

108TH CONGRESS
1ST SESSION

H. R. 26

To amend title XVIII of the Social Security Act to revise and improve payments to providers of services under the Medicare Program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 7, 2003

Mr. CARDIN introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XVIII of the Social Security Act to revise and improve payments to providers of services under the Medicare Program, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECU-**
4 **RITY ACT; REFERENCES TO BIPA AND SEC-**
5 **RETARY; TABLE OF CONTENTS.**

6 (a) SHORT TITLE.—This Act may be cited as the
7 “Medicare Payment Restoration and Benefits Improve-
8 ment Act of 2003”.

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

7 (c) BIPA; SECRETARY.—In this Act:

8 (1) BIPA.—The term “BIPA” means the
 9 Medicare, Medicaid, and SCHIP Benefits Improve-
 10 ment and Protection Act of 2000, as enacted into
 11 law by section 1(a)(6) of Public Law 106–554.

12 (2) SECRETARY.—The term “Secretary” means
 13 the Secretary of Health and Human Services.

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

Sec. 1. Short title; amendments to Social Security Act; references to BIPA and Secretary; table of contents.

TITLE I—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

Sec. 101. Revision of acute care hospital payment updates.

Sec. 102. 2-year phased-in increase in the standardized amount in rural and small urban areas to achieve a single, uniform standardized amount.

Sec. 103. 3-year increase in level of adjustment for indirect costs of medical education (IME).

Sec. 104. More frequent update in weights used in hospital market basket.

Sec. 105. Relief for certain non-teaching hospitals.

Sec. 106. Enhanced disproportionate share hospital (DSH) treatment for rural hospitals and urban hospitals with fewer than 100 beds.

Sec. 107. Recognition of new medical technologies under inpatient hospital PPS.

Sec. 108. Improvements to critical access hospital program.

Sec. 109. Phase-in of Federal rate for hospitals in Puerto Rico.

Sec. 110. GAO study on improving the hospital wage index.

Subtitle B—Skilled Nursing Facility Services

Sec. 121. Payment for covered skilled nursing facility services.

Subtitle C—Hospice Care

- Sec. 131. Coverage of hospice consultation services.
 Sec. 132. 10 percent increase in payment for hospice care furnished in a frontier area.
 Sec. 133. Rural hospice demonstration project.

TITLE II—PROVISIONS RELATING TO PART B

Subtitle A—Physicians' Services

- Sec. 201. Revision of updates for physicians' services.
 Sec. 202. Studies on access to physicians' services.
 Sec. 203. MedPAC report on payment for physicians' services.
 Sec. 204. 1-year extension of treatment of certain physician pathology services under medicare.
 Sec. 205. Physician fee schedule wage index revision.

Subtitle B—Provisions Relating to Preventive Benefits

- Sec. 211. Coverage of an initial preventive physical examination.
 Sec. 212. Coverage of cholesterol and blood lipid screening.
 Sec. 213. Improved payment for certain mammography services.

Subtitle C—Hospital Outpatient Department Services

Sec. 221. Adjustment to limit decline in payment.

Subtitle D—Other Services

- Sec. 231. Adjustments to local fee schedules for clinical laboratory tests for improvement in cervical cancer detection.
 Sec. 232. Payment for ambulance services.
 Sec. 233. 2-year extension of moratorium on therapy caps; provisions relating to reports.
 Sec. 234. Renal dialysis services.
 Sec. 235. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.
 Sec. 236. Coverage of immunosuppressive drugs for all medicare beneficiaries.

TITLE III—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

- Sec. 301. Elimination of 15 percent reduction in payment rates under the prospective payment system.
 Sec. 302. Update in home health services.
 Sec. 303. Extension of temporary increase for home health services furnished in a rural area.
 Sec. 304. OASIS Task Force; suspension of certain OASIS data collection requirements pending Task Force submittal of report.
 Sec. 305. MedPAC study on medicare margins of home health agencies.

Subtitle B—Other Provisions

- Sec. 311. Modifications to Medicare Payment Advisory Commission (MedPAC).
- Sec. 312. Demonstration project for disease management for certain medicare beneficiaries with diabetes.
- Sec. 313. Demonstration project for medical adult day care services.
- Sec. 314. Publication on final written guidance concerning prohibitions against discrimination by national origin with respect to health care services.

TITLE IV—PROVISIONS RELATING TO MANAGED CARE

- Sec. 401. Medicare+Choice improvements.
- Sec. 402. Specialized Medicare+Choice plans for special needs beneficiaries.
- Sec. 403. Extension of reasonable cost and SHMO contracts.
- Sec. 404. Extension of municipal health service demonstration projects.
- Sec. 405. Payment by PACE providers for medicare and medicaid services furnished by noncontract providers.

TITLE V—REGULATORY REDUCTION AND CONTRACTING REFORM

Subtitle A—Regulatory Reform

- Sec. 501. Construction; definition of supplier.
- Sec. 502. Issuance of regulations.
- Sec. 503. Compliance with changes in regulations and policies.
- Sec. 504. Reports and studies relating to regulatory reform.

Subtitle B—Contracting Reform

- Sec. 511. Increased flexibility in medicare administration.
- Sec. 512. Requirements for information security for medicare administrative contractors.

Subtitle C—Education and Outreach

- Sec. 521. Provider education and technical assistance.
- Sec. 522. Small provider technical assistance demonstration program.
- Sec. 523. Medicare provider ombudsman; medicare beneficiary ombudsman.
- Sec. 524. Beneficiary outreach demonstration program.

Subtitle D—Appeals and Recovery

- Sec. 531. Transfer of responsibility for medicare appeals.
- Sec. 532. Process for expedited access to review.
- Sec. 533. Revisions to medicare appeals process.
- Sec. 534. Prepayment review.
- Sec. 535. Recovery of overpayments.
- Sec. 536. Provider enrollment process; right of appeal.
- Sec. 537. Process for correction of minor errors and omissions on claims without pursuing appeals process.
- Sec. 538. Prior determination process for certain items and services; advance beneficiary notices.
- Sec. 539. Appeals by providers when there is no other party available.

Subtitle E—Miscellaneous Provisions

- Sec. 541. Policy development regarding evaluation and management (E & M) documentation guidelines.

Sec. 542. Prohibition of incidental fees and required purchase of non-covered items or services.

Sec. 543. Improvement in oversight of technology and coverage.

Sec. 544. Treatment of hospitals for certain services under medicare secondary payor (MSP) provisions.

Sec. 545. Authorizing use of arrangements with other hospice programs to provide core hospice services in certain circumstances.

Sec. 546. Application of OSHA bloodborne pathogens standard to certain hospitals.

Sec. 547. BIPA-related technical amendments and corrections.

Sec. 548. Conforming authority to waive a program exclusion.

Sec. 549. Treatment of certain dental claims.

Sec. 550. Annual publication of list of national coverage determinations.

1 **TITLE I—PROVISIONS RELATING**
 2 **TO PART A**
 3 **Subtitle A—Inpatient Hospital**
 4 **Services**

5 **SEC. 101. REVISION OF ACUTE CARE HOSPITAL PAYMENT**
 6 **UPDATES.**

7 Subclause (XVIII) of section 1886(b)(3)(B)(i) (42
 8 U.S.C. 1395ww(b)(3)(B)(i)) is amended to read as fol-
 9 lows:

10 “(XVIII) for fiscal year 2003, the market bas-
 11 ket percentage increase for sole community hospitals
 12 and such increase minus 0.25 percentage points for
 13 other hospitals, and”.

14 **SEC. 102. 2-YEAR PHASED-IN INCREASE IN THE STANDARD-**
 15 **IZED AMOUNT IN RURAL AND SMALL URBAN**
 16 **AREAS TO ACHIEVE A SINGLE, UNIFORM**
 17 **STANDARDIZED AMOUNT.**

18 Section 1886(d)(3)(A)(iv) (42 U.S.C.
 19 1395ww(d)(3)(A)(iv)) is amended—

1 (1) by striking “(iv) For discharges” and in-
2 serting “(iv)(I) Subject to the succeeding provisions
3 of this clause, for discharges”; and

4 (2) by adding at the end the following new sub-
5 clauses:

6 “(II) For discharges occurring during fiscal
7 year 2003, the average standardized amount for hos-
8 pitals located other than in a large urban area shall
9 be increased by $\frac{1}{2}$ of the difference between the av-
10 erage standardized amount determined under sub-
11 clause (I) for hospitals located in large urban areas
12 for such fiscal year and such amount determined
13 (without regard to this subclause) for other hospitals
14 for such fiscal year.

15 “(III) For discharges occurring in a fiscal year
16 beginning with fiscal year 2004, the Secretary shall
17 compute an average standardized amount for hos-
18 pitals located in any area within the United States
19 and within each region equal to the average stand-
20 ardized amount computed for the previous fiscal
21 year under this subparagraph for hospitals located
22 in a large urban area (or, beginning with fiscal year
23 2005, for hospitals located in any area) increased by
24 the applicable percentage increase under subsection
25 (b)(3)(B)(i).”.

1 **SEC. 103. 3-YEAR INCREASE IN LEVEL OF ADJUSTMENT FOR**
2 **INDIRECT COSTS OF MEDICAL EDUCATION**
3 **(IME).**

4 (a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42
5 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

6 (1) in subclause (VI)—

7 (A) by striking “fiscal year 2002” and in-
8 serting “fiscal years 2002, 2003, and 2004”;
9 and

10 (B) by striking “and” at the end;

11 (2) by redesignating subclause (VII) as sub-
12 clause (VIII);

13 (3) in subclause (VIII) as so redesignated, by
14 striking “2002” and inserting “2005”; and

15 (4) by inserting after subclause (VI) the fol-
16 lowing new subclause:

17 “(VII) during fiscal year 2005, ‘e’ is equal
18 to 1.47; and”.

19 (b) CONFORMING AMENDMENT RELATING TO DE-
20 TERMINATION OF STANDARDIZED AMOUNT.—Section
21 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is
22 amended—

23 (1) by striking “1999 or” and inserting
24 “1999,”; and

1 (2) by inserting “, or of section 103(a) of the
2 Medicare Payment Restoration and Benefits Im-
3 provement Act of 2003” after “2000”.

4 **SEC. 104. MORE FREQUENT UPDATE IN WEIGHTS USED IN**
5 **HOSPITAL MARKET BASKET.**

6 (a) MORE FREQUENT UPDATES IN WEIGHTS.—After
7 revising the weights used in the hospital market basket
8 under section 1886(b)(3)(B)(iii) of the Social Security Act
9 (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most cur-
10 rent data available, the Secretary shall establish a fre-
11 quency for revising such weights in such market basket
12 to reflect the most current data available more frequently
13 than once every 5 years.

14 (b) REPORT.—Not later than October 1, 2003, the
15 Secretary shall submit a report to Congress on the fre-
16 quency established under subsection (a), including an ex-
17 planation of the reasons for, and options considered, in
18 determining such frequency.

19 **SEC. 105. RELIEF FOR CERTAIN NON-TEACHING HOS-**
20 **PITALS.**

21 (a) IN GENERAL.—In the case of a non-teaching hos-
22 pital that meets the condition of subsection (b), in each
23 of fiscal years 2003, 2004, and 2005 the amount of pay-
24 ment made to the hospital under section 1886(d) of the
25 Social Security Act for discharges occurring during such

1 fiscal year only shall be increased as though the applicable
2 percentage increase (otherwise applicable to discharges oc-
3 ccurring during such fiscal year under section
4 1886(b)(3)(B)(i) of the Social Security Act (42 U.S.C.
5 1395ww(b)(3)(B)(i)) had been increased by 5 percentage
6 points. The previous sentence shall be applied for each
7 such fiscal year separately without regard to its applica-
8 tion in a previous fiscal year and shall not affect payment
9 for discharges for any hospital occurring during a fiscal
10 year after fiscal year 2005.

11 (b) CONDITION.—A non-teaching hospital meets the
12 condition of this subsection if—

13 (1) it is located in a rural area and the amount
14 of the aggregate payments under subsection (d) of
15 section 1886 of the Social Security Act for hospitals
16 located in rural areas in the State for their cost re-
17 porting periods beginning during fiscal year 1999 is
18 less than the aggregate allowable operating costs of
19 inpatient hospital services (as defined in subsection
20 (a)(4) of such section) for all subsection (d) hos-
21 pitals in such areas in such State with respect to
22 such cost reporting periods; or

23 (2) it is located in an urban area and the
24 amount of the aggregate payments under subsection
25 (d) of such section for hospitals located in urban

1 areas in the State for their cost reporting periods
2 beginning during fiscal year 1999 is less than 103
3 percent of the aggregate allowable operating costs of
4 inpatient hospital services (as defined in subsection
5 (a)(4) of such section) for all subsection (d) hos-
6 pitals in such areas in such State with respect to
7 such cost reporting periods.

8 The amounts under paragraphs (1) and (2) shall be deter-
9 mined by the Secretary of Health and Human Services
10 based on data of the Medicare Payment Advisory Commis-
11 sion.

12 (c) DEFINITIONS.—For purposes of this section:

13 (1) NON-TEACHING HOSPITAL.—The term
14 “non-teaching hospital” means, for a cost reporting
15 period, a subsection (d) hospital (as defined in sub-
16 section (d)(1)(B) of section 1886 of the Social Secu-
17 rity Act, 42 U.S.C. 1395ww) that is not receiving
18 any additional payment under subsection (d)(5)(B)
19 of such section or a payment under subsection (h)
20 of such section for discharges occurring during the
21 period. A subsection (d) hospital that receives addi-
22 tional payments under subsection (d)(5)(B) or (h) of
23 such section shall, for purposes of this section, also
24 be treated as a non-teaching hospital unless a chair-
25 man of a department in the medical school with

1 which the hospital is affiliated is serving or has been
2 appointed as a clinical chief of service in the hos-
3 pital.

4 (2) RURAL; URBAN.—The terms “rural” and
5 “urban” have the meanings given such terms for
6 purposes of section 1886(d) of the Social Security
7 Act (42 U.S.C. 1395ww(d)).

8 **SEC. 106. ENHANCED DISPROPORTIONATE SHARE HOS-**
9 **PITAL (DSH) TREATMENT FOR RURAL HOS-**
10 **PITALS AND URBAN HOSPITALS WITH FEWER**
11 **THAN 100 BEDS.**

12 (a) BLENDING OF PAYMENT AMOUNTS.—

13 (1) IN GENERAL.—Section 1886(d)(5)(F) (42
14 U.S.C. 1395ww(d)(5)(F)) is amended by adding at
15 the end the following new clause:

16 “(xiv)(I) In the case of discharges in a fiscal year
17 beginning on or after October 1, 2002, subject to sub-
18 clause (II), there shall be substituted for the dispropor-
19 tionate share adjustment percentage otherwise determined
20 under clause (iv) (other than subclause (I)) or under
21 clause (viii), (x), (xi), (xii), or (xiii), the old blend propor-
22 tion (specified under subclause (III)) of the dispropor-
23 tionate share adjustment percentage otherwise determined
24 under the respective clause and 100 percent minus such
25 old blend proportion of the disproportionate share adjust-

1 ment percentage determined under clause (vii) (relating
2 to large, urban hospitals).

3 “(II) Under subclause (I), the disproportionate share
4 adjustment percentage shall not exceed 10 percent for a
5 hospital that is not classified as a rural referral center
6 under subparagraph (C).

7 “(III) For purposes of subclause (I), the old blend
8 proportion for fiscal year 2003 is 80 percent, for each sub-
9 sequent year (through 2006) is the old blend proportion
10 under this subclause for the previous year minus 20 per-
11 centage points, and for each year beginning with 2007 is
12 0 percent.”.

13 (2) CONFORMING AMENDMENTS.—Section
14 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is
15 amended—

16 (A) in each of subclauses (II), (III), (IV),
17 (V), and (VI) of clause (iv), by inserting “sub-
18 ject to clause (xiv) and” before “for discharges
19 occurring”;

20 (B) in clause (viii), by striking “The for-
21 mula” and inserting “Subject to clause (xiv),
22 the formula”; and

23 (C) in each of clauses (x), (xi), (xii), and
24 (xiii), by striking “For purposes” and inserting
25 “Subject to clause (xiv), for purposes”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 this section shall apply with respect to discharges occur-
3 ring on or after October 1, 2002.

4 **SEC. 107. RECOGNITION OF NEW MEDICAL TECHNOLOGIES**

5 **UNDER INPATIENT HOSPITAL PPS.**

6 (a) IMPROVING TIMELINESS OF DATA COLLEC-
7 TION.—Section 1886(d)(5)(K) (42 U.S.C.
8 1395ww(d)(5)(K)) is amended by adding at the end the
9 following new clause:

10 “(vii) Under the mechanism under this subpara-
11 graph, the Secretary shall provide for the addition of new
12 diagnosis and procedure codes in April 1 of each year, but
13 the addition of such codes shall not require the Secretary
14 to adjust the payment (or diagnosis-related group classi-
15 fication) under this subsection until the fiscal year that
16 begins after such date.”.

17 (b) ELIGIBILITY STANDARD.—

18 (1) MINIMUM PERIOD FOR RECOGNITION OF
19 NEW TECHNOLOGIES.—Section 1886(d)(5)(K)(vi)
20 (42 U.S.C. 1395ww(d)(5)(K)(vi)) is amended—

21 (A) by inserting “(I)” after “(vi)”; and

22 (B) by adding at the end the following new
23 subclause:

24 “(II) Under such criteria, a service or technology
25 shall not be denied treatment as a new service or tech-

1 nology on the basis of the period of time in which the serv-
2 ice or technology has been in use if such period ends before
3 the end of the 2-to-3-year period that begins on the effec-
4 tive date of implementation of a code under ICD–9–CM
5 (or a successor coding methodology) that enables the iden-
6 tification of a significant sample of specific discharges in
7 which the service or technology has been used.”.

8 (2) ADJUSTMENT OF THRESHOLD.—Section
9 1886(d)(5)(K)(ii)(I) (42 U.S.C.
10 1395ww(d)(5)(K)(ii)(I)) is amended by inserting
11 “(applying a threshold specified by the Secretary
12 that is the lesser of 50 percent of the national aver-
13 age standardized amount for operating costs of inpa-
14 tient hospital services for all hospitals and all diag-
15 nosis-related groups or one standard deviation for
16 the diagnosis-related group involved)” after “is inad-
17 equate”.

18 (3) CRITERION FOR SUBSTANTIAL IMPROVE-
19 MENT.—Section 1886(d)(5)(K)(vi) (42 U.S.C.
20 1395ww(d)(5)(K)(vi)), as amended by paragraph
21 (1), is further amended by adding at the end the fol-
22 lowing subclause:

23 “(III) The Secretary shall by regulation provide for
24 further clarification of the criteria applied to determine
25 whether a new service or technology represents an advance

1 in medical technology that substantially improves the diag-
2 nosis or treatment of beneficiaries. Under such criteria,
3 in determining whether a new service or technology rep-
4 resents an advance in medical technology that substan-
5 tially improves the diagnosis or treatment of beneficiaries,
6 the Secretary shall deem a service or technology as meet-
7 ing such requirement if the service or technology is a drug
8 or biological that is designated under section 506 or 526
9 of the Federal Food, Drug, and Cosmetic Act, approved
10 under section 314.510 or 601.41 of title 21, Code of Fed-
11 eral Regulations, or designated for priority review when
12 the marketing application for such drug or biological was
13 filed or is a medical device for which an exemption has
14 been granted under section 520(m) of such Act, or for
15 which priority review has been provided under section
16 515(d)(5) of such Act.”.

17 (4) PROCESS FOR PUBLIC INPUT.—Section
18 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as
19 amended by paragraph (1), is amended—

20 (A) in clause (i), by adding at the end the
21 following: “Such mechanism shall be modified
22 to meet the requirements of clause (viii).”;

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

1 “(viii) The mechanism established pursuant to clause
2 (i) shall be adjusted to provide, before publication of a
3 proposed rule, for public input regarding whether a new
4 service or technology not described in the second sentence
5 of clause (vi)(III) represents an advance in medical tech-
6 nology that substantially improves the diagnosis or treat-
7 ment of beneficiaries as follows:

8 “(I) The Secretary shall make public and peri-
9 odically update a list of all the services and tech-
10 nologies for which an application for additional pay-
11 ment under this subparagraph is pending.

12 “(II) The Secretary shall accept comments, rec-
13 ommendations, and data from the public regarding
14 whether the service or technology represents a sub-
15 stantial improvement.

16 “(III) The Secretary shall provide for a meeting
17 at which organizations representing hospitals, physi-
18 cians, medicare beneficiaries, manufacturers, and
19 any other interested party may present comments,
20 recommendations, and data to the clinical staff of
21 the Centers for Medicare & Medicaid Services before
22 publication of a notice of proposed rulemaking re-
23 garding whether service or technology represents a
24 substantial improvement.”.

1 (c) PREFERENCE FOR USE OF DRG ADJUSTMENT.—
2 Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is
3 further amended by adding at the end the following new
4 clause:

5 “(ix) Before establishing any add-on payment under
6 this subparagraph with respect to a new technology, the
7 Secretary shall seek to identify one or more diagnosis-re-
8 lated groups associated with such technology, based on
9 similar clinical or anatomical characteristics and the cost
10 of the technology. Within such groups the Secretary shall
11 assign an eligible new technology into a diagnosis-related
12 group where the average costs of care most closely approx-
13 imate the costs of care of using the new technology. In
14 such case, no add-on payment under this subparagraph
15 shall be made with respect to such new technology and
16 this clause shall not affect the application of paragraph
17 (4)(C)(iii).”.

18 (d) IMPROVEMENT IN PAYMENT FOR NEW TECH-
19 NOLOGY.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C.
20 1395ww(d)(5)(K)(ii)(III)) is amended by inserting after
21 “the estimated average cost of such service or technology”
22 the following: “(based on the marginal rate applied to
23 costs under subparagraph (A))”.

24 (e) EFFECTIVE DATE.—

1 (1) IN GENERAL.—The Secretary shall imple-
2 ment the amendments made by this section so that
3 they apply to classification for fiscal years beginning
4 with fiscal year 2004.

5 (2) RECONSIDERATIONS OF APPLICATIONS FOR
6 FISCAL YEAR 2003 THAT ARE DENIED.—In the case
7 of an application for a classification of a medical
8 service or technology as a new medical service or
9 technology under section 1886(d)(5)(K) of the Social
10 Security Act (42 U.S.C. 1395ww(d)(5)(K)) that was
11 filed for fiscal year 2003 and that is denied—

12 (A) the Secretary shall automatically re-
13 consider the application as an application for
14 fiscal year 2004 under the amendments made
15 by this section; and

16 (B) the maximum time period otherwise
17 permitted for such classification of the service
18 or technology shall be extended by 12 months.

19 **SEC. 108. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL**
20 **PROGRAM.**

21 (a) REINSTATEMENT OF PERIODIC INTERIM PAY-
22 MENT (PIP).—Section 1815(e)(2) (42 U.S.C.
23 1395g(e)(2)) is amended—

24 (1) by striking “and” at the end of subpara-
25 graph (C);

1 (2) by adding “and” at the end of subpara-
2 graph (D); and

3 (3) by inserting after subparagraph (D) the fol-
4 lowing new subparagraph:

5 “(E) inpatient critical access hospital services;”.

6 (b) CONDITION FOR APPLICATION OF SPECIAL PHY-
7 SICIAN PAYMENT ADJUSTMENT.—Section 1834(g)(2) (42
8 U.S.C. 1395m(g)(2)) is amended by adding after and
9 below subparagraph (B) the following:

10 “The Secretary may not require, as a condition for
11 applying subparagraph (B) with respect to a critical
12 access hospital, that each physician providing profes-
13 sional services in the hospital must assign billing
14 rights with respect to such services, except that such
15 subparagraph shall not apply to those physicians
16 who have not assigned such billing rights.”.

17 (c) FLEXIBILITY IN BED LIMITATION FOR HOS-
18 PITALS.—Section 1820 (42 U.S.C. 1395i–4) is amended—

19 (1) in subsection (c)(2)(B)(iii), by inserting
20 “subject to paragraph (3)” after “(iii) provides”;

21 (2) by adding at the end of subsection (c) the
22 following new paragraph:

23 “(3) INCREASE IN MAXIMUM NUMBER OF BEDS
24 FOR HOSPITALS WITH STRONG SEASONAL CENSUS
25 FLUCTUATIONS.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graph (C), in the case of a hospital that dem-
3 onstrates that it meets the standards estab-
4 lished under subparagraph (B) and has not
5 made the election described in subsection
6 (f)(2)(A), the bed limitations otherwise applica-
7 ble under paragraph (2)(B)(iii) and subsection
8 (f) shall be increased by 5 beds.

9 “(B) STANDARDS.—The Secretary shall
10 specify standards for determining whether a
11 critical access hospital has sufficiently strong
12 seasonal variations in patient admissions to jus-
13 tify the increase in bed limitation provided
14 under subparagraph (A).”; and

15 (3) in subsection (f)—

16 (A) by inserting “(1)” after “(f)”; and

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

19 “(2)(A) A hospital may elect to treat the reference
20 in paragraph (1) to ‘15 beds’ as a reference to ‘25 beds’,
21 but only if no more than 10 beds in the hospital are at
22 any time used for non-acute care services. A hospital that
23 makes such an election is not eligible for the increase pro-
24 vided under subsection (c)(3)(A).

1 “(B) The limitations in numbers of beds under the
2 first sentence of paragraph (1) are subject to adjustment
3 under subsection (c)(3).”.

4 (d) 5-YEAR EXTENSION OF THE AUTHORIZATION
5 FOR APPROPRIATIONS FOR GRANT PROGRAM.—Section
6 1820(j) (42 U.S.C. 1395i–4(j)) is amended by striking
7 “through 2002” and inserting “through 2007”.

8 (e) PROHIBITION OF RETROACTIVE RECOUPMENT.—
9 The Secretary shall not recoup (or otherwise seek to re-
10 cover) overpayments made for outpatient critical access
11 hospital services under part B of title XVIII of the Social
12 Security Act, for services furnished in cost reporting peri-
13 ods that began before October 1, 2002, insofar as such
14 overpayments are attributable to payment being based on
15 80 percent of reasonable costs (instead of 100 percent of
16 reasonable costs minus 20 percent of charges).

17 (f) EFFECTIVE DATES.—

18 (1) REINSTATEMENT OF PIP.—The amend-
19 ments made by subsection (a) shall apply to pay-
20 ments made on or after January 1, 2003.

21 (2) PHYSICIAN PAYMENT ADJUSTMENT CONDI-
22 TION.—The amendment made by subsection (b)
23 shall be effective as if included in the enactment of
24 section 403(d) of the Medicare, Medicaid, and

1 SCHIP Balanced Budget Refinement Act of 1999
2 (113 Stat. 1501A–371).

3 (3) FLEXIBILITY IN BED LIMITATION.—The
4 amendments made by subsection (c) shall apply to
5 designations made on or after January 1, 2003, but
6 shall not apply to critical access hospitals that were
7 designated as of such date.

8 **SEC. 109. PHASE-IN OF FEDERAL RATE FOR HOSPITALS IN**
9 **PUERTO RICO.**

10 Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is
11 amended—

12 (1) in subparagraph (A)—

13 (A) in clause (i), by striking “for dis-
14 charges beginning on or after October 1, 1997,
15 50 percent (and for discharges between October
16 1, 1987, and September 30, 1997, 75 percent)”
17 and inserting “the applicable Puerto Rico per-
18 centage (specified in subparagraph (E))”; and

19 (B) in clause (ii), by striking “for dis-
20 charges beginning in a fiscal year beginning on
21 or after October 1, 1997, 50 percent (and for
22 discharges between October 1, 1987, and Sep-
23 tember 30, 1997, 25 percent)” and inserting
24 “the applicable Federal percentage (specified in
25 subparagraph (E))”; and

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

3 “(E) For purposes of subparagraph (A), for dis-
4 charges occurring—

5 “(i) between October 1, 1987, and September
6 30, 1997, the applicable Puerto Rico percentage is
7 75 percent and the applicable Federal percentage is
8 25 percent;

9 “(ii) on or after October 1, 1997, and before
10 October 1, 2003, the applicable Puerto Rico percent-
11 age is 50 percent and the applicable Federal per-
12 centage is 50 percent;

13 “(iii) during fiscal year 2004, the applicable
14 Puerto Rico percentage is 45 percent and the appli-
15 cable Federal percentage is 55 percent;

16 “(iv) during fiscal year 2005, the applicable
17 Puerto Rico percentage is 40 percent and the appli-
18 cable Federal percentage is 60 percent;

19 “(v) during fiscal year 2006, the applicable
20 Puerto Rico percentage is 35 percent and the appli-
21 cable Federal percentage is 65 percent;

22 “(vi) during fiscal year 2007, the applicable
23 Puerto Rico percentage is 30 percent and the appli-
24 cable Federal percentage is 70 percent; and

1 “(vii) on or after October 1, 2007, the applica-
2 ble Puerto Rico percentage is 25 percent and the ap-
3 plicable Federal percentage is 75 percent.”.

4 **SEC. 110. GAO STUDY ON IMPROVING THE HOSPITAL WAGE**

5 **INDEX.**

6 (a) **STUDY.**—

7 (1) **IN GENERAL.**—The Comptroller General of
8 the United States shall conduct a study on the im-
9 provements that can be made in the measurement of
10 regional differences in hospital wages reflected in the
11 hospital wage index under section 1886(d) of the So-
12 cial Security Act (42 U.S.C. 1395ww(d)).

13 (2) **EXAMINATION OF USE OF METROPOLITAN**
14 **STATISTICAL AREAS (MSAS).**—The study shall spe-
15 cifically examine the use of metropolitan statistical
16 areas for purposes of computing and applying the
17 wage index and whether the boundaries of such
18 areas accurately reflect local labor markets. In addi-
19 tion, the study shall examine whether regional in-
20 equities are created as a result of infrequent updates
21 of such boundaries and policies of the Bureau of the
22 Census relating to commuting criteria.

23 (3) **WAGE DATA.**—The study shall specifically
24 examine the portions of the hospital cost reports re-
25 lating to wages, and methods for improving the ac-

1 curacy of the wage data and for reducing inequities
 2 resulting from differences among hospitals in the re-
 3 porting of wage data.

4 (b) CONSULTATION WITH OMB.—The Comptroller
 5 General shall consult with the Director of Office of Man-
 6 agement and Budget in conducting the study under sub-
 7 section (a)(2).

8 (c) REPORT.—Not later than July 1, 2003, the
 9 Comptroller General shall submit to Congress a report on
 10 the study conducted under subsection (a) and shall include
 11 in the report such recommendations as may be appropriate
 12 on—

13 (1) changes in the definition of labor market
 14 areas used for purposes of the area wage index
 15 under section 1886 of the Social Security Act; and

16 (2) improvements in methods for the collection
 17 of wage data.

18 **Subtitle B—Skilled Nursing** 19 **Facility Services**

20 **SEC. 121. PAYMENT FOR COVERED SKILLED NURSING FA-** 21 **CILITY SERVICES.**

22 (a) 2-YEAR EXTENSION OF TEMPORARY INCREASE
 23 IN NURSING COMPONENT OF PPS FEDERAL RATE.—Sec-
 24 tion 312(a) of BIPA is amended by striking “, and before

1 October 1, 2002” and inserting “and before October 1,
2 2004”.

3 (b) ADJUSTMENT TO RUGS FOR AIDS RESI-
4 DENTS.—

5 (1) IN GENERAL.—Paragraph (12) of section
6 1888(e) (42 U.S.C. 1395yy(e)) is amended to read
7 as follows:

8 “(12) ADJUSTMENT FOR RESIDENTS WITH
9 AIDS.—

10 “(A) IN GENERAL.—Subject to subpara-
11 graph (B), in the case of a resident of a skilled
12 nursing facility who is afflicted with acquired
13 immune deficiency syndrome (AIDS), the per
14 diem amount of payment otherwise applicable
15 shall be increased by 128 percent to reflect in-
16 creased costs associated with such residents.

17 “(B) SUNSET.—Subparagraph (A) shall
18 not apply on and after such date as the Sec-
19 retary certifies that there is an appropriate ad-
20 justment in the case mix under paragraph
21 (4)(G)(i) to compensate for the increased costs
22 associated with residents described in such sub-
23 paragraph.”.

1 (2) EFFECTIVE DATE.—The amendment made
2 by paragraph (1) shall apply to services furnished on
3 or after October 1, 2003.

4 (c) CMS STUDY AND REPORT.—

5 (1) STUDY.—The Secretary shall conduct a
6 study to review the adequacy of funding under the
7 medicaid program under title XIX of the Social Se-
8 curity Act for nursing facility care.

9 (2) REPORT.—Not later than one year after the
10 date of the enactment of this Act, the Secretary
11 shall submit to Congress a report on the study con-
12 ducted under paragraph (1). The report shall in-
13 clude recommendations of the Secretary with respect
14 to structural reform of funding systems to ensure
15 quality nursing facility services for those eligible for
16 benefits under the medicaid program.

17 **Subtitle C—Hospice Care**

18 **SEC. 131. COVERAGE OF HOSPICE CONSULTATION SERV-**

19 **ICES.**

20 (a) COVERAGE OF HOSPICE CONSULTATION SERV-
21 ICES.—Section 1812(a) (42 U.S.C. 1395d(a)) is amend-
22 ed—

23 (1) by striking “and” at the end of paragraph
24 (3);

1 (2) by striking the period at the end of para-
2 graph (4) and inserting “; and”; and

3 (3) by inserting after paragraph (4) the fol-
4 lowing new paragraph:

5 “(5) for individuals who are terminally ill, have
6 not made an election under subsection (d)(1), and
7 have not previously received services under this
8 paragraph, services that are furnished by a physi-
9 cian who is either the medical director or an em-
10 ployee of a hospice program and that consist of—

11 “(A) an evaluation of the individual’s need
12 for pain and symptom management;

13 “(B) counseling the individual with respect
14 to end-of-life issues and care options; and

15 “(C) advising the individual regarding ad-
16 vanced care planning.”.

17 (b) PAYMENT.—Section 1814(i) (42 U.S.C. 1395f(i))
18 is amended by adding at the end the following new para-
19 graph:

20 “(4) The amount paid to a hospice program with re-
21 spect to the services under section 1812(a)(5) for which
22 payment may be made under this part shall be equal to
23 an amount equivalent to the amount established for an
24 office or other outpatient visit for evaluation and manage-
25 ment associated with presenting problems of moderate se-

1 verity under the fee schedule established under section
 2 1848(b), other than the portion of such amount attrib-
 3 utable to the practice expense component.”.

4 (c) CONFORMING AMENDMENT.—Section
 5 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is
 6 amended by inserting before the comma at the end the
 7 following: “and services described in section 1812(a)(5)”.

8 (d) EFFECTIVE DATE.—The amendments made by
 9 this section shall apply to services provided by a hospice
 10 program on or after January 1, 2004.

11 **SEC. 132. 10 PERCENT INCREASE IN PAYMENT FOR HOS-**
 12 **PICE CARE FURNISHED IN A FRONTIER AREA.**

13 (a) IN GENERAL.—Section 1814(i)(1) (42 U.S.C.
 14 1395f(i)(1)) is amended by adding at the end the following
 15 new subparagraph:

16 “(D) With respect to hospice care furnished in a fron-
 17 tier area on or after January 1, 2003, and before January
 18 1, 2008, the payment rates otherwise established for such
 19 care shall be increased by 10 percent. For purposes of this
 20 subparagraph, the term ‘frontier area’ means a county in
 21 which the population density is less than 7 persons per
 22 square mile.”.

23 (b) REPORT ON COSTS.—Not later than January 1,
 24 2007, the Comptroller General of the United States shall
 25 submit to Congress a report on the costs of furnishing

1 hospice care in frontier areas. Such report shall include
2 recommendations regarding the appropriateness of extend-
3 ing, and modifying, the payment increase provided under
4 the amendment made by subsection (a).

5 **SEC. 133. RURAL HOSPICE DEMONSTRATION PROJECT.**

6 (a) IN GENERAL.—The Secretary shall conduct a
7 demonstration project for the delivery of hospice care to
8 medicare beneficiaries in rural areas. Under the project
9 medicare beneficiaries who are unable to receive hospice
10 care in the home for lack of an appropriate caregiver are
11 provided such care in a facility of 20 or fewer beds which
12 offers, within its walls, the full range of services provided
13 by hospice programs under section 1861(dd) of the Social
14 Security Act (42 U.S.C. 1395x(dd)).

15 (b) SCOPE OF PROJECT.—The Secretary shall con-
16 duct the project under this section with respect to no more
17 than 3 hospice programs over a period of not longer than
18 5 years each.

19 (c) COMPLIANCE WITH CONDITIONS.—Under the
20 demonstration project—

21 (1) the hospice program shall comply with oth-
22 erwise applicable requirements, except that it shall
23 not be required to offer services outside of the home
24 or to meet the requirements of section
25 1861(dd)(2)(A)(iii) of the Social Security Act; and

1 (2) payments for hospice care shall be made at
2 the rates otherwise applicable to such care under
3 title XVIII of such Act.

4 The Secretary may require the program to comply with
5 such additional quality assurance standards for its provi-
6 sion of services in its facility as the Secretary deems ap-
7 propriate.

8 (d) REPORT.—Upon completion of the project, the
9 Secretary shall submit a report to Congress on the project
10 and shall include in the report recommendations regarding
11 extension of such project to hospice programs serving
12 rural areas.

13 **TITLE II—PROVISIONS**
14 **RELATING TO PART B**
15 **Subtitle A—Physicians’ Services**

16 **SEC. 201. REVISION OF UPDATES FOR PHYSICIANS’ SERV-**
17 **ICES.**

18 (a) UPDATE FOR 2003 THROUGH 2005.—

19 (1) IN GENERAL.—Section 1848(d) (42 U.S.C.
20 1395w-4(d)) is amended by adding at the end the
21 following new paragraphs:

22 “(5) UPDATE FOR 2003.—The update to the
23 single conversion factor established in paragraph
24 (1)(C) for 2003 is 2 percent.

1 “(6) SPECIAL RULES FOR UPDATE FOR 2004
2 AND 2005.—The following rules apply in determining
3 the update adjustment factors under paragraph
4 (4)(B) for 2004 and 2005:

5 “(A) USE OF 2002 DATA IN DETERMINING
6 ALLOWABLE COSTS.—

7 “(i) The reference in clause (ii)(I) of
8 such paragraph to April 1, 1996, is
9 deemed to be a reference to January 1,
10 2002.

11 “(ii) The allowed expenditures for
12 2002 is deemed to be equal to the actual
13 expenditures for physicians’ services fur-
14 nished during 2002, as estimated by the
15 Secretary.

16 “(B) 1 PERCENTAGE POINT INCREASE IN
17 GDP UNDER SGR.—The annual average percent-
18 age growth in real gross domestic product per
19 capita under subsection (f)(2)(C) for each of
20 2003, 2004, and 2005 is deemed to be in-
21 creased by 1 percentage point.”.

22 (2) CONFORMING AMENDMENT.—Paragraph
23 (4)(B) of such section is amended, in the matter be-
24 fore clause (i), by inserting “and paragraph (6)”
25 after “subparagraph (D)”.

1 (3) NOT TREATED AS CHANGE IN LAW AND
2 REGULATION IN SUSTAINABLE GROWTH RATE DE-
3 TERMINATION.—The amendments made by this sub-
4 section shall not be treated as a change in law for
5 purposes of applying section 1848(f)(2)(D) of the
6 Social Security Act (42 U.S.C. 1395w-4(f)(2)(D)).

7 (b) USE OF 10-YEAR ROLLING AVERAGE IN COM-
8 PUTING GROSS DOMESTIC PRODUCT.—

9 (1) IN GENERAL.—Section 1848(f)(2)(C) (42
10 U.S.C. 1395w-4(f)(2)(C)) is amended—

11 (A) by striking “projected” and inserting
12 “annual average”; and

13 (B) by striking “from the previous applica-
14 ble period to the applicable period involved”
15 and inserting “during the 10-year period ending
16 with the applicable period involved”.

17 (2) EFFECTIVE DATE.—The amendment made
18 by paragraph (1) shall apply to computations of the
19 sustainable growth rate for years beginning with
20 2002.

21 (c) ELIMINATION OF TRANSITIONAL ADJUSTMENT.—
22 Section 1848(d)(4)(F) (42 U.S.C. 1395w-4(d)(4)(F)) is
23 amended by striking “subparagraph (A)” and all that fol-
24 lows and inserting “subparagraph (A), for each of 2001
25 and 2002, of -0.2 percent.”.

1 (d) GAO STUDY OF MEDICARE PAYMENT FOR INHA-
2 LATION THERAPY.—

3 (1) STUDY.—The Comptroller General of the
4 United States shall conduct a study to examine the
5 adequacy of current reimbursements for inhalation
6 therapy under the medicare program.

7 (2) REPORT.—Not later than July 1, 2003, the
8 Comptroller General shall submit to Congress a re-
9 port on the study conducted under paragraph (1).

10 **SEC. 202. STUDIES ON ACCESS TO PHYSICIANS' SERVICES.**

11 (a) GAO STUDY ON BENEFICIARY ACCESS TO PHYSI-
12 CIANS' SERVICES.—

13 (1) STUDY.—The Comptroller General of the
14 United States shall conduct a study on access of
15 medicare beneficiaries to physicians' services under
16 the medicare program. The study shall include—

17 (A) an assessment of the use by bene-
18 ficiaries of such services through an analysis of
19 claims submitted by physicians for such services
20 under part B of the medicare program;

21 (B) an examination of changes in the use
22 by beneficiaries of physicians' services over
23 time;

1 (C) an examination of the extent to which
2 physicians are not accepting new medicare
3 beneficiaries as patients.

4 (2) REPORT.—Not later than 18 months after
5 the date of the enactment of this Act, the Comp-
6 troller General shall submit to Congress a report on
7 the study conducted under paragraph (1). The re-
8 port shall include a determination whether—

9 (A) data from claims submitted by physi-
10 cians under part B of the medicare program in-
11 dicate potential access problems for medicare
12 beneficiaries in certain geographic areas; and

13 (B) access by medicare beneficiaries to
14 physicians' services may have improved, re-
15 mained constant, or deteriorated over time.

16 (b) STUDY AND REPORT ON SUPPLY OF PHYSI-
17 CIANS.—

18 (1) STUDY.—The Secretary shall request the
19 Institute of Medicine of the National Academy of
20 Sciences to conduct a study on the adequacy of the
21 supply of physicians (including specialists) in the
22 United States and the factors that affect such sup-
23 ply.

24 (2) REPORT TO CONGRESS.—Not later than 2
25 years after the date of enactment of this section, the

1 Secretary shall submit to Congress a report on the
2 results of the study described in paragraph (1), in-
3 cluding any recommendations for legislation.

4 **SEC. 203. MEDPAC REPORT ON PAYMENT FOR PHYSICIANS'**
5 **SERVICES.**

6 Not later than 1 year after the date of the enactment
7 of this Act, the Medicare Payment Advisory Commission
8 shall submit to Congress a report on the effect of refine-
9 ments to the practice expense component of payments for
10 physicians' services, after the transition to a full resource-
11 based payment system in 2002, under section 1848 of the
12 Social Security Act (42 U.S.C. 1395w-4). Such report
13 shall examine the following matters by physician specialty:

14 (1) The effect of such refinements on payment
15 for physicians' services.

16 (2) The interaction of the practice expense com-
17 ponent with other components of and adjustments to
18 payment for physicians' services under such section.

19 (3) The appropriateness of the amount of com-
20 pensation by reason of such refinements.

21 (4) The effect of such refinements on access to
22 care by medicare beneficiaries to physicians' serv-
23 ices.

24 (5) The effect of such refinements on physician
25 participation under the medicare program.

1 **SEC. 204. 1-YEAR EXTENSION OF TREATMENT OF CERTAIN**
2 **PHYSICIAN PATHOLOGY SERVICES UNDER**
3 **MEDICARE.**

4 Section 542(c) of BIPA is amended by striking “2-
5 year period” and inserting “3-year period”.

6 **SEC. 205. PHYSICIAN FEE SCHEDULE WAGE INDEX REVI-**
7 **SION.**

8 (a) INDEX REVISION.—

9 (1) IN GENERAL.—Subject to paragraph (2),
10 notwithstanding any other provision of law, for pur-
11 poses of payment under the physician fee schedule
12 under section 1848 of the Social Security Act (42
13 U.S.C. 1395w-4) for physicians’ services furnished
14 during 2004, in no case may the work geographic
15 index otherwise calculated under subsection
16 (e)(1)(A)(iii) of such section be less than 0.985.

17 (2) SECRETARIAL DISCRETION.—Paragraph (1)
18 shall not take effect or be in force if the Secretary
19 determines, taking into account the report of the
20 Comptroller General under subsection (b)(2), that
21 there is no sound economic rationale for the imple-
22 mentation of such paragraph.

23 (3) EXEMPTION FROM LIMITATION ON ANNUAL
24 ADJUSTMENTS.—Any increase in expenditures at-
25 tributable to paragraph (1) during 2004 shall not be
26 taken into account in applying section

1 1848(e)(2)(B)(ii)(II) of the Social Security Act (42
2 U.S.C. 1395w-4(e)(2)(B)(ii)(II)) for that year.

3 (b) GAO REPORT.—

4 (1) EVALUATION.—As part of the study on geo-
5 graphic differences in payments for physicians' serv-
6 ices conducted under section 309, the Comptroller
7 General shall evaluate the following:

8 (A) Whether there is a sound economic
9 basis for the implementation of the adjustment
10 under subsection (a)(1) in those areas in which
11 the adjustment applies.

12 (B) The effect of such adjustment on phy-
13 sician location and retention in areas affected
14 by such adjustment, taking into account—

15 (i) differences in recruitment costs
16 and retention rates for physicians, includ-
17 ing specialists, between large urban areas
18 and other areas; and

19 (ii) the mobility of physicians, includ-
20 ing specialists, over the last decade.

21 (C) The appropriateness of establishing a
22 floor of 1.0 for the work geographic index.

23 (2) REPORT.—By not later than September 1,
24 2003, the Comptroller General shall submit to Con-

1 gress and to the Secretary a report on the evaluation
2 conducted under paragraph (1).

3 **Subtitle B—Provisions Relating to**
4 **Preventive Benefits**

5 **SEC. 211. COVERAGE OF AN INITIAL PREVENTIVE PHYS-**
6 **ICAL EXAMINATION.**

7 (a) **COVERAGE.**—Section 1861(s)(2) (42 U.S.C.
8 1395x(s)(2)) is amended—

9 (1) in subparagraph (U), by striking “and” at
10 the end;

11 (2) in subparagraph (V), by inserting “and” at
12 the end; and

13 (3) by adding at the end the following new sub-
14 paragraph:

15 “(W) an initial preventive physical examination
16 (as defined in subsection (ww));”.

17 (b) **SERVICES DESCRIBED.**—Section 1861 (42 U.S.C.
18 1395x) is amended by adding at the end the following new
19 subsection:

20 “Initial Preventive Physical Examination

21 “(ww) The term ‘initial preventive physical examina-
22 tion’ means physicians’ services consisting of a physical
23 examination with the goal of health promotion and disease
24 detection and includes items and services (excluding clin-
25 ical laboratory tests), as determined by the Secretary, con-

1 sistent with the recommendations of the United States
2 Preventive Services Task Force.”.

3 (c) WAIVER OF DEDUCTIBLE AND COINSURANCE.—

4 (1) DEDUCTIBLE.—The first sentence of sec-
5 tion 1833(b) (42 U.S.C. 1395l(b)) is amended—

6 (A) by striking “and” before “(6)”, and

7 (B) by inserting before the period at the
8 end the following: “, and (7) such deductible
9 shall not apply with respect to an initial preven-
10 tive physical examination (as defined in section
11 1861(wv))”.

12 (2) COINSURANCE.—Section 1833(a)(1) (42
13 U.S.C. 1395l(a)(1)) is amended—

14 (A) in clause (N), by inserting “(or 100
15 percent in the case of an initial preventive phys-
16 ical examination, as defined in section
17 1861(wv))” after “80 percent”; and

18 (B) in clause (O), by inserting “(or 100
19 percent in the case of an initial preventive phys-
20 ical examination, as defined in section
21 1861(wv))” after “80 percent”.

22 (d) PAYMENT AS PHYSICIANS’ SERVICES.—Section
23 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)) is amended by in-
24 serting “(2)(W),” after “(2)(S),”.

1 (e) OTHER CONFORMING AMENDMENTS.—Section
2 1862(a) (42 U.S.C. 1395y(a)) is amended—

3 (1) in paragraph (1)—

4 (A) by striking “and” at the end of sub-
5 paragraph (H);

6 (B) by striking the semicolon at the end of
7 subparagraph (I) and inserting “, and”; and

8 (C) by adding at the end the following new
9 subparagraph:

10 “(J) in the case of an initial preventive physical
11 examination, which is performed not later than 1
12 year after the date the individual’s first coverage pe-
13 riod begins under part B;” and

14 (2) in paragraph (7), by striking “or (H)” and
15 inserting “(H), or (J)”.

16 (f) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to services furnished on or after
18 January 1, 2004, but only for individuals whose coverage
19 period begins on or after such date.

20 **SEC. 212. COVERAGE OF CHOLESTEROL AND BLOOD LIPID**
21 **SCREENING.**

22 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.
23 1395x(s)(2)), as amended by section 211(a), is amended—

24 (1) in subparagraph (V), by striking “and” at
25 the end;

1 (2) in subparagraph (W), by inserting “and” at
2 the end; and

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

5 “(X) cholesterol and other blood lipid
6 screening tests (as defined in subsection
7 (XX));”.

8 (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.
9 1395x), as amended by section 211(b), is amended by add-
10 ing at the end the following new subsection:

11 “Cholesterol and Other Blood Lipid Screening Tests

12 “(xx)(1) The term ‘cholesterol and other blood lipid
13 screening tests’ means diagnostic testing of cholesterol
14 and other lipid levels of the blood for the purpose of early
15 detection of abnormal cholesterol and other lipid levels.

16 “(2) The Secretary shall establish standards, in con-
17 sultation with appropriate organizations, regarding the
18 frequency and type of cholesterol and other blood lipid
19 screening tests, except that such frequency may not be
20 more often than once every 2 years.”.

21 (c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C.
22 1395y(a)(1)), as amended by section 514(e), is amend-
23 ed—

24 (1) by striking “and” at the end of subpara-
25 graph (I);

1 (2) by striking the semicolon at the end of sub-
2 paragraph (J) and inserting “; and”; and

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

5 “(K) in the case of a cholesterol and other
6 blood lipid screening tests (as defined in section
7 1861(xx)(1)), which is performed more frequently
8 than is covered under section 1861(xx)(2).”.

9 (d) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to tests furnished on or after Janu-
11 ary 1, 2004.

12 **SEC. 213. IMPROVED PAYMENT FOR CERTAIN MAMMOG-**
13 **RAPHY SERVICES.**

14 (a) EXCLUSION FROM OPD FEE SCHEDULE.—Sec-
15 tion 1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is
16 amended by inserting before the period at the end the fol-
17 lowing: “and does not include screening mammography (as
18 defined in section 1861(jj)) and unilateral and bilateral
19 diagnostic mammography”.

20 (b) ADJUSTMENT TO TECHNICAL COMPONENT.—For
21 diagnostic mammography performed on or after January
22 1, 2004, for which payment is made under the physician
23 fee schedule under section 1848 of the Social Security Act
24 (42 U.S.C. 1395w-4), the Secretary, based on the most
25 recent cost data available, shall provide for an appropriate

1 adjustment in the payment amount for the technical com-
2 ponent of the diagnostic mammography.

3 (c) EFFECTIVE DATE.—The amendment made by
4 subsection (a) shall apply to mammography performed on
5 or after January 1, 2004.

6 **Subtitle C—Hospital Outpatient**
7 **Department Services**

8 **SEC. 221. ADJUSTMENT TO LIMIT DECLINE IN PAYMENT.**

9 Section 1833(t)(7) (42 U.S.C. 1395l(t)(7)) is amend-
10 ed—

11 (1) in the heading, by striking “TRANSITIONAL
12 ADJUSTMENT” and inserting “ADJUSTMENT”;

13 (2) in subparagraph (A)—

14 (A) in the heading, by striking “BEFORE
15 2002” and inserting “IN GENERAL”;

16 (B) in the matter preceding clause (i)—

17 (i) by striking “subparagraph (D)”
18 and inserting “subparagraph (B)”;

19 (ii) by striking “furnished before Jan-
20 uary 1, 2002,”; and

21 (iii) by striking “subparagraph (E)”
22 and inserting “subparagraph (C)”;

23 (C) in clause (i), by striking “subpara-
24 graph (F)” and inserting “subparagraph (D)”;

1 (3) by striking subparagraph (D) and inserting
2 the following new subparagraph:

3 “(D) HOLD HARMLESS PROVISIONS FOR
4 CANCER AND CHILDREN’S HOSPITALS.—In the
5 case of a hospital that is described in clause
6 (iii) or (v) of section 1886(d)(1)(B), for covered
7 OPD services—

8 “(i) that are furnished on or after the
9 date on which payment is first made under
10 this subsection; and

11 “(ii) for which the PPS amount is less
12 than the pre-BBA amount (or for services
13 furnished on or after January 1, 2002, is
14 less than the greater of the pre-BBA
15 amount or the reasonable costs incurred in
16 furnishing such services),

17 the amount of payment under this subsection
18 shall be increased by the amount of such dif-
19 ference.”;

20 (4) in subparagraph (F)(ii)(I), by striking
21 “subparagraph (E)” and inserting “subparagraph
22 (C)”;

23 (5) by striking subparagraphs (B) and (C) and
24 redesignating subparagraphs (D), (E), (F), (G),

1 (H), and (I) as subparagraphs (B), (C), (D), (E),
2 (F), and (G), respectively.

3 **Subtitle D—Other Services**

4 **SEC. 231. ADJUSTMENTS TO LOCAL FEE SCHEDULES FOR**
5 **CLINICAL LABORATORY TESTS FOR IM-**
6 **PROVEMENT IN CERVICAL CANCER DETEC-**
7 **TION.**

8 Section 1833(h)(2) (42 U.S.C. 1395l(h)(2)) is
9 amended by adding at the end the following new subpara-
10 graph:

11 “(C) Notwithstanding any other provision of law, in
12 the case of a diagnostic test for the detection of cervical
13 cancer utilizing automated thin layer preparation tech-
14 niques for specimens collected in fluid medium, and for
15 which a national limitation amount has been set pursuant
16 to the parenthetical in paragraph (4)(B)(viii), furnished
17 on or after July 1, 2003, and before June 30, 2005, the
18 Secretary shall permit carriers and medicare administra-
19 tive contractors, as the case may be, to raise their local
20 fee schedule amount for purposes of determining payment
21 for such tests under this section, up to, but not to exceed
22 the national limitation amount previously established for
23 that test. Any such adjustment shall not affect such na-
24 tional limitation amount.”.

1 **SEC. 232. PAYMENT FOR AMBULANCE SERVICES.**

2 (a) PHASE-IN PROVIDING FLOOR USING BLEND OF
3 FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—Sec-
4 tion 1834(l) (42 U.S.C. 1395m(l)) is amended—

5 (1) in paragraph (2)(E), by inserting “con-
6 sistent with paragraph (10)” after “in an efficient
7 and fair manner”;

8 (2) by redesignating the paragraph (8) added
9 by section 221(a) of BIPA as paragraph (9); and

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

12 “(10) PHASE-IN PROVIDING FLOOR USING
13 BLEND OF FEE SCHEDULE AND REGIONAL FEE
14 SCHEDULES.—In carrying out the phase-in under
15 paragraph (2)(E) for each level of service furnished
16 in a year before January 1, 2007, the portion of the
17 payment amount that is based on the fee schedule
18 shall not be less than the following blended rate of
19 the fee schedule under paragraph (1) and of a re-
20 gional fee schedule for the region involved:

21 “(A) For 2003, the blended rate shall be
22 based 20 percent on the fee schedule under
23 paragraph (1) and 80 percent on the regional
24 fee schedule.

25 “(B) For 2004, the blended rate shall be
26 based 40 percent on the fee schedule under

1 paragraph (1) and 60 percent on the regional
2 fee schedule.

3 “(C) For 2005, the blended rate shall be
4 based 60 percent on the fee schedule under
5 paragraph (1) and 40 percent on the regional
6 fee schedule.

7 “(D) For 2006, the blended rate shall be
8 based 80 percent on the fee schedule under
9 paragraph (1) and 20 percent on the regional
10 fee schedule.

11 For purposes of this paragraph, the Secretary shall
12 establish a regional fee schedule for each of the 9
13 Census divisions using the methodology (used in es-
14 tablishing the fee schedule under paragraph (1)) to
15 calculate a regional conversion factor and a regional
16 mileage payment rate and using the same payment
17 adjustments and the same relative value units as
18 used in the fee schedule under such paragraph.”.

19 (b) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG
20 TRIPS.—Section 1834(l), as amended by subsection (a),
21 is further amended by adding at the end the following new
22 paragraph:

23 “(11) ADJUSTMENT IN PAYMENT FOR CERTAIN
24 LONG TRIPS.—In the case of ground ambulance
25 services furnished on or after January 1, 2003, and

1 before January 1, 2008, regardless of where the
2 transportation originates, the fee schedule estab-
3 lished under this subsection shall provide that, with
4 respect to the payment rate for mileage for a trip
5 above 50 miles the per mile rate otherwise estab-
6 lished shall be increased by $\frac{1}{4}$ of the payment per
7 mile otherwise applicable to such miles.”.

8 (c) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to ambulance services furnished
10 on or after January 1, 2003.

11 **SEC. 233. 2-YEAR EXTENSION OF MORATORIUM ON THER-**
12 **APY CAPS; PROVISIONS RELATING TO RE-**
13 **PORTS.**

14 (a) 2-YEAR EXTENSION OF MORATORIUM ON THER-
15 APY CAPS.—Section 1833(g)(4) (42 U.S.C. 1395l(g)(4))
16 is amended by striking “and 2002” and inserting “2002,
17 2003, and 2004”.

18 (b) PROMPT SUBMISSION OF OVERDUE REPORTS ON
19 PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY
20 SERVICES.—Not later than December 31, 2002, the Sec-
21 retary shall submit to Congress the reports required under
22 section 4541(d)(2) of the Balanced Budget Act of 1997
23 (relating to alternatives to a single annual dollar cap on
24 outpatient therapy) and under section 221(d) of the Medi-
25 care, Medicaid, and SCHIP Balanced Budget Refinement

1 Act of 1999 (relating to utilization patterns for outpatient
2 therapy).

3 (c) IDENTIFICATION OF CONDITIONS AND DISEASES
4 JUSTIFYING WAIVER OF THERAPY CAP.—

5 (1) STUDY.—The Secretary shall request the
6 Institute of Medicine of the National Academy of
7 Sciences to identify conditions or diseases that
8 should justify conducting an assessment of the need
9 to waive the therapy caps under section 1833(g)(4)
10 of the Social Security Act (42 U.S.C. 1395l(g)(4)).

11 (2) REPORTS TO CONGRESS.—Not later than
12 September 1, 2003, the Secretary shall submit to
13 Congress a preliminary report on the conditions and
14 diseases identified under paragraph (1) and not later
15 than December 31, 2003, a final report on the con-
16 ditions and diseases so identified.

17 (d) GAO STUDY OF PATIENT ACCESS TO PHYSICAL
18 THERAPIST SERVICES.—

19 (1) STUDY.—The Comptroller General of the
20 United States shall conduct a study on access to
21 physical therapist services in States authorizing such
22 services without a physician referral and in States
23 that require such a physician referral. The study
24 shall—

1 (A) examine the use of and referral pat-
2 terns for physical therapist services for patients
3 age 50 and older in States that authorize such
4 services without a physician referral and in
5 States that require such a physician referral;

6 (B) examine the use of and referral pat-
7 terns for physical therapist services for patients
8 who are medicare beneficiaries;

9 (C) examine the potential effect of prohib-
10 iting a physician from referring patients to
11 physical therapy services owned by the physi-
12 cian and provided in the physician's office;

13 (D) examine the delivery of physical thera-
14 pists' services within the facilities of Depart-
15 ment of Defense; and

16 (E) analyze the potential impact on medi-
17 care beneficiaries and on expenditures under
18 the medicare program of eliminating the need
19 for a physician referral and physician certifi-
20 cation for physical therapist services under the
21 medicare program.

22 (2) REPORT.—The Comptroller General shall
23 submit to Congress a report on the study conducted
24 under paragraph (1) by not later than 1 year after
25 the date of the enactment of this Act.

1 **SEC. 234. RENAL DIALYSIS SERVICES.**

2 (a) REPORT ON DIFFERENCES IN COSTS IN DIF-
3 FERENT SETTINGS.—Not later than 1 year after the date
4 of the enactment of this Act, the Comptroller General of
5 the United States shall submit to Congress a report con-
6 taining—

7 (1) an analysis of the differences in costs of
8 providing renal dialysis services under the medicare
9 program in home settings and in facility settings;

10 (2) an assessment of the percentage of overhead
11 costs in home settings and in facility settings; and

12 (3) an evaluation of whether the charges for
13 home dialysis supplies and equipment are reasonable
14 and necessary.

15 (b) RESTORING COMPOSITE RATE EXCEPTIONS FOR
16 PEDIATRIC FACILITIES.—

17 (1) IN GENERAL.—Section 422(a)(2) of BIPA
18 is amended—

19 (A) in subparagraph (A), by striking “and
20 (C)” and inserting “, (C), and (D)”;

21 (B) in subparagraph (B), by striking “In
22 the case” and inserting “Subject to subpara-
23 graph (D), in the case”; and

24 (C) by adding at the end the following new
25 subparagraph:

1 “(D) INAPPLICABILITY TO PEDIATRIC FA-
2 CILITIES.—Subparagraphs (A) and (B) shall
3 not apply, as of October 1, 2002, to pediatric
4 facilities that do not have an exception rate de-
5 scribed in subparagraph (C) in effect on such
6 date. For purposes of this subparagraph, the
7 term ‘pediatric facility’ means a renal facility at
8 least 50 percent of whose patients are individ-
9 uals under 18 years of age.”.

10 (2) CONFORMING AMENDMENT.—The fourth
11 sentence of section 1881(b)(7) (42 U.S.C.
12 1395rr(b)(7)) is amended by striking “The Sec-
13 retary” and inserting “Subject to section 422(a)(2)
14 of the Medicare, Medicaid, and SCHIP Benefits Im-
15 provement and Protection Act of 2000, the Sec-
16 retary”.

17 (c) INCREASE IN RENAL DIALYSIS COMPOSITE RATE
18 FOR SERVICES FURNISHED IN 2004.—Notwithstanding
19 any other provision of law, with respect to payment under
20 part B of title XVIII of the Social Security Act for renal
21 dialysis services furnished in 2004, the composite payment
22 rate otherwise established under section 1881(b)(7) of
23 such Act (42 U.S.C. 1395rr(b)(7)) shall be increased by
24 1.2 percent.

1 **SEC. 235. WAIVER OF PART B LATE ENROLLMENT PENALTY**
2 **FOR CERTAIN MILITARY RETIREES; SPECIAL**
3 **ENROLLMENT PERIOD.**

4 (a) WAIVER OF PENALTY.—

5 (1) IN GENERAL.—Section 1839(b) (42 U.S.C.
6 1395r(b)) is amended by adding at the end the fol-
7 lowing new sentence: “No increase in the premium
8 shall be effected for a month in the case of an indi-
9 vidual who is 65 years of age or older, who enrolls
10 under this part during 2001, 2002, or 2003, and
11 who demonstrates to the Secretary before December
12 31, 2003, that the individual is a covered beneficiary
13 (as defined in section 1072(5) of title 10, United
14 States Code). The Secretary of Health and Human
15 Services shall consult with the Secretary of Defense
16 in identifying individuals described in the previous
17 sentence.”.

18 (2) EFFECTIVE DATE.—The amendment made
19 by paragraph (1) shall apply to premiums for
20 months beginning with January 2003. The Secretary
21 of Health and Human Services shall establish a
22 method for providing rebates of premium penalties
23 paid for months on or after January 2003 for which
24 a penalty does not apply under such amendment but
25 for which a penalty was previously collected.

1 (b) MEDICARE PART B SPECIAL ENROLLMENT PE-
2 RIOD.—

3 (1) IN GENERAL.—In the case of any individual
4 who, as of the date of the enactment of this Act, is
5 65 years of age or older, is eligible to enroll but is
6 not enrolled under part B of title XVIII of the So-
7 cial Security Act, and is a covered beneficiary (as
8 defined in section 1072(5) of title 10, United States
9 Code), the Secretary of Health and Human Services
10 shall provide for a special enrollment period during
11 which the individual may enroll under such part.
12 Such period shall begin as soon as possible after the
13 date of the enactment of this Act and shall end on
14 December 31, 2003.

15 (2) COVERAGE PERIOD.—In the case of an indi-
16 vidual who enrolls during the special enrollment pe-
17 riod provided under paragraph (1), the coverage pe-
18 riod under part B of title XVIII of the Social Secu-
19 rity Act shall begin on the first day of the month
20 following the month in which the individual enrolls.

21 **SEC. 236. COVERAGE OF IMMUNOSUPPRESSIVE DRUGS FOR**
22 **ALL MEDICARE BENEFICIARIES.**

23 (a) IN GENERAL.—Section 1861(s)(2)(J) (42 U.S.C.
24 1395x(s)(2)(J)) is amended by striking “, to an individual
25 who receives” and all that follows before the semicolon at

1 the end and inserting “to an individual who has received
2 an organ transplant”.

3 (b) EFFECTIVE DATE.—The amendments made by
4 this section shall apply to drugs furnished on or after the
5 date of the enactment of this Act.

6 **TITLE III—PROVISIONS**
7 **RELATING TO PARTS A AND B**
8 **Subtitle A—Home Health Services**

9 **SEC. 301. ELIMINATION OF 15 PERCENT REDUCTION IN**
10 **PAYMENT RATES UNDER THE PROSPECTIVE**
11 **PAYMENT SYSTEM.**

12 (a) IN GENERAL.—Section 1895(b)(3)(A) (42 U.S.C.
13 1395fff(b)(3)(A)) is amended to read as follows:

14 “(A) INITIAL BASIS.—Under such system
15 the Secretary shall provide for computation of
16 a standard prospective payment amount (or
17 amounts) as follows:

18 “(i) Such amount (or amounts) shall
19 initially be based on the most current au-
20 dited cost report data available to the Sec-
21 retary and shall be computed in a manner
22 so that the total amounts payable under
23 the system for fiscal year 2001 shall be
24 equal to the total amount that would have
25 been made if the system had not been in

1 effect and if section 1861(v)(1)(L)(ix) had
2 not been enacted.

3 “(ii) For fiscal year 2002 and for the
4 first quarter of fiscal year 2003, such
5 amount (or amounts) shall be equal to the
6 amount (or amounts) determined under
7 this paragraph for the previous fiscal year,
8 updated under subparagraph (B).

9 “(iii) For 2003, such amount (or
10 amounts) shall be equal to the amount (or
11 amounts) determined under this paragraph
12 for fiscal year 2002, updated under sub-
13 paragraph (B) for 2003.

14 “(iv) For 2004 and each subsequent
15 year, such amount (or amounts) shall be
16 equal to the amount (or amounts) deter-
17 mined under this paragraph for the pre-
18 vious year, updated under subparagraph
19 (B).

20 Each such amount shall be standardized in a
21 manner that eliminates the effect of variations
22 in relative case mix and area wage adjustments
23 among different home health agencies in a
24 budget neutral manner consistent with the case
25 mix and wage level adjustments provided under

1 paragraph (4)(A). Under the system, the Sec-
2 retary may recognize regional differences or dif-
3 ferences based upon whether or not the services
4 or agency are in an urbanized area.”.

5 (b) EFFECTIVE DATE.—The amendment made by
6 subsection (a) shall take effect as if included in the
7 amendments made by section 501 of the Medicare, Med-
8 icaid, and SCHIP Benefits Improvement and Protection
9 Act of 2000 (as enacted into law by section 1(a)(6) of
10 Public Law 106–554).

11 **SEC. 302. UPDATE IN HOME HEALTH SERVICES.**

12 (a) CHANGE TO CALENDAR YEAR UPDATE.—

13 (1) IN GENERAL.—Section 1895(b) (42 U.S.C.
14 1395fff(b)(3)) is amended—

15 (A) in paragraph (3)(B)(i)—

16 (i) by striking “each fiscal year (be-
17 ginning with fiscal year 2002)” and insert-
18 ing “fiscal year 2002 and for each subse-
19 quent year (beginning with 2003)”; and

20 (ii) by inserting “or year” after “the
21 fiscal year”;

22 (B) in paragraph (3)(B)(ii)—

23 (i) in subclause (II), by striking “fis-
24 cal year” and inserting “year” and by re-

1 designating such subclause as subclause
2 (III); and

3 (ii) in subclause (I), by striking “each
4 of fiscal years 2002 and 2003” and insert-
5 ing the following: “fiscal year 2002, the
6 home health market basket percentage in-
7 crease (as defined in clause (iii)) minus 1.1
8 percentage points;

9 “(II) 2003”;

10 (C) in paragraph (3)(B)(iii), by inserting
11 “or year” after “fiscal year” each place it ap-
12 pears;

13 (D) in paragraph (3)(B)(iv)—

14 (i) by inserting “or year” after “fiscal
15 year” each place it appears; and

16 (ii) by inserting “or years” after “fis-
17 cal years”; and

18 (E) in paragraph (5), by inserting “or
19 year” after “fiscal year”.

20 (2) TRANSITION RULE.—The standard prospec-
21 tive payment amount (or amounts) under section
22 1895(b)(3) of the Social Security Act for the cal-
23 endar quarter beginning on October 1, 2002, shall
24 be such amount (or amounts) for the previous cal-
25 endar quarter.

1 (b) CHANGES IN UPDATES FOR 2003, 2004, AND
2 2005.—Section 1895(b)(3)(B)(ii) (42 U.S.C.
3 1395fff(b)(3)(B)(ii)), as amended by subsection (a)(1)(B),
4 is amended—

5 (1) in subclause (II), by striking “the home
6 health market basket percentage increase (as defined
7 in clause (iii)) minus 1.1 percentage points” and in-
8 serting “2.0 percentage points”;

9 (2) by striking “or” at the end of subclause
10 (II);

11 (3) by redesignating subclause (III) as sub-
12 clause (V); and

13 (4) by inserting after subclause (II) the fol-
14 lowing new subclause:

15 “(III) 2004, 1.1 percentage
16 points;

17 “(IV) 2005, 2.7 percentage
18 points; or”.

19 (c) PAYMENT ADJUSTMENT.—

20 (1) IN GENERAL.—Section 1895(b)(5) (42
21 U.S.C. 1395fff(b)(5)) is amended by striking “5 per-
22 cent” and inserting “3 percent”.

23 (2) EFFECTIVE DATE.—The amendment made
24 by paragraph (1) shall apply to years beginning with
25 2003.

1 **SEC. 303. EXTENSION OF TEMPORARY INCREASE FOR**
2 **HOME HEALTH SERVICES FURNISHED IN A**
3 **RURAL AREA.**

4 (a) IN GENERAL.—Section 508(a) BIPA (114 Stat.
5 2763A–533) is amended—

6 (1) by striking “24-MONTH INCREASE BEGIN-
7 NING APRIL 1, 2001” and inserting “IN GENERAL”;
8 and

9 (2) by striking “April 1, 2003” and inserting
10 “January 1, 2005”.

11 (b) CONFORMING AMENDMENT.—Section 547(c)(2)
12 of BIPA (114 Stat. 2763A–553) is amended by striking
13 “the period beginning on April 1, 2001, and ending on
14 September 30, 2002,” and inserting “a period under such
15 section”.

16 **SEC. 304. OASIS TASK FORCE; SUSPENSION OF CERTAIN**
17 **OASIS DATA COLLECTION REQUIREMENTS**
18 **PENDING TASK FORCE SUBMITTAL OF RE-**
19 **PORT.**

20 (a) ESTABLISHMENT.—The Secretary of Health and
21 Human Services shall establish and appoint a task force
22 (to be known as the “OASIS Task Force”) to examine
23 the data collection and reporting requirements under
24 OASIS. For purposes of this section, the term “OASIS”
25 means the Outcome and Assessment Information Set re-

1 quired by reason of section 4602(e) of Balanced Budget
2 Act of 1997 (42 U.S.C. 1395fff note).

3 (b) COMPOSITION.—The OASIS Task Force shall be
4 composed of the following:

5 (1) Staff of the Centers for Medicare & Med-
6 icaid Services with expertise in post-acute care.

7 (2) Representatives of home health agencies.

8 (3) Health care professionals and research and
9 health care quality experts outside the Federal Gov-
10 ernment with expertise in post-acute care.

11 (4) Advocates for individuals requiring home
12 health services.

13 (c) DUTIES.—

14 (1) REVIEW AND RECOMMENDATIONS.—The
15 OASIS Task Force shall review and make rec-
16 ommendations to the Secretary regarding changes in
17 OASIS to improve and simplify data collection for
18 purposes of—

19 (A) assessing the quality of home health
20 services; and

21 (B) providing consistency in classification
22 of patients into home health resource groups
23 (HHRGs) for payment under section 1895 of
24 the Social Security Act (42 U.S.C. 1395fff).

1 (2) SPECIFIC ITEMS.—In conducting the review
2 under paragraph (1), the OASIS Task Force shall
3 specifically examine—

4 (A) the 41 outcome measures currently in
5 use;

6 (B) the timing and frequency of data col-
7 lection; and

8 (C) the collection of information on
9 comorbidities and clinical indicators.

10 (3) REPORT.—The OASIS Task Force shall
11 submit a report to the Secretary containing its find-
12 ings and recommendations for changes in OASIS by
13 not later than 18 months after the date of the enact-
14 ment of this Act.

15 (d) SUNSET.—The OASIS Task Force shall termi-
16 nate 60 days after the date on which the report is sub-
17 mitted under subsection (c)(2).

18 (e) NONAPPLICATION OF FACCA.—The provisions of
19 the Federal Advisory Committee Act shall not apply to
20 the OASIS Task Force.

21 (f) SUSPENSION OF OASIS REQUIREMENT FOR COL-
22 LECTION OF DATA ON NON-MEDICARE AND NON-MED-
23 ICAID PATIENTS PENDING TASK FORCE REPORT.—

24 (1) IN GENERAL.—During the period described
25 in paragraph (2), the Secretary of Health and

1 Human Services may not require, under section
2 4602(e) of the Balanced Budget Act of 1997 or oth-
3 erwise under OASIS, a home health agency to gath-
4 er or submit information that relates to an indi-
5 vidual who is not eligible for benefits under either
6 title XVIII or title XIX of the Social Security Act.

7 (2) PERIOD OF SUSPENSION.—The period de-
8 scribed in this paragraph—

9 (A) begins on January 1, 2003, and

10 (B) ends on the last day of the second
11 month beginning after the date the report is
12 submitted under subsection (c)(2).

13 **SEC. 305. MEDPAC STUDY ON MEDICARE MARGINS OF**
14 **HOME HEALTH AGENCIES.**

15 (a) STUDY.—The Medicare Payment Advisory Com-
16 mission shall conduct a study of payment margins of home
17 health agencies under the home health prospective pay-
18 ment system under section 1895 of the Social Security Act
19 (42 U.S.C. 1395fff). Such study shall examine whether
20 systematic differences in payment margins are related to
21 differences in case mix (as measured by home health re-
22 source groups (HHRGs)) among such agencies. The study
23 shall use the partial or full-year cost reports filed by home
24 health agencies.

1 (b) REPORT.—Not later than 2 years after the date
 2 of the enactment of this Act, the Commission shall submit
 3 to Congress a report on the study under subsection (a).

4 **Subtitle B—Other Provisions**

5 **SEC. 311. MODIFICATIONS TO MEDICARE PAYMENT ADVI-** 6 **SORY COMMISSION (MEDPAC).**

7 (a) EXAMINATION OF BUDGET CONSEQUENCES.—
 8 Section 1805(b) (42 U.S.C. 1395b–6(b)) is amended by
 9 adding at the end the following new paragraph:

10 “(8) EXAMINATION OF BUDGET CON-
 11 SEQUENCES.—Before making any recommendations,
 12 the Commission shall examine the budget con-
 13 sequences of such recommendations, directly or
 14 through consultation with appropriate expert enti-
 15 ties.”.

16 (b) CONSIDERATION OF EFFICIENT PROVISION OF
 17 SERVICES.—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b–
 18 6(b)(2)(B)(i)) is amended by inserting “the efficient provi-
 19 sion of” after “expenditures for”.

20 (c) ADDITIONAL REPORTS.—

21 (1) DATA NEEDS AND SOURCES.—The Medicare
 22 Payment Advisory Commission shall conduct a
 23 study, and submit a report to Congress by not later
 24 than June 1, 2003, on the need for current data,
 25 and sources of current data available, to determine

1 the solvency and financial circumstances of hospitals
2 and other medicare providers of services. The Com-
3 mission shall examine data on uncompensated care,
4 as well as the share of uncompensated care ac-
5 counted for by the expenses for treating illegal
6 aliens.

7 (2) USE OF TAX-RELATED RETURNS.—Using
8 return information provided under Form 990 of the
9 Internal Revenue Service, the Commission shall sub-
10 mit to Congress, by not later than July 1, 2003, a
11 report on the following:

12 (A) Investments and capital financing of
13 hospitals participating under the medicare pro-
14 gram and related foundations.

15 (B) Access to capital financing for private
16 and for not-for-profit hospitals.

17 **SEC. 312. DEMONSTRATION PROJECT FOR DISEASE MAN-**
18 **AGEMENT FOR CERTAIN MEDICARE BENE-**
19 **FICIARIES WITH DIABETES.**

20 (a) IN GENERAL.—The Secretary of Health and
21 Human Services shall conduct a demonstration project
22 under this section (in this section referred to as the
23 “project”) to demonstrate the impact on costs and health
24 outcomes of applying disease management to certain medi-
25 care beneficiaries with diagnosed diabetes. In no case may

1 the number of participants in the project exceed 30,000
2 at any time.

3 (b) VOLUNTARY PARTICIPATION.—

4 (1) ELIGIBILITY.—Medicare beneficiaries are
5 eligible to participate in the project only if—

6 (A) they are a member of a health dis-
7 parity population (as defined in section
8 485E(d) of the Public Health Service Act),
9 such as Hispanics;

10 (B) they meet specific medical criteria
11 demonstrating the appropriate diagnosis and
12 the advanced nature of their disease;

13 (C) their physicians approve of participa-
14 tion in the project; and

15 (D) they are not enrolled in a
16 Medicare+Choice plan.

17 (2) BENEFITS.—A medicare beneficiary who is
18 enrolled in the project shall be eligible—

19 (A) for disease management services re-
20 lated to their diabetes; and

21 (B) for payment for all costs for prescrip-
22 tion drugs without regard to whether or not
23 they relate to the diabetes, except that the
24 project may provide for modest cost-sharing
25 with respect to prescription drug coverage.

1 (c) CONTRACTS WITH DISEASE MANAGEMENT ORGA-
2 NIZATIONS.—

3 (1) IN GENERAL.—The Secretary of Health and
4 Human Services shall carry out the project through
5 contracts with up to three disease management orga-
6 nizations. The Secretary shall not enter into such
7 a contract with an organization unless the organiza-
8 tion demonstrates that it can produce improved
9 health outcomes and reduce aggregate medicare ex-
10 penditures consistent with paragraph (2).

11 (2) CONTRACT PROVISIONS.—Under such con-
12 tracts—

13 (A) such an organization shall be required
14 to provide for prescription drug coverage de-
15 scribed in subsection (b)(2)(B);

16 (B) such an organization shall be paid a
17 fee negotiated and established by the Secretary
18 in a manner so that (taking into account sav-
19 ings in expenditures under parts A and B of
20 the medicare program under title XVIII of the
21 Social Security Act) there will be no net in-
22 crease, and to the extent practicable, there will
23 be a net reduction in expenditures under the
24 medicare program as a result of the project;
25 and

1 (C) such an organization shall guarantee,
2 through an appropriate arrangement with a re-
3 insurance company or otherwise, the prohibition
4 on net increases in expenditures described in
5 subparagraph (B).

6 (3) PAYMENTS.—Payments to such organiza-
7 tions shall be made in appropriate proportion from
8 the Trust Funds established under title XVIII of the
9 Social Security Act.

10 (d) APPLICATION OF MEDIGAP PROTECTIONS TO
11 DEMONSTRATION PROJECT ENROLLEES.—(1) Subject to
12 paragraph (2), the provisions of section 1882(s)(3) (other
13 than clauses (i) through (iv) of subparagraph (B)) and
14 1882(s)(4) of the Social Security Act shall apply to enroll-
15 ment (and termination of enrollment) in the demonstra-
16 tion project under this section, in the same manner as they
17 apply to enrollment (and termination of enrollment) with
18 a Medicare+Choice organization in a Medicare+Choice
19 plan.

20 (2) In applying paragraph (1)—

21 (A) any reference in clause (v) or (vi) of section
22 1882(s)(3)(B) of such Act to 12 months is deemed
23 a reference to the period of the demonstration
24 project; and

1 (B) the notification required under section
2 1882(s)(3)(D) of such Act shall be provided in a
3 manner specified by the Secretary of Health and
4 Human Services.

5 (e) DURATION.—The project shall last for not longer
6 than 3 years.

7 (f) WAIVER.—The Secretary of Health and Human
8 Services shall waive such provisions of title XVIII of the
9 Social Security Act as may be necessary to provide for
10 payment for services under the project in accordance with
11 subsection (c)(3).

12 (g) REPORT.—The Secretary of Health and Human
13 Services shall submit to Congress an interim report on the
14 project not later than 2 years after the date it is first im-
15 plemented and a final report on the project not later than
16 6 months after the date of its completion. Such reports
17 shall include information on the impact of the project on
18 costs and health outcomes and recommendations on the
19 cost-effectiveness of extending or expanding the project.

20 (h) WORKING GROUP ON MEDICARE DISEASE MAN-
21 AGEMENT PROGRAMS.—The Secretary shall establish
22 within the Department of Health and Human Services a
23 working group consisting of employees of the Department
24 to carry out the following:

25 (1) To oversee the project.

1 (2) To establish policy and criteria for medicare
2 disease management programs within the Depart-
3 ment, including the establishment of policy and cri-
4 teria for such programs.

5 (3) To identify targeted medical conditions and
6 targeted individuals.

7 (4) To select areas in which such programs are
8 carried out.

9 (5) To monitor health outcomes under such
10 programs.

11 (6) To measure the effectiveness of such pro-
12 grams in meeting any budget neutrality require-
13 ments.

14 (7) Otherwise to serve as a central focal point
15 within the Department for dissemination of informa-
16 tion on medicare disease management programs.

17 (i) GAO STUDY ON DISEASE MANAGEMENT PRO-
18 GRAMS.—The Comptroller General of the United States
19 shall conduct a study that compares disease management
20 programs under title XVIII of the Social Security Act with
21 such programs conducted in the private sector, including
22 the prevalence of such programs and programs for case
23 management. The study shall identify the cost-effective-
24 ness of such programs and any savings achieved by such
25 programs. The Comptroller General shall submit a report

1 on such study to Congress by not later than 18 months
2 after the date of the enactment of this Act.

3 **SEC. 313. DEMONSTRATION PROJECT FOR MEDICAL ADULT**
4 **DAY CARE SERVICES.**

5 (a) ESTABLISHMENT.—Subject to the succeeding
6 provisions of this section, the Secretary of Health and
7 Human Services shall establish a demonstration project
8 (in this section referred to as the “demonstration project”)
9 under which the Secretary shall, as part of a plan of an
10 episode of care for home health services established for
11 a medicare beneficiary, permit a home health agency, di-
12 rectly or under arrangements with a medical adult day
13 care facility, to provide medical adult day care services as
14 a substitute for a portion of home health services that
15 would otherwise be provided in the beneficiary’s home.

16 (b) PAYMENT.—

17 (1) IN GENERAL.—The amount of payment for
18 an episode of care for home health services, a por-
19 tion of which consists of substitute medical adult
20 day care services, under the demonstration project
21 shall be made at a rate equal to 95 percent of the
22 amount that would otherwise apply for such home
23 health services under section 1895 of the Social Se-
24 curity Act (42 U.S.C. 1395fff). In no case may a
25 home health agency, or a medical adult day care fa-

1 cility under arrangements with a home health agen-
2 cy, separately charge a beneficiary for medical adult
3 day care services furnished under the plan of care.

4 (2) BUDGET NEUTRALITY FOR DEMONSTRA-
5 TION PROJECT.—Notwithstanding any other provi-
6 sion of law, the Secretary shall provide for an appro-
7 priate reduction in the aggregate amount of addi-
8 tional payments made under section 1895 of the So-
9 cial Security Act (42 U.S.C. 1395fff) to reflect any
10 increase in amounts expended from the Trust Funds
11 as a result of the demonstration project conducted
12 under this section.

13 (c) DEMONSTRATION PROJECT SITES.—The project
14 established under this section shall be conducted in not
15 more than 5 States selected by the Secretary that license
16 or certify providers of services that furnish medical adult
17 day care services.

18 (d) DURATION.—The Secretary shall conduct the
19 demonstration project for a period of 3 years.

20 (e) VOLUNTARY PARTICIPATION.—Participation of
21 medicare beneficiaries in the demonstration project shall
22 be voluntary. The total number of such beneficiaries that
23 may participate in the project at any given time may not
24 exceed 15,000.

1 (f) PREFERENCE IN SELECTING AGENCIES.—In se-
2 lecting home health agencies to participate under the dem-
3 onstration project, the Secretary shall give preference to
4 those agencies that are currently licensed or certified
5 through common ownership and control to furnish medical
6 adult day care services.

7 (g) WAIVER AUTHORITY.—The Secretary may waive
8 such requirements of title XVIII of the Social Security Act
9 as may be necessary for the purposes of carrying out the
10 demonstration project, other than waiving the requirement
11 that an individual be homebound in order to be eligible
12 for benefits for home health services.

13 (h) EVALUATION AND REPORT.—The Secretary shall
14 conduct an evaluation of the clinical and cost effectiveness
15 of the demonstration project. Not later than 30 months
16 after the commencement of the project, the Secretary shall
17 submit to Congress a report on the evaluation, and shall
18 include in the report the following:

19 (1) An analysis of the patient outcomes and
20 costs of furnishing care to the medicare beneficiaries
21 participating in the project as compared to such out-
22 comes and costs to beneficiaries receiving only home
23 health services for the same health conditions.

1 (2) Such recommendations regarding the exten-
2 sion, expansion, or termination of the project as the
3 Secretary determines appropriate.

4 (i) DEFINITIONS.—In this section:

5 (1) HOME HEALTH AGENCY.—The term “home
6 health agency” has the meaning given such term in
7 section 1861(o) of the Social Security Act (42
8 U.S.C. 1395x(o)).

9 (2) MEDICAL ADULT DAY CARE FACILITY.—The
10 term “medical adult day care facility” means a facil-
11 ity that—

12 (A) has been licensed or certified by a
13 State to furnish medical adult day care services
14 in the State for a continuous 2-year period;

15 (B) is engaged in providing skilled nursing
16 services and other therapeutic services directly
17 or under arrangement with a home health agen-
18 cy;

19 (C) meets such standards established by
20 the Secretary to assure quality of care and such
21 other requirements as the Secretary finds nec-
22 essary in the interest of the health and safety
23 of individuals who are furnished services in the
24 facility; and

1 (D) provides medical adult day care serv-
2 ices.

3 (3) MEDICAL ADULT DAY CARE SERVICES.—

4 The term “medical adult day care services” means—

5 (A) home health service items and services
6 described in paragraphs (1) through (7) of sec-
7 tion 1861(m) furnished in a medical adult day
8 care facility;

9 (B) a program of supervised activities fur-
10 nished in a group setting in the facility that—

11 (i) meet such criteria as the Secretary
12 determines appropriate; and

13 (ii) is designed to promote physical
14 and mental health of the individuals; and

15 (C) such other services as the Secretary
16 may specify.

17 (4) MEDICARE BENEFICIARY.—The term
18 “medicare beneficiary” means an individual entitled
19 to benefits under part A of this title, enrolled under
20 part B of this title, or both.

1 **SEC. 314. PUBLICATION ON FINAL WRITTEN GUIDANCE**
 2 **CONCERNING PROHIBITIONS AGAINST DIS-**
 3 **CRIMINATION BY NATIONAL ORIGIN WITH**
 4 **RESPECT TO HEALTH CARE SERVICES.**

5 Not later than June 1, 2003, the Secretary shall issue
 6 final written guidance concerning the application of the
 7 prohibition in title VI of the Civil Rights Act of 1964 (42
 8 U.S.C. 2000d et seq.) against national origin discrimina-
 9 tion as it affects persons with limited English proficiency
 10 with respect to access to health care services under the
 11 medicare program under title XVIII of the Social Security
 12 Act, the medicaid program under title XIX of such Act,
 13 and the SCHIP program under title XXI of such Act.

14 **TITLE IV—PROVISIONS**
 15 **RELATING TO MANAGED CARE**

16 **SEC. 401. MEDICARE+CHOICE IMPROVEMENTS.**

17 (a) **EQUALIZING PAYMENTS BETWEEN FEE-FOR-**
 18 **SERVICE AND MEDICARE+CHOICE.—**

19 (1) **IN GENERAL.—**Section 1853(c)(1) (42
 20 U.S.C. 1395w-23(c)(1)) is amended by adding at
 21 the end the following:

22 “(D) **BASED ON 100 PERCENT OF FEE-**
 23 **FOR-SERVICE COSTS.—**

24 “(i) **IN GENERAL.—**For 2003 and
 25 2004, the adjusted average per capita cost
 26 for the year involved, determined under

1 section 1876(a)(4) for the
2 Medicare+Choice payment area for serv-
3 ices covered under parts A and B for indi-
4 viduals entitled to benefits under part A
5 and enrolled under part B who are not en-
6 rolled in a Medicare+Choice plan under
7 this part for the year, but adjusted to ex-
8 clude costs attributable to payments under
9 section 1886(h).

10 “(ii) INCLUSION OF COSTS OF VA AND
11 DOD MILITARY FACILITY SERVICES TO
12 MEDICARE-ELIGIBLE BENEFICIARIES.—In
13 determining the adjusted average per cap-
14 ita cost under clause (i) for a year, such
15 cost shall be adjusted to include the Sec-
16 retary’s estimate, on a per capita basis, of
17 the amount of additional payments that
18 would have been made in the area involved
19 under this title if individuals entitled to
20 benefits under this title had not received
21 services from facilities of the Department
22 of Veterans Affairs or the Department of
23 Defense.”.

24 (2) CONFORMING AMENDMENT.—Such section
25 is further amended, in the matter before subpara-

1 graph (A), by striking “or (C)” and inserting “(C),
2 or (D)”.

3 (b) REVISION OF BLEND.—

4 (1) REVISION OF NATIONAL AVERAGE USED IN
5 CALCULATION OF BLEND.—Section
6 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w-
7 23(c)(4)(B)(i)(II)) is amended by inserting “who
8 (with respect to determinations for 2003 and for
9 2004) are enrolled in a Medicare+Choice plan”
10 after “the average number of medicare bene-
11 ficiaries”.

12 (2) CHANGE IN BUDGET NEUTRALITY.—Section
13 1853(c) (42 U.S.C. 1395w-23(c)) is amended—

14 (A) in paragraph (1)(A), by inserting “(for
15 a year before 2003)” after “multiplied”; and

16 (B) in paragraph (5), by inserting “(before
17 2003)” after “for each year”.

18 (c) REVISION IN MINIMUM PERCENTAGE INCREASE
19 FOR 2003 AND 2004.—Section 1853(c)(1)(C) (42 U.S.C.
20 1395w-23(c)(1)(C)) is amended by striking clause (iv)
21 and inserting the following:

22 “(iv) For 2002, 102 percent of the
23 annual Medicare+Choice capitation rate
24 under this paragraph for the area for
25 2001.

1 “(v) For 2003 and 2004, 103 percent
2 of the annual Medicare+Choice capitation
3 rate under this paragraph for the area for
4 the previous year.

5 “(vi) For 2005 and each succeeding
6 year, 102 percent of the annual
7 Medicare+Choice capitation rate under
8 this paragraph for the area for the pre-
9 vious year.”.

10 (d) INCLUSION OF COSTS OF DOD AND VA MILI-
11 TARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENE-
12 FICIARIES IN CALCULATION OF MEDICARE+CHOICE PAY-
13 MENT RATES.—Section 1853(c)(3) (42 U.S.C. 1395w-
14 23(c)(3)) is amended—

15 (1) in subparagraph (A), by striking “subpara-
16 graph (B)” and inserting “subparagraphs (B) and
17 (E)”, and

18 (2) by adding at the end the following new sub-
19 paragraph:

20 “(E) INCLUSION OF COSTS OF DOD AND
21 VA MILITARY FACILITY SERVICES TO MEDICARE-
22 ELIGIBLE BENEFICIARIES.—In determining the
23 area-specific Medicare+Choice capitation rate
24 under subparagraph (A) for a year (beginning
25 with 2003), the annual per capita rate of pay-

1 ment for 1997 determined under section
2 1876(a)(1)(C) shall be adjusted to include in
3 the rate the Secretary's estimate, on a per cap-
4 ita basis, of the amount of additional payments
5 that would have been made in the area involved
6 under this title if individuals entitled to benefits
7 under this title had not received services from
8 facilities of the Department of Defense or the
9 Department of Veterans Affairs.”.

10 (e) ANNOUNCEMENT OF REVISED
11 MEDICARE+CHOICE PAYMENT RATES.—Within 4 weeks
12 after the date of the enactment of this Act, the Secretary
13 shall determine, and shall announce (in a manner intended
14 to provide notice to interested parties) Medicare+Choice
15 capitation rates under section 1853 of the Social Security
16 Act (42 U.S.C. 1395w-23) for 2003, revised in accordance
17 with the provisions of this section.

18 (f) MEDPAC STUDY OF AAPCC.—

19 (1) STUDY.—The Medicare Payment Advisory
20 Commission shall conduct a study that assesses the
21 method used for determining the adjusted average
22 per capita cost (AAPCC) under section 1876(a)(4)
23 of the Social Security Act (42 U.S.C.
24 1395mm(a)(4)). Such study shall examine—

1 (A) the bases for variation in such costs
2 between different areas, including differences in
3 input prices, utilization, and practice patterns;

4 (B) the appropriate geographic area for
5 payment under the Medicare+Choice program
6 under part C of title XVIII of such Act; and

7 (C) the accuracy of risk adjustment meth-
8 ods in reflecting differences in costs of pro-
9 viding care to different groups of beneficiaries
10 served under such program.

11 (2) REPORT.—Not later than 9 months after
12 the date of the enactment of this Act, the Commis-
13 sion shall submit to Congress a report on the study
14 conducted under paragraph (1). Such report shall
15 include recommendations regarding changes in the
16 methods for computing the adjusted average per
17 capita cost among different areas.

18 (g) REPORT ON IMPACT OF INCREASED FINANCIAL
19 ASSISTANCE TO MEDICARE+CHOICE PLANS.—Not later
20 than July 1, 2003, the Secretary of Health and Human
21 Services shall submit to Congress a report that describes
22 the impact of additional financing provided under this Act
23 and other Acts (including the Medicare, Medicaid, and
24 SCHIP Balanced Budget Refinement Act of 1999 and
25 BIPA) on the availability of Medicare+Choice plans in

1 different areas and its impact on lowering premiums and
2 increasing benefits under such plans.

3 **SEC. 402. SPECIALIZED MEDICARE+CHOICE PLANS FOR**
4 **SPECIAL NEEDS BENEFICIARIES.**

5 (a) TREATMENT AS COORDINATED CARE PLAN.—
6 Section 1851(a)(2)(A) (42 U.S.C. 1395w–21(a)(2)(A)) is
7 amended by adding at the end the following new sentence:
8 “Specialized Medicare+Choice plans for special needs
9 beneficiaries (as defined in section 1859(b)(4)) may be
10 any type of coordinated care plan.”.

11 (b) SPECIALIZED MEDICARE+CHOICE PLAN FOR
12 SPECIAL NEEDS BENEFICIARIES DEFINED.—Section
13 1859(b) (42 U.S.C. 1395w–29(b)) is amended by adding
14 at the end the following new paragraph:

15 “(4) SPECIALIZED MEDICARE+CHOICE PLANS
16 FOR SPECIAL NEEDS BENEFICIARIES.—

17 “(A) IN GENERAL.—The term ‘specialized
18 Medicare+Choice plan for special needs bene-
19 ficiaries’ means a Medicare+Choice plan that
20 exclusively serves special needs beneficiaries (as
21 defined in subparagraph (B)).

22 “(B) SPECIAL NEEDS BENEFICIARY.—The
23 term ‘special needs beneficiary’ means a
24 Medicare+Choice eligible individual who—

1 “(i) is institutionalized (as defined by
2 the Secretary);

3 “(ii) is entitled to medical assistance
4 under a State plan under title XIX; or

5 “(iii) meets such requirements as the
6 Secretary may determine would benefit
7 from enrollment in such a specialized
8 Medicare+Choice plan described in sub-
9 paragraph (A) for individuals with severe
10 or disabling chronic conditions.”.

11 (c) RESTRICTION ON ENROLLMENT PERMITTED.—
12 Section 1859 (42 U.S.C. 1395w–29) is amended by add-
13 ing at the end the following new subsection:

14 “(f) RESTRICTION ON ENROLLMENT FOR SPECIAL-
15 IZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS
16 BENEFICIARIES.—In the case of a specialized
17 Medicare+Choice plan (as defined in subsection (b)(4)),
18 notwithstanding any other provision of this part and in
19 accordance with regulations of the Secretary and for peri-
20 ods before January 1, 2007, the plan may restrict the en-
21 rollment of individuals under the plan to individuals who
22 are within one or more classes of special needs bene-
23 ficiaries.”.

24 (d) REPORT TO CONGRESS.—Not later than Decem-
25 ber 31, 2005, the Medicare Benefits Administrator shall

1 submit to Congress a report that assesses the impact of
2 specialized Medicare+Choice plans for special needs bene-
3 ficiaries on the cost and quality of services provided to
4 enrollees. Such report shall include an assessment of the
5 costs and savings to the medicare program as a result of
6 amendments made by subsections (a), (b), and (c).

7 (e) EFFECTIVE DATES.—

8 (1) IN GENERAL.—The amendments made by
9 subsections (a), (b), and (c) shall take effect upon
10 the date of the enactment of this Act.

11 (2) DEADLINE FOR ISSUANCE OF REQUIRE-
12 MENTS FOR SPECIAL NEEDS BENEFICIARIES; TRAN-
13 SITION.—No later than 6 months after the date of
14 the enactment of this Act, the Secretary of Health
15 and Human Services shall issue final regulations to
16 establish requirements for special needs beneficiaries
17 under section 1859(b)(4)(B)(iii) of the Social Secu-
18 rity Act, as added by subsection (b).

19 **SEC. 403. EXTENSION OF REASONABLE COST AND SHMO**
20 **CONTRACTS.**

21 (a) REASONABLE COST CONTRACTS.—

22 (1) IN GENERAL.—Section 1876(h)(5)(C) (42
23 U.S.C. 1395mm(h)(5)(C)) is amended—

24 (A) by inserting “(i)” after “(C)”;

1 (B) by inserting before the period the fol-
2 lowing: “, except (subject to clause (ii)) in the
3 case of a contract for an area which is not cov-
4 ered in the service area of 1 or more coordi-
5 nated care Medicare+Choice plans under part
6 C”; and

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

9 “(ii) In the case in which—

10 “(I) a reasonable cost reimbursement contract
11 includes an area in its service area as of a date that
12 is after December 31, 2003;

13 “(II) such area is no longer included in such
14 service area after such date by reason of the oper-
15 ation of clause (i) because of the inclusion of such
16 area within the service area of a Medicare+Choice
17 plan; and

18 “(III) all Medicare+Choice plans subsequently
19 terminate coverage in such area;

20 such reasonable cost reimbursement contract may be ex-
21 tended and renewed to cover such area (so long as it is
22 not included in the service area of any Medicare+Choice
23 plan).”.

24 (2) STUDY.—The Medicare Benefits Adminis-
25 trator shall conduct a study of an appropriate tran-

1 sition for plans offered under reasonable cost con-
2 tracts under section 1876 of the Social Security Act
3 on and after January 1, 2005. Such a transition
4 may take into account whether there are one or
5 more coordinated care Medicare+Choice plans being
6 offered in the areas involved. Not later than Feb-
7 ruary 1, 2004, the Administrator shall submit to
8 Congress a report on such study and shall include
9 recommendations regarding any changes in the
10 amendment made by paragraph (1) as the Adminis-
11 trator determines to be appropriate.

12 (b) EXTENSION OF SOCIAL HEALTH MAINTENANCE
13 ORGANIZATION (SHMO) DEMONSTRATION PROJECT.—

14 (1) IN GENERAL.—Section 4018(b)(1) of the
15 Omnibus Budget Reconciliation Act of 1987 is
16 amended by striking “the date that is 30 months
17 after the date that the Secretary submits to Con-
18 gress the report described in section 4014(c) of the
19 Balanced Budget Act of 1997” and inserting “De-
20 cember 31, 2004”.

21 (2) SHMOS OFFERING MEDICARE+CHOICE
22 PLANS.—Nothing in such section 4018 shall be con-
23 strued as preventing a social health maintenance or-
24 ganization from offering a Medicare+Choice plan

1 under part C of title XVIII of the Social Security
2 Act.

3 **SEC. 404. EXTENSION OF MUNICIPAL HEALTH SERVICE**
4 **DEMONSTRATION PROJECTS.**

5 The last sentence of section 9215(a) of the Consoli-
6 dated Omnibus Budget Reconciliation Act of 1985 (42
7 U.S.C. 1395b–1 note), as previously amended, is amended
8 by striking “December 31, 2004, but only with respect
9 to” and all that follows and inserting “December 31,
10 2009, but only with respect to individuals who reside in
11 the city in which the project is operated and so long as
12 the total number of individuals participating in the project
13 does not exceed the number of such individuals partici-
14 pating as of January 1, 1996.”.

15 **SEC. 405. PAYMENT BY PACE PROVIDERS FOR MEDICARE**
16 **AND MEDICAID SERVICES FURNISHED BY**
17 **NONCONTRACT PROVIDERS.**

18 (a) MEDICARE SERVICES.—

19 (1) MEDICARE SERVICES FURNISHED BY PRO-
20 VIDERS OF SERVICES.—Section 1866(a)(1)(O) (42
21 U.S.C. 1395cc(a)(1)(O)) is amended—

22 (A) by striking “part C or” and inserting
23 “part C, with a PACE provider under section
24 1894 or 1934, or”;

25 (B) by striking “(i)”;

1 (C) by striking “and (ii)”; and

2 (D) by striking “members of the organiza-
3 tion” and inserting “members of the organiza-
4 tion or PACE program eligible individuals en-
5 rolled with the PACE provider,”.

6 (2) MEDICARE SERVICES FURNISHED BY PHYSI-
7 CIANS AND OTHER ENTITIES.—Section 1894(b) (42
8 U.S.C. 1395eee(b)) is amended by adding at the end
9 the following new paragraphs:

10 “(3) TREATMENT OF MEDICARE SERVICES FUR-
11 NISHED BY NONCONTRACT PHYSICIANS AND OTHER
12 ENTITIES.—

13 “(A) APPLICATION OF MEDICARE+CHOICE
14 REQUIREMENT WITH RESPECT TO MEDICARE
15 SERVICES FURNISHED BY NONCONTRACT PHY-
16 SICIANS AND OTHER ENTITIES.—Section
17 1852(k)(1) (relating to limitations on balance
18 billing against Medicare+Choice organizations
19 for noncontract physicians and other entities
20 with respect to services covered under this title)
21 shall apply to PACE providers, PACE program
22 eligible individuals enrolled with such PACE
23 providers, and physicians and other entities
24 that do not have a contract establishing pay-
25 ment amounts for services furnished to such an

1 individual in the same manner as such section
2 applies to Medicare+Choice organizations, indi-
3 viduals enrolled with such organizations, and
4 physicians and other entities referred to in such
5 section.

6 “(B) REFERENCE TO RELATED PROVISION
7 FOR NONCONTRACT PROVIDERS OF SERVICES.—
8 For the provision relating to limitations on bal-
9 ance billing against PACE providers for serv-
10 ices covered under this title furnished by non-
11 contract providers of services, see section
12 1866(a)(1)(O).

13 “(4) REFERENCE TO RELATED PROVISION FOR
14 SERVICES COVERED UNDER TITLE XIX BUT NOT
15 UNDER THIS TITLE.—For provisions relating to limi-
16 tations on payments to providers participating under
17 the State plan under title XIX that do not have a
18 contract with a PACE provider establishing payment
19 amounts for services covered under such plan (but
20 not under this title) when such services are fur-
21 nished to enrollees of that PACE provider, see sec-
22 tion 1902(a)(66).”.

23 (b) MEDICAID SERVICES.—

24 (1) REQUIREMENT UNDER STATE PLAN.—Sec-
25 tion 1902(a) (42 U.S.C. 1396a(a) is amended—

1 (A) in paragraph (64), by striking “and”
2 at the end;

3 (B) in paragraph (65), by striking the pe-
4 riod at the end and inserting “; and”; and

5 (C) by inserting after paragraph (65) the
6 following new paragraph:

7 “(66) provide, with respect to services cov-
8 ered under the State plan (but not under title
9 XVIII) that are furnished to a PACE program
10 eligible individual enrolled with a PACE pro-
11 vider by a provider participating under the
12 State plan that does not have a contract with
13 the PACE provider that establishes payment
14 amounts for such services, that such partici-
15 pating provider may not require the PACE pro-
16 vider to pay the participating provider an
17 amount greater than the amount that would
18 otherwise be payable for the service to the par-
19 ticipating provider under the State plan for the
20 State where the PACE provider is located (in
21 accordance with regulations issued by the Sec-
22 retary).”.

23 (2) REFERENCE IN MEDICAID STATUTE.—Sec-
24 tion 1934(b) (42 U.S.C. 1396u–4(b)) is amended by
25 adding at the end the following new paragraphs:

1 “(3) TREATMENT OF MEDICARE SERVICES FUR-
2 NISHED BY NONCONTRACT PHYSICIANS AND OTHER
3 ENTITIES.—

4 “(A) APPLICATION OF MEDICARE+CHOICE
5 REQUIREMENT WITH RESPECT TO MEDICARE
6 SERVICES FURNISHED BY NONCONTRACT PHY-
7 SICIANS AND OTHER ENTITIES.—Section
8 1852(k)(1) (relating to limitations on balance
9 billing against Medicare+Choice organizations
10 for noncontract physicians and other entities
11 with respect to services covered under title
12 XVIII) shall apply to PACE providers, PACE
13 program eligible individuals enrolled with such
14 PACE providers, and physicians and other enti-
15 ties that do not have a contract establishing
16 payment amounts for services furnished to such
17 an individual in the same manner as such sec-
18 tion applies to Medicare+Choice organizations,
19 individuals enrolled with such organizations,
20 and physicians and other entities referred to in
21 such section.

22 “(B) REFERENCE TO RELATED PROVISION
23 FOR NONCONTRACT PROVIDERS OF SERVICES.—
24 For the provision relating to limitations on bal-
25 ance billing against PACE providers for serv-

1 ices covered under title XVIII furnished by non-
 2 contract providers of services, see section
 3 1866(a)(1)(O).

4 “(4) REFERENCE TO RELATED PROVISION FOR
 5 SERVICES COVERED UNDER THIS TITLE BUT NOT
 6 UNDER TITLE XVIII.—For provisions relating to lim-
 7 itations on payments to providers participating
 8 under the State plan under this title that do not
 9 have a contract with a PACE provider establishing
 10 payment amounts for services covered under such
 11 plan (but not under title XVIII) when such services
 12 are furnished to enrollees of that PACE provider,
 13 see section 1902(a)(66).”.

14 (c) EFFECTIVE DATE.—The amendments made by
 15 this section shall apply to services furnished on or after
 16 January 1, 2003.

17 **TITLE V—REGULATORY REDUC-**
 18 **TION AND CONTRACTING RE-**
 19 **FORM**

20 **Subtitle A—Regulatory Reform**

21 **SEC. 501. CONSTRUCTION; DEFINITION OF SUPPLIER.**

22 (a) CONSTRUCTION.—Nothing in this title shall be
 23 construed—

24 (1) to compromise or affect existing legal rem-
 25 edies for addressing fraud or abuse, whether it be

1 criminal prosecution, civil enforcement, or adminis-
2 trative remedies, including under sections 3729
3 through 3733 of title 31, United States Code
4 (known as the False Claims Act); or

5 (2) to prevent or impede the Department of
6 Health and Human Services in any way from its on-
7 going efforts to eliminate waste, fraud, and abuse in
8 the medicare program.

9 Furthermore, the consolidation of medicare administrative
10 contracting set forth in this Act does not constitute con-
11 solidation of the Federal Hospital Insurance Trust Fund
12 and the Federal Supplementary Medical Insurance Trust
13 Fund or reflect any position on that issue.

14 (b) DEFINITION OF SUPPLIER.—Section 1861 (42
15 U.S.C. 1395x) is amended by inserting after subsection
16 (c) the following new subsection:

17 “Supplier

18 “(d) The term ‘supplier’ means, unless the context
19 otherwise requires, a physician or other practitioner, a fa-
20 cility, or other entity (other than a provider of services)
21 that furnishes items or services under this title.”.

22 **SEC. 502. ISSUANCE OF REGULATIONS.**

23 (a) CONSOLIDATION OF PROMULGATION TO ONCE A
24 MONTH.—

1 (1) IN GENERAL.—Section 1871 (42 U.S.C.
2 1395hh) is amended by adding at the end the fol-
3 lowing new subsection:

4 “(d)(1) Subject to paragraph (2), the Secretary shall
5 issue proposed or final (including interim final) regula-
6 tions to carry out this title only on one business day of
7 every month.

8 “(2) The Secretary may issue a proposed or final reg-
9 ulation described in paragraph (1) on any other day than
10 the day described in paragraph (1) if the Secretary—

11 “(A) finds that issuance of such regulation on
12 another day is necessary to comply with require-
13 ments under law; or

14 “(B) finds that with respect to that regulation
15 the limitation of issuance on the date described in
16 paragraph (1) is contrary to the public interest.

17 If the Secretary makes a finding under this paragraph,
18 the Secretary shall include such finding, and brief state-
19 ment of the reasons for such finding, in the issuance of
20 such regulation.

21 “(3) The Secretary shall coordinate issuance of new
22 regulations described in paragraph (1) relating to a cat-
23 egory of provider of services or suppliers based on an anal-
24 ysis of the collective impact of regulatory changes on that
25 category of providers or suppliers.”.

1 (2) GAO REPORT ON PUBLICATION OF REGULA-
2 TIONS ON A QUARTERLY BASIS.—Not later than 3
3 years after the date of the enactment of this Act, the
4 Comptroller General of the United States shall sub-
5 mit to Congress a report on the feasibility of requir-
6 ing that regulations described in section 1871(d) of
7 the Social Security Act be promulgated on a quar-
8 terly basis rather than on a monthly basis.

9 (3) EFFECTIVE DATE.—The amendment made
10 by paragraph (1) shall apply to regulations promul-
11 gated on or after the date that is 30 days after the
12 date of the enactment of this Act.

13 (b) REGULAR TIMELINE FOR PUBLICATION OF
14 FINAL RULES.—

15 (1) IN GENERAL.—Section 1871(a) (42 U.S.C.
16 1395hh(a)) is amended by adding at the end the fol-
17 lowing new paragraph:

18 “(3)(A) The Secretary, in consultation with the Di-
19 rector of the Office of Management and Budget, shall es-
20 tablish and publish a regular timeline for the publication
21 of final regulations based on the previous publication of
22 a proposed regulation or an interim final regulation.

23 “(B) Such timeline may vary among different regula-
24 tions based on differences in the complexity of the regula-
25 tion, the number and scope of comments received, and

1 other relevant factors, but shall not be longer than 3 years
2 except under exceptional circumstances. If the Secretary
3 intends to vary such timeline with respect to the publica-
4 tion of a final regulation, the Secretary shall cause to have
5 published in the Federal Register notice of the different
6 timeline by not later than the timeline previously estab-
7 lished with respect to such regulation. Such notice shall
8 include a brief explanation of the justification for such
9 variation.

10 “(C) In the case of interim final regulations, upon
11 the expiration of the regular timeline established under
12 this paragraph for the publication of a final regulation
13 after opportunity for public comment, the interim final
14 regulation shall not continue in effect unless the Secretary
15 publishes (at the end of the regular timeline and, if appli-
16 cable, at the end of each succeeding 1-year period) a notice
17 of continuation of the regulation that includes an expla-
18 nation of why the regular timeline (and any subsequent
19 1-year extension) was not complied with. If such a notice
20 is published, the regular timeline (or such timeline as pre-
21 viously extended under this paragraph) for publication of
22 the final regulation shall be treated as having been ex-
23 tended for 1 additional year.

24 “(D) The Secretary shall annually submit to Con-
25 gress a report that describes the instances in which the

1 Secretary failed to publish a final regulation within the
2 applicable regular timeline under this paragraph and that
3 provides an explanation for such failures.”.

4 (2) EFFECTIVE DATE.—The amendment made
5 by paragraph (1) shall take effect on the date of the
6 enactment of this Act. The Secretary shall provide
7 for an appropriate transition to take into account
8 the backlog of previously published interim final reg-
9 ulations.

10 (c) LIMITATIONS ON NEW MATTER IN FINAL REGU-
11 LATIONS.—

12 (1) IN GENERAL.—Section 1871(a) (42 U.S.C.
13 1395hh(a)), as amended by subsection (b), is further
14 amended by adding at the end the following new
15 paragraph:

16 “(4) If the Secretary publishes notice of proposed
17 rulemaking relating to a regulation (including an interim
18 final regulation), insofar as such final regulation includes
19 a provision that is not a logical outgrowth of such notice
20 of proposed rulemaking, that provision shall be treated as
21 a proposed regulation and shall not take effect until there
22 is the further opportunity for public comment and a publi-
23 cation of the provision again as a final regulation.”.

24 (2) EFFECTIVE DATE.—The amendment made
25 by paragraph (1) shall apply to final regulations

1 published on or after the date of the enactment of
2 this Act.

3 **SEC. 503. COMPLIANCE WITH CHANGES IN REGULATIONS**
4 **AND POLICIES.**

5 (a) NO RETROACTIVE APPLICATION OF SUB-
6 STANTIVE CHANGES.—

7 (1) IN GENERAL.—Section 1871 (42 U.S.C.
8 1395hh), as amended by section 502(a), is amended
9 by adding at the end the following new subsection:

10 “(e)(1)(A) A substantive change in regulations, man-
11 ual instructions, interpretative rules, statements of policy,
12 or guidelines of general applicability under this title shall
13 not be applied (by extrapolation or otherwise) retroactively
14 to items and services furnished before the effective date
15 of the change, unless the Secretary determines that—

16 “(i) such retroactive application is necessary to
17 comply with statutory requirements; or

18 “(ii) failure to apply the change retroactively
19 would be contrary to the public interest.”.

20 (2) EFFECTIVE DATE.—The amendment made
21 by paragraph (1) shall apply to substantive changes
22 issued on or after the date of the enactment of this
23 Act.

24 (b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE
25 CHANGES AFTER NOTICE.—

1 (1) IN GENERAL.—Section 1871(e)(1), as
2 added by subsection (a), is amended by adding at
3 the end the following:

4 “(B)(i) Except as provided in clause (ii), a sub-
5 stantive change referred to in subparagraph (A) shall not
6 become effective before the end of the 30-day period that
7 begins on the date that the Secretary has issued or pub-
8 lished, as the case may be, the substantive change.

9 “(ii) The Secretary may provide for such a sub-
10 stantive change to take effect on a date that precedes the
11 end of the 30-day period under clause (i) if the Secretary
12 finds that waiver of such 30-day period is necessary to
13 comply with statutory requirements or that the application
14 of such 30-day period is contrary to the public interest.
15 If the Secretary provides for an earlier effective date pur-
16 suant to this clause, the Secretary shall include in the
17 issuance or publication of the substantive change a finding
18 described in the first sentence, and a brief statement of
19 the reasons for such finding.

20 “(C) No action shall be taken against a provider of
21 services or supplier with respect to noncompliance with
22 such a substantive change for items and services furnished
23 before the effective date of such a change.”.

24 (2) EFFECTIVE DATE.—The amendment made
25 by paragraph (1) shall apply to compliance actions

1 undertaken on or after the date of the enactment of
2 this Act.

3 (c) RELIANCE ON GUIDANCE.—

4 (1) IN GENERAL.—Section 1871(e), as added
5 by subsection (a), is further amended by adding at
6 the end the following new paragraph:

7 “(2)(A) If—

8 “(i) a provider of services or supplier follows
9 the written guidance (which may be transmitted
10 electronically) provided by the Secretary or by a
11 medicare contractor (as defined in section 1889(g))
12 acting within the scope of the contractor’s contract
13 authority, with respect to the furnishing of items or
14 services and submission of a claim for benefits for
15 such items or services with respect to such provider
16 or supplier;

17 “(ii) the Secretary determines that the provider
18 of services or supplier has accurately presented the
19 circumstances relating to such items, services, and
20 claim to the contractor in writing; and

21 “(iii) the guidance was in error;

22 the provider of services or supplier shall not be subject
23 to any sanction (including any penalty or requirement for
24 repayment of any amount) if the provider of services or
25 supplier reasonably relied on such guidance.

1 “(B) Subparagraph (A) shall not be construed as pre-
2 venting the recoupment or repayment (without any addi-
3 tional penalty) relating to an overpayment insofar as the
4 overpayment was solely the result of a clerical or technical
5 operational error.”.

6 (2) EFFECTIVE DATE.—The amendment made
7 by paragraph (1) shall take effect on the date of the
8 enactment of this Act but shall not apply to any
9 sanction for which notice was provided on or before
10 the date of the enactment of this Act.

11 **SEC. 504. REPORTS AND STUDIES RELATING TO REGU-**
12 **LATORY REFORM.**

13 (a) GAO STUDY ON ADVISORY OPINION AUTHOR-
14 ITY.—

15 (1) STUDY.—The Comptroller General of the
16 United States shall conduct a study to determine the
17 feasibility and appropriateness of establishing in the
18 Secretary authority to provide legally binding advi-
19 sory opinions on appropriate interpretation and ap-
20 plication of regulations to carry out the medicare
21 program under title XVIII of the Social Security
22 Act. Such study shall examine the appropriate time-
23 frame for issuing such advisory opinions, as well as
24 the need for additional staff and funding to provide
25 such opinions.

1 (2) REPORT.—The Comptroller General shall
2 submit to Congress a report on the study conducted
3 under paragraph (1) by not later than January 1,
4 2004.

5 (b) REPORT ON LEGAL AND REGULATORY INCON-
6 SISTENCIES.—Section 1871 (42 U.S.C. 1395hh), as
7 amended by section 503(a), is amended by adding at the
8 end the following new subsection:

9 “(f)(1) Not later than 2 years after the date of the
10 enactment of this subsection, and every 2 years thereafter,
11 the Secretary shall submit to Congress a report with re-
12 spect to the administration of this title and areas of incon-
13 sistency or conflict among the various provisions under
14 law and regulation.

15 “(2) In preparing a report under paragraph (1), the
16 Secretary shall collect—

17 “(A) information from individuals entitled to
18 benefits under part A or enrolled under part B, or
19 both, providers of services, and suppliers and from
20 the Medicare Beneficiary Ombudsman and the Medi-
21 care Provider Ombudsman with respect to such
22 areas of inconsistency and conflict; and

23 “(B) information from medicare contractors
24 that tracks the nature of written and telephone in-
25 quiries.

1 “(3) A report under paragraph (1) shall include a de-
 2 scription of efforts by the Secretary to reduce such incon-
 3 sistency or conflicts, and recommendations for legislation
 4 or administrative action that the Secretary determines ap-
 5 propriate to further reduce such inconsistency or con-
 6 flicts.”.

7 **Subtitle B—Contracting Reform**

8 **SEC. 511. INCREASED FLEXIBILITY IN MEDICARE ADMINIS-** 9 **TRATION.**

10 (a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE
 11 ADMINISTRATION.—

12 (1) IN GENERAL.—Title XVIII is amended by
 13 inserting after section 1874 the following new sec-
 14 tion:

15 “CONTRACTS WITH MEDICARE ADMINISTRATIVE
 16 CONTRACTORS

17 “SEC. 1874A. (a) AUTHORITY.—

18 “(1) AUTHORITY TO ENTER INTO CON-
 19 TRACTS.—The Secretary may enter into contracts
 20 with any eligible entity to serve as a medicare ad-
 21 ministrative contractor with respect to the perform-
 22 ance of any or all of the functions described in para-
 23 graph (4) or parts of those functions (or, to the ex-
 24 tent provided in a contract, to secure performance
 25 thereof by other entities).

1 “(2) ELIGIBILITY OF ENTITIES.—An entity is
2 eligible to enter into a contract with respect to the
3 performance of a particular function described in
4 paragraph (4) only if—

5 “(A) the entity has demonstrated capa-
6 bility to carry out such function;

7 “(B) the entity complies with such conflict
8 of interest standards as are generally applicable
9 to Federal acquisition and procurement;

10 “(C) the entity has sufficient assets to fi-
11 nancially support the performance of such func-
12 tion; and

13 “(D) the entity meets such other require-
14 ments as the Secretary may impose.

15 “(3) MEDICARE ADMINISTRATIVE CONTRACTOR
16 DEFINED.—For purposes of this title and title XI—

17 “(A) IN GENERAL.—The term ‘medicare
18 administrative contractor’ means an agency, or-
19 ganization, or other person with a contract
20 under this section.

21 “(B) APPROPRIATE MEDICARE ADMINIS-
22 TRATIVE CONTRACTOR.—With respect to the
23 performance of a particular function in relation
24 to an individual entitled to benefits under part
25 A or enrolled under part B, or both, a specific

1 provider of services or supplier (or class of such
2 providers of services or suppliers), the ‘appro-
3 priate’ medicare administrative contractor is the
4 medicare administrative contractor that has a
5 contract under this section with respect to the
6 performance of that function in relation to that
7 individual, provider of services or supplier or
8 class of provider of services or supplier.

9 “(4) FUNCTIONS DESCRIBED.—The functions
10 referred to in paragraphs (1) and (2) are payment
11 functions, provider services functions, and functions
12 relating to services furnished to individuals entitled
13 to benefits under part A or enrolled under part B,
14 or both, as follows:

15 “(A) DETERMINATION OF PAYMENT
16 AMOUNTS.—Determining (subject to the provi-
17 sions of section 1878 and to such review by the
18 Secretary as may be provided for by the con-
19 tracts) the amount of the payments required
20 pursuant to this title to be made to providers
21 of services, suppliers and individuals.

22 “(B) MAKING PAYMENTS.—Making pay-
23 ments described in subparagraph (A) (including
24 receipt, disbursement, and accounting for funds
25 in making such payments).

1 “(C) BENEFICIARY EDUCATION AND AS-
2 SISTANCE.—Providing education and outreach
3 to individuals entitled to benefits under part A
4 or enrolled under part B, or both, and pro-
5 viding assistance to those individuals with spe-
6 cific issues, concerns or problems.

7 “(D) PROVIDER CONSULTATIVE SERV-
8 ICES.—Providing consultative services to insti-
9 tutions, agencies, and other persons to enable
10 them to establish and maintain fiscal records
11 necessary for purposes of this title and other-
12 wise to qualify as providers of services or sup-
13 pliers.

14 “(E) COMMUNICATION WITH PRO-
15 VIDERS.—Communicating to providers of serv-
16 ices and suppliers any information or instruc-
17 tions furnished to the medicare administrative
18 contractor by the Secretary, and facilitating
19 communication between such providers and sup-
20 pliers and the Secretary.

21 “(F) PROVIDER EDUCATION AND TECH-
22 NICAL ASSISTANCE.—Performing the functions
23 relating to provider education, training, and
24 technical assistance.

1 “(G) ADDITIONAL FUNCTIONS.—Per-
2 forming such other functions as are necessary
3 to carry out the purposes of this title.

4 “(5) RELATIONSHIP TO MIP CONTRACTS.—

5 “(A) NONDUPLICATION OF DUTIES.—In
6 entering into contracts under this section, the
7 Secretary shall assure that functions of medi-
8 care administrative contractors in carrying out
9 activities under parts A and B do not duplicate
10 activities carried out under the Medicare Integ-
11 rity Program under section 1893. The previous
12 sentence shall not apply with respect to the ac-
13 tivity described in section 1893(b)(5) (relating
14 to prior authorization of certain items of dura-
15 ble medical equipment under section
16 1834(a)(15)).

17 “(B) CONSTRUCTION.—An entity shall not
18 be treated as a medicare administrative con-
19 tractor merely by reason of having entered into
20 a contract with the Secretary under section
21 1893.

22 “(6) APPLICATION OF FEDERAL ACQUISITION
23 REGULATION.—Except to the extent inconsistent
24 with a specific requirement of this title, the Federal

1 Acquisition Regulation applies to contracts under
2 this title.

3 “(b) CONTRACTING REQUIREMENTS.—

4 “(1) USE OF COMPETITIVE PROCEDURES.—

5 “(A) IN GENERAL.—Except as provided in
6 laws with general applicability to Federal acqui-
7 sition and procurement or in subparagraph (B),
8 the Secretary shall use competitive procedures
9 when entering into contracts with medicare ad-
10 ministrative contractors under this section, tak-
11 ing into account performance quality as well as
12 price and other factors.

13 “(B) RENEWAL OF CONTRACTS.—The Sec-
14 retary may renew a contract with a medicare
15 administrative contractor under this section
16 from term to term without regard to section 5
17 of title 41, United States Code, or any other
18 provision of law requiring competition, if the
19 medicare administrative contractor has met or
20 exceeded the performance requirements applica-
21 ble with respect to the contract and contractor,
22 except that the Secretary shall provide for the
23 application of competitive procedures under
24 such a contract not less frequently than once
25 every five years.

1 “(C) TRANSFER OF FUNCTIONS.—The
2 Secretary may transfer functions among medi-
3 care administrative contractors consistent with
4 the provisions of this paragraph. The Secretary
5 shall ensure that performance quality is consid-
6 ered in such transfers. The Secretary shall pro-
7 vide public notice (whether in the Federal Reg-
8 ister or otherwise) of any such transfer (includ-
9 ing a description of the functions so trans-
10 ferred, a description of the providers of services
11 and suppliers affected by such transfer, and
12 contact information for the contractors in-
13 volved).

14 “(D) INCENTIVES FOR QUALITY.—The
15 Secretary shall provide incentives for medicare
16 administrative contractors to provide quality
17 service and to promote efficiency.

18 “(2) COMPLIANCE WITH REQUIREMENTS.—No
19 contract under this section shall be entered into with
20 any medicare administrative contractor unless the
21 Secretary finds that such medicare administrative
22 contractor will perform its obligations under the con-
23 tract efficiently and effectively and will meet such
24 requirements as to financial responsibility, legal au-

1 thority, quality of services provided, and other mat-
2 ters as the Secretary finds pertinent.

3 “(3) PERFORMANCE REQUIREMENTS.—

4 “(A) DEVELOPMENT OF SPECIFIC PER-
5 FORMANCE REQUIREMENTS.—In developing
6 contract performance requirements, the Sec-
7 retary shall develop performance requirements
8 applicable to functions described in subsection
9 (a)(4).

10 “(B) CONSULTATION.— In developing such
11 requirements, the Secretary may consult with
12 providers of services and suppliers, organiza-
13 tions representing individuals entitled to bene-
14 fits under part A or enrolled under part B, or
15 both, and organizations and agencies per-
16 forming functions necessary to carry out the
17 purposes of this section with respect to such
18 performance requirements.

19 “(C) INCLUSION IN CONTRACTS.—All con-
20 tractor performance requirements shall be set
21 forth in the contract between the Secretary and
22 the appropriate medicare administrative con-
23 tractor. Such performance requirements—

24 “(i) shall reflect the performance re-
25 quirements developed under subparagraph

1 (A), but may include additional perform-
2 ance requirements;

3 “(ii) shall be used for evaluating con-
4 tractor performance under the contract;
5 and

6 “(iii) shall be consistent with the writ-
7 ten statement of work provided under the
8 contract.

9 “(4) INFORMATION REQUIREMENTS.—The Sec-
10 retary shall not enter into a contract with a medi-
11 care administrative contractor under this section un-
12 less the contractor agrees—

13 “(A) to furnish to the Secretary such time-
14 ly information and reports as the Secretary may
15 find necessary in performing his functions
16 under this title; and

17 “(B) to maintain such records and afford
18 such access thereto as the Secretary finds nec-
19 essary to assure the correctness and verification
20 of the information and reports under subpara-
21 graph (A) and otherwise to carry out the pur-
22 poses of this title.

23 “(5) SURETY BOND.—A contract with a medi-
24 care administrative contractor under this section
25 may require the medicare administrative contractor,

1 and any of its officers or employees certifying pay-
2 ments or disbursing funds pursuant to the contract,
3 or otherwise participating in carrying out the con-
4 tract, to give surety bond to the United States in
5 such amount as the Secretary may deem appro-
6 priate.

7 “(c) TERMS AND CONDITIONS.—

8 “(1) IN GENERAL.—A contract with any medi-
9 care administrative contractor under this section
10 may contain such terms and conditions as the Sec-
11 retary finds necessary or appropriate and may pro-
12 vide for advances of funds to the medicare adminis-
13 trative contractor for the making of payments by it
14 under subsection (a)(4)(B).

15 “(2) PROHIBITION ON MANDATES FOR CERTAIN
16 DATA COLLECTION.—The Secretary may not require,
17 as a condition of entering into, or renewing, a con-
18 tract under this section, that the medicare adminis-
19 trative contractor match data obtained other than in
20 its activities under this title with data used in the
21 administration of this title for purposes of identi-
22 fying situations in which the provisions of section
23 1862(b) may apply.

24 “(d) LIMITATION ON LIABILITY OF MEDICARE AD-
25 MINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

1 “(1) CERTIFYING OFFICER.—No individual des-
2 ignated pursuant to a contract under this section as
3 a certifying officer shall, in the absence of gross neg-
4 ligence or intent to defraud the United States, be
5 liable with respect to any payments certified by the
6 individual under this section.

7 “(2) DISBURSING OFFICER.—No disbursing of-
8 ficer shall, in the absence of gross negligence or in-
9 tent to defraud the United States, be liable with re-
10 spect to any payment by such officer under this sec-
11 tion if it was based upon an authorization (which
12 meets the applicable requirements for such internal
13 controls established by the Comptroller General) of
14 a certifying officer designated as provided in para-
15 graph (1) of this subsection.

16 “(3) LIABILITY OF MEDICARE ADMINISTRATIVE
17 CONTRACTOR.—No medicare administrative con-
18 tractor shall be liable to the United States for a pay-
19 ment by a certifying or disbursing officer unless in
20 connection with such payment or in the supervision
21 of or selection of such officer the medicare adminis-
22 trative contractor acted with gross negligence.

23 “(4) INDEMNIFICATION BY SECRETARY.—

24 “(A) IN GENERAL.—Subject to subpara-
25 graphs (B) and (D), in the case of a medicare

1 administrative contractor (or a person who is a
2 director, officer, or employee of such a con-
3 tractor or who is engaged by the contractor to
4 participate directly in the claims administration
5 process) who is made a party to any judicial or
6 administrative proceeding arising from or relat-
7 ing directly to the claims administration process
8 under this title, the Secretary may, to the ex-
9 tent the Secretary determines to be appropriate
10 and as specified in the contract with the con-
11 tractor, indemnify the contractor and such per-
12 sons.

13 “(B) CONDITIONS.—The Secretary may
14 not provide indemnification under subparagraph
15 (A) insofar as the liability for such costs arises
16 directly from conduct that is determined by the
17 judicial proceeding or by the Secretary to be
18 criminal in nature, fraudulent, or grossly neg-
19 ligent. If indemnification is provided by the Sec-
20 retary with respect to a contractor before a de-
21 termination that such costs arose directly from
22 such conduct, the contractor shall reimburse the
23 Secretary for costs of indemnification.

24 “(C) SCOPE OF INDEMNIFICATION.—In-
25 demnification by the Secretary under subpara-

1 graph (A) may include payment of judgments,
2 settlements (subject to subparagraph (D)),
3 awards, and costs (including reasonable legal
4 expenses).

5 “(D) WRITTEN APPROVAL FOR SETTLE-
6 MENTS.—A contractor or other person de-
7 scribed in subparagraph (A) may not propose to
8 negotiate a settlement or compromise of a pro-
9 ceeding described in such subparagraph without
10 the prior written approval of the Secretary to
11 negotiate such settlement or compromise. Any
12 indemnification under subparagraph (A) with
13 respect to amounts paid under a settlement or
14 compromise of a proceeding described in such
15 subparagraph are conditioned upon prior writ-
16 ten approval by the Secretary of the final settle-
17 ment or compromise.

18 “(E) CONSTRUCTION.—Nothing in this
19 paragraph shall be construed—

20 “(i) to change any common law immu-
21 nity that may be available to a medicare
22 administrative contractor or person de-
23 scribed in subparagraph (A); or

24 “(ii) to permit the payment of costs
25 not otherwise allowable, reasonable, or allo-

1 cable under the Federal Acquisition Regu-
2 lations.”.

3 (2) CONSIDERATION OF INCORPORATION OF
4 CURRENT LAW STANDARDS.—In developing contract
5 performance requirements under section 1874A(b)
6 of the Social Security Act, as inserted by paragraph
7 (1), the Secretary shall consider inclusion of the per-
8 formance standards described in sections 1816(f)(2)
9 of such Act (relating to timely processing of recon-
10 siderations and applications for exemptions) and sec-
11 tion 1842(b)(2)(B) of such Act (relating to timely
12 review of determinations and fair hearing requests),
13 as such sections were in effect before the date of the
14 enactment of this Act.

15 (b) CONFORMING AMENDMENTS TO SECTION 1816
16 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816
17 (42 U.S.C. 1395h) is amended as follows:

18 (1) The heading is amended to read as follows:
19 “PROVISIONS RELATING TO THE ADMINISTRATION OF
20 PART A”.

21 (2) Subsection (a) is amended to read as fol-
22 lows:

23 “(a) The administration of this part shall be con-
24 ducted through contracts with medicare administrative
25 contractors under section 1874A.”.

26 (3) Subsection (b) is repealed.

1 (4) Subsection (c) is amended—

2 (A) by striking paragraph (1); and

3 (B) in each of paragraphs (2)(A) and
4 (3)(A), by striking “agreement under this sec-
5 tion” and inserting “contract under section
6 1874A that provides for making payments
7 under this part”.

8 (5) Subsections (d) through (i) are repealed.

9 (6) Subsections (j) and (k) are each amended—

10 (A) by striking “An agreement with an
11 agency or organization under this section” and
12 inserting “A contract with a medicare adminis-
13 trative contractor under section 1874A with re-
14 spect to the administration of this part”; and

15 (B) by striking “such agency or organiza-
16 tion” and inserting “such medicare administra-
17 tive contractor” each place it appears.

18 (7) Subsection (l) is repealed.

19 (c) CONFORMING AMENDMENTS TO SECTION 1842
20 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C.
21 1395u) is amended as follows:

22 (1) The heading is amended to read as follows:

23 “PROVISIONS RELATING TO THE ADMINISTRATION OF
24 PART B”.

25 (2) Subsection (a) is amended to read as fol-
26 lows:

1 “(a) The administration of this part shall be con-
2 ducted through contracts with medicare administrative
3 contractors under section 1874A.”.

4 (3) Subsection (b) is amended—

5 (A) by striking paragraph (1);

6 (B) in paragraph (2)—

7 (i) by striking subparagraphs (A) and
8 (B);

9 (ii) in subparagraph (C), by striking
10 “carriers” and inserting “medicare admin-
11 istrative contractors”; and

12 (iii) by striking subparagraphs (D)
13 and (E);

14 (C) in paragraph (3)—

15 (i) in the matter before subparagraph
16 (A), by striking “Each such contract shall
17 provide that the carrier” and inserting
18 “The Secretary”;

19 (ii) by striking “will” the first place it
20 appears in each of subparagraphs (A), (B),
21 (F), (G), (H), and (L) and inserting
22 “shall”;

23 (iii) in subparagraph (B), in the mat-
24 ter before clause (i), by striking “to the
25 policyholders and subscribers of the car-

1 rier” and inserting “to the policyholders
2 and subscribers of the medicare adminis-
3 trative contractor”;

4 (iv) by striking subparagraphs (C),
5 (D), and (E);

6 (v) in subparagraph (H)—

7 (I) by striking “if it makes deter-
8 minations or payments with respect to
9 physicians’ services,” in the matter
10 preceding clause (i); and

11 (II) by striking “carrier” and in-
12 serting “medicare administrative con-
13 tractor” in clause (i);

14 (vi) by striking subparagraph (I);

15 (vii) in subparagraph (L), by striking
16 the semicolon and inserting a period;

17 (viii) in the first sentence, after sub-
18 paragraph (L), by striking “and shall con-
19 tain” and all that follows through the pe-
20 riod; and

21 (ix) in the seventh sentence, by insert-
22 ing “medicare administrative contractor,”
23 after “carrier,”; and

24 (D) by striking paragraph (5);

1 (E) in paragraph (6)(D)(iv), by striking
2 “carrier” and inserting “medicare administra-
3 tive contractor”; and

4 (F) in paragraph (7), by striking “the car-
5 rier” and inserting “the Secretary” each place
6 it appears.

7 (4) Subsection (c) is amended—

8 (A) by striking paragraph (1);

9 (B) in paragraph (2)(A), by striking “con-
10 tract under this section which provides for the
11 disbursement of funds, as described in sub-
12 section (a)(1)(B),” and inserting “contract
13 under section 1874A that provides for making
14 payments under this part”;

15 (C) in paragraph (3)(A), by striking “sub-
16 section (a)(1)(B)” and inserting “section
17 1874A(a)(3)(B)”;

18 (D) in paragraph (4), in the matter pre-
19 ceding subparagraph (A), by striking “carrier”
20 and inserting “medicare administrative con-
21 tractor”; and

22 (E) by striking paragraphs (5) and (6).

23 (5) Subsections (d), (e), and (f) are repealed.

1 (6) Subsection (g) is amended by striking “car-
2 rier or carriers” and inserting “medicare administra-
3 tive contractor or contractors”.

4 (7) Subsection (h) is amended—

5 (A) in paragraph (2)—

6 (i) by striking “Each carrier having
7 an agreement with the Secretary under
8 subsection (a)” and inserting “The Sec-
9 retary”; and

10 (ii) by striking “Each such carrier”
11 and inserting “The Secretary”;

12 (B) in paragraph (3)(A)—

13 (i) by striking “a carrier having an
14 agreement with the Secretary under sub-
15 section (a)” and inserting “medicare ad-
16 ministrative contractor having a contract
17 under section 1874A that provides for
18 making payments under this part”; and

19 (ii) by striking “such carrier” and in-
20 serting “such contractor”;

21 (C) in paragraph (3)(B)—

22 (i) by striking “a carrier” and insert-
23 ing “a medicare administrative contractor”
24 each place it appears; and

1 (ii) by striking “the carrier” and in-
2 sserting “the contractor” each place it ap-
3 pears; and

4 (D) in paragraphs (5)(A) and (5)(B)(iii),
5 by striking “carriers” and inserting “medicare
6 administrative contractors” each place it ap-
7 pears.

8 (8) Subsection (l) is amended—

9 (A) in paragraph (1)(A)(iii), by striking
10 “carrier” and inserting “medicare administra-
11 tive contractor”; and

12 (B) in paragraph (2), by striking “carrier”
13 and inserting “medicare administrative con-
14 tractor”.

15 (9) Subsection (p)(3)(A) is amended by striking
16 “carrier” and inserting “medicare administrative
17 contractor”.

18 (10) Subsection (q)(1)(A) is amended by strik-
19 ing “carrier”.

20 (d) EFFECTIVE DATE; TRANSITION RULE.—

21 (1) EFFECTIVE DATE.—

22 (A) IN GENERAL.—Except as otherwise
23 provided in this subsection, the amendments
24 made by this section shall take effect on Octo-
25 ber 1, 2004, and the Secretary is authorized to

1 take such steps before such date as may be nec-
2 essary to implement such amendments on a
3 timely basis.

4 (B) CONSTRUCTION FOR CURRENT CON-
5 TRACTS.—Such amendments shall not apply to
6 contracts in effect before the date specified
7 under subparagraph (A) that continue to retain
8 the terms and conditions in effect on such date
9 (except as otherwise provided under this Act,
10 other than under this section) until such date
11 as the contract is let out for competitive bid-
12 ding under such amendments.

13 (C) DEADLINE FOR COMPETITIVE BID-
14 DING.—The Secretary shall provide for the let-
15 ting by competitive bidding of all contracts for
16 functions of medicare administrative contrac-
17 tors for annual contract periods that begin on
18 or after October 1, 2009.

19 (D) WAIVER OF PROVIDER NOMINATION
20 PROVISIONS DURING TRANSITION.—During the
21 period beginning on the date of the enactment
22 of this Act and before the date specified under
23 subparagraph (A), the Secretary may enter into
24 new agreements under section 1816 of the So-
25 cial Security Act (42 U.S.C. 1395h) without re-

1 gard to any of the provider nomination provi-
2 sions of such section.

3 (2) GENERAL TRANSITION RULES.—The Sec-
4 retary shall take such steps, consistent with para-
5 graph (1)(B) and (1)(C), as are necessary to provide
6 for an appropriate transition from contracts under
7 section 1816 and section 1842 of the Social Security
8 Act (42 U.S.C. 1395h, 1395u) to contracts under
9 section 1874A, as added by subsection (a)(1).

10 (3) AUTHORIZING CONTINUATION OF MIP
11 FUNCTIONS UNDER CURRENT CONTRACTS AND
12 AGREEMENTS AND UNDER ROLLOVER CONTRACTS.—
13 The provisions contained in the exception in section
14 1893(d)(2) of the Social Security Act (42 U.S.C.
15 1395ddd(d)(2)) shall continue to apply notwith-
16 standing the amendments made by this section, and
17 any reference in such provisions to an agreement or
18 contract shall be deemed to include a contract under
19 section 1874A of such Act, as inserted by subsection
20 (a)(1), that continues the activities referred to in
21 such provisions.

22 (e) REFERENCES.—On and after the effective date
23 provided under subsection (d)(1), any reference to a fiscal
24 intermediary or carrier under title XI or XVIII of the So-
25 cial Security Act (or any regulation, manual instruction,

1 interpretative rule, statement of policy, or guideline issued
2 to carry out such titles) shall be deemed a reference to
3 an appropriate medicare administrative contractor (as
4 provided under section 1874A of the Social Security Act).

5 (f) REPORTS ON IMPLEMENTATION.—

6 (1) PLAN FOR IMPLEMENTATION.—By not later
7 than October 1, 2003, the Secretary shall submit a
8 report to Congress and the Comptroller General of
9 the United States that describes the plan for imple-
10 mentation of the amendments made by this section.
11 The Comptroller General shall conduct an evaluation
12 of such plan and shall submit to Congress, not later
13 than 6 months after the date the report is received,
14 a report on such evaluation and shall include in such
15 report such recommendations as the Comptroller
16 General deems appropriate.

17 (2) STATUS OF IMPLEMENTATION.—The Sec-
18 retary shall submit a report to Congress not later
19 than October 1, 2007, that describes the status of
20 implementation of such amendments and that in-
21 cludes a description of the following:

22 (A) The number of contracts that have
23 been competitively bid as of such date.

24 (B) The distribution of functions among
25 contracts and contractors.

1 (C) A timeline for complete transition to
2 full competition.

3 (D) A detailed description of how the Sec-
4 retary has modified oversight and management
5 of medicare contractors to adapt to full com-
6 petition.

7 **SEC. 512. REQUIREMENTS FOR INFORMATION SECURITY**
8 **FOR MEDICARE ADMINISTRATIVE CONTRAC-**
9 **TORS.**

10 (a) IN GENERAL.—Section 1874A, as added by sec-
11 tion 511(a)(1), is amended by adding at the end the fol-
12 lowing new subsection:

13 “(e) REQUIREMENTS FOR INFORMATION SECUR-
14 RITY.—

15 “(1) DEVELOPMENT OF INFORMATION SECUR-
16 RITY PROGRAM.—A medicare administrative con-
17 tractor that performs the functions referred to in
18 subparagraphs (A) and (B) of subsection (a)(4) (re-
19 lating to determining and making payments) shall
20 implement a contractor-wide information security
21 program to provide information security for the op-
22 eration and assets of the contractor with respect to
23 such functions under this title. An information secu-
24 rity program under this paragraph shall meet the re-
25 quirements for information security programs im-

1 posed on Federal agencies under section 3534(b)(2)
2 of title 44, United States Code (other than require-
3 ments under subparagraphs (B)(ii), (F)(iii), and
4 (F)(iv) of such section).

5 “(2) INDEPENDENT AUDITS.—

6 “(A) PERFORMANCE OF ANNUAL EVALUA-
7 TIONS.—Each year a medicare administrative
8 contractor that performs the functions referred
9 to in subparagraphs (A) and (B) of subsection
10 (a)(4) (relating to determining and making pay-
11 ments) shall undergo an evaluation of the infor-
12 mation security of the contractor with respect
13 to such functions under this title. The evalua-
14 tion shall—

15 “(i) be performed by an entity that
16 meets such requirements for independence
17 as the Inspector General of the Depart-
18 ment of Health and Human Services may
19 establish; and

20 “(ii) test the effectiveness of informa-
21 tion security control techniques for an ap-
22 propriate subset of the contractor’s infor-
23 mation systems (as defined in section
24 3502(8) of title 44, United States Code)
25 relating to such functions under this title

1 and an assessment of compliance with the
2 requirements of this subsection and related
3 information security policies, procedures,
4 standards and guidelines.

5 “(B) DEADLINE FOR INITIAL EVALUA-
6 TION.—

7 “(i) NEW CONTRACTORS.—In the case
8 of a medicare administrative contractor
9 covered by this subsection that has not
10 previously performed the functions referred
11 to in subparagraphs (A) and (B) of sub-
12 section (a)(4) (relating to determining and
13 making payments) as a fiscal intermediary
14 or carrier under section 1816 or 1842, the
15 first independent evaluation conducted
16 pursuant subparagraph (A) shall be com-
17 pleted prior to commencing such functions.

18 “(ii) OTHER CONTRACTORS.—In the
19 case of a medicare administrative con-
20 tractor covered by this subsection that is
21 not described in clause (i), the first inde-
22 pendent evaluation conducted pursuant
23 subparagraph (A) shall be completed with-
24 in 1 year after the date the contractor

1 commences functions referred to in clause
2 (i) under this section.

3 “(C) REPORTS ON EVALUATIONS.—

4 “(i) TO THE INSPECTOR GENERAL.—

5 The results of independent evaluations
6 under subparagraph (A) shall be submitted
7 promptly to the Inspector General of the
8 Department of Health and Human Serv-
9 ices.

10 “(ii) TO CONGRESS.—The Inspector
11 General of Department of Health and
12 Human Services shall submit to Congress
13 annual reports on the results of such eval-
14 uations.”.

15 (b) APPLICATION OF REQUIREMENTS TO FISCAL
16 INTERMEDIARIES AND CARRIERS.—

17 (1) IN GENERAL.—The provisions of section
18 1874A(e)(2) of the Social Security Act (other than
19 subparagraph (B)), as added by subsection (a), shall
20 apply to each fiscal intermediary under section 1816
21 of the Social Security Act (42 U.S.C. 1395h) and
22 each carrier under section 1842 of such Act (42
23 U.S.C. 1395u) in the same manner as they apply to
24 medicare administrative contractors under such pro-
25 visions.

1 (2) DEADLINE FOR INITIAL EVALUATION.—In
 2 the case of such a fiscal intermediary or carrier with
 3 an agreement or contract under such respective sec-
 4 tion in effect as of the date of the enactment of this
 5 Act, the first evaluation under section
 6 1874A(e)(2)(A) of the Social Security Act (as added
 7 by subsection (a)), pursuant to paragraph (1), shall
 8 be completed (and a report on the evaluation sub-
 9 mitted to the Secretary) by not later than 1 year
 10 after such date.

11 **Subtitle C—Education and** 12 **Outreach**

13 **SEC. 521. PROVIDER EDUCATION AND TECHNICAL ASSIST-** 14 **ANCE.**

15 (a) COORDINATION OF EDUCATION FUNDING.—

16 (1) IN GENERAL.—The Social Security Act is
 17 amended by inserting after section 1888 the fol-
 18 lowing new section:

19 “PROVIDER EDUCATION AND TECHNICAL ASSISTANCE
 20 “SEC. 1889. (a) COORDINATION OF EDUCATION
 21 FUNDING.—The Secretary shall coordinate the edu-
 22 cational activities provided through medicare contractors
 23 (as defined in subsection (g), including under section
 24 1893) in order to maximize the effectiveness of Federal
 25 education efforts for providers of services and suppliers.”.

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

4 (3) REPORT.—Not later than October 1, 2003,
5 the Secretary shall submit to Congress a report that
6 includes a description and evaluation of the steps
7 taken to coordinate the funding of provider edu-
8 cation under section 1889(a) of the Social Security
9 Act, as added by paragraph (1).

10 (b) INCENTIVES TO IMPROVE CONTRACTOR PER-
11 FORMANCE.—

12 (1) IN GENERAL.—Section 1874A, as added by
13 section 511(a)(1) and as amended by section 512(a),
14 is amended by adding at the end the following new
15 subsection:

16 “(f) INCENTIVES TO IMPROVE CONTRACTOR PER-
17 FORMANCE IN PROVIDER EDUCATION AND OUTREACH.—
18 In order to give medicare administrative contractors an
19 incentive to implement effective education and outreach
20 programs for providers of services and suppliers, the Sec-
21 retary shall develop and implement a methodology to
22 measure the specific claims payment error rates of such
23 contractors in the processing or reviewing of medicare
24 claims.”.

1 (2) APPLICATION TO FISCAL INTERMEDIARIES
2 AND CARRIERS.—The provisions of section 1874A(f)
3 of the Social Security Act, as added by paragraph
4 (1), shall apply to each fiscal intermediary under
5 section 1816 of the Social Security Act (42 U.S.C.
6 1395h) and each carrier under section 1842 of such
7 Act (42 U.S.C. 1395u) in the same manner as they
8 apply to medicare administrative contractors under
9 such provisions.

10 (3) GAO REPORT ON ADEQUACY OF METHODOLOGY.—Not later than October 1, 2003, the Comptroller General of the United States shall submit to
11 Congress and to the Secretary a report on the adequacy of the methodology under section 1874A(f) of
12 the Social Security Act, as added by paragraph (1),
13 and shall include in the report such recommendations as the Comptroller General determines appropriate with respect to the methodology.

14 (4) REPORT ON USE OF METHODOLOGY IN ASSESSING CONTRACTOR PERFORMANCE.—Not later
15 than October 1, 2003, the Secretary shall submit to
16 Congress a report that describes how the Secretary
17 intends to use such methodology in assessing medicare contractor performance in implementing effective education and outreach programs, including

1 whether to use such methodology as a basis for per-
2 formance bonuses. The report shall include an anal-
3 ysis of the sources of identified errors and potential
4 changes in systems of contractors and rules of the
5 Secretary that could reduce claims error rates.

6 (c) PROVISION OF ACCESS TO AND PROMPT RE-
7 SPONSES FROM MEDICARE ADMINISTRATIVE CONTRAC-
8 TORS.—

9 (1) IN GENERAL.—Section 1874A, as added by
10 section 511(a)(1) and as amended by section 512(a)
11 and subsection (b), is further amended by adding at
12 the end the following new subsection:

13 “(g) COMMUNICATIONS WITH BENEFICIARIES, PRO-
14 VIDERS OF SERVICES AND SUPPLIERS.—

15 “(1) COMMUNICATION STRATEGY.—The Sec-
16 retary shall develop a strategy for communications
17 with individuals entitled to benefits under part A or
18 enrolled under part B, or both, and with providers
19 of services and suppliers under this title.

20 “(2) RESPONSE TO WRITTEN INQUIRIES.—Each
21 medicare administrative contractor shall, for those
22 providers of services and suppliers which submit
23 claims to the contractor for claims processing and
24 for those individuals entitled to benefits under part
25 A or enrolled under part B, or both, with respect

1 to whom claims are submitted for claims processing,
2 provide general written responses (which may be
3 through electronic transmission) in a clear, concise,
4 and accurate manner to inquiries of providers of
5 services, suppliers and individuals entitled to bene-
6 fits under part A or enrolled under part B, or both,
7 concerning the programs under this title within 45
8 business days of the date of receipt of such inquiries.

9 “(3) RESPONSE TO TOLL-FREE LINES.—The
10 Secretary shall ensure that each medicare adminis-
11 trative contractor shall provide, for those providers
12 of services and suppliers which submit claims to the
13 contractor for claims processing and for those indi-
14 viduals entitled to benefits under part A or enrolled
15 under part B, or both, with respect to whom claims
16 are submitted for claims processing, a toll-free tele-
17 phone number at which such individuals, providers
18 of services and suppliers may obtain information re-
19 garding billing, coding, claims, coverage, and other
20 appropriate information under this title.

21 “(4) MONITORING OF CONTRACTOR RE-
22 SPONSES.—

23 “(A) IN GENERAL.—Each medicare admin-
24 istrative contractor shall, consistent with stand-

1 ards developed by the Secretary under subpara-
2 graph (B)—

3 “(i) maintain a system for identifying
4 who provides the information referred to in
5 paragraphs (2) and (3); and

6 “(ii) monitor the accuracy, consist-
7 ency, and timeliness of the information so
8 provided.

9 “(B) DEVELOPMENT OF STANDARDS.—

10 “(i) IN GENERAL.—The Secretary
11 shall establish and make public standards
12 to monitor the accuracy, consistency, and
13 timeliness of the information provided in
14 response to written and telephone inquiries
15 under this subsection. Such standards shall
16 be consistent with the performance require-
17 ments established under subsection (b)(3).

18 “(ii) EVALUATION.—In conducting
19 evaluations of individual medicare adminis-
20 trative contractors, the Secretary shall
21 take into account the results of the moni-
22 toring conducted under subparagraph (A)
23 taking into account as performance re-
24 quirements the standards established
25 under clause (i). The Secretary shall, in

1 consultation with organizations rep-
2 resenting providers of services, suppliers,
3 and individuals entitled to benefits under
4 part A or enrolled under part B, or both,
5 establish standards relating to the accu-
6 racy, consistency, and timeliness of the in-
7 formation so provided.

8 “(C) DIRECT MONITORING.—Nothing in
9 this paragraph shall be construed as preventing
10 the Secretary from directly monitoring the ac-
11 curacy, consistency, and timeliness of the infor-
12 mation so provided.”.

13 (2) EFFECTIVE DATE.—The amendment made
14 by paragraph (1) shall take effect October 1, 2003.

15 (3) APPLICATION TO FISCAL INTERMEDIARIES
16 AND CARRIERS.—The provisions of section 1874A(g)
17 of the Social Security Act, as added by paragraph
18 (1), shall apply to each fiscal intermediary under
19 section 1816 of the Social Security Act (42 U.S.C.
20 1395h) and each carrier under section 1842 of such
21 Act (42 U.S.C. 1395u) in the same manner as they
22 apply to medicare administrative contractors under
23 such provisions.

24 (d) IMPROVED PROVIDER EDUCATION AND TRAIN-
25 ING.—

1 (1) IN GENERAL.—Section 1889, as added by
2 subsection (a), is amended by adding at the end the
3 following new subsections:

4 “(b) ENHANCED EDUCATION AND TRAINING.—

5 “(1) ADDITIONAL RESOURCES.—There are au-
6 thorized to be appropriated to the Secretary (in ap-
7 propriate part from the Federal Hospital Insurance
8 Trust Fund and the Federal Supplementary Medical
9 Insurance Trust Fund) \$25,000,000 for each of fis-
10 cal years 2004 and 2005 and such sums as may be
11 necessary for succeeding fiscal years.

12 “(2) USE.—The funds made available under
13 paragraph (1) shall be used to increase the conduct
14 by medicare contractors of education and training of
15 providers of services and suppliers regarding billing,
16 coding, and other appropriate items and may also be
17 used to improve the accuracy, consistency, and time-
18 liness of contractor responses.

19 “(c) TAILORING EDUCATION AND TRAINING ACTIVI-
20 TIES FOR SMALL PROVIDERS OR SUPPLIERS.—

21 “(1) IN GENERAL.—Insofar as a medicare con-
22 tractor conducts education and training activities, it
23 shall tailor such activities to meet the special needs
24 of small providers of services or suppliers (as defined
25 in paragraph (2)).

1 “(2) SMALL PROVIDER OF SERVICES OR SUP-
2 PLIER.—In this subsection, the term ‘small provider
3 of services or supplier’ means—

4 “(A) a provider of services with fewer than
5 25 full-time-equivalent employees; or

6 “(B) a supplier with fewer than 10 full-
7 time-equivalent employees.”.

8 (2) EFFECTIVE DATE.—The amendment made
9 by paragraph (1) shall take effect on October 1,
10 2003.

11 (e) REQUIREMENT TO MAINTAIN INTERNET
12 SITES.—

13 (1) IN GENERAL.—Section 1889, as added by
14 subsection (a) and as amended by subsection (d), is
15 further amended by adding at the end the following
16 new subsection:

17 “(d) INTERNET SITES; FAQs.—The Secretary, and
18 each medicare contractor insofar as it provides services
19 (including claims processing) for providers of services or
20 suppliers, shall maintain an Internet site which—

21 “(1) provides answers in an easily accessible
22 format to frequently asked questions, and

23 “(2) includes other published materials of the
24 contractor,

1 that relate to providers of services and suppliers under the
2 programs under this title (and title XI insofar as it relates
3 to such programs).”.

4 (2) EFFECTIVE DATE.—The amendment made
5 by paragraph (1) shall take effect on October 1,
6 2003.

7 (f) ADDITIONAL PROVIDER EDUCATION PROVI-
8 SIONS.—

9 (1) IN GENERAL.—Section 1889, as added by
10 subsection (a) and as amended by subsections (d)
11 and (e), is further amended by adding at the end the
12 following new subsections:

13 “(e) ENCOURAGEMENT OF PARTICIPATION IN EDU-
14 CATION PROGRAM ACTIVITIES.—A medicare contractor
15 may not use a record of attendance at (or failure to at-
16 tend) educational activities or other information gathered
17 during an educational program conducted under this sec-
18 tion or otherwise by the Secretary to select or track pro-
19 viders of services or suppliers for the purpose of con-
20 ducting any type of audit or prepayment review.

21 “(f) CONSTRUCTION.—Nothing in this section or sec-
22 tion 1893(g) shall be construed as providing for disclosure
23 by a medicare contractor of information that would com-
24 promise pending law enforcement activities or reveal find-
25 ings of law enforcement-related audits.

1 “(g) DEFINITIONS.—For purposes of this section, the
2 term ‘medicare contractor’ includes the following:

3 “(1) A medicare administrative contractor with
4 a contract under section 1874A, including a fiscal
5 intermediary with a contract under section 1816 and
6 a carrier with a contract under section 1842.

7 “(2) An eligible entity with a contract under
8 section 1893.

9 Such term does not include, with respect to activities of
10 a specific provider of services or supplier an entity that
11 has no authority under this title or title IX with respect
12 to such activities and such provider of services or sup-
13 plier.”.

14 (2) EFFECTIVE DATE.—The amendment made
15 by paragraph (1) shall take effect on the date of the
16 enactment of this Act.

17 **SEC. 522. SMALL PROVIDER TECHNICAL ASSISTANCE DEM-**
18 **ONSTRATION PROGRAM.**

19 (a) ESTABLISHMENT.—

20 (1) IN GENERAL.—The Secretary shall establish
21 a demonstration program (in this section referred to
22 as the “demonstration program”) under which tech-
23 nical assistance described in paragraph (2) is made
24 available, upon request and on a voluntary basis, to
25 small providers of services or suppliers in order to

1 improve compliance with the applicable requirements
2 of the programs under medicare program under title
3 XVIII of the Social Security Act (including provi-
4 sions of title XI of such Act insofar as they relate
5 to such title and are not administered by the Office
6 of the Inspector General of the Department of
7 Health and Human Services).

8 (2) FORMS OF TECHNICAL ASSISTANCE.—The
9 technical assistance described in this paragraph is—

10 (A) evaluation and recommendations re-
11 garding billing and related systems; and

12 (B) information and assistance regarding
13 policies and procedures under the medicare pro-
14 gram, including coding and reimbursement.

15 (3) SMALL PROVIDERS OF SERVICES OR SUP-
16 PLIERS.—In this section, the term “small providers
17 of services or suppliers” means—

18 (A) a provider of services with fewer than
19 25 full-time-equivalent employees; or

20 (B) a supplier with fewer than 10 full-
21 time-equivalent employees.

22 (b) QUALIFICATION OF CONTRACTORS.—In con-
23 ducting the demonstration program, the Secretary shall
24 enter into contracts with qualified organizations (such as
25 peer review organizations or entities described in section

1 1889(g)(2) of the Social Security Act, as inserted by sec-
2 tion 5(f)(1)) with appropriate expertise with billing sys-
3 tems of the full range of providers of services and sup-
4 pliers to provide the technical assistance. In awarding such
5 contracts, the Secretary shall consider any prior investiga-
6 tions of the entity's work by the Inspector General of De-
7 partment of Health and Human Services or the Comp-
8 troller General of the United States.

9 (c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The
10 technical assistance provided under the demonstration
11 program shall include a direct and in-person examination
12 of billing systems and internal controls of small providers
13 of services or suppliers to determine program compliance
14 and to suggest more efficient or effective means of achiev-
15 ing such compliance.

16 (d) AVOIDANCE OF RECOVERY ACTIONS FOR PROB-
17 LEMS IDENTIFIED AS CORRECTED.—The Secretary shall
18 provide that, absent evidence of fraud and notwith-
19 standing any other provision of law, any errors found in
20 a compliance review for a small provider of services or sup-
21 plier that participates in the demonstration program shall
22 not be subject to recovery action if the technical assistance
23 personnel under the program determine that—

24 (1) the problem that is the subject of the com-
25 pliance review has been corrected to their satisfac-

1 tion within 30 days of the date of the visit by such
2 personnel to the small provider of services or sup-
3 plier; and

4 (2) such problem remains corrected for such pe-
5 riod as is appropriate.

6 The previous sentence applies only to claims filed as part
7 of the demonstration program and lasts only for the dura-
8 tion of such program and only as long as the small pro-
9 vider of services or supplier is a participant in such pro-
10 gram.

11 (e) GAO EVALUATION.—Not later than 2 years after
12 the date of the date the demonstration program is first
13 implemented, the Comptroller General, in consultation
14 with the Inspector General of the Department of Health
15 and Human Services, shall conduct an evaluation of the
16 demonstration program. The evaluation shall include a de-
17 termination of whether claims error rates are reduced for
18 small providers of services or suppliers who participated
19 in the program and the extent of improper payments made
20 as a result of the demonstration program. The Comp-
21 troller General shall submit a report to the Secretary and
22 the Congress on such evaluation and shall include in such
23 report recommendations regarding the continuation or ex-
24 tension of the demonstration program.

1 (f) FINANCIAL PARTICIPATION BY PROVIDERS.—The
2 provision of technical assistance to a small provider of
3 services or supplier under the demonstration program is
4 conditioned upon the small provider of services or supplier
5 paying an amount estimated (and disclosed in advance of
6 a provider’s or supplier’s participation in the program) to
7 be equal to 25 percent of the cost of the technical assist-
8 ance.

9 (g) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated to the Secretary (in ap-
11 propriate part from the Federal Hospital Insurance Trust
12 Fund and the Federal Supplementary Medical Insurance
13 Trust Fund) to carry out the demonstration program—

14 (1) for fiscal year 2004, \$1,000,000, and

15 (2) for fiscal year 2005, \$6,000,000.

16 **SEC. 523. MEDICARE PROVIDER OMBUDSMAN; MEDICARE**
17 **BENEFICIARY OMBUDSMAN.**

18 (a) MEDICARE PROVIDER OMBUDSMAN.—Section
19 1868 (42 U.S.C. 1395ee) is amended—

20 (1) by adding at the end of the heading the fol-
21 lowing: “; MEDICARE PROVIDER OMBUDSMAN”;

22 (2) by inserting “PRACTICING PHYSICIANS AD-
23 VISORY COUNCIL.—(1)” after “(a)”;

1 (3) in paragraph (1), as so redesignated under
2 paragraph (2), by striking “in this section” and in-
3 sserting “in this subsection”;

4 (4) by redesignating subsections (b) and (c) as
5 paragraphs (2) and (3), respectively; and

6 (5) by adding at the end the following new sub-
7 section:

8 “(b) MEDICARE PROVIDER OMBUDSMAN.—The Sec-
9 retary shall appoint within the Department of Health and
10 Human Services a Medicare Provider Ombudsman. The
11 Ombudsman shall—

12 “(1) provide assistance, on a confidential basis,
13 to providers of services and suppliers with respect to
14 complaints, grievances, and requests for information
15 concerning the programs under this title (including
16 provisions of title XI insofar as they relate to this
17 title and are not administered by the Office of the
18 Inspector General of the Department of Health and
19 Human Services) and in the resolution of unclear or
20 conflicting guidance given by the Secretary and
21 medicare contractors to such providers of services
22 and suppliers regarding such programs and provi-
23 sions and requirements under this title and such
24 provisions; and

1 “(2) submit recommendations to the Secretary
2 for improvement in the administration of this title
3 and such provisions, including—

4 “(A) recommendations to respond to recur-
5 ring patterns of confusion in this title and such
6 provisions (including recommendations regard-
7 ing suspending imposition of sanctions where
8 there is widespread confusion in program ad-
9 ministration), and

10 “(B) recommendations to provide for an
11 appropriate and consistent response (including
12 not providing for audits) in cases of self-identi-
13 fied overpayments by providers of services and
14 suppliers.

15 The Ombudsman shall not serve as an advocate for any
16 increases in payments or new coverage of services, but
17 may identify issues and problems in payment or coverage
18 policies.”.

19 (b) **MEDICARE BENEFICIARY OMBUDSMAN.**—Title
20 XVIII, as amended by sections 105 and 701, is amended
21 by inserting after section 1808 the following new section:

22 “**MEDICARE BENEFICIARY OMBUDSMAN**

23 “**SEC. 1809. (a) IN GENERAL.**—The Secretary shall
24 appoint within the Department of Health and Human
25 Services a Medicare Beneficiary Ombudsman who shall
26 have expertise and experience in the fields of health care

1 and education of (and assistance to) individuals entitled
2 to benefits under this title.

3 “(b) DUTIES.—The Medicare Beneficiary Ombuds-
4 man shall—

5 “(1) receive complaints, grievances, and re-
6 quests for information submitted by individuals enti-
7 tled to benefits under part A or enrolled under part
8 B, or both, with respect to any aspect of the medi-
9 care program;

10 “(2) provide assistance with respect to com-
11 plaints, grievances, and requests referred to in para-
12 graph (1), including—

13 “(A) assistance in collecting relevant infor-
14 mation for such individuals, to seek an appeal
15 of a decision or determination made by a fiscal
16 intermediary, carrier, Medicare+Choice organi-
17 zation, or the Secretary; and

18 “(B) assistance to such individuals with
19 any problems arising from disenrollment from a
20 Medicare+Choice plan under part C; and

21 “(3) submit annual reports to Congress and the
22 Secretary that describe the activities of the Office
23 and that include such recommendations for improve-
24 ment in the administration of this title as the Om-
25 budsman determines appropriate.

1 The Ombudsman shall not serve as an advocate for any
2 increases in payments or new coverage of services, but
3 may identify issues and problems in payment or coverage
4 policies.

5 “(c) WORKING WITH HEALTH INSURANCE COUN-
6 SELING PROGRAMS.—To the extent possible, the Ombuds-
7 man shall work with health insurance counseling programs
8 (receiving funding under section 4360 of Omnibus Budget
9 Reconciliation Act of 1990) to facilitate the provision of
10 information to individuals entitled to benefits under part
11 A or enrolled under part B, or both regarding
12 Medicare+Choice plans and changes to those plans. Noth-
13 ing in this subsection shall preclude further collaboration
14 between the Ombudsman and such programs.”.

15 (c) DEADLINE FOR APPOINTMENT.—The Secretary
16 shall appoint the Medicare Provider Ombudsman and the
17 Medicare Beneficiary Ombudsman, under the amendments
18 made by subsections (a) and (b), respectively, by not later
19 than 1 year after the date of the enactment of this Act.

20 (d) FUNDING.—There are authorized to be appro-
21 priated to the Secretary (in appropriate part from the
22 Federal Hospital Insurance Trust Fund and the Federal
23 Supplementary Medical Insurance Trust Fund) to carry
24 out the provisions of subsection (b) of section 1868 of the
25 Social Security Act (relating to the Medicare Provider

1 Ombudsman), as added by subsection (a)(5) and section
2 1809 of such Act (relating to the Medicare Beneficiary
3 Ombudsman), as added by subsection (b), such sums as
4 are necessary for fiscal year 2003 and each succeeding fis-
5 cal year.

6 (e) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-
7 MEDICARE).—

8 (1) PHONE TRIAGE SYSTEM; LISTING IN MEDI-
9 CARE HANDBOOK INSTEAD OF OTHER TOLL-FREE
10 NUMBERS.—Section 1804(b) (42 U.S.C. 1395b-
11 2(b)) is amended by adding at the end the following:
12 “The Secretary shall provide, through the toll-free
13 number 1-800-MEDICARE, for a means by which
14 individuals seeking information about, or assistance
15 with, such programs who phone such toll-free num-
16 ber are transferred (without charge) to appropriate
17 entities for the provision of such information or as-
18 sistance. Such toll-free number shall be the toll-free
19 number listed for general information and assistance
20 in the annual notice under subsection (a) instead of
21 the listing of numbers of individual contractors.”.

22 (2) MONITORING ACCURACY.—

23 (A) STUDY.—The Comptroller General of
24 the United States shall conduct a study to mon-
25 itor the accuracy and consistency of information

1 provided to individuals entitled to benefits
2 under part A or enrolled under part B, or both,
3 through the toll-free number 1-800-MEDI-
4 CARE, including an assessment of whether the
5 information provided is sufficient to answer
6 questions of such individuals. In conducting the
7 study, the Comptroller General shall examine
8 the education and training of the individuals
9 providing information through such number.

10 (B) REPORT.—Not later than 1 year after
11 the date of the enactment of this Act, the
12 Comptroller General shall submit to Congress a
13 report on the study conducted under subpara-
14 graph (A).

15 **SEC. 524. BENEFICIARY OUTREACH DEMONSTRATION PRO-**
16 **GRAM.**

17 (a) IN GENERAL.—The Secretary shall establish a
18 demonstration program (in this section referred to as the
19 “demonstration program”) under which medicare special-
20 ists employed by the Department of Health and Human
21 Services provide advice and assistance to individuals enti-
22 tled to benefits under part A of title XVIII of the Social
23 Security Act, or enrolled under part B of such title, or
24 both, regarding the medicare program at the location of
25 existing local offices of the Social Security Administration.

1 (b) LOCATIONS.—

2 (1) IN GENERAL.—The demonstration program
3 shall be conducted in at least 6 offices or areas.
4 Subject to paragraph (2), in selecting such offices
5 and areas, the Secretary shall provide preference for
6 offices with a high volume of visits by individuals re-
7 ferred to in subsection (a).

8 (2) ASSISTANCE FOR RURAL BENEFICIARIES.—
9 The Secretary shall provide for the selection of at
10 least 2 rural areas to participate in the demonstra-
11 tion program. In conducting the demonstration pro-
12 gram in such rural areas, the Secretary shall provide
13 for medicare specialists to travel among local offices
14 in a rural area on a scheduled basis.

15 (c) DURATION.—The demonstration program shall be
16 conducted over a 3-year period.

17 (d) EVALUATION AND REPORT.—

18 (1) EVALUATION.—The Secretary shall provide
19 for an evaluation of the demonstration program.
20 Such evaluation shall include an analysis of—

21 (A) utilization of, and satisfaction of those
22 individuals referred to in subsection (a) with,
23 the assistance provided under the program; and

24 (B) the cost-effectiveness of providing ben-
25 efiary assistance through out-stationing medi-

1 care specialists at local offices of the Social Se-
2 curity Administration.

3 (2) REPORT.—The Secretary shall submit to
4 Congress a report on such evaluation and shall in-
5 clude in such report recommendations regarding the
6 feasibility of permanently out-stationing medicare
7 specialists at local offices of the Social Security Ad-
8 ministration.

9 **Subtitle D—Appeals and Recovery**

10 **SEC. 531. TRANSFER OF RESPONSIBILITY FOR MEDICARE**

11 **APPEALS.**

12 (a) TRANSITION PLAN.—

13 (1) IN GENERAL.—Not later than October 1,
14 2003, the Commissioner of Social Security and the
15 Secretary shall develop and transmit to Congress
16 and the Comptroller General of the United States a
17 plan under which the functions of administrative law
18 judges responsible for hearing cases under title
19 XVIII of the Social Security Act (and related provi-
20 sions in title XI of such Act) are transferred from
21 the responsibility of the Commissioner and the So-
22 cial Security Administration to the Secretary and
23 the Department of Health and Human Services.

24 (2) GAO EVALUATION.—The Comptroller Gen-
25 eral of the United States shall evaluate the plan

1 and, not later than the date that is 6 months after
2 the date on which the plan is received by the Comp-
3 troller General, shall submit to Congress a report on
4 such evaluation.

5 (b) TRANSFER OF ADJUDICATION AUTHORITY.—

6 (1) IN GENERAL.—Not earlier than July 1,
7 2004, and not later than October 1, 2004, the Com-
8 missioner of Social Security and the Secretary shall
9 implement the transition plan under subsection (a)
10 and transfer the administrative law judge functions
11 described in such subsection from the Social Secu-
12 rity Administration to the Secretary.

13 (2) ASSURING INDEPENDENCE OF JUDGES.—

14 The Secretary shall assure the independence of ad-
15 ministrative law judges performing the administra-
16 tive law judge functions transferred under para-
17 graph (1) from the Centers for Medicare & Medicaid
18 Services and its contractors.

19 (3) GEOGRAPHIC DISTRIBUTION.—The Sec-

20 retary shall provide for an appropriate geographic
21 distribution of administrative law judges performing
22 the administrative law judge functions transferred
23 under paragraph (1) throughout the United States
24 to ensure timely access to such judges.

1 (4) HIRING AUTHORITY.—Subject to the
2 amounts provided in advance in appropriations Act,
3 the Secretary shall have authority to hire adminis-
4 trative law judges to hear such cases, giving priority
5 to those judges with prior experience in handling
6 medicare appeals and in a manner consistent with
7 paragraph (3), and to hire support staff for such
8 judges.

9 (5) FINANCING.—Amounts payable under law
10 to the Commissioner for administrative law judges
11 performing the administrative law judge functions
12 transferred under paragraph (1) from the Federal
13 Hospital Insurance Trust Fund and the Federal
14 Supplementary Medical Insurance Trust Fund shall
15 become payable to the Secretary for the functions so
16 transferred.

17 (6) SHARED RESOURCES.—The Secretary shall
18 enter into such arrangements with the Commissioner
19 as may be appropriate with respect to transferred
20 functions of administrative law judges to share office
21 space, support staff, and other resources, with ap-
22 propriate reimbursement from the Trust Funds de-
23 scribed in paragraph (5).

24 (c) INCREASED FINANCIAL SUPPORT.—In addition to
25 any amounts otherwise appropriated, to ensure timely ac-

1 tion on appeals before administrative law judges and the
2 Departmental Appeals Board consistent with section 1869
3 of the Social Security Act (as amended by section 521 of
4 BIPA, 114 Stat. 2763A–534), there are authorized to be
5 appropriated (in appropriate part from the Federal Hos-
6 pital Insurance Trust Fund and the Federal Supple-
7 mentary Medical Insurance Trust Fund) to the Secretary
8 such sums as are necessary for fiscal year 2004 and each
9 subsequent fiscal year to—

10 (1) increase the number of administrative law
11 judges (and their staffs) under subsection (b)(4);

12 (2) improve education and training opportuni-
13 ties for administrative law judges (and their staffs);
14 and

15 (3) increase the staff of the Departmental Ap-
16 peals Board.

17 (d) CONFORMING AMENDMENT.—Section
18 1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)), as added
19 by section 522(a) of BIPA (114 Stat. 2763A–543), is
20 amended by striking “of the Social Security Administra-
21 tion”.

22 **SEC. 532. PROCESS FOR EXPEDITED ACCESS TO REVIEW.**

23 (a) EXPEDITED ACCESS TO JUDICIAL REVIEW.—Sec-
24 tion 1869(b) (42 U.S.C. 1395ff(b)) as amended by BIPA,
25 is amended—

1 (1) in paragraph (1)(A), by inserting “, subject
2 to paragraph (2),” before “to judicial review of the
3 Secretary’s final decision”;

4 (2) in paragraph (1)(F)—

5 (A) by striking clause (ii);

6 (B) by striking “PROCEEDING” and all
7 that follows through “DETERMINATION” and in-
8 serting “DETERMINATIONS AND RECONSIDER-
9 ATIONS”; and

10 (C) by redesignating subclauses (I) and
11 (II) as clauses (i) and (ii) and by moving the
12 indentation of such subclauses (and the matter
13 that follows) 2 ems to the left; and

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

16 “(2) EXPEDITED ACCESS TO JUDICIAL RE-
17 VIEW.—

18 “(A) IN GENERAL.—The Secretary shall
19 establish a process under which a provider of
20 services or supplier that furnishes an item or
21 service or an individual entitled to benefits
22 under part A or enrolled under part B, or both,
23 who has filed an appeal under paragraph (1)
24 may obtain access to judicial review when a re-
25 view panel (described in subparagraph (D)), on

1 its own motion or at the request of the appel-
2 lant, determines that no entity in the adminis-
3 trative appeals process has the authority to de-
4 cide the question of law or regulation relevant
5 to the matters in controversy and that there is
6 no material issue of fact in dispute. The appel-
7 lant may make such request only once with re-
8 spect to a question of law or regulation in a
9 case of an appeal.

10 “(B) PROMPT DETERMINATIONS.—If, after
11 or coincident with appropriately filing a request
12 for an administrative hearing, the appellant re-
13 quests a determination by the appropriate re-
14 view panel that no review panel has the author-
15 ity to decide the question of law or regulations
16 relevant to the matters in controversy and that
17 there is no material issue of fact in dispute and
18 if such request is accompanied by the docu-
19 ments and materials as the appropriate review
20 panel shall require for purposes of making such
21 determination, such review panel shall make a
22 determination on the request in writing within
23 60 days after the date such review panel re-
24 ceives the request and such accompanying docu-
25 ments and materials. Such a determination by

1 such review panel shall be considered a final de-
2 cision and not subject to review by the Sec-
3 retary.

4 “(C) ACCESS TO JUDICIAL REVIEW.—

5 “(i) IN GENERAL.—If the appropriate
6 review panel—

7 “(I) determines that there are no
8 material issues of fact in dispute and
9 that the only issue is one of law or
10 regulation that no review panel has
11 the authority to decide; or

12 “(II) fails to make such deter-
13 mination within the period provided
14 under subparagraph (B);

15 then the appellant may bring a civil action
16 as described in this subparagraph.

17 “(ii) DEADLINE FOR FILING.—Such
18 action shall be filed, in the case described
19 in—

20 “(I) clause (i)(I), within 60 days
21 of date of the determination described
22 in such subparagraph; or

23 “(II) clause (i)(II), within 60
24 days of the end of the period provided

1 under subparagraph (B) for the deter-
2 mination.

3 “(iii) VENUE.—Such action shall be
4 brought in the district court of the United
5 States for the judicial district in which the
6 appellant is located (or, in the case of an
7 action brought jointly by more than one
8 applicant, the judicial district in which the
9 greatest number of applicants are located)
10 or in the district court for the District of
11 Columbia.

12 “(iv) INTEREST ON AMOUNTS IN CON-
13 TROVERSY.—Where a provider of services
14 or supplier seeks judicial review pursuant
15 to this paragraph, the amount in con-
16 troversy shall be subject to annual interest
17 beginning on the first day of the first
18 month beginning after the 60-day period
19 as determined pursuant to clause (ii) and
20 equal to the rate of interest on obligations
21 issued for purchase by the Federal Hos-
22 pital Insurance Trust Fund and by the
23 Federal Supplementary Medical Insurance
24 Trust Fund for the month in which the
25 civil action authorized under this para-

1 graph is commenced, to be awarded by the
2 reviewing court in favor of the prevailing
3 party. No interest awarded pursuant to the
4 preceding sentence shall be deemed income
5 or cost for the purposes of determining re-
6 imbursement due providers of services or
7 suppliers under this Act.

8 “(D) REVIEW PANELS.—For purposes of
9 this subsection, a ‘review panel’ is a panel con-
10 sisting of 3 members (who shall be administra-
11 tive law judges, members of the Departmental
12 Appeals Board, or qualified individuals associ-
13 ated with a qualified independent contractor (as
14 defined in subsection (c)(2)) or with another
15 independent entity) designated by the Secretary
16 for purposes of making determinations under
17 this paragraph.”.

18 (b) APPLICATION TO PROVIDER AGREEMENT DETER-
19 MINATIONS.—Section 1866(h)(1) (42 U.S.C.
20 1395cc(h)(1)) is amended—

21 (1) by inserting “(A)” after “(h)(1)”; and

22 (2) by adding at the end the following new sub-
23 paragraph:

24 “(B) An institution or agency described in subpara-
25 graph (A) that has filed for a hearing under subparagraph

1 (A) shall have expedited access to judicial review under
2 this subparagraph in the same manner as providers of
3 services, suppliers, and individuals entitled to benefits
4 under part A or enrolled under part B, or both, may ob-
5 tain expedited access to judicial review under the process
6 established under section 1869(b)(2). Nothing in this sub-
7 paragraph shall be construed to affect the application of
8 any remedy imposed under section 1819 during the pend-
9 ency of an appeal under this subparagraph.”.

10 (c) EFFECTIVE DATE.—The amendments made by
11 this section shall apply to appeals filed on or after October
12 1, 2003.

13 (d) EXPEDITED REVIEW OF CERTAIN PROVIDER
14 AGREEMENT DETERMINATIONS.—

15 (1) TERMINATION AND CERTAIN OTHER IMME-
16 DIATE REMEDIES.—The Secretary shall develop and
17 implement a process to expedite proceedings under
18 sections 1866(h) of the Social Security Act (42
19 U.S.C. 1395cc(h)) in which the remedy of termi-
20 nation of participation, or a remedy described in
21 clause (i) or (iii) of section 1819(h)(2)(B) of such
22 Act (42 U.S.C. 1395i–3(h)(2)(B)) which is applied
23 on an immediate basis, has been imposed. Under
24 such process priority shall be provided in cases of
25 termination.

1 (2) INCREASED FINANCIAL SUPPORT.—In addi-
2 tion to any amounts otherwise appropriated, to re-
3 duce by 50 percent the average time for administra-
4 tive determinations on appeals under section
5 1866(h) of the Social Security Act (42 U.S.C.
6 1395cc(h)), there are authorized to be appropriated
7 (in appropriate part from the Federal Hospital In-
8 surance Trust Fund and the Federal Supplementary
9 Medical Insurance Trust Fund) to the Secretary
10 such additional sums for fiscal year 2004 and each
11 subsequent fiscal year as may be necessary. The
12 purposes for which such amounts are available in-
13 clude increasing the number of administrative law
14 judges (and their staffs) and the appellate level staff
15 at the Departmental Appeals Board of the Depart-
16 ment of Health and Human Services and educating
17 such judges and staffs on long-term care issues.

18 **SEC. 533. REVISIONS TO MEDICARE APPEALS PROCESS.**

19 (a) REQUIRING FULL AND EARLY PRESENTATION OF
20 EVIDENCE.—

21 (1) IN GENERAL.—Section 1869(b) (42 U.S.C.
22 1395ff(b)), as amended by BIPA and as amended by
23 section 532(a), is further amended by adding at the
24 end the following new paragraph:

1 “(3) REQUIRING FULL AND EARLY PRESEN-
2 TATION OF EVIDENCE BY PROVIDERS.—A provider
3 of services or supplier may not introduce evidence in
4 any appeal under this section that was not presented
5 at the reconsideration conducted by the qualified
6 independent contractor under subsection (c), unless
7 there is good cause which precluded the introduction
8 of such evidence at or before that reconsideration.”.

9 (2) EFFECTIVE DATE.—The amendment made
10 by paragraph (1) shall take effect on October 1,
11 2003.

12 (b) USE OF PATIENTS’ MEDICAL RECORDS.—Section
13 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)), as
14 amended by BIPA, is amended by inserting “(including
15 the medical records of the individual involved)” after
16 “clinical experience”.

17 (c) NOTICE REQUIREMENTS FOR MEDICARE AP-
18 PEALS.—

19 (1) INITIAL DETERMINATIONS AND REDETER-
20 MINATIONS.—Section 1869(a) (42 U.S.C.
21 1395ff(a)), as amended by BIPA, is amended by
22 adding at the end the following new paragraph:

23 “(4) REQUIREMENTS OF NOTICE OF DETER-
24 MINATIONS AND REDETERMINATIONS.—A written
25 notice of a determination on an initial determination

1 or on a redetermination, insofar as such determina-
2 tion or redetermination results in a denial of a claim
3 for benefits, shall include—

4 “(A) the specific reasons for the deter-
5 mination, including—

6 “(i) upon request, the provision of the
7 policy, manual, or regulation used in mak-
8 ing the determination; and

9 “(ii) as appropriate in the case of a
10 redetermination, a summary of the clinical
11 or scientific evidence used in making the
12 determination;

13 “(B) the procedures for obtaining addi-
14 tional information concerning the determination
15 or redetermination; and

16 “(C) notification of the right to seek a re-
17 determination or otherwise appeal the deter-
18 mination and instructions on how to initiate
19 such a redetermination or appeal under this
20 section.

21 The written notice on a redetermination shall be
22 provided in printed form and written in a manner
23 calculated to be understood by the individual entitled
24 to benefits under part A or enrolled under part B,
25 or both.”.

1 (2) RECONSIDERATIONS.—Section
2 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)), as
3 amended by BIPA, is amended—

4 (A) by inserting “be written in a manner
5 calculated to be understood by the individual
6 entitled to benefits under part A or enrolled
7 under part B, or both, and shall include (to the
8 extent appropriate)” after “in writing, ”; and

9 (B) by inserting “and a notification of the
10 right to appeal such determination and instruc-
11 tions on how to initiate such appeal under this
12 section” after “such decision,”.

13 (3) APPEALS.—Section 1869(d) (42 U.S.C.
14 1395ff(d)), as amended by BIPA, is amended—

15 (A) in the heading, by inserting “; NO-
16 TICE” after “SECRETARY”; and

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

19 “(4) NOTICE.—Notice of the decision of an ad-
20 ministrative law judge shall be in writing in a man-
21 ner calculated to be understood by the individual en-
22 titled to benefits under part A or enrolled under part
23 B, or both, and shall include—

24 “(A) the specific reasons for the deter-
25 mination (including, to the extent appropriate,

1 a summary of the clinical or scientific evidence
2 used in making the determination);

3 “(B) the procedures for obtaining addi-
4 tional information concerning the decision; and

5 “(C) notification of the right to appeal the
6 decision and instructions on how to initiate
7 such an appeal under this section.”.

8 (4) SUBMISSION OF RECORD FOR APPEAL.—

9 Section 1869(c)(3)(J)(i) (42 U.S.C.
10 1395ff(c)(3)(J)(i)) by striking “prepare” and insert-
11 ing “submit” and by striking “with respect to” and
12 all that follows through “and relevant policies”.

13 (d) QUALIFIED INDEPENDENT CONTRACTORS.—

14 (1) ELIGIBILITY REQUIREMENTS OF QUALIFIED
15 INDEPENDENT CONTRACTORS.—Section 1869(c)(3)
16 (42 U.S.C. 1395ff(c)(3)), as amended by BIPA, is
17 amended—

18 (A) in subparagraph (A), by striking “suf-
19 ficient training and expertise in medical science
20 and legal matters” and inserting “sufficient
21 medical, legal, and other expertise (including
22 knowledge of the program under this title) and
23 sufficient staffing”; and

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

1 “(K) INDEPENDENCE REQUIREMENTS.—

2 “(i) IN GENERAL.—Subject to clause
3 (ii), a qualified independent contractor
4 shall not conduct any activities in a case
5 unless the entity—

6 “(I) is not a related party (as de-
7 fined in subsection (g)(5));

8 “(II) does not have a material fa-
9 miliary, financial, or professional rela-
10 tionship with such a party in relation
11 to such case; and

12 “(III) does not otherwise have a
13 conflict of interest with such a party.

14 “(ii) EXCEPTION FOR REASONABLE
15 COMPENSATION.—Nothing in clause (i)
16 shall be construed to prohibit receipt by a
17 qualified independent contractor of com-
18 pensation from the Secretary for the con-
19 duct of activities under this section if the
20 compensation is provided consistent with
21 clause (iii).

22 “(iii) LIMITATIONS ON ENTITY COM-
23 PENSATION.—Compensation provided by
24 the Secretary to a qualified independent
25 contractor in connection with reviews

1 under this section shall not be contingent
2 on any decision rendered by the contractor
3 or by any reviewing professional.”.

4 (2) ELIGIBILITY REQUIREMENTS FOR REVIEW-
5 ERS.—Section 1869 (42 U.S.C. 1395ff), as amended
6 by BIPA, is amended—

7 (A) by amending subsection (c)(3)(D) to
8 read as follows:

9 “(D) QUALIFICATIONS FOR REVIEWERS.—
10 The requirements of subsection (g) shall be met
11 (relating to qualifications of reviewing profes-
12 sionals).”; and

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

15 “(g) QUALIFICATIONS OF REVIEWERS.—

16 “(1) IN GENERAL.—In reviewing determina-
17 tions under this section, a qualified independent con-
18 tractor shall assure that—

19 “(A) each individual conducting a review
20 shall meet the qualifications of paragraph (2);

21 “(B) compensation provided by the con-
22 tractor to each such reviewer is consistent with
23 paragraph (3); and

24 “(C) in the case of a review by a panel de-
25 scribed in subsection (c)(3)(B) composed of

1 physicians or other health care professionals
2 (each in this subsection referred to as a ‘review-
3 ing professional’), each reviewing professional
4 meets the qualifications described in paragraph
5 (4) and, where a claim is regarding the fur-
6 nishing of treatment by a physician (allopathic
7 or osteopathic) or the provision of items or
8 services by a physician (allopathic or osteo-
9 pathic), each reviewing professional shall be a
10 physician (allopathic or osteopathic).

11 “(2) INDEPENDENCE.—

12 “(A) IN GENERAL.—Subject to subpara-
13 graph (B), each individual conducting a review
14 in a case shall—

15 “(i) not be a related party (as defined
16 in paragraph (5));

17 “(ii) not have a material familial, fi-
18 nancial, or professional relationship with
19 such a party in the case under review; and

20 “(iii) not otherwise have a conflict of
21 interest with such a party.

22 “(B) EXCEPTION.—Nothing in subpara-
23 graph (A) shall be construed to—

24 “(i) prohibit an individual, solely on
25 the basis of a participation agreement with

1 a fiscal intermediary, carrier, or other con-
2 tractor, from serving as a reviewing profes-
3 sional if—

4 “(I) the individual is not involved
5 in the provision of items or services in
6 the case under review;

7 “(II) the fact of such an agree-
8 ment is disclosed to the Secretary and
9 the individual entitled to benefits
10 under part A or enrolled under part
11 B, or both, (or authorized representa-
12 tive) and neither party objects; and

13 “(III) the individual is not an
14 employee of the intermediary, carrier,
15 or contractor and does not provide
16 services exclusively or primarily to or
17 on behalf of such intermediary, car-
18 rier, or contractor;

19 “(ii) prohibit an individual who has
20 staff privileges at the institution where the
21 treatment involved takes place from serv-
22 ing as a reviewer merely on the basis of
23 having such staff privileges if the existence
24 of such privileges is disclosed to the Sec-
25 retary and such individual (or authorized

1 representative), and neither party objects;
2 or

3 “(iii) prohibit receipt of compensation
4 by a reviewing professional from a con-
5 tractor if the compensation is provided
6 consistent with paragraph (3).

7 For purposes of this paragraph, the term ‘par-
8 ticipation agreement’ means an agreement re-
9 lating to the provision of health care services by
10 the individual and does not include the provi-
11 sion of services as a reviewer under this sub-
12 section.

13 “(3) LIMITATIONS ON REVIEWER COMPENSA-
14 TION.—Compensation provided by a qualified inde-
15 pendent contractor to a reviewer in connection with
16 a review under this section shall not be contingent
17 on the decision rendered by the reviewer.

18 “(4) LICENSURE AND EXPERTISE.—Each re-
19 viewing professional shall be—

20 “(A) a physician (allopathic or osteopathic)
21 who is appropriately credentialed or licensed in
22 one or more States to deliver health care serv-
23 ices and has medical expertise in the field of
24 practice that is appropriate for the items or
25 services at issue; or

1 “(B) a health care professional who is le-
2 gally authorized in one or more States (in ac-
3 cordance with State law or the State regulatory
4 mechanism provided by State law) to furnish
5 the health care items or services at issue and
6 has medical expertise in the field of practice
7 that is appropriate for such items or services.

8 “(5) RELATED PARTY DEFINED.—For purposes
9 of this section, the term ‘related party’ means, with
10 respect to a case under this title involving a specific
11 individual entitled to benefits under part A or en-
12 rolled under part B, or both, any of the following:

13 “(A) The Secretary, the medicare adminis-
14 trative contractor involved, or any fiduciary, of-
15 ficer, director, or employee of the Department
16 of Health and Human Services, or of such con-
17 tractor.

18 “(B) The individual (or authorized rep-
19 resentative).

20 “(C) The health care professional that pro-
21 vides the items or services involved in the case.

22 “(D) The institution at which the items or
23 services (or treatment) involved in the case are
24 provided.

1 “(E) The manufacturer of any drug or
2 other item that is included in the items or serv-
3 ices involved in the case.

4 “(F) Any other party determined under
5 any regulations to have a substantial interest in
6 the case involved.”.

7 (3) EFFECTIVE DATE.—The amendments made
8 by paragraphs (1) and (2) shall be effective as if in-
9 cluded in the enactment of the respective provisions
10 of subtitle C of title V of BIPA, (114 Stat. 2763A–
11 534).

12 (4) TRANSITION.—In applying section 1869(g)
13 of the Social Security Act (as added by paragraph
14 (2)), any reference to a medicare administrative con-
15 tractor shall be deemed to include a reference to a
16 fiscal intermediary under section 1816 of the Social
17 Security Act (42 U.S.C. 1395h) and a carrier under
18 section 1842 of such Act (42 U.S.C. 1395u).

19 **SEC. 534. PREPAYMENT REVIEW.**

20 (a) IN GENERAL.—Section 1874A, as added by sec-
21 tion 511(a)(1) and as amended by sections 512(b),
22 521(b)(1), and 521(c)(1), is further amended by adding
23 at the end the following new subsection:

24 “(h) CONDUCT OF PREPAYMENT REVIEW.—

1 “(1) CONDUCT OF RANDOM PREPAYMENT RE-
2 VIEW.—

3 “(A) IN GENERAL.—A medicare adminis-
4 trative contractor may conduct random prepay-
5 ment review only to develop a contractor-wide
6 or program-wide claims payment error rates or
7 under such additional circumstances as may be
8 provided under regulations, developed in con-
9 sultation with providers of services and sup-
10 pliers.

11 “(B) USE OF STANDARD PROTOCOLS
12 WHEN CONDUCTING PREPAYMENT REVIEWS.—
13 When a medicare administrative contractor con-
14 ducts a random prepayment review, the con-
15 tractor may conduct such review only in accord-
16 ance with a standard protocol for random pre-
17 payment audits developed by the Secretary.

18 “(C) CONSTRUCTION.—Nothing in this
19 paragraph shall be construed as preventing the
20 denial of payments for claims actually reviewed
21 under a random prepayment review.

22 “(D) RANDOM PREPAYMENT REVIEW.—
23 For purposes of this subsection, the term ‘ran-
24 dom prepayment review’ means a demand for

1 the production of records or documentation ab-
2 sent cause with respect to a claim.

3 “(2) LIMITATIONS ON NON-RANDOM PREPAY-
4 MENT REVIEW.—

5 “(A) LIMITATIONS ON INITIATION OF NON-
6 RANDOM PREPAYMENT REVIEW.—A medicare
7 administrative contractor may not initiate non-
8 random prepayment review of a provider of
9 services or supplier based on the initial identi-
10 fication by that provider of services or supplier
11 of an improper billing practice unless there is a
12 likelihood of sustained or high level of payment
13 error (as defined in subsection (i)(3)(A)).

14 “(B) TERMINATION OF NON-RANDOM PRE-
15 PAYMENT REVIEW.—The Secretary shall issue
16 regulations relating to the termination, includ-
17 ing termination dates, of non-random prepay-
18 ment review. Such regulations may vary such a
19 termination date based upon the differences in
20 the circumstances triggering prepayment re-
21 view.”.

22 (b) EFFECTIVE DATE.—

23 (1) IN GENERAL.—Except as provided in this
24 subsection, the amendment made by subsection (a)

1 shall take effect 1 year after the date of the enact-
2 ment of this Act.

3 (2) DEADLINE FOR PROMULGATION OF CER-
4 TAIN REGULATIONS.—The Secretary shall first issue
5 regulations under section 1874A(h) of the Social Se-
6 curity Act, as added by subsection (a), by not later
7 than 1 year after the date of the enactment of this
8 Act.

9 (3) APPLICATION OF STANDARD PROTOCOLS
10 FOR RANDOM PREPAYMENT REVIEW.—Section
11 1874A(h)(1)(B) of the Social Security Act, as added
12 by subsection (a), shall apply to random prepayment
13 reviews conducted on or after such date (not later
14 than 1 year after the date of the enactment of this
15 Act) as the Secretary shall specify.

16 (c) APPLICATION TO FISCAL INTERMEDIARIES AND
17 CARRIERS.—The provisions of section 1874A(h) of the So-
18 cial Security Act, as added by subsection (a), shall apply
19 to each fiscal intermediary under section 1816 of the So-
20 cial Security Act (42 U.S.C. 1395h) and each carrier
21 under section 1842 of such Act (42 U.S.C. 1395u) in the
22 same manner as they apply to medicare administrative
23 contractors under such provisions.

1 **SEC. 535. RECOVERY OF OVERPAYMENTS.**

2 (a) IN GENERAL.—Section 1893 (42 U.S.C.
3 1395ddd) is amended by adding at the end the following
4 new subsection:

5 “(f) RECOVERY OF OVERPAYMENTS.—

6 “(1) USE OF REPAYMENT PLANS.—

7 “(A) IN GENERAL.—If the repayment,
8 within 30 days by a provider of services or sup-
9 plier, of an overpayment under this title would
10 constitute a hardship (as defined in subpara-
11 graph (B)), subject to subparagraph (C), upon
12 request of the provider of services or supplier
13 the Secretary shall enter into a plan with the
14 provider of services or supplier for the repay-
15 ment (through offset or otherwise) of such over-
16 payment over a period of at least 6 months but
17 not longer than 3 years (or not longer than 5
18 years in the case of extreme hardship, as deter-
19 mined by the Secretary). Interest shall accrue
20 on the balance through the period of repay-
21 ment. Such plan shall meet terms and condi-
22 tions determined to be appropriate by the Sec-
23 retary.

24 “(B) HARDSHIP.—

25 “(i) IN GENERAL.—For purposes of
26 subparagraph (A), the repayment of an

1 overpayment (or overpayments) within 30
2 days is deemed to constitute a hardship
3 if—

4 “(I) in the case of a provider of
5 services that files cost reports, the ag-
6 gregate amount of the overpayments
7 exceeds 10 percent of the amount paid
8 under this title to the provider of
9 services for the cost reporting period
10 covered by the most recently sub-
11 mitted cost report; or

12 “(II) in the case of another pro-
13 vider of services or supplier, the ag-
14 gregate amount of the overpayments
15 exceeds 10 percent of the amount paid
16 under this title to the provider of
17 services or supplier for the previous
18 calendar year.

19 “(ii) RULE OF APPLICATION.—The
20 Secretary shall establish rules for the ap-
21 plication of this subparagraph in the case
22 of a provider of services or supplier that
23 was not paid under this title during the
24 previous year or was paid under this title
25 only during a portion of that year.

1 “(iii) TREATMENT OF PREVIOUS
2 OVERPAYMENTS.—If a provider of services
3 or supplier has entered into a repayment
4 plan under subparagraph (A) with respect
5 to a specific overpayment amount, such
6 payment amount under the repayment plan
7 shall not be taken into account under
8 clause (i) with respect to subsequent over-
9 payment amounts.

10 “(C) EXCEPTIONS.—Subparagraph (A)
11 shall not apply if—

12 “(i) the Secretary has reason to sus-
13 pect that the provider of services or sup-
14 plier may file for bankruptcy or otherwise
15 cease to do business or discontinue partici-
16 pation in the program under this title; or

17 “(ii) there is an indication of fraud or
18 abuse committed against the program.

19 “(D) IMMEDIATE COLLECTION IF VIOLA-
20 TION OF REPAYMENT PLAN.—If a provider of
21 services or supplier fails to make a payment in
22 accordance with a repayment plan under this
23 paragraph, the Secretary may immediately seek
24 to offset or otherwise recover the total balance

1 outstanding (including applicable interest)
2 under the repayment plan.

3 “(E) RELATION TO NO FAULT PROVI-
4 SION.—Nothing in this paragraph shall be con-
5 strued as affecting the application of section
6 1870(c) (relating to no adjustment in the cases
7 of certain overpayments).

8 “(2) LIMITATION ON RECOUPMENT.—

9 “(A) IN GENERAL.—In the case of a pro-
10 vider of services or supplier that is determined
11 to have received an overpayment under this title
12 and that seeks a reconsideration by a qualified
13 independent contractor on such determination
14 under section 1869(b)(1), the Secretary may
15 not take any action (or authorize any other per-
16 son, including any medicare contractor, as de-
17 fined in subparagraph (C)) to recoup the over-
18 payment until the date the decision on the re-
19 consideration has been rendered. If the provi-
20 sions of section 1869(b)(1) (providing for such
21 a reconsideration by a qualified independent
22 contractor) are not in effect, in applying the
23 previous sentence any reference to such a recon-
24 sideration shall be treated as a reference to a

1 redetermination by the fiscal intermediary or
2 carrier involved.

3 “(B) COLLECTION WITH INTEREST.—Inso-
4 far as the determination on such appeal is
5 against the provider of services or supplier, in-
6 terest on the overpayment shall accrue on and
7 after the date of the original notice of overpay-
8 ment. Insofar as such determination against the
9 provider of services or supplier is later reversed,
10 the Secretary shall provide for repayment of the
11 amount recouped plus interest at the same rate
12 as would apply under the previous sentence for
13 the period in which the amount was recouped.

14 “(C) MEDICARE CONTRACTOR DEFINED.—
15 For purposes of this subsection, the term ‘medi-
16 care contractor’ has the meaning given such
17 term in section 1889(g).

18 “(3) LIMITATION ON USE OF EXTRAPO-
19 LATION.—A medicare contractor may not use ex-
20 trapolation to determine overpayment amounts to be
21 recovered by recoupment, offset, or otherwise un-
22 less—

23 “(A) there is a sustained or high level of
24 payment error (as defined by the Secretary by
25 regulation); or

1 “(B) documented educational intervention
2 has failed to correct the payment error (as de-
3 termined by the Secretary).

4 “(4) PROVISION OF SUPPORTING DOCUMENTA-
5 TION.—In the case of a provider of services or sup-
6 plier with respect to which amounts were previously
7 overpaid, a medicare contractor may request the
8 periodic production of records or supporting docu-
9 mentation for a limited sample of submitted claims
10 to ensure that the previous practice is not con-
11 tinuing.

12 “(5) CONSENT SETTLEMENT REFORMS.—

13 “(A) IN GENERAL.—The Secretary may
14 use a consent settlement (as defined in sub-
15 paragraph (D)) to settle a projected overpay-
16 ment.

17 “(B) OPPORTUNITY TO SUBMIT ADDI-
18 TIONAL INFORMATION BEFORE CONSENT SET-
19 TLEMENT OFFER.—Before offering a provider
20 of services or supplier a consent settlement, the
21 Secretary shall—

22 “(i) communicate to the provider of
23 services or supplier—

24 “(I) that, based on a review of
25 the medical records requested by the

1 Secretary, a preliminary evaluation of
2 those records indicates that there
3 would be an overpayment;

4 “(II) the nature of the problems
5 identified in such evaluation; and

6 “(III) the steps that the provider
7 of services or supplier should take to
8 address the problems; and

9 “(ii) provide for a 45-day period dur-
10 ing which the provider of services or sup-
11 plier may furnish additional information
12 concerning the medical records for the
13 claims that had been reviewed.

14 “(C) CONSENT SETTLEMENT OFFER.—The
15 Secretary shall review any additional informa-
16 tion furnished by the provider of services or
17 supplier under subparagraph (B)(ii). Taking
18 into consideration such information, the Sec-
19 retary shall determine if there still appears to
20 be an overpayment. If so, the Secretary—

21 “(i) shall provide notice of such deter-
22 mination to the provider of services or sup-
23 plier, including an explanation of the rea-
24 son for such determination; and

1 “(ii) in order to resolve the overpay-
2 ment, may offer the provider of services or
3 supplier—

4 “(I) the opportunity for a statis-
5 tically valid random sample; or

6 “(II) a consent settlement.

7 The opportunity provided under clause (ii)(I)
8 does not waive any appeal rights with respect to
9 the alleged overpayment involved.

10 “(D) CONSENT SETTLEMENT DEFINED.—

11 For purposes of this paragraph, the term ‘con-
12 sent settlement’ means an agreement between
13 the Secretary and a provider of services or sup-
14 plier whereby both parties agree to settle a pro-
15 jected overpayment based on less than a statis-
16 tically valid sample of claims and the provider
17 of services or supplier agrees not to appeal the
18 claims involved.

19 “(6) NOTICE OF OVER-UTILIZATION OF
20 CODES.—The Secretary shall establish, in consulta-
21 tion with organizations representing the classes of
22 providers of services and suppliers, a process under
23 which the Secretary provides for notice to classes of
24 providers of services and suppliers served by the con-
25 tractor in cases in which the contractor has identi-

1 fied that particular billing codes may be overutilized
2 by that class of providers of services or suppliers
3 under the programs under this title (or provisions of
4 title XI insofar as they relate to such programs).

5 “(7) PAYMENT AUDITS.—

6 “(A) WRITTEN NOTICE FOR POST-PAY-
7 MENT AUDITS.—Subject to subparagraph (C), if
8 a medicare contractor decides to conduct a
9 post-payment audit of a provider of services or
10 supplier under this title, the contractor shall
11 provide the provider of services or supplier with
12 written notice (which may be in electronic form)
13 of the intent to conduct such an audit.

14 “(B) EXPLANATION OF FINDINGS FOR ALL
15 AUDITS.—Subject to subparagraph (C), if a
16 medicare contractor audits a provider of serv-
17 ices or supplier under this title, the contractor
18 shall—

19 “(i) give the provider of services or
20 supplier a full review and explanation of
21 the findings of the audit in a manner that
22 is understandable to the provider of serv-
23 ices or supplier and permits the develop-
24 ment of an appropriate corrective action
25 plan;

1 “(ii) inform the provider of services or
2 supplier of the appeal rights under this
3 title as well as consent settlement options
4 (which are at the discretion of the Sec-
5 retary);

6 “(iii) give the provider of services or
7 supplier an opportunity to provide addi-
8 tional information to the contractor; and

9 “(iv) take into account information
10 provided, on a timely basis, by the provider
11 of services or supplier under clause (iii).

12 “(C) EXCEPTION.—Subparagraphs (A)
13 and (B) shall not apply if the provision of no-
14 tice or findings would compromise pending law
15 enforcement activities, whether civil or criminal,
16 or reveal findings of law enforcement-related
17 audits.

18 “(8) STANDARD METHODOLOGY FOR PROBE
19 SAMPLING.—The Secretary shall establish a stand-
20 ard methodology for medicare contractors to use in
21 selecting a sample of claims for review in the case
22 of an abnormal billing pattern.”.

23 (b) EFFECTIVE DATES AND DEADLINES.—

24 (1) USE OF REPAYMENT PLANS.—Section
25 1893(f)(1) of the Social Security Act, as added by

1 subsection (a), shall apply to requests for repayment
2 plans made after the date of the enactment of this
3 Act.

4 (2) LIMITATION ON RECOUPMENT.—Section
5 1893(f)(2) of the Social Security Act, as added by
6 subsection (a), shall apply to actions taken after the
7 date of the enactment of this Act.

8 (3) USE OF EXTRAPOLATION.—Section
9 1893(f)(3) of the Social Security Act, as added by
10 subsection (a), shall apply to statistically valid ran-
11 dom samples initiated after the date that is 1 year
12 after the date of the enactment of this Act.

13 (4) PROVISION OF SUPPORTING DOCUMENTA-
14 TION.—Section 1893(f)(4) of the Social Security
15 Act, as added by subsection (a), shall take effect on
16 the date of the enactment of this Act.

17 (5) CONSENT SETTLEMENT.—Section
18 1893(f)(5) of the Social Security Act, as added by
19 subsection (a), shall apply to consent settlements en-
20 tered into after the date of the enactment of this
21 Act.

22 (6) NOTICE OF OVERUTILIZATION.—Not later
23 than 1 year after the date of the enactment of this
24 Act, the Secretary shall first establish the process
25 for notice of overutilization of billing codes under

1 section 1893A(f)(6) of the Social Security Act, as
2 added by subsection (a).

3 (7) PAYMENT AUDITS.—Section 1893A(f)(7) of
4 the Social Security Act, as added by subsection (a),
5 shall apply to audits initiated after the date of the
6 enactment of this Act.

7 (8) STANDARD FOR ABNORMAL BILLING PAT-
8 TERNS.—Not later than 1 year after the date of the
9 enactment of this Act, the Secretary shall first es-
10 tablish a standard methodology for selection of sam-
11 ple claims for abnormal billing patterns under sec-
12 tion 1893(f)(8) of the Social Security Act, as added
13 by subsection (a).

14 **SEC. 536. PROVIDER ENROLLMENT PROCESS; RIGHT OF AP-**
15 **PEAL.**

16 (a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc)
17 is amended—

18 (1) by adding at the end of the heading the fol-
19 lowing: “; ENROLLMENT PROCESSES”; and

20 (2) by adding at the end the following new sub-
21 section:

22 “(j) ENROLLMENT PROCESS FOR PROVIDERS OF
23 SERVICES AND SUPPLIERS.—

24 “(1) ENROLLMENT PROCESS.—

1 “(A) IN GENERAL.—The Secretary shall
2 establish by regulation a process for the enroll-
3 ment of providers of services and suppliers
4 under this title.

5 “(B) DEADLINES.—The Secretary shall es-
6 tablish by regulation procedures under which
7 there are deadlines for actions on applications
8 for enrollment (and, if applicable, renewal of
9 enrollment). The Secretary shall monitor the
10 performance of medicare administrative con-
11 tractors in meeting the deadlines established
12 under this subparagraph.

13 “(C) CONSULTATION BEFORE CHANGING
14 PROVIDER ENROLLMENT FORMS.—The Sec-
15 retary shall consult with providers of services
16 and suppliers before making changes in the pro-
17 vider enrollment forms required of such pro-
18 viders and suppliers to be eligible to submit
19 claims for which payment may be made under
20 this title.

21 “(2) HEARING RIGHTS IN CASES OF DENIAL OR
22 NON-RENEWAL.—A provider of services or supplier
23 whose application to enroll (or, if applicable, to
24 renew enrollment) under this title is denied may
25 have a hearing and judicial review of such denial

1 under the procedures that apply under subsection
2 (h)(1)(A) to a provider of services that is dissatisfied
3 with a determination by the Secretary.”.

4 (b) EFFECTIVE DATES.—

5 (1) ENROLLMENT PROCESS.—The Secretary
6 shall provide for the establishment of the enrollment
7 process under section 1866(j)(1) of the Social Secu-
8 rity Act, as added by subsection (a)(2), within 6
9 months after the date of the enactment of this Act.

10 (2) CONSULTATION.—Section 1866(j)(1)(C) of
11 the Social Security Act, as added by subsection
12 (a)(2), shall apply with respect to changes in pro-
13 vider enrollment forms made on or after January 1,
14 2003.

15 (3) HEARING RIGHTS.—Section 1866(j)(2) of
16 the Social Security Act, as added by subsection
17 (a)(2), shall apply to denials occurring on or after
18 such date (not later than 1 year after the date of
19 the enactment of this Act) as the Secretary specifies.

20 **SEC. 537. PROCESS FOR CORRECTION OF MINOR ERRORS**
21 **AND OMISSIONS ON CLAIMS WITHOUT PUR-**
22 **SUING APPEALS PROCESS.**

23 The Secretary shall develop, in consultation with ap-
24 propriate medicare contractors (as defined in section
25 1889(g) of the Social Security Act, as inserted by section

1 521(a)(1)) and representatives of providers of services and
2 suppliers, a process whereby, in the case of minor errors
3 or omissions (as defined by the Secretary) that are de-
4 tected in the submission of claims under the programs
5 under title XVIII of such Act, a provider of services or
6 supplier is given an opportunity to correct such an error
7 or omission without the need to initiate an appeal. Such
8 process shall include the ability to resubmit corrected
9 claims.

10 **SEC. 538. PRIOR DETERMINATION PROCESS FOR CERTAIN**
11 **ITEMS AND SERVICES; ADVANCE BENE-**
12 **FICIARY NOTICES.**

13 (a) IN GENERAL.—Section 1869 (42 U.S.C.
14 1395ff(b)), as amended by sections 521 and 522 of BIPA
15 and section 533(d)(2)(B), is further amended by adding
16 at the end the following new subsection:

17 “(h) PRIOR DETERMINATION PROCESS FOR CERTAIN
18 ITEMS AND SERVICES.—

19 “(1) ESTABLISHMENT OF PROCESS.—

20 “(A) IN GENERAL.—With respect to a
21 medicare administrative contractor that has a
22 contract under section 1874A that provides for
23 making payments under this title with respect
24 to eligible items and services described in sub-
25 paragraph (C), the Secretary shall establish a

1 prior determination process that meets the re-
2 quirements of this subsection and that shall be
3 applied by such contractor in the case of eligible
4 requesters.

5 “(B) ELIGIBLE REQUESTER.—For pur-
6 poses of this subsection, each of the following
7 shall be an eligible requester:

8 “(i) A physician, but only with respect
9 to eligible items and services for which the
10 physician may be paid directly.

11 “(ii) An individual entitled to benefits
12 under this title, but only with respect to an
13 item or service for which the individual re-
14 ceives, from the physician who may be paid
15 directly for the item or service, an advance
16 beneficiary notice under section 1879(a)
17 that payment may not be made (or may no
18 longer be made) for the item or service
19 under this title.

20 “(C) ELIGIBLE ITEMS AND SERVICES.—
21 For purposes of this subsection and subject to
22 paragraph (2), eligible items and services are
23 items and services which are physicians’ serv-
24 ices (as defined in paragraph (4)(A) of section

1 1848(f) for purposes of calculating the sustain-
2 able growth rate under such section).

3 “(2) SECRETARIAL FLEXIBILITY.—The Sec-
4 retary shall establish by regulation reasonable limits
5 on the categories of eligible items and services for
6 which a prior determination of coverage may be re-
7 quested under this subsection. In establishing such
8 limits, the Secretary may consider the dollar amount
9 involved with respect to the item or service, adminis-
10 trative costs and burdens, and other relevant factors.

11 “(3) REQUEST FOR PRIOR DETERMINATION.—

12 “(A) IN GENERAL.—Subject to paragraph
13 (2), under the process established under this
14 subsection an eligible requester may submit to
15 the contractor a request for a determination,
16 before the furnishing of an eligible item or serv-
17 ice involved as to whether the item or service is
18 covered under this title consistent with the ap-
19 plicable requirements of section 1862(a)(1)(A)
20 (relating to medical necessity).

21 “(B) ACCOMPANYING DOCUMENTATION.—
22 The Secretary may require that the request be
23 accompanied by a description of the item or
24 service, supporting documentation relating to
25 the medical necessity for the item or service,

1 and any other appropriate documentation. In
2 the case of a request submitted by an eligible
3 requester who is described in paragraph
4 (1)(B)(ii), the Secretary may require that the
5 request also be accompanied by a copy of the
6 advance beneficiary notice involved.

7 “(4) RESPONSE TO REQUEST.—

8 “(A) IN GENERAL.—Under such process,
9 the contractor shall provide the eligible re-
10 quester with written notice of a determination
11 as to whether—

12 “(i) the item or service is so covered;

13 “(ii) the item or service is not so cov-
14 ered; or

15 “(iii) the contractor lacks sufficient
16 information to make a coverage determina-
17 tion.

18 If the contractor makes the determination de-
19 scribed in clause (iii), the contractor shall in-
20 clude in the notice a description of the addi-
21 tional information required to make the cov-
22 erage determination.

23 “(B) DEADLINE TO RESPOND.—Such no-
24 tice shall be provided within the same time pe-
25 riod as the time period applicable to the con-

1 tractor providing notice of initial determinations
2 on a claim for benefits under subsection
3 (a)(2)(A).

4 “(C) INFORMING BENEFICIARY IN CASE OF
5 PHYSICIAN REQUEST.—In the case of a request
6 in which an eligible requester is not the indi-
7 vidual described in paragraph (1)(B)(ii), the
8 process shall provide that the individual to
9 whom the item or service is proposed to be fur-
10 nished shall be informed of any determination
11 described in clause (ii) (relating to a determina-
12 tion of non-coverage) and the right (referred to
13 in paragraph (6)(B)) to obtain the item or serv-
14 ice and have a claim submitted for the item or
15 service.

16 “(5) EFFECT OF DETERMINATIONS.—

17 “(A) BINDING NATURE OF POSITIVE DE-
18 TERMINATION.—If the contractor makes the de-
19 termination described in paragraph (4)(A)(i),
20 such determination shall be binding on the con-
21 tractor in the absence of fraud or evidence of
22 misrepresentation of facts presented to the con-
23 tractor.

24 “(B) NOTICE AND RIGHT TO REDETER-
25 MINATION IN CASE OF A DENIAL.—

1 “(i) IN GENERAL.—If the contractor
2 makes the determination described in para-
3 graph (4)(A)(ii)—

4 “(I) the eligible requester has the
5 right to a redetermination by the con-
6 tractor on the determination that the
7 item or service is not so covered; and

8 “(II) the contractor shall include
9 in notice under paragraph (4)(A) a
10 brief explanation of the basis for the
11 determination, including on what na-
12 tional or local coverage or noncov-
13 erage determination (if any) the de-
14 termination is based, and the right to
15 such a redetermination.

16 “(ii) DEADLINE FOR REDETERMINA-
17 TIONS.—The contractor shall complete and
18 provide notice of such redetermination
19 within the same time period as the time
20 period applicable to the contractor pro-
21 viding notice of redeterminations relating
22 to a claim for benefits under subsection
23 (a)(3)(C)(ii).

24 “(6) LIMITATION ON FURTHER REVIEW.—

1 “(A) IN GENERAL.—Contractor determina-
2 tions described in paragraph (4)(A)(ii) or
3 (4)(A)(iii) (and redeterminations made under
4 paragraph (5)(B)), relating to pre-service
5 claims are not subject to further administrative
6 appeal or judicial review under this section or
7 otherwise.

8 “(B) DECISION NOT TO SEEK PRIOR DE-
9 TERMINATION OR NEGATIVE DETERMINATION
10 DOES NOT IMPACT RIGHT TO OBTAIN SERVICES,
11 SEEK REIMBURSEMENT, OR APPEAL RIGHTS.—
12 Nothing in this subsection shall be construed as
13 affecting the right of an individual who—

14 “(i) decides not to seek a prior deter-
15 mination under this subsection with re-
16 spect to items or services; or

17 “(ii) seeks such a determination and
18 has received a determination described in
19 paragraph (4)(A)(ii),
20 from receiving (and submitting a claim for)
21 such items services and from obtaining adminis-
22 trative or judicial review respecting such claim
23 under the other applicable provisions of this
24 section. Failure to seek a prior determination
25 under this subsection with respect to items and

1 services shall not be taken into account in such
2 administrative or judicial review.

3 “(C) NO PRIOR DETERMINATION AFTER
4 RECEIPT OF SERVICES.—Once an individual is
5 provided items and services, there shall be no
6 prior determination under this subsection with
7 respect to such items or services.”.

8 (b) EFFECTIVE DATE; TRANSITION.—

9 (1) EFFECTIVE DATE.—The Secretary shall es-
10 tablish the prior determination process under the
11 amendment made by subsection (a) in such a man-
12 ner as to provide for the acceptance of requests for
13 determinations under such process filed not later
14 than 18 months after the date of the enactment of
15 this Act.

16 (2) TRANSITION.—During the period in which
17 the amendment made by subsection (a) has become
18 effective but contracts are not provided under sec-
19 tion 1874A of the Social Security Act with medicare
20 administrative contractors, any reference in section
21 1869(g) of such Act (as added by such amendment)
22 to such a contractor is deemed a reference to a fiscal
23 intermediary or carrier with an agreement under
24 section 1816, or contract under section 1842, re-
25 spectively, of such Act.

1 (3) LIMITATION ON APPLICATION TO SGR.—For
2 purposes of applying section 1848(f)(2)(D) of the
3 Social Security Act (42 U.S.C. 1395w-4(f)(2)(D)),
4 the amendment made by subsection (a) shall not be
5 considered to be a change in law or regulation.

6 (c) PROVISIONS RELATING TO ADVANCE BENE-
7 FICIARY NOTICES; REPORT ON PRIOR DETERMINATION
8 PROCESS.—

9 (1) DATA COLLECTION.—The Secretary shall
10 establish a process for the collection of information
11 on the instances in which an advance beneficiary no-
12 tice (as defined in paragraph (4)) has been provided
13 and on instances in which a beneficiary indicates on
14 such a notice that the beneficiary does not intend to
15 seek to have the item or service that is the subject
16 of the notice furnished.

17 (2) OUTREACH AND EDUCATION.—The Sec-
18 retary shall establish a program of outreach and
19 education for beneficiaries and providers of services
20 and other persons on the appropriate use of advance
21 beneficiary notices and coverage policies under the
22 medicare program.

23 (3) GAO REPORT REPORT ON USE OF ADVANCE
24 BENEFCIARY NOTICES.—Not later than 18 months
25 after the date on which section 1869(g) of the Social

1 Security Act (as added by subsection (a)) takes ef-
2 fect, the Comptroller General of the United States
3 shall submit to Congress a report on the use of ad-
4 vance beneficiary notices under title XVIII of such
5 Act. Such report shall include information con-
6 cerning the providers of services and other persons
7 that have provided such notices and the response of
8 beneficiaries to such notices.

9 (4) GAO REPORT ON USE OF PRIOR DETER-
10 MINATION PROCESS.—Not later than 18 months
11 after the date on which section 1869(g) of the Social
12 Security Act (as added by subsection (a)) takes ef-
13 fect, the Comptroller General of the United States
14 shall submit to Congress a report on the use of the
15 prior determination process under such section. Such
16 report shall include—

17 (A) information concerning the types of
18 procedures for which a prior determination has
19 been sought, determinations made under the
20 process, and changes in receipt of services re-
21 sulting from the application of such process;
22 and

23 (B) an evaluation of whether the process
24 was useful for physicians (and other suppliers)
25 and beneficiaries, whether it was timely, and

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall take effect on the date of the enact-
3 ment of this Act and shall apply to items and services fur-
4 nished on or after such date.

5 **Subtitle E—Miscellaneous**
6 **Provisions**

7 **SEC. 541. POLICY DEVELOPMENT REGARDING EVALUATION**
8 **AND MANAGEMENT (E & M) DOCUMENTATION**
9 **GUIDELINES.**

10 (a) IN GENERAL.—The Secretary may not implement
11 any new documentation guidelines for evaluation and man-
12 agement physician services under the title XVIII of the
13 Social Security Act on or after the date of the enactment
14 of this Act unless the Secretary—

15 (1) has developed the guidelines in collaboration
16 with practicing physicians (including both generalists
17 and specialists) and provided for an assessment of
18 the proposed guidelines by the physician community;

19 (2) has established a plan that contains specific
20 goals, including a schedule, for improving the use of
21 such guidelines;

22 (3) has conducted appropriate and representa-
23 tive pilot projects under subsection (b) to test modi-
24 fications to the evaluation and management docu-
25 mentation guidelines;

1 (4) finds that the objectives described in sub-
2 section (c) will be met in the implementation of such
3 guidelines; and

4 (5) has established, and is implementing, a pro-
5 gram to educate physicians on the use of such guide-
6 lines and that includes appropriate outreach.

7 The Secretary shall make changes to the manner in which
8 existing evaluation and management documentation guide-
9 lines are implemented to reduce paperwork burdens on
10 physicians.

11 (b) PILOT PROJECTS TO TEST EVALUATION AND
12 MANAGEMENT DOCUMENTATION GUIDELINES.—

13 (1) IN GENERAL.—The Secretary shall conduct
14 under this subsection appropriate and representative
15 pilot projects to test new evaluation and manage-
16 ment documentation guidelines referred to in sub-
17 section (a).

18 (2) LENGTH AND CONSULTATION.—Each pilot
19 project under this subsection shall—

20 (A) be voluntary;

21 (B) be of sufficient length as determined
22 by the Secretary to allow for preparatory physi-
23 cian and medicare contractor education, anal-
24 ysis, and use and assessment of potential eval-
25 uation and management guidelines; and

1 (C) be conducted, in development and
2 throughout the planning and operational stages
3 of the project, in consultation with practicing
4 physicians (including both generalists and spe-
5 cialists).

6 (3) RANGE OF PILOT PROJECTS.—Of the pilot
7 projects conducted under this subsection—

8 (A) at least one shall focus on a peer re-
9 view method by physicians (not employed by a
10 medicare contractor) which evaluates medical
11 record information for claims submitted by phy-
12 sicians identified as statistical outliers relative
13 to definitions published in the Current Proce-
14 dures Terminology (CPT) code book of the
15 American Medical Association;

16 (B) at least one shall focus on an alter-
17 native method to detailed guidelines based on
18 physician documentation of face to face encoun-
19 ter time with a patient;

20 (C) at least one shall be conducted for
21 services furnished in a rural area and at least
22 one for services furnished outside such an area;
23 and

24 (D) at least one shall be conducted in a
25 setting where physicians bill under physicians'

1 services in teaching settings and at least one
2 shall be conducted in a setting other than a
3 teaching setting.

4 (4) BANNING OF TARGETING OF PILOT
5 PROJECT PARTICIPANTS.—Data collected under this
6 subsection shall not be used as the basis for overpay-
7 ment demands or post-payment audits. Such limita-
8 tion applies only to claims filed as part of the pilot
9 project and lasts only for the duration of the pilot
10 project and only as long as the provider is a partici-
11 pant in the pilot project.

12 (5) STUDY OF IMPACT.—Each pilot project
13 shall examine the effect of the new evaluation and
14 management documentation guidelines on—

15 (A) different types of physician practices,
16 including those with fewer than 10 full-time-
17 equivalent employees (including physicians);
18 and

19 (B) the costs of physician compliance, in-
20 cluding education, implementation, auditing,
21 and monitoring.

22 (6) PERIODIC REPORTS.—The Secretary shall
23 submit to Congress periodic reports on the pilot
24 projects under this subsection.

1 (c) OBJECTIVES FOR EVALUATION AND MANAGE-
2 MENT GUIDELINES.—The objectives for modified evalua-
3 tion and management documentation guidelines developed
4 by the Secretary shall be to—

5 (1) identify clinically relevant documentation
6 needed to code accurately and assess coding levels
7 accurately;

8 (2) decrease the level of non-clinically pertinent
9 and burdensome documentation time and content in
10 the physician's medical record;

11 (3) increase accuracy by reviewers; and

12 (4) educate both physicians and reviewers.

13 (d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF
14 DOCUMENTATION FOR PHYSICIAN CLAIMS.—

15 (1) STUDY.—The Secretary shall carry out a
16 study of the matters described in paragraph (2).

17 (2) MATTERS DESCRIBED.—The matters re-
18 ferred to in paragraph (1) are—

19 (A) the development of a simpler, alter-
20 native system of requirements for documenta-
21 tion accompanying claims for evaluation and
22 management physician services for which pay-
23 ment is made under title XVIII of the Social
24 Security Act; and

1 (B) consideration of systems other than
2 current coding and documentation requirements
3 for payment for such physician services.

4 (3) CONSULTATION WITH PRACTICING PHYSI-
5 CIANS.—In designing and carrying out the study
6 under paragraph (1), the Secretary shall consult
7 with practicing physicians, including physicians who
8 are part of group practices and including both gen-
9 eralists and specialists.

10 (4) APPLICATION OF HIPAA UNIFORM CODING
11 REQUIREMENTS.—In developing an alternative sys-
12 tem under paragraph (2), the Secretary shall con-
13 sider requirements of administrative simplification
14 under part C of title XI of the Social Security Act.

15 (5) REPORT TO CONGRESS.—(A) Not later than
16 October 1, 2004, the Secretary shall submit to Con-
17 gress a report on the results of the study conducted
18 under paragraph (1).

19 (B) The Medicare Payment Advisory Commis-
20 sion shall conduct an analysis of the results of the
21 study included in the report under subparagraph (A)
22 and shall submit a report on such analysis to Con-
23 gress.

24 (e) STUDY ON APPROPRIATE CODING OF CERTAIN
25 EXTENDED OFFICE VISITS.—The Secretary shall conduct

1 a study of the appropriateness of coding in cases of ex-
2 tended office visits in which there is no diagnosis made.
3 Not later than October 1, 2004, the Secretary shall submit
4 a report to Congress on such study and shall include rec-
5 ommendations on how to code appropriately for such visits
6 in a manner that takes into account the amount of time
7 the physician spent with the patient.

8 (f) DEFINITIONS.—In this section—

9 (1) the term “rural area” has the meaning
10 given that term in section 1886(d)(2)(D) of the So-
11 cial Security Act, 42 U.S.C. 1395ww(d)(2)(D); and

12 (2) the term “teaching settings” are those set-
13 tings described in section 415.150 of title 42, Code
14 of Federal Regulations.

15 **SEC. 542. PROHIBITION OF INCIDENTAL FEES AND RE-**
16 **QUIRED PURCHASE OF NON-COVERED ITEMS**
17 **OR SERVICES.**

18 (a) IN GENERAL.—Section 1842 of the Social Secu-
19 rity Act (42 U.S.C. 1395u) is amended by adding at the
20 end the following new subsection:

21 “(u) PROHIBITION OF INCIDENTAL FEES OR RE-
22 QUIRING PURCHASE OF NON-COVERED ITEMS OR SERV-
23 ICES.—

1 “(1) IN GENERAL.—A physician, practitioner
2 (as described in section 1842(b)(18)(C)), or other
3 individual may not—

4 “(A) charge a membership fee or any other
5 incidental fee to a medicare beneficiary (as de-
6 fined in section 1802(b)(5)(A)), or

7 “(B) require a medicare beneficiary (as so
8 defined) to purchase a non-covered item or
9 service,

10 as a prerequisite for the provision of a covered item
11 or service to the beneficiary under this title.

12 “(2) ENFORCEMENT.—If a physician, practi-
13 tioner, or other individual knowingly and willfully
14 charges a fee, or requires purchase of a non-covered
15 item or service, in violation of paragraph (1), the
16 Secretary may apply sanctions against such physi-
17 cian in accordance with subsection (j)(2), except the
18 maximum period of exclusion resulting from the ap-
19 plication of this paragraph shall not exceed 2
20 years.”.

21 (b) EFFECTIVE DATE.—The amendment made by
22 subsection (a) shall apply to membership fees and other
23 charges made, or purchases of items and services required,
24 on or after the date of enactment of this Act.

1 **SEC. 543. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY**
2 **AND COVERAGE.**

3 (a) IMPROVED COORDINATION BETWEEN FDA AND
4 CMS ON COVERAGE OF BREAKTHROUGH MEDICAL DE-
5 VICES.—

6 (1) IN GENERAL.—Upon request by an appli-
7 cant and to the extent feasible (as determined by the
8 Secretary), the Secretary shall, in the case of a class
9 III medical device that is subject to premarket ap-
10 proval under section 515 of the Federal Food, Drug,
11 and Cosmetic Act, ensure the sharing of appropriate
12 information from the review for application for pre-
13 market approval conducted by the Food and Drug
14 Administration for coverage decisions under title
15 XVIII of the Social Security Act.

16 (2) PUBLICATION OF PLAN.—Not later than 6
17 months after the date of the enactment of this Act,
18 the Secretary shall submit to appropriate Commit-
19 tees of Congress a report that contains the plan for
20 improving such coordination and for shortening the
21 time lag between the premarket approval by the
22 Food and Drug Administration and coding and cov-
23 erage decisions by the Centers for Medicare & Med-
24 icaid Services.

25 (3) CONSTRUCTION.—Nothing in this sub-
26 section shall be construed as changing the criteria

1 for coverage of a medical device under title XVIII of
2 the Social Security Act nor premarket approval by
3 the Food and Drug Administration and nothing in
4 this subsection shall be construed to increase pre-
5 market approval application requirements under the
6 Federal Food, Drug, and Cosmetic Act.

7 (b) COUNCIL FOR TECHNOLOGY AND INNOVATION.—
8 Section 1868 (42 U.S.C. 1395ee), as amended by section
9 523(a), is amended by adding at the end the following new
10 subsection:

11 “(c) COUNCIL FOR TECHNOLOGY AND INNOVA-
12 TION.—

13 “(1) ESTABLISHMENT.—The Secretary shall es-
14 tablish a Council for Technology and Innovation
15 within the Centers for Medicare & Medicaid Services
16 (in this section referred to as ‘CMS’).

17 “(2) COMPOSITION.—The Council shall be com-
18 posed of senior CMS staff and clinicians and shall
19 be chaired by the Executive Coordinator for Tech-
20 nology and Innovation (appointed or designated
21 under paragraph (4)).

22 “(3) DUTIES.—The Council shall coordinate the
23 activities of coverage, coding, and payment processes
24 under this title with respect to new technologies and
25 procedures, including new drug therapies, and shall

1 coordinate the exchange of information on new tech-
2 nologies between CMS and other entities that make
3 similar decisions.

4 “(4) EXECUTIVE COORDINATOR FOR TECH-
5 NOLOGY AND INNOVATION.—The Secretary shall ap-
6 point (or designate) a noncareer appointee (as de-
7 fined in section 3132(a)(7) of title 5, United States
8 Code) who shall serve as the Executive Coordinator
9 for Technology and Innovation. Such executive coor-
10 dinator shall report to the Administrator of CMS,
11 shall chair the Council, shall oversee the execution of
12 its duties, and shall serve as a single point of con-
13 tact for outside groups and entities regarding the
14 coverage, coding, and payment processes under this
15 title.”.

16 (c) GAO STUDY ON IMPROVEMENTS IN EXTERNAL
17 DATA COLLECTION FOR USE IN THE MEDICARE INPA-
18 TIENT PAYMENT SYSTEM.—

19 (1) STUDY.—The Comptroller General of the
20 United States shall conduct a study that analyzes
21 which external data can be collected in a shorter
22 time frame by the Centers for Medicare & Medicaid
23 Services for use in computing payments for inpatient
24 hospital services. The study may include an evalua-
25 tion of the feasibility and appropriateness of using

1 of quarterly samples or special surveys or any other
2 methods. The study shall include an analysis of
3 whether other executive agencies, such as the Bu-
4 reau of Labor Statistics in the Department of Com-
5 merce, are best suited to collect this information.

6 (2) REPORT.—By not later than October 1,
7 2003, the Comptroller General shall submit a report
8 to Congress on the study under paragraph (1).

9 (d) IOM STUDY ON LOCAL COVERAGE DETERMINA-
10 TIONS.—

11 (1) STUDY.—The Secretary shall enter into an
12 arrangement with the Institute of Medicine of the
13 National Academy of Sciences under which the Insti-
14 tute shall conduct a study on local coverage deter-
15 minations (including the application of local medical
16 review policies) under the medicare program under
17 title XVIII of the Social Security Act. Such study
18 shall examine—

19 (A) the consistency of the definitions used
20 in such determinations;

21 (B) the types of evidence on which such
22 determinations are based, including medical and
23 scientific evidence;

24 (C) the advantages and disadvantages of
25 local coverage decisionmaking, including the

1 flexibility it offers for ensuring timely patient
2 access to new medical technology for which data
3 are still be collected;

4 (D) the manner in which the local coverage
5 determination process is used to develop data
6 needed for a national coverage determination,
7 including the need for collection of such data
8 within a protocol and informed consent by indi-
9 viduals entitled to benefits under part A of title
10 XVIII of the Social Security Act, or enrolled
11 under part B of such title, or both; and

12 (E) the advantages and disadvantages of
13 maintaining local medicare contractor advisory
14 committees that can advise on local coverage
15 decisions based on an open, collaborative public
16 process.

17 (2) REPORT.—Such arrangement shall provide
18 that the Institute shall submit to the Secretary a re-
19 port on such study by not later than 3 years after
20 the date of the enactment of this Act. The Secretary
21 shall promptly transmit a copy of such report to
22 Congress.

23 (e) METHODS FOR DETERMINING PAYMENT BASIS
24 FOR NEW LAB TESTS.—Section 1833(h) (42 U.S.C.
25 1395l(h)) is amended by adding at the end the following:

1 “(8)(A) The Secretary shall establish by regulation
2 procedures for determining the basis for, and amount of,
3 payment under this subsection for any clinical diagnostic
4 laboratory test with respect to which a new or substan-
5 tially revised HCPCS code is assigned on or after January
6 1, 2004 (in this paragraph referred to as ‘new tests’).

7 “(B) Determinations under subparagraph (A) shall
8 be made only after the Secretary—

9 “(i) makes available to the public (through an
10 Internet site and other appropriate mechanisms) a
11 list that includes any such test for which establish-
12 ment of a payment amount under this subsection is
13 being considered for a year;

14 “(ii) on the same day such list is made avail-
15 able, causes to have published in the Federal Reg-
16 ister notice of a meeting to receive comments and
17 recommendations (and data on which recommenda-
18 tions are based) from the public on the appropriate
19 basis under this subsection for establishing payment
20 amounts for the tests on such list;

21 “(iii) not less than 30 days after publication of
22 such notice convenes a meeting, that includes rep-
23 resentatives of officials of the Centers for Medicare
24 & Medicaid Services involved in determining pay-
25 ment amounts, to receive such comments and rec-

1 ommendations (and data on which the recommenda-
2 tions are based);

3 “(iv) taking into account the comments and rec-
4 ommendations (and accompanying data) received at
5 such meeting, develops and makes available to the
6 public (through an Internet site and other appro-
7 priate mechanisms) a list of proposed determinations
8 with respect to the appropriate basis for establishing
9 a payment amount under this subsection for each
10 such code, together with an explanation of the rea-
11 sons for each such determination, the data on which
12 the determinations are based, and a request for pub-
13 lic written comments on the proposed determination;
14 and

15 “(v) taking into account the comments received
16 during the public comment period, develops and
17 makes available to the public (through an Internet
18 site and other appropriate mechanisms) a list of
19 final determinations of the payment amounts for
20 such tests under this subsection, together with the
21 rationale for each such determination, the data on
22 which the determinations are based, and responses
23 to comments and suggestions received from the pub-
24 lic.

1 “(C) Under the procedures established pursuant to
2 subparagraph (A), the Secretary shall—

3 “(i) set forth the criteria for making determina-
4 tions under subparagraph (A); and

5 “(ii) make available to the public the data
6 (other than proprietary data) considered in making
7 such determinations.

8 “(D) The Secretary may convene such further public
9 meetings to receive public comments on payment amounts
10 for new tests under this subsection as the Secretary deems
11 appropriate.

12 “(E) For purposes of this paragraph:

13 “(i) The term ‘HCPCS’ refers to the Health
14 Care Procedure Coding System.

15 “(ii) A code shall be considered to be ‘substan-
16 tially revised’ if there is a substantive change to the
17 definition of the test or procedure to which the code
18 applies (such as a new analyte or a new methodology
19 for measuring an existing analyte-specific test).”.

20 **SEC. 544. TREATMENT OF HOSPITALS FOR CERTAIN SERV-**
21 **ICES UNDER MEDICARE SECONDARY PAYOR**
22 **(MSP) PROVISIONS.**

23 (a) IN GENERAL.—The Secretary shall not require
24 a hospital (including a critical access hospital) to ask ques-
25 tions (or obtain information) relating to the application

1 of section 1862(b) of the Social Security Act (relating to
2 medicare secondary payor provisions) in the case of ref-
3 erence laboratory services described in subsection (b), if
4 the Secretary does not impose such requirement in the
5 case of such services furnished by an independent labora-
6 tory.

7 (b) REFERENCE LABORATORY SERVICES DE-
8 SCRIBED.—Reference laboratory services described in this
9 subsection are clinical laboratory diagnostic tests (or the
10 interpretation of such tests, or both) furnished without a
11 face-to-face encounter between the individual entitled to
12 benefits under part A or enrolled under part B, or both,
13 and the hospital involved and in which the hospital sub-
14 mits a claim only for such test or interpretation.

15 **SEC. 545. AUTHORIZING USE OF ARRANGEMENTS WITH**
16 **OTHER HOSPICE PROGRAMS TO PROVIDE**
17 **CORE HOSPICE SERVICES IN CERTAIN CIR-**
18 **CUMSTANCES.**

19 (a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C.
20 1395x(dd)(5)) is amended by adding at the end the fol-
21 lowing new subparagraph:

22 “(D) In extraordinary, exigent, or other non-routine
23 circumstances, such as unanticipated periods of high pa-
24 tient loads, staffing shortages due to illness or other
25 events, or temporary travel of a patient outside a hospice

1 program’s service area, a hospice program may enter into
2 arrangements with another hospice program for the provi-
3 sion by that other program of services described in para-
4 graph (2)(A)(ii)(I). The provisions of paragraph
5 (2)(A)(ii)(II) shall apply with respect to the services pro-
6 vided under such arrangements.”.

7 (b) CONFORMING PAYMENT PROVISION.—Section
8 1814(i) (42 U.S.C. 1395f(i)), as amended by section
9 421(b), is amended by adding at the end the following new
10 paragraph:

11 “(5) In the case of hospice care provided by a hospice
12 program under arrangements under section
13 1861(dd)(5)(D) made by another hospice program, the
14 hospice program that made the arrangements shall bill
15 and be paid for the hospice care.”.

16 (c) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to hospice care provided on or after
18 the date of the enactment of this Act.

19 **SEC. 546. APPLICATION OF OSHA BLOODBORNE PATHO-**
20 **GENS STANDARD TO CERTAIN HOSPITALS.**

21 (a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc)
22 is amended—

23 (1) in subsection (a)(1)—

24 (A) in subparagraph (R), by striking

25 “and” at the end;

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

3 (C) by inserting after subparagraph (S)
4 the following new subparagraph:

5 “(T) in the case of hospitals that are not other-
6 wise subject to the Occupational Safety and Health
7 Act of 1970, to comply with the Bloodborne Patho-
8 gens standard under section 1910.1030 of title 29 of
9 the Code of Federal Regulations (or as subsequently
10 redesignated).”; and

11 (2) by adding at the end of subsection (b) the
12 following new paragraph:

13 “(4)(A) A hospital that fails to comply with the re-
14 quirement of subsection (a)(1)(T) (relating to the
15 Bloodborne Pathogens standard) is subject to a civil
16 money penalty in an amount described in subparagraph
17 (B), but is not subject to termination of an agreement
18 under this section.

19 “(B) The amount referred to in subparagraph (A) is
20 an amount that is similar to the amount of civil penalties
21 that may be imposed under section 17 of the Occupational
22 Safety and Health Act of 1970 for a violation of the
23 Bloodborne Pathogens standard referred to in subsection
24 (a)(1)(T) by a hospital that is subject to the provisions
25 of such Act.

1 “(C) A civil money penalty under this paragraph shall
2 be imposed and collected in the same manner as civil
3 money penalties under subsection (a) of section 1128A are
4 imposed and collected under that section.”.

5 (b) EFFECTIVE DATE.—The amendments made by
6 this subsection (a) shall apply to hospitals as of July 1,
7 2003.

8 **SEC. 547. BIPA-RELATED TECHNICAL AMENDMENTS AND**
9 **CORRECTIONS.**

10 (a) TECHNICAL AMENDMENTS RELATING TO ADVI-
11 SORY COMMITTEE UNDER BIPA SECTION 522.—(1) Sub-
12 section (i) of section 1114 (42 U.S.C. 1314)—

13 (A) is transferred to section 1862 and added at
14 the end of such section; and

15 (B) is redesignated as subsection (j).

16 (2) Section 1862 (42 U.S.C. 1395y) is amended—

17 (A) in the last sentence of subsection (a), by
18 striking “established under section 1114(f)”; and

19 (B) in subsection (j), as so transferred and re-
20 designated—

21 (i) by striking “under subsection (f)”; and

22 (ii) by striking “section 1862(a)(1)” and
23 inserting “subsection (a)(1)”.

1 (b) TERMINOLOGY CORRECTIONS.—(1) Section
2 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as
3 amended by section 521 of BIPA, is amended—

4 (A) in subclause (III), by striking “policy” and
5 inserting “determination”; and

6 (B) in subclause (IV), by striking “medical re-
7 view policies” and inserting “coverage determina-
8 tions”.

9 (2) Section 1852(a)(2)(C) (42 U.S.C. 1395w-
10 22(a)(2)(C)) is amended by striking “policy” and “POL-
11 ICY” and inserting “determination” each place it appears
12 and “DETERMINATION”, respectively.

13 (c) REFERENCE CORRECTIONS.—Section 1869(f)(4)
14 (42 U.S.C. 1395ff(f)(4)), as added by section 522 of
15 BIPA, is amended—

16 (1) in subparagraph (A)(iv), by striking “sub-
17 clause (I), (II), or (III)” and inserting “clause (i),
18 (ii), or (iii)”;

19 (2) in subparagraph (B), by striking “clause
20 (i)(IV)” and “clause (i)(III)” and inserting “sub-
21 paragraph (A)(iv)” and “subparagraph (A)(iii)”, re-
22 spectively; and

23 (3) in subparagraph (C), by striking “clause
24 (i)”, “subclause (IV)” and “subparagraph (A)” and
25 inserting “subparagraph (A)”, “clause (iv)” and

1 “paragraph (1)(A)”, respectively each place it ap-
2 pears.

3 (d) OTHER CORRECTIONS.—Effective as if included
4 in the enactment of section 521(c) of BIPA, section
5 1154(e) (42 U.S.C. 1320e–3(e)) is amended by striking
6 paragraph (5).

7 (e) EFFECTIVE DATE.—Except as otherwise pro-
8 vided, the amendments made by this section shall be effec-
9 tive as if included in the enactment of BIPA.

10 **SEC. 548. CONFORMING AUTHORITY TO WAIVE A PROGRAM**

11 **EXCLUSION.**

12 The first sentence of section 1128(c)(3)(B) (42
13 U.S.C. 1320a–7(c)(3)(B)) is amended to read as follows:
14 “Subject to subparagraph (G), in the case of an exclusion
15 under subsection (a), the minimum period of exclusion
16 shall be not less than five years, except that, upon the
17 request of the administrator of a Federal health care pro-
18 gram (as defined in section 1128B(f)) who determines
19 that the exclusion would impose a hardship on individuals
20 entitled to benefits under part A of title XVIII or enrolled
21 under part B of such title, or both, the Secretary may
22 waive the exclusion under subsection (a)(1), (a)(3), or
23 (a)(4) with respect to that program in the case of an indi-
24 vidual or entity that is the sole community physician or

1 sole source of essential specialized services in a commu-
2 nity.”.

3 **SEC. 549. TREATMENT OF CERTAIN DENTAL CLAIMS.**

4 (a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y)
5 is amended by adding after subsection (g) the following
6 new subsection:

7 “(h)(1) Subject to paragraph (2), a group health plan
8 (as defined in subsection (a)(1)(A)(v)) providing supple-
9 mental or secondary coverage to individuals also entitled
10 to services under this title shall not require a medicare
11 claims determination under this title for dental benefits
12 specifically excluded under subsection (a)(12) as a condi-
13 tion of making a claims determination for such benefits
14 under the group health plan.

15 “(2) A group health plan may require a claims deter-
16 mination under this title in cases involving or appearing
17 to involve inpatient dental hospital services or dental serv-
18 ices expressly covered under this title pursuant to actions
19 taken by the Secretary.”.

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

1 **SEC. 550. ANNUAL PUBLICATION OF LIST OF NATIONAL**
2 **COVERAGE DETERMINATIONS.**

3 The Secretary shall provide, in an appropriate annual
4 publication available to the public, a list of national cov-
5 erage determinations made under title XVIII of the Social
6 Security Act in the previous year and information on how
7 to get more information with respect to such determina-
8 tions.

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