(4)) is amended by striking "clauses (i) or (iii) of subsection (s)(2)(K)" and inserting "subsection (s)(2)(K)".

(C) Section 1862(a)(14) (42 U.S.C. 1395y(a)(14)) is amended by striking "section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)" and inserting "section 1861(s)(2)(K)".

(D) Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)) is amended by striking "section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)" and inserting "section 1861(s)(2)(K)".

(E) Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)), as added by section 5301(a), is amended by striking "through (iii)" and inserting "and (ii)".

(b) INCREASED PAYMENT.—

(1) FEE SCHEDULE AMOUNT.—Clause (O) of section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended to read as follows: "(O) with respect to services described in section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse

specialist services), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848, or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery; and".

(2) CONFORMING AMENDMENTS.—(A) Section 1833(r) (42 U.S.C. 1395l(r)) is amended—

(i) in paragraph (1), by striking "section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area)" and inserting "section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services)";

(ii) by striking paragraph (2);

(iii) in paragraph (3), by striking "section 1861(s)(2)(K)(iii)" and inserting "section 1861(s)(2)(K)(ii)"; and

(iv) by redesignating paragraph (3) as paragraph (2).

(B) Section 1842(b)(12)(A) (42 U.S.C. 1395u(b)(12)(A)) is amended, in the matter preceding clause (i), by striking "clauses (i), (ii), or (iv) of section 1861(s)(2)(K) (relating to a physician assistants and nurse practitioners)" and inserting "section 1861(s)(2)(K)(i) (relating to physician assistants)".

(c) DIRECT PAYMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.—

(1) IN GENERAL.—Section 1832(a)(2)(B)(iv) (42 U.S.C. 1395k(a)(2)(B)(iv)) is amended by striking "provided in a rural area (as defined in section 1886(d)(2)(D))" and inserting "but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services".

(2) CONFORMING AMENDMENT.—Section 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is amended—

(A) by striking "clauses (i), (ii), or (iv)" and inserting "clause (i)"; and

(B) by striking "or nurse practitioner".

(d) DEFINITION OF CLINICAL NURSE SPECIALIST CLARIFIED.—Section 1861(aa)(5) (42 U.S.C. 1395x(aa)(5)) is amended—

(1) by inserting "(A)" after "(5)";

(2) by striking "The term 'physician assistant'" and all that follows through "who performs" and inserting "The term 'physician assistant' and the term 'nurse practitioner' mean, for purposes of this title, a physician assistant or nurse practitioner who performs"; and

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

"(B) The term 'clinical nurse specialist' means, for purposes of this title, an individual who—

"(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

"(ii) holds a master's degree in a defined clinical area of nursing from an accredited educational institution.".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after January 1, 1998.

SEC. 5507. INCREASED MEDICARE REIMBURSEMENT FOR PHYSICIAN ASSISTANTS.

(a) REMOVAL OF RESTRICTION ON SETTINGS.—Section 1861(s)(2)(K)(i) (42 U.S.C. 1395x(s)(2)(K)(i)), as amended by the section 5506, is amended—

(1) by striking "(I) in a hospital" and all that follows through "shortage area,", and

(2) by adding at the end the following: "but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services,".

(b) INCREASED PAYMENT.—Paragraph (12) of section 1842(b) (42 U.S.C. 1395u(b)), as amended by section 5506(b)(2)(B), is amended to read as follows:

"(12) With respect to services described in section 1861(s)(2)(K)(i)—

"(A) payment under this part may only be made on an assignment-related basis; and

"(B) the amounts paid under this part shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848 for the same service provided by a physician who is not a specialist; or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery.".

(c) REMOVAL OF RESTRICTION ON EMPLOYMENT RELATIONSHIP.—Section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by adding at the end the following new sentence: "For purposes of clause (C) of the first sentence of this paragraph, an employment relationship may include any independent contractor arrangement, and employer status shall be determined in accordance with the law of the State in which the services described in such clause are performed.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after January 1, 1998.

SEC. 5508. CHIROPRACTIC SERVICES COVERAGE DEMONSTRATION PROJECT.

(a) DEMONSTRATION.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct demonstration projects, for a period of 2 years, to begin not later than 1 year after the date of enactment of this Act, for the purpose of evaluating methods under which access to chiropractic services by individuals entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) and enrolled under part B of such title (42 U.S.C. 1395j et seq.) (in this section referred to as "medicare beneficiaries") would be provided, on a cost effective basis, as a benefit to medicare beneficiaries.

(b) ELEMENTS OF THE DEMONSTRATION PROJECT.—A demonstration project conducted under this section shall include the evaluation of the following elements:

(l) The effect on the medicare program of allowing chiropractors to order x-rays and to receive payment under the medicare program for providing such x-rays.

(2) The effect on the medicare program of eliminating the requirement for an x-ray under section 1861(r)(5) of such Act (42 U.S.C. 1395x(r)(5)).

(3) The effect on the medicare program of allowing chiropractors, within the scope of their licensure, to provide physicians' services (as defined in section 1861(q) of the Social Security Act (42 U.S.C. 1395x(q))) to medicare beneficiaries.

(4) The cost effectiveness of allowing a medicare beneficiary who is enrolled with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm) or with a Medicare Choice organization under part C of such Act to have direct access to chiropractors.

In this section, the term "direct access" means allowing a medicare beneficiary to go directly to a chiropractor affiliated with the organizations referred to in paragraph (4) without prior approval from a physician (other than another chiropractor) or other entity.

(c) CONDUCT OF THE DEMONSTRATION PROJECT.—

(1) PROJECT LOCATIONS.—A demonstration project (that includes each element under subsection (b)) shall be conducted in—

(A) 3 or more rural areas (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)));

(B) 3 or more urban areas (as defined in such section); and

(C) 3 or more areas having a shortage of primary medical care professionals (as designed under section 332 of the Public Health Service Act (42 U.S.C. 254e)).

(2) CONSULTATION.—For the design and conduct of the demonstration project, the Secretary shall consult, on a ongoing basis, with chiropractors, organizations representing chiropractors, and representatives of medicare beneficiary consumer groups.

(3) DIRECT ACCESS ELEMENT.—

(A) IN GENERAL.—The Secretary shall study the element to be evaluated under subsection (b)(4) by involving at least 10 eligible organizations under section 1876 of the Social Security Act (42 U.S.C. 1395mm) or Medicare Choice organizations under part C of such title that have voluntarily elected to participate in the demonstration project.

(B) PAYMENT.—The Secretary shall provide a small incentive payment to each such organization participating in the demonstration project.

(C) FULL SCOPE OF SERVICES.—Any such organization may allow chiropractors to practice the full scope of services for which they are licensed by the State in which those services are furnished, as if those services were both a covered benefit under the medicare program and included in such organization's contract under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). The Secretary shall agree to as many of such proposals as possible,

giving due regard for the overall design of the demonstration project.

(d) EVALUATION.—The Secretary shall evaluate the demonstration projects, taking into account the differences in demonstration project locations, in order to determine—

(1) whether medicare beneficiaries who receive chiropractic services use a lesser overall amount of items and services under the medicare program than medicare beneficiaries who do not receive chiropractic services;

(2) the overall cost effects on medicare program spending of the increased access of medicare beneficiaries to chiropractors;

(3) beneficiary satisfaction with chiropractic services, including quality of care; and

(4) such other matters as the Secretary deems appropriate.

(e) REPORT TO CONGRESS.—

(1) PRELIMINARY REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary shall submit a preliminary report to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and to the Committee on Finance of the Senate on the progress made in the demonstration programs, including—

(A) a description of the locations in which the demonstration projects under this section are being conducted; and

(B) the chiropractic services being furnished in each location.

(2) FINAL REPORT.—

(A) IN GENERAL.—Not later than January 1, 2001, the Secretary shall submit a final report on the demonstration project to the committees described in paragraph (1).

(B) CONTENTS.—The report submitted under subparagraph (A) shall include a summary of the evaluation prepared under subsection (d) and recommendations for appropriate legislative changes.

(C) RECOMMENDED LEGISLATION.—The legislative recommendations described in subparagraph (B) shall include a legislative draft of specific amendments to the Social Security Act that authorize payment under the medicare program for elements described in subsection (b) that the Secretary determines to be cost effective, based on the results of the demonstration projects.

(f) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395t) such funds as the Secretary determines to be necessary for the costs of carrying out the demonstration projects under this section.

(2) PAYMENTS OF AMOUNTS.—Grants and payments under contracts for purposes of the demonstration project may be made either in advance or by reimbursement, as determined by the Secretary, and shall be made in such installments and on

such conditions as the Secretary finds necessary to carry out the purpose of this section.

(g) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of titles XI, XVIII, and XIX of the Social Security Act (42 U.S.C. 1301 et seq., 1395 et seq., 1396 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects under this section.

(h) IMPLEMENTING EXPANDED COVERAGE OF CHIROPRACTIC SERVICES.—As soon as possible after the submission of a final report under subsection (e), the Secretary shall issue regulations to implement, on a permanent basis, the elements of the demonstration project that are cost effective for the medicare program.

CHAPTER 2—OTHER PAYMENT PROVISIONS

SEC. 5521. REDUCTION IN UPDATES TO PAYMENT AMOUNTS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS; STUDY ON LABORATORY SERVICES.

(a) CHANGE IN UPDATE.—Section 1833(h)(2)(A)(ii) (42 U.S.C. 1395l(h)(2)(A)(ii)) is amended by striking "and" at the end of subclause (III), by striking the period at the end of subclause (IV) and inserting ", and", and by adding at the end the following:

"(V) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1998 through 2002 shall be reduced (but not below zero) by 2.0 percentage points."

(b) LOWERING CAP ON PAYMENT AMOUNTS.—Section 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)) is amended—

(1) in clause (vi), by striking "and" at the end;

(2) in clause (vii)—

(A) by inserting "and before January 1, 1998," after "1995,", and

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

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

"(viii) after December 31, 1997, is equal to 74 percent of such median.".

(c) STUDY AND REPORT ON CLINICAL LABORATORY SERVICES.—

(1) IN GENERAL.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to conduct a study of payments under part B of title XVIII of the Social Security Act for clinical laboratory services. The study shall include a review of the adequacy of the current methodology and recommendations regarding alternative payment systems. The study shall also analyze and discuss the relationship between such payment systems and access to high quality laboratory services for medicare beneficiaries, including availability and access to new testing methodologies.

(2) REPORT TO CONGRESS.—The Secretary shall, not later than 2 years after the date of enactment of this section, report to the appropriate committees of Congress the results of the study described in paragraph (1), including any recommendations for legislation.

SEC. 5522. IMPROVEMENTS IN ADMINISTRATION OF LABORATORY SERVICES BENEFIT.

(a) SELECTION OF REGIONAL CARRIERS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall—

(A) divide the United States into no more than 5 regions, and

(B) designate a single carrier for each such region,

for the purpose of payment of claims under part B of title XVIII of the Social Security Act with respect to clinical diagnostic laboratory services furnished on or after such date (not later than January 1, 1999) as the Secretary specifies.

(2) DESIGNATION.—In designating such carriers, the Secretary shall consider, among other criteria—

(A) a carrier's timeliness, quality, and experience in claims processing, and

(B) a carrier's capacity to conduct electronic data interchange with laboratories and data matches with other carriers.

(3) SINGLE DATA RESOURCE.—The Secretary shall select one of the designated carriers to serve as a central statistical resource for all claims information relating to such clinical diagnostic laboratory services handled by all the designated carriers under such part.

(4) ALLOCATION OF CLAIMS.—The allocation of claims for clinical diagnostic laboratory services to particular designated carriers shall be based on whether a carrier serves the geographic area where the laboratory specimen was collected or other method specified by the Secretary.

(5) TEMPORARY EXCEPTION.—Paragraph (1) shall not apply with respect to clinical diagnostic laboratory services furnished by independent physician offices until such time as the Secretary determines that such offices would not be unduly burdened by the application of billing responsibilities with respect to more than one carrier.

(b) ADOPTION OF UNIFORM POLICIES FOR CLINICAL LABORATORY BENEFITS.—

(1) IN GENERAL.—Not later than July 1, 1998, the Secretary shall first adopt, consistent with paragraph (2), uniform coverage, administration, and payment policies for clinical diagnostic laboratory tests under part B of title XVIII of the Social Security Act, using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code.

(2) CONSIDERATIONS IN DESIGN OF UNIFORM POLICIES.—The policies under paragraph (1) shall be designed to promote program integrity and uniformity and simplify administrative requirements with respect to clinical diagnostic laboratory tests payable under such part in connection with the following:

(A) Beneficiary information required to be submitted with each claim or order for laboratory services.

(B) Physicians' obligations regarding documentation requirements and recordkeeping.

(C) Procedures for filing claims and for providing remittances by electronic media.

(D) The documentation of medical necessity.

(E) Limitation on frequency of coverage for the same tests performed on the same individual.

(3) CHANGES IN LABORATORY POLICIES PENDING ADOPTION OF UNIFORM POLICY.—During the period that begins on the date of the enactment of this Act and ends on the date the Secretary first implements uniform policies pursuant to regulations promulgated under this subsection, a carrier under such part may implement changes relating to requirements for the submission of a claim for clinical diagnostic laboratory tests.

(4) USE OF INTERIM POLICIES.—After the date the Secretary first implements such uniform policies, the Secretary shall permit any carrier to develop and implement interim policies of the type described in paragraph (1), in accordance with guidelines established by the Secretary, in cases in which a uniform national policy has not been established under this subsection and there is a demonstrated need for a policy to respond to aberrant utilization or provision of unnecessary services. Except as the Secretary specifically permits, no policy shall be implemented under this paragraph for a period of longer than 2 years.

(5) INTERIM NATIONAL GUIDELINES.—After the date the Secretary first designates regional carriers under subsection (a), the Secretary shall establish a process under which designated carriers can collectively develop and implement interim national guidelines of the type described in paragraph (1). No such policy shall be implemented under this paragraph for a period of longer than 2 years.

(6) BIENNIAL REVIEW PROCESS.—Not less often than once every 2 years, the Secretary shall solicit and review comments regarding changes in the uniform policies established under this subsection. As part of such biennial review process, the Secretary shall specifically review and consider whether to incorporate or supersede interim, regional, or national policies developed under paragraph (4) or (5). Based upon such review, the Secretary may provide for appropriate changes in the uniform policies previously adopted under this subsection.

(7) REQUIREMENT AND NOTICE.—The Secretary shall ensure that any guidelines adopted under paragraph (3), (4), or (5) shall apply to all laboratory claims payable under part B of title XVIII of the Social Security Act, and shall provide for advance notice to interested parties and a 45-day period in which such parties may submit comments on the proposed change.

(c) INCLUSION OF LABORATORY REPRESENTATIVE ON CARRIER ADVISORY COMMITTEES.—The Secretary shall direct that any advisory committee established by such a carrier, to advise with respect to coverage, administration or payment policies under part B of title XVIII of the Social Security Act, shall include an individual to represent the interest and views of independent clinical laboratories and such other laboratories as the Secretary deems appropriate. Such individual shall be selected by such committee from among nominations submitted by national and local organizations that represent independent clinical laboratories.

SEC. 5523. PAYMENTS FOR DURABLE MEDICAL EQUIPMENT.

(a) REDUCTION IN PAYMENT AMOUNTS FOR ITEMS OF DURABLE MEDICAL EQUIPMENT.—

(1) FREEZE IN UPDATE FOR COVERED ITEMS.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended to read as follows:

"(14) COVERED ITEM UPDATE.—In this subsection—

"(A) IN GENERAL.—The term 'covered item update' means, with respect to any year, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

"(B) REDUCTION FOR CERTAIN YEARS.—In the case of each of the years 1998 through 2002, the covered item update under subparagraph (A) shall be reduced (but not below zero) by 2.0 percentage points."

(2) UPDATE FOR ORTHOTICS AND PROSTHETICS.—Section 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A)) is amended to read as follows:

"(A) the term 'applicable percentage increase' means, with respect to any year, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year, except that in each of the years 1998 through 2000, such increase shall be reduced (but not below zero) by 2.0 percentage points;".

(3) EFFECTIVE DATE.—The amendments made by this subsection applies to items furnished on and after January 1, 1998.

(b) REDUCTION IN INCREASE FOR PARENTERAL AND ENTERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT.—The reasonable charge under part B of title XVIII of the Social Security Act for parenteral and enteral nutrients, supplies, and equipment furnished during each of the years 1998 through 2002, shall not exceed the reasonable charge for such items furnished during the previous year (after application of this subsection), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year reduced (but not below zero) by 2.0 percentage points.

SEC. 5524. OXYGEN AND OXYGEN EQUIPMENT.

(a) IN GENERAL.—Section 1834(a)(9)(B) (42 U.S.C. 1395m(a)(9)(B)) is amended—

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

(2) in clause (iv)—

(A) by striking "a subsequent year" and inserting "1995, 1996, and 1997", and

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

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

"(v) in 1998, 75 percent of the amount determined under this subparagraph for 1997;

"(vi) in 1999, 62.5 percent of the amount determined under this subparagraph for 1997; and

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

(b) UPGRADED DURABLE MEDICAL EQUIPMENT.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by inserting after paragraph (15) the following new paragraph:

"(16) CERTAIN UPGRADED ITEMS.—

"(A) INDIVIDUAL'S RIGHT TO CHOOSE UPGRADED ITEM.—Notwithstanding any other provision of law, effective on the date on which the Secretary issues regulations under subparagraph (C), an individual may purchase or rent from a supplier an item of upgraded durable medical equipment for which payment would be made under this subsection if the item were a standard item.

"(B) PAYMENTS TO SUPPLIER.—In the case of the purchase or rental of an upgraded item under subparagraph (A)—

"(i) the supplier shall receive payment under this subsection with respect to such item as if such item were a standard item; and

"(ii) the individual purchasing or renting the item shall pay the supplier an amount equal to the difference between the supplier's charge and the amount under clause (i).

In no event may the supplier's charge for an upgraded item exceed the applicable fee schedule amount (if any) for such item.

"(C) CONSUMER PROTECTION SAFEGUARDS.—The Secretary shall issue regulations providing for consumer protection standards with respect to the furnishing of upgraded equipment under subparagraph (A). Such regulations shall provide for—

"(i) determination of fair market prices with respect to an upgraded item;

"(ii) full disclosure of the availability and price of standard items and proof of receipt of such disclosure information by the beneficiary before the furnishing of the upgraded item;

"(iii) conditions of participation for suppliers in the simplified billing arrangement;

"(iv) sanctions of suppliers who are determined to engage in coercive or abusive practices, including exclusion; and

"(v) such other safeguards as the Secretary determines are necessary."

(c) ESTABLISHMENT OF CLASSES FOR PAYMENT.—Section 1848(a)(9) (42 U.S.C. 1395m(a)(9)) is amended by adding at the end the following:

"(D) AUTHORITY TO CREATE CLASSES.—

"(i) IN GENERAL.—Subject to clause (ii), the Secretary may establish separate classes for any item of oxygen and oxygen equipment and separate national

limited monthly payment rates for each of such classes.

"(ii) BUDGET NEUTRALITY.—The Secretary may take actions under clause (i) only to the extent such actions do not result in expenditures for any year to be more or less than the expenditures which would have been made if such actions had not been taken."

(d) STANDARDS AND ACCREDITATION.—The Secretary shall as soon as practicable establish service standards and accreditation requirements for persons seeking payment under part B of title XVIII of the Social Security Act for the providing of oxygen and oxygen equipment to beneficiaries within their homes.

(e) ACCESS TO HOME OXYGEN EQUIPMENT.—

(1) STUDY.—The Comptroller General of the United States shall study issues relating to access to home oxygen equipment and shall, within 6 months after the date of the enactment of this Act, report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate the results of the study, including recommendations (if any) for legislation.

(2) PEER REVIEW EVALUATION.—The Secretary of Health and Human Services shall arrange for peer review organizations established under section 1154 of the Social Security Act to evaluate access to, and quality of, home oxygen equipment.

(f) DEMONSTRATION PROJECT.—Not later than 6 months after the date of enactment of this Act, the Secretary shall, in consultation with appropriate organizations, initiate a demonstration project in which the Secretary utilizes a competitive bidding process for the furnishing of home oxygen equipment to medicare beneficiaries under title XVIII of the Social Security Act.

(g) EFFECTIVE DATE.—

(1) OXYGEN.—The amendments made by subsection (a) shall apply to items furnished on and after January 1, 1998.

(2) OTHER PROVISIONS.—The amendments made by this section other than subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 5525. UPDATES FOR AMBULATORY SURGICAL SERVICES.

Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is amended by inserting at the end the following: "In each of the fiscal years 1998 through 2002, the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points."

SEC. 5526. REIMBURSEMENT FOR DRUGS AND BIOLOGICALS.

(a) IN GENERAL.—Section 1842 (42 U.S.C. 1395u) is amended by inserting after subsection (n) the following new subsection:

"(o)(1) If a physician's, supplier's, or any other person's bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the amount payable for the drug or biological is equal to 95 percent of the average wholesale price, as specified by the Secretary.

"(2) In the case of any drug or biological for which payment was made under this part on May 1, 1997, the amount determined

under paragraph (1) shall not exceed the amount payable under this part for such drug or biological on such date.

"(3) If payment for a drug or biological is made to a licensed pharmacy approved to dispense drugs or biologicals under this part, the Secretary shall pay a dispensing fee (less the applicable deductible and insurance amounts) to the pharmacy, as the Secretary determines appropriate."

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to drugs and biologicals furnished on or after January 1, 1999.

CHAPTER 3—PART B PREMIUM AND RELATED PROVISIONS

SEC. 5541. PART B PREMIUM.

(a) IN GENERAL.—Section 1839(a)(3) (42 U.S.C. 1395r(a)(3)) is amended by striking the first 3 sentences and inserting the following: "The Secretary, during September of each year, shall determine and promulgate a monthly premium rate for the succeeding calendar year that is equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1), for that succeeding calendar year.".

(b) CONFORMING AND TECHNICAL AMENDMENTS.—

(1) SECTION 1839.—Section 1839 (42 U.S.C. 1395r) is amended—

(A) in subsection (a)(2), by striking "(b) and (e)" and inserting "(b), (c), and (f)",

(B) in the last sentence of subsection (a)(3)—

(i) by inserting "rate" after "premium", and

(ii) by striking "and the derivation of the dollar amounts specified in this paragraph",

(C) by striking subsection (e), and

(D) by redesignating subsection (g) as subsection (e) and inserting that subsection after subsection (d).

(2) SECTION 1844.—Subparagraphs (A)(i) and (B)(i) of section 1844(a)(1) (42 U.S.C. 1395w(a)(1)) are each amended by striking "or 1839(e), as the case may be".

SEC. 5542. INCOME-RELATED REDUCTION IN MEDICARE PART B DEDUCTIBLE TO REFLECT RECAPTURE OF PART B SUBSIDY.

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

"(t) INCOME-RELATED INCREASE IN DEDUCTIBLE.—

"(1) INCREASE IN DEDUCTION.—

"(A) IN GENERAL.—In the case of an individual to whom this subsection applies for any calendar year, the $100 deductible under subsection (b) shall be increased by an amount equal to the product of—

"(i) the applicable percentage, and

"(ii) 300 percent of an amount equal to the product of 12 times the monthly premium in effect under section 1839 for such calendar year.

"(B) APPLICABLE PERCENTAGE.—For purposes of this paragraph, the applicable percentage for any individual for

any calendar year is the percentage (not greater than 100 percent) determined by dividing—

"(i) the amount of the individual's modified adjusted gross income for the taxable year of the individual ending with or within the calendar year in excess of the threshold amount, by

"(ii) $50,000.

"(2) INDIVIDUALS TO WHOM SUBSECTION APPLIES.—This subsection shall apply to any individual whose modified adjusted gross income for a taxable year ending with or within a calendar year (as initially determined under paragraph (4)) exceeds the threshold amount.

"(3) ADMINISTRATION OF INCREASE.—

"(A) TRADITIONAL FEE-FOR-SERVICE MEDICARE.—Notwithstanding any other provision of this part, the Secretary shall provide for such adjustments in the payment for items and services furnished under this part to any individual to whom this subsection applies so that the increase in the deductible under paragraph (1) is reflected in such payments. The Secretary shall also provide that such adjustments may be reflected in the amount of any payment the individual is required to make to the provider or supplier of such items and services.

"(B) MEDICARE CHOICE.—Notwithstanding any other provision of part C, the Secretary shall reduce any payment under section 1853 to a Medicare Choice organization with respect to an individual to whom this subsection applies and who is enrolled in a Medicare Choice plan offered by such organization by an amount the Secretary determines (on the basis of actuarial value) to be equivalent to the amount of the increase in the deductible under paragraph (1). The Secretary shall prescribe regulations which allow such Medicare Choice organization to recoup the amount of the reduction under this subparagraph.

"(4) DETERMINATION OF AMOUNT OF INCOME.—For purposes of this subsection, the Secretary shall make an initial determination of the amount of an individual's modified adjusted gross income for a taxable year ending with or within a calendar year as follows:

"(A) Not later than September 1 of the year preceding the year, the Secretary shall provide notice to each individual whom the Secretary finds (on the basis of the individual's actual modified adjusted gross income for the most recent taxable year for which such information is available or other information provided to the Secretary by the Secretary of the Treasury) will be subject to an increase under this subsection, and shall include in such notice the Secretary's estimate of the individual's modified adjusted gross income for the year.

"(B) If, during the 30-day period beginning on the date notice is provided to an individual under subparagraph (A), the individual provides the Secretary with information on the individual's anticipated modified adjusted gross income for the year, the amount initially determined by the

Secretary under this paragraph with respect to the individual shall be based on the information provided by the individual.

"(C) If an individual does not provide the Secretary with information under subparagraph (B), the amount initially determined by the Secretary under this paragraph with respect to the individual shall be the amount included in the notice provided to the individual under subparagraph (A).

"(5) CORRECTION OF INCORRECT ESTIMATED AMOUNTS.—

"(A) IN GENERAL.—If the Secretary determines (on the basis of final information provided by the Secretary of the Treasury) that the amount of an individual's actual modified adjusted gross income for a taxable year ending with or within a calendar year is less than or greater than the amount initially determined by the Secretary under paragraph (4), the Secretary shall properly adjust the amount of the adjustments under paragraph (3) to reflect the change in the amount of the increase in the deductible under paragraph (1).

"(B) REPAYMENTS.—In the case of an individual who has paid in excess of the required deductible under this part for any calendar year by reason of an incorrect estimate of the individual's modified adjusted gross income, the Secretary shall pay to such individual the amount of such excess.

"(C) RECOVERY.—In the case of an individual who has paid less in deductibles than required under this part for any calendar year by reason of an incorrect estimate of the individual's modified adjusted gross income, the Secretary shall take such steps as the Secretary considers appropriate to recover from the individual the amount by which the individual has underpaid.

"(6) DEFINITIONS.—In this subsection, the following definitions apply:

"(A) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

"(i) determined without regard to sections 135, 911, 931, and 933 of such Code, and

"(ii) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax under such Code.

"(B) THRESHOLD AMOUNT.—The term 'threshold amount' means—

"(i) except as otherwise provided in this paragraph, $50,000,

"(ii) $75,000, in the case of a joint return (as defined in section 7701(a)(38) of such Code), and

"(iii) zero in the case of a taxpayer who—

"(I) is married at the close of the taxable year but does not file a joint return (as so defined) for such year, and

"(II) does not live apart from his spouse at all times during the taxable year.

"(7) TRANSFER OF PAYMENTS TO PART A TRUST FUND.—The Secretary shall transfer amounts equal to the reduction in payments under parts B and C by reason of the application of this subsection to the Federal Hospital Insurance Trust Fund."

(b) CONFORMING AMENDMENT.—Section 1833(b) (42 U.S.C. 1395l(b)) is amended by inserting "except as provided in subsection (t)," before "$100".

(c) REPORTING REQUIREMENTS FOR SECRETARY OF THE TREASURY.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to confidentiality and disclosure of returns and return information) is amended by adding at the end the following new paragraph:

"(16) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT INCOME-RELATED REDUCTION IN MEDICARE PART B PREMIUM.—

"(A) IN GENERAL.—The Secretary may, upon written request from the Secretary of Health and Human Services, disclose to officers and employees of the Health Care Financing Administration return information with respect to a taxpayer who is required to pay a monthly premium under section 1839 of the Social Security Act. Such return information shall be limited to—

"(i) taxpayer identity information with respect to such taxpayer,

"(ii) the filing status of such taxpayer,

"(iii) the adjusted gross income of such taxpayer,

"(iv) the amounts excluded from such taxpayer's gross income under sections 135 and 911,

"(v) the interest received or accrued during the taxable year which is exempt from the tax imposed by chapter 1 to the extent such information is available, and

"(vi) the amounts excluded from such taxpayer's gross income by sections 931 and 933 to the extent such information is available.

"(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Health Care Financing Administration only for the purposes of, and to the extent necessary in, carrying out their responsibilities under section 1833(t) of the Social Security Act."

(2) CONFORMING AMENDMENT.—Paragraphs (3)(A) and (4) of section 6103(p) of such Code are each amended by striking "or (15)" each place it appears and inserting "(15), or (16)".

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsections (a) and (b) shall apply to deductibles under section 1833 of the Social Security Act for months beginning with January 1998.

(2) INFORMATION FOR PRIOR YEARS.—The Secretary of Health and Human Services may request information under section 6013(l)(16) of the Social Security Act (as added by sub-

section (c)) for taxable years beginning after December 31, 1994.

Subtitle H—Provisions Relating to Parts A and B

CHAPTER 1—SECONDARY PAYOR PROVISIONS

SEC. 5601. EXTENSION AND EXPANSION OF EXISTING REQUIREMENTS.

(a) DATA MATCH.—

(1) ELIMINATION OF MEDICARE SUNSET.—Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) ELIMINATION OF INTERNAL REVENUE CODE SUNSET.—Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) APPLICATION TO DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

(1) IN GENERAL.—Section 1862(b)(1)(B) (42 U.S.C. 1395y(b)(1)(B)) is amended—

(A) in clause (i), by striking "clause (iv)" and inserting "clause (iii)";

(B) by striking clause (iii); and

(C) by redesignating clause (iv) as clause (iii).

(2) CONFORMING AMENDMENTS.—Paragraphs (1) through (3) of section 1837(i) (42 U.S.C. 1395p(i)) and the second sentence of section 1839(b) (42 U.S.C. 1395r(b)) are each amended by striking "1862(b)(1)(B)(iv)" each place it appears and inserting "1862(b)(1)(B)(iii)".

(c) INDIVIDUALS WITH END STAGE RENAL DISEASE.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the last sentence by striking "October 1, 1998" and inserting "the date of enactment of the Balanced Budget Act of 1997"; and

(2) by adding at the end the following: "Effective for items and services furnished on or after the date of enactment of the Balanced Budget Act of 1997, (with respect to periods beginning on or after the date that is 18 months prior to such date), clauses (i) and (ii) shall be applied by substituting '30-month' for '12-month' each place it appears.".

SEC. 5602. IMPROVEMENTS IN RECOVERY OF PAYMENTS.

(a) PERMITTING RECOVERY AGAINST THIRD PARTY ADMINISTRATORS OF PRIMARY PLANS.—Section 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is amended—

(1) by striking "under this subsection to pay" and inserting "(directly, as a third-party administrator, or otherwise) to make payment"; and

(2) by adding at the end the following: "The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.".

(b) EXTENSION OF CLAIMS FILING PERIOD.—Section 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amended by adding at the end the following:

"(v) CLAIMS-FILING PERIOD.—Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.".

(c) EFFECTIVE DATE.—The amendments made by this section apply to items and services furnished on or after the date of enactment of this Act.

CHAPTER 2—OTHER PROVISIONS

SEC. 5611. CONFORMING AGE FOR ELIGIBILITY UNDER MEDICARE TO RETIREMENT AGE FOR SOCIAL SECURITY BENEFITS.

(a) ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS.—Section 226 (42 U.S.C. 426) is amended by striking "age 65" each place such term appears and inserting "retirement age".

(b) HOSPITAL INSURANCE BENEFITS FOR THE AGED.—Section 1811 (42 U.S.C. 1395c) is amended by striking "age 65" each place such term appears and inserting "retirement age (as such term is defined in section 216(*l*)(1))".

(c) HOSPITAL INSURANCE BENEFITS FOR UNINSURED ELDERLY INDIVIDUALS NOT OTHERWISE ELIGIBLE.—Section 1818 (42 U.S.C. 1395i–2) is amended—

(1) in subsection (a)(1), by striking "age of 65" and inserting "retirement age (as such term is defined in section 216(*l*)(1))";

(2) in subsection (d)(1), by striking "age 65" and inserting "retirement age (as such term is defined in section 216(*l*)(1))"; and

(3) in subsection (d)(3), by striking "65" and inserting "retirement age (as such term is defined in section 216(*l*)(1))".

(d) HOSPITAL INSURANCE BENEFITS FOR DISABLED INDIVIDUALS WHO HAVE EXHAUSTED OTHER ENTITLEMENT.—Section 1818A(a)(1) (42 U.S.C. 1395i–2a(a)(1)) is amended by striking "the age of 65" and inserting "retirement age (as such term is defined in section 216(*l*)(1))".

(e) ELIGIBILITY FOR PART B BENEFITS.—

(1) IN GENERAL.—Section 1836 (42 U.S.C. 1395o) is amended by striking "age 65" each place such term appears and inserting "retirement age (as such term is defined in section 216(*l*)(1))".

(2) ENROLLMENT PERIODS.—Section 1837 (42 U.S.C. 1395p) is amended by striking "age 65" and "the age of 65" each place such terms appear and inserting "retirement age (as such term is defined in section 216(*l*)(1))".

(3) COVERAGE PERIOD.—Section 1838(c) (42 U.S.C. 1395q(c)) is amended by striking "the age of 65" and inserting "retirement age (as such term is defined in section 216(*l*)(1))".

(4) AMOUNTS OF PREMIUMS.—Section 1839 (42 U.S.C. 1395r) is amended by striking "age 65" and "the age of 65" each place such terms appear and inserting "retirement age (as such term is defined in section 216(*l*)(1))".

(f) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS AND CONTINGENCY RESERVE.—Section 1844(a)(1) (42 U.S.C. 1395w) is amended by striking "age 65" each place such term appears and inserting "retirement age".

(g) MEDICARE SECONDARY PAYER.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended by striking "age 65" each place such term appears and inserting "retirement age (as such term is defined in section 216(*l*)(1))".

(h) MEDICARE SUPPLEMENTAL POLICIES.—Section 1882(s)(2)(A) (42 U.S.C. 1395ss(s)(2)(A)) is amended by striking "65 years of age" and inserting "retirement age (as such term is defined in section 216(*l*)(1))".

SEC. 5612. INCREASED CERTIFICATION PERIOD FOR CERTAIN ORGAN PROCUREMENT ORGANIZATIONS.

Section 1138(b)(1)(A)(ii) (42 U.S.C. 1320b–8(b)(1)(A)(ii)) is amended by striking "two years" and inserting "2 years (3 years if the Secretary determines appropriate for an organization on the basis of its past practices)".

DIVISION 2—MEDICAID AND CHILDREN'S HEALTH INSURANCE INITIATIVES

Subtitle I—Medicaid

CHAPTER 1—MEDICAID SAVINGS

Subchapter A—Managed Care Reforms

SEC. 5701. STATE OPTION FOR MANDATORY MANAGED CARE.

(a) IN GENERAL.—Title XIX is amended—

(1) by inserting after the title heading the following:

"PART A—GENERAL PROVISIONS"; and

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

"PART B—PROVISIONS RELATING TO MANAGED CARE

"SEC. 1941. BENEFICIARY CHOICE; ENROLLMENT.

"(a) STATE OPTIONS FOR ENROLLMENT OF BENEFICIARIES IN MANAGED CARE ARRANGEMENTS.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this part and notwithstanding paragraphs (1), (10)(B), and (23)(A) of section 1902(a), a State may require an individual who is eligible for medical assistance under the State plan under this title and who is not a special needs individual (as

defined in subsection (e)) to enroll with a managed care entity (as defined in section 1950(a)(1)) as a condition of receiving such assistance (and, with respect to assistance furnished by or under arrangements with such entity, to receive such assistance through the entity), if the following provisions are met:

"(A) ENTITY MEETS REQUIREMENTS.—The entity meets the applicable requirements of this part.

"(B) CONTRACT WITH STATE.—The entity enters into a contract with the State to provide services for the benefit of individuals eligible for benefits under this title under which prepaid payments to such entity are made on an actuarially sound basis. Such contract shall specify benefits the provision (or arrangement) for which the entity is responsible.

"(C) CHOICE OF COVERAGE.—

"(i) IN GENERAL.—The State permits an individual to choose a managed care entity from managed care organizations and primary care case managers who meet the requirements of this part but not less than from—

"(I) 2 medicaid managed care organizations,

"(II) a medicaid managed care organization and a primary care case manager, or

"(III) a primary care case manager as long as an individual may choose between 2 primary care case managers.

"(ii) STATE OPTION.—At the option of the State, a State shall be considered to meet the requirements of clause (i) in the case of an individual residing in a rural area, if the State—

"(I) requires the individual to enroll with a medicaid managed care organization or a primary care case manager if such organization or entity permits the individual to receive such assistance through not less than 2 physicians or case managers (to the extent that at least 2 physicians or case managers are available to provide such assistance in the area), and

"(II) permits the individual to obtain such assistance from any other provider in appropriate circumstances (as established by the State under regulations of the Secretary).

"(D) CHANGES IN ENROLLMENT.—The State—

"(i) provides the individual with the opportunity to change enrollment among managed care entities once annually and notifies the individual of such opportunity not later than 60 days prior to the first date on which the individual may change enrollment, and

"(ii) permits individuals to terminate their enrollment as provided under paragraph (2).

"(E) ENROLLMENT PRIORITIES.—The State establishes a method for establishing enrollment priorities in the case of a managed care entity that does not have sufficient capacity to enroll all such individuals seeking enrollment under

which individuals already enrolled with the entity are given priority in continuing enrollment with the entity.

"(F) DEFAULT ENROLLMENT PROCESS.—The State establishes a default enrollment process which meets the requirements described in paragraph (3) and under which any such individual who does not enroll with a managed care entity during the enrollment period specified by the State shall be enrolled by the State with such an entity in accordance with such process.

"(G) SANCTIONS.—The State establishes the sanctions provided for in section 1949.

"(H) INDIAN ENROLLMENT.—No individual who is an Indian (as defined in section 4 of the Indian Health Care Improvement Act of 1976) is required to enroll in any entity that is not one of the following (and only if such entity is participating under the plan):

"(i) The Indian Health Service.

"(ii) An Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.).

"(iii) An urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

"(2) TERMINATION OF ENROLLMENT.—

"(A) IN GENERAL.—The State, enrollment broker, and managed care entity (if any) shall permit an individual eligible for medical assistance under the State plan under this title who is enrolled with the entity to terminate such enrollment for cause at any time, and without cause during the 90-day period beginning on the date the individual receives notice of enrollment and at least every 12 months thereafter, and shall notify each such individual of the opportunity to terminate enrollment under these conditions.

"(B) FRAUDULENT INDUCEMENT OR COERCION AS GROUNDS FOR CAUSE.—For purposes of subparagraph (A), an individual terminating enrollment with a managed care entity on the grounds that the enrollment was based on fraudulent inducement or was obtained through coercion or pursuant to the imposition against the managed care entity of the sanction described in section 1949(b)(3) shall be considered to terminate such enrollment for cause.

"(C) NOTICE OF TERMINATION.—

"(i) NOTICE TO STATE.—

"(I) BY INDIVIDUALS.—Each individual terminating enrollment with a managed care entity under subparagraph (A) shall do so by providing notice of the termination to an office of the State agency administering the State plan under this title, the State or local welfare agency, or an office of a managed care entity.

"(II) BY ORGANIZATIONS.—Any managed care entity which receives notice of an individual's termination of enrollment with such entity through receipt of such notice at an office of a managed care entity shall provide timely notice of the termination to the State agency administering the State plan under this title.

"(ii) NOTICE TO PLAN.—The State agency administering the State plan under this title or the State or local welfare agency which receives notice of an individual's termination of enrollment with a managed care entity under clause (i) shall provide timely notice of the termination to such entity.

"(3) DEFAULT ENROLLMENT PROCESS REQUIREMENTS.—The requirements of a default enrollment process established by a State under paragraph (1)(F) are as follows:

"(A) The process shall provide that the State may not enroll individuals with a managed care entity which is not in compliance with the applicable requirements of this part.

"(B) The process shall provide (consistent with subparagraph (A)) for enrollment of such an individual with a medicaid managed care organization—

"(i) that maintains existing provider-individual relationships or that has entered into contracts with providers (such as Federally qualified health centers, rural health clinics, hospitals that qualify for disproportionate share hospital payments under section 1886(d)(5)(F), and hospitals described in section 1886(d)(1)(B)(iii)) that have traditionally served beneficiaries under this title, and

"(ii) if there is no provider described in clause (i), in a manner that provides for an equitable distribution of individuals among all qualified managed care entities available to enroll individuals through such default enrollment process, consistent with the enrollment capacities of such entities.

"(C) The process shall permit and assist an individual enrolled with an entity under such process to change such enrollment to another managed care entity during a period (of at least 90 days) after the effective date of the enrollment.

"(D) The process may provide for consideration of factors such as quality, geographic proximity, continuity of providers, and capacity of the plan when conducting such process.

"(b) REENROLLMENT OF INDIVIDUALS WHO REGAIN ELIGIBILITY.—

"(1) IN GENERAL.—If an individual eligible for medical assistance under a State plan under this title and enrolled with a managed care entity with a contract under subsection (a)(1)(B) ceases to be eligible for such assistance for a period of not greater than 2 months, the State may provide for the automatic reenrollment of the individual with the entity as of

the first day of the month in which the individual is again eligible for such assistance, and may consider factors such as quality, geographic proximity, continuity of providers, and capacity of the plan when conducting such reenrollment.

"(2) CONDITIONS.—Paragraph (1) shall only apply if—

"(A) the month for which the individual is to be reenrolled occurs during the enrollment period covered by the individual's original enrollment with the managed care entity,

"(B) the managed care entity continues to have a contract with the State agency under subsection (a)(1)(B) as of the first day of such month, and

"(C) the managed care entity complies with the applicable requirements of this part.

"(3) NOTICE OF REENROLLMENT.—The State shall provide timely notice to a managed care entity of any reenrollment of an individual under this subsection.

"(c) STATE OPTION OF MINIMUM ENROLLMENT PERIOD.—

"(1) IN GENERAL.—In the case of an individual who is enrolled with a managed care entity under this part and who would (but for this subsection) lose eligibility for benefits under this title before the end of the minimum enrollment period (defined in paragraph (2)), the State plan under this title may provide, notwithstanding any other provision of this title, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but, except for benefits furnished under section 1902(a)(23)(B), only with respect to such benefits provided to the individual as an enrollee of such entity.

"(2) MINIMUM ENROLLMENT PERIOD DEFINED.—For purposes of paragraph (1), the term 'minimum enrollment period' means, with respect to an individual's enrollment with an entity under a State plan, a period, established by the State, of not more than 6 months beginning on the date the individual's enrollment with the entity becomes effective, except that a State may extend such period for up to a total of 12 months in the case of an individual's enrollment with a managed care entity (as defined in section 1950(a)(1)) so long as such extension is done uniformly for all individuals enrolled with all such entities.

"(d) OTHER ENROLLMENT-RELATED PROVISIONS.—

"(1) NONDISCRIMINATION.—A managed care entity may not discriminate on the basis of health status or anticipated need for services in the enrollment, reenrollment, or disenrollment of individuals eligible to receive medical assistance under a State plan under this title or by discouraging enrollment (except as permitted by this section) by eligible individuals.

"(2) PROVISION OF INFORMATION.—

"(A) IN GENERAL.—Each State, enrollment broker, or managed care organization shall provide all enrollment notices and informational and instructional materials in a manner and form which may be easily understood by enrollees of the entity who are eligible for medical assistance under the State plan under this title, including enrollees

and potential enrollees who are blind, deaf, disabled, or cannot read or understand the English language.

"(B) INFORMATION TO HEALTH CARE PROVIDERS, ENROLLEES, AND POTENTIAL ENROLLEES.—Each medicaid managed care organization shall—

"(i) upon request, make the information described in section 1945(c)(1) available to enrollees and potential enrollees in the organization's service area, and

"(ii) provide to enrollees and potential enrollees information regarding all items and services that are available to enrollees under the contract between the State and the organization that are covered either directly or through a method of referral and prior authorization.

"(e) SPECIAL NEEDS INDIVIDUALS DESCRIBED.—In this part, the term 'special needs individual' means any of the following individuals:

"(1) SPECIAL NEEDS CHILD.—An individual who is under 19 years of age who—

"(A) is eligible for supplemental security income under title XVI;

"(B) is described under section 501(a)(1)(D);

"(C) is a child described in section 1902(e)(3); or

"(D) is not described in any preceding subparagraph but is in foster care or otherwise in an out-of-home placement.

"(2) MEDICARE BENEFICIARIES.—A qualified medicare beneficiary (as defined in section 1905(p)(1)) or an individual otherwise eligible for benefits under title XVIII.

"(f) RULE OF CONSTRUCTION.—Nothing in this part shall be construed as allowing a managed care entity that has entered into a contract with the State under this part to restrict the choice of an individual in receiving services described in section 1905(a)(4)(C).

"SEC. 1942. BENEFICIARY ACCESS TO SERVICES GENERALLY.

"(a) ACCESS TO SERVICES.—

"(1) IN GENERAL.—Each managed care entity shall provide or arrange for the provision of all medically necessary medical assistance under this title which is specified in the contract entered into between such entity and the State under section 1941(a)(1)(B) for enrollees who are eligible for medical assistance under the State plan under this title.

"(2) PRIMARY-CARE-PROVIDER-TO-ENROLLEE RATIO AND MAXIMUM TRAVEL TIME.—Each such entity shall assure adequate access to primary care services by meeting standards, established by the Secretary, relating to the maximum ratio of enrollees under this title to full-time-equivalent primary care providers available to serve such enrollees and to maximum travel time for such enrollees to access such providers. The Secretary may permit such a maximum ratio to vary depending on the area and population served. Such standards shall be based on standards commonly applied in the commercial market, commonly used in accreditation of managed care organizations, and standards used in the approval of waiver applications

under section 1115, and shall be consistent with the requirements of section 1876(c)(4)(A) and part C of title XVIII.

"(b) REFERRAL TO SPECIALTY CARE FOR ENROLLEES REQUIRING TREATMENT BY SPECIALISTS.—

"(1) IN GENERAL.—In the case of an enrollee under a managed care entity and who has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist, the entity shall make or provide for a referral to a specialist who is available and accessible to provide the treatment for such condition or disease.

"(2) SPECIALIST DEFINED.—For purposes of this subsection, the term 'specialist' means, with respect to a condition, a health care practitioner, facility, or center (such as a center of excellence) that has adequate expertise through appropriate training and experience (including, in the case of a child, an appropriate pediatric specialist) to provide high quality care in treating the condition.

"(3) CARE UNDER REFERRAL.—Care provided pursuant to such referral under paragraph (1) shall be—

"(A) pursuant to a treatment plan (if any) developed by the specialist and approved by the entity, in consultation with the designated primary care provider or specialist and the enrollee (or the enrollee's designee), and

"(B) in accordance with applicable quality assurance and utilization review standards of the entity.

Nothing in this subsection shall be construed as preventing such a treatment plan for an enrollee from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

"(4) REFERRALS TO PARTICIPATING PROVIDERS.—An entity is not required under paragraph (1) to provide for a referral to a specialist that—

"(A) is not a participating provider, unless the entity does not have an appropriate specialist that is available and accessible to treat the enrollee's condition, and

"(B) is a participating provider with respect to such treatment.

"(5) TREATMENT OF NONPARTICIPATING PROVIDERS.—If an entity refers an enrollee to a nonparticipating specialist, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received by such a specialist that is a participating provider.

"(c) TIMELY DELIVERY OF SERVICES.—Each managed care entity shall respond to requests from enrollees for the delivery of medical assistance in a manner which—

"(1) makes such assistance—

"(A) available and accessible to each such individual, within the area served by the entity, with reasonable promptness and in a manner which assures continuity; and

"(B) when medically necessary, available and accessible 24 hours a day and 7 days a week, and

"(2) with respect to assistance provided to such an individual other than through the entity, or without prior authorization, in the case of a primary care case manager, provides for reimbursement to the individual (if applicable under the contract between the State and the entity) if—

"(A) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition and meet the requirements for access to emergency care under section 1943; and

"(B) it was not reasonable given the circumstances to obtain the services through the entity, or, in the case of a primary care case manager, with prior authorization.

"(d) INTERNAL GRIEVANCE PROCEDURE.—Each medicaid managed care organization shall establish an internal grievance procedure under which an enrollee who is eligible for medical assistance under the State plan under this title, or a provider on behalf of such an enrollee, may challenge the denial of coverage of or payment for such assistance.

"(e) INFORMATION ON BENEFIT CARVE OUTS.—Each managed care entity shall inform each enrollee, in a written and prominent manner, of any benefits to which the enrollee may be entitled to medical assistance under this title but which are not made available to the enrollee through the entity. Such information shall include information on where and how such enrollees may access benefits not made available to the enrollee through the entity.

"(f) DEMONSTRATION OF ADEQUATE CAPACITY AND SERVICES.—Each medicaid managed care organization shall provide the State and the Secretary with adequate assurances (as determined by the Secretary) that the organization, with respect to a service area—

"(1) has the capacity to serve the expected enrollment in such service area,

"(2) offers an appropriate range of services for the population expected to be enrolled in such service area, including transportation services and translation services consisting of the principal languages spoken in the service area,

"(3) maintains a sufficient number, mix, and geographic distribution of providers of services included in the contract with the State to ensure that services are available to individuals receiving medical assistance and enrolled in the organization to the same extent that such services are available to individuals enrolled in the organization who are not recipients of medical assistance under the State plan under this title,

"(4) maintains extended hours of operation with respect to primary care services that are beyond those maintained during a normal business day,

"(5) provides preventive and primary care services in locations that are readily accessible to members of the community,

"(6) provides information concerning educational, social, health, and nutritional services offered by other programs for which enrollees may be eligible, and

"(7) complies with such other requirements relating to access to care as the Secretary or the State may impose.

"(g) COMPLIANCE WITH CERTAIN MATERNITY AND MENTAL HEALTH REQUIREMENTS.—Each medicaid managed care organiza-

tion shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

"(h) TREATMENT OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS.—

"(1) IN GENERAL.—In the case of an enrollee of a managed care entity who is a child described in section 1941(e)(1)—

"(A) if any medical assistance specified in the contract with the State is identified in a treatment plan prepared for the enrollee, the managed care entity shall provide (or arrange to be provided) such assistance in accordance with the treatment plan either—

"(i) by referring the enrollee to a pediatric health care provider who is trained and experienced in the provision of such assistance and who has a contract with the managed care entity to provide such assistance; or

"(ii) if appropriate services are not available through the managed care entity, permitting such enrollee to seek appropriate specialty services from pediatric health care providers outside of or apart from the managed care entity, and

"(B) the managed care entity shall require each health care provider with whom the managed care entity has entered into an agreement to provide medical assistance to enrollees to furnish the medical assistance specified in such enrollee's treatment plan to the extent the health care provider is able to carry out such treatment plan.

"(2) PRIOR AUTHORIZATION.—An enrollee referred for treatment under paragraph (1)(A)(i), or permitted to seek treatment outside of or apart from the managed care entity under paragraph (1)(A)(ii) shall be deemed to have obtained any prior authorization required by the entity.

"SEC. 1943. REQUIREMENTS FOR ACCESS TO EMERGENCY CARE.

"(a) IN GENERAL.—A managed care entity shall—

"(1) provide coverage for emergency services (as defined in subsection (c)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization; and

"(2) comply with such guidelines as the Secretary shall prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable in accordance with section 1867.

"(b) CONTENT OF GUIDELINES.—The guidelines prescribed under subsection (a) shall provide that—

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

"(2) the entity shall respond in a timely fashion to the initial contact with the entity with a decision as to whether the

services for which approval is requested will be authorized, and

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

"(c) DEFINITION OF EMERGENCY SERVICES.—In this section—

"(1) IN GENERAL.—The term 'emergency services' means, with respect to an individual enrolled with a managed care entity, covered inpatient and outpatient services that—

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

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

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

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

"(B) serious impairment to bodily functions, or

"(C) serious dysfunction of any bodily organ or part.

"SEC. 1944. OTHER BENEFICIARY PROTECTIONS.

"(a) PROTECTING ENROLLEES AGAINST THE INSOLVENCY OF MANAGED CARE ENTITIES AND AGAINST THE FAILURE OF THE STATE TO PAY SUCH ENTITIES.—Each managed care entity shall provide that an individual eligible for medical assistance under the State plan under this title who is enrolled with the entity may not be held liable—

"(1) for the debts of the managed care entity, in the event of the entity's insolvency,

"(2) for services provided to the individual—

"(A) in the event of the entity failing to receive payment from the State for such services; or

"(B) in the event of a health care provider with a contractual or other arrangement with the entity failing to receive payment from the State or the managed care entity for such services, or

"(3) for the debts of any health care provider with a contractual or other arrangement with the entity to provide services to the individual, in the event of the insolvency of the health care provider.

"(b) PROTECTION OF BENEFICIARIES AGAINST BALANCE BILLING THROUGH SUBCONTRACTORS.—

"(1) IN GENERAL.—Any contract between a managed care entity that has an agreement with a State under this title and another entity under which the other entity (or any other entity pursuant to the contract) provides directly or indirectly for the provision of services to beneficiaries under the agreement

with the State shall include such provisions as the Secretary may require in order to assure that the other entity complies with balance billing limitations and other requirements of this title (such as limitation on withholding of services) as they would apply to the managed care entity if such entity provided such services directly and not through a contract with another entity.

"(2) APPLICATION OF SANCTIONS FOR VIOLATIONS.—The provisions of section 1128A(b)(2)(B) and 1128B(d)(1) shall apply with respect to entities contracting directly or indirectly with a managed care entity (with a contract with a State under this title) for the provision of services to beneficiaries under such a contract in the same manner as such provisions would apply to the managed care entity if it provided such services directly and not through a contract with another entity.

"SEC. 1945. ASSURING QUALITY CARE.

"(a) EXTERNAL INDEPENDENT REVIEW OF MANAGED CARE ENTITY ACTIVITIES.—

"(1) REVIEW OF MEDICAID MANAGED CARE ORGANIZATION CONTRACT.—

"(A) IN GENERAL.—Except as provided in paragraph (2), each medicaid managed care organization shall be subject to an annual external independent review of the quality outcomes and timeliness of, and access to, the items and services specified in such organization's contract with the State under section 1941(a)(1)(B). Such review shall specifically evaluate the extent to which the medicaid managed care organization provides such services in a timely manner.

"(B) CONTENTS OF REVIEW.—An external independent review conducted under this subsection shall include—

"(i) a review of the entity's medical care, through sampling of medical records or other appropriate methods, for indications of quality of care and inappropriate utilization (including overutilization) and treatment,

"(ii) a review of enrollee inpatient and ambulatory data, through sampling of medical records or other appropriate methods, to determine trends in quality and appropriateness of care,

"(iii) notification of the entity and the State when the review under this paragraph indicates inappropriate care, treatment, or utilization of services (including overutilization), and

"(iv) other activities as prescribed by the Secretary or the State.

"(C) USE OF PROTOCOLS.—An external independent review conducted under this subsection on and after January 1, 1999, shall use protocols that have been developed, tested, and validated by the Secretary and that are at least as rigorous as those used by the National Committee on Quality Assurance as of the date of the enactment of this section.

"(D) AVAILABILITY OF RESULTS.—The results of each external independent review conducted under this paragraph shall be available to participating health care providers, enrollees, and potential enrollees of the medicaid managed care organization, except that the results may not be made available in a manner that discloses the identity of any individual patient.

"(2) DEEMED COMPLIANCE.—

"(A) MEDICARE ORGANIZATIONS.—The requirements of paragraph (1) shall not apply with respect to a medicaid managed care organization if the organization is an eligible organization with a contract in effect under section 1876 or under part C of title XVIII.

"(B) PRIVATE ACCREDITATION.—

"(i) IN GENERAL.—The requirements of paragraph (1) shall not apply with respect to a medicaid managed care organization if—

"(I) the organization is accredited by an organization meeting the requirements described in subparagraph (C)), and

"(II) the standards and process under which the organization is accredited meet such requirements as are established under clause (ii), without regard to whether or not the time requirement of such clause is satisfied.

"(ii) STANDARDS AND PROCESS.—Not later than 180 days after the date of the enactment of this section, the Secretary shall specify requirements for the standards and process under which a medicaid managed care organization is accredited by an organization meeting the requirements of subparagraph (B).

"(C) ACCREDITING ORGANIZATION.—An accrediting organization meets the requirements of this subparagraph if the organization—

"(i) is a private, nonprofit organization,

"(ii) exists for the primary purpose of accrediting managed care organizations or health care providers, and

"(iii) is independent of health care providers or associations of health care providers.

"(3) REVIEW OF PRIMARY CARE CASE MANAGER CONTRACT.—Each primary care case manager shall be subject to an annual external independent review of the quality and timeliness of, and access to, the items and services specified in the contract entered into between the State and the primary care case manager under section 1941(a)(1)(B).

"(4) USE OF VALIDATION SURVEYS.—The Secretary shall conduct surveys each year to validate external reviews of the number of managed care entities in the year. In conducting such surveys the Secretary shall use the same protocols as were used in preparing the external reviews. If an external review finds that an individual managed care entity meets applicable requirements, but the Secretary determines that the entity does not meet such requirements, the Secretary's deter-

mination as to the entity's noncompliance with such requirements is binding and supersedes that of the previous survey.

"(b) FEDERAL MONITORING RESPONSIBILITIES.—The Secretary shall review the external independent reviews conducted pursuant to subsection (a) and shall monitor the effectiveness of the State's monitoring of managed care entities and any followup activities required under this part. If the Secretary determines that a State's monitoring and followup activities are not adequate to ensure that the requirements of such section are met, the Secretary shall undertake appropriate followup activities to ensure that the State improves its monitoring and followup activities.

"(c) PROVIDING INFORMATION ON SERVICES.—

"(1) REQUIREMENTS FOR MEDICAID MANAGED CARE ORGANIZATIONS.—Each medicaid managed care organization shall provide to the State complete and timely information concerning the following:

"(A) The services that the organization provides to (or arranges to be provided to) individuals eligible for medical assistance under the State plan under this title.

"(B) The identity, locations, qualifications, and availability of participating health care providers.

"(C) The rights and responsibilities of enrollees.

"(D) The services provided by the organization which are subject to prior authorization by the organization as a condition of coverage (in accordance with subsection (d)).

"(E) The procedures available to an enrollee and a health care provider to appeal the failure of the organization to cover a service.

"(F) The performance of the organization in serving individuals eligible for medical assistance under the State plan under this title.

Such information shall be provided in a form consistent with the reporting of similar information by eligible organizations under section 1876 or under part C of title XVIII.

"(2) REQUIREMENTS FOR PRIMARY CARE CASE MANAGERS.—Each primary care case manager shall—

"(A) provide to the State (at least at such frequency as the Secretary may require), complete and timely information concerning the services that the primary care case manager provides to (or arranges to be provided to) individuals eligible for medical assistance under the State plan under this title,

"(B) make available to enrollees and potential enrollees information concerning services available to the enrollee for which prior authorization by the primary care case manager is required,

"(C) provide enrollees and potential enrollees information regarding all items and services that are available to enrollees under the contract between the State and the primary care case manager that are covered either directly or through a method of referral and prior authorization, and

"(D) provide assurances that such entities and their professional personnel are licensed as required by State

law and qualified to provide case management services, through methods such as ongoing monitoring of compliance with applicable requirements and providing information and technical assistance.

"(3) REQUIREMENTS FOR BOTH MEDICAID MANAGED CARE ORGANIZATIONS AND PRIMARY CARE CASE MANAGERS.—Each managed care entity shall provide the State with aggregate encounter data for all items and services, including early and periodic screening, diagnostic, and treatment services under section 1905(r) furnished to individuals under 21 years of age. Any such data provided may be audited by the State.

"(d) CONDITIONS FOR PRIOR AUTHORIZATION.—Subject to section 1943, a managed care entity may require the approval of medical assistance for nonemergency services before the assistance is furnished to an enrollee only if the system providing for such approval provides that such decisions are made in a timely manner, depending upon the urgency of the situation.

"(e) PATIENT ENCOUNTER DATA.—Each medicaid managed care organization shall maintain sufficient patient encounter data to identify the health care provider who delivers services to patients and to otherwise enable the State plan to meet the requirements of section 1902(a)(27) and shall submit such data to the State or the Secretary upon request. The medicaid managed care organization shall incorporate such information in the maintenance of patient encounter data with respect to such health care provider.

"(f) INCENTIVES FOR HIGH QUALITY MANAGED CARE ENTITIES.—The Secretary and the State may establish a program to reward, through public recognition, incentive payments, or enrollment of additional individuals (or combinations of such rewards), managed care entities that provide the highest quality care to individuals eligible for medical assistance under the State plan under this title who are enrolled with such entities. For purposes of section 1903(a)(7), proper expenses incurred by a State in carrying out such a program shall be considered to be expenses necessary for the proper and efficient administration of the State plan under this title.

"(g) QUALITY ASSURANCE STANDARDS.—Any contract between a State and a managed care entity shall provide—

"(1) that the State agency will develop and implement a State specific quality assessment and improvement strategy, consistent with standards that the Secretary, in consultation with the States, shall establish and monitor (but that shall not preempt any State standards that are more stringent than the standards established under this paragraph), and that includes—

"(A) standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity; and

"(B) procedures for monitoring and evaluating the quality and appropriateness of care and services to beneficiaries that reflect the full spectrum of populations enrolled in the plan and that include—

"(i) requirements for provision of quality assurance data to the State using the data and information set that the Secretary, in consultation with the States, shall specify with respect to entities contracting under section 1876 or under part C of title XVIII or alternative data requirements approved by the Secretary;

"(ii) if necessary, an annual examination of the scope and content of the quality improvement strategy; and

"(iii) other aspects of care and service directly related to the improvement of quality of care (including grievance procedures and marketing and information standards),

"(2) that entities entering into such agreements under which payment is made on a prepaid capitated or other risk basis shall be required—

"(A) to submit to the State agency information that demonstrates significant improvement in the care delivered to members;

"(B) to maintain an internal quality assurance program consistent with paragraph (1), and meeting standards that the Secretary, in consultation with the States, shall establish in regulations; and

"(C) to provide effective procedures for hearing and resolving grievances between the entity and members enrolled with the entity under this section, and

"(3) that provision is made, consistent with State law or with regulations under State law, with respect to the solvency of those entities, financial reporting by those entities, and avoidance of waste, fraud, and abuse.

"SEC. 1946. PROTECTIONS FOR PROVIDERS.

"(a) TIMELINESS OF PAYMENT.—A medicaid managed care organization shall make payment to health care providers for items and services which are subject to the contract under section 1941(a)(1)(B) and which are furnished to individuals eligible for medical assistance under the State plan under this title who are enrolled with the entity on a timely basis consistent with section 1943 and under the claims payment procedures described in section 1902(a)(37)(A), unless the health care provider and the managed care entity agree to an alternate payment schedule.

"(b) PHYSICIAN INCENTIVE PLANS.—Each medicaid managed care organization shall require that any physician incentive plan covering physicians who are participating in the medicaid managed care organization shall meet the requirements of section 1876(i)(8) and comparable requirements under part C of title XVIII.

"(c) WRITTEN PROVIDER PARTICIPATION AGREEMENTS FOR CERTAIN PROVIDERS.—

"(1) IN GENERAL.—Each medicaid managed care organization that enters into a written provider participation agreement with a provider described in paragraph (2) shall—

"(A) include terms and conditions that are no more restrictive than the terms and conditions that the medicaid managed care organization includes in its agreements with other participating providers with respect to—

"(i) the scope of covered services for which payment is made to the provider;

"(ii) the assignment of enrollees by the organization to the provider;

"(iii) the limitation on financial risk or availability of financial incentives to the provider;

"(iv) accessibility of care;

"(v) professional credentialing and recredentialing;

"(vi) licensure;

"(vii) quality and utilization management;

"(viii) confidentiality of patient records;

"(ix) grievance procedures; and

"(x) indemnification arrangements between the organizations and providers; and

"(B) provide for payment to the provider on a basis that is comparable to the basis on which other providers are paid.

"(2) PROVIDERS DESCRIBED.—The providers described in this paragraph are the following:

"(A) Rural health clinics, as defined in section 1905(l)(1).

"(B) Federally-qualified health centers, as defined in section 1905(l)(2)(B).

"(C) Clinics which are eligible to receive payment for services provided under title X of the Public Health Service Act.

"(d) PAYMENTS TO RURAL HEALTH CLINICS AND FEDERALLY-QUALIFIED HEALTH CENTERS.—Each medicaid managed care organization that has a contract under this title with respect to the provision of services of a rural health clinic or a Federally-qualified health center shall provide, at the election of such clinic or center, that the organization shall provide payments to such a clinic or center for services described in 1905(a)(2)(C) at the rates of payment specified in section 1902(a)(13)(E).

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

"SEC. 1947. ASSURING ADEQUACY OF PAYMENTS TO MEDICAID MANAGED CARE ORGANIZATIONS AND ENTITIES.

A State shall find, determine, and make assurances satisfactory to the Secretary that the rates it pays a managed care entity for individuals eligible under the State plan have been determined by an independent actuary that meets the standards for qualification and practice established by the Actuarial Standards Board, to be sufficient and not excessive with respect to the estimated costs of the services provided.

"SEC. 1948. FRAUD AND ABUSE.

"(a) PROVISIONS APPLICABLE TO MANAGED CARE ENTITIES.—

"(1) PROHIBITING AFFILIATIONS WITH INDIVIDUALS DEBARRED BY FEDERAL AGENCIES.—

"(A) IN GENERAL.—A managed care entity may not knowingly—

"(i) have a person described in subparagraph (C) as a director, officer, partner, or person with beneficial ownership of more than 5 percent of the entity's equity, or

"(ii) have an employment, consulting, or other agreement with a person described in such subparagraph for the provision of items and services that are significant and material to the entity's obligations under its contract with the State.

"(B) EFFECT OF NONCOMPLIANCE.—If a State finds that a managed care entity is not in compliance with clause (i) or (ii) of subparagraph (A), the State—

"(i) shall notify the Secretary of such noncompliance,

"(ii) may continue an existing agreement with the entity unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) directs otherwise, and

"(iii) may not renew or otherwise extend the duration of an existing agreement with the entity unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) provides to the State and to the Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

"(C) PERSONS DESCRIBED.—A person is described in this subparagraph if such person—

"(i) is debarred, suspended, or otherwise excluded from participating in procurement activities under any Federal procurement or nonprocurement program or activity, as provided for in the Federal Acquisition Streamlining Act of 1994 (Public Law 103–355; 108 Stat. 3243), or

"(ii) is an affiliate (as defined in such Act) of a person described in clause (i).

"(2) RESTRICTIONS ON MARKETING.—

"(A) DISTRIBUTION OF MATERIALS.—

"(i) IN GENERAL.—A managed care entity may not distribute directly or through any agent or independent contractor marketing materials within any State—

"(I) without the prior approval of the State, and

"(II) that contain false or materially misleading information.

"(ii) CONSULTATION IN REVIEW OF MARKET MATERIALS.—In the process of reviewing and approving such materials, the State shall provide for consultation with a medical care advisory committee.

"(iii) PROHIBITION.—The State may not enter into or renew a contract with a managed care entity for the provision of services to individuals enrolled under the State plan under this title if the State determines that the entity distributed directly or through any agent or independent contractor marketing materials in violation of clause (i).

"(B) SERVICE MARKET.—A managed care entity shall distribute marketing materials to the entire service area of such entity.

"(C) PROHIBITION OF TIE-INS.—A managed care entity, or any agency of such entity, may not seek to influence an individual's enrollment with the entity in conjunction with the sale of any other insurance.

"(D) PROHIBITING MARKETING FRAUD.—Each managed care entity shall comply with such procedures and conditions as the Secretary prescribes in order to ensure that, before an individual is enrolled with the entity, the individual is provided accurate oral and written and sufficient information to make an informed decision whether or not to enroll.

"(E) PROHIBITION OF COLD CALL MARKETING.—Each managed care entity shall not, directly or indirectly, conduct door-to-door, telephonic, or other 'cold call' marketing of enrollment under this title.

"(b) PROVISIONS APPLICABLE ONLY TO MEDICAID MANAGED CARE ORGANIZATIONS.—

"(1) STATE CONFLICT-OF-INTEREST SAFEGUARDS IN MEDICAID RISK CONTRACTING.—A medicaid managed care organization may not enter into a contract with any State under section 1941(a)(1)(B) unless the State has in effect conflict-of-interest safeguards with respect to officers and employees of the State with responsibilities relating to contracts with such organizations or to the default enrollment process described in section 1941(a)(1)(F) that are at least as effective as the Federal safeguards provided under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423), against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.

"(2) REQUIRING DISCLOSURE OF FINANCIAL INFORMATION.—In addition to any requirements applicable under paragraph (27) or (35) of section 1902(a), a medicaid managed care organization shall—

"(A) report to the State such financial information as the State may require to demonstrate that—

"(i) the organization has the ability to bear the risk of potential financial losses and otherwise has a fiscally sound operation;

"(ii) the organization uses the funds paid to it by the State for activities consistent with the requirements of this title and the contract between the State and organization; and

"(iii) the organization does not place an individual physician, physician group, or other health care pro-

vider at substantial risk for services not provided by such physician, group, or health care provider, by providing adequate protection to limit the liability of such physician, group, or health care provider, through measures such as stop loss insurance or appropriate risk corridors,

"(B) agree that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the organization (and of any subcontractor) relating to the information reported pursuant to subparagraph (A) and any information required to be furnished under section paragraphs (27) or (35) of section 1902(a),

"(C) make available to the Secretary and the State a description of each transaction described in subparagraphs (A) through (C) of section 1318(a)(3) of the Public Health Service Act between the organization and a party in interest (as defined in section 1318(b) of such Act),

"(D) agree to make available to its enrollees upon reasonable request—

"(i) the information reported pursuant to subparagraph (A); and

"(ii) the information required to be disclosed under sections 1124 and 1126,

"(E) comply with subsections (a) and (c) of section 1318 of the Public Health Service Act (relating to disclosure of certain financial information) and with the requirement of section 1301(c)(8) of such Act (relating to liability arrangements to protect members), and

"(F) notify the State of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties.

Each State is required to conduct audits on the books and records of at least 1 percent of the number of medicaid managed care organizations operating in the State.

"(3) ADEQUATE PROVISION AGAINST RISK OF INSOLVENCY.—

"(A) ESTABLISHMENT OF STANDARDS.—The Secretary shall establish standards, including appropriate equity standards, under which each medicaid managed care organization shall make adequate provision against the risk of insolvency.

"(B) CONSIDERATION OF OTHER STANDARDS.—In establishing the standards described in subparagraph (A), the Secretary shall consider solvency standards applicable to eligible organizations with a risk-sharing contract under section 1876 or under part C of title XVIII.

"(C) MODEL CONTRACT ON SOLVENCY.—At the earliest practicable time after the date of the enactment of this section, the Secretary shall issue guidelines concerning solvency standards for risk contracting entities and subcontractors of such risk contracting entities. Such guidelines shall take into account characteristics that may differ among risk contracting entities, including whether such an entity is at risk for inpatient hospital services.

"(4) REQUIRING REPORT ON NET EARNINGS AND ADDITIONAL BENEFITS.—Each medicaid managed care organization shall submit a report to the State not later than 12 months after the close of a contract year containing the most recent audited financial statement of the organization's net earnings and consistent with generally accepted accounting principles.

"(c) DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION.—Each medicaid managed care organization shall provide for disclosure of information in accordance with section 1124.

"(d) DISCLOSURE OF TRANSACTION INFORMATION.—

"(1) IN GENERAL.—Each medicaid managed care organization which is not a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) shall report to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General, a description of transactions between the organization and a party in interest (as defined in section 1318(b) of such Act), including the following transactions:

"(A) Any sale or exchange, or leasing of any property between the organization and such a party.

"(B) Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

"(C) Any lending of money or other extension of credit between the organization and such a party.

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

"(2) DISCLOSURE TO ENROLLEES.—Each such organization shall make the information reported pursuant to paragraph (1) available to its enrollees upon reasonable request.

"(e) CONTRACT OVERSIGHT.—

"(1) IN GENERAL.—The Secretary must provide prior review and approval for contracts under this part with a medicaid managed care organization providing for expenditures under this title in excess of $1,000,000.

"(2) INSPECTOR GENERAL REVIEW.—As part of such approval process, the Inspector General in the Department of Health and Human Services, effective October 1, 1997, shall make a determination (to the extent practicable) as to whether persons with an ownership interest (as defined in section 1124(a)(3)) or an officer, director, agent, or managing employee (as defined in section 1126(b)) of the organization are or have been described in subsection (a)(1)(C) based on a ground relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct or obstruction of an investigation.

"(f) LIMITATION ON AVAILABILITY OF FFP FOR USE OF ENROLLMENT BROKERS.—Amounts expended by a State for the use of an

enrollment broker in marketing managed care entities to eligible individuals under this title shall be considered, for purposes of section 1903(a)(7), to be necessary for the proper and efficient administration of the State plan but only if the following conditions are met with respect to the broker:

"(1) The broker is independent of any such entity and of any health care providers (whether or not any such provider participates in the State plan under this title) that provide coverage of services in the same State in which the broker is conducting enrollment activities.

"(2) No person who is an owner, employee, consultant, or has a contract with the broker either has any direct or indirect financial interest with such an entity or health care provider or has been excluded from participation in the program under this title or title XVIII or debarred by any Federal agency, or subject to a civil money penalty under this Act.

"(g) USE OF UNIQUE PHYSICIAN IDENTIFIER FOR PARTICIPATING PHYSICIANS.—Each medicaid managed care organization shall require each physician providing services to enrollees eligible for medical assistance under the State plan under this title to have a unique identifier in accordance with the system established under section 1173(b).

"(h) SECRETARIAL RECOVERY OF FFP FOR CAPITATION PAYMENTS FOR INSOLVENT MANAGED CARE ENTITIES.—The Secretary shall provide for the recovery and offset against any amount owed a State under section 1903(a)(1) in an amount equal to the amounts paid to the State for medical assistance provided under such section, for expenditures for capitation payments to a managed care entity that becomes insolvent or for services contracted for with, but not provided by, such organization.

"SEC. 1949. SANCTIONS FOR NONCOMPLIANCE BY MANAGED CARE ENTITIES.

"(a) USE OF INTERMEDIATE SANCTIONS BY THE STATE TO ENFORCE REQUIREMENTS.—

"(1) IN GENERAL.—Each State shall establish intermediate sanctions, which may include any of the types described in subsection (b) other than the termination of a contract with a managed care entity, which the State may impose against a managed care entity with a contract under section 1941(a)(1)(B) if the entity—

"(A) fails substantially to provide medically necessary items and services that are required (under law or under such entity's contract with the State) to be provided to an enrollee covered under the contract,

"(B) imposes premiums or charges on enrollees in excess of the premiums or charges permitted under this title,

"(C) acts to discriminate among enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to reenroll an individual, except as permitted by this part, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the entity by eligible individuals whose medical condition or history indicates a need for substantial future medical services,

"(D) misrepresents or falsifies information that is furnished—

"(i) to the Secretary or the State under this part; or

"(ii) to an enrollee, potential enrollee, or a health care provider under such sections, or

"(E) fails to comply with the requirements of section 1876(i)(8) (or comparable requirements under part C of title XVIII) or this part.

"(2) RULE OF CONSTRUCTION.—For purposes of paragraph (1)(A), the term 'medically necessary' shall not be construed as requiring an abortion be performed for any individual, except if necessary to save the life of the mother or if a pregnancy is the result of an act of rape or incest.

"(b) INTERMEDIATE SANCTIONS.—The sanctions described in this subsection are as follows:

"(1) Civil money penalties as follows:

"(A) Except as provided in subparagraph (B), (C), or (D), not more than $25,000 for each determination under subsection (a).

"(B) With respect to a determination under paragraph (3) or (4)(A) of subsection (a), not more than $100,000 for each such determination.

"(C) With respect to a determination under subsection (a)(2), double the excess amount charged in violation of such subsection (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned).

"(D) Subject to subparagraph (B), with respect to a determination under subsection (a)(3), $15,000 for each individual not enrolled as a result of a practice described in such subsection.

"(2) The appointment of temporary management—

"(A) to oversee the operation of the medicaid-only managed care entity upon a finding by the State that there is continued egregious behavior by the plan, or

"(B) to assure the health of the entity's enrollees, if there is a need for temporary management while—

"(i) there is an orderly termination or reorganization of the managed care entity; or

"(ii) improvements are made to remedy the violations found under subsection (a),

except that temporary management under this paragraph may not be terminated until the State has determined that the managed care entity has the capability to ensure that the violations shall not recur.

"(3) Permitting individuals enrolled with the managed care entity to terminate enrollment without cause, and notifying such individuals of such right to terminate enrollment.

"(4) Suspension or default of all enrollment of individuals under this title after the date the Secretary or the State notifies the entity of a determination of a violation of any requirement of this part.

"(5) Suspension of payment to the entity under this title for individuals enrolled after the date the Secretary or State notifies the entity of such a determination and until the Secretary or State is satisfied that the basis for such determination has been corrected and is not likely to recur.

"(c) TREATMENT OF CHRONIC SUBSTANDARD ENTITIES.—In the case of a managed care entity which has repeatedly failed to meet the requirements of sections 1942 through 1946, the State shall (regardless of what other sanctions are provided) impose the sanctions described in paragraphs (2) and (3) of subsection (b).

"(d) AUTHORITY TO TERMINATE CONTRACT.—In the case of a managed care entity which has failed to meet the requirements of this part, the State shall have the authority to terminate its contract with such entity under section 1941(a)(1)(B) and to enroll such entity's enrollees with other managed care entities (or to permit such enrollees to receive medical assistance under the State plan under this title other than through a managed care entity).

"(e) AVAILABILITY OF SANCTIONS TO THE SECRETARY.—

"(1) INTERMEDIATE SANCTIONS.—In addition to the sanctions described in paragraph (2) and any other sanctions available under law, the Secretary may provide for any of the sanctions described in subsection (b) if the Secretary determines that a managed care entity with a contract under section 1941(a)(1)(B) fails to meet any of the requirements of this part.

"(2) DENIAL OF PAYMENTS TO THE STATE.—The Secretary may deny payments to the State for medical assistance furnished under the contract under section 1941(a)(1)(B) for individuals enrolled after the date the Secretary notifies a managed care entity of a determination under subsection (a) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

"(f) DUE PROCESS FOR MANAGED CARE ENTITIES.—

"(1) AVAILABILITY OF HEARING PRIOR TO TERMINATION OF CONTRACT.—A State may not terminate a contract with a managed care entity under section 1941(a)(1)(B) unless the entity is provided with a hearing prior to the termination.

"(2) NOTICE TO ENROLLEES OF TERMINATION HEARING.—A State shall notify all individuals enrolled with a managed care entity which is the subject of a hearing to terminate the entity's contract with the State of the hearing and that the enrollees may immediately disenroll with the entity without cause.

"(3) OTHER PROTECTIONS FOR MANAGED CARE ENTITIES AGAINST SANCTIONS IMPOSED BY STATE.—Before imposing any sanction against a managed care entity other than termination of the entity's contract, the State shall provide the entity with notice and such other due process protections as the State may provide, except that a State may not provide a managed care entity with a pre-termination hearing before imposing the sanction described in subsection (b)(2).

"(4) IMPOSITION OF CIVIL MONETARY PENALTIES BY SECRETARY.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply with respect to a civil money penalty imposed by the Secretary under subsection (b)(1) in the

same manner as such provisions apply to a penalty or proceeding under section 1128A.

"SEC. 1950. DEFINITIONS; MISCELLANEOUS PROVISIONS.

"(a) DEFINITIONS.—For purposes of this title:

"(1) MANAGED CARE ENTITY.—The term 'managed care entity' means—

"(A) a medicaid managed care organization; or

"(B) a primary care case manager.

"(2) MEDICAID MANAGED CARE ORGANIZATION.—The term 'medicaid managed care organization' means a health maintenance organization, an eligible organization with a contract under section 1876 or under part C of title XVIII, a provider sponsored network, or any other organization which is organized under the laws of a State, has made adequate provision (as determined under standards established for purposes of eligible organizations under section 1876 or under part C of title XVIII, and through its capitalization or otherwise) against the risk of insolvency, and provides or arranges for the provision of one or more items and services to individuals eligible for medical assistance under the State plan under this title in accordance with a contract with the State under section 1941(a)(1)(B).

"(3) PRIMARY CARE CASE MANAGER.—

"(A) IN GENERAL.—The term 'primary care case manager' has the meaning given such term in section 1905(t)(2).".

(b) STUDIES AND REPORTS.—

(1) REPORT ON PUBLIC HEALTH SERVICES.—

(A) IN GENERAL.—Not later than January 1, 1998, the Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall report to the Committee on Finance of the Senate and the Committee on Commerce of the House of Representatives on the effect of managed care entities (as defined in section 1950(a)(1) of the Social Security Act) on the delivery of and payment for the services traditionally provided through providers described in section 1941(a)(2)(B)(i) of such Act.

(B) CONTENTS OF REPORT.—The report referred to in subparagraph (A) shall include—

(i) information on the extent to which enrollees with eligible managed care entities seek services at local health departments, public hospitals, and other facilities that provide care without regard to a patient's ability to pay;

(ii) information on the extent to which the facilities described in clause (i) provide services to enrollees with eligible managed care entities without receiving payment;

(iii) information on the effectiveness of systems implemented by facilities described in clause (i) for educating such enrollees on services that are available through eligible managed care entities with which such enrollees are enrolled;

(iv) to the extent possible, identification of the types of services most frequently sought by such enrollees at such facilities; and

(v) recommendations about how to ensure the timely delivery of the services traditionally provided through providers described in section 1941(a)(2)(B)(i) of the Social Security Act to enrollees of managed care entities and how to ensure that local health departments, public hospitals, and other facilities are adequately compensated for the provision of such services to such enrollees.

(2) REPORT ON PAYMENTS TO HOSPITALS.—

(A) IN GENERAL.—Not later than October 1 of each year, beginning with October 1, 1998, the Secretary and the Comptroller General shall analyze and submit a report to the Committee on Finance of the Senate and the Committee on Commerce of the House of Representatives on rates paid for hospital services under managed care entities under contracts under section 1941(a)(1)(B) of the Social Security Act.

(B) CONTENTS OF REPORT.—The information in the report described in subparagraph (A) shall—

(i) be organized by State, type of hospital, type of service; and

(ii) include a comparison of rates paid for hospital services under managed care entities with rates paid for hospital services furnished to individuals who are entitled to benefits under a State plan under title XIX of the Social Security Act and are not enrolled with such entities.

(3) REPORTS BY STATES.—Each State shall transmit to the Secretary, at such time and in such manner as the Secretary determines appropriate, the information on hospital rates submitted to such State under section 1947(b)(2) of the Social Security Act.

(4) INDEPENDENT STUDY AND REPORT ON QUALITY ASSURANCE AND ACCREDITATION STANDARDS.—The Institute of Medicine of the National Academy of Sciences shall conduct a study and analysis of the quality assurance programs and accreditation standards applicable to managed care entities operating in the private sector or to such entities that operate under contracts under the medicare program under title XVIII of the Social Security Act to determine if such programs and standards include consideration of the accessibility and quality of the health care items and services delivered under such contracts to low-income individuals.

(c) CONFORMING AMENDMENTS.—

(1) REPEAL OF CURRENT REQUIREMENTS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), section 1903(m) (42 U.S.C. 1396b(m)) is repealed on the date of the enactment of this Act.

(B) EXISTING CONTRACTS.—In the case of any contract under section 1903(m) of such Act which is in effect on the day before the date of the enactment of this Act, the provi-

sions of such section shall apply to such contract until the earlier of—

(i) the day after the date of the expiration of the contract; or

(ii) the date which is 1 year after the date of the enactment of this Act.

(2) FEDERAL FINANCIAL PARTICIPATION.—

(A) CLARIFICATION OF APPLICATION OF FFP DENIAL RULES TO PAYMENTS MADE PURSUANT TO MANAGED CARE ENTITIES.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended by adding at the end the following new sentence: "Paragraphs (1)(A), (1)(B), (2), (5), and (12) shall apply with respect to items or services furnished and amounts expended by or through a managed care entity (as defined in section 1950(a)(1)) in the same manner as such paragraphs apply to items or services furnished and amounts expended directly by the State.".

(B) FFP FOR EXTERNAL QUALITY REVIEW ORGANIZATIONS.—Section 1903(a)(3)(C) (42 U.S.C. 1396b(a)(3)(C)) is amended—

(i) by inserting "(i)" after "(C)", and

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

"(ii) 75 percent of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of independent external reviews of managed care entities (as defined in section 1950(a)(1)) by external quality review organizations, but only if such organizations conduct such reviews under protocols approved by the Secretary and only in the case of such organizations that meet standards established by the Secretary relating to the independence of such organizations from agencies responsible for the administration of this title or eligible managed care entities; and".

(3) EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN PROGRAM.—Section 1128(b)(6)(C) (42 U.S.C. 1320a–7(b)(6)(C)) is amended—

(A) in clause (i), by striking "a health maintenance organization (as defined in section 1903(m))" and inserting "a managed care entity, as defined in section 1950(a)(1),"; and

(B) in clause (ii), by inserting "section 1115 or" after "approved under".

(4) STATE PLAN REQUIREMENTS.—Section 1902 (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(30)(C), by striking "section 1903(m)" and inserting "section 1941(a)(1)(B)"; and

(B) in subsection (a)(57), by striking "health maintenance organization (as defined in section 1903(m)(1)(A))" and inserting "managed care entity, as defined in section 1950(a)(1)";

(C) in subsection (e)(2)(A), by striking "or with an entity described in paragraph (2)(B)(iii), (2)(E), (2)(G), or (6)

of section 1903(m) under a contract described in section 1903(m)(2)(A)" and inserting "or with a managed care entity, as defined in section 1950(a)(1);

(D) in subsection (p)(2)—

(i) by striking "a health maintenance organization (as defined in section 1903(m))" and inserting "a managed care entity, as defined in section 1950(a)(1),";

(ii) by striking "an organization" and inserting "an entity"; and

(iii) by striking "any organization" and inserting "any entity"; and

(E) in subsection (w)(1), by striking "sections 1903(m)(1)(A) and" and inserting "section".

(5) PAYMENT TO STATES.—Section 1903(w)(7)(A)(viii) (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended to read as follows:

"(viii) Services of a managed care entity with a contract under section 1941(a)(1)(B).".

(6) USE OF ENROLLMENT FEES AND OTHER CHARGES.—Section 1916 (42 U.S.C. 1396o) is amended in subsections (a)(2)(D) and (b)(2)(D) by striking "a health maintenance organization (as defined in section 1903(m))" and inserting "a managed care entity, as defined in section 1950(a)(1)," each place it appears.

(7) EXTENSION OF ELIGIBILITY FOR MEDICAL ASSISTANCE.—Section 1925(b)(4)(D)(iv) (42 U.S.C. 1396r–6(b)(4)(D)(iv)) is amended to read as follows:

"(iv) ENROLLMENT WITH MANAGED CARE ENTITY.—Enrollment of the caretaker relative and dependent children with a managed care entity, as defined in section 1950(a)(1), less than 50 percent of the membership (enrolled on a prepaid basis) of which consists of individuals who are eligible to receive benefits under this title (other than because of the option offered under this clause). The option of enrollment under this clause is in addition to, and not in lieu of, any enrollment option that the State might offer under subparagraph (A)(i) with respect to receiving services through a managed care entity in accordance with part B.".

(8) PAYMENT FOR COVERED OUTPATIENT DRUGS.—Section 1927(j)(1) (42 U.S.C. 1396r–8(j)(1)) is amended by striking "***Health Maintenance Organizations, including those organizations that contract under section 1903(m)," and inserting "health maintenance organizations and medicaid managed care organizations, as defined in section 1950(a)(2),".

(9) APPLICATION OF SANCTIONS FOR BALANCED BILLING THROUGH SUBCONTRACTORS.—(A) Section 1128A(b)(2)(B) (42 U.S.C. 1320a–7a(b)) is amended by inserting ", including section 1944(b)" after "title XIX".

(B) Section 1128B(d)(1) (42 U.S.C. 1320a–7b(d)(1)) is amended by inserting "or, in the case of an individual enrolled with a managed care entity under part B of title XIX, the applicable rates established by the entity under the agreement with the State agency under such part" after "established by the State".

(10) REPEAL OF CERTAIN RESTRICTIONS ON OBSTETRICAL AND PEDIATRIC PROVIDERS.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended by striking paragraph (12).

(11) DEMONSTRATION PROJECTS TO STUDY EFFECT OF ALLOWING STATES TO EXTEND MEDICAID COVERAGE FOR CERTAIN FAMILIES.—Section 4745(a)(5)(A) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1396a note) is amended by striking "(except section 1903(m)" and inserting "(except part B)".

(12) CONFORMING AMENDMENT FOR DISCLOSURE REQUIREMENTS FOR MANAGED CARE ENTITIES.—Section 1124(a)(2)(A) (42 U.S.C. 1320a–3(a)(2)(A)) is amended by inserting "managed care entity under title XIX," after "renal dialysis facility,".

(13) ELIMINATION OF REGULATORY PAYMENT CAP.—The Secretary of Health and Human Services may not, under the authority of section 1902(a)(30)(A) of the Social Security Act or any other provision of title XIX of such Act, impose a limit by regulation on the amount of the capitation payments that a State may make to qualified entities under such title, and section 447.361 of title 42, Code of Federal Regulations (relating to upper limits of payment: risk contracts), is hereby nullified.

(14) CONTINUATION OF ELIGIBILITY.—Section 1902(e)(2) (42 U.S.C. 1396a(e)(2)) is amended to read as follows:

"(2) For provision providing for extended liability in the case of certain beneficiaries enrolled with managed care entities, see section 1941(c).".

(15) CONFORMING AMENDMENTS TO FREEDOM-OF-CHOICE PROVISIONS.—Section 1902(a)(23) (42 U.S.C. 1396a(a)(23)) is amended—

(A) in the matter preceding subparagraph (A), by striking "subsection (g) and in section 1915" and inserting "subsection (g), section 1915, and section 1941,"; and

(B) in subparagraph (B), by striking "a health maintenance organization, or a" and inserting "or with a managed care entity, as defined in section 1950(a)(1), or".

(d) EFFECTIVE DATE; STATUS OF WAIVERS.—

(1) EFFECTIVE DATE.—Except as provided in paragraph (2), the amendments made by this section shall apply to medical assistance furnished—

(A) during quarters beginning on or after October 1, 1997; or

(B) in the case of assistance furnished under a contract described in subsection (c)(1)(B), during quarters beginning after the earlier of—

(i) the date of the expiration of the contract; or

(ii) the expiration of the 1-year period which begins on the date of the enactment of this Act.

(2) APPLICATION TO WAIVERS.—If any waiver granted to a State under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n), or otherwise, which relates to the provision of medical assistance under a State plan under title XIX of the such Act (42 U.S.C. 1396 et seq.), is in effect or approved by the Secretary of Health and Human Services as of the applicable effective date described in paragraph (1), the amend-

ments made by this section shall not apply with respect to the State before the expiration (determined without regard to any extensions) of the waiver to the extent such amendments are inconsistent with the terms of the waiver.

SEC. 5702. PRIMARY CARE CASE MANAGEMENT SERVICES AS STATE OPTION WITHOUT NEED FOR WAIVER.

(a) OPTIONAL COVERAGE AS PART OF MEDICAL ASSISTANCE.—

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

(A) by striking "and" at the end of paragraph (24);

(B) by redesignating paragraph (25) as paragraph (26); and

(C) by inserting after paragraph (24) the following new paragraph:

"(25) primary care case management services (as defined in subsection (t)); and".

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(10)(C)(iv) (42 U.S.C. 1396a(a)(10)(C)(iv)) is amended by striking "through (24)" and inserting "through (25)".

(B) Section 1902(j) (42 U.S.C. 1396a(j)) is amended by striking "through (25)" and inserting "through (26)".

(b) PRIMARY CARE CASE MANAGEMENT SERVICES DEFINED.—Section 1905 (42 U.S.C. 1396d)) is amended by adding at the end the following new subsection:

"(t)(1) The term 'primary care case management services' means case-management related services (including coordination and monitoring of health care services) provided by a primary care case manager under a primary care case management contract.

"(2)(A) The term 'primary care case manager' means, with respect to a primary care case management contract, a provider described in subparagraph (B).

"(B) A provider described in this subparagraph is—

"(i) a physician, a physician group practice, or an entity employing or having other arrangements with physicians who provide case management services; or

"(ii) at State option—

"(I) a nurse practitioner (as described in section 1905(a)(21));

"(II) a certified nurse-midwife (as defined in section 1861(gg)(2)); or

"(III) a physician assistant (as defined in section 1861(aa)(5)).

"(3) The term 'primary care case management contract' means a contract with a State agency under which a primary care case manager undertakes to locate, coordinate, and monitor covered primary care, covered primary care (and such other covered services as may be specified under the contract) to all individuals enrolled with the primary care case manager, and that provides for—

"(A) reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment with respect to medical emergencies;

"(B) restriction of enrollment to individuals residing sufficiently near a service delivery site of the entity to be able to

reach that site within a reasonable time using available and affordable modes of transportation;

"(C) employment of, or contracts or other arrangements with, sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

"(D) a prohibition on discrimination on the basis of health status or requirements for health services in the enrollment or disenrollment of individuals eligible for medical assistance under this title; and

"(E) a right for an enrollee to terminate enrollment without cause during the first month of each enrollment period, which period shall not exceed 6 months in duration, and to terminate enrollment at any time for cause.

"(4) For purposes of this subsection, the term 'primary care' includes all health care services customarily provided in accordance with State licensure and certification laws and regulations, and all laboratory services customarily provided by or through, a general practitioner, family medicine physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.".

(c) CONFORMING AMENDMENT.—Section 1915(b)(1) (42 U.S.C. 1396n(b)(1)) is repealed.

(d) EFFECTIVE DATE.—The amendments made by this section apply to primary care case management services furnished on or after October 1, 1997.

SEC. 5703. ADDITIONAL REFORMS TO EXPAND AND SIMPLIFY MANAGED CARE.

(a) ELIMINATION OF 75:25 RESTRICTION ON RISK CONTRACTS.—

(1) 75 PERCENT LIMIT ON MEDICARE AND MEDICAID ENROLLMENT.—

(A) IN GENERAL.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended by striking clause (ii).

(B) CONFORMING AMENDMENTS.—

(i) Section 1903(m)(2) (42 U.S.C. 1396b(m)(2)) is amended—

(I) by striking subparagraphs (C), (D), and (E); and

(II) in subparagraph (G), by striking "clauses (i) and (ii)" and inserting "clause (i)".

(ii) Section 1902(e)(2)(A) (42 U.S.C. 1396a(e)(2)(A)) is amended by striking "(2)(E),".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply on and after June 20, 1997.

(b) ELIMINATION OF PROHIBITION ON COPAYMENTS FOR SERVICES FURNISHED BY HEALTH MAINTENANCE ORGANIZATIONS.—Section 1916 (42 U.S.C.1396o) is amended—

(1) in subsection (a)(2)(D), by striking "or services furnished" and all that follows through "enrolled,"; and

(2) in subsection (b)(2)(D), by striking "or (at the option" and all that follows through "enrolled,".

Subchapter B—Management Flexibility Reforms

SEC. 5711. ELIMINATION OF BOREN AMENDMENT REQUIREMENTS FOR PROVIDER PAYMENT RATES.

(a) PLAN AMENDMENTS.—Section 1902(a)(13) is amended—

(1) by striking all that precedes subparagraph (D) and inserting the following:

"(13) provide—

"(A) for a public process for determination of rates of payment under the plan for hospital services (and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), nursing facility services, services provided in intermediate care facilities for the mentally retarded, and home and community-based services, under which—

"(i) proposed rates, the methodologies underlying the establishment of such rates, and a description of how such methodologies will affect access to services, quality of services, and safety of beneficiaries are published, and providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on such proposed rates, methodologies, and description; and

"(ii) final rates, the methodologies underlying the establishment of such rates, and justifications for such rates (that may take into account public comments received by the State (if any) are published in 1 or more daily newspapers of general circulation in the State or in any publication used by the State to publish State statutes or rules); and";

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

(3) in subparagraph (B), as so redesignated, by adding "and" at the end; and

(4) by striking subparagraph (F).

(b) STUDY AND REPORT.—

(1) STUDY.—The Secretary of Health and Human Services shall study the effect on access to services, the quality of services, and the safety of services provided to beneficiaries of the rate-setting methods used by States pursuant to section 1902(a)(13) of the Social Security Act (42 U.S.C. 1396a(a)(13), as amended by subsection (a).

(2) REPORT.—Not later than 4 years after the date of enactment of this Act, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the conclusions of the study conducted under paragraph (1), together with any recommendations for legislation as a result of such conclusions.

(c) CONFORMING AMENDMENTS.—

(1) Section 1903(m)(2)(A)(ix) (42 U.S.C. 1396b(m)(2)(A)(ix)) is amended by striking "1902(a)(13)(E)" each place it appears and inserting "1902(a)(13)(C)".

(2) Section 1905(o)(3) (42 U.S.C. 1396d(o)(3)) is amended by striking "amount described in section 1902(a)(13)(D)" and inserting "amount determined in section 1902(a)(13)(B)".

(3) Section 1913(b)(3) (42 U.S.C. 1396l(b)(3)) is amended by striking "1902(a)(13)(A)" and inserting "1902(a)(13)".

(4) Section 1923 (42 U.S.C. 1396r–4) is amended in subsections (a)(1) and (e)(1), by striking "1902(a)(13)(A)" each place it appears and inserting "1902(a)(13)".

SEC. 5712. MEDICAID PAYMENT RATES FOR QUALIFIED MEDICARE BENEFICIARIES.

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

(1) by inserting "(1)" after "(n)", and

(2) by adding at the end the following:

"(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for a coinsurance or copayment for medicare cost-sharing if the amount of the payment under title XVIII for the service exceeds the payment amount that otherwise would be made under the State plan under this title for such service.

"(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (1) or (2) of this subsection—

"(A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service,

"(B) the beneficiary shall not have any legal liability to make payment to the provider for the service, and

"(C) any lawful sanction that may be imposed upon a provider for excess charges under this title or title XVIII shall apply to the imposition of any charge on the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.".

(b) LIMITATION IN MEDICARE PROVIDER AGREEMENTS.—Section 1866(a)(1)(A) (42 U.S.C. 1395cc(a)(1)(A)) is amended—

(1) by inserting "(i)" after "(A)", and

(2) by inserting before the comma at the end the following: ", and (ii) not to impose any charge that may not be charged under section 1902(n)(3)".

(c) LIMITATION ON NONPARTICIPATING PROVIDERS.—Section 1848(g)(3)(A) (42 U.S.C. 1395w–4(g)(3)(A)) is amended by inserting before the period at the end the following: "and the provisions of section 1902(n)(3)(A) apply to further limit permissible charges under this section".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to payment for items and services furnished on or after the later of—

(1) October 1, 1997; or

(2) the termination date of a provider agreement under the medicare program under title XVIII or under a State plan

under title XIX that is in effect on the date of the enactment of this Act.

SEC. 5713. NO WAIVER REQUIRED FOR PROVIDER SELECTIVITY.

Section 1915(a) (42 U.S.C. 1396n(a)) is amended—

(1) in paragraph (1), by striking "or" at the end;

(2) in paragraph (2), by striking the period and inserting "; or"; and

(3) by adding at the end the following:

"(3) contracts, on a capitated or other negotiated basis, with selected health care plans, individual health care providers, managed care entities, as defined in section 1950(a)(1), or other entities for the provision or arrangement of medical assistance, for case management services, or for coordination of medical assistance provided under the State plan this title.".

Subchapter C—Reduction of Disproportionate Share Hospital (DSH) Payments

SEC. 5721. DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

(a) REDUCTION OF PAYMENTS.—Section 1923(f) (42 U.S.C. 1396r–4(f)) is amended to read as follows:

"(f) LIMITATION ON FEDERAL FINANCIAL PARTICIPATION.—

"(1) IN GENERAL.—Beginning with fiscal year 1998, payment under section 1903(a) shall not be made to a State with respect to any payment adjustment made under this section for hospitals in a State for quarters in a fiscal year in excess of the disproportionate share hospital (in this subsection referred to as 'DSH') allotment for the State for the fiscal year, as specified in paragraphs (2), (3), (4), and (5).

"(2) DETERMINATION OF STATE DSH ALLOTMENTS FOR FISCAL YEAR 1998.—

"(A) IN GENERAL.—Except as provided in subparagraph (B) and paragraph (4), the DSH allotment for a State for fiscal year 1998 is equal to the State 1995 DSH spending amount.

"(B) HIGH DSH STATES.—In the case of any State that is a high DSH State, the DSH allotment for that State for fiscal year 1998 is equal to the sum of—

"(i) the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for inpatient hospital services provided (based on reporting data specified by the State on HCFA Form 64 as inpatient DSH); and

"(ii) 70 percent of the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for services provided by institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH).

"(3) DETERMINATION OF STATE DSH ALLOTMENTS FOR FISCAL YEARS 1999 THROUGH 2002.—

"(A) NON HIGH DSH STATES.—

"(i) IN GENERAL.—Except as provided in subparagraph (B) and paragraph (4), the DSH allotment for a State for each of fiscal years 1999 through 2002 is equal to the applicable percentage of the State 1995 DSH spending amount.

"(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the applicable percentage with respect to a State described in that clause is—

"(A) for fiscal year 1999, 98 percent;

"(B) for fiscal year 2000, 95 percent;

"(C) for fiscal year 2001, 90 percent; and

"(D) for fiscal year 2002, 85 percent.

"(B) HIGH DSH STATES.—

"(i) IN GENERAL.—In the case of any State that is a high DSH State, the DSH allotment for that State for each of fiscal years 1999 through 2002 is equal to the applicable reduction percentage of the high DSH State modified 1995 spending amount for that fiscal year.

"(ii) HIGH DSH STATE MODIFIED 1995 SPENDING AMOUNT.—

"(I) IN GENERAL.—For purposes of clause (i), the high DSH State modified 1995 spending amount means, with respect to a State and a fiscal year, the sum of—

"(aa) the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for inpatient hospital services provided (based on reporting data specified by the State on HCFA Form 64 as inpatient DSH); and

"(bb) the applicable mental health percentage for such fiscal year of the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for services provided by institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH).

"(II) APPLICABLE MENTAL HEALTH PERCENTAGE.—For purposes of subclause (I)(bb), the applicable mental health percentage for such fiscal year is—

"(aa) for fiscal year 1999, 50 percent;

"(bb) for fiscal year 2000, 20 percent; and

"(cc) for fiscal years 2001 and 2002, 0 percent.

"(iii) APPLICABLE REDUCTION PERCENTAGE.—For purposes of clause (i), the applicable reduction percentage described in that clause is—

"(A) for fiscal year 1999, 86 percent; and

"(B) for fiscal years 2000 through 2002, 80 percent.

"(4) EXCEPTIONS.—

"(A) CERTAIN STATES WITHOUT 1995 MENTAL HEALTH DSH SPENDING.—In the case of any State with a State 1995 DSH spending amount that exceeds 12 percent of the Federal medical assistance percentage of expenditures made under the State plan under this title for medical assistance during fiscal year 1995 and that, during such fiscal year, did not make any payment adjustments to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for services provided by institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH), the DSH allotment for that State for each of fiscal years 1998 through 2002 is equal to the average of the State 1995 DSH spending amount and the State 1996 DSH spending amount.

"(B) STATES WITH LOW STATE 1995 DSH SPENDING AMOUNTS.—In the case of any State with a State 1995 DSH spending amount that is less than 3 percent of the Federal medical assistance percentage of expenditures made under the State plan under this title for medical assistance during fiscal year 1995, the DSH allotment for that State for each of fiscal years 1998 through 2002 is equal to the State 1995 DSH spending amount.

"(C) STATES WITH STATE 1995 DSH SPENDING AMOUNTS BELOW 12 PERCENT.—In the case of any State with a State 1995 DSH spending amount that is less than 12 percent but more than 3 percent of the Federal medical assistance percentage of expenditures made under the State plan under this title for medical assistance during fiscal year 1995, the DSH allotment for that State for each of fiscal years 1999 through 2002 is equal to the greater of—

"(i) the amount otherwise determined for such State under paragraph (3); or

"(ii) 50 percent of the State 1995 DSH spending amount.

"(5) DETERMINATION OF STATE DSH ALLOTMENTS FOR FISCAL YEAR 2003 AND THEREAFTER.—The DSH allotment for any State for fiscal year 2003 and each fiscal year thereafter is equal to the DSH allotment for the State for the preceding fiscal year, increased by the estimated percentage change in the consumer price index for medical services (as determined by the Bureau of Labor Statistics).

"(6) DEFINITIONS.—

"(A) HIGH DSH STATE.—The term 'high DSH State' means a State that, with respect to fiscal year 1997, had a State base allotment under this section that exceeded 12 percent of the Federal medical assistance percentage of expenditures made under the State plan under this title for medical assistance during such fiscal year, as determined using the preliminary State DSH allotment for the State for fiscal year 1997, as published in the Federal Register on January 31, 1997.

"(B) STATE.—In this subsection, the term 'State' means the 50 States and the District of Columbia.".

"(C) STATE 1995 DSH SPENDING AMOUNT.—The term 'State 1995 DSH spending amount' means, with respect to a State, the Federal medical assistance percentage of payment adjustments made under subsection (c) under the State plan during fiscal year 1995 as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary.

"(D) STATE 1996 DSH SPENDING AMOUNT.—The term 'State 1996 DSH spending amount' means, with respect to a State, the Federal share of payment adjustments made under subsection (c) under the State plan during fiscal year 1996 as reported by the State not later than December 31, 1997, on HCFA Form 64, and as approved by the Secretary.".

(b) LIMITATION ON PAYMENTS TO INSTITUTIONS FOR MENTAL DISEASES.—Section 1923 of the Social Security Act (42 U.S.C. 1396r–4) is amended by adding at the end the following:

"(h) LIMITATION ON CERTAIN STATE DSH EXPENDITURES.—

"(1) IN GENERAL.—Notwithstanding any other provision of this section, payment under section 1903(a) shall not be made to a State with respect to any payment adjustments made under this section for quarters in a fiscal year to institutions for mental diseases or other mental health facilities, in excess of—

"(A) the total State expenditures incurred for fiscal year 1995 for providing services under the State plan under this title to individuals who were patients in institutions for mental diseases; or

"(B) the amount of such payment adjustment which is equal to the applicable percentage of the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for services provided by institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH).

"(2) APPLICABLE PERCENTAGE.—

"(A) IN GENERAL.—For purposes of paragraph (1), the applicable percentage with respect to a fiscal year is the lesser of the percentage determined under subparagraph (B) or—

"(i) for fiscal year 2000, 50 percent;

"(ii) for fiscal year 2001, 40 percent; and

"(iii) for fiscal year 2002, 33 percent.

"(B) 1995 PERCENTAGE.—The percentage determined under this subparagraph is the ratio (determined as a percentage) of the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for services provided by institutions for mental diseases and other mental health facilities, to the State 1995 DSH spending amount, as defined under subsection (f)(6)(C).".

(c) TARGETING PAYMENTS.—Section 1923(a)(2) (42 U.S.C. 1396r–4(a)(2)) is amended by adding at the end the following:

"(D) A State plan under this title shall not be considered to meet the requirements of section 1902(a)(13)(A) (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs), as of October 1, 1998, unless the State has provided assurances to the Secretary that the State has developed a methodology for prioritizing payments to disproportionate share hospitals, including children's hospitals, on the basis of the proportion of low-income and medicaid patients served by such hospitals. In making such assurances, the State plan shall provide a definition of high-volume disproportionate share hospitals and a detailed description of the specific methodology to be used to provide disproportionate share payments to such hospitals. The State shall provide an annual report to the Secretary describing the disproportionate share payments to such high-volume disproportionate share hospitals.".

(d) EFFECTIVE DATE.—The amendments made by this section apply on and after October 1, 1997.

CHAPTER 2—EXPANSION OF MEDICAID ELIGIBILITY

SEC. 5731. STATE OPTION TO PERMIT WORKERS WITH DISABILITIES TO BUY INTO MEDICAID.

Section 1902(a)(10)(A)(ii) (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(1) in subclause (XI), by striking "or" at the end;
(2) in subclause (XII), by adding "or" at the end; and
(3) by adding at the end the following:

"(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1619(b), would be considered to be receiving supplemental security income (subject, notwithstanding section 1916, to payment of premiums or other charges (set on a sliding scale based on income) that the State may determine);".

SEC. 5732. 12-MONTH CONTINUOUS ELIGIBILITY FOR CHILDREN.

(a) IN GENERAL.—Section 1902(e) (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

"(12) At the option of the State, the State plan may provide that an individual who is under an age specified by the State (not to exceed 19 years of age) and who is determined to be eligible for benefits under a State plan approved under this title under subsection (a)(10)(A) shall remain eligible for those benefits until the earlier of—

"(A) the end of the 12-month period following the determination; or

"(B) the date that the individual exceeds that age.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to medical assistance for items and services furnished on or after October 1, 1997.

CHAPTER 3—PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

SEC. 5741. ESTABLISHMENT OF PACE PROGRAM AS MEDICAID STATE OPTION.

(a) IN GENERAL.—Title XIX is amended—

(1) in section 1905(a) (42 U.S.C. 1396d(a)), as amended by section 5702(a)(1)—

(A) by striking "and" at the end of paragraph (25);

(B) by redesignating paragraph (26) as paragraph (27); and

(C) by inserting after paragraph (25) the following new paragraph:

"(26) services furnished under a PACE program under section 1932 to PACE program eligible individuals enrolled under the program under such section; and";

(2) by redesignating section 1932 as section 1933; and

(3) by inserting after section 1931 the following new section:

"PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

"SEC. 1932. (a) STATE OPTION.—

"(1) IN GENERAL.—A State may elect to provide medical assistance under this section with respect to PACE program services to PACE program eligible individuals who are eligible for medical assistance under the State plan and who are enrolled in a PACE program under a PACE program agreement. Such individuals need not be eligible for benefits under part A, or enrolled under part B, of title XVIII to be eligible to enroll under this section. In the case of an individual enrolled with a PACE program pursuant to such an election—

"(A) the individual shall receive benefits under the plan solely through such program, and

"(B) the PACE provider shall receive payment in accordance with the PACE program agreement for provision of such benefits.

"(2) PACE PROGRAM DEFINED.—For purposes of this section and section 1894, the term 'PACE program' means a program of all-inclusive care for the elderly that meets the following requirements:

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

"(B) COMPREHENSIVE BENEFITS.—The program provides comprehensive health care services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

"(C) TRANSITION.—In the case of an individual who is enrolled under the program under this section and whose

enrollment ceases for any reason (including that the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or otherwise), the program provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.

"(3) PACE PROVIDER DEFINED.—

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

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

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

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

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

"(ii) after the date the report under section 5743(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C), or (D) of paragraph (2) of such section are true.

"(4) PACE PROGRAM AGREEMENT DEFINED.—For purposes of this section, the term 'PACE program agreement' means, with respect to a PACE provider, an agreement, consistent with this section, section 1894 (if applicable), and regulations promulgated to carry out such sections, among the PACE provider, the Secretary, and a State administering agency for the operation of a PACE program by the provider under such sections.

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

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

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

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

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

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

"(7) PACE DEMONSTRATION WAIVER PROGRAM DEFINED.—For purposes of this section, the term 'PACE demonstration

waiver program' means a demonstration program under either of the following sections (as in effect before the date of their repeal):

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

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

"(8) STATE ADMINISTERING AGENCY DEFINED.—For purposes of this section, the term 'State administering agency' means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under this title in the State) responsible for administering PACE program agreements under this section and section 1894 in the State.

"(9) TRIAL PERIOD DEFINED.—

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

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

"(10) REGULATIONS.—For purposes of this section, the term 'regulations' refers to interim final or final regulations promulgated under subsection (f) to carry out this section and section 1894.

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

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

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

"(i) all items and services covered under title XVIII (for individuals enrolled under section 1894) and all items and services covered under this title, but without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost-sharing that would otherwise apply under such title or this title, respectively; and

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

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

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

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

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

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

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

"(c) ELIGIBILITY DETERMINATIONS.—

"(1) IN GENERAL.—The determination of—

"(A) whether an individual is a PACE program eligible individual shall be made under and in accordance with the PACE program agreement, and

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

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

"(3) ANNUAL ELIGIBILITY RECERTIFICATIONS.—

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

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

"(4) CONTINUATION OF ELIGIBILITY.—An individual who is a PACE program eligible individual may be deemed to con-

tinue to be such an individual notwithstanding a determination that the individual no longer meets the requirement of subsection (a)(5)(B) if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6-month period.

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

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

"(1) IN GENERAL.—In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the State shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section.

"(2) CAPITATION AMOUNT.—The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be an amount, specified under the PACE agreement, which is less than the amount that would otherwise have been made under the State plan if the individuals were not so enrolled and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. The payment under this section shall be in addition to any payment made under section 1894 for individuals who are enrolled in a PACE program under such section.

"(e) PACE PROGRAM AGREEMENT.—

"(1) REQUIREMENT.—

"(A) IN GENERAL.—The Secretary, in close cooperation with the State administering agency, shall establish procedures for entering into, extending, and terminating PACE program agreements for the operation of PACE programs by entities that meet the requirements for a PACE provider under this section, section 1894, and regulations.

"(B) NUMERICAL LIMITATION.—

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

"(I) 40 as of the date of the enactment of this section, or

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

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

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

"(I) is operating under a demonstration project waiver under subsection (h), or

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

"(2) SERVICE AREA AND ELIGIBILITY.—

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

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

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

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

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

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

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

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

"(A) DATA COLLECTION.—

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

"(I) collect data;

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

"(III) submit to the Secretary and the State administering agency such reports as the Secretary finds (in consultation with State administering agencies) necessary to monitor the operation, cost, and effectiveness of the PACE program.

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

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

"(4) OVERSIGHT.—

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

"(i) an onsite visit to the program site;

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

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

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

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

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

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

"(5) TERMINATION OF PACE PROVIDER AGREEMENTS.—

"(A) IN GENERAL.—Under regulations—

"(i) the Secretary or a State administering agency may terminate a PACE program agreement for cause, and

"(ii) a PACE provider may terminate such an agreement after appropriate notice to the Secretary, the State administering agency, and enrollees.

"(B) CAUSES FOR TERMINATION.—In accordance with regulations establishing procedures for termination of PACE program agreements, the Secretary or a State administering agency may terminate a PACE program agreement with a PACE provider for, among other reasons, the fact that—

"(i) the Secretary or State administering agency determines that—

"(I) there are significant deficiencies in the quality of care provided to enrolled participants; or

"(II) the provider has failed to comply substantially with conditions for a program or provider under this section or section 1894; and

"(ii) the entity has failed to develop and successfully initiate, within 30 days of the date of the receipt of written notice of such a determination, a plan to correct the deficiencies, or has failed to continue implementation of such a plan.

"(C) TERMINATION AND TRANSITION PROCEDURES.—An entity whose PACE provider agreement is terminated under this paragraph shall implement the transition procedures required under subsection (a)(2)(C).

"(6) SECRETARY'S OVERSIGHT; ENFORCEMENT AUTHORITY.—

"(A) IN GENERAL.—Under regulations, if the Secretary determines (after consultation with the State administering agency) that a PACE provider is failing substantially to comply with the requirements of this section and regulations, the Secretary (and the State administering agency) may take any or all of the following actions:

"(i) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

"(ii) Withhold some or all further payments under the PACE program agreement under this section or section 1894 with respect to PACE program services furnished by such provider until the deficiencies have been corrected.

"(iii) Terminate such agreement.

"(B) APPLICATION OF INTERMEDIATE SANCTIONS.—Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in section 1857(f)(2) (or, for periods before January 1, 1999, section 1876(i)(6)(B)) or 1903(m)(5)(B) in the case of violations by the provider of the type described in section 1857(f)(1) (or 1876(i)(6)(A) for such periods) or 1903(m)(5)(A), respectively (in relation to agreements, en-

rollees, and requirements under section 1894 or this section, respectively).

"(7) PROCEDURES FOR TERMINATION OR IMPOSITION OF SANCTIONS.—Under regulations, the provisions of section 1857(g) (or for periods before January 1, 1999, section 1876(i)(9)) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and a Medicare Choice organization under part C of title XVIII (or for such periods an eligible organization under section 1876).

"(8) TIMELY CONSIDERATION OF APPLICATIONS FOR PACE PROGRAM PROVIDER STATUS.—In considering an application for PACE provider program status, the application shall be deemed approved unless the Secretary, within 90 days after the date of the submission of the application to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information that is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

"(f) REGULATIONS.—

"(1) IN GENERAL.—The Secretary shall issue interim final or final regulations to carry out this section and section 1894.

"(2) USE OF PACE PROTOCOL.—

"(A) IN GENERAL.—In issuing such regulations, the Secretary shall, to the extent consistent with the provisions of this section, incorporate the requirements applied to PACE demonstration waiver programs under the PACE protocol.

"(B) FLEXIBILITY.—In order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use nonstaff physicians according to State licensing law requirements) under this section and section 1894, the Secretary (in close consultation with State administering agencies) may modify or waive provisions of the PACE protocol so long as any such modification or waiver is not inconsistent with and would not impair the essential elements, objectives, and requirements of this section, but may not modify or waive any of the following provisions:

"(i) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

"(ii) The delivery of comprehensive, integrated acute and long-term care services.

"(iii) The interdisciplinary team approach to care management and service delivery.

"(iv) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

"(v) The assumption by the provider of full financial risk.

"(3) APPLICATION OF CERTAIN ADDITIONAL BENEFICIARY AND PROGRAM PROTECTIONS.—

"(A) IN GENERAL.—In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of part C of title XVIII (or, for periods before January 1, 1999, section 1876) and section 1903(m) relating to protection of beneficiaries and program integrity as would apply to Medicare Choice organizations under such part C (or for such periods eligible organizations under risk-sharing contracts under section 1876) and to health maintenance organizations under prepaid capitation agreements under section 1903(m).

"(B) CONSIDERATIONS.—In issuing such regulations, the Secretary shall—

"(i) take into account the differences between populations served and benefits provided under this section and under part C of title XVIII (or, for periods before January 1, 1999, section 1876) and section 1903(m);

"(ii) not include any requirement that conflicts with carrying out PACE programs under this section; and

"(iii) not include any requirement restricting the proportion of enrollees who are eligible for benefits under this title or title XVIII.

"(g) WAIVERS OF REQUIREMENTS.—With respect to carrying out a PACE program under this section, the following requirements of this title (and regulations relating to such requirements) shall not apply:

"(1) Section 1902(a)(1), relating to any requirement that PACE programs or PACE program services be provided in all areas of a State.

"(2) Section 1902(a)(10), insofar as such section relates to comparability of services among different population groups.

"(3) Sections 1902(a)(23) and 1915(b)(4), relating to freedom of choice of providers under a PACE program.

"(4) Section 1903(m)(2)(A), insofar as it restricts a PACE provider from receiving prepaid capitation payments.

"(h) DEMONSTRATION PROJECT FOR FOR-PROFIT ENTITIES.—

"(1) IN GENERAL.—In order to demonstrate the operation of a PACE program by a private, for-profit entity, the Secretary (in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) that a PACE provider may not be a for-profit, private entity.

"(2) SIMILAR TERMS AND CONDITIONS.—

"(A) IN GENERAL.—Except as provided under subparagraph (B), and paragraph (1), the terms and conditions for operation of a PACE program by a provider under this subsection shall be the same as those for PACE providers that are nonprofit, private organizations.

"(B) NUMERICAL LIMITATION.—The number of programs for which waivers are granted under this subsection shall not exceed 10. Programs with waivers granted under this subsection shall not be counted against the numerical limitation specified in subsection (e)(1)(B).

"(i) POST-ELIGIBILITY TREATMENT OF INCOME.—A State may provide for post-eligibility treatment of income for individuals enrolled in PACE programs under this section in the same manner as a State treats post-eligibility income for individuals receiving services under a waiver under section 1915(c).

"(j) MISCELLANEOUS PROVISIONS.—Nothing in this section or 1894 shall be construed as preventing a PACE provider from entering into contracts with other governmental or nongovernmental payers for the care of PACE program eligible individuals who are not eligible for benefits under part A, or enrolled under part B, of title XVIII or eligible for medical assistance under this title.".

(b) CONFORMING AMENDMENTS.—

(1) Section 1902(j) (42 U.S.C. 1396a(j)), as amended by section 5702(a)(2)(B), is amended by striking "(26)" and inserting "(27)".

(2) Section 1924(a)(5) (42 U.S.C. 1396r–5(a)(5)) is amended—

(A) in the heading, by striking "FROM ORGANIZATIONS RECEIVING CERTAIN WAIVERS" and inserting "UNDER PACE PROGRAMS"; and

(B) by striking "from any organization" and all t[illegible].t follows and inserting "under a PACE demonstration wa[illegible]er program (as defined in section 1932(a)(7)) or under a PACE program under section 1932 or 1894.".

(3) Section 1903(f)(4)(C) (42 U.S.C. 1396b(f)(4)(C)) is amended by inserting "or who is a PACE program eligible individual enrolled in a PACE program under section 1932," after "section 1902(a)(10)(A),".

SEC. 5742. EFFECTIVE DATE; TRANSITION.

(a) TIMELY ISSUANCE OF REGULATIONS; EFFECTIVE DATE.—The Secretary of Health and Human Services shall promulgate regulations to carry out this chapter in a timely manner. Such regulations shall be designed so that entities may establish and operate PACE programs under sections 1894 and 1932 of the Social Security Act (as added by sections 5011 and 5741 of this Act) for periods beginning not later than 1 year after the date of the enactment of this Act.

(b) EXPANSION AND TRANSITION FOR PACE DEMONSTRATION PROJECT WAIVERS.—

(1) EXPANSION IN CURRENT NUMBER AND EXTENSION OF DEMONSTRATION PROJECTS.—Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 4118(g) of the Omnibus Budget Reconciliation Act of 1987, is amended—

(A) in paragraph (1), by inserting before the period at the end the following: ", except that the Secretary shall grant waivers of such requirements to up to the applicable numerical limitation specified in section 1933(e)(1)(B) of the Social Security Act"; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking ", including permitting the organization to assume progressively (over the initial 3-year period of the waiver) the full financial risk"; and

(ii) in subparagraph (C), by adding at the end the following: "In granting further extensions, an organization shall not be required to provide for reporting of information which is only required because of the demonstration nature of the project.".

(2) ELIMINATION OF REPLICATION REQUIREMENT.—Section 9412(b)(2)(B) of such Act, as so amended, shall not apply to waivers granted under such section after the date of the enactment of this Act.

(3) TIMELY CONSIDERATION OF APPLICATIONS.—In considering an application for waivers under such section before the effective date of the repeals under subsection (d), subject to the numerical limitation under the amendment made by paragraph (1). the application shall be deemed approved unless the Secretary of Health and Human Services, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information which is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

(c) PRIORITY AND SPECIAL CONSIDERATION IN APPLICATION.—During the 3-year period beginning on the date of the enactment of this Act:

(1) PROVIDER STATUS.—The Secretary of Health and Human Services shall give priority in processing applications of entities to qualify as PACE programs under section 1894 or 1932 of the Social Security Act—

(A) first, to entities that are operating a PACE demonstration waiver program (as defined in section 1932(a)(7) of such Act), and

(B) then to entities that have applied to operate such a program as of May 1, 1997.

(2) NEW WAIVERS.—The Secretary shall give priority, in the awarding of additional waivers under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986—

(A) to any entities that have applied for such waivers under such section as of May 1, 1997; and

(B) to any entity that, as of May 1, 1997, has formally contracted with a State to provide services for which payment is made on a capitated basis with an understanding that the entity was seeking to become a PACE provider.

(3) SPECIAL CONSIDERATION.—The Secretary shall give special consideration, in the processing of applications described in paragraph (1) and the awarding of waivers described in paragraph (2), to an entity which as of May 1, 1997, through formal activities (such as entering into contracts for feasibility studies) has indicated a specific intent to become a PACE provider.

(d) REPEAL OF CURRENT PACE DEMONSTRATION PROJECT WAIVER AUTHORITY.—

(1) IN GENERAL.—Subject to paragraph (2), the following provisions of law are repealed:

(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21).

(B) Section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

(C) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

(2) DELAY IN APPLICATION.—

(A) IN GENERAL.—Subject to subparagraph (B), the repeals made by paragraph (1) shall not apply to waivers granted before the initial effective date of regulations described in subsection (a).

(B) APPLICATION TO APPROVED WAIVERS.—Such repeals shall apply to waivers granted before such date only after allowing such organizations a transition period (of up to 24 months) in order to permit sufficient time for an orderly transition from demonstration project authority to general authority provided under the amendments made by this chapter.

SEC. 5743. STUDY AND REPORTS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in close consultation with State administering agencies, as defined in section 1932(a)(8) of the Social Security Act) shall conduct a study of the quality and cost of providing PACE program services under the medicare and medicaid programs under the amendments made by this chapter.

(2) STUDY OF PRIVATE, FOR-PROFIT PROVIDERS.—Such study shall specifically compare the costs, quality, and access to services by entities that are private, for-profit entities operating under demonstration projects waivers granted under section 1932(h) of the Social Security Act with the costs, quality, and access to services of other PACE providers.

(b) REPORT.—

(1) IN GENERAL.—Not later than 4 years after the date of the enactment of this Act, the Secretary shall provide for a report to Congress on the impact of such amendments on quality and cost of services. The Secretary shall include in such report such recommendations for changes in the operation of such amendments as the Secretary deems appropriate.

(2) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.—The report shall include specific findings on whether any of the following findings is true:

(A) The number of covered lives enrolled with entities operating under demonstration project waivers under section 1932(h) of the Social Security Act is fewer than 800 (or such lesser number as the Secretary may find statistically sufficient to make determinations respecting findings described in the succeeding subparagraphs).

(B) The population enrolled with such entities is less frail than the population enrolled with other PACE providers.

(C) Access to or quality of care for individuals enrolled with such entities is lower than such access or quality for individuals enrolled with other PACE providers.

(D) The application of such section has resulted in an increase in expenditures under the medicare or medicaid programs above the expenditures that would have been made if such section did not apply.

(c) INFORMATION INCLUDED IN ANNUAL RECOMMENDATIONS.—The Physician Payment Review Commission shall include in its annual recommendations under section 1845(b) of the Social Security Act (42 U.S.C. 1395w–1), and the Prospective Payment Review Commission shall include in its annual recommendations reported under section 1886(e)(3)(A) of such Act (42 U.S.C. 1395ww(e)(3)(A)), recommendations on the methodology and level of payments made to PACE providers under section 1894(d) of such Act and on the treatment of private, for-profit entities as PACE providers. References in the preceding sentence to the Physician Payment Review Commission and the Prospective Payment Review Commission shall be deemed to be references to the Medicare Payment Advisory Commission (MedPAC) established under section 5022(a) after the termination of the Physician Payment Review Commission and the Prospective Payment Review Commission provided for in section 5022(c)(2).

CHAPTER 4—MEDICAID MANAGEMENT AND PROGRAM REFORMS

SEC. 5751. ELIMINATION OF REQUIREMENT TO PAY FOR PRIVATE INSURANCE.

(a) REPEAL OF STATE PLAN PROVISION.—Section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) is amended—

(1) by striking subparagraph (G); and

(2) by redesignating subparagraphs (H) and (I) as subparagraphs (G) and (H), respectively.

(b) REPEAL OF ENROLLMENT REQUIREMENTS.—Section 1906 (42 U.S.C. 1396e) is repealed.

(c) REINSTATEMENT OF STATE OPTION.—Section 1905(a) (42 U.S.C. 1396a(a)) is amended, in the matter preceding clause (i), by inserting "(including, at State option, through purchase or payment of enrollee costs of health insurance)" after "The term 'medical assistance' means payment".

SEC. 5752. ELIMINATION OF OBSTETRICAL AND PEDIATRIC PAYMENT RATE REQUIREMENTS.

(a) IN GENERAL.—Section 1926 (42 U.S.C. 1396r–7) is repealed.

(b) EFFECTIVE DATE.—The repeal made by subsection (a) shall apply to services furnished on or after October 1, 1997.

SEC. 5753. PHYSICIAN QUALIFICATION REQUIREMENTS.

(a) IN GENERAL.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended by striking paragraph (12)

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after the date of the enactment of this Act.

SEC. 5754. EXPANDED COST-SHARING REQUIREMENTS.

Section 1916 (42 U.S.C. 1396o) is amended by adding at the end the following:

"(g)(1) Notwithstanding any other provision of this title, the State plan may impose cost-sharing with respect to any medical assistance provided to an individual who is not described in section 1902(a)(10)(A)(i) in accordance with the provisions of this subsection.

"(2) Any cost-sharing imposed under this subsection shall be pursuant to a public schedule and shall reflect such economic factors, employment status, and family size with respect to each such individual as the State determines appropriate.

"(3) In the case of any family whose income is less than 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved, the total annual amount of cost-sharing that may be imposed for such family shall not exceed 3 percent of the family's average gross monthly earnings (less the average monthly costs for such child care as is necessary for the employment of the caretaker relative) for such period.

"(4) In the case of any family whose income exceeds 150 percent, but does not exceed 200 percent of, such poverty line, paragraph (3) shall be applied by substituting '5 percent' for '3 percent'.

"(5) Nothing in this subsection shall be construed as preventing a State from imposing cost-sharing with respect to individuals eligible for medical assistance under the State plan, or with respect to items or services provided as medical assistance under such plan, if the provisions of this title otherwise allow the State to do so or if the State has received a waiver that authorizes such cost-sharing.

"(6) In this subsection, the term 'cost-sharing' includes copayments, deductibles, coinsurance, enrollment fees, premiums, and other charges for the provision of health care services.".

SEC. 5755. PENALTY FOR FRAUDULENT ELIGIBILITY.

Section 1128B(a) (42 U.S.C. 1320a–7b(a)), as amended by section 217 of the Health Insurance Portability and Accountability Act of 1996, is amended—

(1) by amending paragraph (6) to read as follows:

"(6) for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c),"; and

(2) in clause (ii) of the matter following such paragraph, by striking "failure, or conversion by any other person" and inserting "failure, conversion, or provision of counsel or assistance by any other person".

SEC. 5756. ELIMINATION OF WASTE, FRAUD, AND ABUSE.

(a) BAN ON SPENDING FOR NONHEALTH RELATED ITEMS.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(1) in paragraphs (2) and (15), by striking the period at the end and inserting "; or";

(2) in paragraphs (10)(B), (11), and (13), by adding "or" at the end; and

(3) by inserting after paragraph (15), the following:

"(16) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under a State plan under this title.".

(b) DISCLOSURE OF INFORMATION AND SURETY BOND REQUIREMENT FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.—

(1) REQUIREMENT.—Section 1902(a) (42 U.S.C. 1396a(a)), is amended—

(A) by striking "and" at the end of paragraph (62);

(B) by striking the period at the end of paragraph (63) and inserting "; and"; and

(C) by inserting after paragraph (63) the following:

"(64) provide that the State shall not issue or renew a provider number for a supplier of medical assistance consisting of durable medical equipment, as defined in section 1861(n), for purposes of payment under this part for such assistance that is furnished by the supplier, unless the supplier provides the State agency on a continuing basis with—

"(A)(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1124(a)(3)) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest; and

(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1124(a)(2)) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity; and

"(B) a surety bond in a form specified by the State and in an amount that is not less than $50,000.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to suppliers of medical assistance consisting of durable medical equipment furnished on or after January 1, 1998.

(c) SURETY BOND REQUIREMENT FOR HOME HEALTH AGENCIES.—

(1) IN GENERAL.—Section 1905(a)(7) (42 U.S.C. 1396d(a)(7) is amended by inserting ", provided that the agency or organization providing such services provides the State agency on a continuing basis with a surety bond in a form specified by the State and in an amount that is not less than $50,000" after "services".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to home health agencies with respect to services furnished on or after January 1, 1998.

(d) CONFLICT OF INTEREST SAFEGUARDS.—Section 1902(a)(4) (42 U.S.C. 1396a(a)(4)) is amended to read as follows:

"(4) provide—

"(A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

"(B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency; and

"(C) that each State or local officer or employee, or independent contractor—

"(i) who is responsible for the expenditure of substantial amounts of funds under the State plan, or who is responsible for administering the State plan under this title, each individual who formerly was such an officer, employee, or independent contractor, and each partner of such an officer, employee, or independent contractor shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of title 18, United States Code; and

"(ii) who is responsible for selecting, awarding, or otherwise obtaining items and services under the State plan shall be subject to safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) to persons described in subsection (a)(2) of such section of that Act;".

(e) AUTHORITY TO REFUSE TO ENTER INTO MEDICAID AGREEMENTS WITH INDIVIDUALS OR ENTITIES CONVICTED OF FELONIES.—Section 1902(a)(23) (42 U.S.C. 1396a(a)(23)) is amended to read as follows:

"(23) provide that—

"(A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services; and

"(B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1915(b)(1)), a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1905(a)(4)(C),

except as provided in subsection (g) and in section 1915, except in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for items or services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interest of beneficiaries under the State plan;".

(f) MONITORING PAYMENTS FOR DUAL ELIGIBLES.—The Administrator of the Health Care Financing Administration shall—

(1) develop mechanisms to better monitor and prevent inappropriate payments under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) in the case of individuals who are dually eligible for benefits under such program and under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.);

(2) study the use of case management or care coordination in order to improve the appropriateness of care, quality of care, and cost effectiveness of care for individuals who are dually eligible for benefits under such programs; and

(3) work with the States to ensure better care coordination for dual eligibles and make recommendations to Congress as to any statutory changes that would not compromise beneficiary protections and that would improve or facilitate such care..

(g) BENEFICIARY AND PROGRAM PROTECTION AGAINST WASTE, FRAUD, AND ABUSE.—Section 1902(a) (42 U.S.C. 1396a(a)), as amended by subsection (b)(1), is amended—

(1) by striking "and" at the end of paragraph (63);

(2) by striking the period at the end of paragraph (64) and inserting "; and"; and

(3) by inserting after paragraph (64) the following:

"(65) provide programs—

"(A) to ensure program integrity, protect and advocate on behalf of individuals, and to report to the State data concerning beneficiary concerns and complaints and instances of beneficiary abuse or program waste or fraud by managed care plans operating in the State under contact with the State agency;

"(B) to provide assistance to beneficiaries, with particular emphasis on the families of special needs children and persons with disabilities to—

"(i) explain the differences between managed care and fee-for-service plans;

"(ii) clarify the coverage for such beneficiaries under any managed care plan offered under the State plan under this title;

"(iii) explain the implications of the choices between competing plans;

"(iv) assist such beneficiaries in understanding their rights under any managed care plan offered under the State plan, including their right to—

"(I) access and benefits;

"(II) nondiscrimination;

"(III) grievance and appeal mechanisms; and

"(IV) change plans, as designated in the State plan; and

"(v) exercise the rights described in clause (iv); and

"(C) to collect and report to the State data on the number of complaints or instances identified under subparagraph (A) and to report to the State annually on any systematic problems in the implementation of managed care entities contracting with the State under the State plan under this title.".

SEC. 5757. STUDY ON EPSDT BENEFITS.

(a) STUDY.—The Secretary of Health and Human Services, in consultation with Governors, directors of State medicaid and State maternal and child programs, the Institute of Medicine, the American Academy of Pediatrics, and representatives of beneficiaries under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) shall conduct a study of the early and periodic screening, diagnostic, and treatment services provided under State plans under title XIX of the Social Security Act in accordance with section 1905(r) of such Act (42 U.S.C. 1396d(r)).

(b) REPORT.—Not later than 12 months after the date of enactment of this Act, the Secretary of Health and Human Services shall submit a report to Congress on the results of the conducted study under subsection (a).

SEC. 5758. STUDY ON EFFECTIVENESS OF MANAGED CARE ENTITIES IN MEETING THE NEEDS OF ENROLLEES WITH SPECIAL HEALTH CARE NEEDS.

(a) STUDY.—The Secretary of Health and Human Services, in consultation with States, managed care entities, as defined in section 1950(a)(1) of the Social Security Act (as added by section 5701(a)(2) of this Act), the National Academy of State Health Policy, representatives of beneficiaries under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) with special health care needs (as determined by the Secretary), and experts in the provision of specialized care, shall conduct a study of the health care items and services provided to such beneficiaries with special health care needs by managed care entities under part B of title XIX of the Social Security Act (as added by section 5701(a)(2) of this Act) or under a waiver. Such study shall consider the unique health care requirements of such beneficiaries, including any problems that are identified with respect to access to

care that may be experienced by people with chronic conditions, and shall evaluate the extent to which the special health care needs of such beneficiaries are being satisfied by such entities.

(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall submit a report to Congress on the results of the study conducted under subsection (a).

CHAPTER 5—MISCELLANEOUS

SEC. 5761. INCREASED FMAPS.

Section 1905(b) (42 U.S.C. 1396d(b)(1)) is amended—

(1) by striking "and (2)" and inserting "(2)"; and

(2) by striking the period and inserting ", and (3) during the period beginning on October 1, 1997, and ending on September 30, 2000, the Federal medical assistance percentage for the District of Columbia shall be 60 per centum, and the Federal medical assistance percentage for Alaska shall be 59.8 per centum (but only, in the case of such States, with respect to expenditures under a State plan under this title).".

SEC. 5762. INCREASE IN PAYMENT CAPS FOR TERRITORIES.

Section 1108 (42 U.S.C. 1308) is amended—

(1) in subsection (f), by striking "The" and inserting "Subject to subsection (g), the"; and

(2) by adding at the end the following:

"(g) MEDICAID PAYMENTS TO TERRITORIES FOR FISCAL YEAR 1998 AND THEREAFTER.—

"(1) FISCAL YEAR 1998.—With respect to fiscal year 1998, the amounts otherwise determined for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa under subsection (f) for such fiscal year shall be increased in the following manner:

"(A) For Puerto Rico, $30,000,000.

"(B) For the Virgin Islands, $750,000.

"(C) For Guam, $750,000.

"(D) For the Northern Mariana Islands, $500,000.

"(E) For American Samoa, $500,000.

"(2) FISCAL YEAR 1999 AND THEREAFTER.—Notwithstanding subsection (f), with respect to fiscal year 1999 and any fiscal year thereafter, the total amount certified by the Secretary under title XIX for payment to—

"(A) Puerto Rico shall not exceed the sum of—

"(i) the amount provided in this subsection for the preceding fiscal year; and

"(ii) $30,000,000,

increased by the percentage increase in the medical care component of the consumer price index for all urban consumers (as published by the Bureau of Labor Statistics) for the twelve-month period ending in March preceding the beginning of the fiscal year, rounded to the nearest $100,000;

"(B) the Virgin Islands shall not exceed the sum of—

"(i) the amount provided in this subsection for the preceding fiscal year; and

"(ii) $750,000,

increased by the percentage increase referred to in subparagraph (A), rounded to the nearest $10,000;

"(C) Guam shall not exceed the sum of—

"(i) the amount provided in this subsection for the preceding fiscal year; and

"(ii) $750,000,

increased by the percentage increase referred to in subparagraph (A), rounded to the nearest $10,000;

"(D) Northern Mariana Islands shall not exceed the sum of—

"(i) the amount provided in this subsection for the preceding fiscal year; and

"(ii) $500,000,

increased by the percentage increase referred to in subparagraph (A), rounded to the nearest $10,000; and

"(E) American Samoa shall not exceed the sum of—

"(i) the amount provided in this subsection for the preceding fiscal year; and

"(ii) $500,000,

increased by the percentage increase referred to in subparagraph (A), rounded to the nearest $10,000.".

SEC. 5763. COMMUNITY-BASED MENTAL HEALTH SERVICES.

(a) IN GENERAL.—Section 1905(a) (42 U.S.C. 1396d(a)), as amended by section 5741(a)(1), is amended—

(1) by striking "and" at the end of paragraph (26);

(2) by redesignating paragraph (27) as paragraph (28); and

(3) by inserting after paragraph (26) the following new paragraph:

"(27) outpatient and intensive community-based mental health services, including psychiatric rehabilitation, day treatment, intensive in-home services for children, assertive community treatment, therapeutic out-of-home placements (excluding room and board), clinic services, partial hospitalization, and targeted case management; and".

(b) CONFORMING AMENDMENTS.—

(1) Section 1902(a)(10)(C)(iv) (42 U.S.C. 1396a(a)(10)(C)(iv)), as amended by section 5702(a)(2)(A), is amended by inserting "or (27)" after "(25)".

(2) Section 1902(j) (42 U.S.C. 1396a(j)), as amended by section 5741(b)(1), is amended by striking "(27)" and inserting "(28)".

SEC. 5764. OPTIONAL MEDICAID COVERAGE OF CERTAIN CDC-SCREENED BREAST CANCER PATIENTS.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—Section 1902(a)(10)(A)(ii) (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(1) in subclause (XI), by striking "or" at the end;

(2) in subclause (XII), by adding "or" at the end; and

(3) by adding at the end the following:

"(XIII) who are described in subsection (aa)(1)(relating to certain CDC-screened breast cancer patients);".

(b) GROUP AND BENEFIT DESCRIBED.—Section 1902 (42 U.S.C. 1396a) is amended by adding at the end the following:

"(aa)(1) Individuals described in this paragraph are individuals not described in subsection (a)(10)(A)(i) who—

"(A) have not attained age 65;

"(B) have been diagnosed with breast cancer through participation in the program to screen women for breast and cervical cancer conducted by the Director of the Centers for Disease Control and Prevention under title 15 of the Public Health Service Act (42 U.S.C. 300k et seq.);

"(C) satisfy the income and resource eligibility criteria established by such Director for participation in such program; and

"(D) are not otherwise eligible for medical assistance under the State plan under this title.

"(2) For purposes of subsection (a)(10), the term "breast cancer-related services" means each of the following services relating to treatment of breast cancer:

"(A) Prescribed drugs.

"(B) Physicians' services and services described in section 1905(a)(2).

"(C) Laboratory and X-ray services (including services to confirm the presence of breast cancer).

"(D) Rural health clinic services and Federally-qualified health center services.

"(E) Case management services (as defined in section 1915(g)(2)).

"(F) Services (other than room and board) designed to encourage completion of regimens of prescribed drugs by outpatients, including services to observe directly the intake of prescribed drugs.".

(c) LIMITATION ON BENEFITS.—Section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (F)—

(1) by striking ", and (XIII)"; and

(2) by inserting before the semicolon at the end the following: ", and (XIV) the medical assistance made available to an individual described in subsection (aa)(1) who is eligible for medical assistance only because of subparagraph (A)(ii)(XIII) shall be limited to medical assistance for breast cancer-related services (described in subsection (aa)(2))".

(d) CONFORMING AMENDMENTS.—

(1) Section 1905(a) (42 U.S.C. 1396d(a)) is amended—

(A) in clause (x), by striking "or" at the end;

(B) in clause (xi), by adding "or" at the end;

(C) by inserting after clause (xi) the following:

"(xii) individuals described in section 1902(aa)(1),"; and

(D) by striking paragraph (19) and inserting the following:

"(19) case management services (as defined in section 1915(g)(2)), TB-related services described in section 1902(z)(2)(F), and breast cancer-related services described in section 1902)(2)(F);".

(2) Section 1915(g)(1) (42 U.S.C. 1396n(g)(1)) is amended by inserting "or section 1902(aa)(1)" after "section 1902(z)(1)(A)".

(e) EFFECTIVE DATE.—The amendments made by this section apply to medical assistance furnished on or after October 1, 1997, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 5765. TREATMENT OF STATE TAXES IMPOSED ON CERTAIN HOSPITALS THAT PROVIDE FREE CARE.

(a) EXCEPTION FROM TAX DOES NOT DISQUALIFY AS BROAD-BASED TAX.—Section 1903(w)(3) (42 U.S.C. 1396b(w)(3)) is amended—

(1) in subparagraph (B), by striking "and (E)" and inserting "(E), and (F)"; and

(2) by adding at the end the following:

"(F) In no case shall a tax not qualify as a broad-based health care related tax under this paragraph because it does not apply to a hospital that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code and that does not accept payment under the State plan under this title or under title XVIII.".

(b) REDUCTION IN FEDERAL FINANCIAL PARTICIPATION IN CASE OF IMPOSITION OF TAX.—Section 1903(b) (42 U.S.C. 1396b(b)) is amended by adding at the end the following:

"(4) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State shall be decreased in a quarter by the amount of any health care related taxes (described in section 1902(w)(3)(A)) that are imposed on a hospital described in subsection (w)(3)(F) in that quarter.".

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to taxes imposed before, on, or after the date of the enactment of this Act and the amendment made by subsection (b) shall apply to taxes imposed on or after such date.

SEC. 5766. TREATMENT OF VETERANS PENSIONS UNDER MEDICAID.

(a) POST-ELIGIBILITY.—Section 1902(r)(1) of the Social Security Act (42 U.S.C. 1396a(r)(1)) is amended to read as follows:

"(r)(1) For purposes of sections 1902(a)(17) and 1924(d)(1)(D) and for purposes of a waiver under section 1915, with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver—

"(A) there shall be disregarded reparation payments made by the Federal Republic of Germany;

"(B) there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

"(i) medicare and other health insurance premiums, deductibles, or coinsurance, and

"(ii) necessary medical or remedial care recognized under State law but not covered under the State plan under this title, subject to reasonable limits the State may establish on the amount of these expenses; and

"(C) in the case of a resident in a State veterans home, there shall be taken into account, as income, any and all payments received under a Department of Veterans Affairs pension or compensation program, including payments attributable to the recipient's medical expenses or to the recipient's need for aid and attendance, but excluding that part of any augmented benefit attributable to a dependent.

For purposes of subparagraph (C), any Department of Veterans Affairs pension benefit that has been limited to $90 per month pursuant to section 5503(f) of title 38, United States Code, may be applied to meet the monthly personal needs allowance provided by the State plan under this title, but shall not otherwise be used to reduce the amount paid to a facility under the State plan.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall be effective with respect to periods beginning on and after July 1, 1994.

SEC. 5767. EFFECTIVE DATE.

(a) IN GENERAL.—Except as otherwise specifically provided, the provisions of and amendments made by this subtitle shall apply with respect to State programs under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) on and after October 1, 1997.

(b) EXTENSION FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this subtitle, the State plan shall not be regarded as failing to comply with the requirements of this subtitle solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

Subtitle J—Children's Health Insurance Initiatives

SEC. 5801. ESTABLISHMENT OF CHILDREN'S HEALTH INSURANCE INITIATIVES.

(a) IN GENERAL.—The Social Security Act is amended by adding at the end the following:

"TITLE XXI—CHILD HEALTH INSURANCE INITIATIVES

"SEC. 2101. PURPOSE.

The purpose of this title is to provide funds to States to enable such States to expand the provision of health insurance coverage for low-income children. Funds provided under this title shall be used to achieve this purpose through outreach activities described in section 2106(a) and, at the option of the State through—

"(1) a grant program conducted in accordance with section 2107 and the other requirements of this title; or

"(2) expansion of coverage of such children under the State medicaid program who are not required to be provided medical assistance under section 1902(l) (taking into account the process of individuals aging into eligibility under subsection (l)(1)(D)).

"SEC. 2102. DEFINITIONS.

In this title:

"(1) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—The term 'base-year covered low-income child population' means the total number of low-income children with respect to whom, as of fiscal year 1996, an eligible State provides or pays the cost of health benefits either through a State funded program or through eligibility under the State plan under title XIX (including under a waiver of such plan), as determined by the Secretary.

"(2) CHILD.—The term 'child' means an individual under 19 years of age.

"(3) ELIGIBLE STATE.—The term 'eligible State' means, with respect to a fiscal year, a State that—

"(A) provides, under section 1902(l)(1)(D) or under a waiver, for eligibility for medical assistance under a State plan under title XIX of individuals under 19 years of age, regardless of date of birth; and

"(B) has submitted to the Secretary under section 2104 a program outline that—

"(i) sets forth how the State intends to use the funds provided under this title to provide health insurance coverage for low-income children consistent with the provisions of this title; and

"(ii) is approved under section 2104; and

"(iii) otherwise satisfies the requirements of this title.

"(4) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' means, with respect to a State, the meaning given that term under section 1905(b).

"(5) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The term 'FEHBP-equivalent children's health insurance coverage' means, with respect to a State, any plan or arrangement that provides, or pays the cost of, health benefits that the Secretary has certified are actuarially equivalent to the benefits required to be offered for a child under chapter 89 of title 5, United States Code, and that otherwise satisfies State insurance standards and requirements.

"(6) INDIANS.—The term 'Indians' has the meaning given that term in section 4(c) of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

"(7) LOW-INCOME CHILD.—The term 'low-income child' means a child in a family whose income is below 200 percent of the poverty line for a family of the size involved.

"(8) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

"(9) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

"(10) STATE.—The term 'State' means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands.

"(11) STATE CHILDREN'S HEALTH EXPENDITURES.—The term 'State children's health expenditures' means the State share of expenditures by the State for providing children with health care items and services under—

"(A) the State plan for medical assistance under title XIX;

"(B) the maternal and child health services block grant program under title V;

"(C) the preventive health services block grant program under part A of title XIX of the Public Health Services Act (42 U.S.C. 300w et seq.);

"(D) State-funded programs that are designed to provide health care items and services to children;

"(E) school-based health services programs;

"(F) State programs that provide uncompensated or indigent health care;

"(G) county-indigent care programs for which the State requires a matching share by a county government or for which there are intergovernmental transfers from a county to State government; and

"(H) any other program under which the Secretary determines the State incurs uncompensated expenditures for providing children with health care items and services.

"(12) STATE MEDICAID PROGRAM.—The term 'State medicaid program' means the program of medical assistance provided under title XIX.

"SEC. 2103. APPROPRIATION.

"(a) APPROPRIATION.—

"(1) IN GENERAL.—Subject to subsection (b), out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated for the purpose of carrying out this title—

"(A) for fiscal year 1998, $2,500,000,000;

"(B) for each of fiscal years 1999 through 2001, $3,200,000,000;

"(C) for fiscal year 2002, $3,900,000,000; and

"(D) for each of fiscal years 2003 through 2007, $4,580,000,000.

"(2) AVAILABILITY.—Funds appropriated under this section shall remain available without fiscal year limitation, as provided under section 2105(b)(4).

"(b) REDUCTION FOR INCREASED MEDICAID EXPENDITURES.—With respect to each of the fiscal years described in subsection (a)(1), the amount appropriated under subsection (a)(1) for each such fiscal year shall be reduced by an amount equal to the amount of the total Federal outlays under the medicaid program under title XIX resulting from—

"(1) the amendment made by section 5732 of the Balanced Budget Act of 1997 (regarding the State option to provide 12-month continuous eligibility for children);

"(2) increased enrollment under State plans approved under such program as a result of outreach activities under section 2106(a); and

"(3) the requirement under section 2102(3)A) to provide eligibility for medical assistance under the State plan under title XIX for all children under 19 years of age who have families with income that is at or below the poverty line.

"(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided in accordance with the provisions of this title.

"(d) EFFECTIVE DATE.—No State is eligible for payments under section 2105 for any calendar quarter beginning before October 1, 1997.

"SEC. 2104. PROGRAM OUTLINE.

"(a) GENERAL DESCRIPTION.—A State shall submit to the Secretary a program outline, consistent with the requirements of this title, that—

"(1) identifies which of the 2 options described in section 2101 the State intends to use to provide low-income children in the State with health insurance coverage;

"(2) describes the manner in which such coverage shall be provided; and

"(3) provides such other information as the Secretary may require.

"(b) OTHER REQUIREMENTS.—The program outline submitted under this section shall include the following:

"(1) ELIGIBILITY STANDARDS AND METHODOLOGIES.—A summary of the standards and methodologies used to determine the eligibility of low-income children for health insurance coverage under a State program funded under this title.

"(2) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE.—A description of the procedures to be used to ensure—

"(A) through both intake and followup screening, that only low-income children are furnished health insurance coverage through funds provided under this title; and

"(B) that any health insurance coverage provided for children through funds under this title does not reduce the number of children who are provided such coverage through any other publicly or privately funded health plan.

"(3) INDIANS.—A description of how the State will ensure that Indians are served through a State program funded under this title.

"(c) DEADLINE FOR SUBMISSION.—A State program outline shall be submitted to the Secretary by not later than March 31 of any fiscal year (October 1, 1997, in the case of fiscal year 1998).

"SEC. 2105. DISTRIBUTION OF FUNDS.

"(a) ESTABLISHMENT OF FUNDING POOLS.—

"(1) IN GENERAL.—From the amount appropriated under section 2103(a)(1) for each fiscal year, determined after the reduction required under section 2103(b), the Secretary shall, for purposes of fiscal year 1998, reserve 85 percent of such amount for distribution to eligible States through the basic allotment pool under subsection (b) and 15 percent of such amount for distribution through the new coverage incentive pool under subsection (c)(2)(B)(ii).

"(2) ANNUAL ADJUSTMENT OF RESERVE PERCENTAGES.—The Secretary shall annually adjust the amount of the percentages described in paragraph (1) in order to provide sufficient basic allotments and sufficient new coverage incentives to achieve the purpose of this title.

"(b) DISTRIBUTION OF FUNDS UNDER THE BASIC ALLOTMENT POOL.—

"(1) STATES.—

"(A) IN GENERAL.—From the total amount reserved under subsection (a) for a fiscal year for distribution through the basic allotment pool, the Secretary shall first set aside 0.25 percent for distribution under paragraph (2) and shall allot from the amount remaining to each eligible State not described in such paragraph the State's allotment percentage for such fiscal year.

"(B) STATE'S ALLOTMENT PERCENTAGE.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the allotment percentage for a fiscal year for each State is the percentage equal to the ratio of the number of low-income children in the base period in the State to the total number of low-income children in the base period in all States not described in paragraph (2).

"(ii) NUMBER OF LOW-INCOME CHILDREN IN THE BASE PERIOD.—In clause (i), the number of low-income children in the base period for a fiscal year in a State is equal to the average of the number of low-income children in the State for the period beginning on October 1, 1992, and ending on September 30, 1995, as reported in the March 1994, March 1995, and March 1996 supplements to the Current Population Survey of the Bureau of the Census.

"(2) OTHER STATES.—

"(A) IN GENERAL.—From the amount set aside under paragraph (1)(A) for each fiscal year, the Secretary shall make allotments for such fiscal year in accordance with the percentages specified in subparagraph (B) to Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands, if such States are eligible States for such fiscal year.

"(B) PERCENTAGES SPECIFIED.—The percentages specified in this subparagraph are in the case of—

"(i) Puerto Rico, 91.6 percent;

"(ii) Guam, 3.5 percent;

"(iii) the Virgin Islands, 2.6 percent;

"(iv) American Samoa, 1.2 percent; and

"(v) the Northern Mariana Islands, 1.1 percent.

"(3) THREE-YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

"(4) PROCEDURE FOR DISTRIBUTION OF UNUSED FUNDS.—The Secretary shall determine an appropriate procedure for distribution of funds to eligible States that remain unused under this subsection after the expiration of the availability of funds required under paragraph (3). Such procedure shall be developed and administered in a manner that is consistent with the purpose of this title.

"(c) PAYMENTS.—

"(1) IN GENERAL.—The Secretary shall—

"(A) before October 1 of any fiscal year, pay an eligible State an amount equal to 1 percent of the amount allotted to the State under subsection (b) for conducting the outreach activities required under section 2106(a); and

"(B) make quarterly fiscal year payments to an eligible State from the amount remaining of such allotment for such fiscal year in an amount equal to the Federal medical assistance percentage for the State, as determined under section 1905(b)(1), of the cost of providing health insurance coverage for a low-income child in the State plus the applicable bonus amount.

"(2) APPLICABLE BONUS.—

"(A) IN GENERAL.—For purposes of paragraph (1), the applicable bonus amount is—

"(i) 5 percent of the cost, with respect to a period, of providing health insurance coverage for the base-year covered low-income child population (measured in full year equivalency); and

"(ii) 10 percent of the cost, with respect to a period, of providing health insurance coverage for the number (as so measured) of low-income children that are in excess of such population.

"(B) SOURCE OF BONUSES.—

"(i) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—A bonus described in subparagraph (A)(i) shall be paid out of an eligible State's allotment for a fiscal year.

"(ii) FOR OTHER LOW-INCOME CHILD POPULATIONS.—A bonus described in subparagraph (A)(ii) shall be paid out of the new coverage incentive pool reserved under subsection (a)(1).

"(3) DEFINITION OF COST OF PROVIDING HEALTH INSURANCE COVERAGE.—For purposes of this subsection the cost of providing health insurance coverage for a low-income child in the State means—

"(A) in the case of an eligible State that opts to use funds provided under this title through the medicaid program, the cost of providing such child with medical assistance under the State plan under title XIX; and

"(B) in the case of an eligible State that opts to use funds provided under this title under section 2107, the cost of providing such child with health insurance coverage under such section.

"(4) LIMITATION ON TOTAL PAYMENTS.—With respect to a fiscal year, the total amount paid to an eligible State under this title (including any bonus payments) shall not exceed 85 percent of the total cost of a State program conducted under this title for such fiscal year.

"(5) MAINTENANCE OF EFFORT.—No funds shall be paid to a State under this title if—

"(A) in the case of fiscal year 1998, the State children's health expenditures are less than the amount of such expenditures for fiscal year 1996; and

"(B) in the case of any succeeding fiscal year, the State children's health expenditures described in section 2102(11)(A) are less than the amount of such expenditures for fiscal year 1996, increased by a medicaid child population growth factor determined by the Secretary.

"(6) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this subsection for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and shall reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

"SEC. 2106. USE OF FUNDS.

"(a) SET-ASIDE FOR OUTREACH ACTIVITIES.—

"(1) IN GENERAL.—From the amount allotted to a State under section 2105(b) for a fiscal year, each State shall conduct outreach activities described in paragraph (2).

"(2) OUTREACH ACTIVITIES DESCRIBED.—The outreach activities described in this paragraph include activities to—

"(A) identify and enroll children who are eligible for medical assistance under the State plan under title XIX; and

"(B) conduct public awareness campaigns to encourage employers to provide health insurance coverage for children.

"(b) STATE OPTIONS FOR REMAINDER.—A State may use the amount remaining of the allotment to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), in accordance with section 2107 or the State medicaid program (but not both).

"(c) PROHIBITION ON USE FOR ABORTIONS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), no funds provided under this title may be used to pay for any abortion or to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion.

"(2) EXCEPTION.—Paragraph (1) shall not apply to an abortion if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

"(d) USE LIMITED TO STATE PROGRAM EXPENDITURES.—Funds provided to an eligible State under this title shall only be used to carry out the purpose of this title.

"(e) ADMINISTRATIVE EXPENDITURES.—Not more than 10 percent of the amount allotted to a State under section 2105(b), determined after the payment required under section 2105(c)(1)(A), shall be used for administrative expenditures for the program funded under this title.

"(f) NONAPPLICATION OF FIVE-YEAR LIMITED ELIGIBILITY FOR MEANS-TESTED PUBLIC BENEFITS.—The provisions of section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613) shall not apply with respect to a State program funded under this title.

"SEC. 2107. STATE OPTION FOR THE PURCHASE OR PROVISION OF CHILDREN'S HEALTH INSURANCE.

"(a) STATE OPTION.—

"(1) IN GENERAL.—An eligible State that opts to use funds provided under this title under this section shall use such funds to—

"(A) subsidize payment of employee contributions for health insurance coverage for a dependent low-income child that is available through group health insurance coverage offered by an employer in the State; or

"(B) to provide FEHBP-equivalent children's health insurance coverage for low-income children who reside in the State.

"(2) PRIORITY FOR LOW-INCOME CHILDREN.—A State that uses funds provided under this title under this section shall not cover low-income children with higher family income without covering such children with a lower family income.

"(3) DETERMINATION OF ELIGIBILITY AND FORM OF ASSISTANCE.—An eligible State may establish any additional eligibility criteria for the provision of health insurance coverage for a low-income child through funds provided under this title, so long as such criteria and assistance are consistent with the purpose and provisions of this title.

"(b) NONENTITLEMENT.—Nothing in this section shall be construed as providing an entitlement for an individual or person to any health insurance coverage, assistance, or service provided through a State program funded under this title. If, with respect to a fiscal year, an eligible State determines that the funds provided under this title are not sufficient to provide health insurance coverage for all the low-income children that the State proposes to cover in the State program outline submitted under section 2104 for such fiscal year, the State may adjust the applicable eligibility criteria for such children appropriately or adjust the State program in another manner specified by the Secretary, so long as any such adjustments are consistent with the purpose of this title.

"SEC. 2108. PROGRAM INTEGRITY.

"The following provisions of the Social Security Act shall apply to eligible States under this title in the same manner as such provisions apply to a State under title XIX:

"(1) Section 1116 (relating to administrative and judicial review).

"(2) Section 1124 (relating to disclosure of ownership and related information).

"(3) Section 1126 (relating to disclosure of information about certain convicted individuals).

"(4) Section 1128A (relating to exclusion from individuals and entities from participation in State health care plans).

"(5) Section 1128B(d) (relating to criminal penalties for certain additional charges).

"(6) Section 1132 (relating to periods within which claims must be filed).

"(7) Section 1902(a)(4)(C) (relating to conflict of interest standards).

"(8) Section 1903(i) (relating to limitations on payment).

"(9) Section 1903(w) (relating to limitations on provider taxes and donations).

"(10) Section 1905(a)(B) (relating to the exclusion of care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases from the definition of medical assistance).

"(11) Section 1921 (relating to state licensure authorities).

"(12) Sections 1902(a)(25), 1912(a)(1)(A), and 1903(o) (insofar as such sections relate to third party liability).

"SEC. 2109. ANNUAL REPORTS.

"(a) ANNUAL STATE ASSESSMENT OF PROGRESS.—An eligible State shall—

"(1) assess the operation of the State program funded under this title in each fiscal year, including the progress made in providing health insurance coverage for low-income children; and

"(2) report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

"(b) REPORT OF THE SECRETARY.—The Secretary shall submit to the appropriate committees of Congress an annual report and evaluation of the State programs funded under this title based on the State assessments and reports submitted under subsection (a). Such report shall include any conclusions and recommendations that the Secretary considers appropriate.".

(b) CONFORMING AMENDMENT.—Section 1128(h) (42 U.S.C. 1320a–7(h)) is amended by—

(1) in paragraph (2), by striking "or" at the end;

(2) in paragraph (3), by striking the period and inserting ", or"; and

(3) by adding at the end the following:

"(4) a program funded under title XXI.".

(c) EFFECTIVE DATE.—The amendments made by this section apply on and after October 1, 1997.

DIVISION 3—INCOME SECURITY AND OTHER PROVISIONS

Subtitle K—Income Security, Welfare-to-Work Grant Program, and Other Provisions

CHAPTER 1—INCOME SECURITY

SEC. 5811. SSI ELIGIBILITY FOR ALIENS RECEIVING SSI ON AUGUST 22, 1996.

(a) IN GENERAL.—Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding after subparagraph (D) the following new subparagraph:

"(E) ALIENS RECEIVING SSI ON AUGUST 22, 1996.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to an alien who is lawfully residing in any State and who was receiving such benefits on August 22, 1996.".

(b) STATUS OF CUBAN AND HAITIAN ENTRANTS.—For purposes of section 402(a)(2)(E) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(E)), an alien who is a Cuban and Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980, shall be considered a qualified alien.

(c) CONFORMING AMENDMENTS.—Section 402(a)(2)(D) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(D)) is amended—

(1) by striking clause (i);

(2) in the subparagraph heading by striking "BENEFITS" and inserting "FOOD STAMPS";

(3) by striking "(ii) FOOD STAMPS"; and

(4) by redesignating subclauses (I), (II), and (III) as clauses (i), (ii), and (iii).

SEC. 5812. EXTENSION OF ELIGIBILITY PERIOD FOR REFUGEES AND CERTAIN OTHER QUALIFIED ALIENS FROM 5 TO 7 YEARS FOR SSI AND MEDICAID.

(a) SSI.—Section 402(a)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A)) is amended to read as follows:

"(A) TIME-LIMITED EXCEPTION FOR REFUGEES AND ASYLEES.—

"(i) SSI.—With respect to the specified Federal program described in paragraph (3)(A) paragraph 1 shall not apply to an alien until 7 years after the date—

"(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

"(II) an alien is granted asylum under section 208 of such Act; or

"(III) an alien's deportation is withheld under section 243(h) of such Act.

"(ii) FOOD STAMPS.—With respect to the specified Federal program described in paragraph (3)(B), paragraph 1 shall not apply to an alien until 5 years after the date—

"(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

"(II) an alien is granted asylum under section 208 of such Act; or

"(III) an alien's deportation is withheld under section 243(h) of such Act.".

(b) MEDICAID.—Section 402(b)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)(A)) is amended to read as follows:

"(A) TIME-LIMITED EXCEPTION FOR REFUGEES AND ASYLEES.—

"(i) MEDICAID.—With respect to the designated Federal program described in paragraph (3)(C), paragraph 1 shall not apply to an alien until 7 years after the date—

"(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

"(II) an alien is granted asylum under section 208 of such Act; or

"(III) an alien's deportation is withheld under section 243(h) of such Act.

"(ii) OTHER DESIGNATED FEDERAL PROGRAMS.—With respect to the designated Federal programs under paragraph (3) (other than subparagraph (C)), paragraph 1 shall not apply to an alien until 5 years after the date—

"(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

"(II) an alien is granted asylum under section 208 of such Act; or

"(III) an alien's deportation is withheld under section 243(h) of such Act.".

(c) STATUS OF CUBAN AND HAITIAN ENTRANTS.—For purposes of sections 402(a)(2)(A) and 402(b)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A), (b)(2)(A)), an alien who is a Cuban and Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980, shall be considered a refugee.

SEC. 5813. SSI ELIGIBILITY FOR PERMANENT RESIDENT ALIENS WHO ARE MEMBERS OF AN INDIAN TRIBE.

Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) (as

amended by section 5811) is amended by adding at the end the following:

"(F) PERMANENT RESIDENT ALIENS WHO ARE MEMBERS OF AN INDIAN TRIBE.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to an alien who—

"(i) is lawfully admitted for permanent residence under the Immigration and Nationality Act; and

"(ii) is a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act).".

SEC. 5814. SSI ELIGIBILITY FOR DISABLED LEGAL ALIENS IN THE UNITED STATES ON AUGUST 22, 1996.

Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) (as amended by section 5813) is amended by adding at the end the following:

"(G) DISABLED ALIENS LAWFULLY RESIDING IN THE UNITED STATES ON AUGUST 22, 1996.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to an alien who—

"(i) is lawfully residing in any State on August 22, 1996; and

"(ii) is disabled, as defined in section 1614(a)(3) of the Social Security Act (42 U.S.C. 1382c(a)(3)),

but only if the alien applies for benefits under such program on or before September 30, 1997.".

SEC. 5815. EXEMPTION FROM RESTRICTION ON SUPPLEMENTAL SECURITY INCOME PROGRAM PARTICIPATION BY CERTAIN RECIPIENTS ELIGIBLE ON THE BASIS OF VERY OLD APPLICATIONS.

Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) (as amended by section 5814) is amended by adding at the end the following:

"(H) SSI EXCEPTION FOR CERTAIN RECIPIENTS ON THE BASIS OF VERY OLD APPLICATIONS.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to any individual—

"(i) who is receiving benefits under such program for months after July 1996 on the basis of an application filed before January 1, 1979; and

"(ii) with respect to whom the Commissioner of Social Security lacks clear and convincing evidence that such individual is an alien ineligible for such benefits as a result of the application of this section.".

SEC. 5816. REINSTATEMENT OF ELIGIBILITY FOR BENEFITS.

(a) FOOD STAMPS.—The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended by adding after section 435 the following new section:

"SEC. 436. DERIVATIVE ELIGIBILITY FOR BENEFITS.

Notwithstanding any other provision of law, an alien who under the provisions of this title is ineligible for benefits under the food stamp program (as defined in section 402(a)(3)(A)) shall not be eligible for such benefits because the alien receives benefits under the supplemental security income program (as defined in section 402(a)(3)(B)).".

(b) MEDICAID.—Section 402(b)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended by adding at the end the following:

"(E) MEDICAID EXCEPTION FOR ALIENS RECEIVING SSI.—An alien who is receiving benefits under the program defined in subsection (a)(3)(A) (relating to the supplemental security income program) shall be eligible for medical assistance under a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) under the same terms and conditions that apply to other recipients of benefits under the program defined in such subsection.".

(c) CLERICAL AMENDMENT.—Section 2 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended by adding after the item related to section 435 the following:

"Sec. 436. Derivative eligibility for benefits.".

SEC. 5817. EXEMPTION FOR CHILDREN WHO ARE LEGAL ALIENS FROM 5-YEAR BAN ON MEDICAID ELIGIBILITY.

Section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613)) is amended by adding at the end the following:

"(e) MEDICAID ELIGIBILITY EXEMPTION FOR CHILDREN.—The limitation under subsection (a) shall not apply to any alien who has not attained age 19 and is lawfully residing in any State, but only with respect to such alien's eligibility for medical assistance under a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).".

SEC. 5818. EFFECTIVE DATE.

The amendments made by this chapter shall take effect as if they were included in the enactment of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2260).

CHAPTER 2—WELFARE-TO-WORK GRANT PROGRAM

SEC. 5821. WELFARE-TO-WORK GRANTS.

(a) GRANTS TO STATES.—

(1) IN GENERAL.—Section 403(a) (42 U.S.C. 603(a)) is amended by adding at the end the following:

"(5) WELFARE-TO-WORK GRANTS.—

"(A) NONCOMPETITIVE GRANTS.—

"(i) ENTITLEMENT.—A State shall be entitled to receive from the Secretary a grant for each fiscal year specified in subparagraph (H) of this paragraph for which the State is a welfare-to-work State, in an amount that does not exceed the greater of—

"(I) the allotment of the State under clause (iii) of this subparagraph for the fiscal year; or

"(II) 0.5 percent of the amount specified in subparagraph (H) for each fiscal year minus the total of the amounts reserved pursuant to subparagraphs (F) and (G) for the fiscal year.

"(ii) WELFARE-TO-WORK STATE.—A State shall be considered a welfare-to-work State for a fiscal year for purposes of this subparagraph if the Secretary determines that the State meets the following requirements:

"(I) The State has submitted to the Secretary (in the form of an addendum to the State plan submitted under section 402) a plan which—

"(aa) describes how, consistent with this subparagraph, the State will use any funds provided under this subparagraph during the fiscal year;

"(bb) specifies the formula to be used pursuant to clause (vi) to distribute funds in the State, and describes the process by which the formula was developed;

"(cc) contains evidence that the plan was developed in consultation and coordination with sub-State areas; and

"(dd) is approved by the agency administering the State program funded under this part.

"(II) The State certifies to the Secretary that the State intends to expend during the fiscal year (excluding expenditures described in section 409(a)(7)(B)(iv)) for activities described in subparagraph (C)(i) of this paragraph an amount equal to not less than 33 percent of the Federal funds provided under this paragraph.

"(III) The State has agreed to negotiate in good faith with the Secretary with respect to the substance of any evaluation under section 413(j), and to cooperate with the conduct of any such evaluation.

"(IV) The State is an eligible State for the fiscal year.

"(V) Qualified State expenditures (within the meaning of section 409(a)(7)) are at least 75 percent of historic State expenditures (within the meaning of such section), with respect to the fiscal year or the immediately preceding fiscal year.

"(iii) ALLOTMENTS TO WELFARE-TO-WORK STATES.—The allotment of a welfare-to-work State for a fiscal year shall be the available amount for the fiscal year multiplied by the State percentage for the fiscal year.

"(iv) AVAILABLE AMOUNT.—As used in this subparagraph, the term 'available amount' means, for a fiscal year, the sum of—

"(I) 75 percent of the sum of—

"(aa) the amount specified in subparagraph (H) for the fiscal year, minus the total of the amounts reserved pursuant to subparagraphs (F) and (G) for the fiscal year; and

"(bb) any amount reserved pursuant to subparagraph (F) for the immediately preceding fiscal year that has not been obligated; and

"(II) any available amount for the immediately preceding fiscal year that has not been obligated by a State or sub-State entity.

"(v) STATE PERCENTAGE.—As used in clause (iii), the term 'State percentage' means, with respect to a fiscal year, ⅓ of the sum of—

"(I) the percentage represented by the number of individuals in the State whose income is less than the poverty line divided by the number of such individuals in the United States;

"(II) the percentage represented by the number of unemployed individuals in the State divided by the number of such individuals in the United States; and

"(III) the percentage represented by the number of individuals who are adult recipients of assistance under the State program funded under this part divided by the number of individuals in the United States who are adult recipients of assistance under any State program funded under this part.

"(vi) DISTRIBUTION OF FUNDS WITHIN STATES.—

"(I) IN GENERAL.—A State to which a grant is made under this subparagraph shall distribute not less than 85 percent of the grant funds among the political subdivisions in the State in which the percentage represented by the number of individuals in the State whose income is less than the poverty line divided by the number of such individuals in the State, and the percentage represented by the number of unemployed individuals in the State divided by the number of such individuals in the State are both above the average such percentages for the State, in accordance with a formula which—

"(aa) determines the amount to be distributed for the benefit of a political subdivision in proportion to the number (if any) of individuals residing in the political subdivision with an income that is less than the poverty line, relative to such number of individuals for the other political subdivisions in the State, and accords a weight of not less than 50 percent to this factor;

"(bb) may determine the amount to be distributed for the benefit of a political subdivision in proportion to the number of adults residing in the political subdivision who are recipients of assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act first applied to the State) for at least 30 months (whether or not consecutive) relative to the number of such adults residing in the other political subdivisions in the State; and

"(cc) may determine the amount to be distributed for the benefit of a political subdivision in proportion to the number of unemployed individuals residing in the political subdivision relative to the number of such individuals residing in the other political subdivisions in the State.

"(II) SPECIAL RULE.—Notwithstanding subclause (I), if the formula used pursuant to subclause (I) would result in the distribution of less than $100,000 during a fiscal year for the benefit of a political subdivision, then in lieu of distributing such sum in accordance with the formula, such sum shall be available for distribution under subclause (III) during the fiscal year.

"(III) PROJECTS TO HELP LONG-TERM RECIPIENTS OF ASSISTANCE INTO THE WORK FORCE.—The Governor of a State to which a grant is made under this subparagraph may distribute not more than 15 percent of the grant funds (plus any amount required to be distributed under this subclause by reason of subclause (II)) to projects that appear likely to help long-term recipients of assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act first applied to the State) enter the work force.

"(vii) ADMINISTRATION.—

"(I) IN GENERAL.—A grant made under this subparagraph to a State shall be administered by the State agency that is administering, or supervising the administration of, the State program funded under this part.

"(B) COMPETITIVE GRANTS.—

"(i) IN GENERAL.—The Secretary shall award grants in accordance with this subparagraph, in fiscal years 1998 and 2000, for projects proposed by eligible applicants, based on the following:

"(I) The effectiveness of the proposal in—

"(aa) expanding the base of knowledge about programs aimed at moving recipients of assistance under State programs funded under this part who are least job ready into the work force.

"(bb) moving recipients of assistance under State programs funded under this part who are least job ready into the work force; and

"(cc) moving recipients of assistance under State programs funded under this part who are least job ready into the work force, even in labor markets that have a shortage of low-skill jobs.

"(II) At the discretion of the Secretary, any of the following:

"(aa) The history of success of the applicant in moving individuals with multiple barriers into work.

"(bb) Evidence of the applicant's ability to leverage private, State, and local resources.

"(cc) Use by the applicant of State and local resources beyond those required by subparagraph (A).

"(dd) Plans of the applicant to coordinate with other organizations at the local and State level.

"(ee) Use by the applicant of current or former recipients of assistance under a State program funded under this part as mentors, case managers, or service providers.

"(III) Evidence that the proposal has the approval of the State agency administering the program under this part.

"(ii) ELIGIBLE APPLICANTS.—As used in clause (i), the term 'eligible applicant' means a political subdivision of a State that submits a proposal that is approved by the agency administering the State program funded under this part.

"(iii) DETERMINATION OF GRANT AMOUNT.—In determining the amount of a grant to be made under this subparagraph for a project proposed by an applicant, the Secretary shall provide the applicant with an amount sufficient to ensure that the project has a reasonable opportunity to be successful, taking into account the number of long-term recipients of assistance under a State program funded under this part, the level of unemployment, the job opportunities and job growth, the poverty rate, and such other factors as the Secretary deems appropriate, in the area to be served by the project.

"(iv) TARGETING OF FUNDS TO RURAL AREAS.—

"(I) IN GENERAL.—The Secretary shall use not less than 30 percent of the funds available for

grants under this subparagraph for a fiscal year to award grants for expenditures in rural areas.

"(II) RURAL AREA DEFINED.—As used in subclause (I), the term 'rural area' means a city, town, or unincorporated area that has a population of 50,000 or fewer inhabitants and that is not an urbanized area immediately adjacent to a city, town, or unincorporated area that has a population of more than 50,000 inhabitants.

"(v) FUNDING.—For grants under this subparagraph for each fiscal year specified in subparagraph (H), there shall be available to the Secretary an amount equal to the sum of—

"(I) 25 percent of the sum of—

"(aa) the amount specified in subparagraph (H) for the fiscal year, minus the total of the amounts reserved pursuant to subparagraphs (F) and (G) for the fiscal year; and

"(bb) any amount reserved pursuant to subparagraph (F) for the immediately preceding fiscal year that has not been obligated; and

"(II) any amount available for grants under this subparagraph for the immediately preceding fiscal year that has not been obligated.

"(C) LIMITATIONS ON USE OF FUNDS.—

"(i) ALLOWABLE ACTIVITIES.—An entity to which funds are provided under this paragraph may use the funds to move into the work force recipients of assistance under the program funded under this part of the State in which the entity is located and the noncustodial parent of any minor who is such a recipient, by means of any of the following:

"(I) Job creation through public or private sector employment wage subsidies.

"(II) On-the-job training.

"(III) Contracts with public or private providers of readiness, placement, and post-employment services.

"(IV) Job vouchers for placement, readiness, and post-employment services.

"(V) Job support services (excluding child care services) if such services are not otherwise available.

"(ii) REQUIRED BENEFICIARIES.—An entity that operates a project with funds provided under this paragraph shall expend at least 90 percent of all funds provided to the project for the benefit of recipients of assistance under the program funded under this part of the State in which the entity is located who meet the requirements of either of the following subclauses:

"(I) At least 2 of the following apply to the recipient:

"(aa) The individual has not completed secondary school or obtained a certificate of general equivalency, and has low skills in reading and mathematics.

"(bb) The individual requires substance abuse treatment for employment.

"(cc) The individual has a poor work history.

The Secretary shall prescribe such regulations as may be necessary to interpret this subclause.

"(II) The individual—

"(aa) has received assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 first apply to the State) for at least 30 months (whether or not consecutive); or

"(bb) within 12 months, will become ineligible for assistance under the State program funded under this part by reason of a durational limit on such assistance, without regard to any exemption provided pursuant to section 408(a)(7)(C) that may apply to the individual.

"(iii) LIMITATION ON APPLICABILITY OF SECTION 404.—The rules of section 404, other than subsections (b), (f), and (h) of section 404, shall not apply to a grant made under this paragraph.

"(iv) COOPERATION WITH TANF AGENCY.—On a determination by the Secretary an entity that operates a project with funds provided under this paragraph and the agency administering the State program funded under this part are not adhering to the agreement to implement any plan or project for which the funds are provided, the recipient of the funds shall remit the funds to the Secretary.

"(v) PROHIBITION AGAINST USE OF GRANT FUNDS FOR ANY OTHER FUND MATCHING REQUIREMENT.—An entity to which funds are provided under this paragraph shall not use any part of the funds to fulfill any obligation of any State, or political subdivision to contribute funds under other Federal law.

"(vi) DEADLINE FOR EXPENDITURE.—An entity to which funds are provided under this paragraph shall remit to the Secretary any part of the funds that are not expended within 3 years after the date the funds are so provided.

"(D) INDIVIDUALS WITH INCOME LESS THAN THE POVERTY LINE.—For purposes of this paragraph, the number of individuals with an income that is less than the poverty line shall be determined based on the methodology used by

the Bureau of the Census to produce and publish intercensal poverty data for 1993 for States and counties.

"(E) SET-ASIDE FOR HIGH PERFORMANCE BONUS.—$100,000,000 of the amount specified in subparagraph (H) for fiscal year 1999 shall be reserved for use by the Secretary to make bonus grants (in the same manner as such grants are determined under paragraph (4)) for fiscal year 2003 to those States that receive funds under this paragraph and that are most successful in increasing the earnings of individuals described in subparagraph (C)(ii)(II).

"(F) SET-ASIDE FOR INDIAN TRIBES.—1 percent of the amount specified in subparagraph (H) for each fiscal year shall be reserved for grants to Indian tribes under section 412(a)(3).

"(G) SET-ASIDE FOR EVALUATIONS.—0.5 percent of the amount specified in subparagraph (H) for each fiscal year shall be reserved for use by the Secretary to carry out section 413(j).

"(H) FUNDING.—The amount specified in this subparagraph is—

"(i) $750,000,000 for fiscal year 1998;

"(ii) $1,250,000,000 for fiscal year 1999; and

"(iii) $1,000,000,000 for fiscal year 2000.

"(I) AVAILABILITY OF FUNDS.—Amounts appropriated pursuant to this paragraph shall remain available through fiscal year 2002.

"(J) BUDGET SCORING.—Notwithstanding section 457(b)(2) of the Balanced Budget and Emergency Deficit Control Act of 1985, the baseline shall assume that no grant shall be awarded under this paragraph or under section 412(a)(3) after fiscal year 2000.

"(K) NONDISPLACEMENT IN WORK ACTIVITIES.—

"(i) PROHIBITIONS.—

"(I) GENERAL PROHIBITION.—A participant in a work activity pursuant to this paragraph shall not displace (including a partial displacement, such as a reduction in the hours of nonovertime work, wages, or employment benefits) any individual who, as of the date of the participation, is an employee.

"(II) PROHIBITION ON IMPAIRMENT OF CONTRACTS.—A work activity pursuant to this paragraph shall not impair an existing contract for services or collective bargaining agreement, and a work activity that would be inconsistent with the terms of a collective bargaining agreement shall not be undertaken without the written concurrence of the labor organization and employer concerned.

"(III) OTHER PROHIBITIONS.—A participant in a work activity shall not be employed in a job—

"(aa) when any other individual is on layoff from the same or any substantially equivalent job;

"(bb) when the employer has terminated the employment of any regular employee or otherwise reduced the workforce of the employer with the intention of filling the vacancy so created with the participant; or

"(cc) which is created in a promotional line that will infringe in any way upon the promotional opportunities of employed individuals.

"(ii) HEALTH AND SAFETY.—Health and safety standards established under Federal and State law otherwise applicable to working conditions of employees shall be equally applicable to working conditions of participants engaged in a work activity pursuant to this paragraph. To the extent that a State workers' compensation law applies, workers' compensation shall be provided to participants on the same basis as the compensation is provided to other individuals in the State in similar employment.

"(iii) GRIEVANCE PROCEDURE.—

"(I) IN GENERAL.—Each State to which a grant is made under this paragraph shall establish and maintain a procedure for grievances or complaints alleging violations of clauses (i) or (ii) from participants and other interested or affected parties. The procedure shall include an opportunity for a hearing and be completed within 60 days after the grievance or complaint is filed.

"(II) INVESTIGATION.—

"(aa) IN GENERAL.—The Secretary of Labor shall investigate an allegation of a violation of clause (i) or (ii) if a decision relating to the violation is not reached within 60 days after the date of the filing of the grievance or complaint, and either party appeals to the Secretary of Labor, or a decision relating to the violation is reached within the 60-day period, and the party to which the decision is adverse appeals the decision to the Secretary of Labor.

"(bb) ADDITIONAL REQUIREMENT.—The Secretary of Labor shall make a final determination relating to an appeal made under item (aa) not later than 120 days after receiving the appeal.

"(III) REMEDIES.—Remedies for violation of clause (i) or (ii) shall be limited to—

"(aa) suspension or termination of payments under this paragraph;

"(bb) prohibition of placement of a participant with an employer that has violated clause (i) or (ii);

"(cc) where applicable, reinstatement of an employee, payment of lost wages and bene-

fits, and reestablishment of other relevant terms, conditions and privileges of employment; and

"(dd) where appropriate, other equitable relief.".

(2) CONFORMING AMENDMENT.—Section 409(a)(7)(B)(iv) of such Act (42 U.S.C. 609(a)(7)(B)(iv)) is amended to read as follows:

"(iv) EXPENDITURES BY THE STATE.—The term 'expenditures by the State' does not include—

"(I) any expenditure from amounts made available by the Federal Government;

"(II) any State funds expended for the medicaid program under title XIX;

"(III) any State funds which are used to match Federal funds provided under section 403(a)(5); or

"(IV) any State funds which are expended as a condition of receiving Federal funds other than under this part.

Notwithstanding subclause (IV) of the preceding sentence, such term includes expenditures by a State for child care in a fiscal year to the extent that the total amount of the expenditures does not exceed the amount of State expenditures in fiscal year 1994 or 1995 (whichever is the greater) that equal the non-Federal share for the programs described in section 418(a)(1)(A).".

(b) GRANTS TO OUTLYING AREAS.—Section 1108(a)(1) of such Act (42 U.S.C. 1308(a)(1)) is amended by inserting "(except section 403(a)(5))" after "title IV".

(c) GRANTS TO INDIAN TRIBES.—Section 412(a) of such Act (42 U.S.C. 612(a)) is amended by adding at the end the following:

"(3) WELFARE-TO-WORK GRANTS.—

"(A) IN GENERAL.—The Secretary shall award a grant in accordance with this paragraph to an Indian tribe for each fiscal year specified in section 403(a)(5)(H) for which the Indian tribe is a welfare-to-work tribe, in such amount as the Secretary deems appropriate, subject to subparagraph (B) of this paragraph.

"(B) WELFARE-TO-WORK TRIBE.—An Indian tribe shall be considered a welfare-to-work tribe for a fiscal year for purposes of this paragraph if the Indian tribe meets the following requirements:

"(i) The Indian tribe has submitted to the Secretary (in the form of an addendum to the tribal family assistance plan, if any, of the Indian tribe) a plan which describes how, consistent with section 403(a)(5), the Indian tribe will use any funds provided under this paragraph during the fiscal year.

"(ii) The Indian tribe has provided the Secretary with an estimate of the amount that the Indian tribe intends to expend during the fiscal year (excluding tribal expenditures described in section

409(a)(7)(B)(iv)) for activities described in section 403(a)(5)(C)(i).

"(iii) The Indian tribe has agreed to negotiate in good faith with the Secretary of Health and Human Services with respect to the substance of any evaluation under section 413(j), and to cooperate with the conduct of any such evaluation.

"(C) LIMITATIONS ON USE OF FUNDS.—Section 403(a)(5)(C) shall apply to funds provided to Indian tribes under this paragraph in the same manner in which such section applies to funds provided under section 403(a)(5).".

(d) FUNDS RECEIVED FROM GRANTS TO BE DISREGARDED IN APPLYING DURATIONAL LIMIT ON ASSISTANCE.—Section 408(a)(7) of such Act (42 U.S.C. 608(a)(7)) is amended by adding at the end the following:

"(G) INAPPLICABILITY TO WELFARE-TO-WORK GRANTS AND ASSISTANCE.—For purposes of subparagraph (A) of this paragraph, a grant made under section 403(a)(5) shall not be considered a grant made under section 403, and assistance from funds provided under section 403(a)(5) shall not be considered assistance.".

(e) EVALUATIONS.—Section 413 of such Act (42 U.S.C. 613) is amended by adding at the end the following:

"(j) EVALUATION OF WELFARE-TO-WORK PROGRAMS.—

"(1) EVALUATION.—The Secretary—

"(A) shall, in consultation with the Secretary of Labor, develop a plan to evaluate how grants made under sections 403(a)(5) and 412(a)(3) have been used;

"(B) may evaluate the use of such grants by such grantees as the Secretary deems appropriate, in accordance with an agreement entered into with the grantees after good-faith negotiations; and

"(C) shall include the following outcome measures in the plan developed under subparagraph (A):

"(i) Placements in the labor force and placements in the labor force that last for at least 6 months.

"(ii) Placements in the private and public sectors.

"(iii) Earnings of individuals who obtain employment.

"(iv) Average expenditures per placement.

"(2) REPORTS TO THE CONGRESS.—

"(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Secretary, in consultation with the Secretary of Labor and the Secretary of Housing and Urban Development, shall submit to the Congress reports on the projects funded under sections 403(a)(5) and 412(a)(3) and on the evaluations of the projects.

"(B) INTERIM REPORT.—Not later than January 1, 1999, the Secretary shall submit an interim report on the matter described in subparagraph (A).

"(C) FINAL REPORT.—Not later than January 1, 2001 (or at a later date, if the Secretary informs the committees of the Congress with jurisdiction over the subject matter of

the report) the Secretary shall submit a final report on the matter described in subparagraph (A).".

SEC. 5822. ENROLLMENT FLEXIBILITY.

(a) DETERMINATION OF ELIGIBILITY.—Nothing in this section shall be construed as affecting—

(1) the conditions for eligibility for benefits under a program described in subsection (b)(2) (including any conditions relating to income or resources);

(2) any right to challenge determinations regarding eligibility or rights to benefits under such programs (including any rights to grievance procedures or appeal);

(3) any determinations regarding quality control or error rates with respect to eligibility determinations under or the administration of such programs; or

(4) any safeguards for the privacy, confidentiality, and protections of individuals eligible for or receiving benefits under a program described in subsection (b)(2) that are provided under Federal or State law.

(b) AUTHORIZATION FOR STATE PLAN TO CONSOLIDATE AND AUTOMATE THE ADMINISTRATION OF LOW-INCOME BENEFIT PROGRAMS, INCLUDING MEDICAID, AND TO COMPETITIVELY CONTRACT FOR THE ADMINISTRATION OF SUCH PROGRAMS.—

(1) APPROVAL OF STATE PLAN.—

(A) IN GENERAL.—A State plan described in subparagraph (B) that was submitted by a State to the Secretary of Health and Human Services (in this section referred to as the "Secretary") prior to June 1, 1997, shall be deemed by the Secretary to be approved in its entirety (including any subsequent technical, clerical, and clarifying corrections, or any subsequent proposal submitted to comply with applicable State law). Any State that has a State plan described in subparagraph (B) approved shall remain eligible for Federal financial assistance for the procurement, development, and operation of the automated data processing equipment and services described in the State plan in accordance with the provisions of law applicable to such procurement, development, and operation. No provision of law shall be construed as preventing a State that has a State plan described in subparagraph (B) approved from allowing eligibility determinations described in paragraph (2) to be made by an entity that is not a State or local government, or by an individual who is not an employee of a State or local government, so long as such entity or individual meets such qualifications as the State determines. Any eligibility determinations made by an entity or individual described in the preceding sentence shall, to the extent necessary to comply with the requirements of any applicable Federal law, be considered to have been made by the State or by a State agency.

(B) STATE PLAN DESCRIBED.—A State plan described in this subparagraph is a State plan, including any request for offers, waivers, or other State submissions, to integrate and automate enrollment procedures for eligibility deter-

minations described in paragraph (2) through the use of automated data processing equipment and services.

(2) ELIGIBILITY DETERMINATIONS DESCRIBED.—The eligibility determinations described in this paragraph are eligibility determinations for low-income individuals and households to receive assistance and benefits under the medicaid program and other programs using the integrated and automated procedures under a State plan described in paragraph (1)(B).

(3) EVALUATION.—A State that has a State plan described in paragraph (1)(B) approved shall, not later than 5 years after the date of the approval of such plan, have an independent evaluation of the State plan conducted and shall submit a copy of the evaluation report to the appropriate committees of Congress.

SEC. 5823. CLARIFICATION OF A STATE'S ABILITY TO SANCTION AN INDIVIDUAL RECEIVING ASSISTANCE UNDER TANF FOR NONCOMPLIANCE.

(a) IN GENERAL.—Section 408 (42 U.S.C. 608) is amended—

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b), the following:

"(c) NONAPPLICATION OF ANY MINIMUM WAGE REQUIREMENTS WITH RESPECT TO INDIVIDUAL SANCTIONS.—Notwithstanding any other provision of law, any requirement imposed by law, regulation, or otherwise that requires that an individual in a family that receives assistance under the State program funded under this part receive the applicable minimum wage under section 6 of the Fair Labor Standards Act (29 U.S.C. 206), shall not prohibit a State from imposing against a family that includes such an individual any penalty that may be imposed under the State program funded under this part for failure to comply with a requirement under such program.".

(b) RETROACTIVITY.—The amendment made by subsection (a) shall take effect as if included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2112).

CHAPTER 3—UNEMPLOYMENT COMPENSATION

SEC. 5831. INCREASE IN FEDERAL UNEMPLOYMENT ACCOUNT CEILING.

(a) IN GENERAL.—Section 902(a)(2) (42 U.S.C. 1102(a)(2)) is amended by striking "0.25 percent" and inserting "0.5 percent".

(b) EFFECTIVE DATE.—This section and the amendment made by this section—

(1) shall take effect on October 1, 2001, and

(2) shall apply to fiscal years beginning on or after that date.

SEC. 5832. SPECIAL DISTRIBUTION TO STATES FROM UNEMPLOYMENT TRUST FUND.

(a) IN GENERAL.—Section 903(a) (42 U.S.C. 1103(a)) is amended by adding at the end the following new paragraph:

"(3)(A) Notwithstanding any other provision of this section, for purposes of carrying out this subsection with respect to any excess amount (referred to in paragraph (1)) remaining in the employment

security administration account as of the close of fiscal year 1999, 2000, or 2001, such amount shall—

"(i) to the extent of any amounts not in excess of $100,000,000, be subject to subparagraph (B), and

"(ii) to the extent of any amounts in excess of $100,000,000, be subject to subparagraph (C).

"(B) Paragraphs (1) and (2) shall apply with respect to any amounts described in subparagraph (A)(i), except that—

"(i) in carrying out the provisions of paragraph (2)(B) with respect to such amounts (to determine the portion of such amounts which is to be allocated to a State for a succeeding fiscal year), the ratio to be applied under such provisions shall be the same as the ratio that—

"(I) the amount of funds to be allocated to such State for such fiscal year pursuant to title III, bears to

"(II) the total amount of funds to be allocated to all States for such fiscal year pursuant to title III,

as determined by the Secretary of Labor, and

"(ii) the amounts allocated to a State pursuant to this subparagraph shall be available to such State, subject to the last sentence of subsection (c)(2).

Nothing in this paragraph shall preclude the application of subsection (b) with respect to any allocation determined under this subparagraph.

"(C) Any amounts described in clause (ii) of subparagraph (A) (remaining in the employment security administration account as of the close of any fiscal year specified in such subparagraph) shall, as of the beginning of the succeeding fiscal year, accrue to the Federal unemployment account, without regard to the limit provided in section 902(a).".

(b) CONFORMING AMENDMENT.—Paragraph (2) of section 903(c) of the Social Security Act is amended by adding at the end, as a flush left sentence, the following:

"Any amount allocated to a State under this section for fiscal year 2000, 2001, or 2002 may be used by such State only to pay expenses incurred by it for the administration of its unemployment compensation law, and may be so used by it without regard to any of the conditions prescribed in any of the preceding provisions of this paragraph.".

SEC. 5833. CLARIFYING PROVISION RELATING TO BASE PERIODS.

(a) IN GENERAL.—No provision of a State law under which the base period for such State is defined or otherwise determined shall, for purposes of section 303(a)(1) of the Social Security Act (42 U.S.C. 503(a)(1)), be considered a provision for a method of administration.

(b) DEFINITIONS.—For purposes of this section, the terms "State law", "base period", and "State" shall have the meanings given them under section 205 of the Federal-State Extended Unemployment Compensation Act of 1970 (26 U.S.C. 3304 note).

(c) EFFECTIVE DATE.—This section shall apply for purposes of any period beginning before, on, or after the date of the enactment of this Act.

SEC. 5834. TREATMENT OF CERTAIN SERVICES PERFORMED BY INMATES.

(a) IN GENERAL.—Subsection (c) of section 3306 of the Internal Revenue Code of 1986 (defining employment) is amended—

(1) by striking "or" at the end of paragraph (19),

(2) by striking the period at the end of paragraph (20) and inserting "; or", and

(3) by adding at the end the following new paragraph:

"(21) service performed by a person committed to a penal institution."

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to service performed after March 26, 1996.

DIVISION 4—EARNED INCOME CREDIT AND OTHER PROVISIONS

Subtitle L—Earned Income Credit and Other Provisions

CHAPTER 1—EARNED INCOME CREDIT

SEC. 5851. RESTRICTIONS ON AVAILABILITY OF EARNED INCOME CREDIT FOR TAXPAYERS WHO IMPROPERLY CLAIMED CREDIT IN PRIOR YEAR.

(a) IN GENERAL.—Section 32 of the Internal Revenue Code of 1986 (relating to earned income credit) is amended by redesignating subsections (k) and (l) as subsections (l) and (m), respectively, and by inserting after subsection (j) the following new subsection:

"(k) RESTRICTIONS ON TAXPAYERS WHO IMPROPERLY CLAIMED CREDIT IN PRIOR YEAR.—

"(1) TAXPAYERS MAKING PRIOR FRAUDULENT OR RECKLESS CLAIMS.—

"(A) IN GENERAL.—No credit shall be allowed under this section for any taxable year in the disallowance period.

"(B) DISALLOWANCE PERIOD.—For purposes of paragraph (1), the disallowance period is—

"(i) the period of 10 taxable years after the most recent taxable year for which there was a final determination that the taxpayer's claim of credit under this section was due to fraud, and

"(ii) the period of 2 taxable years after the most recent taxable year for which there was a final determination that the taxpayer's claim of credit under this section was due to reckless or intentional disregard of rules and regulations (but not due to fraud).

"(2) TAXPAYERS MAKING IMPROPER PRIOR CLAIMS.—In the case of a taxpayer who is denied credit under this section for any taxable year as a result of the deficiency procedures under subchapter B of chapter 63, no credit shall be allowed under this section for any subsequent taxable year unless the taxpayer provides such information as the Secretary may require to demonstrate eligibility for such credit."

(b) DUE DILIGENCE REQUIREMENT ON INCOME TAX RETURN PREPARERS.—Section 6695 of the Internal Revenue Code of 1986 (relating to other assessable penalties with respect to the preparation of income tax returns for other persons) is amended by adding at the end the following new subsection:

"(g) FAILURE TO BE DILIGENT IN DETERMINING ELIGIBILITY FOR EARNED INCOME CREDIT.—Any person who is an income tax preparer with respect to any return or claim for refund who fails to comply with due diligence requirements imposed by the Secretary by regulations with respect to determining eligibility for, or the amount of, the credit allowable by section 32 shall pay a penalty of $100 for each such failure."

(c) EXTENSION PROCEDURES APPLICABLE TO MATHEMATICAL OR CLERICAL ERRORS.—Paragraph (2) of section 6213(g) (relating to the definition of mathematical or clerical errors) is amended by striking "and" at the end of subparagraph (H), by striking the period at the end of subparagraph (I) and inserting ", and", and by inserting after subparagraph (I) the following new subparagraph:

"(J) an omission of information required by section 32(k)(2) (relating to taxpayers making improper prior claims of earned income credit)."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

CHAPTER 2—INCREASE IN PUBLIC DEBT LIMIT

SEC. 5861. INCREASE IN PUBLIC DEBT LIMIT.

Subsection (b) of section 3101 of title 31, United States Code, is amended by striking the dollar amount contained therein and inserting "$5,950,000,000,000".

CHAPTER 3—MISCELLANEOUS

SEC. 5871. SENSE OF THE SENATE REGARDING THE CORRECTION OF COST-OF-LIVING ADJUSTMENTS.

(a) FINDINGS.—The Senate makes the following findings:

(1) The final report of the Senate Finance Committee's Advisory Commission to Study the Consumer Price Index, chaired by Professor Michael Boskin, has concluded that the Consumer Price Index overstates the cost of living in the United States by 1.1 percentage points.

(2) Dr. Alan Greenspan, Chairman of the Board of Governors of the Federal Reserve System, has testified before the Senate Finance Committee that "the best available evidence suggests that there is virtually no chance that the CPI as currently published understates" the cost of living and that there is "a very high probability that the upward bias ranges between ½ percentage point per year and 1½ percentage points per year".

(3) The overstatement of the cost of living by the Consumer Price Index has been recognized by economists since at least 1961, when a report noting the existence of the overstatement was issued by a National Bureau of Economic Research Committee, chaired by Professor George J. Stigler.

(4) Congress and the President, through the indexing of Federal tax brackets, Social Security benefits, and other Federal program benefits, have undertaken to protect taxpayers and beneficiaries of such programs from the erosion of purchasing power due to inflation.

(5) Congress and the President intended the indexing of Federal tax brackets, Social Security benefits, and other Federal program benefits to accurately reflect changes in the cost of living.

(6) The overstatement of the cost of living increases the deficit and undermines the equitable administration of Federal benefits and tax policies.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that all cost-of-living adjustments required by statute should accurately reflect the best available estimate of changes in the cost of living.

Subtitle M—Welfare Reform Technical Corrections

SEC. 5900. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the "Welfare Reform Technical Corrections Act of 1997".

CHAPTER 1—BLOCK GRANTS FOR TEMPORARY ASSISTANCE TO NEEDY FAMILIES

SEC. 5901. AMENDMENT OF THE SOCIAL SECURITY ACT.

Except as otherwise expressly provided, wherever in this chapter an amendment or repeal 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 a section or other provision of the Social Security Act, and if the section or other provision is of part A of title IV of such Act, the reference shall be considered to be made to the section or other provision as amended by section 103, and as in effect pursuant to section 116, of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

SEC. 5902. ELIGIBLE STATES; STATE PLAN.

(a) LATER DEADLINE FOR SUBMISSION OF STATE PLANS.—Section 402(a) (42 U.S.C. 602(a)) is amended by striking "2-year period immediately preceding" and inserting "27-month period ending with the close of the 1st quarter of".

(b) CLARIFICATION OF SCOPE OF WORK PROVISIONS.—Section 402(a)(1)(A)(ii) (42 U.S.C. 602(a)(1)(A)(ii)) is amended by inserting ", consistent with section 407(e)(2)" before the period.

(c) CORRECTION OF CROSS-REFERENCE.—Section 402(a)(1)(A)(v) (42 U.S.C. 602(a)(1)(A)(v)) is amended by striking "403(a)(2)(B)" and inserting "403(a)(2)(C)(iii)".

(d) NOTIFICATION OF PLAN AMENDMENTS.—Section 402 (42 U.S.C. 602) is amended—

(1) by redesignating subsection (b) as subsection (c) and inserting after subsection (a) the following:

"(b) PLAN AMENDMENTS.—Within 30 days after a State amends a plan submitted pursuant to subsection (a), the State shall notify the Secretary of the amendment."; and

(2) in subsection (c) (as so redesignated), by inserting "or plan amendment" after "plan".

SEC. 5903. GRANTS TO STATES.

(a) BONUS FOR DECREASE IN ILLEGITIMACY MODIFIED TO TAKE ACCOUNT OF CERTAIN TERRITORIES.—

(1) IN GENERAL.—Section 403(a)(2)(B) (42 U.S.C. 603(a)(2)(B)) is amended to read as follows:

"(B) AMOUNT OF GRANT.—

"(i) IN GENERAL.—If, for a bonus year, none of the eligible States is Guam, the Virgin Islands, or American Samoa, then the amount of the grant shall be—

"(I) $20,000,000 if there are 5 eligible States; or

"(II) $25,000,000 if there are fewer than 5 eligible States.

"(ii) AMOUNT IF CERTAIN TERRITORIES ARE ELIGIBLE.—If, for a bonus year, Guam, the Virgin Islands, or American Samoa is an eligible State, then the amount of the grant shall be—

"(I) in the case of such a territory, 25 percent of the mandatory ceiling amount (as defined in section 1108(c)(4)) with respect to the territory; and

"(II) in the case of a State that is not such a territory—

"(aa) if there are 5 eligible States other than such territories, $20,000,000, minus ⅕ of the total amount of the grants payable under this paragraph to such territories for the bonus year; or

"(bb) if there are fewer than 5 such eligible States, $25,000,000, or such lesser amount as may be necessary to ensure that the total amount of grants payable under this paragraph for the bonus year does not exceed $100,000,000.".

(2) CERTAIN TERRITORIES TO BE IGNORED IN RANKING OTHER STATES.—Section 403(a)(2)(C)(i)(I)(aa) (42 U.S.C. 603(a)(2)(C)(i)(I)(aa)) is amended by adding at the end the following: "In the case of a State that is not a territory specified in subparagraph (B), the comparative magnitude of the decrease for the State shall be determined without regard to the magnitude of the corresponding decrease for any such territory.".

(b) COMPUTATION OF BONUS BASED ON RATIOS OF OUT-OF-WEDLOCK BIRTHS TO ALL BIRTHS INSTEAD OF NUMBERS OF OUT-OF-WEDLOCK BIRTHS.—Section 403(a)(2) (42 U.S.C. 603(a)(2)) is amended—

(1) in the paragraph heading, by inserting "RATIO" before the period;

(2) in subparagraph (A), by striking all that follows "bonus year" and inserting a period; and

(3) in subparagraph (C)—

(A) in clause (i)—

(i) in subclause (I)(aa)—

(I) by striking "number of out-of-wedlock births that occurred in the State during" and inserting "illegitimacy ratio of the State for"; and

(II) by striking "number of such births that occurred during" and inserting "illegitimacy ratio of the State for"; and

(ii) in subclause (II)(aa)—

(I) by striking "number of out-of-wedlock births that occurred in" each place such term appears and inserting "illegitimacy ratio of"; and

(II) by striking "calculate the number of out-of-wedlock births" and inserting "calculate the illegitimacy ratio"; and

(B) by adding at the end the following:

"(iii) ILLEGITIMACY RATIO.—The term 'illegitimacy ratio' means, with respect to a State and a period—

"(I) the number of out-of-wedlock births to mothers residing in the State that occurred during the period; divided by

"(II) the number of births to mothers residing in the State that occurred during the period.".

(c) USE OF CALENDAR YEAR DATA INSTEAD OF FISCAL YEAR DATA IN CALCULATING BONUS FOR DECREASE IN ILLEGITIMACY RATIO.—Section 403(a)(2)(C) (42 U.S.C. 603(a)(2)(C)) is amended—

(1) in clause (i)—

(A) in subclause (I)(bb)—

(i) by striking "the fiscal year" and inserting "the calendar year for which the most recent data are available"; and

(ii) by striking "fiscal year 1995" and inserting "calendar year 1995";

(B) in subclause (II), by striking "fiscal" each place such term appears and inserting "calendar"; and

(2) in clause (ii), by striking "fiscal years" and inserting "calendar years".

(d) CORRECTION OF HEADING.—Section 403(a)(3)(C)(ii) (42 U.S.C. 603(a)(3)(C)(ii)) is amended in the heading by striking "1997" and inserting "1998".

(e) CLARIFICATION OF CONTINGENCY FUND PROVISION.—Section 403(b) (42 U.S.C. 603(b)) is amended—

(1) in paragraph (6), by striking "(5)" and inserting "(4)";

(2) by striking paragraph (4) and redesignating paragraphs (5) and (6) as paragraphs (4) and (5), respectively; and

(3) by inserting after paragraph (5) the following:

"(6) ANNUAL RECONCILIATION.—

"(A) IN GENERAL.—Notwithstanding paragraph (3), if the Secretary makes a payment to a State under this subsection in a fiscal year, then the State shall remit to the Secretary, within 1 year after the end of the first subse-

quent period of 3 consecutive months for which the State is not a needy State, an amount equal to the amount (if any) by which—

"(i) the total amount paid to the State under paragraph (3) of this subsection in the fiscal year; exceeds

"(ii) the product of—

"(I) the Federal medical assistance percentage for the State (as defined in section 1905(b), as such section was in effect on September 30, 1995);

"(II) the State's reimbursable expenditures for the fiscal year; and

"(III) 1/12 times the number of months during the fiscal year for which the Secretary made a payment to the State under such paragraph (3).

"(B) DEFINITIONS.—As used in subparagraph (A):

"(i) REIMBURSABLE EXPENDITURES.—The term 'reimbursable expenditures' means, with respect to a State and a fiscal year, the amount (if any) by which—

"(I) countable State expenditures for the fiscal year; exceeds

"(II) historic State expenditures (as defined in section 409(a)(7)(B)(iii)), excluding any amount expended by the State for child care under subsection (g) or (i) of section 402 (as in effect during fiscal year 1994) for fiscal year 1994.

"(ii) COUNTABLE STATE EXPENDITURES.—The term 'countable expenditures' means, with respect to a State and a fiscal year—

"(I) the qualified State expenditures (as defined in section 409(a)(7)(B)(i) (other than the expenditures described in subclause (I)(bb) of such section)) under the State program funded under this part for the fiscal year; plus

"(II) any amount paid to the State under paragraph (3) during the fiscal year that is expended by the State under the State program funded under this part.".

(f) ADMINISTRATION OF CONTINGENCY FUND TRANSFERRED TO THE SECRETARY OF HHS.—Section 403(b)(7) (42 U.S.C. 603(b)(7)) is amended to read as follows:

"(7) STATE DEFINED.—As used in this subsection, the term 'State' means each of the 50 States and the District of Columbia.".

SEC. 5904. USE OF GRANTS.

Section 404(a)(2) (42 U.S.C. 604(a)(2)) is amended by inserting ", or (at the option of the State) August 21, 1996" before the period.

SEC. 5905. MANDATORY WORK REQUIREMENTS.

(a) FAMILY WITH A DISABLED PARENT NOT TREATED AS A 2-PARENT FAMILY.—Section 407(b)(2) (42 U.S.C. 607(b)(2)) is amended by adding at the end the following:

"(C) FAMILY WITH A DISABLED PARENT NOT TREATED AS A 2-PARENT FAMILY.—A family that includes a disabled par-

ent shall not be considered a 2-parent family for purposes of subsections (a) and (b) of this section.".

(b) CORRECTION OF HEADING.—Section 407(b)(3) (42 U.S.C. 607(b)(3)) is amended in the heading by inserting "AND NOT RESULTING FROM CHANGES IN STATE ELIGIBILITY CRITERIA" before the period.

(c) STATE OPTION TO INCLUDE INDIVIDUALS RECEIVING ASSISTANCE UNDER A TRIBAL WORK PROGRAM IN PARTICIPATION RATE CALCULATION.—Section 407(b)(4) (42 U.S.C. 607(b)(4)) is amended—

(1) in the heading, by inserting "OR TRIBAL WORK PROGRAM" before the period; and

(2) by inserting "or under a tribal work program to which funds are provided under this part" before the period.

(d) SHARING OF 35-HOUR WORK REQUIREMENT BETWEEN PARENTS IN 2-PARENT FAMILIES.—Section 407(c)(1)(B) (42 U.S.C. 607(c)(1)(B)) is amended—

(1) in clause (i)—

(A) by striking "is" and inserting "and the other parent in the family are"; and

(B) by inserting "a total of" before "at least"; and

(2) in clause (ii)—

(A) by striking "individual's spouse is" and inserting "individual and the other parent in the family are";

(B) by inserting "for a total of at least 55 hours per week" before "during the month"; and

(C) by striking "20" and inserting "50".

(e) CLARIFICATION OF EFFORT REQUIRED IN WORK ACTIVITIES.—Section 407(c)(1)(B) (42 U.S.C. 607(c)(1)(B)) is amended by striking "making progress" each place such term appears and inserting "participating".

(f) ADDITIONAL CONDITION UNDER WHICH 12 WEEKS OF JOB SEARCH MAY COUNT AS WORK.—Section 407(c)(2)(A)(i) (42 U.S.C. 607(c)(2)(A)(i)) is amended by inserting "or the State is a needy State (within the meaning of section 403(b)(6))" after "United States".

(g) CARETAKER RELATIVE OF CHILD UNDER AGE 6 DEEMED TO BE MEETING WORK REQUIREMENTS IF ENGAGED IN WORK FOR 20 HOURS PER WEEK.—Section 407(c)(2)(B) (42 U.S.C. 607(c)(2)(B)) is amended—

(1) in the heading, by inserting "OR RELATIVE" after "PARENT" each place such term appears; and

(2) by striking "in a 1-parent family who is the parent" and inserting "who is the only parent or caretaker relative in the family".

(h) EXTENSION TO MARRIED TEENS OF RULE THAT RECEIPT OF SUFFICIENT EDUCATION IS ENOUGH TO MEET WORK PARTICIPATION REQUIREMENTS.—Section 407(c)(2)(C) (42 U.S.C. 607(c)(2)(C)) is amended—

(1) in the heading, by striking "TEEN HEAD OF HOUSEHOLD" and inserting "SINGLE TEEN HEAD OF HOUSEHOLD OR MARRIED TEEN"; and

(2) by striking "a single" and inserting "married or a".

(i) CLARIFICATION OF NUMBER OF HOURS OF PARTICIPATION IN EDUCATION DIRECTLY RELATED TO EMPLOYMENT THAT ARE REQUIRED IN ORDER FOR SINGLE TEEN HEAD OF HOUSEHOLD OR MARRIED TEEN TO BE DEEMED TO BE ENGAGED IN WORK.—Section 407(c)(2)(C)(ii) (42 U.S.C. 607(c)(2)(C)(ii)) is amended by striking "at least" and all that follows through "subsection" and inserting "an average of at least 20 hours per week during the month".

(j) CLARIFICATION OF REFUSAL TO WORK FOR PURPOSES OF WORK PENALTIES FOR INDIVIDUALS.—Section 407(e)(2) (42 U.S.C. 607(e)(2)) is amended by striking "work" and inserting "engage in work required in accordance with this section".

(k) CLARIFICATION OF REMOVAL OF TEEN PARENTS WITH RESPECT TO VOCATIONAL EDUCATION.—Section 407(c)(2) (42 U.S.C. 607(c)(2)) is amended—

(1) in subparagraph (C), by striking ", subject to subparagraph (D) of this paragraph,"; and

(2) by striking subparagraph (D) and inserting the following:

"(D) NUMBER OF PERSONS THAT MAY BE TREATED AS ENGAGED IN WORK BY VIRTUE OF PARTICIPATION IN VOCATIONAL EDUCATION ACTIVITIES.—For purposes of determining monthly participation rates under paragraphs (1)(B)(i) and (2)(B) of subsection (b), not more than 20 percent of individuals in all families and in 2-parent families (other than individuals in such families who are described in subparagraph (C)) may be determined to be engaged in work in the State for a month by reason of participation in vocational educational training.".

SEC. 5906. PROHIBITIONS; REQUIREMENTS.

(a) ELIMINATION OF REDUNDANT LANGUAGE; CLARIFICATION OF HOME RESIDENCE REQUIREMENT.—Section 408(a)(1) (42 U.S.C. 608(a)(1)) is amended to read as follows:

"(1) NO ASSISTANCE FOR FAMILIES WITHOUT A MINOR CHILD.—A State to which a grant is made under section 403 shall not use any part of the grant to provide assistance to a family, unless the family includes a minor child who resides with the family (consistent with paragraph (10)) or a pregnant individual.".

(b) CLARIFICATION OF TERMINOLOGY.—Section 408(a)(3) (42 U.S.C. 608(a)(3)) is amended—

(1) by striking "leaves" the 1st, 3rd, and 4th places such term appears and inserting "ceases to receive assistance under"; and

(2) by striking "the date the family leaves the program" the 2nd place such term appears and inserting "such date".

(c) ELIMINATION OF SPACE.—Section 408(a)(5)(A)(ii) (42 U.S.C. 608(a)(5)(A)(ii)) is amended by striking "DESCRIBED.— For" and inserting "DESCRIBED.—For".

(d) CORRECTIONS TO 5-YEAR LIMIT ON ASSISTANCE.—

(1) CLARIFICATION OF LIMITATION ON HARDSHIP EXEMPTION.—Section 408(a)(7)(C)(ii) (42 U.S.C. 608(a)(7)(C)(ii)) is amended—

(A) by striking "The number" and inserting "The average monthly number"; and

(B) by inserting "during the fiscal year or the immediately preceding fiscal year (but not both), as the State may elect" before the period.

(2) RESIDENCE EXCEPTION MADE MORE UNIFORM AND EASIER TO ADMINISTER.—Section 408(a)(7)(D) (42 U.S.C. 608(a)(7)(D)) is amended to read as follows:

"(D) DISREGARD OF MONTHS OF ASSISTANCE RECEIVED BY ADULT WHILE LIVING IN INDIAN COUNTRY OR AN ALASKAN NATIVE VILLAGE WITH 50 PERCENT UNEMPLOYMENT.—

"(i) IN GENERAL.—In determining the number of months for which an adult has received assistance under a State or tribal program funded under this part, the State or tribe shall disregard any month during which the adult lived in Indian country or an Alaskan Native village if the most reliable data available with respect to the month (or a period including the month) indicate that at least 50 percent of the adults living in Indian country or in the village were not employed.

"(ii) INDIAN COUNTRY DEFINED.—As used in clause (i), the term 'Indian country' has the meaning given such term in section 1151 of title 18, United States Code.".

(e) REINSTATEMENT OF DEEMING AND OTHER RULES APPLICABLE TO ALIENS WHO ENTERED THE UNITED STATES UNDER AFFIDAVITS OF SUPPORT FORMERLY USED.—Section 408 (42 U.S.C. 608) is amended by striking subsection (d) and inserting the following:

"(d) SPECIAL RULES RELATING TO TREATMENT OF CERTAIN ALIENS.—For special rules relating to the treatment of certain aliens, see title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

"(e) SPECIAL RULES RELATING TO THE TREATMENT OF NON-213A ALIENS.—The following rules shall apply if a State elects to take the income or resources of any sponsor of a non-213A alien into account in determining whether the alien is eligible for assistance under the State program funded under this part, or in determining the amount or types of such assistance to be provided to the alien:

"(1) DEEMING OF SPONSOR'S INCOME AND RESOURCES.—For a period of 3 years after a non-213A alien enters the United States:

"(A) INCOME DEEMING RULE.—The income of any sponsor of the alien and of any spouse of the sponsor is deemed to be income of the alien, to the extent that the total amount of the income exceeds the sum of—

"(i) the lesser of—

"(I) 20 percent of the total of any amounts received by the sponsor or any such spouse in the month as wages or salary or as net earnings from self-employment, plus the full amount of any costs incurred by the sponsor and any such spouse in producing self-employment income in such month; or

"(II) $175;

"(ii) the cash needs standard established by the State for purposes of determining eligibility for assistance under the State program funded under this part for a family of the same size and composition as the sponsor and any other individuals living in the same household as the sponsor who are claimed by the sponsor as dependents for purposes of determining the sponsor's Federal personal income tax liability but whose needs are not taken into account in determining whether the sponsor's family has met the cash needs standard;

"(iii) any amounts paid by the sponsor or any such spouse to individuals not living in the household who are claimed by the sponsor as dependents for purposes of determining the sponsor's Federal personal income tax liability; and

"(iv) any payments of alimony or child support with respect to individuals not living in the household.

"(B) RESOURCE DEEMING RULE.—The resources of a sponsor of the alien and of any spouse of the sponsor are deemed to be resources of the alien to the extent that the aggregate value of the resources exceeds $1,500.

"(C) SPONSORS OF MULTIPLE NON-213A ALIENS.—If a person is a sponsor of 2 or more non-213A aliens who are living in the same home, the income and resources of the sponsor and any spouse of the sponsor that would be deemed income and resources of any such alien under subparagraph (A) shall be divided into a number of equal shares equal to the number of such aliens, and the State shall deem the income and resources of each such alien to include 1 such share.

"(2) INELIGIBILITY OF NON-213A ALIENS SPONSORED BY AGENCIES; EXCEPTION.—A non-213A alien whose sponsor is or was a public or private agency shall be ineligible for assistance under a State program funded under this part, during a period of 3 years after the alien enters the United States, unless the State agency administering the program determines that the sponsor either no longer exists or has become unable to meet the alien's needs.

"(3) INFORMATION PROVISIONS.—

"(A) DUTIES OF NON-213A ALIENS.—A non-213A alien, as a condition of eligibility for assistance under a State program funded under this part during the period of 3 years after the alien enters the United States, shall be required to provide to the State agency administering the program—

"(i) such information and documentation with respect to the alien's sponsor as may be necessary in order for the State agency to make any determination required under this subsection, and to obtain any cooperation from the sponsor necessary for any such determination; and

"(ii) such information and documentation as the State agency may request and which the alien or the

alien's sponsor provided in support of the alien's immigration application.

"(B) DUTIES OF FEDERAL AGENCIES.—The Secretary shall enter into agreements with the Secretary of State and the Attorney General under which any information available to them and required in order to make any determination under this subsection will be provided by them to the Secretary (who may, in turn, make the information available, upon request, to a concerned State agency).

"(4) NON-213A ALIEN DEFINED.—An alien is a non-213A alien for purposes of this subsection if the affidavit of support or similar agreement with respect to the alien that was executed by the sponsor of the alien's entry into the United States was executed other than pursuant to section 213A of the Immigration and Nationality Act.

"(5) INAPPLICABILITY TO ALIEN MINOR SPONSORED BY A PARENT.—This subsection shall not apply to an alien who is a minor child if the sponsor of the alien or any spouse of the sponsor is a parent of the alien.

"(6) INAPPLICABILITY TO CERTAIN CATEGORIES OF ALIENS.—This subsection shall not apply to an alien who is—

"(A) admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

"(B) paroled into the United States under section 212(d)(5) of such Act for a period of at least 1 year; or

"(C) granted political asylum by the Attorney General under section 208 of such Act.".

SEC. 5907. PENALTIES.

(a) STATES GIVEN MORE TIME TO FILE QUARTERLY REPORTS.—Section 409(a)(2)(A) (42 U.S.C. 609(a)(2)(A)) is amended by striking "1 month" and inserting "45 days".

(b) TREATMENT OF SUPPORT PAYMENTS PASSED THROUGH TO FAMILIES AS QUALIFIED STATE EXPENDITURES.—Section 409(a)(7)(B)(i)(I)(aa) (42 U.S.C. 609(a)(7)(B)(i)(I)(aa)) is amended by inserting ", including any amount collected by the State as support pursuant to a plan approved under part D, on behalf of a family receiving assistance under the State program funded under this part, that is distributed to the family under section 457(a)(1)(B) and disregarded in determining the eligibility of the family for, and the amount of, such assistance" before the period.

(c) DISREGARD OF EXPENDITURES MADE TO REPLACE PENALTY GRANT REDUCTIONS.—Section 409(a)(7)(B)(i) (42 U.S.C. 609(a)(7)(B)(i)) is amended by redesignating subclause (III) as subclause (IV) and by inserting after subclause (II) the following:

"(III) EXCLUSION OF AMOUNTS EXPENDED TO REPLACE PENALTY GRANT REDUCTIONS.—Such term does not include any amount expended in order to comply with paragraph (12).".

(d) TREATMENT OF FAMILIES OF CERTAIN ALIENS AS ELIGIBLE FAMILIES.—Section 409(a)(7)(B)(i)(IV) (42 U.S.C. 609(a)(7)(B)(i)(IV)), as so redesignated by subsection (c) of this section, is amended—

(1) by striking "and families" and inserting "families"; and

(2) by striking "Act or section 402" and inserting "Act, and families of aliens lawfully present in the United States that would be eligible for such assistance but for the application of title IV".

(e) ELIMINATION OF MEANINGLESS LANGUAGE.—Section 409(a)(7)(B)(ii) (42 U.S.C. 609(a)(7)(B)(ii)) is amended by striking "reduced (if appropriate) in accordance with subparagraph (C)(ii)".

(f) CLARIFICATION OF SOURCE OF DATA TO BE USED IN DETERMINING HISTORIC STATE EXPENDITURES.—Section 409(a)(7)(B) (42 U.S.C. 609(a)(7)(B)) is amended by adding at the end the following:

"(v) SOURCE OF DATA.—In determining expenditures by a State for fiscal years 1994 and 1995, the Secretary shall use information which was reported by the State on ACF Form 231 or (in the case of expenditures under part F) ACF Form 331, available as of the dates specified in clauses (ii) and (iii) of section 403(a)(1)(D).".

(g) CONFORMING TITLE IV–A PENALTIES TO TITLE IV–D PERFORMANCE-BASED STANDARDS.—Section 409(a)(8) (42 U.S.C. 609(a)(8)) is amended to read as follows:

"(8) NONCOMPLIANCE OF STATE CHILD SUPPORT ENFORCEMENT PROGRAM WITH REQUIREMENTS OF PART D.—

"(A) IN GENERAL.—If the Secretary finds, with respect to a State's program under part D, in a fiscal year beginning on or after October 1, 1997—

"(i)(I) on the basis of data submitted by a State pursuant to section 454(15)(B), or on the basis of the results of a review conducted under section 452(a)(4), that the State program failed to achieve the paternity establishment percentages (as defined in section 452(g)(2)), or to meet other performance measures that may be established by the Secretary;

"(II) on the basis of the results of an audit or audits conducted under section 452(a)(4)(C)(i) that the State data submitted pursuant to section 454(15)(B) is incomplete or unreliable; or

"(III) on the basis of the results of an audit or audits conducted under section 452(a)(4)(C) that a State failed to substantially comply with 1 or more of the requirements of part D; and

"(ii) that, with respect to the succeeding fiscal year—

"(I) the State failed to take sufficient corrective action to achieve the appropriate performance levels or compliance as described in subparagraph (A)(i); or

"(II) the data submitted by the State pursuant to section 454(15)(B) is incomplete or unreliable;

the amounts otherwise payable to the State under this part for quarters following the end of such succeeding fiscal year, prior to quarters following the end of the first quarter throughout which the State program has achieved the paternity establishment percentages or other performance measures as described in subparagraph (A)(i)(I), or is

in substantial compliance with 1 or more of the requirements of part D as described in subparagraph (A)(i)(III), as appropriate, shall be reduced by the percentage specified in subparagraph (B).

"(B) AMOUNT OF REDUCTIONS.—The reductions required under subparagraph (A) shall be—

"(i) not less than 1 nor more than 2 percent;

"(ii) not less than 2 nor more than 3 percent, if the finding is the 2nd consecutive finding made pursuant to subparagraph (A); or

"(iii) not less than 3 nor more than 5 percent, if the finding is the 3rd or a subsequent consecutive such finding.

"(C) DISREGARD OF NONCOMPLIANCE WHICH IS OF A TECHNICAL NATURE.—For purposes of this section and section 452(a)(4), a State determined as a result of an audit—

"(i) to have failed to have substantially complied with 1 or more of the requirements of part D shall be determined to have achieved substantial compliance only if the Secretary determines that the extent of the noncompliance is of a technical nature which does not adversely affect the performance of the State's program under part D; or

"(ii) to have submitted incomplete or unreliable data pursuant to section 454(15)(B) shall be determined to have submitted adequate data only if the Secretary determines that the extent of the incompleteness or unreliability of the data is of a technical nature which does not adversely affect the determination of the level of the State's paternity establishment percentages (as defined under section 452(g)(2)) or other performance measures that may be established by the Secretary.".

(h) CORRECTION OF REFERENCE TO 5-YEAR LIMIT ON ASSISTANCE.—Section 409(a)(9) (42 U.S.C. 609(a)(9)) is amended by striking "408(a)(1)(B)" and inserting "408(a)(7)".

(i) CORRECTION OF ERRORS IN PENALTY FOR FAILURE TO MEET MAINTENANCE OF EFFORT REQUIREMENT APPLICABLE TO THE CONTINGENCY FUND.—Section 409(a)(10) (42 U.S.C. 609(a)(10)) is amended—

(1) by striking "the expenditures under the State program funded under this part for the fiscal year (excluding any amounts made available by the Federal Government)" and inserting "the qualified State expenditures (as defined in paragraph (7)(B)(i) (other than the expenditures described in subclause (I)(bb) of that paragraph)) under the State program funded under this part for the fiscal year";

(2) by inserting "excluding any amount expended by the State for child care under subsection (g) or (i) of section 402 (as in effect during fiscal year 1994) for fiscal year 1994," after "(as defined in paragraph (7)(B)(iii) of this subsection),"; and

(3) by inserting "that the State has not remitted under section 403(b)(6)" before the period.

(j) PENALTY FOR STATE FAILURE TO EXPEND ADDITIONAL STATE FUNDS TO REPLACE GRANT REDUCTIONS.—Section 409(a)(12) (42 U.S.C. 609(a)(12)) is amended—

(1) in the heading—

(A) by striking "FAILURE" and inserting "REQUIREMENT"; and

(B) by striking "REDUCTIONS" and inserting "REDUCTIONS; PENALTY FOR FAILURE TO DO SO"; and

(2) by inserting ", and if the State fails to do so, the Secretary may reduce the grant payable to the State under section 403(a)(1) for the fiscal year that follows such succeeding fiscal year by an amount equal to not more than 2 percent of the State family assistance grant" before the period.

(k) ELIMINATION OF CERTAIN REASONABLE CAUSE EXCEPTIONS.—Section 409(b)(2) (42 U.S.C. 609(b)(2)) is amended by striking "(7) or (8)" and inserting "(6), (7), (8), (10), or (12)".

(l) CLARIFICATION OF WHAT IT MEANS TO CORRECT A VIOLATION.—Section 409(c) (42 U.S.C. 609(c)) is amended—

(1) in each of subparagraphs (A) and (B) of paragraph (1), by inserting "or discontinue, as appropriate," after "correct";

(2) in paragraph (2)—

(A) in the heading, by inserting "OR DISCONTINUING" after "CORRECTING"; and

(B) by inserting "or discontinues, as appropriate" after "corrects"; and

(3) in paragraph (3)—

(A) in the heading, by inserting "OR DISCONTINUE" after "CORRECT"; and

(B) by inserting "or discontinue, as appropriate," before "the violation".

(m) CERTAIN PENALTIES NOT AVOIDABLE THROUGH CORRECTIVE COMPLIANCE PLANS.—Section 409(c)(4) (42 U.S.C. 609(c)(4)) is amended to read as follows:

"(4) INAPPLICABILITY TO CERTAIN PENALTIES.—This subsection shall not apply to the imposition of a penalty against a State under paragraph (6), (7), (8), (10), or (12) of subsection (a).".

SEC. 5908. DATA COLLECTION AND REPORTING.

Section 411(a) (42 U.S.C. 611(a)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A)—

(i) by striking clause (ii) and inserting the following:

"(ii) Whether a child receiving such assistance or an adult in the family is receiving—

"(I) Federal disability insurance benefits;

"(II) benefits based on Federal disability status;

"(III) aid under a State plan approved under title XIV (as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972));

"(IV) aid or assistance under a State plan approved under title XVI (as in effect without regard

to such amendment) by reason of being permanently and totally disabled; or

"(V) supplemental security income benefits under title XVI (as in effect pursuant to such amendment) by reason of disability.";

(ii) in clause (iv), by striking "youngest child in" and inserting "head of";

(iii) in each of clauses (vii) and (viii), by striking "status" and inserting "level"; and

(iv) by adding at the end the following:

"(xvii) With respect to each individual in the family who has not attained 20 years of age, whether the individual is a parent of a child in the family."; and

(B) in subparagraph (B)—

(i) in the heading, by striking "ESTIMATES" and inserting "SAMPLES"; and

(ii) in clause (i), by striking "an estimate which is obtained" and inserting "disaggregated case record information on a sample of families selected"; and

(2) by redesignating paragraph (6) as paragraph (7) and inserting after paragraph (5) the following:

"(6) REPORT ON FAMILIES RECEIVING ASSISTANCE.—The report required by paragraph (1) for a fiscal quarter shall include for each month in the quarter the number of families and individuals receiving assistance under the State program funded under this part (including the number of 2-parent and 1-parent families), and the total dollar value of such assistance received by all families.".

SEC. 5909. DIRECT FUNDING AND ADMINISTRATION BY INDIAN TRIBES.

(a) PRORATING OF TRIBAL FAMILY ASSISTANCE GRANTS.—Section 412(a)(1)(A) (42 U.S.C. 612(a)(1)(A)) is amended by inserting "which shall be reduced for a fiscal year, on a pro rata basis for each quarter, in the case of a tribal family assistance plan approved during a fiscal year for which the plan is to be in effect," before "and shall".

(b) TRIBAL OPTION TO OPERATE WORK ACTIVITIES PROGRAM.—Section 412(a)(2)(A) (42 U.S.C. 612(a)(2)(A)) is amended by striking "The Secretary" and all that follows through "2002" and inserting "For each of fiscal years 1997, 1998, 1999, 2000, 2001, and 2002, the Secretary shall pay to each eligible Indian tribe that proposes to operate a program described in subparagraph (C)".

(c) DISCRETION OF TRIBES TO SELECT POPULATION TO BE SERVED BY TRIBAL WORK ACTIVITIES PROGRAM.—Section 412(a)(2)(C) (42 U.S.C. 612(a)(2)(C)) is amended by striking "members of the Indian tribe" and inserting "such population and such service area or areas as the tribe specifies".

(d) REDUCTION OF APPROPRIATION FOR TRIBAL WORK ACTIVITIES PROGRAMS.—Section 412(a)(2)(D) (42 U.S.C. 612(a)(2)(D)) is amended by striking "$7,638,474" and inserting "$7,633,287".

(e) AVAILABILITY OF CORRECTIVE COMPLIANCE PLANS TO INDIAN TRIBES.—Section 412(f)(1) (42 U.S.C. 612(f)(1)) is amended by striking "and (b)" and inserting "(b), and (c)".

(f) ELIGIBILITY OF TRIBES FOR FEDERAL LOANS FOR WELFARE PROGRAMS.—Section 412 (42 U.S.C. 612) is amended by redesignating subsections (f), (g), and (h) as subsections (g), (h), and (i), respectively, and by inserting after subsection (e) the following:

"(f) ELIGIBILITY FOR FEDERAL LOANS.—Section 406 shall apply to an Indian tribe with an approved tribal assistance plan in the same manner as such section applies to a State, except that section 406(c) shall be applied by substituting 'section 412(a)' for 'section 403(a)'.".

SEC. 5910. RESEARCH, EVALUATIONS, AND NATIONAL STUDIES.

(a) RESEARCH.—

(1) METHODS.—Section 413(a) (42 U.S.C. 613(a)) is amended by inserting ", directly or through grants, contracts, or interagency agreements," before "shall conduct".

(2) CORRECTION OF CROSS REFERENCE.—Section 413(a) (42 U.S.C. 613(a)) is amended by striking "409" and inserting "407".

(b) CORRECTION OF ERRONEOUSLY INDENTED PARAGRAPH.—Section 413(e)(1) (42 U.S.C. 613(e)(1)) is amended to read as follows:

"(1) IN GENERAL.—The Secretary shall annually rank States to which grants are made under section 403 based on the following ranking factors:

"(A) ABSOLUTE OUT-OF-WEDLOCK RATIOS.—The ratio represented by—

"(i) the total number of out-of-wedlock births in families receiving assistance under the State program under this part in the State for the most recent year for which information is available; over

"(ii) the total number of births in families receiving assistance under the State program under this part in the State for the year.

"(B) NET CHANGES IN THE OUT-OF-WEDLOCK RATIO.—The difference between the ratio described in subparagraph (A) with respect to a State for the most recent year for which such information is available and the ratio with respect to the State for the immediately preceding year.".

(c) FUNDING OF PRIOR AUTHORIZED DEMONSTRATIONS.—Section 413(h)(1)(D) (42 U.S.C. 613(h)(1)(D)) is amended by striking "September 30, 1995" and inserting "August 22, 1996".

(d) CHILD POVERTY REPORTS.—

(1) DELAYED DUE DATE FOR INITIAL REPORT.—Section 413(i)(1) (42 U.S.C. 613(i)(1)) is amended by striking "90 days after the date of the enactment of this part" and inserting "November 30, 1997".

(2) MODIFICATION OF FACTORS TO BE USED IN ESTABLISHING METHODOLOGY FOR USE IN DETERMINING CHILD POVERTY RATES.—Section 413(i)(5) (42 U.S.C. 613(i)(5)) is amended by striking "the county-by-county" and inserting ", to the extent available, county-by-county".

SEC. 5911. REPORT ON DATA PROCESSING.

Section 106(a)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110

Stat. 2164) is amended by striking "(whether in effect before or after October 1, 1995)".

SEC. 5912. STUDY ON ALTERNATIVE OUTCOMES MEASURES.

Section 107(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2164) is amended by striking "409(a)(7)(C)" and inserting "408(a)(7)(C)".

SEC. 5913. LIMITATION ON PAYMENTS TO THE TERRITORIES.

(a) CERTAIN PAYMENTS TO BE DISREGARDED IN DETERMINING LIMITATION.—Section 1108(a) (42 U.S.C. 1308) is amended to read as follows:

"(a) LIMITATION ON TOTAL PAYMENTS TO EACH TERRITORY.—

"(1) IN GENERAL.—Notwithstanding any other provision of this Act (except for paragraph (2) of this subsection), the total amount certified by the Secretary of Health and Human Services under titles I, X, XIV, and XVI, under parts A and E of title IV, and under subsection (b) of this section, for payment to any territory for a fiscal year shall not exceed the ceiling amount for the territory for the fiscal year.

"(2) CERTAIN PAYMENTS DISREGARDED.—Paragraph (1) of this subsection shall be applied without regard to any payment made under section 403(a)(2), 403(a)(4), 406, or 413(f).".

(b) CERTAIN CHILD CARE AND SOCIAL SERVICES EXPENDITURES BY TERRITORIES TREATED AS IV–A EXPENDITURES FOR PURPOSES OF MATCHING GRANT.—Section 1108(b)(1)(A) (42 U.S.C. 1308(b)(1)(A)) is amended by inserting ", including any amount paid to the State under part A of title IV that is transferred in accordance with section 404(d) and expended under the program to which transferred" before the semicolon.

(c) ELIMINATION OF DUPLICATIVE MAINTENANCE OF EFFORT REQUIREMENT.—Section 1108 (42 U.S.C. 1308) is amended by striking subsection (e).

SEC. 5914. CONFORMING AMENDMENTS TO THE SOCIAL SECURITY ACT.

(a) AMENDMENTS TO PART D OF TITLE IV.—

(1) CORRECTIONS TO DETERMINATION OF PATERNITY ESTABLISHMENT PERCENTAGES.—Section 452 (42 U.S.C. 652) is amended—

(A) in subsection (d)(3)(A), by striking all that follows "for purposes of" and inserting "section 409(a)(8), to achieve the paternity establishment percentages (as defined under section 452(g)(2)) and other performance measures that may be established by the Secretary, and to submit data under section 454(15)(B) that is complete and reliable, and to substantially comply with the requirements of this part; and"; and

(B) in subsection (g)(1), by striking "section 403(h)" and inserting "section 409(a)(8)".

(2) ELIMINATION OF OBSOLETE LANGUAGE.—Section 108(c)(8)(C) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2165) is amended by inserting "and all that follows

through 'the best interests of such child to do so'" before "and inserting".

(3) INSERTION OF LANGUAGE INADVERTENTLY OMITTED.—Section 108(c)(13) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2166) is amended by inserting "and inserting 'pursuant to section 408(a)(3)'" before the period.

(4) ELIMINATION OF OBSOLETE CROSS REFERENCE.—Section 464(a)(1) (42 U.S.C. 664(a)(1)) is amended by striking "section 402(a)(26)" and inserting "section 408(a)(3)".

(b) AMENDMENTS TO PART E OF TITLE IV.—Each of the following is amended by striking "June 1, 1995" each place such term appears and inserting "July 16, 1996":

(1) Section 472(a) (42 U.S.C. 672(a)).
(2) Section 472(h) (42 U.S.C. 672(h)).
(3) Section 473(a)(2) (42 U.S.C. 673(a)(2)).
(4) Section 473(b) (42 U.S.C. 673(b)).

SEC. 5915. OTHER CONFORMING AMENDMENTS.

(a) ELIMINATION OF AMENDMENTS INCLUDED INADVERTENTLY.—Section 110(l) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2173) is amended—

(1) by striking paragraphs (1), (4), (5), and (7);

(2) by redesignating paragraphs (2), (3), (6), and (8) as paragraphs (1), (2), (3), and (4), respectively; and

(3) by adding "and" at the end of paragraph (3), as so redesignated.

(b) CORRECTION OF CITATION.—Section 109(f) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2177) is amended by striking "93–186" and inserting "93–86".

(c) CORRECTION OF INTERNAL CROSS REFERENCE.—Section 103(a)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2112) is amended by striking "603(b)(2)" and inserting "603(b)".

(d) CORRECTION OF REFERENCES.—Section 416 (42 U.S.C. 616) is amended by striking "amendment made by section 2103 of the Personal Responsibility and Work Opportunity" and inserting "amendments made by section 103 of the Personal Responsibility and Work Opportunity Reconciliation".

SEC. 5916. MODIFICATIONS TO THE JOB OPPORTUNITIES FOR CERTAIN LOW-INCOME INDIVIDUALS PROGRAM.

Section 112(5) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2177) is amended in each of subparagraphs (A) and (B) by inserting "under" after "funded".

SEC. 5917. DENIAL OF ASSISTANCE AND BENEFITS FOR DRUG-RELATED CONVICTIONS.

(a) EXTENSION OF CERTAIN REQUIREMENTS COORDINATED WITH DELAYED EFFECTIVE DATE FOR SUCCESSOR PROVISIONS.—Section 115(d)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2181) is

amended by striking "convictions" and inserting "a conviction if the conviction is for conduct".

(b) IMMEDIATE EFFECTIVENESS OF PROVISIONS RELATING TO RESEARCH, EVALUATIONS, AND NATIONAL STUDIES.—Section 116(a) of such Act (Public Law 104–193; 110 Stat. 2181) is amended by adding at the end the following:

"(6) RESEARCH, EVALUATIONS, AND NATIONAL STUDIES.—Section 413 of the Social Security Act, as added by the amendment made by section 103(a) of this Act, shall take effect on the date of the enactment of this Act.".

SEC. 5918. TRANSITION RULE.

Section 116 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2181) is amended—

(1) in subsection (a)(2), by inserting "(but subject to subsection (b)(1)(A)(ii))" after "this section"; and

(2) in subsection (b)(1)(A)(ii), by striking "June 30, 1997" and inserting "the later of June 30, 1997, or the day before the date described in subsection (a)(2)(B) of this section".

SEC. 5919. EFFECTIVE DATES.

(a) AMENDMENTS TO PART A OF TITLE IV OF THE SOCIAL SECURITY ACT.—The amendments made by this chapter to a provision of part A of title IV of the Social Security Act shall take effect as if the amendments had been included in section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 at the time such section became law.

(b) AMENDMENTS TO PARTS D AND E OF TITLE IV OF THE SOCIAL SECURITY ACT.—The amendments made by section 5914 of this Act shall take effect as if the amendments had been included in section 108 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 at the time such section 108 became law.

(c) AMENDMENTS TO OTHER AMENDATORY PROVISIONS.—The amendments made by section 5915(a) of this Act shall take effect as if the amendments had been included in section 110 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 at the time such section 110 became law.

(d) AMENDMENTS TO FREESTANDING PROVISIONS OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996.—The amendments made by this chapter to a provision of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 that, as of July 1, 1997, will not have become part of another statute shall take effect as if the amendments had been included in the provision at the time the provision became law.

CHAPTER 2—SUPPLEMENTAL SECURITY INCOME

SEC. 5921. CONFORMING AND TECHNICAL AMENDMENTS RELATING TO ELIGIBILITY RESTRICTIONS.

(a) DENIAL OF SSI BENEFITS FOR FUGITIVE FELONS AND PROBATION AND PAROLE VIOLATORS.—Section 1611(e)(6) (42 U.S.C. 1382(e)(6)) is amended by inserting "and section 1106(c) of this Act" after "of 1986".

(b) TREATMENT OF PRISONERS.—Section 1611(e)(1)(I)(i)(II) (42 U.S.C. 1382(e)(1)(I)(i)(II)) is amended by striking "inmate of the institution" and all that follows through "this subparagraph" and inserting "individual who receives in the month preceding the first month throughout which such individual is an inmate of the jail, prison, penal institution, or correctional facility that furnishes information respecting such individual pursuant to subclause (I), or is confined in the institution (that so furnishes such information) as described in section 202(x)(1)(A)(ii), a benefit under this title for such preceding month, and who is determined by the Commissioner to be ineligible for benefits under this title by reason of confinement based on the information provided by such institution".

(c) CORRECTION OF REFERENCE.—Section 1611(e)(1)(I)(i)(I) (42 U.S.C. 1382(e)(1)(I)(i)(I)) is amended by striking "paragraph (1)" and inserting "this paragraph".

SEC. 5922. CONFORMING AND TECHNICAL AMENDMENTS RELATING TO BENEFITS FOR DISABLED CHILDREN.

(a) ELIGIBILITY REDETERMINATIONS FOR CURRENT RECIPIENTS.—Section 211(d)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (42 U.S.C. 1382c note) is amended by striking "1 year" and inserting "18 months".

(b) ELIGIBILITY REDETERMINATIONS AND CONTINUING DISABILITY REVIEWS.—

(1) DISABILITY ELIGIBILITY REDETERMINATIONS REQUIRED FOR SSI RECIPIENTS WHO ATTAIN 18 YEARS OF AGE.—Section 1614(a)(3)(H)(iii) (42 U.S.C. 1382c(a)(3)(H)(iii)) is amended by striking subclauses (I) and (II) and all that follows and inserting the following:

"(I) by applying the criteria used in determining initial eligibility for individuals who are age 18 or older; and

"(II) either during the 1-year period beginning on the individual's 18th birthday or, in lieu of a continuing disability review, whenever the Commissioner determines that an individual's case is subject to a redetermination under this clause.

With respect to any redetermination under this clause, paragraph (4) shall not apply.".

(2) CONTINUING DISABILITY REVIEW REQUIRED FOR LOW BIRTH WEIGHT BABIES.—Section 1614(a)(3)(H)(iv) (42 U.S.C. 1382c(a)(3)(H)(iv)) is amended—

(A) in subclause (I), by striking "Not" and inserting "Except as provided in subclause (VI), not"; and

(B) by adding at the end the following:

"(VI) Subclause (I) shall not apply in the case of an individual described in that subclause who, at the time of the individual's initial disability determination, the Commissioner determines has an impairment that is not expected to improve within 12 months after the birth of that individual, and who the Commissioner schedules for a continuing disability review at a date that is after the individual attains 1 year of age.".

(c) ADDITIONAL ACCOUNTABILITY REQUIREMENTS.—Section 1631(a)(2)(F) (42 U.S.C. 1383(a)(2)(F)) is amended—

(1) in clause (ii)(III)(bb), by striking "the total amount" and all that follows through "1613(c)" and inserting "in any case in which the individual knowingly misapplies benefits from such

an account, the Commissioner shall reduce future benefits payable to such individual (or to such individual and his spouse) by an amount equal to the total amount of such benefits so misapplied"; and

(2) by striking clause (iii) and inserting the following:

"(iii) The representative payee may deposit into the account established under clause (i) any other funds representing past due benefits under this title to the eligible individual, provided that the amount of such past due benefits is equal to or exceeds the maximum monthly benefit payable under this title to an eligible individual (including State supplementary payments made by the Commissioner pursuant to an agreement under section 1616 or section 212(b) of Public Law 93–66).".

(d) REDUCTION IN CASH BENEFITS PAYABLE TO INSTITUTIONALIZED INDIVIDUALS WHOSE MEDICAL COSTS ARE COVERED BY PRIVATE INSURANCE.—Section 1611(e) (42 U.S.C. 1382(e)) is amended—

(1) in paragraph (1)(B)—

(A) in the matter preceding clause (i), by striking "hospital, extended care facility, nursing home, or intermediate care facility" and inserting "medical treatment facility";

(B) in clause (ii)—

(i) in the matter preceding subclause (I), by striking "hospital, home or"; and

(ii) in subclause (I), by striking "hospital, home, or";

(C) in clause (iii), by striking "hospital, home, or"; and

(D) in the matter following clause (iii), by striking "hospital, extended care facility, nursing home, or intermediate care facility which is a 'medical institution or nursing facility' within the meaning of section 1917(c)" and inserting "medical treatment facility that provides services described in section 1917(c)(1)(C)";

(2) in paragraph (1)(E)—

(A) in clause (i)(II), by striking "hospital, extended care facility, nursing home, or intermediate care facility" and inserting "medical treatment facility"; and

(B) in clause (iii), by striking "hospital, extended care facility, nursing home, or intermediate care facility" and inserting "medical treatment facility";

(3) in paragraph (1)(G), in the matter preceding clause (i)—

(A) by striking "or which is a hospital, extended care facility, nursing home, or intermediate care" and inserting "or is in a medical treatment"; and

(B) by inserting "or, in the case of an individual who is a child under the age of 18, under any health insurance policy issued by a private provider of such insurance" after "title XIX"; and

(4) in paragraph (3)—

(A) by striking "same hospital, home, or facility" and inserting "same medical treatment facility"; and

(B) by striking "same such hospital, home, or facility" and inserting "same such facility".

(e) CORRECTION OF U.S.C. CITATION.—Section 211(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2189) is amended by striking "1382(a)(4)" and inserting "1382c(a)(4)".

SEC. 5923. ADDITIONAL TECHNICAL AMENDMENTS TO TITLE XVI.

Section 1615(d) (42 U.S.C. 1382d(d)) is amended—

(1) in the first sentence, by inserting a comma after "subsection (a)(1)"; and

(2) in the last sentence, by striking "him" and inserting "the Commissioner".

SEC. 5924. ADDITIONAL TECHNICAL AMENDMENTS RELATING TO TITLE XVI.

Section 1110(a)(3) (42 U.S.C. 1310(a)(3)) is amended—

(1) by inserting "(or the Commissioner, with respect to any jointly financed cooperative agreement or grant concerning title XVI)" after "Secretary" the first place it appears; and

(2) by inserting "(or the Commissioner, as applicable)" after "Secretary" the second place it appears.

SEC. 5925. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided in subsection (b), the amendments made by this part shall take effect as if included in the enactment of title II of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2185).

(b) EXCEPTION.—The amendments made by section 5925 shall take effect as if included in the enactment of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296; 108 Stat. 1464).

CHAPTER 3—CHILD SUPPORT

SEC. 5935. STATE OBLIGATION TO PROVIDE CHILD SUPPORT ENFORCEMENT SERVICES.

(a) INDIVIDUALS SUBJECT TO FEE FOR CHILD SUPPORT ENFORCEMENT SERVICES.—Section 454(6)(B) (42 U.S.C. 654(6)(B)) is amended by striking "individuals not receiving assistance under any State program funded under part A, which" and inserting "an individual, other than an individual receiving assistance under a State program funded under part A or E, or under a State plan approved under title XIX, or who is required by the State to cooperate with the State agency administering the program under this part pursuant to subsection (l) or (m) of section 6 of the Food Stamp Act of 1977, and".

(b) CORRECTION OF REFERENCE.—Section 464(a)(2)(A) (42 U.S.C. 654(a)(2)(A)) is amended in the first sentence by striking "section 454(6)" and inserting "section 454(4)(A)(ii)".

SEC. 5936. DISTRIBUTION OF COLLECTED SUPPORT.

(a) CONTINUATION OF ASSIGNMENTS.—Section 457(b) (42 U.S.C. 657(b)) is amended—

(1) by striking "which were assigned" and inserting "assigned"; and

(2) by striking "and which were in effect" and all that follows and inserting "and in effect on September 30, 1997 (or

such earlier date, on or after August 22, 1996, as the State may choose), shall remain assigned after such date.".

(b) STATE OPTION FOR APPLICABILITY.—

(1) IN GENERAL.—Section 457(a) (42 U.S.C. 657(a)) is amended by adding at the end the following:

"(6) STATE OPTION FOR APPLICABILITY.—Notwithstanding any other provision of this subsection, a State may elect to apply the rules described in clauses (i)(II), (ii)(II), and (v) of paragraph (2)(B) to support arrearages collected on and after October 1, 1998, and, if the State makes such an election, shall apply the provisions of this section, as in effect and applied on the day before the date of enactment of section 302 of the Personal Responsibility and Work Opportunity Act of 1996 (Public Law 104–193, 110 Stat. 2200), other than subsection (b)(1) (as so in effect), to amounts collected before October 1, 1998.".

(2) CONFORMING AMENDMENTS.—Section 408(a)(3)(A) (42 U.S.C. 608(a)(3)(A)) is amended—

(A) in clause (i), by inserting "(I)" after "(i)";

(B) in clause (ii)—

(i) by striking "(ii)" and inserting "(II)"; and

(ii) by striking the period and inserting "; or"; and

(C) by adding at the end, the following:

"(ii) if the State elects to distribute collections under section 457(a)(6), the date the family ceases to receive assistance under the program, if the assignment is executed on or after October 1, 1998.".

(c) DISTRIBUTION OF COLLECTIONS WITH RESPECT TO FAMILIES RECEIVING ASSISTANCE.—Section 457(a)(1) (42 U.S.C. 657(a)(1)) is amended by adding at the end the following flush language:

"In no event shall the total of the amounts paid to the Federal Government and retained by the State exceed the total of the amounts that have been paid to the family as assistance by the State.".

(d) FAMILIES UNDER CERTAIN AGREEMENTS.—Section 457(a)(4) (42 U.S.C. 657(a)(4)) is amended to read as follows:

"(4) FAMILIES UNDER CERTAIN AGREEMENTS.—In the case of an amount collected for a family in accordance with a cooperative agreement under section 454(33), distribute the amount so collected pursuant to the terms of the agreement.".

(e) STUDY AND REPORT.—Section 457(a)(5) (42 U.S.C. 657(a)(5)) is amended by striking "1998" and inserting "1999".

(f) CORRECTIONS OF REFERENCES.—Section 457(a)(2)(B) (42 U.S.C. 657(a)(2)(B)) is amended—

(1) in clauses (i)(I) and (ii)(I)—

(A) by striking "(other than subsection (b)(1))" each place it appears; and

(B) by inserting "(other than subsection (b)(1) (as so in effect))" after "1996" each place it appears; and

(2) in clause (ii)(II), by striking "paragraph (4)" and inserting "paragraph (5)".

(g) CORRECTION OF TERRITORIAL MATCH.—Section 457(c)(3)(A) (42 U.S.C. 657(c)(3)(A)) is amended by striking "the Federal medical assistance percentage (as defined in section 1118)" and inserting "75 percent".

(h) DEFINITIONS.—

(1) FEDERAL SHARE.—Section 457(c)(2) (42 U.S.C. 657(c)(2)) is amended by striking "collected" the second place it appears and inserting "distributed".

(2) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—Section 457(c)(3)(B) (42 U.S.C. 657(c)(3)(B)) is amended by striking "as in effect on September 30, 1996" and inserting "as such section was in effect on September 30, 1995".

(i) CONFORMING AMENDMENTS.—

(1) Section 464(a)(2)(A) (42 U.S.C. 664(a)(2)(A)) is amended, in the penultimate sentence, by inserting "in accordance with section 457" after "owed".

(2) Section 466(a)(3)(B) (42 U.S.C. 666(a)(3)(B)) is amended by striking "457(b)(4) or (d)(3)" and inserting "457".

SEC. 5937. CIVIL PENALTIES RELATING TO STATE DIRECTORY OF NEW HIRES.

Section 453A (42 U.S.C. 653a) is amended—

(1) in subsection (d)—

(A) in the matter preceding paragraph (1), by striking "shall be less than" and inserting "shall not exceed"; and

(B) in paragraph (1), by striking "$25" and inserting "$25 per failure to meet the requirements of this section with respect to a newly hired employee"; and

(2) in subsection (g)(2)(B), by striking "extracts" and all that follows through "Labor" and inserting "information".

SEC. 5938. FEDERAL PARENT LOCATOR SERVICE.

(a) IN GENERAL.—Section 453 (42 U.S.C. 653) is amended—

(1) in subsection (a)—

(A) by inserting "(1)" after "(a)"; and

(B) by striking "to obtain" and all that follows through the period and inserting "for the purposes specified in paragraphs (2) and (3).

"(2) For the purpose of establishing parentage, establishing, setting the amount of, modifying, or enforcing child support obligations, the Federal Parent Locator Service shall obtain and transmit to any authorized person specified in subsection (c)—

"(A) information on, or facilitating the discovery of, the location of any individual—

"(i) who is under an obligation to pay child support;

"(ii) against whom such an obligation is sought; or

"(iii) to whom such an obligation is owed,

including the individual's social security number (or numbers), most recent address, and the name, address, and employer identification number of the individual's employer;

"(B) information on the individual's wages (or other income) from, and benefits of, employment (including rights to or enrollment in group health care coverage); and

"(C) information on the type, status, location, and amount of any assets of, or debts owed by or to, any such individual.

"(3) For the purpose of enforcing any Federal or State law with respect to the unlawful taking or restraint of a child, or making or enforcing a child custody or visitation determination, as defined in section 463(d)(1), the Federal Parent Locator Service shall be used

to obtain and transmit the information specified in section 463(c) to the authorized persons specified in section 463(d)(2).";

(2) by striking subsection (b) and inserting the following:

"(b)(1) Upon request, filed in accordance with subsection (d), of any authorized person, as defined in subsection (c) for the information described in subsection (a)(2), or of any authorized person, as defined in section 463(d)(2) for the information described in section 463(c), the Secretary shall, notwithstanding any other provision of law, provide through the Federal Parent Locator Service such information to such person, if such information—

"(A) is contained in any files or records maintained by the Secretary or by the Department of Health and Human Services; or

"(B) is not contained in such files or records, but can be obtained by the Secretary, under the authority conferred by subsection (e), from any other department, agency, or instrumentality of the United States or of any State,

and is not prohibited from disclosure under paragraph (2).

"(2) No information shall be disclosed to any person if the disclosure of such information would contravene the national policy or security interests of the United States or the confidentiality of census data. The Secretary shall give priority to requests made by any authorized person described in subsection (c)(1). No information shall be disclosed to any person if the State has notified the Secretary that the State has reasonable evidence of domestic violence or child abuse and the disclosure of such information could be harmful to the custodial parent or the child of such parent, provided that—

"(A) in response to a request from an authorized person (as defined in subsection (c) and section 463(d)(2)), the Secretary shall advise the authorized person that the Secretary has been notified that there is reasonable evidence of domestic violence or child abuse and that information can only be disclosed to a court or an agent of a court pursuant to subparagraph (B); and

"(B) information may be disclosed to a court or an agent of a court described in subsection (c)(2) or section 463(d)(2)(B), if—

"(i) upon receipt of information from the Secretary, the court determines whether disclosure to any other person of that information could be harmful to the parent or the child; and

"(ii) if the court determines that disclosure of such information to any other person could be harmful, the court and its agents shall not make any such disclosure.

"(3) Information received or transmitted pursuant to this section shall be subject to the safeguard provisions contained in section 454(26).";

(3) in subsection (c)—

(A) in paragraph (1), by striking "or to seek to enforce orders providing child custody or visitation rights"; and

(B) in paragraph (2)—

(i) by inserting "or to serve as the initiating court in an action to seek an order" after "issue an order"; and

(ii) by striking "or to issue an order against a resident parent for child custody or visitation rights".

(b) USE OF THE FEDERAL PARENT LOCATOR SERVICE.—Section 463 (42 U.S.C. 663) is amended—

(1) in subsection (a)—

(A) in the matter preceding paragraph (1)—

(i) by striking "any State which is able and willing to do so," and inserting "every State"; and

(ii) by striking "such State" and inserting "each State"; and

(B) in paragraph (2), by inserting "or visitation" after "custody";

(2) in subsection (b)(2), by inserting "or visitation" after "custody";

(3) in subsection (d)—

(A) in paragraph (1), by inserting "or visitation" after "custody"; and

(B) in subparagraphs (A) and (B) of paragraph (2), by inserting "or visitation" after "custody" each place it appears;

(4) in subsection (f)(2), by inserting "or visitation" after "custody"; and

(5) by striking "noncustodial" each place it appears.

SEC. 5939. ACCESS TO REGISTRY DATA FOR RESEARCH PURPOSES.

(a) IN GENERAL.—Section 453(j)(5) (42 U.S.C. 653(j)(5)) is amended by inserting "data in each component of the Federal Parent Locator Service maintained under this section and to" before "information".

(b) CONFORMING AMENDMENTS.—Section 453 (42 U.S.C. 653) is amended—

(1) in subsection (j)(3)(B), by striking "registries" and inserting "components"; and

(2) in subsection (k)(2), by striking "subsection (j)(3)" and inserting "section 453A(g)(2)".

SEC. 5940. COLLECTION AND USE OF SOCIAL SECURITY NUMBERS FOR USE IN CHILD SUPPORT ENFORCEMENT.

Section 466(a)(13) (42 U.S.C. 666(a)(13)) is amended—

(1) in subparagraph (A)—

(A) by striking "commercial"; and

(B) by inserting "recreational license," after "occupational license,"; and

(2) in the matter following subparagraph (C), by inserting "to be used on the face of the document while the social security number is kept on file at the agency" after "other than the social security number".

SEC. 5941. ADOPTION OF UNIFORM STATE LAWS.

Section 466(f) (42 U.S.C. 666(f)) is amended by striking "together" and all that follows and inserting "and as in effect on August 22, 1996, including any amendments officially adopted as of such date by the National Conference of Commissioners on Uniform State Laws.".

SEC. 5942. STATE LAWS PROVIDING EXPEDITED PROCEDURES.

Section 466(c) (42 U.S.C. 666(c)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (E), by inserting ", part E," after "part A"; and

(B) in subparagraph (G), by inserting "any current support obligation and" after "to satisfy"; and

(2) in paragraph (2)(A)—

(A) in clause (i), by striking "the tribunal and"; and

(B) in clause (ii)—

(i) by striking "tribunal may" and inserting "court or administrative agency of competent jurisdiction shall"; and

(ii) by striking "filed with the tribunal" and inserting "filed with the State case registry".

SEC. 5943. VOLUNTARY PATERNITY ACKNOWLEDGEMENT.

Section 466(a)(5)(C)(i) (42 U.S.C. 666(a)(5)(C)(i)) is amended by inserting ", or through the use of video or audio equipment," after "orally".

SEC. 5944. CALCULATION OF PATERNITY ESTABLISHMENT PERCENTAGE.

Section 452(g)(2) (42 U.S.C. 652(g)(2)) is amended, in the matter following subparagraph (C), by striking "subparagraph (A)" and inserting "subparagraphs (A) and (B)".

SEC. 5945. MEANS AVAILABLE FOR PROVISION OF TECHNICAL ASSISTANCE AND OPERATION OF FEDERAL PARENT LOCATOR SERVICE.

(a) TECHNICAL ASSISTANCE.—Section 452(j) (42 U.S.C. 652(j)), is amended, in the matter preceding paragraph (1), by striking "to cover costs incurred by the Secretary" and inserting "which shall be available for use by the Secretary, either directly or through grants, contracts, or interagency agreements,".

(b) OPERATION OF FEDERAL PARENT LOCATOR SERVICE.—

(1) MEANS AVAILABLE.—Section 453(o) (42 U.S.C. 653(o)) is amended—

(A) in the heading, by striking "RECOVERY OF COSTS" and inserting "USE OF SET-ASIDE FUNDS"; and

(B) by striking "to cover costs incurred by the Secretary" and inserting "which shall be available for use by the Secretary, either directly or through grants, contracts, or interagency agreements,".

(2) AVAILABILITY OF FUNDS.—Section 453(o) (42 U.S.C. 653(o)) is amended by adding at the end the following: "Amounts appropriated under this subsection for each of fiscal years 1997 through 2001 shall remain available until expended.".

SEC. 5946. AUTHORITY TO COLLECT SUPPORT FROM FEDERAL EMPLOYEES.

(a) RESPONSE TO NOTICE OR PROCESS.—Section 459(c)(2)(C) (42 U.S.C. 659(c)(2)(C)) is amended by striking "respond to the order, process, or interrogatory" and inserting "withhold available sums in response to the order or process, or answer the interrogatory".

(b) MONEYS SUBJECT TO PROCESS.—Section 459(h)(1) (42 U.S.C. 659(h)(1)) is amended—

(1) in the matter preceding subparagraph (A) and in subparagraph (A)(i), by striking "paid or" each place it appears;

(2) in subparagraph (A)—

(A) in clause (ii)(V), by striking "and" at the end;

(B) in clause (iii)—

(i) by inserting "or payable" after "paid"; and

(ii) by striking "but" and inserting "; and"; and

(C) by inserting after clause (iii), the following:

"(iv) benefits paid or payable under the Railroad Retirement System, but"; and

(3) in subparagraph (B)—

(A) in clause (i), by striking "or" at the end;

(B) in clause (ii), by striking the period and inserting "; or"; and

(C) by adding at the end the following:

"(iii) of periodic benefits under title 38, United States Code, except as provided in subparagraph (A)(ii)(V).".

(c) CONFORMING AMENDMENT.—Section 454(19)(B)(ii) (42 U.S.C. 654(19)(B)(ii)) is amended by striking "section 462(e)" and inserting "section 459(i)(5)".

SEC. 5947. DEFINITION OF SUPPORT ORDER.

Section 453(p) (42 U.S.C. 653(p)), is amended by striking "a child and" and inserting "of".

SEC. 5948. STATE LAW AUTHORIZING SUSPENSION OF LICENSES.

Section 466(a)(16) (42 U.S.C. 666(a)(16)) is amended by inserting "and sporting" after "recreational".

SEC. 5949. INTERNATIONAL SUPPORT ENFORCEMENT.

Section 454(32)(A) (42 U.S.C. 654(32)(A)) is amended by striking "section 459A(d)(2)" and inserting "section 459A(d)".

SEC. 5950. CHILD SUPPORT ENFORCEMENT FOR INDIAN TRIBES.

(a) COOPERATIVE AGREEMENTS BY INDIAN TRIBES AND STATES FOR CHILD SUPPORT ENFORCEMENT.—Section 454(33) (42 U.S.C. 654(33)) is amended—

(1) by striking "and enforce support orders, and" and inserting "or enforce support orders, or";

(2) by striking "guidelines established by such tribe or organization" and inserting "guidelines established or adopted by such tribe or organization";

(3) by striking "funding collected" and inserting "collections"; and

(4) by striking "such funding" and inserting "such collections".

(b) CORRECTION OF SUBSECTION DESIGNATION.—Section 455 (42 U.S.C. 655), is amended by redesignating subsection (b), as added by section 375(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193, 110 Stat. 2256), as subsection (f).

(c) DIRECT GRANTS TO TRIBES.—Section 455(f) (42 U.S.C. 655(f)), as redesignated by subsection (b), is amended to read as follows:

"(f) The Secretary may make direct payments under this part to an Indian tribe or tribal organization that demonstrates to the satisfaction of the Secretary that it has the capacity to operate a child support enforcement program meeting the objectives of this part, including establishment of paternity, establishment, modification, and enforcement of support orders, and location of absent parents. The Secretary shall promulgate regulations establishing the requirements which must be met by an Indian tribe or tribal organization to be eligible for a grant under this subsection.".

SEC. 5951. CONTINUATION OF RULES FOR DISTRIBUTION OF SUPPORT IN THE CASE OF A TITLE IV-E CHILD.

Section 457 (42 U.S.C. 657) is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by striking "subsection (e)" and inserting "subsections (e) and (f)"; and

(2) by adding at the end, the following:

"(f) Notwithstanding the preceding provisions of this section, amounts collected by a State as child support for months in any period on behalf of a child for whom a public agency is making foster care maintenance payments under part E—

"(1) shall be retained by the State to the extent necessary to reimburse it for the foster care maintenance payments made with respect to the child during such period (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing);

"(2) shall be paid to the public agency responsible for supervising the placement of the child to the extent that the amounts collected exceed the foster care maintenance payments made with respect to the child during such period but not the amounts required by a court or administrative order to be paid as support on behalf of the child during such period; and the responsible agency may use the payments in the manner it determines will serve the best interests of the child, including setting such payments aside for the child's future needs or making all or a part thereof available to the person responsible for meeting the child's day-to-day needs; and

"(3) shall be retained by the State, if any portion of the amounts collected remains after making the payments required under paragraphs (1) and (2), to the extent that such portion is necessary to reimburse the State (with appropriate reimbursement to the Federal Government to the extent of its participation in the financing) for any past foster care maintenance payments (or payments of assistance under the State program funded under part A) which were made with respect to the child (and with respect to which past collections have not previously been retained);

and any balance shall be paid to the State agency responsible for supervising the placement of the child, for use by such agency in accordance with paragraph (2).".

SEC. 5952. GOOD CAUSE IN FOSTER CARE AND FOOD STAMP CASES.

(a) STATE PLAN.—Section 454(4)(A)(i) (42 U.S.C. 654(4)(A)(i)) is amended—

(1) by striking "or" before "(III)"; and

(2) by inserting "or (IV) cooperation is required pursuant to section 6(l)(1) of the Food Stamp Act of 1977 (7 U.S.C. 2015(l)(1))," after "title XIX,".

(b) CONFORMING AMENDMENTS.—Section 454(29) (42 U.S.C. 654(29)) is amended—

(1) in subparagraph (A)—

(A) in the matter preceding clause (i), by striking "part A of this title or the State program under title XIX" and inserting "part A, the State program under part E, the State program under title XIX, or the food stamp program, as defined under section 3(h) of the Food Stamp Act of 1977 (7 U.S.C. 2012(h))."; and

(B) by striking clauses (i) and (ii) and all that follows through the semicolon and inserting the following:

"(i) in the case of the State program funded under part A, the State program under part E, or the State program under title XIX shall, at the option of the State, be defined, taking into account the best interests of the child, and applied in each case, by the State agency administering such program; and

"(ii) in the case of the food stamp program, as defined under section 3(h) of the Food Stamp Act of 1977 (7 U.S.C. 2012(h)), shall be defined and applied in each case under that program in accordance with section 6(l)(2) of the Food Stamp Act of 1977 (7 U.S.C. 2015(l)(2));";

(2) in subparagraph (D), by striking "or the State program under title XIX" and inserting "the State program under part E, the State program under title XIX, or the food stamp program, as defined under section 3(h) of the Food Stamp Act of 1977 (7 U.S.C. 2012(h))"; and

(3) in subparagraph (E), by striking "individual," and all that follows through "XIX," and inserting "individual and the State agency administering the State program funded under part A, the State agency administering the State program under part E, the State agency administering the State program under title XIX, or the State agency administering the food stamp program, as defined under section 3(h) of the Food Stamp Act of 1977 (7 U.S.C. 2012(h)),".

SEC. 5953. DATE OF COLLECTION OF SUPPORT.

Section 454B(c)(1) (42 U.S.C. 654B(c)(1)) is amended by adding at the end the following: "The date of collection for amounts collected and distributed under this part is the date of receipt by the State disbursement unit, except that if current support is withheld by an employer in the month when due and is received by the State disbursement unit in a month other than the month when due, the date of withholding may be deemed to be the date of collection.".

SEC. 5954. ADMINISTRATIVE ENFORCEMENT IN INTERSTATE CASES.

(a) PROCEDURES.—Section 466(a)(14) (42 U.S.C. 666(a)(14)) is amended to read as follows:

"(14) HIGH-VOLUME, AUTOMATED ADMINISTRATIVE ENFORCEMENT IN INTERSTATE CASES.—

"(A) IN GENERAL.—Procedures under which—

"(i) the State shall use high-volume automated administrative enforcement, to the same extent as used for intrastate cases, in response to a request made by another State to enforce support orders, and shall promptly report the results of such enforcement procedure to the requesting State;

"(ii) the State may, by electronic or other means, transmit to another State a request for assistance in enforcing support orders through high-volume, automated administrative enforcement, which request—

"(I) shall include such information as will enable the State to which the request is transmitted to compare the information about the cases to the information in the data bases of the State; and

"(II) shall constitute a certification by the requesting State—

"(aa) of the amount of support under an order the payment of which is in arrears; and

"(bb) that the requesting State has complied with all procedural due process requirements applicable to each case;

"(iii) if the State provides assistance to another State pursuant to this paragraph with respect to a case, neither State shall consider the case to be transferred to the caseload of such other State; and

"(iv) the State shall maintain records of—

"(I) the number of such requests for assistance received by the State;

"(II) the number of cases for which the State collected support in response to such a request; and

"(III) the amount of such collected support.

"(B) HIGH-VOLUME AUTOMATED ADMINISTRATIVE ENFORCEMENT.—In this part, the term 'high-volume automated administrative enforcement' means the use of automatic data processing to search various State data bases, including license records, employment service data, and State new hire registries, to determine whether information is available regarding a parent who owes a child support obligation.".

(b) INCENTIVE PAYMENTS.—Section 458(d) (42 U.S.C. 658(d)) is amended by inserting ", including amounts collected under section 466(a)(14)," after "another State".

SEC. 5955. WORK ORDERS FOR ARREARAGES.

Section 466(a)(15) (42 U.S.C. 666(a)(15)) is amended to read as follows:

"(15) PROCEDURES TO ENSURE THAT PERSONS OWING OVERDUE SUPPORT WORK OR HAVE A PLAN FOR PAYMENT OF SUCH SUPPORT.—Procedures under which the State has the authority, in any case in which an individual owes overdue support with respect to a child receiving assistance under a State program funded under part A, to issue an order or to request that

a court or an administrative process established pursuant to State law issue an order that requires the individual to—

"(A) pay such support in accordance with a plan approved by the court, or, at the option of the State, a plan approved by the State agency administering the State program under this part; or

"(B) if the individual is subject to such a plan and is not incapacitated, participate in such work activities (as defined in section 407(d)) as the court, or, at the option of the State, the State agency administering the State program under this part, deems appropriate.".

SEC. 5956. ADDITIONAL TECHNICAL STATE PLAN AMENDMENTS.

Section 454 (42 U.S.C. 654) is amended—

(1) in paragraph (8)—

(A) in the matter preceding subparagraph (A)—

(i) by striking "noncustodial"; and

(ii) by inserting ", for the purpose of establishing parentage, establishing, setting the amount of, modifying, or enforcing child support obligations, or making or enforcing a child custody or visitation determination, as defined in section 463(d)(1)" after "provide that";

(B) in subparagraph (A), by striking the comma and inserting a semicolon;

(C) in subparagraph (B), by striking the semicolon and inserting a comma; and

(D) by inserting after subparagraph (B), the following flush language:

"and shall, subject to the privacy safeguards required under paragraph (26), disclose only the information described in sections 453 and 463 to the authorized persons specified in such sections for the purposes specified in such sections;";

(2) in paragraph (17)—

(A) by striking "in the case of a State which has" and inserting "provide that the State will have"; and

(B) by inserting "and" after "section 453,"; and

(3) in paragraph (26)—

(A) in the matter preceding subparagraph (A), by striking "will";

(B) in subparagraph (A)—

(i) by inserting ", modify," after "establish", the second place it appears; and

(ii) by inserting ", or to make or enforce a child custody determination" after "support";

(C) in subparagraph (B)—

(i) by inserting "or the child" after "1 party";

(ii) by inserting "or the child" after "former party"; and

(iii) by striking "and" at the end;

(D) in subparagraph (C)—

(i) by inserting "or the child" after "1 party";

(ii) by striking "another party" and inserting "another person";

(iii) by inserting "to that person" after "release of the information"; and

(iv) by striking "former party" and inserting "party or the child"; and

(E) by adding at the end the following:

"(D) in cases in which the prohibitions under subparagraphs (B) and (C) apply, the requirement to notify the Secretary, for purposes of section 453(b)(2), that the State has reasonable evidence of domestic violence or child abuse against a party or the child and that the disclosure of such information could be harmful to the party or the child; and

"(E) procedures providing that when the Secretary discloses information about a parent or child to a State court or an agent of a State court described in section 453(c)(2) or 463(d)(2)(B), and advises that court or agent that the Secretary has been notified that there is reasonable evidence of domestic violence or child abuse pursuant to section 453(b)(2), the court shall determine whether disclosure to any other person of information received from the Secretary could be harmful to the parent or child and, if the court determines that disclosure to any other person could be harmful, the court and its agents shall not make any such disclosure;".

SEC. 5957. FEDERAL CASE REGISTRY OF CHILD SUPPORT ORDERS.

Section 453(h) (42 U.S.C. 653(h)) is amended—

(1) in paragraph (1), by inserting "and order" after "with respect to each case"; and

(2) in paragraph (2)—

(A) in the heading, by inserting "AND ORDER" after "CASE";

(B) by inserting "or an order" after "with respect to a case" and

(C) by inserting "or order" after "and the State or States which have the case".

SEC. 5958. FULL FAITH AND CREDIT FOR CHILD SUPPORT ORDERS.

Section 1738B(f) of title 28, United States Code, is amended—

(1) in paragraph (4), by striking "a court may" and all that follows and inserting "a court having jurisdiction over the parties shall issue a child support order, which must be recognized."; and

(2) in paragraph (5), by inserting "under subsection (d)" after "jurisdiction".

SEC. 5959. DEVELOPMENT COSTS OF AUTOMATED SYSTEMS.

(a) DEFINITION OF STATE.—Section 455(a)(3)(B) (42 U.S.C. 655(a)(3)(B)) is amended—

(1) in clause (i)—

(A) by inserting "or system described in clause (iii)" after "each State"; and

(B) by inserting "or system" after "the State"; and

(2) by adding at the end the following:

"(iii) For purposes of clause (i), a system described in this clause is a system that has been approved by the Secretary to receive enhanced funding pursuant to the Family Support Act of

1988 (Public Law 100–485; 102 Stat. 2343) for the purpose of developing a system that meets the requirements of sections 454(16) (as in effect on and after September 30, 1995) and 454A, including systems that have received funding for such purpose pursuant to a waiver under section 1115(a).".

(b) TEMPORARY LIMITATION ON PAYMENTS.—Section 344(b)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (42 U.S.C. 655 note) is amended—

(1) in subparagraph (B)—

(A) by inserting "or a system described in subparagraph (C)" after "to a State"; and

(B) by inserting "or system" after "for the State"; and

(2) in subparagraph (C), by striking "Act," and all that follows and inserting "Act, and among systems that have been approved by the Secretary to receive enhanced funding pursuant to the Family Support Act of 1988 (Public Law 100–485; 102 Stat. 2343) for the purpose of developing a system that meets the requirements of sections 454(16) (as in effect on and after September 30, 1995) and 454A, including systems that have received funding for such purpose pursuant to a waiver under section 1115(a), which shall take into account—

"(i) the relative size of such State and system caseloads under part D of title IV of the Social Security Act; and

"(ii) the level of automation needed to meet the automated data processing requirements of such part.".

SEC. 5960. ADDITIONAL TECHNICAL AMENDMENTS.

(a) ELIMINATION OF SURPLUSAGE.—Section 466(c)(1)(F) (42 U.S.C. 666(c)(1)(F)) is amended by striking "of section 466".

(b) CORRECTION OF AMBIGUOUS AMENDMENT.—Section 344(a)(1)(F) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2234) is amended by inserting "the first place such term appears" before "and all that follows".

(c) CORRECTION OF ERRONEOUSLY DRAFTED PROVISION.—Section 215 of the Department of Health and Human Services Appropriations Act, 1997, (as contained in section 101(e) of the Omnibus Consolidated Appropriations Act, 1997) is amended to read as follows:

"SEC. 215. Sections 452(j) and 453(o) of the Social Security Act (42 U.S.C. 652(j) and 653(o)), as amended by section 345 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2237) are each amended by striking 'section 457(a)' and inserting 'a plan approved under this part'. Amounts available under such sections 452(j) and 453(o) shall be calculated as though the amendments made by this section were effective October 1, 1995.".

(d) ELIMINATION OF SURPLUSAGE.—Section 456(a)(2)(B) (42 U.S.C. 656(a)(2)(B)) is amended by striking ", and" and inserting a period.

(e) CORRECTION OF DATE.—Section 466(a)(1)(B) (42 U.S.C. 666(a)(1)(B)) is amended by striking "October 1, 1996" and inserting "January 1, 1994".

SEC. 5961. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in subsection (b), the amendments made by this chapter shall take effect as if included in the enactment of title III of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2105).

(b) EXCEPTION.—The amendments made by section 5936(b)(2) shall take effect as if the amendments had been included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2112).

CHAPTER 4—RESTRICTING WELFARE AND PUBLIC BENEFITS FOR ALIENS

Subchapter A—Eligibility for Federal Benefits

SEC. 5965. ALIEN ELIGIBILITY FOR FEDERAL BENEFITS: LIMITED APPLICATION TO MEDICARE AND BENEFITS UNDER THE RAILROAD RETIREMENT ACT.

(a) LIMITED APPLICATION TO MEDICARE.—Section 401(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1611(b)) is amended by adding at the end the following:

"(3) Subsection (a) shall not apply to any benefit payable under title XVIII of the Social Security Act (relating to the medicare program) to an alien who is lawfully present in the United States as determined by the Attorney General and, with respect to benefits payable under part A of such title, who was authorized to be employed with respect to any wages attributable to employment which are counted for purposes of eligibility for such benefits.".

(b) LIMITED APPLICATION TO BENEFITS UNDER THE RAILROAD RETIREMENT ACT.—Section 401(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1611(b)) (as amended by subsection (a)) is amended by inserting at the end the following:

"(4) Subsection (a) shall not apply to any benefit payable under the Railroad Retirement Act of 1974 or the Railroad Unemployment Insurance Act to an alien who is lawfully present in the United States as determined by the Attorney General or to an alien residing outside the United States.".

SEC. 5966. EXCEPTIONS TO BENEFIT LIMITATIONS: CORRECTIONS TO REFERENCE CONCERNING ALIENS WHOSE DEPORTATION IS WITHHELD.

Sections 402(a)(2)(A)(i)(III), 402(a)(2)(A)(ii)(III), 402(b)(2)(A)(iii), 403(b)(1)(C), 412(b)(1)(C), and 431(b)(5) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A)(iii), 1612(b)(2)(A)(iii), 1613(b)(1)(C), 1622(b)(1)(C), and 1641(b)(5)) are each amended by striking "section 243(h) of such Act" each place it appears and inserting "section 243(h) of such Act (as in effect immediately before the effective date of section 307 of division C of Public Law 104–208) or section 241(b)(3) of such Act (as amended by section 305(a) of division C of Public Law 104–208)".

SEC. 5967. VETERANS EXCEPTION: APPLICATION OF MINIMUM ACTIVE DUTY SERVICE REQUIREMENT; EXTENSION TO UNREMARRIED SURVIVING SPOUSE; EXPANDED DEFINITION OF VETERAN.

(a) APPLICATION OF MINIMUM ACTIVE DUTY SERVICE REQUIREMENT.—Sections 402(a)(2)(C)(i), 402(b)(2)(C)(i), 403(b)(2)(A), and 412(b)(3)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(C)(i), 1612(b)(2)(C)(i), 1613(b)(2)(A), and 1622(b)(3)(A)) are each amended by inserting "and who fulfills the minimum active-duty service requirements of section 5303A(d) of title 38, United States Code" after "alienage".

(b) EXCEPTION APPLICABLE TO UNREMARRIED SURVIVING SPOUSE.—Section 402(a)(2)(C)(iii), 402(b)(2)(C)(iii), 403(b)(2)(C), and 412(b)(3)(C) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(C)(iii), 1612(b)(2)(C)(iii), 1613(b)(2)(C), and 1622(b)(3)(C)) are each amended by inserting before the period "or the unremarried surviving spouse of an individual described in clause (i) or (ii) who is deceased if the marriage fulfills the requirements of section 1304 of title 38, United States Code".

(c) EXPANDED DEFINITION OF VETERAN.—Sections 402(a)(2)(C)(i), 402(b)(2)(C)(i), 403(b)(2)(A), and 412(b)(3)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(C)(i), 1612(b)(2)(C)(i), 1613(b)(2)(A), and 1622(b)(3)(A)) are each amended by inserting ", 1101, or 1301, or as described in section 107" after "section 101".

SEC. 5968. CORRECTION OF REFERENCE CONCERNING CUBAN AND HAITIAN ENTRANTS.

Section 403(d) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613(d)) is amended—

(1) by striking "section 501 of the Refugee" and insert "section 501(a) of the Refugee"; and

(2) by striking "section 501(e)(2)" and inserting "section 501(e)".

SEC. 5969. NOTIFICATION CONCERNING ALIENS NOT LAWFULLY PRESENT: CORRECTION OF TERMINOLOGY.

Section 1631(e)(9) of the Social Security Act (42 U.S.C. 1383(e)(9)) and section 27 of the United States Housing Act of 1937, as added by section 404 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, are each amended by striking "unlawfully in the United States" each place it appears and inserting "not lawfully present in the United States".

SEC. 5970. FREELY ASSOCIATED STATES: CONTRACTS AND LICENSES.

Sections 401(c)(2)(A) and 411(c)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1611(c)(2)(A) and 1621(c)(2)(A)) are each amended by inserting before the semicolon at the end ", or to a citizen of a freely associated state, if section 141 of the applicable compact of free association approved in Public Law 99–239 or 99–658 (or a successor provision) is in effect".

SEC. 5971. CONGRESSIONAL STATEMENT REGARDING BENEFITS FOR HMONG AND OTHER HIGHLAND LAO VETERANS.

(a) FINDINGS.—The Congress makes the following findings:

(1) Hmong and other Highland Lao tribal peoples were recruited, armed, trained, and funded for military operations by the United States Department of Defense, Central Intelligence Agency, Department of State, and Agency for International Development to further United States national security interests during the Vietnam conflict.

(2) Hmong and other Highland Lao tribal forces sacrificed their own lives and saved the lives of American military personnel by rescuing downed American pilots and aircrews and by engaging and successfully fighting North Vietnamese troops.

(3) Thousands of Hmong and other Highland Lao veterans who fought in special guerilla units on behalf of the United States during the Vietnam conflict, along with their families, have been lawfully admitted to the United States in recent years.

(4) The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193), the new national welfare reform law, restricts certain welfare benefits for noncitizens of the United States and the exceptions for noncitizen veterans of the Armed Forces of the United States do not extend to Hmong veterans of the Vietnam conflict era, making Hmong veterans and their families receiving certain welfare benefits subject to restrictions despite their military service on behalf of the United States.

(b) CONGRESSIONAL STATEMENT.—It is the sense of the Congress that Hmong and other Highland Lao veterans who fought on behalf of the Armed Forces of the United States during the Vietnam conflict and have lawfully been admitted to the United States for permanent residence should be considered veterans for purposes of continuing certain welfare benefits consistent with the exceptions provided other noncitizen veterans under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

Subchapter B—General Provisions

SEC. 5972. DETERMINATION OF TREATMENT OF BATTERED ALIENS AS QUALIFIED ALIENS; INCLUSION OF ALIEN CHILD OF BATTERED PARENT AS QUALIFIED ALIEN.

(a) DETERMINATION OF STATUS BY AGENCY PROVIDING BENEFITS.—Section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) is amended in subsections (c)(1)(A) and (c)(2)(A) by striking "Attorney General, which opinion is not subject to review by any court)" each place it appears and inserting "agency providing such benefits)".

(b) GUIDANCE ISSUED BY ATTORNEY GENERAL.—Section 431(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(c)) is amended by adding at the end the following new undesignated paragraph:

"After consultation with the Secretaries of Health and Human Services, Agriculture, and Housing and Urban Development, the Commissioner of Social Security, and with the heads of such Federal agencies administering benefits as the Attorney General considers appropriate, the Attorney General shall issue guidance (in the Attorney General's sole and unreviewable discretion) for pur-

poses of this subsection and section 421(f), concerning the meaning of the terms 'battery' and 'extreme cruelty', and the standards and methods to be used for determining whether a substantial connection exists between battery or cruelty suffered and an individual's need for benefits under a specific Federal, State, or local program.".

(c) INCLUSION OF ALIEN CHILD OF BATTERED PARENT AS QUALIFIED ALIEN.—Section 431(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(c)) is amended—

(1) at the end of paragraph (1)(B)(iv) by striking "or";

(2) at the end of paragraph (2)(B) by striking the period and inserting "; or"; and

(3) by inserting after paragraph (2)(B) and before the last sentence of such subsection the following new paragraph:

"(3) an alien child who—

"(A) resides in the same household as a parent who has been battered or subjected to extreme cruelty in the United States by that parent's spouse or by a member of the spouse's family residing in the same household as the parent and the spouse consented or acquiesced to such battery or cruelty, but only if (in the opinion of the agency providing such benefits) there is a substantial connection between such battery or cruelty and the need for the benefits to be provided; and

"(B) who meets the requirement of subparagraph (B) of paragraph (1).".

(d) INCLUSION OF ALIEN CHILD OF BATTERED PARENT UNDER SPECIAL RULE FOR ATTRIBUTION OF INCOME.—Section 421(f)(1)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1631(f)(1)(A)) is amended—

(1) at the end of clause (i) by striking "or"; and

(2) by striking "and the battery or cruelty described in clause (i) or (ii)" and inserting "or (iii) the alien is a child whose parent (who resides in the same household as the alien child) has been battered or subjected to extreme cruelty in the United States by that parent's spouse, or by a member of the spouse's family residing in the same household as the parent and the spouse consented to, or acquiesced in, such battery or cruelty, and the battery or cruelty described in clause (i), (ii), or (iii)".

SEC. 5973. VERIFICATION OF ELIGIBILITY FOR BENEFITS.

(a) REGULATIONS AND GUIDANCE.—Section 432(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1642(a)) is amended—

(1) by inserting at the end of paragraph (1) the following: "Not later than 90 days after the date of the enactment of the Welfare Reform Technical Corrections Act of 1997, the Attorney General of the United States, after consultation with the Secretary of Health and Human Services, shall issue interim verification guidance."; and

(2) by adding after paragraph (2) the following new paragraph:

"(3) Not later than 90 days after the date of the enactment of the Welfare Reform Technical Corrections Act of 1997, the Attorney

General shall promulgate regulations which set forth the procedures by which a State or local government can verify whether an alien applying for a State or local public benefit is a qualified alien, a nonimmigrant under the Immigration and Nationality Act, or an alien paroled into the United States under section 212(d)(5) of the Immigration and Nationality Act for less than 1 year, for purposes of determining whether the alien is ineligible for benefits under section 411 of this Act.".

(b) DISCLOSURE OF INFORMATION FOR VERIFICATION.—Section 384(b) of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (division C of Public Law 104–208) is amended by adding after paragraph (4) the following new paragraph:

"(5) The Attorney General is authorized to disclose information, to Federal, State, and local public and private agencies providing benefits, to be used solely in making determinations of eligibility for benefits pursuant to section 431(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.".

SEC. 5974. QUALIFYING QUARTERS: DISCLOSURE OF QUARTERS OF COVERAGE INFORMATION; CORRECTION TO ASSURE THAT CREDITING APPLIES TO ALL QUARTERS EARNED BY PARENTS BEFORE CHILD IS 18.

(a) DISCLOSURE OF QUARTERS OF COVERAGE INFORMATION.—Section 435 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1645) is amended by adding at the end the following: "Notwithstanding section 6103 of the Internal Revenue Code of 1986, the Commissioner of Social Security is authorized to disclose quarters of coverage information concerning an alien and an alien's spouse or parents to a government agency for the purposes of this title.".

(b) CORRECTION TO ASSURE THAT CREDITING APPLIES TO ALL QUARTERS EARNED BY PARENTS BEFORE CHILD IS 18.—Section 435(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1645(1)) is amended by striking "while the alien was under age 18," and inserting "before the date on which the alien attains age 18,".

SEC. 5975. STATUTORY CONSTRUCTION: BENEFIT ELIGIBILITY LIMITATIONS APPLICABLE ONLY WITH RESPECT TO ALIENS PRESENT IN THE UNITED STATES.

Section 433 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1643) is amended—

(1) by redesignated subsections (b) and (c) as subsections (c) and (d); and

(2) by adding after subsection (a) the following new subsection:

"(b) BENEFIT ELIGIBILITY LIMITATIONS APPLICABLE ONLY WITH RESPECT TO ALIENS PRESENT IN THE UNITED STATES.—Notwithstanding any other provision of this title, the limitations on eligibility for benefits under this title shall not apply to eligibility for benefits of aliens who are not residing, or present, in the United States with respect to—

"(1) wages, pensions, annuities, and other earned payments to which an alien is entitled resulting from employment by, or on behalf of, a Federal, State, or local government agen-

cy which was not prohibited during the period of such employment or service under section 274A or other applicable provision of the Immigration and Nationality Act; or

"(2) benefits under laws administered by the Secretary of Veterans Affairs.".

Subchapter C—Miscellaneous Clerical and Technical Amendments; Effective Date

SEC. 5976. CORRECTING MISCELLANEOUS CLERICAL AND TECHNICAL ERRORS.

(a) INFORMATION REPORTING UNDER TITLE IV OF THE SOCIAL SECURITY ACT.—Effective July 1, 1997, section 408 of the Social Security Act (42 U.S.C. 608), as amended by section 5903, and as in effect pursuant to section 116 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and as amended by section 5906(e) of this Act, is amended by adding at the end the following new subsection:

"(f) STATE REQUIRED TO PROVIDE CERTAIN INFORMATION.—Each State to which a grant is made under section 403 shall, at least 4 times annually and upon request of the Immigration and Naturalization Service, furnish the Immigration and Naturalization Service with the name and address of, and other identifying information on, any individual who the State knows is not lawfully present in the United States.".

(b) MISCELLANEOUS CLERICAL AND TECHNICAL CORRECTIONS.—

(1) Section 411(c)(3) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1621(c)(3)) is amended by striking "4001(c)" and inserting "401(c)".

(2) Section 422(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1632(a)) is amended by striking "benefits (as defined in section 412(c))," and inserting "benefits,".

(3) Section 412(b)(1)(C) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1622(b)(1)(C)) is amended by striking "with-holding" and inserting "withholding".

(4) The subtitle heading for subtitle D of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended to read as follows:

"Subtitle D—General Provisions".

(5) The subtitle heading for subtitle F of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended to read as follows:

"Subtitle F—Earned Income Credit Denied to Unauthorized Employees".

(6) Section 431(c)(2)(B) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(c)(2)(B)) is amended by striking "clause (ii) of subparagraph (A)" and inserting "subparagraph (B) of paragraph (1)".

(7) Section 431(c)(1)(B) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(c)(1)(B)) is amended—

(A) in clause (iii) by striking ", or" and inserting "(as in effect prior to April 1, 1997),"; and

(B) by adding after clause (iv) the following new clause:

"(v) cancellation of removal pursuant to section 240A(b)(2) of such Act;".

SEC. 5977. EFFECTIVE DATE.

Except as otherwise provided, the amendments made by this chapter shall be effective as if included in the enactment of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

CHAPTER 5—CHILD PROTECTION

SEC. 5981. CONFORMING AND TECHNICAL AMENDMENTS RELATING TO CHILD PROTECTION.

(a) METHODS PERMITTED FOR CONDUCT OF STUDY OF CHILD WELFARE.—Section 429A(a) (42 U.S.C. 628b(a)) is amended by inserting "(directly, or by grant, contract, or interagency agreement)" after "conduct".

(b) REDESIGNATION OF PARAGRAPH.—Section 471(a) (42 U.S.C. 671(a)) is amended—

(1) by striking "and" at the end of paragraph (17);

(2) by striking the period at the end of paragraph (18) (as added by section 1808(a) of the Small Business Job Protection Act of 1996 (Public Law 104–188; 110 Stat. 1903)) and inserting "; and"; and

(3) by redesignating paragraph (18) (as added by section 505(3) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2278)) as paragraph (19).

SEC. 5982. ADDITIONAL TECHNICAL AMENDMENTS RELATING TO CHILD PROTECTION.

(a) PART B AMENDMENTS.—

(1) IN GENERAL.—Part B of title IV (42 U.S.C. 620-635) is amended—

(A) in section 422(b)—

(i) by striking the period at the end of the paragraph (9) (as added by section 554(3) of the Improving America's Schools Act of 1994 (Public Law 103–382; 108 Stat. 4057)) and inserting a semicolon;

(ii) by redesignating paragraph (10) as paragraph (11); and

(iii) by redesignating paragraph (9), as added by section 202(a)(3) of the Social Security Act Amendments of 1994 (Public Law 103–432, 108 Stat. 4453), as paragraph (10);

(B) in sections 424(b) and 425(a), by striking "422(b)(9)" each place it appears and inserting "422(b)(10)"; and

(C) by transferring section 429A (as added by section 503 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2277)) to the end of subpart 1.

(2) CLARIFICATION OF CONFLICTING AMENDMENTS.—Section 204(a)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432; 108 Stat. 4456) is amended by inserting "(as added by such section 202(a))" before "and inserting".

(b) PART E AMENDMENTS.—Section 472(d) (42 U.S.C. 672(d)) is amended by striking "422(b)(9)" and inserting "422(b)(10)".

SEC. 5983. EFFECTIVE DATE.

The amendments made by this chapter shall take effect as if included in the enactment of title V of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2277).

CHAPTER 6—CHILD CARE

SEC. 5985. CONFORMING AND TECHNICAL AMENDMENTS RELATING TO CHILD CARE.

(a) FUNDING.—Section 418(a) (42 U.S.C. 618(a)) is amended—

(1) in paragraph (1)—

(A) in the matter preceding subparagraph (A), by inserting "the greater of" after "equal to";

(B) in subparagraph (A)—

(i) by striking "the sum of";

(ii) by striking "amounts expended" and inserting "expenditures"; and

(iii) by striking "section—" and all that follows and inserting "subsections (g) and (i) of section 402 (as in effect before October 1, 1995); or";

(C) in subparagraph (B)—

(i) by striking "sections" and inserting "subsections"; and

(ii) by striking the semicolon at the end and inserting a period; and

(D) in the matter following subparagraph (B), by striking "whichever is greater."; and

(2) in paragraph (2)—

(A) by striking subparagraph (B) and inserting the following:

"(B) ALLOTMENTS TO STATES.—The total amount available for payments to States under this paragraph, as determined under subparagraph (A), shall be allotted among the States based on the formula used for determining the amount of Federal payments to each State under section 403(n) (as in effect before October 1, 1995).";

(B) by striking subparagraph (C) and inserting the following:

"(C) FEDERAL MATCHING OF STATE EXPENDITURES EXCEEDING HISTORICAL EXPENDITURES.—The Secretary shall pay to each eligible State for a fiscal year an amount equal to the lesser of the State's allotment under subparagraph (B) or the Federal medical assistance percentage for the State for the fiscal year (as defined in section 1905(b), as such section was in effect on September 30, 1995) of so much of the State's expenditures for child care in that fiscal year as exceed the total amount of expenditures by the State (including expenditures from amounts made available from Federal funds) in fiscal year 1994 or 1995 (whichever is greater) for the programs described in paragraph (1)(A)."; and

(C) in subparagraph (D)(i)—

(i) by striking "amounts under any grant awarded" and inserting "any amounts allotted"; and

(ii) by striking "the grant is made" and inserting "such amounts are allotted".

(b) DATA USED TO DETERMINE HISTORIC STATE EXPENDITURES.—Section 418(a) (42 U.S.C. 618(a)), is amended by adding at the end the following:

"(5) DATA USED TO DETERMINE STATE AND FEDERAL SHARES OF EXPENDITURES.—In making the determinations concerning expenditures required under paragraphs (1) and (2)(C), the Secretary shall use information that was reported by the State on ACF Form 231 and available as of the applicable dates specified in clauses (i)(I), (ii), and (iii)(III) of section 403(a)(1)(D).".

(c) DEFINITION OF STATE.—Section 418(d) (42 U.S.C. 618(d)) is amended by striking "or" and inserting "and".

SEC. 5986. ADDITIONAL CONFORMING AND TECHNICAL AMENDMENTS.

The Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.) is amended—

(1) in section 658E(c)(2)(E)(ii), by striking "tribal organization" and inserting "tribal organizations";

(2) in section 658K(a)—

(A) in paragraph (1)—

(i) in subparagraph (B)—

(I) by striking clause (iv) and inserting the following:

"(iv) whether the head of the family unit is a single parent;";

(II) in clause (v)—

(aa) in the matter preceding subclause (I), by striking "including the amount obtained

from (and separately identified)—" and inserting "including—"; and

(bb) by striking subclause (II) and inserting the following:

"(II) cash or other assistance under—

"(aa) the temporary assistance for needy families program under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.); and

"(bb) a State program for which State spending is counted toward the maintenance of effort requirement under section 409(a)(7) of the Social Security Act (42 U.S.C. 609(a)(7));"; and

(III) in clause (x), by striking "week" and inserting "month"; and

(ii) by striking subparagraph (D) and inserting the following:

"(D) USE OF SAMPLES.—

"(i) AUTHORITY.—A State may comply with the requirement to collect the information described in subparagraph (B) through the use of disaggregated case record information on a sample of families selected through the use of scientifically acceptable sampling methods approved by the Secretary.

"(ii) SAMPLING AND OTHER METHODS.—The Secretary shall provide the States with such case sampling plans and data collection procedures as the Secretary deems necessary to produce statistically valid samples of the information described in subparagraph (B). The Secretary may develop and implement procedures for verifying the quality of data submitted by the States."; and

(B) in paragraph (2)—

(i) in the heading, by striking "BIANNUAL" and inserting "ANNUAL"; and

(ii) by striking "6" and inserting "12";

(3) in section 658L, by striking "1997" and inserting "1998";

(4) in section 658O(c)(6)(C), by striking "(A)" and inserting "(B)"; and

(5) in section 658P(13), by striking "or" and inserting "and".

SEC. 5987. REPEALS.

(a) CHILD DEVELOPMENT ASSOCIATE SCHOLARSHIP ASSISTANCE ACT OF 1985.—Title VI of the Human Services Reauthorization Act of 1986 (42 U.S.C. 10901–10905) is repealed.

(b) STATE DEPENDENT CARE DEVELOPMENT GRANTS ACT.—Subchapter E of chapter 8 of subtitle A of title VI of the Omnibus Budget Reconciliation Act of 1981 (42 U.S.C. 9871–9877) is repealed.

(c) PROGRAMS OF NATIONAL SIGNIFICANCE.—Title X of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8001 et seq.) is amended—

(1) in section 10413(a), by striking paragraph (4);

(2) in section 10963(b)(2), by striking subparagraph (G); and

(3) in section 10974(a)(6), by striking subparagraph (G).

(d) NATIVE HAWAIIAN FAMILY-BASED EDUCATION CENTERS.—Section 9205 of the Native Hawaiian Education Act (20 U.S.C. 7905) is repealed.

SEC. 5988. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided in subsection (b), this chapter and the amendments made by this chapter shall take effect as if included in the enactment of title VI of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2278).

(b) EXCEPTIONS.—The amendment made by section 5985(a)(2)(B) and the repeal made by section 5987(d) shall each take effect on October 1, 1997.

CHAPTER 7—ERISA AMENDMENTS RELATING TO MEDICAL CHILD SUPPORT ORDERS

SEC. 5991. AMENDMENTS RELATING TO SECTION 303 OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996.

(a) PRIVACY SAFEGUARDS FOR MEDICAL CHILD SUPPORT ORDERS.—Section 609(a)(3)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(a)(3)(A)) is amended by adding at the end the following: "except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such alternate recipient,".

(b) PAYMENT TO STATE OFFICIAL TREATED AS SATISFACTION OF PLAN'S OBLIGATION.—Section 609(a) of such Act (29 U.S.C. 1169(a)) is amended by adding at the end the following new paragraph:

"(9) PAYMENT TO STATE OFFICIAL TREATED AS SATISFACTION OF PLAN'S OBLIGATION TO MAKE PAYMENT TO ALTERNATE RECIPIENT.—Payment of benefits by a group health plan to an official of a State or a political subdivision thereof who is named in a qualified medical child support order in lieu of the alternate recipient, pursuant to paragraph (3)(A), shall be treated, for purposes of this title, as payment of benefits to the alternate recipient.".

(c) EFFECTIVE DATE.—The amendments made by this section shall be apply with respect to medical child support orders issued on or after the date of the enactment of this Act.

SEC. 5992. AMENDMENT RELATING TO SECTION 381 OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996.

(a) CLARIFICATION OF EFFECT OF ADMINISTRATIVE NOTICES.—Section 609(a)(2)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(a)(2)(B)) is amended by adding at the end the following new sentence: "For purposes of this subparagraph, an administrative notice which is issued pursuant to an administrative process referred to in subclause (II) of the preceding sentence and which has the effect of an order described in clause

(i) or (ii) of the preceding sentence shall be treated as such an order.".

(b) EFFECTIVE DATE.—The amendment made by this section shall be effective as if included in the enactment of section 381 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2257).

SEC. 5993. AMENDMENTS RELATING TO SECTION 382 OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996.

(a) ELIMINATION OF REQUIREMENT THAT ORDERS SPECIFY AFFECTED PLANS.—Section 609(a)(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(a)(3)) is amended—

(1) in subparagraph (C), by striking ", and" and inserting a period; and

(2) by striking subparagraph (D).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to medical child support orders issued on or after the date of the enactment of this Act.

○

41-420 (484)