(Mrs. FEINSTEIN) was added as a cosponsor of S. 1825, a bill to amend title 18, United States Code, to provide penalties for the sale and use of unauthorized mobile infrared transmitters.

S. 1853

At the request of Mr. KENNEDY, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 1853, a bill to provide extended unemployment benefits to displaced workers.

S. 1858

At the request of Mr. COCHRAN, the names of the Senator from Kansas (Mr. ROBERTS), the Senator from Georgia (Mr. MILLER) and the Senator from Michigan (Ms. STABENOW) were added as cosponsors of S. 1858, a bill to authorize the Secretary of Agriculture to conduct a loan repayment program to encourage the provision of veterinary services in shortage and emergency situations.

S. 1879

At the request of Ms. MIKULSKI, the name of the Senator from New Hampshire (Mr. GREGG) was added as a cosponsor of S. 1879, a bill to amend the Public Health Service Act to revise and extend provisions relating to mammography quality standards.

S. 1907

At the request of Mr. DASCHLE, the name of the Senator from North Dakota (Mr. DORGAN) was added as a cosponsor of S. 1907, a bill to promote rural safety and improve rural law enforcement.

S. CON. RES. 77

At the request of Mr. SESSIONS, the names of the Senator from Utah (Mr. HATCH), the Senator from Iowa (Mr. GRASSLEY), the Senator from Kentucky (Mr. BUNNING), the Senator from Oklahoma (Mr. INHOFE) and the Senator from Georgia (Mr. CHAMBLISS) were added as cosponsors of S. Con. Res. 77, a concurrent resolution expressing the sense of Congress supporting vigorous enforcement of the Federal obscenity laws.

S. CON. RES. 81

At the request of Mrs. FEINSTEIN, the name of the Senator from Ohio (Mr. VOINOVICH) was added as a cosponsor of S. Con. Res. 81, a concurrent resolution expressing the deep concern of Congress regarding the failure of the Islamic Republic of Iran to adhere to its obligations under a safeguards agreement with the International Atomic Energy Agency and the engagement by Iran in activities that appear to be designed to develop nuclear weapons.

S. CON. RES. 83

At the request of Mr. BIDEN, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. Con. Res. 83, a concurrent resolution promoting the establishment of a democracy caucus within the United Nations.

S. RES. 120

At the request of Mr. JEFFORDS, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. Res. 120, a resolution commemorating the 25th anniversary of Vietnam Veterans of America.

S. RES. 253

At the request of Mr. CAMPBELL, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. Res. 253, a resolution to recognize the evolution and importance of motorsports.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. JEFFORDS (for himself, Ms. SNOWE, and Mr. HATCH):

S. 1912. A bill to amend the Internal Revenue Code of 1986 to expand pension coverage and savings opportunities and to provide other pension reforms; to the Committee on Finance.

Mr. JEFFORDS. Mr. President, today, together with Senators HATCH and SNOWE, I am introducing, the Retirement Account Portability and Improvement Act of 2003. This legislation improves the portability of retirement savings by eliminating unnecessary complexities and barriers in the retirement savings system, and helps preserve retirement savings by giving American workers tools that will help them consolidate their retirement savings into one easily managed account.

In brief, this bill will make a number of improvements in the retirement savings system to help families preserve retirement assets. It will, for example, enhance the portability of retirement savings by expanding rollover options in traditional IRAs, Roth IRAs, and SIMPLE Plans. The bill also clarifies that when employees are permitted to make after-tax contributions to retirement plans, those after-tax amounts may be rolled over into other retirement plans eligible to receive such rollovers. This clarification will make it easier for workers to move all elements of their 401(k) of 403(b) savings when they change jobs and move between private sector and the tax-exempt sector.

In addition, the bill builds on defined contribution plan reforms enacted in 2001 by requiring a shortened vesting schedule for employer non-elective contributions, such as profit-sharing contributions, to defined contribution plans. As a result, employer contributions will become employee property more quickly, helping workers to build more meaningful retirement benefits. This new vesting schedule corresponds to rules for 401(k) matching contributions enacted in 2001.

Another provision in the bill would end an unfair tax penalty faced by non-spouse beneficiaries. Today, when an employee dies, the benefits in that employee's retirement account are paid out to a non-spouse beneficiary in one payment. The beneficiary must pay tax on the entire amount, and is often forced into a higher tax bracket as a result of the payment. A provision in this bill would allow non-spouse beneficiaries—siblings, children, domestic partners, parents—to roll over the money from the plan to an IRA. This will prevent an immediate tax bite to grieving beneficiaries and allow them to withdraw the money from their IRA over five years or over their own life expectancy.

The bill also helps preserve retirement savings by allowing plans to designate default IRAs or annuity contracts to which employee rollovers may be directed. Employers should be more willing to establish default IRA and annuity rollover options as a result, making it easier for employees to keep savings in the retirement system when they change jobs.

For workers who leave a job without claiming their retirement benefits, the bill improves on the automatic rollover provisions enacted in 2001, by allowing certain small distributions from retirement plans to be sent to the Pension Benefit Guaranty Corporation (PBGC), ensuring that participants are ultimately reunited with their earned benefits. The bill also expands the scope of the PBGC's successful Missing Participants program that matches workers with lost pension benefits.

Employees of state and local governments, including teachers, will benefit from a number of this bill's technical corrections that will facilitate the purchase of service credits in public pension programs, allowing state and local employees to more easily attain a full pension in the jurisdiction where they conclude their career. The bill also contains provisions that would clarify eligibility rights of certain state and local employees who participate in a Section 457 deferred compensation plan.

Congress must take every opportunity to encourage American workers not only to save for retirement, but also to preserve those hard-earned retirement savings. These portability improvements offer one set of tools for making it easier to navigate the retirement savings system and reach retirement with an adequate nest egg. There are many pressing and complex retirement issues that demand attention, but I am hopeful that this legislation, narrowly focused on portability, can be considered quickly and on its own merits.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1912

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

SECTION 1. SHORT TITLE; AMENDMENT OF 1986 CODE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Retirement Acount Portability Act of 2003''.

(b) AMENDMENT OF 1986 CODE.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

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

Sec. 1. Short title; amendment of 1986 Code; table of contents.

TITLE I—BUILDING AND PRESERVING RETIREMENT ASSETS AND ENHANCING PORTABILITY

Sec. 101. Allow rollovers by nonspouse beneficiaries of certain retirement plan distributions.
Sec. 102. Facilitation under fiduciary rules of certain rollovers and annuity distributions.
Sec. 103. Faster vesting of employer nonelective contributions.
Sec. 104. Allow rollover of after-tax amounts in annuity contracts.

TITLE II—EXPANDING RETIREMENT PLAN COVERAGE TO EMPLOYEES OF SMALL BUSINESSES

Sec. 201. Elimination of higher penalty on certain Simple distributions.
Sec. 202. Simple plan portability.

TITLE III—EXPANDING RETIREMENT SAVINGS FOR TAX-EXEMPT ORGANIZATION AND GOVERNMENT EMPLOYEES

Sec. 301. Clarifications regarding purchase of permissive service credit.
Sec. 302. Eligibility for participation in retirement plans.

TITLE IV—SIMPLIFICATION AND EQUITY

Sec. 401. Allow direct rollovers from retirement plans to Roth IRAs.
Sec. 402. Transfers to the PBGC.

TITLE I—BUILDING AND PRESERVING RETIREMENT ASSETS AND ENHANCING PORTABILITY

SEC. 101. ALLOW ROLLOVERS BY NONSPOUSE BENEFICIARIES OF CERTAIN RETIREMENT PLAN DISTRIBUTIONS.

(a) IN GENERAL.—

(1) QUALIFIED PLANS.—Section 402(c) (relating to rollovers from exempt trusts) is amended by adding at the end the following new paragraph:

''(11) DISTRIBUTIONS TO INHERITED INDIVIDUAL RETIREMENT PLAN OF NONSPOUSE BENEFICIARY.—

''(A) IN GENERAL.—If, with respect to any portion of a distribution from an eligible retirement plan of a deceased employee, a direct trustee-to-trustee transfer is made to an individual retirement plan described in clause (i) or (ii) of paragraph (8)(B) established for the purposes of receiving the distribution on behalf of an individual who is a designated beneficiary (as defined by section 401(a)(9)(E)) of the employee and who is not the surviving spouse of the employee—

''(i) the transfer shall be treated as an eligible rollover distribution for purposes of this subsection,

''(ii) the individual retirement plan shall be treated as an inherited individual retirement account or individual retirement annuity (within the meaning of section 408(d)(3)(C)) for purposes of this title, and

''(iii) section 401(a)(9)(B) (other than clause (iv) thereof) shall apply to such plan.

''(B) CERTAIN TRUSTS TREATED AS BENEFICIARIES.—For purposes of this paragraph, to the extent provided in rules prescribed by the Secretary, a trust maintained for the benefit of one or more designated beneficiaries shall be treated in the same manner as a trust designated beneficiary.''.

(2) SECTION 403(a) PLANS.—Subparagraph (B) of section 403(a)(4) (relating to rollover amounts) is amended by inserting ''and (11)'' after ''(7)''.

(3) SECTION 403(b) PLANS.—Subparagraph (B) of section 403(b)(8) (relating to rollover amounts) is amended by striking ''and (9)'' and inserting '', (9), and (11)''.

(4) SECTION 457 PLANS.—Subparagraph (B) of section 457(e)(16) (relating to rollover amounts) is amended by striking ''and (9)'' and inserting '', (9), and (11)''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions after December 31, 2003.

SEC. 102. FACILITATION UNDER FIDUCIARY RULES OF CERTAIN ROLLOVERS AND ANNUITY DISTRIBUTIONS.

(a) IN GENERAL.—Section 404(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1104(c)) is amended by adding at the end the following new paragraph:

''(4)(A) In the case of a pension plan which makes a transfer under section 401(a)(31)(A) of the Internal Revenue Code of 1986 to an individual retirement plan (as defined in section 7701(a)(37) of such Code) in connection with a participant or beneficiary or makes a distribution to a participant or beneficiary of an annuity contract described in subparagraph (B), the participant or beneficiary shall, for purposes of paragraph (1), be treated as exercising control over the transfer or distribution if—

''(i) the participant or beneficiary elected such transfer or distribution, and

''(ii) in connection with such election, the participant or beneficiary was given an opportunity to elect any other individual retirement plan (in the case of a transfer) or any other annuity contract described in subparagraph (B) (in the case of a distribution).

''(B) An annuity contract is described in this subparagraph if it provides, either on an immediate or deferred basis, a series of substantially equal periodic payments (not less frequently than annually) for the life of the participant or beneficiary or the joint lives of the participant or beneficiary and such individual's designated beneficiary. Annuity payments shall not fail to be treated as part of a series of substantially equal periodic payments because the amount of the periodic payments may vary in accordance with investment experience, reallocations among investment options, actuarial gains or losses, cost of living indices, or similar fluctuating criteria. The availability of a commutation benefit, a minimum period of payments certain, or a minimum amount to be paid in any event shall not affect the treatment of an annuity contract as an annuity contract described in this subparagraph.

''(C) Under regulations prescribed by the Secretary, this paragraph shall apply without regard to whether the particular individual retirement plan receiving the transfer or the particular annuity contract being distributed is specifically identified by the pension plan as available to the participant or beneficiary.

''(D) Notwithstanding the preceding provisions of this paragraph, paragraph (1)(B) shall not apply with respect to liability under section 406 in connection with the specific identification of any individual retirement plan or annuity contract as being available to the participant or beneficiary.''.

(b) EFFECTIVE DATE AND RELATED RULES.—

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

(2) ISSUANCE OF FINAL REGULATIONS.—Final regulations under section 404(c)(4) of the Employee Retirement Income Security Act of 1974 (added by this section) shall be issued no later than 1 year after the date of the enactment of this Act.

SEC. 103. FASTER VESTING OF EMPLOYER NONELECTIVE CONTRIBUTIONS.

(a) AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.—

(1) IN GENERAL.—Paragraph (2) of section 411(a) (relating to employer contributions) is amended to read as follows:

''(2) EMPLOYER CONTRIBUTIONS.—

''(A) DEFINED BENEFIT PLANS.—

''(i) IN GENERAL.—In the case of a defined benefit plan, a plan satisfies the requirements of this paragraph if it satisfies the requirements of clause (ii) or (iii).

''(ii) 5-YEAR VESTING.—A plan satisfies the requirements of this clause if an employee who has completed at least 5 years of service has a nonforfeitable right to 100 percent of the employee's accrued benefit derived from employer contributions.

''(iii) 3 TO 7 YEAR VESTING.—A plan satisfies the requirements of this clause if an employee has a nonforfeitable right to a percentage of the employee's accrued benefit derived from employer contributions determined under the following table:

"Years of service:	The nonforfeitable percentage is:
3	20
4	40
5	60
6	80
7 or more	100.

''(B) DEFINED CONTRIBUTION PLANS.—

''(i) IN GENERAL.—In the case of a defined contribution plan, a plan satisfies the requirements of this paragraph if it satisfies the requirements of clause (ii) or (iii).

''(ii) 3-YEAR VESTING.—A plan satisfies the requirements of this clause if an employee who has completed at least 3 years of service has a nonforfeitable right to 100 percent of the employee's accrued benefit derived from employer contributions.

''(iii) 2 TO 6 YEAR VESTING.—A plan satisfies the requirements of this clause if an employee has a nonforfeitable right to a percentage of the employee's accrued benefit derived from employer contributions determined under the following table:

"Years of service:	The nonforfeitable percentage is:
2	20
3	40
4	60
5	80
6	100.''.

(2) CONFORMING AMENDMENT.—Section 411(a) (relating to general rule for minimum vesting standards) is amended by striking paragraph (12).

(b) AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) IN GENERAL.—Paragraph (2) of section 203(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1053(a)(2)) is amended to read as follows:

''(2)(A)(i) In the case of a defined benefit plan, a plan satisfies the requirements of this paragraph if it satisfies the requirements of clause (ii) or (iii).

''(ii) A plan satisfies the requirements of this clause if an employee who has completed at least 5 years of service has a nonforfeitable right to 100 percent of the employee's accrued benefit derived from employer contributions.

''(iii) A plan satisfies the requirements of this clause if an employee has a nonforfeitable right to a percentage of the employee's accrued benefit derived from employer contributions determined under the following table:

"Years of service:	The nonforfeitable percentage is:
3	20
4	40
5	60
6	80
7 or more	100.

''(B)(i) In the case of an individual account plan, a plan satisfies the requirements of this paragraph if it satisfies the requirements of clause (ii) or (iii).

''(ii) A plan satisfies the requirements of this clause if an employee who has completed at least 3 years of service has a nonforfeitable right to 100 percent of the employee's accrued benefit derived from employer contributions.

''(iii) A plan satisfies the requirements of this clause if an employee has a nonforfeitable right to a percentage of the employee's accrued benefit derived from employer contributions determined under the following table:

"Years of service:	The nonforfeitable percentage is:
2	20
3	40
4	60
5	80
6	100.''.

(2) CONFORMING AMENDMENT.—Section 203(a) of such Act is amended by striking paragraph (4).

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to contributions for plan years beginning after December 31, 2003.

(2) COLLECTIVE BARGAINING AGREEMENTS.—In the case of a plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to contributions on behalf of employees covered by any such agreement for plan years beginning before the earlier of—

(A) the later of—

(i) the date on which the last of such collective bargaining agreements terminates (determined without regard to any extension thereof on or after such date of the enactment); or

(ii) January 1, 2004; or

(B) January 1, 2006.

(3) SERVICE REQUIRED.—With respect to any plan, the amendments made by this section shall not apply to any employee before the date that such employee has 1 hour of service under such plan in any plan year to which the amendments made by this section apply.

SEC. 104. ALLOW ROLLOVER OF AFTER-TAX AMOUNTS IN ANNUITY CONTRACTS.

(a) IN GENERAL.—Subparagraph (A) of section 402(c)(2) (maximum amount which may be rolled over) is amended by striking ''and which'' and inserting ''or to an annuity contract described in section 403(b) and such plan or contract''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 2003.

TITLE II—EXPANDING RETIREMENT PLAN COVERAGE TO EMPLOYEES OF SMALL BUSINESSES

SEC. 201. ELIMINATION OF HIGHER PENALTY ON CERTAIN SIMPLE DISTRIBUTIONS.

(a) IN GENERAL.—Subsection (t) of section 72 (relating to 10-percent additional tax on early distributions from qualified retirement plans) is amended by striking paragraph (6) and redesignating paragraphs (7), (8), and (9) as paragraphs (6), (7), and (8), respectively.

(b) CONFORMING AMENDMENTS.—

(1) Section 72(t)(2)(E) is amended by striking ''paragraph (7)'' and inserting ''paragraph (6)''.

(2) Section 72(t)(2)(F) is amended by striking ''paragraph (8)'' and inserting ''paragraph (7)''.

(3) Section 408(d)(3)(G) is amended by striking ''applies'' and inserting ''applied on the day before the date of the enactment of the Retirement Account Portability Act of 2003)''.

(4) Section 457(a)(2) is amended by striking ''section 72(t)(9)'' and inserting ''section 72(t)(8)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to years beginning after December 31, 2003.

SEC. 202. SIMPLE PLAN PORTABILITY.

(a) REPEAL OF LIMITATION.—Paragraph (3) of section 408(d) (relating to rollover contributions), as amended by this Act, is amended by striking subparagraph (G) and redesignating subparagraph (H) as subparagraph (G).

(b) Section 402(c)(8)(B) is amended by adding at the end the following new sentence: ''Individual retirement accounts and individual retirement annuities described in clauses (i) and (ii) shall be treated as eligible retirement plans without regard to whether they are part of a simplified employee pension (within the meaning of section 408(k)) or a simplified retirement account (within the meaning of section 408(p)).''.

(c) EFFECTIVE DATE.—The amendment made by this section shall apply to years beginning after December 31, 2003.

TITLE III—EXPANDING RETIREMENT SAVINGS FOR TAX-EXEMPT ORGANIZATION AND GOVERNMENT EMPLOYEES

SEC. 301. CLARIFICATIONS REGARDING PURCHASE OF PERMISSIVE SERVICE CREDIT.

(a) IN GENERAL.—Subparagraph (A) of section 457(e)(17) (relating to trustee-to-trustee transfers to purchase permissive service credit), and subparagraph (A) of section 403(b)(13) (relating to trustee-to-trustee transfers to purchase permissive service credit), are both amended by striking ''section 415(n)(3)(A)'' and inserting ''section 415(n)(3) (without regard to subparagraphs (B) and (C) thereof)''.

(b) DISTRIBUTION REQUIREMENTS.—Section 457(e)(17) and section 403(b)(13) are both amended by adding at the end the following sentence: ''Amounts transferred under this paragraph shall be distributed solely in accordance with section 401(a) as applicable to such defined benefit plan.''.

(c) SERVICE CREDIT.—Clause (ii) of section 415(n)(3)(A) is amended to read as follows:

''(ii) which relates to benefits with respect to which such –participant is not otherwise entitled, and''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the amendments made by section 647 of the Economic Growth and Tax Relief Reconciliation Act of 2001.

SEC. 302. ELIGIBILITY FOR PARTICIPATION IN RETIREMENT PLANS.

An individual shall not be precluded from participating in an eligible deferred compensation plan by reason of having received a distribution under section 457(e)(9) of the Internal Revenue Code of 1986, as in effect prior to the enactment of the Small Business Job Protection Act of 1996.

TITLE IV—SIMPLIFICATION AND EQUITY

SEC. 401. ALLOW DIRECT ROLLOVERS FROM RETIREMENT PLANS TO ROTH IRAS.

(a) IN GENERAL.—Subsection (e) of section 408A (defining qualified rollover contribution) is amended to read as follows:

''(e) QUALIFIED ROLLOVER CONTRIBUTION.—For purposes of this section, the term 'qualified rollover contribution' means a rollover contribution—

''(1) to a Roth IRA from another such account,

''(2) from an eligible retirement plan, but only if—

''(A) in the case of an individual retirement plan, such rollover contribution meets the requirements of section 408(d)(3), and

''(B) in the case of any eligible retirement plan (as defined in section 402(c)(8)(B) other than clauses (i) and (ii) thereof), such rollover contribution meets the requirements of section 402(c), 403(b)(8), or 457(e)(16), as applicable.

For purposes of section 408(d)(3)(B), there shall be disregarded any qualified rollover contribution from an individual retirement plan (other than a Roth IRA) to a Roth IRA.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 408A(c)(3)(B) is amended—

(A) in the text by striking ''individual retirement plan'' and inserting ''an eligible retirement plan (as defined by section 402(c)(8)(B))'', and

(B) in the heading by striking ''IRA'' and inserting ''ELIGIBLE RETIREMENT PLAN''.

(2) Section 408A(d)(3) is amended—

(A) in subparagraph (A) by striking ''section 408(d)(3)'' inserting ''sections 402(c), 403(b)(8), 408(d)(3), and 457(e)(16)'',

(B) in subparagraph (B) by striking ''individual retirement plan'' and inserting ''eligible retirement plan (as defined by section 402(c)(8)(B))'',

(C) in subparagraph (D) by striking ''or 6047'' after ''408(i)'',

(D) in subparagraph (D) by striking ''or both'' and inserting ''persons subject to section 6047(d)(1), or all of the foregoing persons'', and

(E) in the heading by striking ''IRA'' and inserting ''ELIGIBLE RETIREMENT PLAN''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions after December 31, 2003.

SEC. 402. TRANSFERS TO THE PBGC.

(a) MANDATORY DISTRIBUTIONS TO PBGC.—Clause (i) of section 401(a)(31)(B) (relating to general rule for certain mandatory distributions) is amended by inserting ''to the Pension Benefit Guaranty Corporation in accordance with section 4050(e) of the Employee Retirement Income Security Act of 1974 or'' after ''such transfer''.

(b) TAX TREATMENT OF DISTRIBUTIONS.—Subparagraph (B) of section 401(a)(31) is amended by adding at the end the following new clause:

''(iii) INCOME TAX TREATMENT OF TRANSFERS TO PBGC.—For purposes of determining the income tax treatment relating to transfers to the Pension Benefit Guaranty Corporation under clause (i)—

''(I) the transfer of amounts to the Pension Benefit Guaranty Corporation pursuant to clause (i) shall be treated as a transfer to an individual retirement plan under such clause, and

''(II) the distribution of such amounts from the Pension Benefit Guaranty Corporation shall be treated as a distribution from an individual retirement plan.''.

(c) MISSING PARTICIPANTS AND BENEFICIARIES.—

(1) IN GENERAL.—Section 4050 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1350) is amended by redesignating subsection (c) as subsection (f) and by inserting after subsection (b) the following new subsections:

''(c) MULTIEMPLOYER PLANS.—The corporation shall prescribe rules similar to the rules in subsection (a) for multiemployer plans covered by this title that terminate under section 4041A.

''(d) PLANS NOT OTHERWISE SUBJECT TO TITLE.—

''(1) TRANSFER TO CORPORATION.—The plan administrator of a plan described in paragraph (4) may elect to transfer the benefits of a missing participant or beneficiary to the corporation upon termination of the plan.

''(2) INFORMATION TO THE CORPORATION.—To the extent provided in regulations, the plan administrator of a plan described in paragraph (4) shall, upon termination of the plan, provide the corporation information with respect to benefits of a missing participant or beneficiary if the plan transfers such benefits—

''(A) to the corporation, or

''(B) to an entity other than the corporation or a plan described in paragraph (4)(B)(ii).

"(3) PAYMENT BY THE CORPORATION.—If benefits of a missing participant or beneficiary were transferred to the corporation under paragraph (1), the corporation shall, upon location of the participant or beneficiary, pay to the participant or beneficiary the amount transferred (or the appropriate survivor benefit) either—

"(A) in a single sum (plus interest), or

"(B) in such other form as is specified in regulations of the corporation.

"(4) PLANS DESCRIBED.—A plan is described in this paragraph if—

"(A) the plan is a pension plan (within the meaning of section 3(2))—

"(i) to which the provisions of this section do not apply (without regard to this subsection), and

"(ii) which is not a plan described in paragraphs (2) through (11) of section 4021(b), and

"(B) at the time the assets are to be distributed upon termination, the plan—

"(i) has one or more missing participants or beneficiaries, and

"(ii) has not provided for the transfer of assets to pay the benefits of all missing participants and beneficiaries to another pension plan (within the meaning of section 3(2)).

"(5) CERTAIN PROVISIONS NOT TO APPLY.—Subsections (a)(1) and (a)(3) shall not apply to a plan described in paragraph (4).

"(e) INVOLUNTARY CASHOUTS.—

"(1) PAYMENT BY THE CORPORATION.—If benefits under a plan described in paragraph (2) were transferred to the corporation under section 401(a)(31)(B) of the Internal Revenue Code of 1986, the corporation shall, upon application filed by the participant or beneficiary with the corporation in such form and manner as may be prescribed in regulations of the corporation, pay to the participant or beneficiary the amount transferred (or the appropriate survivor benefit) either—

"(A) in a single sum (plus interest), or

"(B) in such other form as is specified in regulations of the corporation.

"(2) INFORMATION TO THE CORPORATION.—To the extent provided in regulations, the plan administrator of a plan described in paragraph (3) shall, upon transferred to the corporation under section 401(a)(31)(B) of such Code, provide the corporation information with respect to benefits of the participant or beneficiary so transferred.

"(3) PLANS DESCRIBED.—A plan is described in this paragraph if the plan is a pension plan (within the meaning of section 3(2))—

"(A) which provides for mandatory distributions under section 401(a)(31)(B) of the Internal Revenue Code of 1986, and

"(B) which is not a plan described in paragraphs (2) through (11) of section 4021(b).

"(4) CERTAIN PROVISIONS NOT TO APPLY.—Subsections (a)(1) and (a)(3) shall not apply to a plan described in paragraph (2).".

(2) CONFORMING AMENDMENTS.—Section 206(f) of such Act (29 U.S.C. 1056(f)) is amended—

(A) by striking "title IV" and inserting "section 4050"; and

(B) by striking "the plan shall provide that,".

(d) EFFECTIVE DATE.—

(1) INTERNAL REVENUE CODE OF 1986 PROVISIONS.—The amendments made by subsections (a) and (b) shall take effect as if included in the amendments made by section 657 of the Economic Growth and Tax Relief Reconciliation Act of 2001.

(2) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 PROVISIONS.—The amendments made by subsection (c) shall apply to distributions made after final regulations implementing subsections (c), (d), and (e) of section 4050 of the Employee Retirement Income Security Act of 1974 (as added by subsection (c)), respectively, are prescribed.

(3) REGULATIONS.—The Pension Benefit Guaranty Corporation shall issue regulations necessary to carry out the amendments made by subsection (c) not later than December 31, 2004.

By Mr. MCCAIN (for himself and Mr. FEINGOLD):

S. 1913. A bill to amend the Internal Revenue Code of 1986 to reform the system of public financing for Presidential elections, and for other purposes; to the Committee on Finance.

Mr. MCCAIN. Mr. President, along with Senator RUSS FEINGOLD, I am proud today to introduce the Presidential Funding Act of 2003. This legislation will improve and reform the presidential public financing system. With major presidential candidates opting out of public financing for their 2004 primary campaigns, reform of the system of financing presidential nominations is needed more than ever.

The presidential public financing system has been in place for three decades and has achieved broad public acceptance. From 1976 to 2000, every major party presidential nominee has accepted public financing for the general election and, nearly all of the nominees have also accepted it for their primary elections. A total of 46 Democrats and 29 Republicans have accepted public financing for the presidential primaries during this period.

Since its creation, the presidential financing system has worked non-ideologically, with victories for three Republicans and two Democrats. It has also provided for competitive elections. In the five races that have been run under the system involving an incumbent president, challengers have won in three of those elections. This system of voluntary spending limits in exchange for public funding has been a nonpartisan success.

Last year's enactment of a ban on soft money addressed what had become a basic problem for the effectiveness and credibility of the presidential system. For the system to continue serving the nation effectively, its remaining problems now must be solved. This legislation will repair and revitalize the presidential campaign finance system in the following ways.

First, our legislation increases the overall spending limit for the presidential primaries and provide more public matching funds for presidential primary candidates.

The overall spending limit in the primaries for publicly financed candidates has failed to keep pace with reality. This was demonstrated when in 2000, public financing and spending limits for the primaries were rejected and a record $100 million in private contributions was spent to gain the Republican party's nomination—more than twice the amount that the publicly financed candidates were allowed to spend. During the 2004 presidential primary period, it is expected that Republicans will raise and spend as much as $200 million.

Our legislation increases the individual contribution limit from $1,000 to $2,000. Therefore, it will be easier over time for other candidates to reject public financing and raise private money in excess of the overall primary spending limit, thereby worsening the competitive disadvantage of publicly-financed candidates.

In addition, the "front-loading" of presidential primaries has created a much shorter nominating period—now likely to end by early March—and a longer actual general election period than existed when the presidential financing system was created in 1974. As a result, a potential "gap" exists in funds available for a publicly financed nominee to spend between gaining the party nomination in March and the party's summer nominating convention, when the nominee receives public funds for the general election. This creates a further competitive disadvantage.

To address these problems, our legislation increases the overall spending limit for the presidential primaries to $75 million from the $45 million limit in effect for the 2004 presidential election. This would equal the $75 million spending limit in effect for the general election, which applies to a much shorter period than the primaries.

The amount of public matching funds for individual contributions in the primaries is also increased from the current one-to-one match to a four-to-one match for up to $250 of each individual contribution. This would greatly increase the value of smaller contributions in the presidential nominating process, as was intended by the presidential financing system. It would decrease the reliance on larger contributions, provide more public funds to meet the higher spending limit, and improve the ability of publicly financed candidates to run competitive elections.

When the $1000 individual contribution limit was doubled last year, increasing the potential role of private contributions in the presidential financing system, no similar adjustment was made to increase the role of public matching funds. A new four-to-one multiple match for up to $250 of each individual contribution would accomplish that goal.

In addition, the threshold for qualifying for matching public funds in the primary has not changed since the system was established. Our legislation increases the qualifying threshold should be increased by more than doubling the threshold to require candidates to raise $15,000 in each of 20 states in amounts of no more than $250 per individual donor. Although the existing threshold has worked well during the history of the current system, a higher qualifying amount is appropriate for the future, especially since candidates would now be eligible to receive greater amounts of matching funds.

Second, our legislation requires a candidate to opt in or out of the public financing system for the entire presidential election, including both the primary and general election.

The purpose of the presidential public financing system is to allow candidates to run competitive races for the presidency without becoming dependent on or obligated to campaign donors. That purpose is undermined when a candidate opts out of the system to raise and spend large amounts of private money for a primary or general election race. Such candidates should not be able to reject public financing and then get the system's benefits when it suits their tactical advantage. A candidate should have to opt in or out of the system for the whole election.

Third, our legislation repeals the state-by-state primary spending limits and allows publicly financed primary candidates to receive their public matching funds before January 1st of the presidential election year.

The State-by-State primary spending limits have not worked. The limits have proven to be ineffective and have served to unjustifiably micromanage presidential campaigns.

Under current law, primary candidates can begin to raise private contributions eligible to be matched beginning on January 1 of the year before a presidential election year. They are not eligible, however, to receive any of the matching public funds until January 1 of the presidential election year. With the current ''front-loaded'' primary system, and with the nomination likely to be decided in the early months of a presidential election year, primary candidates need to be able to spend more funds at an earlier period than before. As a result, under our legislation, presidential primary candidates will be eligible to start receiving matching public funds on July 1 of the year before a presidential election year.

Fourth, our legislation provides additional public funds in the presidential general election for a publicly financed candidate facing a privately financed candidate who has substantially outspent the combined primary and general election spending limits.

As more wealthy individuals decide to spend their personal wealth to run for public office, the potential grows for an individual to spend an enormous amount of personal wealth to seek the presidency. There already have been candidates for the U.S. Senate and in mayoral races, for example, who have spent as much in personal wealth on their races as each major party presidential nominee received in public funds in 2000 to run their general election campaign.

In addition, with the increased individual contribution limit, a presidential candidate could decide to forgo public funding and raise and spend private contributions far in excess of the spending limits for publicly financed candidates.

To address this potential problem, our legislation makes a publicly financed major party nominee eligible to receive an additional $75 million for the general election race, when a privately financed general election candidate has spent more than 50 percent above the total primary and general election spending limit for the publicly financed candidate.

In other words, once a presidential general election candidate has spent more than a total of $225 million to seek the presidency, a publicly financed major party nominee, subject to a spending limit of $75 million for the primaries and $75 million for the general election, would receive an additional $75 million for the general election race.

Fifth, our legislation increases the funds available to finance the presidential public financing system.

Currently, the public financing system is funded by a voluntary $3 check-off available to taxpayers on their tax forms on an annual basis. This mechanism will not raise sufficient resources in the long term to finance the costs of a revised presidential system.

The $3 tax check-off is increased to $6 and indexed for inflation to help ensure there are sufficient funds available for future presidential elections. In addition, the Federal Election Commission (FEC) is authorized to conduct a public education campaign to explain to citizens why the check-off exists and how it works, including the fact that it does not increase the tax liability of taxpayers.

The current presidential public financing law creates a priority system that allocates available public funds from the check-off to the nomination conventions, the presidential general election and the presidential primaries in that order. This order of priority does not make sense.

Our legislation revises the order of priority for use of public funds to make funding of the general election candidates the first priority, funding of the primary election candidates the second priority, and funding of the nomination conventions the third priority.

Furthermore, a U.S. Department of the Treasury ruling prohibits taking into account the tax check-off revenues that will be received in April of the presidential election year in determining at the start of each presidential election year the total amount of funds available to be given to eligible candidates from the fund. This has had the effect of artificially lowering the amount of funds available and creating temporary shortfalls for primary candidates during the opening months of the presidential election year at the time when they need the funds the most.

Our legislation revises the law to require the U.S. Department of the Treasury (as it used to do) to estimate at the end of the year prior to a presidential election year the amount of check-off funds that will be received in the presidential election year and to take these funds into account in determining the total amount of funds available under the presidential system.

Finally, our legislation implements the soft money ban to ensure that the parties and federal officeholders and candidates do not raise or spend soft money in connection with the presidential nominating conventions.

Despite the passage of the new campaign finance law and its ban on soft money, federal officeholders and national party officials have continued to raise soft money to finance the national nomination conventions on the fictional premise that such funds are not in connection with a ''federal election'' but rather are for municipal or civic purposes.

The reality is that a presidential nominating convention is defined as a ''federal election'' election under the campaign finance law. Furthermore, federal officeholders and candidates and national party officials who raise soft money for the conventions are subject to precisely the same kind of problems of corruption and the appearance of corruption that the new law prevents by banning soft money.

To reaffirm that the soft money ban applies to the presidential nominating conventions, our legislation explicitly prohibits the national parties and federal officeholders and candidates from raising and spending soft money to pay for the presidential nominating conventions, including for a host committee, civic committee or municipality.

The highly expensive, front-loaded, nationalized, primary system requires that we more than ever fix the presidential public funding system. We must continue to promote competition in order to give voters choices. Our legislation not only saves the existing system but improves it as well. It not only shores up the financial foundations of the system but it would also bring more donors into the system, making financial participation more democratic. It would give our citizens a stake in their government. It is our hope that with the enactment of this legislation, candidates will no longer take small donors for granted and finally hear their voices. In return, all of our citizens will feel reconnected to the presidential financing process that at times, has left them behind.

Mr. FEINGOLD. Mr. President, it is pleasure to join my friend and colleague Senator McCain in introducing a bill to repair and strengthen the presidential public financing system. The Presidential Funding Act of 2003 will ensure that this system that has served our country so well for over a generation will continue to fulfill its promise in the 21st century.

The presidential public financing system was put into place in the wake of the Watergate scandals as part of the Federal Election Campaign Act of 1974. It was held to be constitutional by the Supreme Court in Buckley v. Valeo. Every major party nominee for President since 1976 has participated in the

system for the general election. The system, of course, is voluntary, as the Supreme Court required. In the last election, then-Governor George W. Bush opted out of the system for the presidential primaries, but elected to take the taxpayer funded grant in the general election. He appears ready to make the same choice in this election, and so far two of the Democratic presidential candidates have decided not to seek federal matching funds in the primaries. Before 2000, almost all serious candidates for President had participated in the system.

It is unfortunate that the matching funds system for the primaries is becoming less viable. The system reduces the fundraising pressures on candidates and levels the playing field between candidates. It allows candidates to run viable campaigns without becoming overly dependent on private donors. The system has worked well in the past, and its advantages for candidates and for the country make it worth repairing so that it can work in the future. If we don't repair it, the pressures on candidates to opt out because their opponents are opting out will increase until the system collapse from disuse.

At the outset, I want to emphasize that this bill is not designed to have any impact on the ongoing presidential race. It will take effect only after the 2004 elections. Therefore, there is no partisan purpose here. Once again, Senator MCCAIN and I are working together to try to improve the campaign finance system, regardless of any partisan impact that these reforms might have. Second, we do not expect Congress to take action on this bill during an election year. Instead, our hope is that by introducing a bill now we can begin a conversation with our colleagues and with the public that will allow us to take quick action beginning in 2005 so that a new system can be in place for the 2008 election.

The bill makes changes to both the primary and general election system to address the weaknesses and problems that have been identified by both participants in the system and experts on the presidential election financing process. First and most important, it eliminates the state-by-state spending limits in the current law and substantially increases the overall spending limit from the current limit of approximately $45 million to $75 million. This should make the system more viable for serious candidates facing opponents who are capable of raising significant sums outside the system. The bill also makes available significantly more public money for participating candidates by increasing the match of small contributions from 1:1 to 4:1. Thus, significantly more public money will be available to those candidates who choose to participate in the system.

One very important provision of this bill ties the primary and general election systems together and requires candidates to make a single decision on whether to participate. Candidates who opt out of the primary system and decide to rely solely on private money cannot return to the system for the general election. And candidates must commit to participate in the system in the general election if they want to receive federal matching funds in the primaries. The bill also increases the spending limits for participating candidates in the primaries who face a non-participating opponent if that opponent raises more than 33 percent more than the spending limit. This provides some protection against being far outspent by a non-participating opponent.

The bill also sets the general election spending limit at $75 million, indexed for inflation, which is about what it is projected to be in 2008. And if a general election candidate does not participate in the system and spends more than 33 percent more than the combined primary and general election spending limits, a participating candidate will receive a grant equal to twice the general election spending limit.

This bill also addresses what some have called the ''gap'' between the primary and general election seasons. Presumptive presidential nominees have emerged earlier in the election year over the life of the public financing system. This had led to some nominees being essentially out of money between the time that they nail down the nomination and the convention where they are formally nominated and become eligible for the general election grant. For a few cycles, soft money raised by the parties filled in that gap, but the Bipartisan Campaign Reform Act of 2002 thankfully has now closed that loophole. This bill doubles the amount of hard money that parties can spend in coordination with their candidates, allowing them to fill the gap once the party has a presumptive nominee.

Fixing the presidential public financing system will obviously cost money, but our best calculations at the present time indicate that the changes to the system in this bill can be paid for by doubling the income tax check-off on an individual return from $3 to just $6. The total cost of the changes to the system is projected to be around $175 million over the four-year election cycle. Of course, these projections may change as we get more data from the 2004 elections. But even a somewhat larger cost would be a very small investment to make to protect the health of our democracy and integrity of our presidential elections. The American people do not want to see a return to the pre-Watergate days of unlimited spending on presidential elections and candidates entirely beholden to private donors. We must act now to preserve the crown jewel of the Watergate reforms and assure the fairness of our elections and the confidence of our citizens in the process.

By Ms. STABENOW (for herself and Mr. LEVIN):

S. 1914. A bill to prohibit the closure or realignment of inpatient services at the Aleda E. Lutz Department of Veterans Affairs Medical Center in Saginaw, Michigan, as proposed under the Capital Asset Realignment for Enhanced Services initiatives; to the Committee on Veterans' Affairs.

Ms. STABENOW. Mr. President, I rise today to introduce legislation that would prevent the closure of the Saginaw Veterans Administration Medical Center in Saginaw, MI.

As of August 2003, there were almost one million veterans in lower Michigan and Northwestern Ohio. These one million veterans are served by four V.A. Medical Centers—Saginaw, Detroit, Ann Arbor and Battle Creek—and 12 Community Based Outpatient Clinics (CBOCs), all located in lower Michigan or Toledo, OH.

Regrettably, the Department of Veterans Affairs' Capitol Asset Realignment for Enhanced Services (CARES) Commission is recommending closing all acute care beds at the Aleda E. Lutz Department of Veterans Affairs Medical Center in Saginaw, MI. The geographic range for the acute services in Saginaw is vast. The facility essentially covers half of Michigan's Lower Peninsula. Therefore, closing these inpatient beds in Saginaw would have a devastating impact on veterans who live in Central and Northern Michigan.

If the Saginaw facility were to close, a veteran who lived in Mackinaw City would have to drive 281 miles to the Detroit facility or 272 miles to the Ann Arbor facility for medical care. Under ideal conditions these trips would take six hours instead of the current two hour trip that it would take to reach the existing Saginaw facility. Asking a veteran to go from Mackinaw City to Detroit is like asking a veteran to go from southeast Michigan to Buffalo, New York to get acute care.

How can we ask veterans, many of whom are sick and frail, to travel six hours to get necessary inpatient services? Going through a major illness is tough enough for our veterans. The closing of this hospital would add insult to injury.

This bill seeks to stop this closure and ensure that the thousands of veterans who live in central and northern Michigan have access to the medical services they deserve. I urge my colleagues to support this bill.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1914

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

SECTION 1. PROHIBITION ON CLOSURE OR REALIGNMENT OF INPATIENT SERVICES AT ALEDA E. LUTZ DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER IN SAGINAW, MICHIGAN.

The Secretary of Veterans Affairs shall not carry out the closure or realignment of inpatient services at the Aleda E. Lutz Department of Veterans Affairs Medical Center in Saginaw, Michigan, as proposed under the Capital Asset Realignment for Enhanced Services (CARES) initiative.

By Mrs. HUTCHISON:

S. 1917. A bill to amend the Internal Revenue Code of 1986 to permit the issuance of tax-exempt bonds for certain air and water pollution control facilities, and to provide that the volume cap for private activity bonds shall not apply to bonds for facilities for the furnishing of water, sewage facilities, and air or water pollution control facilities; to the Committee on Finance.

Mrs. HUTCHISON. Mr. President, I am proud to offer the Clean Air and Water Investment and Infrastructure Act.

Texas, like many States, faces increasingly difficult challenges in improving air and water quality.

The Clean Air Act requires the Environmental Protection Agency to set air quality standards and establishes deadlines for State and local governments to achieve those levels. Today, more than 90 communities across the country are out of compliance with the Clean Air Act. These so-called ''non-attainment'' areas are threated with regulatory sanctions, such as loss of federal highway funding, if they do not meet mandated ozone levels by 2007.

Texas has four non-attainment areas: Beaumont-Port Arthur, Dallas-Fort Worth, El Paso and Houston. The Houston area alone needs an estimated $4.1 billion annually in order to meet Federal air quality standards.

These communities will not achieve compliance without assistance. Too many industrial plants need to install expensive equipment. If these environmental investments do not become more affordable, communities will either suffer sanctions or force industrial facilities to close and move offshore, causing substantial economic hardship.

Texas and many areas of the country, especially in the Southwest and West, also face critical water and wastewater problems. Investments in sources of clean water must be made or we will face shortages in the coming decades. However, necessary water infrastructure improvements are extremely expensive. According to the Texas State water plan, the cost of water supply acquisition projects, water and wastewater treatment, and other infrastructure projects in Texas through 2050 will be more than $100 billion.

Currently, air and water pollution control facilities cannot be financed by tax-exempt bonds. Even if they could, they would be limited by a cap which sets the total amount of tax-exempt private activity bonds issued by a state. Given the demands of other projects, such as housing, relatively few of the air and water pollution projects would have an opportunity to access this financing option.

In order to help us meet the challenges, I am introducing the Clear Air and Water Investment and Infrastructure Act. My bill will allow federal tax-exempt bonds to be used by private firms for air and water pollution control projects. Given the importance of these critical projects, these bonds also would be issued outside the constraints of the private-activity bond caps. The Texas Water Development Board estimates this could save 30 percent in financing costs for water projects.

For example, this bill would allow tax-exempt debt to be used to finance private systems along the Gulf Coast that desalinate seawater and brackish groundwater, and to install air pollution facilities on electric utility plants. States and communities would have an important new tool for addressing air and water pollution control needs.

Pollution control is a problem for all of us. It is to everyone's benefit to develop ways to promote public and private partnerships which can finance projects to improve air and water quality. I hope my colleagues will support this effort.

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

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1917

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Clean Air and Water Investment and Infrastructure Act''.

SEC. 2. TAX-EXEMPT BONDS FOR AIR AND WATER POLLUTION CONTROL FACILITIES.

(a) IN GENERAL.—Subsection (a) of section 142 of the Internal Revenue Code of 1986 (defining exempt facility bond) is amended by striking ''or'' at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting '', or'', and by adding at the end the following new paragraph:

''(14) air or water pollution control facilities.''.

(b) AIR OR WATER POLLUTION CONTROL FACILITIES.—Section 142 of the Internal Revenue Code of 1986 (relating to exempt facility bond) is amended by adding at the end the following new subsection:

''(l) POLLUTION CONTROL FACILITIES ACQUIRED BY REGIONAL POLLUTION CONTROL AUTHORITIES.—

''(1) IN GENERAL.—For purposes of paragraph (14) of subsection (a), a bond shall be treated as described in such paragraph if it is part of an issue substantially all of the proceeds of which are used by a qualified regional pollution control authority to acquire existing air or water pollution control facilities which the authority itself will operate in order to maintain or improve the control of pollutants.

''(2) RESTRICTIONS.—Paragraph (1) shall apply only if—

''(A) the amount paid, directly or indirectly, for a facility does not exceed the fair market value of the facility,

''(B) the fees or charges imposed, directly or indirectly, on the seller for any use of the facility after the sale of such facility are not less than the amounts that would be charged if the facility were financed with obligations the interest on which is not exempt from tax, and

''(C) no person other than the qualified regional pollution control authority is considered after the sale as the owner of the facility for the purposes of Federal income taxes.

''(3) QUALIFIED REGIONAL POLLUTION CONTROL AUTHORITY.—For purposes of this subsection, the term 'qualified regional pollution control authority' means an authority which—

''(A) is a political subdivision created by State law to control air or water pollution,

''(B) has within its jurisdictional boundaries all or part of at least 2 counties (or equivalent political subdivisions), and

''(C) operates air or water pollution control facilities.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to bonds issued after the date of the enactment of this Act.

SEC. 3. EXEMPTION FROM VOLUME CAP FOR FACILITIES FURNISHING WATER, SEWAGE FACILITIES, AND AIR OR WATER POLLUTION CONTROL FACILITIES.

(a) IN GENERAL.—Paragraph (3) of section 146(g) of the Internal Revenue Code of 1986 (relating to exception for certain bonds) is amended—

(1) by inserting ''(4), (5),'' after ''(2),'',

(2) by striking ''or (13)'' and inserting ''(13), or (14)'',

(3) by inserting ''facilities for the furnishing of water, sewage facilities,'' after ''wharves,'',

(4) by striking ''and'' before ''qualified'', and

(5) by inserting '', and air or water pollution control facilities'' after ''educational facilities''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to bonds issued after the date of the enactment of this Act.

By Mr. SANTORUM (for himself and Mrs. FEINSTEIN):

S. 1918. A bill to amend the Internal Revenue Code of 1986 to provide that qualified homeowner downpayment assistance is a charitable purpose; to the Committee on Finance.

Mr. SANTORUM. Mr. President, I am please to introduce today, along with my colleague from California, Senator FEINSTEIN, legislation that will further one of the most important public policy goals we have as a Nation—the goal of homeownership. Homeownership is a significant part of the American dream. It has been called the backbone of our economy. It is widely considered the primary means by which American families create middle-class wealth and build financial security.

Homeownership is all those things and more. It is the cornerstone of healthy communities across our Nation. It is good for families, good for our schools, good for our neighborhoods. Equity in homes is the leading source for collateral for small business start-up borrowing, and home equity loans are the leading provider of funds for a college education. Some experts even say home owners are more likely to vote.

Despite the many benefits, there are still too many Americans for whom the

American dream of homeownership is unreachable. There are too many American families who pay rent month after month, never accumulating equity, never experiencing the joy of raising their children in a home they own, and look forward to passing along to future generations. That is especially true among Americans from minority populations. Though nationwide nearly 70 percent of Americans own their own home, homeownership rates among African-Americans and Hispanics is less than 50 percent.

There are any number of obstacles to homeownership, but there is one problem that is widely considered the single biggest obstacle: the lack of funds for a down payment. Again, this is disproportionately true among minority families, which frequently have less accumulated wealth that can be used for a down payment.

President Bush has proposed creating the American Dream Down Payment Fund, which would provide down payment assistance to 40,000 families every year. I support that effort, and I applaud President Bush for proposing this bold new initiative. The President has set a goal of increasing the number of minority homeowners by at least 5.5 million by the end of this decade, which the Department of Housing and Urban Development estimates would create $256 billion in economic activity. I believe that is an important goal for us as a Nation.

I also believe that as we work to find ways for the Federal Government to increase homeownership, we need to encourage the private sector to do the same. There are a number of non-profit organizations in our country doing just that by providing a gift of down payment assistance to potential homeowners. These gifts of down payment assistance go to families and individuals who have the income to afford a mortgage, but who would otherwise be prevented from buying a home because they lack funds for a down payment. Last year non-profit organizations provided gifts of down payment assistance to over 85,000 home buyers—and the number will likely be much higher this year. One organization alone has helped over 160,000 individuals and families become homeowners, by providing a gift of funds for a down payment. And all without collecting a single dime of government funding.

That is why I am so pleased to be introducing this legislation today. I want to be sure the private sector can continue playing such a vital role in increasing homeownership by providing down payment assistance. Although many charities holding tax exemptions under section 501(c)(3) of the Internal Revenue Code provide down payment assistance, IRS regulations do not clearly address down payment assistance programs.

Our legislation will clarify that, under certain circumstances, the provision of down payment assistance to American families for use in purchasing low or moderate price homes constitutes charitable activity. Rather than developing our own standard for eligible home purchases, we have relied on the National Housing Act rule for FHA-insured loans. Our provision applies to purchases of a principal residence if the amount of the mortgage is less than the maximum mortgage amount eligible for FHA insurance in the geographic area in which the home is located. That will ensure that a charitable down payment assistance program is not used to support the purchase of rental properties or expensive homes.

Our legislation also includes one other provision designed to protect the Treasury. Home sellers often contribute to charitable down payment assistance providers in connection with the sale of a home. Those contributions are used to replenish the pool to make available gift assistance for other home buyers. Although the contributions are being made to a charity, they are not charitable in nature; they are expenses of selling a home. The legislation clarifies that a party to a home sale transaction may not claim a charitable contribution deduction for a contribution to a down payment assistance provider made in connection with the sale.

Although IRS regulations do not clearly address down payment assistance programs, our legislation merely codifies current practice. As a result, I do not anticipate that the legislation will result in a significant change in tax revenues.

Non-profit providers of down payment assistance help tens of thousands of Americans every year become homeowners. These organizations are changing lives, changing families, changing our communities—and they are doing it all without a single dime of taxpayer funds. I am pleased my colleague from California, Senator FEINSTEIN, has joined me in introducing this legislation. I ask all of my colleagues to join us in this important effort.

Mrs. FEINSTEIN. Mr. President, I am pleased to join with the distinguished Senator from Pennsylvania, Senator SANTORUM, to introduce legislation that will promote the American dream of homeownership.

Our legislation will specify that providing homeownership down payment assistance to American families constitutes a charitable activity under the regulations of the Internal Revenue Service.

As the cornerstone of middle-class wealth in our nation, we should be doing everything possible to promote broad investment in owner-occupied housing. Today, we have that chance.

It should not be a surprise that homeownership among low to moderate income families is lower than for those with higher incomes. The single biggest obstacle to achieving this dream is the lack of a downpayment.

Across America there are organizations that assist low to moderate income families with that first important step toward homeownership. In California, one of these groups, the Nehemiah Corporation, helps literally thousands of families each year by providing down payments.

While the Federal Government provides tax incentives for increased homeownership, we should make it easier for the private sector to provide their own brand of incentives. Importantly, this legislation will do several things to ensure that the private sector continues to have the tools it needs to provide this important assistance.

One, our legislation will specify that homeownership down payment assistance to American families constitutes a charitable activity.

Currently, Internal Revenue Service regulations do not clearly address the special circumstances of those organizations that provide downpayment assistance to families.

Two, our bill is structured to ensure that a charitable down payment assistance program is not used to support the purchase of rental properties or expensive homes.

Three, our legislation is designed so that the taxpayers do not pick-up the tab. Since, home sellers often contribute to charitable down payment assistance providers in connection with the sale of a home, those contributions are not charitable in nature; they are an expense related to selling a home.

This legislation clarifies that a party to a home sale transaction may not claim a charitable contribution deduction for a contribution to a down payment assistance organization made in connection with the sale.

And, although Internal Revenue Service regulations do not specifically address down payment assistance programs, our legislation merely codifies current practice.

This legislation will ensure the continued growth of this essential segment of the financial services market at no cost to the taxpayers.

And, as my friend from Pennsylvania has said, equity in homes is the leading source for collateral for small business start-up borrowing.

At a time when the economy still fails to produce jobs, the expansion of small business and the employment they provide is essential to the health of our economy.

It is a win-win situation in the truest sense of the term and I urge my colleagues to support it.

By Mr. SMITH (for himself and Mr. BREAUX):

S. 1922. A bill to amend the Internal Revenue Code of 1986 to comply with the World Trade Organization rulings on the FSC/ETI benefit in a manner that preserves manufacturing jobs and production activities in the United States, and for other purposes; to the Committee on Finance.

Mr. SMITH. Mr. President, I rise today to introduce The American Manufacturing Jobs Bill of 2003—which will

provide a tax rate cut for all manufacturers who employ American workers. I am pleased to be joined in this effort by Senator JOHN BREAUX. On October 1, 2003, the Senate Finance Committee approved on a bipartisan basis S. 1673, the centerpiece of which resolves the FSC/ETI issue by replacing the export tax benefit with a reduction in the tax burden on domestic manufacturing companies.

I applaud S. 1673, a balanced piece of legislation crafted by Chairman CHARLES GRASSLEY, R–IA, and ranking member Senator MAX BAUCUS, D–MT. I am, however, concerned that the domestic manufacturing benefit in S. 1673 is not applied equally to all U.S. manufacturers. This bill includes a provision—a ''haircut''—that provides less of a benefit to companies that also manufacture abroad.

For example, a company that has 55 percent of its manufacturing in the United States and 45 percent abroad will calculate its benefit under the bill and then reduce that benefit by a fraction—the numerator of which is the gross receipts from domestic manufacturing over the same derived from worldwide manufacturing.

This company thus suffers twice. First, the domestic manufacturing benefit in S. 1673 is less valuable than the benefit currently provided under FSC/ETI. Second, this company's manufacturing benefit is further reduced by the ''haircut'' merely because it also has overseas manufacturing operations in order to be closer to their markets.

The ''haircut'' is a discriminatory measure that hurts both foreign-owned and U.S.-owned companies alike. It is structured so that the more a company manufactures abroad, the less of a manufacturing rate cut it gets. The ''haircut'' makes the United States a less competitive location for current and future investment because multinational companies will believe they are being ''cheated'' and discriminated against.

At a time when American manufacturing jobs are leaving our country in record numbers, Congress should support all companies that employ Americans. U.S. companies with global operations employ more than 23 million Americans—9 million of which are in manufacturing jobs—this is tantamount to three out of every five manufacturing jobs in this country. Foreign-owned companies with U.S. operations employ more than 2 million manufacturing workers in the United States. It is these many of millions of manufacturing workers who will suffer if the ''haircut'' remains and companies are therefore discouraged to invest in the United States.

Moreover, the ''haircut'' is inconsistent with historic tax and trade policies to encourage U.S. companies to open up facilities outside the United States. In fact, there is an entire department—the Department of Commerce—set up to assist U.S. companies going global and then to promote and facilitate those same companies' efforts once they have established themselves in-country. I am also concerned that the ''haircut'' invites mirror legislation in other countries and may invite another WTO challenge to this legislation.

I believe we have a duty to encourage the retention and creation of manufacturing jobs in the United States. We must not treat U.S. jobs created by multinational companies as ''less worthy'' than U.S. jobs created by strictly domestic manufacturers. Congress should be in the business of rewarding all well-paid, manufacturing jobs that are created in the United States, not just those created by domestic manufacturers. I believe that by eliminating the ''haircut'' and providing a tax rate cut for all manufacturers who employ American workers, we can help to revitalize the U.S. manufacturing sector. I ask unanimous consent that the full text of this important legislation be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1922

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

SECTION 1. SHORT TITLE; AMENDMENT OF 1986 CODE.

(a) SHORT TITLE.—This Act may be cited as the ''American Manufacturing Jobs Act of 2003''.

(b) AMENDMENT OF 1986 CODE.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

SEC. 2. REPEAL OF EXCLUSION FOR EXTRATERRITORIAL INCOME.

(a) IN GENERAL.—Section 114 is hereby repealed.

(b) CONFORMING AMENDMENTS.—

(1)(A) Subpart E of part III of subchapter N of chapter 1 (relating to qualifying foreign trade income) is hereby repealed.

(B) The table of subparts for such part III is amended by striking the item relating to subpart E.

(2) The table of sections for part III of subchapter B of chapter 1 is amended by striking the item relating to section 114.

(3) The second sentence of section 56(g)(4)(B)(i) is amended by striking ''or under section 114''.

(4) Section 275(a) is amended—

(A) by inserting ''or'' at the end of paragraph (4)(A), by striking ''or'' at the end of paragraph (4)(B) and inserting a period, and by striking subparagraph (C), and

(B) by striking the last sentence.

(5) Paragraph (3) of section 864(e) is amended—

(A) by striking:

''(3) TAX-EXEMPT ASSETS NOT TAKEN INTO ACCOUNT.—

''(A) IN GENERAL.—For purposes of''; and inserting:

''(3) TAX-EXEMPT ASSETS NOT TAKEN INTO ACCOUNT.—For purposes of'', and

(B) by striking subparagraph (B).

(6) Section 903 is amended by striking ''114, 164(a),'' and inserting ''164(a)''.

(7) Section 999(c)(1) is amended by striking ''941(a)(5),''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to transactions occurring after the date of the enactment of this Act.

(2) BINDING CONTRACTS.—The amendments made by this section shall not apply to any transaction in the ordinary course of a trade or business which occurs pursuant to a binding contract—

(A) which is between the taxpayer and a person who is not a related person (as defined in section 943(b)(3) of such Code, as in effect on the day before the date of the enactment of this Act), and

(B) which is in effect on September 17, 2003, and at all times thereafter.

(d) REVOCATION OF SECTION 943(e) ELECTIONS.—

(1) IN GENERAL.—In the case of a corporation that elected to be treated as a domestic corporation under section 943(e) of the Internal Revenue Code of 1986 (as in effect on the day before the date of the enactment of this Act)—

(A) the corporation may, during the 1-year period beginning on the date of the enactment of this Act, revoke such election, effective as of such date of enactment, and

(B) if the corporation does revoke such election—

(i) such corporation shall be treated as a domestic corporation transferring (as of such date of enactment) all of its property to a foreign corporation in connection with an exchange described in section 354 of such Code, and

(ii) no gain or loss shall be recognized on such transfer.

(2) EXCEPTION.—Subparagraph (B)(ii) of paragraph (1) shall not apply to gain on any asset held by the revoking corporation if—

(A) the basis of such asset is determined in whole or in part by reference to the basis of such asset in the hands of the person from whom the revoking corporation acquired such asset,

(B) the asset was acquired by transfer (not as a result of the election under section 943(e) of such Code) occurring on or after the 1st day on which its election under section 943(e) of such Code was effective, and

(C) a principal purpose of the acquisition was the reduction or avoidance of tax (other than a reduction in tax under section 114 of such Code, as in effect on the day before the date of the enactment of this Act).

(e) GENERAL TRANSITION.—

(1) IN GENERAL.—In the case of a taxable year ending after the date of the enactment of this Act and beginning before January 1, 2007, for purposes of chapter 1 of such Code, a current FSC/ETI beneficiary shall be allowed a deduction equal to the transition amount determined under this subsection with respect to such beneficiary for such year.

(2) CURRENT FSC/ETI BENEFICIARY.—The term ''current FSC/ETI beneficiary'' means any corporation which entered into one or more transactions during its taxable year beginning in calendar year 2002 with respect to which FSC/ETI benefits were allowable.

(3) TRANSITION AMOUNT.—For purposes of this subsection—

(A) IN GENERAL.—The transition amount applicable to any current FSC/ETI beneficiary for any taxable year is the phaseout percentage of the base period amount.

(B) PHASEOUT PERCENTAGE.—

(i) IN GENERAL.—In the case of a taxpayer using the calendar year as its taxable year, the phaseout percentage shall be determined under the following table:

Years:	The phaseout percentage is:
2004	80

Years:	The phaseout percentage is:
2005	80
2006	60.

(ii) SPECIAL RULE FOR 2003.—The phaseout percentage for 2003 shall be the amount that bears the same ratio to 100 percent as the number of days after the date of the enactment of this Act bears to 365.

(iii) SPECIAL RULE FOR FISCAL YEAR TAXPAYERS.—In the case of a taxpayer not using the calendar year as its taxable year, the phaseout percentage is the weighted average of the phaseout percentages determined under the preceding provisions of this paragraph with respect to calendar years any portion of which is included in the taxpayer's taxable year. The weighted average shall be determined on the basis of the respective portions of the taxable year in each calendar year.

''(C) SHORT TAXABLE YEAR.—The Secretary shall prescribe guidance for the computation of the transition amount in the case of a short taxable year.

(4) BASE PERIOD AMOUNT.—For purposes of this subsection, the base period amount is the FSC/ETI benefit for the taxpayer's taxable year beginning in calendar year 2002.

(5) FSC/ETI BENEFIT.—For purposes of this subsection, the term ''FSC/ETI benefit'' means—

(A) amounts excludable from gross income under section 114 of such Code, and

(B) the exempt foreign trade income of related foreign sales corporations from property acquired from the taxpayer (determined without regard to section 923(a)(5) of such Code (relating to special rule for military property), as in effect on the day before the date of the enactment of the FSC Repeal and Extraterritorial Income Exclusion Act of 2000).

In determining the FSC/ETI benefit there shall be excluded any amount attributable to a transaction with respect to which the taxpayer is the lessor unless the leased property was manufactured or produced in whole or in significant part by the taxpayer.

(6) SPECIAL RULE FOR AGRICULTURAL AND HORTICULTURAL COOPERATIVES.—Determinations under this subsection with respect to an organization described in section 943(g)(1) of such Code, as in effect on the day before the date of the enactment of this Act, shall be made at the cooperative level and the purposes of this subsection shall be carried out in a manner similar to section 199(h)(2) of such Code, as added by this Act. Such determinations shall be in accordance with such requirements and procedures as the Secretary may prescribe.

(7) CERTAIN RULES TO APPLY.—Rules similar to the rules of section 41(f) of such Code shall apply for purposes of this subsection.

(8) COORDINATION WITH BINDING CONTRACT RULE.—The deduction determined under paragraph (1) for any taxable year shall be reduced by the phaseout percentage of any FSC/ETI benefit realized for the taxable year by reason of subsection (c)(2) or section 5(c)(1)(B) of the FSC Repeal and Extraterritorial Income Exclusion Act of 2000, except that for purposes of this paragraph the phaseout percentage for 2003 shall be treated as being equal to 100 percent.

(9) SPECIAL RULE FOR TAXABLE YEAR WHICH INCLUDES DATE OF ENACTMENT.—In the case of a taxable year which includes the date of the enactment of this Act, the deduction allowed under this subsection to any current FSC/ETI beneficiary shall in no event exceed—

(A) 100 percent of such beneficiary's base period amount for calendar year 2003, reduced by

(B) the FSC/ETI benefit of such beneficiary with respect to transactions occurring during the portion of the taxable year ending on the date of the enactment of this Act.

SEC. 3. DEDUCTION RELATING TO INCOME ATTRIBUTABLE TO UNITED STATES PRODUCTION ACTIVITIES.

(a) IN GENERAL.—Part VI of subchapter B of chapter 1 (relating to itemized deductions for individuals and corporations) is amended by adding at the end the following new section:

''SEC. 199. INCOME ATTRIBUTABLE TO DOMESTIC PRODUCTION ACTIVITIES.

''(a) ALLOWANCE OF DEDUCTION.—

''(1) IN GENERAL.—There shall be allowed as a deduction an amount equal to 9 percent of the qualified production activities income of the taxpayer for the taxable year.

''(2) PHASEIN.—In the case of taxable years beginning in 2003, 2004, 2005, 2006, 2007, or 2008, paragraph (1) shall be applied by substituting for the percentage contained therein the transition percentage determined under the following table:

''Taxable years beginning in:	The transition percentage is:
2003 or 2004	1
2005	2
2006	3
2007 or 2008	6.

''(b) DEDUCTION LIMITED TO WAGES PAID.—

''(1) IN GENERAL.—The amount of the deduction allowable under subsection (a) for any taxable year shall not exceed 50 percent of the W-2 wages of the employer for the taxable year.

''(2) W-2 WAGES.—For purposes of paragraph (1), the term 'W-2 wages' means the sum of the aggregate amounts the taxpayer is required to include on statements under paragraphs (3) and (8) of section 6051(a) with respect to employment of employees of the taxpayer during the taxpayer's taxable year.

''(3) SPECIAL RULES.—

''(A) PASS-THRU ENTITIES.—In the case of an S corporation, partnership, estate or trust, or other pass-thru entity, the limitation under this subsection shall apply at the entity level.

''(B) ACQUISITIONS AND DISPOSITIONS.—The Secretary shall provide for the application of this subsection in cases where the taxpayer acquires, or disposes of, the major portion of a trade or business or the major portion of a separate unit of a trade or business during the taxable year.

''(c) QUALIFIED PRODUCTION ACTIVITIES INCOME.—For purposes of this section, the term 'qualified production activities income' means an amount equal to the portion of the modified taxable income of the taxpayer which is attributable to domestic production activities.

''(d) DETERMINATION OF INCOME ATTRIBUTABLE TO DOMESTIC PRODUCTION ACTIVITIES.—For purposes of this section—

''(1) IN GENERAL.—The portion of the modified taxable income which is attributable to domestic production activities is so much of the modified taxable income for the taxable year as does not exceed—

''(A) the taxpayer's domestic production gross receipts for such taxable year, reduced by

''(B) the sum of—

''(i) the costs of goods sold that are allocable to such receipts,

''(ii) other deductions, expenses, or losses directly allocable to such receipts, and

''(iii) a proper share of other deductions, expenses, and losses that are not directly allocable to such receipts or another class of income.

''(2) ALLOCATION METHOD.—The Secretary shall prescribe rules for the proper allocation of items of income, deduction, expense, and loss for purposes of determining income attributable to domestic production activities.

''(3) SPECIAL RULES FOR DETERMINING COSTS.—

''(A) IN GENERAL.—For purposes of determining costs under clause (i) of paragraph (1)(B), any item or service brought into the United States shall be treated as acquired by purchase, and its cost shall be treated as not less than its fair market value immediately after it entered the United States. A similar rule shall apply in determining the adjusted basis of leased or rented property where the lease or rental gives rise to domestic production gross receipts.

''(B) EXPORTS FOR FURTHER MANUFACTURE.—In the case of any property described in subparagraph (A) that had been exported by the taxpayer for further manufacture, the increase in cost or adjusted basis under subparagraph (A) shall not exceed the difference between the value of the property when exported and the value of the property when brought back into the United States after the further manufacture.

''(4) MODIFIED TAXABLE INCOME.—The term 'modified taxable income' means taxable income computed without regard to the deduction allowable under this section.

''(e) DOMESTIC PRODUCTION GROSS RECEIPTS.—For purposes of this section—

''(1) IN GENERAL.—The term 'domestic production gross receipts' means the gross receipts of the taxpayer which are derived from—

''(A) any sale, exchange, or other disposition of, or

''(B) any lease, rental, or license of,

qualifying production property which was manufactured, produced, grown, or extracted in whole or in significant part by the taxpayer within the United States.

''(2) SPECIAL RULES FOR CERTAIN PROPERTY.—In the case of any qualifying production property described in subsection (f)(1)(C)—

''(A) such property shall be treated for purposes of paragraph (1) as produced in significant part by the taxpayer within the United States if more than 50 percent of the aggregate development and production costs are incurred by the taxpayer within the United States, and

''(B) if a taxpayer acquires such property before such property begins to generate substantial gross receipts, any development or production costs incurred before the acquisition shall be treated as incurred by the taxpayer for purposes of subparagraph (A) and paragraph (1).

''(f) QUALIFYING PRODUCTION PROPERTY.—For purposes of this section—

''(1) IN GENERAL.—Except as otherwise provided in this paragraph, the term 'qualifying production property' means—

''(A) any tangible personal property,

''(B) any computer software, and

''(C) any property described in section 168(f) (3) or (4), including any underlying copyright or trademark.

''(2) EXCLUSIONS FROM QUALIFYING PRODUCTION PROPERTY.—The term 'qualifying production property' shall not include—

''(A) consumable property that is sold, leased, or licensed by the taxpayer as an integral part of the provision of services,

''(B) oil or gas,

''(C) electricity,

''(D) water supplied by pipeline to the consumer,

''(E) utility services, or

''(F) any film, tape, recording, book, magazine, newspaper, or similar property the market for which is primarily topical or otherwise essentially transitory in nature.

''(g) DEFINITIONS AND SPECIAL RULES.—

''(1) APPLICATION OF SECTION TO PASS-THRU ENTITIES.—In the case of an S corporation, partnership, estate or trust, or other pass-thru entity—

''(A) subject to the provisions of paragraph (2) and subsection (b)(3)(A), this section shall be applied at the shareholder, partner, or similar level, and

''(B) the Secretary shall prescribe rules for the application of this section, including rules relating to—

''(i) restrictions on the allocation of the deduction to taxpayers at the partner or similar level, and

''(ii) additional reporting requirements.

''(2) EXCLUSION FOR PATRONS OF AGRICULTURAL AND HORTICULTURAL COOPERATIVES.—

''(A) IN GENERAL.—If any amount described in paragraph (1) or (3) of section 1385(a)—

''(i) is received by a person from an organization to which part I of subchapter T applies which is engaged in the marketing of agricultural or horticultural products, and

''(ii) is allocable to the portion of the qualified production activities income of the organization which is deductible under subsection (a) and designated as such by the organization in a written notice mailed to its patrons during the payment period described in section 1382(d),

then such person shall be allowed an exclusion from gross income with respect to such amount. The taxable income of the organization shall not be reduced under section 1382 by the portion of any such amount with respect to which an exclusion is allowable to a person by reason of this paragraph.

''(B) SPECIAL RULES.—For purposes of applying subparagraph (A), in determining the qualified production activities income of the organization under this section—

''(i) there shall not be taken into account in computing the organization's modified taxable income any deduction allowable under subsection (b) or (c) of section 1382 (relating to patronage dividends, per-unit retain allocations, and nonpatronage distributions), and

''(ii) the organization shall be treated as having manufactured, produced, grown, or extracted in whole or significant part any qualifying production property marketed by the organization which its patrons have so manufactured, produced, grown, or extracted.

''(3) SPECIAL RULE FOR AFFILIATED GROUPS.—

''(A) IN GENERAL.—All members of an expanded affiliated group shall be treated as a single corporation for purposes of this section.

''(B) EXPANDED AFFILIATED GROUP.—The term 'expanded affiliated group' means an affiliated group as defined in section 1504(a), determined—

''(i) by substituting '50 percent' for '80 percent' each place it appears, and

''(ii) without regard to paragraphs (2) and (4) of section 1504(b).

''(4) COORDINATION WITH MINIMUM TAX.—The deduction under this section shall be allowed for purposes of the tax imposed by section 55; except that for purposes of section 55, alternative minimum taxable income shall be taken into account in determining the deduction under this section.

''(5) ORDERING RULE.—The amount of any other deduction allowable under this chapter shall be determined as if this section had not been enacted.

''(6) TRADE OR BUSINESS REQUIREMENT.—This section shall be applied by only taking into account items which are attributable to the actual conduct of a trade or business.

''(7) POSSESSIONS, ETC.—

''(A) IN GENERAL.—For purposes of subsections (d) and (e), the term 'United States' includes the Commonwealth of Puerto Rico, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and the Virgin Islands of the United States.

''(B) SPECIAL RULES FOR APPLYING WAGE LIMITATION.—For purposes of applying the limitation under subsection (b) for any taxable year—

''(i) the determination of W–2 wages of a taxpayer shall be made without regard to any exclusion under section 3401(a)(8) for remuneration paid for services performed in a jurisdiction described in subparagraph (A), and

''(ii) in determining the amount of any credit allowable under section 30A or 936 for the taxable year, there shall not be taken into account any wages which are taken into account in applying such limitation.

''(8) COORDINATION WITH TRANSITION RULES.—For purposes of this section—

''(A) domestic production gross receipts shall not include gross receipts from any transaction if the binding contract transition relief of section 2(c)(2) of the American Manufacturing Jobs Act of 2003 applies to such transaction, and

''(B) any deduction allowed under section 2(e) of such Act shall be disregarded in determining the portion of the taxable income which is attributable to domestic production gross receipts.''.

(b) MINIMUM TAX.—Section 56(g)(4)(C) (relating to disallowance of items not deductible in computing earnings and profits) is amended by adding at the end the following new clause:

''(v) DEDUCTION FOR DOMESTIC PRODUCTION.—Clause (i) shall not apply to any amount allowable as a deduction under section 199.''.

(c) CLERICAL AMENDMENT.—The table of sections for part VI of subchapter B of chapter 1 is amended by adding at the end the following new item:

''Sec. 199. Income attributable to domestic production activities.''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to taxable years ending after the date of the enactment of this Act.

(2) APPLICATION OF SECTION 15.—Section 15 of the Internal Revenue Code of 1986 shall apply to the amendments made by this section as if they were changes in a rate of tax.

By Mr. LEAHY:

S. 1923. A bill to reauthorize and amend the National Film Preservation Act of 1996; to the Committee on the Judiciary.

Mr. LEAHY. Mr. President, I call attention today to a part of American heritage that is literally disintegrating faster than can be saved. Motion pictures are an important part of our American experience and provide an extraordinary record of our history, our dreams, and our aspirations. The National Film Preservation Board and the National Film Preservation Foundation were created by Congress under the auspices of the Library of Congress, to help save America's film heritage. Today, I am introducing the ''National Film Preservation Act of 2003,'' which will reauthorize and extend the ''National Film Preservation Act of 1996.''

We first acted in 1988 in order to recognize both the educational, cultural, and historical importance of our film heritage, and its inherently fragile nature. The ''National Film Preservation Act of 2003'' will allow the Library of Congress to continue its important work in preserving America's fading treasures, as well as providing grants that will help libraries, museums, and archives preserve films, and make those works available for study and research. These continued efforts are more critical today than ever before. Fewer than 20 percent of the features of the 1920s exist in complete form and less than 10 percent of the features of the 1910s have survived into the new millennium.

The films saved by the National Film Preservation Board are precisely those types of films that would be unlikely to survive without public support. At-risk documentaries, silent-era films, avant-garde works, ethnic films, newsreels, and home movies are in many ways more illuminating on the question of who we are as a society than the Hollywood sound features kept and preserved by major studios. What is more, in many cases only one copy of these ''orphaned'' works exists. As the Librarian of Congress, Dr. James H. Billington, has noted, ''Our film heritage is America's living past.'' I encourage my colleagues to support the ''Film Preservation Act of 2003'' so that America's past can survive in order to enlighten and entertain future generations.

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

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1923

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

TITLE I—REAUTHORIZATION OF THE NATIONAL FILM PRESERVATION BOARD

SEC. 101. SHORT TITLE.

This title may be cited as the ''National Film Preservation Act of 2003''.

SEC. 102. REAUTHORIZATION AND AMENDMENT.

(a) DUTIES OF THE LIBRARIAN OF CONGRESS.—Section 103 of the National Film Preservation Act of 1996 (2 U.S.C. 179m) is amended:

(1) in subsection (b)—

(A) by striking ''film copy'' each place that term appears and inserting ''film or other approved copy'';

(B) by striking ''film copies'' each place that term appears and inserting ''film or other approved copies''; and

(C) in the third sentence, by striking ''copyrighted'' and inserting ''copyrighted, mass distributed, broadcast, or published'' ; and

(2) by adding at the end the following:

''(c) COORDINATION OF PROGRAM WITH OTHER COLLECTION, PRESERVATION, AND ACCESSIBILITY ACTIVITIES.—In carrying out the comprehensive national film preservation program for motion pictures established under the National Film Preservation Act of 1992, the Librarian, in consultation with the Board established pursuant to section 104, shall—

''(1) carry out activities to make films included in the National Film registry more broadly accessible for research and educational purposes, and to generate public awareness and support of the Registry and the comprehensive national film preservation program;

''(2) review the comprehensive national film preservation plan, and amend it to the

extent necessary to ensure that it addresses technological advances in the preservation and storage of, and access to film collections in multiple formats; and

''(3) wherever possible, undertake expanded initiatives to ensure the preservation of the moving image heritage of the United States, including film, videotape, television, and born digital moving image formats, by supporting the work of the National Audio-Visual Conservation Center of the Library of Congress, and other appropriate nonprofit archival and preservation organizations.''.

(b) NATIONAL FILM PRESERVATION BOARD.—Section 104 of the National Film Preservation Act of 1996 (2 U.S.C. 179n) is amended—

(1) in subsection (a)(1) by striking ''20'' and inserting ''22'';

(2) in subsection (a) (2) by striking ''three'' and inserting ''5'';

(3) in subsection (d) by striking ''11'' and inserting ''12''; and

(4) by striking subsection (e) and inserting the following:

''(e) REIMBURSEMENT OF EXPENSES.—Members of the Board shall serve without pay, but may receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.''.

(c) RESPONSIBILITIES AND POWERS OF BOARD.—Section 105(c) of the National Film Preservation Act of 1996 (2 U.S.C. 179o) is amended by adding at the end the following:

''(3) REVIEW AND APPROVAL OF SPECIAL FOUNDATION PROJECTS.—The Board shall review special projects submitted for its approval by the National Film Preservation Foundation under section 151711 of title 36, United States Code.''.

(d) NATIONAL FILM REGISTRY.—Section 106 of the National Film Preservation Act of 1996 (2 U.S.C. 179q) is amended by adding at the end the following:

''(e) NATIONAL AUDIO-VISUAL CONSERVATION CENTER.—The Librarian shall utilize the National Audio-Visual Conservation Center of the Library of Congress at Culpeper, Virginia, to ensure that preserved films included in the National Film Registry are stored in a proper manner, and disseminated to researchers, scholars, and the public as may be appropriate in accordance with—

''(1) title 17 of the United States Code; and

''(2) the terms of any agreements between the Librarian and persons who hold copyrights to such audiovisual works.''.

(e) USE OF SEAL.—Section 107 (a) of the National Film Preservation Act of 1996 (2 U.S.C. 179q) is amended—

(1) in paragraph (1), by inserting ''in any format'' after ''or any copy''; and

(2) in paragraph (2), by striking ''or film copy'' and inserting ''in any format''.

(f) EFFECTIVE DATE.—Section 113 of the National Film Preservation Act of 1996 (2 U.S.C. 179w) is amended by striking ''7'' and inserting ''17''.

TITLE II—REAUTHORIZATION OF THE NATIONAL FILM PRESERVATION FOUNDATION

SEC. 201. SHORT TITLE.

This title may be cited as the ''National Film Preservation Foundation Reauthorization Act of 2003''.

SEC. 202. REAUTHORIZATION AND AMENDMENT.

(a) BOARD OF DIRECTORS.—Section 151703 of title 36, United States Code, is amended—

(1) in subsection (b)(2)(A), by striking ''nine'' and inserting ''12''; and

(2) in subsection (b)(4), by striking the second sentence and inserting ''There shall be no limit to the number of terms to which any individual may be appointed.''.

(b) POWERS.—Section 151705 of title 36, United States Code, is amended in subsection (b) by striking ''District of Columbia'' and inserting ''the jurisdiction in which the principal office of the corporation is located''.

(c) PRINCIPAL OFFICE.—Section 151706 of title 36, United States Code, is amended by inserting '', or another place as determined by the board of directors'' after ''District of Columbia''.

(d) AUTHORIZATION OF APPROPRIATIONS.—Section 151711 of title 36, United States Code, is amended by striking subsections (a) and (b) and inserting the following:

''(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Library of Congress amounts necessary to carry out this chapter, not to exceed $500,000 for each of the fiscal years 2004 and 2005, and not to exceed $1,000,000 for each of the fiscal years 2006 through 2013. These amounts are to be made available to the corporation to match any private contributions (whether in currency, services, or property) made to the corporation by private persons and State and local governments.

''(b) LIMITATION RELATED TO ADMINISTRATIVE EXPENSES.—Amounts authorized under this section may not be used by the corporation for management and general or fundraising expenses as reported to the Internal Revenue Service as part of an annual information return required under the Internal Revenue Code of 1986.''.

(e) COOPERATIVE FILM PRESERVATION.—

(1) IN GENERAL.—Chapter 1517 of title 36, United States Code, is amended—

(A) by redesignating sections 151711 and 151712 as sections 151712 and 151713, respectively; and

(B) by adding at the end the following:

''§ 151711. Cooperative film preservation

''(a) COOPERATIVE FILM PRESERVATION.—

''(1) IN GENERAL.—The corporation shall design and support cooperative national film preservation and access initiatives. Such initiatives shall be approved by the corporation, the Librarian of Congress, and the National Film Preservation Board of the Library of Congress under section 105(c)(3) of the National Film Preservation Act of 1996.

''(2) SCOPE.—Cooperative initiatives authorized under paragraph (1) may include—

''(A) the repatriation and preservation of American films that may be found in archives outside of the United States;

''(B) the exhibition and dissemination via broadcast or other means of ''orphan'' films;

''(C) the production of educational materials in various formats to encourage film preservation, preservation initiatives undertaken by 3 or more archives jointly; and

''(D) other activities undertaken in light of significant unfunded film preservation and access needs.

''(b) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There are authorized to be appropriated to the Library of Congress amounts not to exceed $1,000,000 for each of the fiscal years 2006 through 2013, to carry out the purposes of this section.

''(2) MATCHING.—The amounts made available under paragraph (1) are to be made available to the corporation to match any private contributions (whether in currency, services, or property) made to the corporation by private persons and State and local governments.

''(3) LIMITATION RELATED TO ADMINISTRATIVE EXPENSES.—Amounts authorized under this section may not be used by the corporation for management and general or fundraising expenses as reported to the Internal Revenue Service as part of an annual information return required under the Internal Revenue Code of 1986.''.

(2) TECHNICAL AND CONFORMING AMENDMENT.—The table of sections for chapter 1517 of title 36, United States Code, is amended by striking the matter relating to section 151711 and 151712 and inserting the following:

''151711. Cooperative film preservation.
''151712. Authorization of appropriations.
''151713. Annual report.''.

By Mr. JEFFORDS:

S. 1924. A bill to provide for the coverage of milk production under the H–2A nonimmigrant worker program; to the Committee on the Judiciary.

Mr. JEFFORDS. Mr. President, today I rise to introduce the Dairy Farm Workers Fairness Act.

Family dairy farms are critically important to our agricultural economy and to the rural way of life in many parts of the country. These farms support the rural economy by supporting the local tax base and many local businesses. The working landscape created by our farms, especially a patchwork of small farms, is also the best antidote for the urban sprawl that is overtaking so much of the country. And, of course, the availability of fresh, locally produced milk is an amenity that we have come to take for granted. To support our rural economies, the working landscape and our local food supply systems we need to help small family dairy farms survive and thrive.

The most difficult challenge to the family dairy farm, after the volatility in milk price, is finding and hiring workers. In my home State of Vermont, dairy farms are not only an important part of our economy; they are an institution that has come to define our landscape. Vermont's beauty lies in the green fields, the red barns and the cows grazing on the hillside. When a farm family sells their land, which in many cases may have been worked by them and their ancestors for 5 or more generations, the decision is often driven by the non-stop, 7 day a week, 365 days a year work schedule. As fewer rural residents choose to work in agriculture, these farmers have been forced to take on more themselves. The whole family can end up working without vacations, sick leave or having weekends off. Although dairy farming might not seem seasonal, the burden becomes particularly heavy during the growing season when planting, haying, harvesting and storage of feed must all occur.

Dairy farmers are being forced to explore other options to find a predictable source of qualified labor. While other agricultural businesses in the country benefit from the temporary workers qualified under the H2A Work Visa Program, dairy farms do not. The job of milking cows on dairy farms has been judged under the current H2A program to not meet the definition of temporary or seasonal and is thus excluded. The largest labor need on dairy farms during the growing season, remains the need for assistance with milking. The cows must be milked two or three times a day by hired help so the farmer is able to take on the more complex and specialized work of operating large machinery to plant and harvest. While the work of milking is not seasonal or temporary, the need for additional labor to accomplish the

work is seasonal and temporary. I believe the exclusion of dairy farming under the H2A program is an unintended problem in definitions, and our legislation is designed to fix that glitch. We must do this out of fairness, so that dairy farms can benefit from the same access to labor that other farms have, and more importantly to help our farms survive.

Recently, I heard from a farmer who owns and operates, along with his wife, a small dairy farm in central Vermont. The couple is nearing retirement age and have no children of their own. They had attempted to find a farm hand that could live on the farm and help with milking and some of the heavier chores. After placing ads in the paper and working with the state of Vermont's Department of Employment and Training, it became clear that their best option was to hire a family friend who had a strong desire to learn farming. Since the young man was from Honduras they began the visa process only to have their request for certification by the U.S. Department of Labor denied because their need was considered neither temporary nor seasonal. This farm plays such an important role in their rural Vermont community that I heard from several other constituents who asked for my assistance on this family's behalf. The couple continues to work their land but in doing so they are straining their health and pushing themselves harder than they should. They continue to operate their farm because they do not want to sell it since it is land that has been farmed for generations.

The legislation I am introducing today would allow this family farm, and so many others like it, to avail themselves of a labor source that exists for virtually every other farm in this country. By creating a period based on the summer growing season, dairy farms will be able to bring on extra help during the busiest part of the year, providing much needed relief for our farm families. I urge my colleagues to join me in supporting dairy farms across the United States by cosponsoring this important legislation. I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1924

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Dairy Farm Workers Fairness Act''.

SEC. 2. COVERAGE OF MILK PRODUCTION UNDER H–2A NONIMMIGRANT WORKER PROGRAM.

(a) IN GENERAL.—For purposes of the administration of the H–2A worker program in a year, work performed in the production of milk for commercial use not earlier than April 15 or later than October 15 of that year shall qualify as agriculture labor or services of a seasonal nature.

(b) DEFINITIONS.—In this section:

(1) H–2A NONIMMIGRANT WORKER PROGRAM.—The term ''H–2A nonimmigrant worker program'' means the program for the admission to the United States of H–2A nonimmigrant workers.

(2) H–2A NONIMMIGRANT WORKERS.—The term ''H–2A worker'' means a nonimmigrant alien described in section 101(a)(15)(H)(ii)(a) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(H)(ii)(a)).

By Ms. STABENOW (for herself, Mr. GRAHAM of Florida, Mrs. CLINTON, Mrs. MURRAY, Mr. LEAHY, Mr. DASCHLE, Mr. PRYOR, Mr. LEVIN, Mr. SCHUMER, and Ms. CANTWELL):

S. 1926. A bill to amend title XVIII of the Social Security Act to restore the medicare program and for other purposes; to the Committee on Finance.

Ms. STABENOW. Mr. President, I rise today to introduce legislation that would allow us to help our providers and patients now.

If we immediately pass this bill, we can make our providers whole and then go back to the drawing board to get a better Medicare prescription drug benefit bill.

The bill includes all of the provider givebacks in the Conference Report accompanying H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003.

It includes all adjustments, word for word, for the rural provisions, physician updates, graduate medical education, GME, and home health services.

It does not add new language.

It does not include any provider cuts or premium increases in H.R.1.

Congress should pass these provisions on their own to help hospitals, physicians, and patients and not hold them hostage to a prescription drug bill that privatizes Medicare and provides a mediocre benefit to most seniors.

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

There being no objection, the bill was ordered to be printed in the Record, as follows:

S. 1926

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

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BIPA AND SECRETARY; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Support Our Health Care Providers Act of 2003''.

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

(c) BIPA; SECRETARY.—In this Act:

(1) BIPA.—The term ''BIPA'' means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106–554.

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

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

Sec. 1. Short title; table of contents.

TITLE I—RURAL PROVISIONS

Subtitle A—Provisions Relating to Part A Only

Sec. 101. Equalizing urban and rural standardized payment amounts under the medicare inpatient hospital prospective payment system.
Sec. 102. Enhanced disproportionate share hospital (DSH) treatment for rural hospitals and urban hospitals with fewer than 100 beds.
Sec. 103. Adjustment to the medicare inpatient hospital prospective payment system wage index to revise the labor-related share of such index.
Sec. 104. More frequent update in weights used in hospital market basket.
Sec. 105. Improvements to critical access hospital program.
Sec. 106. Medicare inpatient hospital payment adjustment for low-volume hospitals.
Sec. 107. Treatment of missing cost reporting periods for sole community hospitals.
Sec. 108. Recognition of attending nurse practitioners as attending physicians to serve hospice patients.
Sec. 109. Rural hospice demonstration project.
Sec. 110. Exclusion of certain rural health clinic and federally qualified health center services from the prospective payment system for skilled nursing facilities.
Sec. 110A. Rural community hospital demonstration program.

Subtitle B—Provisions Relating to Part B Only

Sec. 111. 2-year extension of hold harmless provisions for small rural hospitals and sole community hospitals under the prospective payment system for hospital outpatient department services.
Sec. 112. Establishment of floor on work geographic adjustment.
Sec. 113. Medicare incentive payment program improvements for physician scarcity.
Sec. 114. Payment for rural and urban ambulance services.
Sec. 115. Providing appropriate coverage of rural air ambulance services.
Sec. 116. Treatment of certain clinical diagnostic laboratory tests furnished to hospital outpatients in certain rural areas.
Sec. 117. Extension of telemedicine demonstration project.
Sec. 118. Report on demonstration project permitting skilled nursing facilities to be originating telehealth sites; authority to implement.

Subtitle C—Provisions Relating to Parts A and B

Sec. 121. 1-year increase for home health services furnished in a rural area.
Sec. 122. Redistribution of unused resident positions.

Subtitle D—Other Provisions

Sec. 131. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.
Sec. 132. Office of rural health policy improvements.

Sec. 133. MedPac study on rural hospital payment adjustments.
Sec. 134. Frontier extended stay clinic demonstration project.

TITLE II—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

Sec. 201. Revision of acute care hospital payment updates.
Sec. 202. Revision of the indirect medical education (IME) adjustment percentage.
Sec. 203. Recognition of new medical technologies under inpatient hospital prospective payment system.
Sec. 204. Increase in Federal rate for hospitals in Puerto Rico.
Sec. 205. Wage index adjustment reclassification reform.
Sec. 206. Limitation on charges for inpatient hospital contract health services provided to Indians by medicare participating hospitals.
Sec. 207. Clarifications to certain exceptions to medicare limits on physician referrals.
Sec. 208. 1-time appeals process for hospital wage index classification.

Subtitle B—Other Provisions

Sec. 211. Payment for covered skilled nursing facility services.
Sec. 212. Coverage of hospice consultation services.
Sec. 213. Study on portable diagnostic ultrasound services for beneficiaries in skilled nursing facilities.

TITLE III—PROVISIONS RELATING TO PART B

Subtitle A—Provisions Relating to Physicians' Services

Sec. 301. Revision of updates for physicians' services.
Sec. 302. Treatment of physicians' services furnished in Alaska.
Sec. 303. Inclusion of podiatrists, dentists, and optometrists under private contracting authority.
Sec. 304. GAO study on access to physicians' services.
Sec. 305. Collaborative demonstration-based review of physician practice expense geographic adjustment data.
Sec. 306. MedPac report on payment for physicians' services.

Subtitle B—Preventive Services

Sec. 311. Coverage of an initial preventive physical examination.
Sec. 312. Coverage of cardiovascular screening blood tests.
Sec. 313. Coverage of diabetes screening tests.
Sec. 314. Improved payment for certain mammography services.

Subtitle C—Other Provisions

Sec. 321. Hospital outpatient department (HOPD) payment reform.
Sec. 322. Limitation of application of functional equivalence standard.
Sec. 323. Payment for renal dialysis services.
Sec. 324. 2-year moratorium on therapy caps; provisions relating to reports.
Sec. 325. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.
Sec. 326. Payment for services furnished in ambulatory surgical centers.
Sec. 327. Payment for certain shoes and inserts under the fee schedule for orthotics and prosthetics.
Sec. 328. 5-year authorization of reimbursement for all medicare part B services furnished by certain Indian hospitals and clinics.

Subtitle D—Additional Demonstrations, Studies, and Other Provisions

Sec. 341. Demonstration project for coverage of certain prescription drugs and biologicals.
Sec. 342. Extension of coverage of intravenous immune globulin (IVIG) for the treatment of primary immune deficiency diseases in the home.
Sec. 343. MedPac study of coverage of surgical first assisting services of certified registered nurse first assistants.
Sec. 344. MedPac study of payment for cardio-thoracic surgeons.
Sec. 345. Studies relating to vision impairments.
Sec. 346. Medicare health care quality demonstration programs.
Sec. 347. MedPac study on direct access to physical therapy services.
Sec. 348. Demonstration project for consumer-directed chronic outpatient services.
Sec. 349. Medicare care management performance demonstration.
Sec. 350. GAO study and report on the propagation of concierge care.
Sec. 351. Demonstration of coverage of chiropractic services under medicare.

TITLE IV—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

Sec. 401. Demonstration project to clarify the definition of homebound.
Sec. 402. Demonstration project for medical adult day-care services.
Sec. 403. Temporary suspension of oasis requirement for collection of data on non-medicare and non-medicaid patients.
Sec. 404. MedPac study on medicare margins of home health agencies.
Sec. 405. Coverage of religious nonmedical health care institution services furnished in the home.

Subtitle B—Graduate Medical Education

Sec. 411. Exception to initial residency period for geriatric residency or fellowship programs.
Sec. 412. Treatment of volunteer supervision.

Subtitle C—Chronic Care Improvement

Sec. 421. Voluntary chronic care improvement under traditional fee-for-service.
Sec. 422. Medicare advantage quality improvement programs.
Sec. 423. Chronically ill medicare beneficiary research, data, demonstration strategy.

Subtitle D—Other Provisions

Sec. 431. Improvements in national and local coverage determination process to respond to changes in technology.
Sec. 432. Extension of treatment of certain physician pathology services under medicare.
Sec. 433. Payment for pancreatic islet cell investigational transplants for medicare beneficiaries in clinical trials.
Sec. 434. Restoration of medicare trust funds.
Sec. 435. Modifications to Medicare Payment Advisory Commission (MedPac).
Sec. 436. Technical amendments.

TITLE V—ADMINISTRATIVE IMPROVEMENTS, REGULATORY REDUCTION, AND CONTRACTING REFORM

Sec. 500. Administrative improvements within the Centers for Medicare & Medicaid Services (CMS).

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 beneficiary ombudsman.
Sec. 524. Beneficiary outreach demonstration program.
Sec. 525. Inclusion of additional information in notices to beneficiaries about skilled nursing facility benefits.
Sec. 526. Information on medicare-certified skilled nursing facilities in hospital discharge plans.

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 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.
Sec. 540. Revisions to appeals timeframes and amounts.
Sec. 540A. Mediation process for local coverage determinations.

Subtitle E—Miscellaneous Provisions

Sec. 541. Policy development regarding evaluation and management (E & M) documentation guidelines.
Sec. 542. Improvement in oversight of technology and coverage.
Sec. 543. Treatment of hospitals for certain services under medicare secondary payor (MSP) provisions.
Sec. 544. EMTALA improvements.
Sec. 545. Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group.
Sec. 546. Authorizing use of arrangements to provide core hospice services in certain circumstances.
Sec. 547. Application of osha bloodborne pathogens standard to certain hospitals.
Sec. 548. Bipa-related technical amendments and corrections.
Sec. 549. Conforming authority to waive a program exclusion.
Sec. 550. Treatment of certain dental claims.
Sec. 551. Furnishing hospitals with information to compute DSH formula.

Sec. 552. Revisions to reassignment provisions.
Sec. 553. Other provisions.

TITLE VI—MEDICAID AND MISCELLANEOUS PROVISIONS

Subtitle A—Medicaid Provisions

Sec. 601. Medicaid disproportionate share hospital (DSH) payments.
Sec. 602. Clarification of inclusion of inpatient drug prices charged to certain public hospitals in the best price exemptions for the medicaid drug rebate program.
Sec. 603. Extension of moratorium.

Subtitle B—Miscellaneous Provisions

Sec. 611. Federal reimbursement of emergency health services furnished to undocumented aliens.
Sec. 612. Commission on Systemic Interoperability.
Sec. 613. Research on outcomes of health care items and services.
Sec. 614. Health care that works for all Americans: Citizens Health Care Working Group.
Sec. 615. Funding start-up administrative costs for medicare reform.
Sec. 616. Health care infrastructure improvement program.

TITLE I—RURAL PROVISIONS

Subtitle A—Provisions Relating to Part A Only

SEC. 101. EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

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

(1) by striking ''(iv) For discharges'' and inserting ''(iv)(I) Subject to subclause (II), for discharges''; and

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

''(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.''.

(b) CONFORMING AMENDMENTS.—

(1) COMPUTING DRG-SPECIFIC RATES.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking ''IN DIFFERENT AREAS'';

(B) in the matter preceding clause (i), by striking '', each of'';

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2004,'' before ''for hospitals''; and

(ii) in subclause (II), by striking ''and'' after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2004,'' before ''for hospitals''; and

(ii) in subclause (II), by striking the period at the end and inserting ''; and''; and

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

''(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

''(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

''(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.''.

(2) TECHNICAL CONFORMING SUNSET.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter preceding subparagraph (A), by inserting '', for fiscal years before fiscal year 1997,'' before ''a regional adjusted DRG prospective payment rate''; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting '', for fiscal years before fiscal year 1997,'' before ''a regional DRG prospective payment rate for each region,''.

(3) ADDITIONAL TECHNICAL AMENDMENT.—Section 1886(d)(3)(A)(iii) (42 U.S.C. 1395ww(d)(3)(A)(iii)) is amended by striking ''in an other urban area'' and inserting ''in an urban area''.

(c) EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM FOR HOSPITALS IN PUERTO RICO.—

(1) IN GENERAL.—Section 1886(d)(9)(A) (42 U.S.C. 1395ww(d)(9)(A)), as amended by section 204, is amended—

(A) in clause (i), by striking ''and'' after the comma at the end; and

(B) by striking clause (ii) and inserting the following new clause:

''(ii) the applicable Federal percentage (specified in subparagraph (E)) of—

''(I) for discharges beginning in a fiscal year beginning on or after October 1, 1997, and before October 1, 2003, the discharge-weighted average of—

''(aa) the national adjusted DRG prospective payment rate (determined under paragraph (3)(D)) for hospitals located in a large urban area,

''(bb) such rate for hospitals located in other urban areas, and

''(cc) such rate for hospitals located in a rural area,

for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels; and

''(II) for discharges in a fiscal year beginning on or after October 1, 2003, the national DRG prospective payment rate determined under paragraph (3)(D)(iii) for hospitals located in any area for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels.

(2) APPLICATION OF PUERTO RICO STANDARDIZED AMOUNT BASED ON LARGE URBAN AREAS.—The authority of the Secretary referred to in paragraph (1) shall apply with respect to the amendments made by subsection (c) (2) of this section in the same manner as that authority applies with respect to the extension of provisions equalizing urban and rural standardized inpatient hospital payments under subsection (a) of such section 402, except that any reference in subsection (b)(2)(A) of such section 402 is deemed to be a reference to April 1, 2004.

SEC. 102 ENHANCED DISPROPORTIONATE SHARE HOSPITAL (DSH) TREATMENT FOR RURAL HOSPITALS AND URBAN HOSPITALS WITH FEWER THAN 100 BEDS.

(a) DOUBLING THE CAP.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended by adding at the end the following new clause:

''(xiv)(I) In the case of discharges occurring on or after April 1, 2004, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other than subclause (I)) or under clause (viii), (x), (xi), (xii), or (xiii), the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

''(II) Under subclause (I,) the disproportionate share adjustment percentage shall not exceed 12 percent for a hospital that is not classified as a rural referral center under subparagraph (C).''.

(b) CONFORMING AMENDMENTS.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended—

(1) in paragraph (5)(F)—

(A) in each of subclauses (II), (III), (IV), (V), and (VI) of clause (iv), by inserting ''subject to clause (xiv) and'' before ''for discharges occurring'';

(B) in clause (vi), by striking ''The Formula'' and inserting ''Subject to clause (xiv), the formula''; and

As used in this section, the term 'subsection (d) Puerto Rico hospital' means a hospital that is located in Puerto Rico and that would be a subsection (d) hospital (as defined in paragraph (1)(B)) if it were located in one of the 50 States.''.

(2) APPLICATION OF PUERTO RICO STANDARDIZED AMOUNT BASED ON LARGE URBAN AREAS.—Section 1886(d)(9)(C) (42 U.S.C. 1395ww(d)(9)(C)) is amended—

(A) in clause (i)—

(i) by striking ''(i) The Secretary'' and inserting ''(i)(I) For discharges in a fiscal year after fiscal year 1988 and before fiscal year 2004, the Secretary''; and

(ii) by adding at the end the following new subclause:

''(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute an average standardized amount for hospitals located in any area of Puerto Rico that is equal to the average standardized amount computed under subclause (I) for fiscal year 2003 for hospitals in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B) for the fiscal year involved.'';

(B) in clause (ii), by inserting ''(or for fiscal year 2004 and thereafter, the average standardized amount)'' after ''each of the average standardized amounts''; and

(C) in clause (iii)(I), by striking ''for hospitals located in an urban or rural area, respectively''.

(d) IMPLEMENTATION.—

(1) IN GENERAL.—The amendments made by subsections (a), (b), and (c)(1) of this section shall have no effect on the authority of the Secretary, under subsection (b)(2) of section 402 of Public Law 108–89, to delay implementation of the extension of provisions equalizing urban and rural standardized inpatient hospital payments under subsection (a) of such section 402.

(2) APPLICATION OF PUERTO RICO STANDARDIZED AMOUNT BASED ON LARGE URBAN AREAS.—The authority of the Secretary referred to in paragraph (1) shall apply with respect to the amendments made by subsection (c)(2) of this section in the same manner as that authority applies with respect to the extension of provisions equalizing urban and rural standardized inpatient hospital payments under subsection (a) of such section 402, except that any reference in subsection (b)(2)(A) of such section 402 is deemed to be a reference to April 1, 2004.

SEC. 102. ENHANCED DISPROPORTIONATE SHARE HOSPITAL (DSH) TREATMENT FOR RURAL HOSPITALS AND URBAN HOSPITALS WITH FEWER THAN 100 BEDS.

(a) DOUBLING THE CAP.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended by adding at the end the following new clause:

''(xiv)(I) In the case of discharges occurring on or after April 1, 2004, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other than subclause (I)) or under clause

(viii), (x), (xi), (xii), or (xiii), the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

''(II) Under subclause (I), the disproportionate share adjustment percentage shall not exceed 12 percent for a hospital that is not classified as a rural referral center under subparagraph (C).''.

(b) CONFORMING AMENDMENTS.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended—

(1) in paragraph (5)(F)—

(A) in each of subclauses (II), (III), (IV), (V), and (VI) of clause (iv), by inserting ''subject to clause (xiv) and'' before ''for discharges occurring'';

(B) in clause (viii), by striking ''The formula'' and inserting ''Subject to clause (xiv), the formula''; and

(C) in each of clauses (x), (xi), (xii), and (xiii), by striking ''For purposes'' and inserting ''Subject to clause (xiv), for purposes''; and

(2) in paragraph (2)(C)(iv)—

(A) by striking ''or'' before ''the enactment of section 303''; and

(B) by inserting before the period at the end the following: '', or the enactment of section 402(a)(1) of the Medicare Provider Restoration Act of 2003''.

SEC. 103. ADJUSTMENT TO THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM WAGE INDEX TO REVISE THE LABOR-RELATED SHARE OF SUCH INDEX.

(a) ADJUSTMENT.—

(1) IN GENERAL.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is amended—

(A) by striking ''WAGE LEVELS.—The Secretary'' and inserting ''WAGE LEVELS.—

''(i) IN GENERAL.—Except as provided in clause (ii), the Secretary''; and

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

''(ii) ALTERNATIVE PROPORTION TO BE ADJUSTED BEGINNING IN FISCAL YEAR 2005.—For discharges occurring on or after October 1, 2004, the Secretary shall substitute '62 percent' for the proportion described in the first sentence of clause (i), unless the application of this clause would result in lower payments to a hospital than would otherwise be made.''.

(2) WAIVING BUDGET NEUTRALITY.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)), as amended by subsection (a), is amended by adding at the end of clause (i) the following new sentence: ''The Secretary shall apply the previous sentence for any period as if the amendments made by section 103(a)(1) of the Medicare Provider Restoration Act of 2003 had not been enacted.''.

(b) APPLICATION TO PUERTO RICO HOSPITALS.—Section 1886(d)(9)(C)(iv) (42 U.S.C. 1395ww(d)(9)(C)(iv)) is amended—

(1) by inserting ''(I)'' after ''(iv)'';

(2) by striking ''paragraph (3)(E)'' and inserting ''paragraph (3)(E)(i)''; and

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

''(II) For discharges occurring on or after October 1, 2004, the Secretary shall substitute '62 percent' for the proportion described in the first sentence of clause (i), unless the application of this subclause would result in lower payments to a hospital than would otherwise be made.''.

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

(a) MORE FREQUENT UPDATES IN WEIGHTS.—After revising the weights used in the hospital market basket under section 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most current data available, the Secretary shall establish a frequency for revising such weights, including the labor share, in such market basket to reflect the most current data available more frequently than once every 5 years.

(b) INCORPORATION OF EXPLANATION IN RULEMAKING.—The Secretary shall include in the publication of the final rule for payment for inpatient hospital services under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) for fiscal year 2006, an explanation of the reasons for, and options considered, in determining frequency established under subsection (a).

SEC. 105. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL PROGRAM.

(a) INCREASE IN PAYMENT AMOUNTS.—

(1) IN GENERAL.—Sections 1814(l), 1834(g)(1), and 1883(a)(3) (42 U.S.C. 1395f(l), 1395m(g)(1), and 1395tt(a)(3)) are each amended by inserting ''equal to 101 percent of'' before ''the reasonable costs''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to payments for services furnished during cost reporting periods beginning on or after January 1, 2004.

(b) COVERAGE OF COSTS FOR CERTAIN EMERGENCY ROOM ON-CALL PROVIDERS.—

(1) IN GENERAL.—Section 1834(g)(5) (42 U.S.C. 1395m(g)(5)) is amended—

(A) in the heading—

(i) by inserting ''CERTAIN'' before ''EMERGENCY''; and

(ii) by striking ''PHYSICIANS'' and inserting ''PROVIDERS'';

(B) by striking ''emergency room physicians who are on-call (as defined by the Secretary)'' and inserting ''physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on-call (as defined by the Secretary) to provide emergency services''; and

(C) by striking ''physicians' services'' and inserting ''services covered under this title''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply with respect to costs incurred for services furnished on or after January 1, 2005.

(c) AUTHORIZATION OF PERIODIC INTERIM PAYMENT (PIP).—

(1) IN GENERAL.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(A) in the matter before subparagraph (A), by inserting '', in the cases described in subparagraphs (A) through (D)'' after ''1986'';

(B) by striking ''and'' at the end of subparagraph (C);

(C) by adding ''and'' at the end of subparagraph (D); and

(D) by inserting after subparagraph (D) the following new subparagraph:

''(E) inpatient critical access hospital services;''.

(2) DEVELOPMENT OF ALTERNATIVE TIMING METHODS OF PERIODIC INTERIM PAYMENTS.—With respect to periodic interim payments to critical access hospitals for inpatient critical access hospital services under section 1815(e)(2)(E) of the Social Security Act, as added by paragraph (1), the Secretary shall develop alternative methods for the timing of such payments.

(3) AUTHORIZATION OF PIP.—The amendments made by paragraph (1) shall apply to payments made on or after July 1, 2004.

(d) CONDITION FOR APPLICATION OF SPECIAL PROFESSIONAL SERVICE PAYMENT ADJUSTMENT.—

(1) IN GENERAL.—Section 1834(g)(2) (42 U.S.C. 1395m(g)(2)) is amended by adding after and below subparagraph (B) the following:

''The Secretary may not require, as a condition for applying subparagraph (B) with respect to a critical access hospital, that each physician or other practitioner providing professional services in the hospital must assign billing rights with respect to such services, except that such subparagraph shall not apply to those physicians and practitioners who have not assigned such billing rights.''.

(2) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after July 1, 2004.

(B) RULE OF APPLICATION.—In the case of a critical access hospital that made an election under section 1834(g)(2) of the Social Security Act (42 U.S.C. 1395m(g)(2)) before November 1, 2003, the amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after July 1, 2001.

(e) REVISION OF BED LIMITATION FOR HOSPITALS.—

(1) IN GENERAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395i–4(c)(2)(B)(iii)) is amended by striking ''15 (or, in the case of a facility under an agreement described in subsection (f), 25)'' and inserting ''25''.

(2) CONFORMING AMENDMENT.—Section 1820(f) (42 U.S.C. 1395i–4(f)) is amended by striking ''and the number of beds used at any time for acute care inpatient services does not exceed 15 beds''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to designations made before, on, or after January 1, 2004, but any election made pursuant to regulations promulgated to carry out such amendments shall only apply prospectively.

(f) PROVISIONS RELATING TO FLEX GRANTS.—

(1) ADDITIONAL 4-YEAR PERIOD OF FUNDING.—Section 1820(j) (42 U.S.C. 1395i–4(j)) is amended by inserting before the period at the end the following: '', and for making grants to all States under paragraphs (1) and (2) of subsection (g), $35,000,000 in each of fiscal years 2005 through 2008''.

(2) ADDITIONAL REQUIREMENTS AND ADMINISTRATION.—Section 1820(g) (42 U.S.C. 1395i–4(g)) is amended by adding at the end the following new paragraphs:

''(4) ADDITIONAL REQUIREMENTS WITH RESPECT TO FLEX GRANTS.—With respect to grants awarded under paragraph (1) or (2) from funds appropriated for fiscal year 2005 and subsequent fiscal years—

''(A) CONSULTATION WITH THE STATE HOSPITAL ASSOCIATION AND RURAL HOSPITALS ON THE MOST APPROPRIATE WAYS TO USE GRANTS.—A State shall consult with the hospital association of such State and rural hospitals located in such State on the most appropriate ways to use the funds under such grant.

''(B) LIMITATION ON USE OF GRANT FUNDS FOR ADMINISTRATIVE EXPENSES.—A State may not expend more than the lesser of—

''(i) 15 percent of the amount of the grant for administrative expenses; or

''(ii) the State's federally negotiated indirect rate for administering the grant.

''(5) USE OF FUNDS FOR FEDERAL ADMINISTRATIVE EXPENSES.—Of the total amount appropriated for grants under paragraphs (1) and (2) for a fiscal year (beginning with fiscal year 2005), up to 5 percent of such amount shall be available to the Health Resources and Services Administration for purposes of administering such grants.''.

(g) AUTHORITY TO ESTABLISH PSYCHIATRIC AND REHABILITATION DISTINCT PART UNITS.—

(1) IN GENERAL.—Section 1820(c)(2) (42 U.S.C. 1395i–4(c)(2)) is amended by adding at the end the following:

''(E) AUTHORITY TO ESTABLISH PSYCHIATRIC AND REHABILITATION DISTINCT PART UNITS.—

''(i) IN GENERAL.—Subject to the succeeding provisions of this subparagraph, a critical access hospital may establish—

''(I) a psychiatric unit of the hospital that is a distinct part of the hospital; and

''(II) a rehabilitation unit of the hospital that is a distinct part of the hospital,

if the distinct part meets the requirements (including conditions of participation) that would otherwise apply to the distinct part if the distinct part were established by a subsection (d) hospital in accordance with the matter following clause (v) of section 1886(d)(1)(B), including any regulations adopted by the Secretary under such section.

''(ii) LIMITATION ON NUMBER OF BEDS.—The total number of beds that may be established under clause (i) for a distinct part unit may not exceed 10.

''(iii) EXCLUSION OF BEDS FROM BED COUNT.—In determining the number of beds of a critical access hospital for purposes of applying the bed limitations referred to in subparagraph (B)(iii) and subsection (f), the Secretary shall not take into account any bed established under clause (i).

''(iv) EFFECT OF FAILURE TO MEET REQUIREMENTS.—If a psychiatric or rehabilitation unit established under clause (i) does not meet the requirements described in such clause with respect to a cost reporting period, no payment may be made under this title to the hospital for services furnished in such unit during such period. Payment to the hospital for services furnished in the unit may resume only after the hospital has demonstrated to the Secretary that the unit meets such requirements.''.

(2) PAYMENT ON A PROSPECTIVE PAYMENT BASIS.—Section 1814(l) (42 U.S.C. 1395f(l)) is amended—

(A) by striking ''(l) The amount'' and inserting ''(l)(1) Except as provided in paragraph (2), the amount''; and

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

''(2) In the case of a distinct part psychiatric or rehabilitation unit of a critical access hospital described in section 1820(c)(2)(E), the amount of payment for inpatient critical access hospital services of such unit shall be equal to the amount of the payment that would otherwise be made if such services were inpatient hospital services of a distinct part psychiatric or rehabilitation unit, respectively, described in the matter following clause (v) of section 1886(d)(1)(B).''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to cost reporting periods beginning on or after October 1, 2004.

(h) WAIVER AUTHORITY.—

(1) IN GENERAL.—Section 1820(c)(2)(B)(i)(II) (42 U.S.C. 1395i–4(c)(2)(B)(i)(II)) is amended by inserting ''before January 1, 2006,'' after ''is certified''.

(2) GRANDFATHERING WAIVER AUTHORITY FOR CERTAIN FACILITIES.—Section 1820(h) (42 U.S.C. 1395i–4(h)) is amended—

(A) in the heading preceding paragraph (1), by striking ''OF CERTAIN FACILITIES'' and inserting ''PROVISIONS''; and

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

''(3) STATE AUTHORITY TO WAIVE 35-MILE RULE.—In the case of a facility that was designated as a critical access hospital before January 1, 2006, and was certified by the State as being a necessary provider of health care services to residents in the area under subsection (c)(2)(B)(i)(II), as in effect before such date, the authority under such subsection with respect to any redesignation of such facility shall continue to apply notwithstanding the amendment made by section 105(h)(1) of the Medicare Provider Restoration Act of 2003.''.

SEC. 106. MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

(a) IN GENERAL.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following new paragraph:

''(12) PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.—

''(A) IN GENERAL.—In addition to any payments calculated under this section for a subsection (d) hospital, for discharges occurring during a fiscal year (beginning with fiscal year 2005), the Secretary shall provide for an additional payment amount to each low-volume hospital (as defined in subparagraph (C)(i)) for discharges occurring during that fiscal year that is equal to the applicable percentage increase (determined under subparagraph (B) for the hospital involved) in the amount paid to such hospital under this section for such discharges (determined without regard to this paragraph).

''(B) APPLICABLE PERCENTAGE INCREASE.—The Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) as follows:

''(i) The Secretary shall determine the empirical relationship for subsection (d) hospitals between the standardized cost-per-case for such hospitals and the total number of discharges of such hospitals and the amount of the additional incremental costs (if any) that are associated with such number of discharges.

''(ii) The applicable percentage increase shall be determined based upon such relationship in a manner that reflects, based upon the number of such discharges for a subsection (d) hospital, such additional incremental costs.

''(iii) In no case shall the applicable percentage increase exceed 25 percent.

''(C) DEFINITIONS.—

''(i) LOW-VOLUME HOSPITAL.—For purposes of this paragraph, the term 'low-volume hospital' means, for a fiscal year, a subsection (d) hospital (as defined in paragraph (1)(B)) that the Secretary determines is located more than 25 road miles from another subsection (d) hospital and has less than 800 discharges during the fiscal year.

''(ii) DISCHARGE.—For purposes of subparagraph (B) and clause (i), the term 'discharge' means an inpatient acute care discharge of an individual regardless of whether the individual is entitled to benefits under part A.''.

(b) JUDICIAL REVIEW.—Section 1886(d)(7)(A) (42 U.S.C. 1395ww(d)(7)(A)) is amended by inserting after ''to subsection (e)(1)'' the following: ''or the determination of the applicable percentage increase under paragraph (12)(A)(ii)''.

SEC. 107. TREATMENT OF MISSING COST REPORTING PERIODS FOR SOLE COMMUNITY HOSPITALS.

(a) IN GENERAL.—Section 1886(b)(3)(I) (42 U.S.C. 1395ww(b)(3)(I)) is amended by adding at the end the following new clause:

''(iii) In no case shall a hospital be denied treatment as a sole community hospital or payment (on the basis of a target rate as such as a hospital) because data are unavailable for any cost reporting period due to changes in ownership, changes in fiscal intermediaries, or other extraordinary circumstances, so long as data for at least one applicable base cost reporting period is available.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to cost reporting periods beginning on or after January 1, 2004.

SEC. 108. RECOGNITION OF ATTENDING NURSE PRACTITIONERS AS ATTENDING PHYSICIANS TO SERVE HOSPICE PATIENTS.

(a) IN GENERAL.—Section 1861(dd)(3)(B) (42 U.S.C. 1395x(dd)(3)(B)) is amended by inserting ''or nurse practitioner (as defined in subsection (aa)(5))'' after ''the physician (as defined in subsection (r)(1))''.

(b) CLARIFICATION OF HOSPICE ROLE OF NURSE PRACTITIONERS.—Section 1814(a)(7)(A)(i)(I) (42 U.S.C. 1395f(a)(7)(A) (i)(I)) is amended by inserting ''(which for purposes of this subparagraph does not include a nurse practitioner)'' after ''attending physician (as defined in section 1861(dd)(3)(B))''.

SEC. 109. RURAL HOSPICE DEMONSTRATION PROJECT.

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

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

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

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

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

The Secretary may require the program to comply with such additional quality assurance standards for its provision of services in its facility as the Secretary deems appropriate.

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

SEC. 110. EXCLUSION OF CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES FROM THE PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITIES.

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

(1) in clause (i)(II), by striking ''clauses (ii) and (iii)'' and inserting ''clauses (ii), (iii), and (iv)''; and

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

''(iv) EXCLUSION OF CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—Services described in this clause are—

''(I) rural health clinic services (as defined in paragraph (1) of section 1861(aa)); and

''(II) Federally qualified health center services (as defined in paragraph (3) of such section);

that would be described in clause (ii) if such services were furnished by an individual not affiliated with a rural health clinic or a Federally qualified health center.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished on or after January 1, 2005.

SEC. 110A. RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT OF RURAL COMMUNITY HOSPITAL (RCH) DEMONSTRATION PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program to test the feasibility and advisability of the establishment of rural community hospitals (as defined in subsection (f)(1)) to furnish covered inpatient hospital services (as defined in subsection (f)(2)) to medicare beneficiaries.

(2) DEMONSTRATION AREAS.—The program shall be conducted in rural areas selected by

the Secretary in States with low population densities, as determined by the Secretary.

(3) APPLICATION.—Each rural community hospital that is located in a demonstration area selected under paragraph (2) that desires to participate in the demonstration program under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(4) SELECTION OF HOSPITALS.—The Secretary shall select from among rural community hospitals submitting applications under paragraph (3) not more than 15 of such hospitals to participate in the demonstration program under this section.

(5) DURATION.—The Secretary shall conduct the demonstration program under this section for a 5-year period.

(6) IMPLEMENTATION.—The Secretary shall implement the demonstration program not later than January 1, 2005, but may not implement the program before October 1, 2004.

(b) PAYMENT.—

(1) IN GENERAL.—The amount of payment under the demonstration program for covered inpatient hospital services furnished in a rural community hospital, other than such services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is—

(A) for discharges occurring in the first cost reporting period beginning on or after the implementation of the demonstration program, the reasonable costs of providing such services; and

(B) for discharges occurring in a subsequent cost reporting period under the demonstration program, the lesser of—

(i) the reasonable costs of providing such services in the cost reporting period involved; or

(ii) the target amount (as defined in paragraph (2), applicable to the cost reporting period involved.

(2) TARGET AMOUNT.—For purposes of paragraph (1)(B)(ii), the term ''target amount'' means, with respect to a rural community hospital for a particular 12-month cost reporting period—

(A) in the case of the second such reporting period for which this subsection is in effect, the reasonable costs of providing such covered inpatient hospital services as determined under paragraph (1)(A), and

(B) in the case of a later reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase (under clause (i) of section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B))) in the market basket percentage increase (as defined in clause (iii) of such section) for that particular cost reporting period.

(c) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(d) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(e) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(f) DEFINITIONS.—In this section:

(1) RURAL COMMUNITY HOSPITAL DEFINED.—

(A) IN GENERAL.—The term ''rural community hospital'' means a hospital (as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e))) that—

(i) is located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) or treated as being so located pursuant to section 1886(d)(8)(E) of such Act (42 U.S.C. 1395ww(d)(8)(E));

(ii) subject to paragraph (2), has fewer than 51 acute care inpatient beds, as reported in its most recent cost report;

(iii) makes available 24-hour emergency care services; and

(iv) is not eligible for designation, or has not been designated, as a critical access hospital under section 1820.

(B) TREATMENT OF PSYCHIATRIC AND REHABILITATION UNITS.—For purposes of paragraph (1)(B), beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital shall not be counted.

(2) COVERED INPATIENT HOSPITAL SERVICES.—The term ''covered inpatient hospital services'' means inpatient hospital services, and includes extended care services furnished under an agreement under section 1883 of the Social Security Act (42 U.S.C. 1395tt).

Subtitle B—Provisions Relating to Part B Only

SEC. 111. 2-YEAR EXTENSION OF HOLD HARMLESS PROVISIONS FOR SMALL RURAL HOSPITALS AND SOLE COMMUNITY HOSPITALS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) HOLD HARMLESS PROVISIONS.—

(1) IN GENERAL.—Section 1833(t)(7)(D)(i) (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(A) in the heading, by striking ''SMALL'' and inserting ''CERTAIN'';

(B) by inserting ''or a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) located in a rural area'' after ''100 beds''; and

(C) by striking ''2004'' and inserting ''2006''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1)(B) shall apply with respect to cost reporting periods beginning on and after January 1, 2004.

(b) STUDY; AUTHORIZATION OF ADJUSTMENT.—Section 1833(t) (42 U.S.C. 1395l(t)) is amended—

(1) by redesignating paragraph (13) as paragraph (16); and

(2) by inserting after paragraph (12) the following new paragraph:

''(13) AUTHORIZATION OF ADJUSTMENT FOR RURAL HOSPITALS.—

''(A) STUDY.—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals located in rural areas by ambulatory payment classification groups (APCs) exceed those costs incurred by hospitals located in urban areas.

''(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals located in rural areas exceed those costs incurred by hospitals located in urban areas, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs by January 1, 2006.''.

SEC. 112. ESTABLISHMENT OF FLOOR ON WORK GEOGRAPHIC ADJUSTMENT.

Section 1848(e)(1) (42 U.S.C. 1395w–4(e)(1)) is amended—

(1) in subparagraph (A), by striking ''subparagraphs (B) and (C)'' and inserting ''subparagraphs (B), (C), and (E)''; and

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

''(E) FLOOR AT 1.0 ON WORK GEOGRAPHIC INDEX.—After calculating the work geographic index in subparagraph (A)(iii), for purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2007, the Secretary shall increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00.''.

SEC. 113. MEDICARE INCENTIVE PAYMENT PROGRAM IMPROVEMENTS FOR PHYSICIAN SCARCITY.

(a) ADDITIONAL INCENTIVE PAYMENT FOR CERTAIN PHYSICIAN SCARCITY AREAS.—Section 1833 (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

''(u) INCENTIVE PAYMENTS FOR PHYSICIAN SCARCITY AREAS.—

''(1) IN GENERAL.—In the case of physicians' services furnished on or after January 1, 2005, and before January 1, 2008—

''(A) by a primary care physician in a primary care scarcity county (identified under paragraph (4)); or

''(B) by a physician who is not a primary care physician in a specialist care scarcity county (as so identified),

in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid an amount equal to 5 percent of the payment amount for the service under this part.

''(2) DETERMINATION OF RATIOS OF PHYSICIANS TO MEDICARE BENEFICIARIES IN AREA.—Based upon available data, the Secretary shall establish for each county or equivalent area in the United States, the following:

''(A) NUMBER OF PHYSICIANS PRACTICING IN THE AREA.—The number of physicians who furnish physicians' services in the active practice of medicine or osteopathy in that county or area, other than physicians whose practice is exclusively for the Federal Government, physicians who are retired, or physicians who only provide administrative services. Of such number, the number of such physicians who are—

''(i) primary care physicians; or

''(ii) physicians who are not primary care physicians.

''(B) NUMBER OF MEDICARE BENEFICIARIES RESIDING IN THE AREA.—The number of individuals who are residing in the county and are entitled to benefits under part A or enrolled under this part, or both (in this subsection referred to as 'individuals').

''(C) DETERMINATION OF RATIOS.—

''(i) PRIMARY CARE RATIO.—The ratio (in this paragraph referred to as the 'primary care ratio') of the number of primary care physicians (determined under subparagraph (A)(i)), to the number of individuals determined under subparagraph (B).

''(ii) SPECIALIST CARE RATIO.—The ratio (in this paragraph referred to as the 'specialist care ratio') of the number of other physicians (determined under subparagraph (A)(ii)), to the number of individuals determined under subparagraph (B).

''(3) RANKING OF COUNTIES.—The Secretary shall rank each such county or area based separately on its primary care ratio and its specialist care ratio.

''(4) IDENTIFICATION OF COUNTIES.—

''(A) IN GENERAL.—The Secretary shall identify—

''(i) those counties and areas (in this paragraph referred to as 'primary care scarcity counties') with the lowest primary care ratios that represent, if each such county or area were weighted by the number of individuals determined under paragraph (2)(B), an

aggregate total of 20 percent of the total of the individuals determined under such paragraph; and

''(ii) those counties and areas (in this subsection referred to as 'specialist care scarcity counties') with the lowest specialist care ratios that represent, if each such county or area were weighted by the number of individuals determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the individuals determined under such paragraph.

''(B) PERIODIC REVISIONS.—The Secretary shall periodically revise the counties or areas identified in subparagraph (A) (but not less often than once every three years) unless the Secretary determines that there is no new data available on the number of physicians practicing in the county or area or the number of individuals residing in the county or area, as identified in paragraph (2).

''(C) IDENTIFICATION OF COUNTIES WHERE SERVICE IS FURNISHED.—For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP Code is in a scarcity county identified in subparagraph (A) or revised in subparagraph (B).

''(D) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting—

''(i) the identification of a county or area;

''(ii) the assignment of a specialty of any physician under this paragraph;

''(iii) the assignment of a physician to a county under paragraph (2); or

''(iv) the assignment of a postal ZIP Code to a county or other area under this subsection.

''(5) RURAL CENSUS TRACTS.—To the extent feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)), as an equivalent area for purposes of qualifying as a primary care scarcity county or specialist care scarcity county under this subsection.

''(6) PHYSICIAN DEFINED.—For purposes of this paragraph, the term 'physician' means a physician described in section 1861(r)(1) and the term 'primary care physician' means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

''(7) PUBLICATION OF LIST OF COUNTIES; POSTING ON WEBSITE.—With respect to a year for which a county or area is identified or revised under paragraph (4), the Secretary shall identify such counties or areas as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the applicable year. The Secretary shall post the list of counties identified or revised under paragraph (4) on the Internet website of the Centers for Medicare & Medicaid Services.''.

(b) IMPROVEMENT TO MEDICARE INCENTIVE PAYMENT PROGRAM.—

(1) IN GENERAL.—Section 1833(m) (42 U.S.C. 13951(m)) is amended—

(A) by inserting ''(1)'' after ''(m)'';

(B) in paragraph (1), as designated by subparagraph (A)—

(i) by inserting ''in a year'' after ''In the case of physicians' services furnished''; and

(ii) by inserting ''as identified by the Secretary prior to the beginning of such year'' after ''as a health professional shortage area''; and

(C) by adding at the end the following new paragraphs:

''(2) For each health professional shortage area identified in paragraph (1) that consists of an entire county, the Secretary shall provide for the additional payment under paragraph (1) without any requirement on the physician to identify the health professional shortage area involved. The Secretary may implement the previous sentence using the method specified in subsection (u)(4)(C).

''(3) The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the health professional shortage areas identified in paragraph (1) that consist of a partial county to facilitate the additional payment under paragraph (1) in such areas.

''(4) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, respecting—

''(A) the identification of a county or area;

''(B) the assignment of a specialty of any physician under this paragraph;

''(C) the assignment of a physician to a county under this subsection; or

''(D) the assignment of a postal zip code to a county or other area under this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to physicians' services furnished on or after January 1, 2005.

(c) GAO STUDY OF GEOGRAPHIC DIFFERENCES IN PAYMENTS FOR PHYSICIANS' SERVICES.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study of differences in payment amounts under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians' services in different geographic areas. Such study shall include—

(A) an assessment of the validity of the geographic adjustment factors used for each component of the fee schedule;

(B) an evaluation of the measures used for such adjustment, including the frequency of revisions;

(C) an evaluation of the methods used to determine professional liability insurance costs used in computing the malpractice component, including a review of increases in professional liability insurance premiums and variation in such increases by State and physician specialty and methods used to update the geographic cost of practice index and relative weights for the malpractice component; and

(D) an evaluation of the effect of the adjustment to the physician work geographic index under section 1848(e)(1)(E) of the Social Security Act, as added by section 112, on physician location and retention in areas affected by such adjustment, taking into account—

(i) differences in recruitment costs and retention rates for physicians, including specialists, between large urban areas and other areas; and

(ii) the mobility of physicians, including specialists, over the last decade.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include recommendations regarding the use of more current data in computing geographic cost of practice indices as well as the use of data directly representative of physicians' costs (rather than proxy measures of such costs).

SEC. 114. PAYMENT FOR RURAL AND URBAN AMBULANCE SERVICES.

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

(1) in paragraph (2)(E), by inserting ''consistent with paragraph (11)'' after ''in an efficient and fair manner''; and

(2) by redesignating paragraph (8), as added by section 221(a) of BIPA (114 Stat. 2763A–486), as paragraph (9); and

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

''(10) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—In carrying out the phase-in under paragraph (2)(E) for each level of ground service furnished in a year, the portion of the payment amount that is based on the fee schedule shall be the greater of the amount determined under such fee schedule (without regard to this paragraph) or the following blended rate of the fee schedule under paragraph (1) and of a regional fee schedule for the region involved:

''(A) For 2004 (for services furnished on or after July 1, 2004), the blended rate shall be based 20 percent on the fee schedule under paragraph (1) and 80 percent on the regional fee schedule.

''(B) For 2005, the blended rate shall be based 40 percent on the fee schedule under paragraph (1) and 60 percent on the regional fee schedule.

''(C) For 2006, the blended rate shall be based 60 percent on the fee schedule under paragraph (1) and 40 percent on the regional fee schedule.

''(D) For 2007, 2008, and 2009, the blended rate shall be based 80 percent on the fee schedule under paragraph (1) and 20 percent on the regional fee schedule.

''(E) For 2010 and each succeeding year, the blended rate shall be based 100 percent on the fee schedule under paragraph (1).

For purposes of this paragraph, the Secretary shall establish a regional fee schedule for each of the nine census divisions (referred to in section 1886(d)(2)) using the methodology (used in establishing the fee schedule under paragraph (1)) to calculate a regional conversion factor and a regional mileage payment rate and using the same payment adjustments and the same relative value units as used in the fee schedule under such paragraph.''.

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

''(11) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—In the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2009, regardless of where the transportation originates, the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile rate otherwise established shall be increased by ¼ of the payment per mile otherwise applicable to miles in excess of 50 miles in such trip.''.

(c) IMPROVEMENT IN PAYMENTS TO RETAIN EMERGENCY CAPACITY FOR AMBULANCE SERVICES IN RURAL AREAS.—

(1) IN GENERAL.—Section 1834(l) (42 U.S.C. 1395m(l)), as amended by subsections (a) and (b), is amended by adding the end the following new paragraph:

''(12) ASSISTANCE FOR RURAL PROVIDERS FURNISHING SERVICES IN LOW POPULATION DENSITY AREAS.—

''(A) IN GENERAL.—In the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2010, for which the transportation originates in a qualified rural area (identified under subparagraph (B)(iii)), the Secretary shall provide for a percent increase in the base rate of the fee schedule for a trip established under this subsection. In establishing such percent increase, the Secretary shall estimate the

average cost per trip for such services (not taking into account mileage) in the lowest quartile as compared to the average cost per trip for such services (not taking into account mileage) in the highest quartile of all rural county populations.

''(B) IDENTIFICATION OF QUALIFIED RURAL AREAS.—

''(i) DETERMINATION OF POPULATION DENSITY IN AREA.—Based upon data from the United States decennial census for the year 2000, the Secretary shall determine, for each rural area, the population density for that area.

''(ii) RANKING OF AREAS.—The Secretary shall rank each such area based on such population density.

''(iii) IDENTIFICATION OF QUALIFIED RURAL AREAS.—The Secretary shall identify those areas (in subparagraph (A) referred to as 'qualified rural areas') with the lowest population densities that represent, if each such area were weighted by the population of such area (as used in computing such population densities), an aggregate total of 25 percent of the total of the population of all such areas.

''(iv) RURAL AREA.—For purposes of this paragraph, the term 'rural area' has the meaning given such term in section 1886(d)(2)(D). If feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725) as a rural area for purposes of this paragraph.

''(v) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of an area under this subparagraph.''.

(2) USE OF DATA.—In order to promptly implement section 1834(l)(12) of the Social Security Act, as added by paragraph (1), the Secretary may use data furnished by the Comptroller General of the United States.

(d) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.—Section 1834(l) (42 U.S.C. 1395m(l)), as amended by subsections (a), (b), and (c), is amended by adding at the end the following new paragraph:

''(13) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.—

''(A) IN GENERAL.—After computing the rates with respect to ground ambulance services under the other applicable provisions of this subsection, in the case of such services furnished on or after July 1, 2004, and before January 1, 2007, for which the transportation originates in—

''(i) a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section shall provide that the rate for the service otherwise established, after the application of any increase under paragraphs (11) and (12), shall be increased by 2 percent; and

''(ii) an area not described in clause (i), the fee schedule established under this subsection shall provide that the rate for the service otherwise established, after the application of any increase under paragraph (11), shall be increased by 1 percent.

''(B) APPLICATION OF INCREASED PAYMENTS AFTER 2006.—The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished after the period specified in such subparagraph.''.

(e) IMPLEMENTATION.—The Secretary may implement the amendments made by this section, and revise the conversion factor applicable under section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)) for purposes of implementing such amendments, on an interim final basis, or by program instruction.

(f) GAO REPORT ON COSTS AND ACCESS.—Not later than December 31, 2005, the Comptroller General of the United States shall submit to Congress an initial report on how costs differ among the types of ambulance providers and on access, supply, and quality of ambulance services in those regions and States that have a reduction in payment under the medicare ambulance fee schedule (under section 1834(l) of the Social Security Act, as amended by this Act). Not later than December 31, 2007, the Comptroller General shall submit to Congress a final report on such access and supply.

(g) TECHNICAL AMENDMENTS.—(1) Section 221(c) of BIPA (114 Stat. 2763A–487) is amended by striking ''subsection (b)(2)'' and inserting ''subsection (b)(3)''.

(2) Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by moving subparagraph (U) 4 ems to the left.

SEC. 115. PROVIDING APPROPRIATE COVERAGE OF RURAL AIR AMBULANCE SERVICES.

(a) COVERAGE.—Section 1834(l) (42 U.S.C. 1395m(l)), as amended by subsections (a), (b), (c), and (d) of section 114, is amended by adding at the end the following new paragraph:

''(14) PROVIDING APPROPRIATE COVERAGE OF RURAL AIR AMBULANCE SERVICES.—

''(A) IN GENERAL.—The regulations described in section 1861(s)(7) shall provide, to the extent that any ambulance services (whether ground or air) may be covered under such section, that a rural air ambulance service (as defined in subparagraph (C)) is reimbursed under this subsection at the air ambulance rate if the air ambulance service—

''(i) is reasonable and necessary based on the health condition of the individual being transported at or immediately prior to the time of the transport; and

''(ii) complies with equipment and crew requirements established by the Secretary.

''(B) SATISFACTION OF REQUIREMENT OF MEDICALLY NECESSARY.—The requirement of subparagraph (A)(i) is deemed to be met for a rural air ambulance service if—

''(i) subject to subparagraph (D), such service is requested by a physician or other qualified medical personnel (as specified by the Secretary) who reasonably determines or certifies that the individual's condition is such that the time needed to transport the individual by land or the instability of transportation by land poses a threat to the individual's survival or seriously endangers the individual's health; or

''(ii) such service is furnished pursuant to a protocol that is established by a State or regional emergency medical service (EMS) agency and recognized or approved by the Secretary under which the use of an air ambulance is recommended, if such agency does not have an ownership interest in the entity furnishing such service.

''(C) RURAL AIR AMBULANCE SERVICE DEFINED.—For purposes of this paragraph, the term 'rural air ambulance service' means fixed wing and rotary wing air ambulance service in which the point of pick up of the individual occurs in a rural area (as defined in section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

''(D) LIMITATION.—

''(i) IN GENERAL.—Subparagraph (B)(i) shall not apply if there is a financial or employment relationship between the person requesting the rural air ambulance service and the entity furnishing the ambulance service, or an entity under common ownership with the entity furnishing the air ambulance service, or a financial relationship between an immediate family member of such requester and such an entity.

''(ii) EXCEPTION.—Where a hospital and the entity furnishing rural air ambulance services are under common ownership, clause (i) shall not apply to remuneration (through employment or other relationship) by the hospital of the requester or immediate family member if the remuneration is for provider-based physician services furnished in a hospital (as described in section 1887) which are reimbursed under part A and the amount of the remuneration is unrelated directly or indirectly to the provision of rural air ambulance services.''.

(b) CONFORMING AMENDMENT.—Section 1861(s)(7) (42 U.S.C. 1395x(s)(7)) is amended by inserting '', subject to section 1834(l)(14),'' after ''but''.

(c) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 2005.

SEC. 116. TREATMENT OF CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL OUTPATIENTS IN CERTAIN RURAL AREAS.

(a) IN GENERAL.—Notwithstanding subsections (a), (b), and (h) of section 1833 of the Social Security Act (42 U.S.C. 1395l) and section 1834(d)(1) of such Act (42 U.S.C. 1395m(d)(1)), in the case of a clinical diagnostic laboratory test covered under part B of title XVIII of such Act that is furnished during a cost reporting period described in subsection (b) by a hospital with fewer than 50 beds that is located in a qualified rural area (identified under paragraph (12)(B)(iii) of section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)), as added by section 114(c)) as part of outpatient services of the hospital, the amount of payment for such test shall be 100 percent of the reasonable costs of the hospital in furnishing such test.

(b) APPLICATION.—A cost reporting period described in this subsection is a cost reporting period beginning during the 2-year period beginning on July 1, 2004.

(c) PROVISION AS PART OF OUTPATIENT HOSPITAL SERVICES.—For purposes of subsection (a), in determining whether clinical diagnostic laboratory services are furnished as part of outpatient services of a hospital, the Secretary shall apply the same rules that are used to determine whether clinical diagnostic laboratory services are furnished as an outpatient critical access hospital service under section 1834(g)(4) of the Social Security Act (42 U.S.C. 1395m(g)(4)).

SEC. 117. EXTENSION OF TELEMEDICINE DEMONSTRATION PROJECT.

Section 4207 of the Balanced Budget Act of 1997 (Public Law 105–33) is amended—

(1) in subsection (a)(4), by striking ''4-year'' and inserting ''8-year''; and

(2) in subsection (d)(3), by striking ''$30,000,000'' and inserting ''$60,000,000''.

SEC. 118. REPORT ON DEMONSTRATION PROJECT PERMITTING SKILLED NURSING FACILITIES TO BE ORIGINATING TELEHEALTH SITES; AUTHORITY TO IMPLEMENT.

(a) EVALUATION.—The Secretary, acting through the Administrator of the Health Resources and Services Administration in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall evaluate demonstration projects conducted by the Secretary under which skilled nursing facilities (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)) are treated as originating sites for telehealth services.

(b) REPORT.—Not later than January 1, 2005, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a). Such report shall include recommendations on mechanisms to ensure that permitting a skilled nursing facility to

serve as an originating site for the use of telehealth services or any other service delivered via a telecommunications system does not serve as a substitute for in-person visits furnished by a physician, or for in-person visits furnished by a physician assistant, nurse practitioner or clinical nurse specialist, as is otherwise required by the Secretary.

(c) AUTHORITY TO EXPAND ORIGINATING TELEHEALTH SITES TO INCLUDE SKILLED NURSING FACILITIES.—Insofar as the Secretary concludes in the report required under subsection (b) that is advisable to permit a skilled nursing facility to be an originating site for telehealth services under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), and that the Secretary can establish the mechanisms to ensure such permission does not serve as a substitute for in-person visits furnished by a physician, or for in-person visits furnished by a physician assistant, nurse practitioner or clinical nurse specialist, the Secretary may deem a skilled nursing facility to be an originating site under paragraph (4)(C)(ii) of such section beginning on January 1, 2006.

Subtitle C—Provisions Relating to Parts A and B

SEC. 121. 1-YEAR INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) IN GENERAL.—With respect to episodes and visits ending on or after April 1, 2004, and before April 1, 2005, in the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))), the Secretary shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 5 percent.

(b) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a).

(c) NO EFFECT ON SUBSEQUENT PERIODS.—The payment increase provided under subsection (a) for a period under such subsection—

(1) shall not apply to episodes and visits ending after such period; and

(2) shall not be taken into account in calculating the payment amounts applicable for episodes and visits occurring after such period.

SEC. 122. REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.

(a) IN GENERAL.—Section 1886(h) (42 U.S.C. 1395ww(h)(4)) is amended—

(1) in paragraph (4)(F)(i), by inserting ''subject to paragraph (7),'' after ''October 1, 1997,'';

(2) in paragraph (4)(H)(i), by inserting ''and subject to paragraph (7),'' after ''subparagraphs (F) and (G)''; and

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

''(7) REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

''(A) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.—

''(i) PROGRAMS SUBJECT TO REDUCTION.—

''(I) IN GENERAL.—Except as provided in subclause (II), if a hospital's reference resident level (specified in clause (ii)) is less than the otherwise applicable resident limit (as defined in subparagraph (C)(ii)), effective for portions of cost reporting periods occurring on or after July 1, 2005, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such otherwise applicable resident limit and such reference resident level.

''(II) EXCEPTION FOR SMALL RURAL HOSPITALS.—This subparagraph shall not apply to a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds.

''(ii) REFERENCE RESIDENT LEVEL.—

''(I) IN GENERAL.—Except as otherwise provided in subclauses (II) and (III), the reference resident level specified in this clause for a hospital is the resident level for the most recent cost reporting period of the hospital ending on or before September 30, 2002, for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

''(II) USE OF MOST RECENT ACCOUNTING PERIOD TO RECOGNIZE EXPANSION OF EXISTING PROGRAMS.—If a hospital submits a timely request to increase its resident level due to an expansion of an existing residency training program that is not reflected on the most recent settled cost report, after audit and subject to the discretion of the Secretary, the reference resident level for such hospital is the resident level for the cost reporting period that includes July 1, 2003, as determined by the Secretary.

''(III) EXPANSIONS UNDER NEWLY APPROVED PROGRAMS.—Upon the timely request of a hospital, the Secretary shall adjust the reference resident level specified under subclause (I) or (II) to include the number of medical residents that were approved in an application for a medical residency training program that was approved by an appropriate accrediting organization (as determined by the Secretary) before January 1, 2002, but which was not in operation during the cost reporting period used under subclause (I) or (II), as the case may be, as determined by the Secretary.

''(iii) AFFILIATION.—The provisions of clause (i) shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) as of July 1, 2003.

''(B) REDISTRIBUTION.—

''(i) IN GENERAL.—The Secretary is authorized to increase the otherwise applicable resident limit for each qualifying hospital that submits a timely application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2005. The aggregate number of increases in the otherwise applicable resident limits under this subparagraph may not exceed the Secretary's estimate of the aggregate reduction in such limits attributable to subparagraph (A).

''(ii) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under clause (i), the Secretary shall take into account the demonstrated likelihood of the hospital filling the positions within the first 3 cost reporting periods beginning on or after July 1, 2005, made available under this subparagraph, as determined by the Secretary.

''(iii) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under clause (i), the Secretary shall distribute the increase to programs of hospitals located in the following priority order:

''(I) First, to hospitals located in rural areas (as defined in subsection (d)(2)(D)(ii)).

''(II) Second, to hospitals located in urban areas that are not large urban areas (as defined for purposes of subsection (d)).

''(III) Third, to other hospitals in a State if the residency training program involved is in a specialty for which there are not other residency training programs in the State.

Increases of residency limits within the same priority category under this clause shall be determined by the Secretary.

''(iv) LIMITATION.—In no case shall more than 25 full-time equivalent additional residency positions be made available under this subparagraph with respect to any hospital.

''(v) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under this subparagraph, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national average per resident amount computed under paragraph (4)(E) for that hospital.

''(vi) CONSTRUCTION.—Nothing in this subparagraph shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6), under a demonstration project approved as of October 31, 2003, under the authority of section 402 of Public Law 90–248, or as affecting the ability of a hospital to establish new medical residency training programs under paragraph (4)(H).

''(C) RESIDENT LEVEL AND LIMIT DEFINED.—In this paragraph:

''(i) RESIDENT LEVEL.—The term 'resident level' means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under paragraph (4)), in the fields of allopathic and osteopathic medicine for the hospital.

''(ii) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph.

''(D) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, with respect to determinations made under this paragraph.''.

(b) CONFORMING PROVISIONS.—(1) Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amended—

(A) in the second sentence of clause (ii), by striking ''For discharges'' and inserting ''Subject to clause (ix), for discharges''; and

(B) in clause (v), by adding at the end the following: ''The provisions of subsection (h)(7) shall apply with respect to the first sentence of this clause in the same manner as it applies with respect to subsection (h)(4)(F)(i).''; and

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

''(ix) For discharges occurring on or after July 1, 2005, insofar as an additional payment amount under this subparagraph is attributable to resident positions redistributed to a hospital under subsection (h)(7)(B), in computing the indirect teaching adjustment factor under clause (ii) the adjustment shall be computed in a manner as if 'c' were equal to 0.66 with respect to such resident positions.''.

(2) Chapter 35 of title 44, United States Code, shall not apply with respect to applications under section 1886(h)(7) of the Social Security Act, as added by subsection (a)(3).

(c) REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM.—Not later than July 1, 2005, the Secretary shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident limits under section 1886(h)(4)(I)(ii)(II) of the Social Security Act (as added by subsection (a)).

Subtitle D—Other Provisions

SEC. 131. PROVIDING SAFE HARBOR FOR CERTAIN COLLABORATIVE EFFORTS THAT BENEFIT MEDICALLY UNDERSERVED POPULATIONS.

(a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C. 1320a–7(b)(3)), as amended by section 101(e)(2), is amended—

(1) in subparagraph (F), by striking ''and'' after the semicolon at the end;

(2) in subparagraph (G), by striking the period at the end and inserting ''; and''; and

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

''(H) any remuneration between a health center entity described under clause (i) or (ii) of section 1905(l)(2)(B) and any individual or entity providing goods, items, services, donations, loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity.''.

(b) RULEMAKING FOR EXCEPTION FOR HEALTH CENTER ENTITY ARRANGEMENTS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary shall establish, on an expedited basis, standards relating to the exception described in section 1128B(b)(3)(H) of the Social Security Act, as added by subsection (a), for health center entity arrangements to the antikickback penalties.

(B) FACTORS TO CONSIDER.—The Secretary shall consider the following factors, among others, in establishing standards relating to the exception for health center entity arrangements under subparagraph (A):

(i) Whether the arrangement between the health center entity and the other party results in savings of Federal grant funds or increased revenues to the health center entity.

(ii) Whether the arrangement between the health center entity and the other party restricts or limits an individual's freedom of choice.

(iii) Whether the arrangement between the health center entity and the other party protects a health care professional's independent medical judgment regarding medically appropriate treatment.

The Secretary may also include other standards and criteria that are consistent with the intent of Congress in enacting the exception established under this section.

(2) DEADLINE.—Not later than 1 year after the date of the enactment of this Act the Secretary shall publish final regulations establishing the standards described in paragraph (1).

SEC. 132. OFFICE OF RURAL HEALTH POLICY IMPROVEMENTS.

Section 711(b) (42 U.S.C. 912(b)) is amended—

(1) in paragraph (3), by striking ''and'' after the comma at the end;

(2) in paragraph (4), by striking the period at the end and inserting '', and''; and

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

''(5) administer grants, cooperative agreements, and contracts to provide technical assistance and other activities as necessary to support activities related to improving health care in rural areas.''.

SEC. 133. MEDPAC STUDY ON RURAL HOSPITAL PAYMENT ADJUSTMENTS.

(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study of the impact of sections 401 through 406, 411, 416, and 505. The Commission shall analyze the effect on total payments, growth in costs, capital spending, and such other payment effects under those sections.

(b) REPORTS.—

(1) INTERIM REPORT.—Not later than 18 months after the date of the enactment of this Act, the Commission shall submit to Congress an interim report on the matters studied under subsection (a) with respect only to changes to the critical access hospital provisions under section 105.

(2) FINAL REPORT.—Not later than 3 years after the date of the enactment of this Act, the Commission shall submit to Congress a final report on all matters studied under subsection (a).

SEC. 134. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary shall waive such provisions of the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas are treated as providers of items and services under the medicare program.

(b) CLINICS DESCRIBED.—A frontier extended stay clinic is described in this subsection if the clinic—

(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

(2) is designed to address the needs of—

(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or

(B) patients who need monitoring and observation for a limited period of time.

(c) SPECIFICATION OF CODES.—The Secretary shall determine the appropriate life-safety codes for such clinics that treat patients for needs referred to in subsection (b)(2).

(d) FUNDING.—

(1) IN GENERAL.—Subject to paragraph (2), there are authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, such sums as are necessary to conduct the demonstration project under this section.

(2) BUDGET NEUTRAL IMPLEMENTATION.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under the medicare program do not exceed the amount which the Secretary would have paid under the medicare program if the demonstration project under this section was not implemented.

(e) 3-YEAR PERIOD.—The Secretary shall conduct the demonstration under this section for a 3-year period.

(f) REPORT.—Not later than the date that is 1 year after the date on which the demonstration project concludes, the Secretary shall submit to Congress a report on the demonstration project, together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

(g) DEFINITIONS.—In this section, the terms ''hospital'' and ''critical access hospital'' have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

TITLE II—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

SEC. 201. REVISION OF ACUTE CARE HOSPITAL PAYMENT UPDATES.

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

(1) by striking ''and'' at the end of subclause (XVIII);

(2) by striking subclause (XIX); and

(3) by inserting after subclause (XVIII) the following new subclauses:

''(XIX) for each of fiscal years 2004 through 2007, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and

''(XX) for fiscal year 2008 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.''.

(b) SUBMISSION OF HOSPITAL QUALITY DATA.—Section 1886(b)(3)(B) (42 U.S.C. 1395ww(b)(3)(B)) is amended by adding at the end the following new clause:

''(vii)(I) For purposes of clause (i)(XIX) for each of fiscal years 2005 through 2007, in a case of a subsection (d) hospital that does not submit data to the Secretary in accordance with subclause (II) with respect to such a fiscal year, the applicable percentage increase under such clause for such fiscal year shall be reduced by 0.4 percentage points. Such reduction shall apply only with respect to the fiscal year involved, and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i)(XIX) for a subsequent fiscal year.

''(II) Each subsection (d) hospital shall submit to the Secretary quality data (for a set of 10 indicators established by the Secretary as of November 1, 2003) that relate to the quality of care furnished by the hospital in inpatient settings in a form and manner, and at a time, specified by the Secretary for purposes of this clause, but with respect to fiscal year 2005, the Secretary shall provide for a 30-day grace period for the submission of data by a hospital.''.

(c) GAO STUDY AND REPORT ON APPROPRIATENESS OF PAYMENTS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES.—

(1) STUDY.—The Comptroller General of the United States, using the most current data available, shall conduct a study to determine—

(A) the appropriate level and distribution of payments in relation to costs under the prospective payment system under section 1886 of the Social Security Act (42 U.S.C. 1395ww) for inpatient hospital services furnished by subsection (d) hospitals (as defined in subsection (d)(1)(B) of such section); and

(B) whether there is a need to adjust such payments under such system to reflect legitimate differences in costs across different geographic areas, kinds of hospitals, and types of cases.

(2) REPORT.—Not later than 24 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislative and administrative action as the Comptroller General determines appropriate.

SEC. 202. REVISION OF THE INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT PERCENTAGE.

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

(1) in subclause (VI), by striking ''and'' after the semicolon at the end;

(2) in subclause (VII)—

(A) by inserting ''and before April 1, 2004,'' after ''on or after October 1, 2002,''; and

(B) by striking the period at the end and inserting a semicolon; and

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

''(VIII) on or after April 1, 2004, and before October 1, 2004, 'c' is equal to 1.47;

''(IX) during fiscal year 2005, 'c' is equal to 1.42;

''(X) during fiscal year 2006, 'c' is equal to 1.37;

''(XI) during fiscal year 2007, 'c' is equal to 1.32; and

''(XII) on or after October 1, 2007, 'c' is equal to 1.35.''.

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended—

(1) by striking ''1999 or'' and inserting ''1999,''; and

(2) by inserting '', or the Medicare Provider Restoration Act of 2003'' after ''2000''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after April 1, 2004.

SEC. 203. RECOGNITION OF NEW MEDICAL TECHNOLOGIES UNDER INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

(a) IMPROVING TIMELINESS OF DATA COLLECTION.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is amended by adding at the end the following new clause:

''(vii) Under the mechanism under this subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) under this subsection until the fiscal year that begins after such date.''.

(b) ELIGIBILITY STANDARD FOR TECHNOLOGY OUTLIERS.—

(1) ADJUSTMENT OF THRESHOLD.—Section 1886(d)(5)(K)(ii)(I) (42 U.S.C. 1395ww(d)(5)(K)(ii)(I)) is amended by inserting ''(applying a threshold specified by the Secretary that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation for the diagnosis-related group involved)'' after ''is inadequate''.

(2) PROCESS FOR PUBLIC INPUT.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as amended by subsection (a), is amended—

(A) in clause (i), by adding at the end the following: ''Such mechanism shall be modified to meet the requirements of clause (viii).''; and

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

''(viii) The mechanism established pursuant to clause (i) shall be adjusted to provide, before publication of a proposed rule, for public input regarding whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of individuals entitled to benefits under part A as follows:

''(I) The Secretary shall make public and periodically update a list of all the services and technologies for which an application for additional payment under this subparagraph is pending.

''(II) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

''(III) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, such individuals, manufacturers, and any other interested party may present comments, recommendations, and data to the clinical staff of the Centers for Medicare & Medicaid Services before publication of a notice of proposed rulemaking regarding whether service or technology represents a substantial improvement.''.

(c) PREFERENCE FOR USE OF DRG ADJUSTMENT.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as amended by subsections (a) and (b), is amended by adding at the end the following new clause:

''(ix) Before establishing any add-on payment under this subparagraph with respect to a new technology, the Secretary shall seek to identify one or more diagnosis-related groups associated with such technology, based on similar clinical or anatomical characteristics and the cost of the technology. Within such groups the Secretary shall assign an eligible new technology into a diagnosis-related group where the average costs of care most closely approximate the costs of care of using the new technology. No add-on payment under this subparagraph shall be made with respect to such new technology and this clause shall not affect the application of paragraph (4)(C)(iii).''.

(d) ESTABLISHMENT OF NEW FUNDING FOR HOSPITAL INPATIENT TECHNOLOGY.—

(1) IN GENERAL.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is amended by striking ''subject to paragraph (4)(C)(iii),''.

(2) NOT BUDGET NEUTRAL.—There shall be no reduction or other adjustment in payments under section 1886 of the Social Security Act because an additional payment is provided under subsection (d)(5)(K)(ii)(III) of such section.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The Secretary shall implement the amendments made by this section so that they apply to classification for fiscal years beginning with fiscal year 2005.

(2) RECONSIDERATIONS OF APPLICATIONS FOR FISCAL YEAR 2004 THAT ARE DENIED.—In the case of an application for a classification of a medical service or technology as a new medical service or technology under section 1886(d)(5)(K) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(K)) that was filed for fiscal year 2004 and that is denied—

(A) the Secretary shall automatically reconsider the application as an application for fiscal year 2005 under the amendments made by this section; and

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

SEC. 204. INCREASE IN FEDERAL RATE FOR HOSPITALS IN PUERTO RICO.

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

(1) in subparagraph (A)—

(A) in clause (i), by striking ''for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)'' and inserting ''the applicable Puerto Rico percentage (specified in subparagraph (E))''; and

(B) in clause (ii), by striking ''for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent)'' and inserting ''the applicable Federal percentage (specified in subparagraph (E))''; and

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

''(E) For purposes of subparagraph (A), for discharges occurring—

''(i) on or after October 1, 1987, and before October 1, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

''(ii) on or after October 1, 1997, and before April 1, 2004, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

''(iii) on or after April 1, 2004, and before October 1, 2004, the applicable Puerto Rico percentage is 37.5 percent and the applicable Federal percentage is 62.5 percent; and

''(iv) on or after October 1, 2004, the applicable Puerto Rico percentage is 25 percent and the applicable Federal percentage is 75 percent.''.

SEC. 205. WAGE INDEX ADJUSTMENT RECLASSIFICATION REFORM.

(a) IN GENERAL.—Section 1886(d) (42 U.S.C. 1395ww(d)), as amended by section 106, is amended by adding at the end the following new paragraph:

''(13)(A) In order to recognize commuting patterns among geographic areas, the Secretary shall establish a process through application or otherwise for an increase of the wage index applied under paragraph (3)(E) for subsection (d) hospitals located in a qualifying county described in subparagraph (B) in the amount computed under subparagraph (D) based on out-migration of hospital employees who reside in that county to any higher wage index area.

''(B) The Secretary shall establish criteria for a qualifying county under this subparagraph based on the out-migration referred to in subparagraph (A) and differences in the area wage indices. Under such criteria the Secretary shall, utilizing such data as the Secretary determines to be appropriate, establish—

''(i) a threshold percentage, established by the Secretary, of the weighted average of the area wage index or indices for the higher wage index areas involved;

''(ii) a threshold (of not less than 10 percent) for minimum out-migration to a higher wage index area or areas; and

''(iii) a requirement that the average hourly wage of the hospitals in the qualifying county equals or exceeds the average hourly wage of all the hospitals in the area in which the qualifying county is located.

''(C) For purposes of this paragraph, the term 'higher wage index area' means, with respect to a county, an area with a wage index that exceeds that of the county.

''(D) The increase in the wage index under subparagraph (A) for a qualifying county shall be equal to the percentage of the hospital employees residing in the qualifying county who are employed in any higher wage index area multiplied by the sum of the products, for each higher wage index area of—

''(i) the difference between—

''(I) the wage index for such higher wage index area, and

''(II) the wage index of the qualifying county; and

''(ii) the number of hospital employees residing in the qualifying county who are employed in such higher wage index area divided by the total number of hospital employees residing in the qualifying county who are employed in any higher wage index area.

''(E) The process under this paragraph may be based upon the process used by the Medicare Geographic Classification Review Board under paragraph (10). As the Secretary determines to be appropriate to carry out such process, the Secretary may require hospitals (including subsection (d) hospitals and other hospitals) and critical access hospitals, as required under section 1866(a)(1)(T), to submit data regarding the location of residence, or the Secretary may use data from other sources.

''(F) A wage index increase under this paragraph shall be effective for a period of 3 fiscal years, except that the Secretary shall establish procedures under which a subsection (d) hospital may elect to waive the application of such wage index increase.

''(G) A hospital in a county that has a wage index increase under this paragraph for a period and that has not waived the application of such an increase under subparagraph (F) is not eligible for reclassification under paragraph (8) or (10) during that period.

''(H) Any increase in a wage index under this paragraph for a county shall not be taken into account for purposes of—

''(i) computing the wage index for portions of the wage index area (not including the county) in which the county is located; or

''(ii) applying any budget neutrality adjustment with respect to such index under paragraph (8)(D).

''(I) The thresholds described in subparagraph (B), data on hospital employees used under this paragraph, and any determination of the Secretary under the process described in subparagraph (E) shall be final and shall not be subject to judicial review.''.

(b) CONFORMING AMENDMENTS.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (R), by striking ''and'' at the end;

(2) in subparagraph (S), by striking the period at the end and inserting '', and''; and

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

''(T) in the case of hospitals and critical access hospitals, to furnish to the Secretary such data as the Secretary determines appropriate pursuant to subparagraph (E) of section 1886(d)(12) to carry out such section.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall first apply to the wage index for discharges occurring on or after October 1, 2004. In initially implementing such amendments, the Secretary may modify the deadlines otherwise applicable under clauses (ii) and (iii)(I) of section 1886(d)(10)(C) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(C)), for submission of, and actions on, applications relating to changes in hospital geographic reclassification.

SEC. 206. LIMITATION ON CHARGES FOR INPATIENT HOSPITAL CONTRACT HEALTH SERVICES PROVIDED TO INDIANS BY MEDICARE PARTICIPATING HOSPITALS.

(a) IN GENERAL.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)), as amended by section 205(b), is amended—

(1) in subparagraph (S), by striking ''and'' at the end;

(2) in subparagraph (T), by striking the period and inserting '', and''; and

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

''(U) in the case of hospitals which furnish inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care both—

''(i) under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian tribe, or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program; and

''(ii) under any program funded by the Indian Health Service and operated by an urban Indian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in such section 4),

in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply as of a date specified by the Secretary of Health and Human Services (but in no case later than 1 year after the date of enactment of this Act) to medicare participation agreements in effect (or entered into) on or after such date.

(c) PROMULGATION OF REGULATIONS.—The Secretary shall promulgate regulations to carry out the amendments made by subsection (a).

SEC. 207. CLARIFICATIONS TO CERTAIN EXCEPTIONS TO MEDICARE LIMITS ON PHYSICIAN REFERRALS.

(a) LIMITS ON PHYSICIAN REFERRALS.—

(1) OWNERSHIP AND INVESTMENT INTERESTS IN WHOLE HOSPITALS.—

(A) IN GENERAL.—Section 1877(d)(3) (42 U.S.C. 1395nn(d)(3)) is amended—

(i) by striking '', and'' at the end of subparagraph (A) and inserting a semicolon; and

(ii) by redesignating subparagraph (B) as subparagraph (C) and inserting after subparagraph (A) the following new subparagraph:

''(B) effective for the 18-month period beginning on the date of the enactment of the Medicare Provider Restoration Act of 2003, the hospital is not a specialty hospital (as defined in subsection (h)(7)); and''.

(B) DEFINITION.—Section 1877(h) (42 U.S.C. 1395nn(h)) is amended by adding at the end the following:

''(7) SPECIALTY HOSPITAL.—

''(A) IN GENERAL.—For purposes of this section, except as provided in subparagraph (B), the term 'specialty hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B)) that is primarily or exclusively engaged in the care and treatment of one of the following categories:

''(i) Patients with a cardiac condition.

''(ii) Patients with an orthopedic condition.

''(iii) Patients receiving a surgical procedure.

''(iv) Any other specialized category of services that the Secretary designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section.

''(B) EXCEPTION.—For purposes of this section, the term 'specialty hospital' does not include any hospital—

''(i) determined by the Secretary—

''(I) to be in operation before November 18, 2003; or

''(II) under development as of such date;

''(ii) for which the number of physician investors at any time on or after such date is no greater than the number of such investors as of such date;

''(iii) for which the type of categories described in subparagraph (A) at any time on or after such date is no different than the type of such categories as of such date;

''(iv) for which any increase in the number of beds occurs only in the facilities on the main campus of the hospital and does not exceed 50 percent of the number of beds in the hospital as of November 18, 2003, or 5 beds, whichever is greater; and

''(v) that meets such other requirements as the Secretary may specify.''.

(2) OWNERSHIP AND INVESTMENT INTERESTS IN A RURAL PROVIDER.—Section 1877(d)(2) (42 U.S.C. 1395nn(d)(2)) is amended to read as follows:

''(2) RURAL PROVIDERS.—In the case of designated health services furnished in a rural area (as defined in section 1886(d)(2)(D)) by an entity, if—

''(A) substantially all of the designated health services furnished by the entity are furnished to individuals residing in such a rural area; and

''(B) effective for the 18-month period beginning on the date of the enactment of the Medicare Provider Restoration Act of 2003, the entity is not a specialty hospital (as defined in subsection (h)(7)).''.

(b) APPLICATION OF EXCEPTION FOR HOSPITALS UNDER DEVELOPMENT.—For purposes of section 1877(h)(7)(B)(i)(II) of the Social Security Act, as added by subsection (a)(1)(B), in determining whether a hospital is under development as of November 18, 2003, the Secretary shall consider—

(1) whether architectural plans have been completed, funding has been received, zoning requirements have been met, and necessary approvals from appropriate State agencies have been received; and

(2) any other evidence the Secretary determines would indicate whether a hospital is under development as of such date.

(c) STUDIES.—

(1) MEDPAC STUDY.—The Medicare Payment Advisory Commission, in consultation with the Comptroller General of the United States, shall conduct a study to determine—

(A) any differences in the costs of health care services furnished to patients by physician-owned specialty hospitals and the costs of such services furnished by local full-service community hospitals within specific diagnosis-related groups;

(B) the extent to which specialty hospitals, relative to local full-service community hospitals, treat patients in certain diagnosis-related groups within a category, such as cardiology, and an analysis of the selection;

(C) the financial impact of physician-owned specialty hospitals on local full-service community hospitals;

(D) how the current diagnosis-related group system should be updated to better reflect the cost of delivering care in a hospital setting; and

(E) the proportions of payments received, by type of payer, between the specialty hospitals and local full-service community hospitals.

(2) HHS STUDY.—The Secretary shall conduct a study of a representative sample of specialty hospitals—

(A) to determine the percentage of patients admitted to physician-owned specialty hospitals who are referred by physicians with an ownership interest;

(B) to determine the referral patterns of physician owners, including the percentage of patients they referred to physician-owned specialty hospitals and the percentage of patients they referred to local full-service community hospitals for the same condition;

(C) to compare the quality of care furnished in physician-owned specialty hospitals and in local full-service community hospitals for similar conditions and patient satisfaction with such care; and

(D) to assess the differences in uncompensated care, as defined by the Secretary, between the specialty hospital and local full-service community hospitals, and the relative value of any tax exemption available to such hospitals.

(3) REPORTS.—Not later than 15 months after the date of the enactment of this Act, the Commission and the Secretary, respectively, shall each submit to Congress a report on the studies conducted under paragraphs (1) and (2), respectively, and shall include any recommendations for legislation or administrative changes.

SEC. 208. 1-TIME APPEALS PROCESS FOR HOSPITAL WAGE INDEX CLASSIFICATION.

(a) ESTABLISHMENT OF PROCESS.—

(1) IN GENERAL.—The Secretary shall establish not later than January 1, 2004, by instruction or otherwise a process under which a hospital may appeal the wage index classification otherwise applicable to the hospital and select another area within the State (or, at the discretion of the Secretary, within a contiguous State) to which to be reclassified.

(2) PROCESS REQUIREMENTS.—The process established under paragraph (1) shall be consistent with the following:

(A) Such an appeal may be filed as soon as possible after the date of the enactment of this Act but shall be filed by not later than February 15, 2004.

(B) Such an appeal shall be heard by the Medicare Geographic Reclassification Review Board.

(C) There shall be no further administrative or judicial review of a decision of such Board.

(3) RECLASSIFICATION UPON SUCCESSFUL APPEAL.—If the Medicare Geographic Reclassification Review Board determines that the hospital is a qualifying hospital (as defined in subsection (c)), the hospital shall be reclassified to the area selected under paragraph (1). Such reclassification shall apply with respect to discharges occurring during the 3-year period beginning with April 1, 2004.

(4) INAPPLICABILITY OF CERTAIN PROVISIONS.—Except as the Secretary may provide, the provisions of paragraphs (8) and (10) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) shall not apply to an appeal under this section.

(b) APPLICATION OF RECLASSIFICATION.—In the case of an appeal decided in favor of a qualifying hospital under subsection (a), the wage index reclassification shall not affect the wage index computation for any area or for any other hospital and shall not be effected in a budget neutral manner. The provisions of this section shall not affect payment for discharges occurring after the end of the 3-year-period referred to in subsection (a).

(c) QUALIFYING HOSPITAL DEFINED.—For purposes of this section, the term ''qualifying hospital'' means a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) that—

(1) does not qualify for a change in wage index classification under paragraph (8) or (10) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) on the basis of requirements relating to distance or commuting; and

(2) meets such other criteria, such as quality, as the Secretary may specify by instruction or otherwise.

The Secretary may modify the wage comparison guidelines promulgated under section 1886(d)(10)(D) of such Act (42 U.S.C. 1395ww(d)(10)(D)) in carrying out this section.

(d) WAGE INDEX CLASSIFICATION.—For purposes of this section, the term ''wage index classification'' means the geographic area in which it is classified for purposes of determining for a fiscal year the factor used to adjust the DRG prospective payment rate under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) for area differences in hospital wage levels that applies to such hospital under paragraph (3)(E) of such section.

(e) LIMITATION ON EXPENDITURES.—The aggregate amount of additional expenditures resulting from the application of this section shall not exceed $900,000,000.

(f) TRANSITIONAL EXTENSION.—Any reclassification of a county or other area made by Act of Congress for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) that expired on September 30, 2003, shall be deemed to be in effect during the period beginning on January 1, 2004, and ending on September 30, 2004.

Subtitle B—Other Provisions

SEC. 211. PAYMENT FOR COVERED SKILLED NURSING FACILITY SERVICES.

(a) ADJUSTMENT TO RUGs FOR AIDS RESIDENTS.—Paragraph (12) of section 1888(e) (42 U.S.C. 1395yy(e)) is amended to read as follows:

''(12) ADJUSTMENT FOR RESIDENTS WITH AIDS.—

''(A) IN GENERAL.—Subject to subparagraph (B), in the case of a resident of a skilled nursing facility who is afflicted with acquired immune deficiency syndrome (AIDS), the per diem amount of payment otherwise applicable (determined without regard to any increase under section 101 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, or under section 314(a) of Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000), shall be increased by 128 percent to reflect increased costs associated with such residents.

''(B) SUNSET.—Subparagraph (A) shall not apply on and after such date as the Secretary certifies that there is an appropriate adjustment in the case mix under paragraph (4)(G)(i) to compensate for the increased costs associated with residents described in such subparagraph.''.

(b) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after October 1, 2004.

SEC. 212. COVERAGE OF HOSPICE CONSULTATION SERVICES.

(a) COVERAGE OF HOSPICE CONSULTATION SERVICES.—Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

(1) by striking ''and'' at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting ''; and''; and

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

''(5) for individuals who are terminally ill, have not made an election under subsection (d)(1), and have not previously received services under this paragraph, services that are furnished by a physician (as defined in section 1861(r)(1)) who is either the medical director or an employee of a hospice program and that—

''(A) consist of—

''(i) an evaluation of the individual's need for pain and symptom management, including the individual's need for hospice care; and

''(ii) counseling the individual with respect to hospice care and other care options; and

''(B) may include advising the individual regarding advanced care planning.''.

(b) PAYMENT.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

''(4) The amount paid to a hospice program with respect to the services under section 1812(a)(5) for which payment may be made under this part shall be equal to an amount established for an office or other outpatient visit for evaluation and management associated with presenting problems of moderate severity and requiring medical decisionmaking of low complexity under the fee schedule established under section 1848(b), other than the portion of such amount attributable to the practice expense component.''.

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

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided by a hospice program on or after January 1, 2005.

SEC. 213. STUDY ON PORTABLE DIAGNOSTIC ULTRASOUND SERVICES FOR BENEFICIARIES IN SKILLED NURSING FACILITIES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of portable diagnostic ultrasound services furnished to medicare beneficiaries in skilled nursing facilities. Such study shall consider the following:

(1) TYPES OF EQUIPMENT; TRAINING.—The types of portable diagnostic ultrasound services furnished to such beneficiaries, the types of portable ultrasound equipment used to furnish such services, and the technical skills, or training, or both, required for technicians to furnish such services.

(2) CLINICAL APPROPRIATENESS.—The clinical appropriateness of transporting portable diagnostic ultrasound diagnostic and technicians to patients in skilled nursing facilities as opposed to transporting such patients to a hospital or other facility that furnishes diagnostic ultrasound services.

(3) FINANCIAL IMPACT.—The financial impact if Medicare were make a separate payment for portable ultrasound diagnostic services, including the impact of separate payments—

(A) for transportation and technician services for residents during a resident in a part A stay, that would otherwise be paid for under the prospective payment system for covered skilled nursing facility services (under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)); and

(B) for such services for residents in a skilled nursing facility after a part A stay.

(4) CREDENTIALING REQUIREMENTS.—Whether the Secretary should establish credentialing or other requirements for technicians that furnish diagnostic ultrasound services to medicare beneficiaries.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a), and shall include any recommendations for legislation or administrative change as the Comptroller General determines appropriate.

TITLE III—PROVISIONS RELATING TO PART B

Subtitle A—Provisions Relating to Physicians' Services

SEC. 301. REVISION OF UPDATES FOR PHYSICIANS' SERVICES.

(a) UPDATE FOR 2004 AND 2005.—

(1) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraph:

''(5) UPDATE FOR 2004 AND 2005.—The update to the single conversion factor established in paragraph (1)(C) for each of 2004 and 2005 shall be not less than 1.5 percent.''.

(2) CONFORMING AMENDMENT.—Paragraph (4)(B) of such section is amended, in the matter before clause (i), by inserting ''and paragraph (5)'' after ''subparagraph (D)''.

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

(b) USE OF 10-YEAR ROLLING AVERAGE IN COMPUTING GROSS DOMESTIC PRODUCT.—

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

(A) by striking ''projected'' and inserting ''annual average''; and

(B) by striking ''from the previous applicable period to the applicable period involved'' and inserting ''during the 10-year period ending with the applicable period involved''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to computations of the sustainable growth rate for years beginning with 2003.

SEC. 302. TREATMENT OF PHYSICIANS' SERVICES FURNISHED IN ALASKA.

Section 1848(e)(1) (42 U.S.C. 1395w–4(e)(1)), as amended by section 121, is amended—

(1) in subparagraph (A), by striking ''subparagraphs (B), (C), (E), and (F)'' and inserting ''subparagraphs (B), (C), (E), (F) and (G)''; and

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

''(G) FLOOR FOR PRACTICE EXPENSE, MALPRACTICE, AND WORK GEOGRAPHIC INDICES FOR SERVICES FURNISHED IN ALASKA.—For purposes of payment for services furnished in Alaska on or after January 1, 2004, and before

January 1, 2006, after calculating the practice expense, malpractice, and work geographic indices in clauses (i), (ii), and (iii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.67 if such index would otherwise be less than 1.67.''.

SEC. 303. INCLUSION OF PODIATRISTS, DENTISTS, AND OPTOMETRISTS UNDER PRIVATE CONTRACTING AUTHORITY.

Section 1802(b)(5)(B) (42 U.S.C. 1395a(b)(5)(B)) is amended by striking ''section 1861(r)(1)'' and inserting ''paragraphs (1), (2), (3), and (4) of section 1861(r)''.

SEC. 304. GAO STUDY ON ACCESS TO PHYSICIANS' SERVICES.

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

(1) an assessment of the use by beneficiaries of such services through an analysis of claims submitted by physicians for such services under part B of the medicare program;

(2) an examination of changes in the use by beneficiaries of physicians' services over time; and

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

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

(1) data from claims submitted by physicians under part B of the medicare program indicate potential access problems for medicare beneficiaries in certain geographic areas; and

(2) access by medicare beneficiaries to physicians' services may have improved, remained constant, or deteriorated over time.

SEC. 305. COLLABORATIVE DEMONSTRATION-BASED REVIEW OF PHYSICIAN PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT DATA.

(a) IN GENERAL.—Not later than January 1, 2005, the Secretary shall, in collaboration with State and other appropriate organizations representing physicians, and other appropriate persons, review and consider alternative data sources than those currently used in establishing the geographic index for the practice expense component under the medicare physician fee schedule under section 1848(e)(1)(A)(i) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(A)(i)).

(b) SITES.—The Secretary shall select two physician payment localities in which to carry out subsection (a). One locality shall include rural areas and at least one locality shall be a statewide locality that includes both urban and rural areas.

(c) REPORT AND RECOMMENDATIONS.—

(1) REPORT.—Not later than January 1, 2006, the Secretary shall submit to Congress a report on the review and consideration conducted under subsection (a). Such report shall include information on the alternative developed data sources considered by the Secretary under subsection (a), including the accuracy and validity of the data as measures of the elements of the geographic index for practice expenses under the medicare physician fee schedule as well as the feasibility of using such alternative data nationwide in lieu of current proxy data used in such index, and the estimated impacts of using such alternative data.

(2) RECOMMENDATIONS.—The report submitted under paragraph (1) shall contain recommendations on which data sources reviewed and considered under subsection (a) are appropriate for use in calculating the geographic index for practice expenses under the medicare physician fee schedule.

SEC. 306. MEDPAC REPORT ON PAYMENT FOR PHYSICIANS' SERVICES.

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

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

(2) The interaction of the practice expense component with other components of and adjustments to payment for physicians' services under such section.

(3) The appropriateness of the amount of compensation by reason of such refinements.

(4) The effect of such refinements on access to care by medicare beneficiaries to physicians' services.

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

(b) VOLUME OF PHYSICIANS' SERVICES.—Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the extent to which increases in the volume of physicians' services under part B of the medicare program are a result of care that improves the health and well-being of medicare beneficiaries. The study shall include the following:

(1) An analysis of recent and historic growth in the components that the Secretary includes under the sustainable growth rate (under section 1848(f) of the Social Security Act (42 U.S.C. 1395w–4(f))).

(2) An examination of the relative growth of volume in physicians' services between medicare beneficiaries and other populations.

(3) An analysis of the degree to which new technology, including coverage determinations of the Centers for Medicare & Medicaid Services, has affected the volume of physicians' services.

(4) An examination of the impact on volume of demographic changes.

(5) An examination of shifts in the site of service or services that influence the number and intensity of services furnished in physicians' offices and the extent to which changes in reimbursement rates to other providers have effected these changes.

(6) An evaluation of the extent to which the Centers for Medicare & Medicaid Services takes into account the impact of law and regulations on the sustainable growth rate.

Subtitle B—Preventive Services

SEC. 311. COVERAGE OF AN INITIAL PREVENTIVE PHYSICAL EXAMINATION.

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

(1) in subparagraph (U), by striking ''and'' at the end;

(2) in subparagraph (V)(iii), by inserting ''and'' at the end; and

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

''(W) an initial preventive physical examination (as defined in subsection (ww));''.

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

''Initial Preventive Physical Examination

''(ww)(1) The term 'initial preventive physical examination' means physicians' services consisting of a physical examination (including measurement of height, weight, and blood pressure, and an electrocardiogram) with the goal of health promotion and disease detection and includes education, counseling, and referral with respect to screening and other preventive services described in paragraph (2), but does not include clinical laboratory tests.

''(2) The screening and other preventive services described in this paragraph include the following:

''(A) Pneumococcal, influenza, and hepatitis B vaccine and administration under subsection (s)(10).

''(B) Screening mammography as defined in subsection (jj).

''(C) Screening pap smear and screening pelvic exam as defined in subsection (nn).

''(D) Prostate cancer screening tests as defined in subsection (oo).

''(E) Colorectal cancer screening tests as defined in subsection (pp).

''(F) Diabetes outpatient self-management training services as defined in subsection (qq)(1).

''(G) Bone mass measurement as defined in subsection (rr).

''(H) Screening for glaucoma as defined in subsection (uu).

''(I) Medical nutrition therapy services as defined in subsection (vv).

''(J) Cardiovascular screening blood tests as defined in subsection (xx)(1).

''(K) Diabetes screening tests as defined in subsection (yy).''.

(c) PAYMENT AS PHYSICIANS' SERVICES.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(W),'' after ''(2)(S),''.

(d) OTHER CONFORMING AMENDMENTS.—(1) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 303(i)(3)(B), is amended—

(A) in paragraph (1)—

(i) by striking ''and'' at the end of subparagraph (I);

(ii) by striking the semicolon at the end of subparagraph (J) and inserting '', and''; and

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

''(K) in the case of an initial preventive physical examination, which is performed not later than 6 months after the date the individual's first coverage period begins under part B;''; a

(B) in paragraph (7), by striking ''or (H)'' and inserting ''(H), or (K)''.

(2) Clauses (i) and (ii) of section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) are each amended by inserting ''and services described in subsection (ww)(1)'' after ''services which would be physicians' services''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2005, but only for individuals whose coverage period under part B begins on or after such date.

SEC. 312. COVERAGE OF CARDIOVASCULAR SCREENING BLOOD TESTS.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by section 311(a), is amended—

(1) in subparagraph (V)(iii), by striking ''and'' at the end;

(2) in subparagraph (W), by inserting ''and'' at the end; and

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

''(X) cardiovascular screening blood tests (as defined in subsection (xx)(1));''.

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

''Cardiovascular Screening Blood Test

''(xx)(1) The term 'cardiovascular screening blood test' means a blood test for the early detection of cardiovascular disease (or abnormalities associated with an elevated

risk of cardiovascular disease) that tests for the following:

''(A) Cholesterol levels and other lipid or triglyceride levels.

''(B) Such other indications associated with the presence of, or an elevated risk for, cardiovascular disease as the Secretary may approve for all individuals (or for some individuals determined by the Secretary to be at risk for cardiovascular disease), including indications measured by noninvasive testing.

The Secretary may not approve an indication under subparagraph (B) for any individual unless a blood test for such is recommended by the United States Preventive Services Task Force.

''(2) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency for each type of cardiovascular screening blood tests, except that such frequency may not be more often than once every 2 years.''.

(c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by section 311(d), is amended—

(1) by striking ''and'' at the end of subparagraph (K);

(2) by striking the semicolon at the end of subparagraph (L) and inserting '', and''; and

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

''(M) in the case of cardiovascular screening blood tests (as defined in section 1861(xx)(1)), which are performed more frequently than is covered under section 1861(xx)(2);''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2005.

SEC. 313. COVERAGE OF DIABETES SCREENING TESTS.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by section 312(a), is amended—

(1) in subparagraph (W), by striking ''and'' at the end;

(2) in subparagraph (X), by adding ''and'' at the end; and

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

''(Y) diabetes screening tests (as defined in subsection (yy));''.

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x), as amended by section 312(b), is amended by adding at the end the following new subsection:

''Diabetes Screening Tests

''(yy)(1) The term 'diabetes screening tests' means testing furnished to an individual at risk for diabetes (as defined in paragraph (2)) for the purpose of early detection of diabetes, including—

''(A) a fasting plasma glucose test; and

''(B) such other tests, and modifications to tests, as the Secretary determines appropriate, in consultation with appropriate organizations.

''(2) For purposes of paragraph (1), the term 'individual at risk for diabetes' means an individual who has any of the following risk factors for diabetes:

''(A) Hypertension.

''(B) Dyslipidemia.

''(C) Obesity, defined as a body mass index greater than or equal to 30 kg/m^2.

''(D) Previous identification of an elevated impaired fasting glucose.

''(E) Previous identification of impaired glucose tolerance.

''(F) A risk factor consisting of at least 2 of the following characteristics:

''(i) Overweight, defined as a body mass index greater than 25, but less than 30, kg/m^2.

''(ii) A family history of diabetes.

''(iii) A history of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds.

''(iv) 65 years of age or older.

''(3) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency of diabetes screening tests, except that such frequency may not be more often than twice within the 12-month period following the date of the most recent diabetes screening test of that individual.''.

(c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by section 312(c), is amended—

(1) by striking ''and'' at the end of subparagraph (L);

(2) by striking the semicolon at the end of subparagraph (M) and inserting '', and''; and

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

''(N) in the case of a diabetes screening test (as defined in section 1861(yy)(1)), which is performed more frequently than is covered under section 1861(yy)(3);''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2005.

SEC. 314. IMPROVED PAYMENT FOR CERTAIN MAMMOGRAPHY SERVICES.

(a) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by inserting before the period at the end the following: ''and does not include screening mammography (as defined in section 1861(jj)) and diagnostic mammography''.

(b) CONFORMING AMENDMENT.—Section 1833(a)(2)(E)(i) (42 U.S.C. 1395l(a)(2)(E)(i)) is amended by inserting ''and, for services furnished on or after January 1, 2005, diagnostic mammography'' after ''screening mammography''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply—

(1) in the case of screening mammography, to services furnished on or after the date of the enactment of this Act; and

(2) in the case of diagnostic mammography, to services furnished on or after January 1, 2005.

Subtitle C—Other Provisions

SEC. 321. HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT REFORM.

(a) PAYMENT FOR DRUGS.—

(1) SPECIAL RULES FOR CERTAIN DRUGS AND BIOLOGICALS.—Section 1833(t) (42 U.S.C. 1395l(t)), as amended by section 111(b), is amended by inserting after paragraph (13) the following new paragraphs:

''(14) DRUG APC PAYMENT RATES.—

''(A) IN GENERAL.—The amount of payment under this subsection for a specified covered outpatient drug (defined in subparagraph (B)) that is furnished as part of a covered OPD service (or group of services)—

''(i) in 2004, in the case of—

''(I) a sole source drug shall in no case be less than 88 percent, or exceed 95 percent, of the reference average wholesale price for the drug;

''(II) an innovator multiple source drug shall in no case exceed 68 percent of the reference average wholesale price for the drug; or

''(III) a noninnovator multiple source drug shall in no case exceed 46 percent of the reference average wholesale price for the drug;

''(ii) in 2005, in the case of—

''(I) a sole source drug shall in no case be less than 83 percent, or exceed 95 percent, of the reference average wholesale price for the drug;

''(II) an innovator multiple source drug shall in no case exceed 68 percent of the reference average wholesale price for the drug; or

''(III) a noninnovator multiple source drug shall in no case exceed 46 percent of the reference average wholesale price for the drug; or

''(iii) in a subsequent year, shall be equal, subject to subparagraph (E)—

''(I) to the average acquisition cost for the drug for that year (which, at the option of the Secretary, may vary by hospital group (as defined by the Secretary based on volume of covered OPD services or other relevant characteristics)), as determined by the Secretary taking into account the hospital acquisition cost survey data under subparagraph (D); or

''(II) if hospital acquisition cost data are not available, the average price for the drug in the year established under section 1842(o), section 1847A, or section 1847B, as the case may be, as calculated and adjusted by the Secretary as necessary for purposes of this paragraph.

''(B) SPECIFIED COVERED OUTPATIENT DRUG DEFINED.—

''(i) IN GENERAL.—In this paragraph, the term 'specified covered outpatient drug' means, subject to clause (ii), a covered outpatient drug (as defined in section 1927(k)(2)) for which a separate ambulatory payment classification group (APC) has been established and that is—

''(I) a radiopharmaceutical; or

''(II) a drug or biological for which payment was made under paragraph (6) (relating to pass-through payments) on or before December 31, 2002.

''(ii) EXCEPTION.—Such term does not include—

''(I) a drug or biological for which payment is first made on or after January 1, 2003, under paragraph (6);

''(II) a drug or biological for which a temporary HCPCS code has not been assigned; or

''(III) during 2004 and 2005, an orphan drug (as designated by the Secretary).

''(C) PAYMENT FOR DESIGNATED ORPHAN DRUGS DURING 2004 AND 2005.—The amount of payment under this subsection for an orphan drug designated by the Secretary under subparagraph (B)(ii)(III) that is furnished as part of a covered OPD service (or group of services) during 2004 and 2005 shall equal such amount as the Secretary may specify.

''(D) ACQUISITION COST SURVEY FOR HOSPITAL OUTPATIENT DRUGS.—

''(i) ANNUAL GAO SURVEYS IN 2004 AND 2005.—

''(I) IN GENERAL.—The Comptroller General of the United States shall conduct a survey in each of 2004 and 2005 to determine the hospital acquisition cost for each specified covered outpatient drug. Not later than April 1, 2005, the Comptroller General shall furnish data from such surveys to the Secretary for use in setting the payment rates under subparagraph (A) for 2006.

''(II) RECOMMENDATIONS.—Upon the completion of such surveys, the Comptroller General shall recommend to the Secretary the frequency and methodology of subsequent surveys to be conducted by the Secretary under clause (ii).

''(ii) SUBSEQUENT SECRETARIAL SURVEYS.—The Secretary, taking into account such recommendations, shall conduct periodic subsequent surveys to determine the hospital acquisition cost for each specified covered outpatient drug for use in setting the payment rates under subparagraph (A).

''(iii) SURVEY REQUIREMENTS.—The surveys conducted under clauses (i) and (ii) shall have a large sample of hospitals that is sufficient to generate a statistically significant estimate of the average hospital acquisition cost for each specified covered outpatient drug. With respect to the surveys conducted under clause (i), the Comptroller General shall report to Congress on the justification for the size of the sample used in order to assure the validity of such estimates.

''(iv) DIFFERENTIATION IN COST.—In conducting surveys under clause (i), the Comptroller General shall determine and report to

Congress if there is (and the extent of any) variation in hospital acquisition costs for drugs among hospitals based on the volume of covered OPD services performed by such hospitals or other relevant characteristics of such hospitals (as defined by the Comptroller General).

''(v) COMMENT ON PROPOSED RATES.—Not later than 30 days after the date the Secretary promulgated proposed rules setting forth the payment rates under subparagraph (A) for 2006, the Comptroller General shall evaluate such proposed rates and submit to Congress a report regarding the appropriateness of such rates based on the surveys the Comptroller General has conducted under clause (i).

''(E) ADJUSTMENT IN PAYMENT RATES FOR OVERHEAD COSTS.—

''(i) MEDPAC REPORT ON DRUG APC DESIGN.—The Medicare Payment Advisory Commission shall submit to the Secretary, not later than July 1, 2005, a report on adjustment of payment for ambulatory payment classifications for specified covered outpatient drugs to take into account overhead and related expenses, such as pharmacy services and handling costs. Such report shall include—

''(I) a description and analysis of the data available with regard to such expenses;

''(II) a recommendation as to whether such a payment adjustment should be made; and

''(III) if such adjustment should be made, a recommendation regarding the methodology for making such an adjustment.

''(ii) ADJUSTMENT AUTHORIZED.—The Secretary may adjust the weights for ambulatory payment classifications for specified covered outpatient drugs to take into account the recommendations contained in the report submitted under clause (i).

''(F) CLASSES OF DRUGS.—For purposes of this paragraph:

''(i) SOLE SOURCE DRUGS.—The term 'sole source drug' means—

''(I) a biological product (as defined under section 1861(t)(1)); or

''(II) a single source drug (as defined in section 1927(k)(7)(A)(iv)).

''(ii) INNOVATOR MULTIPLE SOURCE DRUGS.—The term 'innovator multiple source drug' has the meaning given such term in section 1927(k)(7)(A)(ii).

''(iii) NONINNOVATOR MULTIPLE SOURCE DRUGS.—The term 'noninnovator multiple source drug' has the meaning given such term in section 1927(k)(7)(A)(iii).

''(G) REFERENCE AVERAGE WHOLESALE PRICE.—The term 'reference average wholesale price' means, with respect to a specified covered outpatient drug, the average wholesale price for the drug as determined under section 1842(o) as of May 1, 2003.

''(H) INAPPLICABILITY OF EXPENDITURES IN DETERMINING CONVERSION, WEIGHTING, AND OTHER ADJUSTMENT FACTORS.—Additional expenditures resulting from this paragraph shall not be taken into account in establishing the conversion, weighting, and other adjustment factors for 2004 and 2005 under paragraph (9), but shall be taken into account for subsequent years.

''(15) PAYMENT FOR NEW DRUGS AND BIOLOGICALS UNTIL HCPCS CODE ASSIGNED.—With respect to payment under this part for an outpatient drug or biological that is covered under this part and is furnished as part of covered OPD services for which a HCPCS code has not been assigned, the amount provided for payment for such drug or biological under this part shall be equal to 95 percent of the average wholesale price for the drug or biological.''.

(2) REDUCTION IN THRESHOLD FOR SEPARATE APCS FOR DRUGS.—Section 1833(t)(16), as redesignated section 111(b), is amended by adding at the end the following new subparagraph:

''(B) THRESHOLD FOR ESTABLISHMENT OF SEPARATE APCS FOR DRUGS.—The Secretary shall reduce the threshold for the establishment of separate ambulatory payment classification groups (APCs) with respect to drugs or biologicals to $50 per administration for drugs and biologicals furnished in 2005 and 2006.''.

(3) EXCLUSION OF SEPARATE DRUG APCS FROM OUTLIER PAYMENTS.—Section 1833(t)(5) is amended by adding at the end the following new subparagraph:

''(E) EXCLUSION OF SEPARATE DRUG AND BIOLOGICAL APCS FROM OUTLIER PAYMENTS.—No additional payment shall be made under subparagraph (A) in the case of ambulatory payment classification groups established separately for drugs or biologicals.''.

(4) PAYMENT FOR PASS THROUGH DRUGS.—Section 1833(t)(6)(D)(i) (42 U.S.C. 1395l(t)(6)(D)(i)) is amended by inserting after ''under section 1842(o)'' the following: ''(or if the drug or biological is covered under a competitive acquisition contract under section 1847B, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary for purposes of this paragraph)''.

(5) CONFORMING AMENDMENT TO BUDGET NEUTRALITY REQUIREMENT.—Section 1833(t)(9)(B) (42 U.S.C. 1395l(t)(9)(B)) is amended by adding at the end the following: ''In determining adjustments under the preceding sentence for 2004 and 2005, the Secretary shall not take into account under this subparagraph or paragraph (2)(E) any expenditures that would not have been made but for the application of paragraph (14).''.

(6) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items and services furnished on or after January 1, 2004.

(b) SPECIAL PAYMENT FOR BRACHYTHERAPY.—

(1) IN GENERAL.—Section 1833(t)(16), as redesignated by section 111(b) and as amended by subsection (a)(2), is amended by adding at the end the following new subparagraph:

''(C) PAYMENT FOR DEVICES OF BRACHYTHERAPY AT CHARGES ADJUSTED TO COST.—Notwithstanding the preceding provisions of this subsection, for a device of brachytherapy consisting of a seed or seeds (or radioactive source) furnished on or after January 1, 2004, and before January 1, 2007, the payment basis for the device under this subsection shall be equal to the hospital's charges for each device furnished, adjusted to cost. Charges for such devices shall not be included in determining any outlier payment under this subsection.''.

(2) SPECIFICATION OF GROUPS FOR BRACHYTHERAPY DEVICES.—Section 1833(t)(2) (42 U.S.C. 1395l(t)(2)) is amended—

(A) in subparagraph (F), by striking ''and'' at the end;

(B) in subparagraph (G), by striking the period at the end and inserting ''; and''; and

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

''(H) with respect to devices of brachytherapy consisting of a seed or seeds (or radioactive source), the Secretary shall create additional groups of covered OPD services that classify such devices separately from the other services (or group of services) paid for under this subsection in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished, including separate groups for palladium-103 and iodine-125 devices.''.

(3) GAO REPORT.—The Comptroller General of the United States shall conduct a study to determine appropriate payment amounts under section 1833(t)(16)(C) of the Social Security Act, as added by paragraph (1), for devices of brachytherapy. Not later than January 1, 2005, the Comptroller General shall submit to Congress and the Secretary a report on the study conducted under this paragraph, and shall include specific recommendations for appropriate payments for such devices.

SEC. 322. LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.

Section 1833(t)(6) (42 U.S.C. 1395l(t)(6)) is amended by adding at the end the following new subparagraph:

''(F) LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.—

''(i) IN GENERAL.—The Secretary may not publish regulations that apply a functional equivalence standard to a drug or biological under this paragraph.

''(ii) APPLICATION.—Clause (i) shall apply to the application of a functional equivalence standard to a drug or biological on or after the date of enactment of the Medicare Provider Restoration Act of 2003 unless—

''(I) such application was being made to such drug or biological prior to such date of enactment; and

''(II) the Secretary applies such standard to such drug or biological only for the purpose of determining eligibility of such drug or biological for additional payments under this paragraph and not for the purpose of any other payments under this title.

''(iii) RULE OF CONSTRUCTION.—Nothing in this subparagraph shall be construed to effect the Secretary's authority to deem a particular drug to be identical to another drug if the 2 products are pharmaceutically equivalent and bioequivalent, as determined by the Commissioner of Food and Drugs.''.

SEC. 323. PAYMENT FOR RENAL DIALYSIS SERVICES.

(a) INCREASE IN RENAL DIALYSIS COMPOSITE RATE FOR SERVICES FURNISHED.—The last sentence of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended—

(1) by striking ''and'' before ''for such services'' the second place it appears;

(2) by inserting ''and before January 1, 2005,'' after ''January 1, 2001,''; and

(3) by inserting before the period at the end the following: '', and for such services furnished on or after January 1, 2005, by 1.6 percent above such composite rate payment amounts for such services furnished on December 31, 2004''.

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

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

(A) in subparagraph (A), by striking ''and (C)'' and inserting '', (C), and (D)'';

(B) in subparagraph (B), by striking ''In the case'' and inserting ''Subject to subparagraph (D), in the case''; and

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

''(D) INAPPLICABILITY TO PEDIATRIC FACILITIES.—Subparagraphs (A) and (B) shall not apply, as of October 1, 2002, to pediatric facilities that do not have an exception rate described in subparagraph (C) in effect on such date. For purposes of this subparagraph, the term 'pediatric facility' means a renal facility at least 50 percent of whose patients are individuals under 18 years of age.''.

(2) CONFORMING AMENDMENT.—The fourth sentence of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by striking ''The Secretary'' and inserting ''Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Secretary''.

(c) INSPECTOR GENERAL STUDIES ON ESRD DRUGS.—

(1) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct two studies with respect

to drugs and biologicals (including erythropoietin) furnished to end-stage renal disease patients under the medicare program which are separately billed by end stage renal disease facilities.

(2) STUDIES ON ESRD DRUGS.—

(A) EXISTING DRUGS.—The first study under paragraph (1) shall be conducted with respect to such drugs and biologicals for which a billing code exists prior to January 1, 2004.

(B) NEW DRUGS.—The second study under paragraph (1) shall be conducted with respect to such drugs and biologicals for which a billing code does not exist prior to January 1, 2004.

(3) MATTERS STUDIED.—Under each study conducted under paragraph (1), the Inspector General shall—

(A) determine the difference between the amount of payment made to end stage renal disease facilities under title XVIII of the Social Security Act for such drugs and biologicals and the acquisition costs of such facilities for such drugs and biologicals and which are separately billed by end stage renal disease facilities, and

(B) estimate the rates of growth of expenditures for such drugs and biologicals billed by such facilities.

(4) REPORTS.—

(A) EXISTING ESRD DRUGS.—Not later than April 1, 2004, the Inspector General shall report to the Secretary on the study described in paragraph (2)(A).

(B) NEW ESRD DRUGS.—Not later than April 1, 2006, the Inspector General shall report to the Secretary on the study described in paragraph (2)(B).

(d) BASIC CASE-MIX ADJUSTED COMPOSITE RATE FOR RENAL DIALYSIS FACILITY SERVICES.—(1) Section 1881(b) (42 U.S.C. 1395rr(b)) is amended by adding at the end the following new paragraphs:

''(12)(A) In lieu of payment under paragraph (7) beginning with services furnished on January 1, 2005, the Secretary shall establish a basic case-mix adjusted prospective payment system for dialysis services furnished by providers of services and renal dialysis facilities in a year to individuals in a facility and to such individuals at home. The case-mix under such system shall be for a limited number of patient characteristics.

''(B) The system described in subparagraph (A) shall include—

''(i) the services comprising the composite rate established under paragraph (7); and

''(ii) the difference between payment amounts under this title for separately billed drugs and biologicals (including erythropoietin) and acquisition costs of such drugs and biologicals, as determined by the Inspector General reports to the Secretary as required by section 323(c) of the Medicare Provider Restoration Act of 2003—

''(I) beginning with 2005, for such drugs and biologicals for which a billing code exists prior to January 1, 2004; and

''(II) beginning with 2007, for such drugs and biologicals for which a billing code does not exist prior to January 1, 2004,

adjusted to 2005, or 2007, respectively, as determined to be appropriate by the Secretary.

''(C)(i) In applying subparagraph (B)(ii) for 2005, such payment amounts under this title shall be determined using the methodology specified in paragraph (13)(A)(i).

''(ii) For 2006, the Secretary shall provide for an adjustment to the payments under clause (i) to reflect the difference between the payment amounts using the methodology under paragraph (13)(A)(i) and the payment amount determined using the methodology applied by the Secretary under paragraph (13)(A)(iii) of such paragraph, as estimated by the Secretary.

''(D) The Secretary shall adjust the payment rates under such system by a geographic index as the Secretary determines to be appropriate. If the Secretary applies a geographic index under this paragraph that differs from the index applied under paragraph (7) the Secretary shall phase-in the application of the index under this paragraph over a multiyear period.

''(E)(i) Such system shall be designed to result in the same aggregate amount of expenditures for such services, as estimated by the Secretary, as would have been made for 2005 if this paragraph did not apply.

''(ii) The adjustment made under subparagraph (B)(ii)(II) shall be done in a manner to result in the same aggregate amount of expenditures after such adjustment as would otherwise have been made for such services for 2006 or 2007, respectively, as estimated by the Secretary, if this paragraph did not apply.

''(F) Beginning with 2006, the Secretary shall annually increase the basic case-mix adjusted payment amounts established under this paragraph, by an amount determined by—

''(i) applying the estimated growth in expenditures for drugs and biologicals (including erythropoietin) that are separately billable to the component of the basic case-mix adjusted system described in subparagraph (B)(ii); and

''(ii) converting the amount determined in clause (i) to an increase applicable to the basic case-mix adjusted payment amounts established under subparagraph (B).

Nothing in this paragraph shall be construed as providing for an update to the composite rate component of the basic case-mix adjusted system under subparagraph (B).

''(G) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of the case-mix system, relative weights, payment amounts, the geographic adjustment factor, or the update for the system established under this paragraph, or the determination of the difference between medicare payment amounts and acquisition costs for separately billed drugs and biologicals (including erythropoietin) under this paragraph and paragraph (13).

''(13)(A) The payment amounts under this title for separately billed drugs and biologicals furnished in a year, beginning with 2004, are as follows:

''(i) For such drugs and biologicals (other than erythropoietin) furnished in 2004, the amount determined under section 1842(o)(1)(A)(v) for the drug or biological.

''(ii) For such drugs and biologicals (including erythropoietin) furnished in 2005, the acquisition cost of the drug or biological, as determined by the Inspector General reports to the Secretary as required by section 323(c) of the Medicare Provider Restoration Act of 2003. Insofar as the Inspector General has not determined the acquisition cost with respect to a drug or biological, the Secretary shall determine the payment amount for such drug or biological.

''(iii) For such drugs and biologicals (including erythropoietin) furnished in 2006 and subsequent years, such acquisition cost or the amount determined under section 1847A for the drug or biological, as the Secretary may specify.

''(B)(i) Drugs and biologicals (including erythropoietin) which were separately billed under this subsection on the day before the date of the enactment of the Medicare Provider Restoration Act of 2003 shall continue to be separately billed on and after such date.

''(ii) Nothing in this paragraph, section 1842(o), section 1847A, or section 1847B shall be construed as requiring or authorizing the bundling of payment for drugs and biologicals into the basic case-mix adjusted payment system under this paragraph.''.

(2) Paragraph (7) of such section is amended in the first sentence by striking ''The Secretary'' and inserting ''Subject to paragraph (12), the Secretary''.

(3) Paragraph (11)(B) of such section is amended by inserting ''subject to paragraphs (12) and (13)'' before ''payment for such item''.

(e) DEMONSTRATION OF BUNDLED CASE-MIX ADJUSTED PAYMENT SYSTEM FOR ESRD SERVICES.—

(1) IN GENERAL.—The Secretary shall establish a demonstration project of the use of a fully case-mix adjusted payment system for end stage renal disease services under section 1881 of the Social Security Act (42 U.S.C. 1395rr) for patient characteristics identified in the report under subsection (f) that bundles into such payment rates amounts for—

(A) drugs and biologicals (including erythropoietin) furnished to end-stage renal disease patients under the medicare program which are separately billed by end stage renal disease facilities (as of the date of the enactment of this Act); and

(B) clinical laboratory tests related to such drugs and biologicals.

(2) FACILITIES INCLUDED IN THE DEMONSTRATION.—In conducting the demonstration under this subsection, the Secretary shall ensure the participation of a sufficient number of providers of dialysis services and renal dialysis facilities, but in no case to exceed 500. In selecting such providers and facilities, the Secretary shall ensure that the following types of providers are included in the demonstration:

(A) Urban providers and facilities.

(B) Rural providers and facilities.

(C) Not-for-profit providers and facilities.

(D) For-profit providers and facilities.

(E) Independent providers and facilities.

(F) Specialty providers and facilities, including pediatric providers and facilities and small providers and facilities.

(3) TEMPORARY ADD-ON PAYMENT FOR DIALYSIS SERVICES FURNISHED UNDER THE DEMONSTRATION.—

(A) IN GENERAL.—During the period of the demonstration project, the Secretary shall increase payment rates that would otherwise apply under section 1881(b) of such Act (42 U.S.C. 1395rr(b)) by 1.6 percent for dialysis services furnished in facilities in the demonstration site.

(B) RULES OF CONSTRUCTION.—Nothing in this subsection shall be construed as—

(i) as an annual update under section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b));

(ii) as increasing the baseline for payments under such section; or

(iii) requiring the budget neutral implementation of the demonstration project under this subsection.

(4) 3-YEAR PERIOD.—The Secretary shall conduct the demonstration under this subsection for the 3-year period beginning on January 1, 2006.

(5) USE OF ADVISORY BOARD.—

(A) IN GENERAL.—In carrying out the demonstration under this subsection, the Secretary shall establish an advisory board comprised of representatives described in subparagraph (B) to provide advice and recommendations with respect to the establishment and operation of such demonstration.

(B) REPRESENTATIVES.—Representatives referred to in subparagraph (A) include representatives of the following:

(i) Patient organizations.

(ii) Individuals with expertise in end-stage renal dialysis services, such as clinicians, economists, and researchers.

(iii) The Medicare Payment Advisory Commission, established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6).

(iv) The National Institutes of Health.

(v) Network organizations under section 1881(c) of the Social Security Act (42 U.S.C. 1395rr(c)).

(vi) Medicare contractors to monitor quality of care.

(vii) Providers of services and renal dialysis facilities furnishing end-stage renal disease services.

(C) TERMINATION OF ADVISORY PANEL.—The advisory panel shall terminate on December 31, 2008.

(6) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, $5,000,000 in fiscal year 2006 to conduct the demonstration under this subsection.

(f) REPORT ON A BUNDLED PROSPECTIVE PAYMENT SYSTEM FOR END STAGE RENAL DISEASE SERVICES.—

(1) REPORT.—

(A) IN GENERAL.—Not later than October 1, 2005, the Secretary shall submit to Congress a report detailing the elements and features for the design and implementation of a bundled prospective payment system for services furnished by end stage renal disease facilities including, to the maximum extent feasible, bundling of drugs, clinical laboratory tests, and other items that are separately billed by such facilities. The report shall include a description of the methodology to be used for the establishment of payment rates, including components of the new system described in paragraph (2).

(B) RECOMMENDATIONS.—The Secretary shall include in such report recommendations on elements, features, and methodology for a bundled prospective payment system or other issues related to such system as the Secretary determines to be appropriate.

(2) ELEMENTS AND FEATURES OF A BUNDLED PROSPECTIVE PAYMENT SYSTEM.—The report required under paragraph (1) shall include the following elements and features of a bundled prospective payment system:

(A) BUNDLE OF ITEMS AND SERVICES.—A description of the bundle of items and services to be included under the prospective payment system.

(B) CASE MIX.—A description of the case-mix adjustment to account for the relative resource use of different types of patients.

(C) WAGE INDEX.—A description of an adjustment to account for geographic differences in wages.

(D) RURAL AREAS.—The appropriateness of establishing a specific payment adjustment to account for additional costs incurred by rural facilities.

(E) OTHER ADJUSTMENTS.—Such other adjustments as may be necessary to reflect the variation in costs incurred by facilities in caring for patients with end stage renal disease.

(F) UPDATE FRAMEWORK.—A methodology for appropriate updates under the prospective payment system.

(G) ADDITIONAL RECOMMENDATIONS.—Such other matters as the Secretary determines to be appropriate.

SEC. 324. 2-YEAR MORATORIUM ON THERAPY CAPS; PROVISIONS RELATING TO REPORTS.

(a) ADDITIONAL MORATORIUM ON THERAPY CAPS.—

(1) 2004 AND 2005.—Section 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended by striking "and 2002" and inserting "2002, 2004, and 2005".

(2) REMAINDER OF 2003.—For the period beginning on the date of the enactment of this Act and ending of December 31, 2003, the Secretary shall not apply the provisions of paragraphs (1), (2), and (3) of section 1833(g) to expenses incurred with respect to services described in such paragraphs during such period. Nothing in the preceding sentence shall be construed as affecting the application of such paragraphs by the Secretary before the date of the enactment of this Act.

(b) PROMPT SUBMISSION OF OVERDUE REPORTS ON PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY SERVICES.—Not later than March 31, 2004, the Secretary shall submit to Congress the reports required under section 4541(d)(2) of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 457) (relating to alternatives to a single annual dollar cap on outpatient therapy) and under section 221(d) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Appendix F, 113 Stat. 1501A–352), as enacted into law by section 1000(a)(6) of Public Law 106–113 (relating to utilization patterns for outpatient therapy).

(c) GAO REPORT IDENTIFYING CONDITIONS AND DISEASES JUSTIFYING WAIVER OF THERAPY CAP.—

(1) STUDY.—The Comptroller General of the United States shall identify conditions or diseases that may justify waiving the application of the therapy caps under section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) with respect to such conditions or diseases.

(2) REPORT TO CONGRESS.—Not later than October 1, 2004, the Comptroller General shall submit to Congress a report on the conditions and diseases identified under paragraph (1), and shall include a recommendation of criteria, with respect to such conditions and disease, under which a waiver of the therapy caps would apply.

SEC. 325. WAIVER OF PART B LATE ENROLLMENT PENALTY FOR CERTAIN MILITARY RETIREES; SPECIAL ENROLLMENT PERIOD.

(a) WAIVER OF PENALTY.—

(1) IN GENERAL.—Section 1839(b) (42 U.S.C. 1395r(b)) is amended by adding at the end the following new sentence: "No increase in the premium shall be effected for a month in the case of an individual who enrolls under this part during 2001, 2002, 2003, or 2004 and who demonstrates to the Secretary before December 31, 2004, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to premiums for months beginning with January 2004. The Secretary shall establish a method for providing rebates of premium penalties paid for months on or after January 2004 for which a penalty does not apply under such amendment but for which a penalty was previously collected.

(b) MEDICARE PART B SPECIAL ENROLLMENT PERIOD.—

(1) IN GENERAL.—In the case of any individual who, as of the date of the enactment of this Act, is eligible to enroll but is not enrolled under part B of title XVIII of the Social Security Act and is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code), the Secretary of Health and Human Services shall provide for a special enrollment period during which the individual may enroll under such part. Such period shall begin as soon as possible after the date of the enactment of this Act and shall end on December 31, 2004.

(2) COVERAGE PERIOD.—In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under part B of title XVIII of the Social Security Act shall begin on the first day of the month following the month in which the individual enrolls.

SEC. 326. PAYMENT FOR SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.

(a) REDUCTIONS IN PAYMENT UPDATES.—Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is amended to read as follows:

"(C)(i) Notwithstanding the second sentence of each of subparagraphs (A) and (B), except as otherwise specified in clauses (ii), (iii), and (iv), if the Secretary has not updated amounts established under such subparagraphs or under subparagraph (D), with respect to facility services furnished during a fiscal year (beginning with fiscal year 1986 or a calendar year (beginning with 2006)), such amounts shall be increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

"(ii) In each of the fiscal years 1998 through 2002, the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points.

"(iii) In fiscal year 2004, beginning with April 1, 2004, the increase under this subparagraph shall be the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with March 31, 2003, minus 3.0 percentage points.

"(iv) In fiscal year 2005, the last quarter of calendar year 2005, and each of calendar years 2006 through 2009, the increase under this subparagraph shall be 0 percent.".

(b) REPEAL OF SURVEY REQUIREMENT AND IMPLEMENTATION OF NEW SYSTEM.—Section 1833(i)(2) (42 U.S.C. 1395l(i)(2)) is amended—

(1) in subparagraph (A)—

(A) in the matter preceding clause (i), by striking "The" and inserting "For services furnished prior to the implementation of the system described in subparagraph (D), the"; and

(B) in clause (i), by striking "taken not later than January 1, 1995, and every 5 years thereafter,"; and

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

"(D)(i) Taking into account the recommendations in the report under section 326(d) of Medicare Provider Restoration Act of 2003, the Secretary shall implement a revised payment system for payment of surgical services furnished in ambulatory surgical centers.

"(ii) In the year the system described in clause (i) is implemented, such system shall be designed to result in the same aggregate amount of expenditures for such services as would be made if this subparagraph did not apply, as estimated by the Secretary.

"(iii) The Secretary shall implement the system described in clause (i) for periods in a manner so that it is first effective beginning on or after January 1, 2006, and not later than January 1, 2008.

"(iv) There shall be no administrative or judicial review under section 1869, 1878, or otherwise, of the classification system, the relative weights, payment amounts, and the geographic adjustment factor, if any, under this subparagraph.".

(c) CONFORMING AMENDMENT.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended by adding the following new subparagraph:

"(G) with respect to facility services furnished in connection with a surgical procedure specified pursuant to subsection (i)(1)(A) and furnished to an individual in an ambulatory surgical center described in such subsection, for services furnished beginning with the implementation date of a revised payment system for such services in such facilities specified in subsection (i)(2)(D), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the

amount determined by the Secretary under such revised payment system,''.

(d) GAO STUDY OF AMBULATORY SURGICAL CENTER PAYMENTS.—

(1) STUDY.—

(A) IN GENERAL.—The Comptroller General of the United States shall conduct a study that compares the relative costs of procedures furnished in ambulatory surgical centers to the relative costs of procedures furnished in hospital outpatient departments under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)). The study shall also examine how accurately ambulatory payment categories reflect procedures furnished in ambulatory surgical centers.

(B) CONSIDERATION OF ASC DATA.—In conducting the study under paragraph (1), the Comptroller General shall consider data submitted by ambulatory surgical centers regarding the matters described in clauses (i) through (iii) of paragraph (2)(B).

(2) REPORT AND RECOMMENDATIONS.—

(A) REPORT.—Not later than January 1, 2005, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

(B) RECOMMENDATIONS.—The report submitted under subparagraph (A) shall include recommendations on the following matters:

(i) The appropriateness of using the groups of covered services and relative weights established under the outpatient prospective payment system as the basis of payment for ambulatory surgical centers.

(ii) If the relative weights under such hospital outpatient prospective payment system are appropriate for such purpose—

(I) whether the payment rates for ambulatory surgical centers should be based on a uniform percentage of the payment rates or weights under such outpatient system; or

(II) whether the payment rates for ambulatory surgical centers should vary, or the weights should be revised, based on specific procedures or types of services (such as ophthalmology and pain management services).

(iii) Whether a geographic adjustment should be used for payment of services furnished in ambulatory surgical centers, and if so, the labor and nonlabor shares of such payment.

SEC. 327. PAYMENT FOR CERTAIN SHOES AND INSERTS UNDER THE FEE SCHEDULE FOR ORTHOTICS AND PROSTHETICS.

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

(1) in paragraph (1)(B), by striking ''no more than the limits established under paragraph (2)'' and inserting ''no more than the amount of payment applicable under paragraph (2)''; and

(2) in paragraph (2), to read as follows:

''(2)(A) Except as provided by the Secretary under subparagraphs (B) and (C), the amount of payment under this paragraph for custom molded shoes, extra-depth shoes, and inserts shall be the amount determined for such items by the Secretary under section 1834(h).

''(B) The Secretary may establish payment amounts for shoes and inserts that are lower than the amount established under section 1834(h) if the Secretary finds that shoes and inserts of an appropriate quality are readily available at or below the amount established under such section.

''(C) In accordance with procedures established by the Secretary, an individual entitled to benefits with respect to shoes described in section 1861(s)(12) may substitute modification of such shoes instead of obtaining one (or more, as specified by the Secretary) pair of inserts (other than the original pair of inserts with respect to such shoes). In such case, the Secretary shall substitute, for the payment amount established under section 1834(h), a payment amount that the Secretary estimates will assure that there is no net increase in expenditures under this subsection as a result of this subparagraph.''.

(b) CONFORMING AMENDMENTS.—(1) Section 1834(h)(4)(C) (42 U.S.C. 1395m(h)(4)(C)) is amended by inserting ''(and includes shoes described in section 1861(s)(12))'' after ''in section 1861(s)(9)''.

(2) Section 1842(s)(2) (42 U.S.C. 1395u(s)(2)) is amended by striking subparagraph (C).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items furnished on or after January 1, 2005.

SEC. 329. 5-YEAR AUTHORIZATION OF REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.

Section 1880(e)(1)(A) (42 U.S.C. 1395qq(e)(1)(A)) is amended by inserting ''(and for items and services furnished during the 5-year period beginning on January 1, 2005, all items and services for which payment may be made under part B)'' after ''for services described in paragraph (2)''.

Subtitle D—Additional Demonstrations, Studies, and Other Provisions

SEC. 341. DEMONSTRATION PROJECT FOR COVERAGE OF CERTAIN PRESCRIPTION DRUGS AND BIOLOGICALS.

(a) DEMONSTRATION PROJECT.—The Secretary shall conduct a demonstration project under part B of title XVIII of the Social Security Act under which payment is made for drugs or biologicals that are prescribed as replacements for drugs and biologicals described in section 1861(s)(2)(A) or 1861(s)(2)(Q) of such Act (42 U.S.C. 1395x(s)(2)(A), 1395x(s)(2)(Q)), or both, for which payment is made under such part. Such project shall provide for cost-sharing applicable with respect to such drugs or biologicals.

(b) DEMONSTRATION PROJECT SITES.—The project established under this section shall be conducted in sites selected by the Secretary.

(c) DURATION.—The Secretary shall conduct the demonstration project for the 2-year period beginning on the date that is 90 days after the date of the enactment of this Act, but in no case may the project extend beyond December 31, 2005.

(d) LIMITATION.—Under the demonstration project over the duration of the project, the Secretary may not provide—

(1) coverage for more than 50,000 patients; and

(2) more than $500,000,000 in funding.

(e) REPORT.—Not later than July 1, 2006, the Secretary shall submit to Congress a report on the project. The report shall include an evaluation of patient access to care and patient outcomes under the project, as well as an analysis of the cost effectiveness of the project, including an evaluation of the costs savings (if any) to the medicare program attributable to reduced physicians' services and hospital outpatient departments services for administration of the biological.

SEC. 342. EXTENSION OF COVERAGE OF INTRAVENOUS IMMUNE GLOBULIN (IVIG) FOR THE TREATMENT OF PRIMARY IMMUNE DEFICIENCY DISEASES IN THE HOME.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by sections 611(a) and 612(a) is amended—

(1) in subsection (s)(2)—

(A) by striking ''and'' at the end of subparagraph (X);

(B) by adding ''and'' at the end of subparagraph (Y); and

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

''(Z) intravenous immune globulin for the treatment of primary immune deficiency diseases in the home (as defined in subsection (zz));''; and

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

''Intravenous Immune Globulin

''(zz) The term 'intravenous immune globulin' means an approved pooled plasma derivative for the treatment in the patient's home of a patient with a diagnosed primary immune deficiency disease, but not including items or services related to the administration of the derivative, if a physician determines administration of the derivative in the patient's home is medically appropriate.''.

(b) PAYMENT AS A DRUG OR BIOLOGICAL.—Section 1833(a)(1)(S) (42 U.S.C. 1395l(a)(1)(S)) is amended by inserting ''(including intravenous immune globulin (as defined in section 1861(zz)))'' after ''with respect to drugs and biologicals''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items furnished administered on or after January 1, 2004.

SEC. 343. MEDPAC STUDY OF COVERAGE OF SURGICAL FIRST ASSISTING SERVICES OF CERTIFIED REGISTERED NURSE FIRST ASSISTANTS.

(a) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the ''Commission'') shall conduct a study on the feasibility and advisability of providing for payment under part B of title XVIII of the Social Security Act for surgical first assisting services furnished by a certified registered nurse first assistant to medicare beneficiaries.

(b) REPORT.—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Commission determines to be appropriate.

(c) DEFINITIONS.—In this section:

(1) SURGICAL FIRST ASSISTING SERVICES.—The term ''surgical first assisting services'' means services consisting of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care (as determined by the Secretary) furnished by a certified registered nurse first assistant (as defined in paragraph (2)) which the certified registered nurse first assistant is legally authorized to perform by the State in which the services are performed.

(2) CERTIFIED REGISTERED NURSE FIRST ASSISTANT.—The term ''certified registered nurse first assistant'' means an individual who—

(A) is a registered nurse and is licensed to practice nursing in the State in which the surgical first assisting services are performed;

(B) has completed a minimum of 2,000 hours of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care; and

(C) is certified as a registered nurse first assistant by an organization recognized by the Secretary.

SEC. 344. MEDPAC STUDY OF PAYMENT FOR CARDIO-THORACIC SURGEONS.

(a) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the ''Commission'') shall conduct a study on the practice expense relative values established by the Secretary of Health and Human Services under the medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians in the specialties of thoracic and cardiac surgery to determine whether such values adequately take into account the attendant costs that such physicians incur in providing clinical staff for patient care in hospitals.

(b) REPORT.—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under

subsection (a) together with recommendations for such legislation or administrative action as the Commission determines to be appropriate.

SEC. 345. STUDIES RELATING TO VISION IMPAIRMENTS.

(a) COVERAGE OF OUTPATIENT VISION SERVICES FURNISHED BY VISION REHABILITATION PROFESSIONALS UNDER PART B.—

(1) STUDY.—The Secretary shall conduct a study to determine the feasibility and advisability of providing for payment for vision rehabilitation services furnished by vision rehabilitation professionals.

(2) REPORT.—Not later than January 1, 2005, the Secretary shall submit to Congress a report on the study conducted under paragraph (1) together with recommendations for such legislation or administrative action as the Secretary determines to be appropriate.

(3) VISION REHABILITATION PROFESSIONAL DEFINED.—In this subsection, the term ''vision rehabilitation professional'' means an orientation and mobility specialist, a rehabilitation teacher, or a low vision therapist.

(b) REPORT ON APPROPRIATENESS OF A DEMONSTRATION PROJECT TO TEST FEASIBILITY OF USING PPO NETWORKS TO REDUCE COSTS OF ACQUIRING EYEGLASSES FOR MEDICARE BENEFICIARIES AFTER CATARACT SURGERY.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the feasibility of establishing a two-year demonstration project under which the Secretary enters into arrangements with vision care preferred provider organization networks to furnish and pay for conventional eyeglasses subsequent to each cataract surgery with insertion of an intraocular lens on behalf of Medicare beneficiaries. In such report, the Secretary shall include an estimate of potential cost savings to the Medicare program through the use of such networks, taking into consideration quality of service and beneficiary access to services offered by vision care preferred provider organization networks.

SEC. 346. MEDICARE HEALTH CARE QUALITY DEMONSTRATION PROGRAMS.

Title XVIII (42 U.S.C. 1395 et seq.) is amended by inserting after section 1866B the following new section:

''SEC. 1866C. HEALTH CARE QUALITY DEMONSTRATION PROGRAM.

''SEC. (a) DEFINITIONS.—In this section:

''(1) BENEFICIARY.—The term 'beneficiary' means an individual who is entitled to benefits under part A and enrolled under part B, including any individual who is enrolled in a Medicare Advantage plan under part C.

''(2) HEALTH CARE GROUP.—

''(A) IN GENERAL.—The term 'health care group' means—

''(i) a group of physicians that is organized at least in part for the purpose of providing physician's services under this title;

''(ii) an integrated health care delivery system that delivers care through coordinated hospitals, clinics, home health agencies, ambulatory surgery centers, skilled nursing facilities, rehabilitation facilities and clinics, and employed, independent, or contracted physicians; or

''(iii) an organization representing regional coalitions of groups or systems described in clause (i) or (ii).

''(B) INCLUSION.—As the Secretary determines appropriate, a health care group may include a hospital or any other individual or entity furnishing items or services for which payment may be made under this title that is affiliated with the health care group under an arrangement structured so that such hospital, individual, or entity participates in a demonstration project under this section.

''(3) PHYSICIAN.—Except as otherwise provided for by the Secretary, the term 'physician' means any individual who furnishes services that may be paid for as physicians' services under this title.

''(b) DEMONSTRATION PROJECTS.—The Secretary shall establish a 5-year demonstration program under which the Secretary shall approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care, including—

''(1) the provision of incentives to improve the safety of care provided to beneficiaries;

''(2) the appropriate use of best practice guidelines by providers and services by beneficiaries;

''(3) reduced scientific uncertainty in the delivery of care through the examination of variations in the utilization and allocation of services, and outcomes measurement and research;

''(4) encourage shared decision making between providers and patients;

''(5) the provision of incentives for improving the quality and safety of care and achieving the efficient allocation of resources;

''(6) the appropriate use of culturally and ethnically sensitive health care delivery; and

''(7) the financial effects on the health care marketplace of altering the incentives for care delivery and changing the allocation of resources.

''(c) ADMINISTRATION BY CONTRACT.—

''(1) IN GENERAL.—Except as otherwise provided in this section, the Secretary may administer the demonstration program established under this section in a manner that is similar to the manner in which the demonstration program established under section 1866A is administered in accordance with section 1866B.

''(2) ALTERNATIVE PAYMENT SYSTEMS.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include proposals for the use of alternative payment systems for items and services provided to beneficiaries by the group that are designed to—

''(A) encourage the delivery of high quality care while accomplishing the objectives described in subsection (b); and

''(B) streamline documentation and reporting requirements otherwise required under this title.

''(3) BENEFITS.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include modifications to the package of benefits available under the original medicare fee-for-service program under parts A and B or the package of benefits available through a Medicare Advantage plan under part C. The criteria employed under the demonstration program under this section to evaluate outcomes and determine best practice guidelines and incentives shall not be used as a basis for the denial of medicare benefits under the demonstration program to patients against their wishes (or if the patient is incompetent, against the wishes of the patient's surrogate) on the basis of the patient's age or expected length of life or of the patient's present or predicted disability, degree of medical dependency, or quality of life.

''(d) ELIGIBILITY CRITERIA.—To be eligible to receive assistance under this section, an entity shall—

''(1) be a health care group;

''(2) meet quality standards established by the Secretary, including—

''(A) the implementation of continuous quality improvement mechanisms that are aimed at integrating community-based support services, primary care, and referral care;

''(B) the implementation of activities to increase the delivery of effective care to beneficiaries;

''(C) encouraging patient participation in preference-based decisions;

''(D) the implementation of activities to encourage the coordination and integration of medical service delivery; and

''(E) the implementation of activities to measure and document the financial impact on the health care marketplace of altering the incentives of health care delivery and changing the allocation of resources; and

''(3) meet such other requirements as the Secretary may establish.

''(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII as may be necessary to carry out the purposes of the demonstration program established under this section.

''(f) BUDGET NEUTRALITY.—With respect to the 5-year period of the demonstration program under subsection (b), the aggregate expenditures under this title for such period shall not exceed the aggregate expenditures that would have been expended under this title if the program established under this section had not been implemented.

''(g) NOTICE REQUIREMENTS.—In the case of an individual that receives health care items or services under a demonstration program carried out under this section, the Secretary shall ensure that such individual is notified of any waivers of coverage or payment rules that are applicable to such individual under this title as a result of the participation of the individual in such program.

''(h) PARTICIPATION AND SUPPORT BY FEDERAL AGENCIES.—In carrying out the demonstration program under this section, the Secretary may direct—

''(1) the Director of the National Institutes of Health to expand the efforts of the Institutes to evaluate current medical technologies and improve the foundation for evidence-based practice;

''(2) the Administrator of the Agency for Healthcare Research and Quality to, where possible and appropriate, use the program under this section as a laboratory for the study of quality improvement strategies and to evaluate, monitor, and disseminate information relevant to such program; and

''(3) the Administrator of the Centers for Medicare & Medicaid Services and the Administrator of the Center for Medicare Choices to support linkages of relevant medicare data to registry information from participating health care groups for the beneficiary populations served by the participating groups, for analysis supporting the purposes of the demonstration program, consistent with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996.''.

SEC. 347. MEDPAC STUDY ON DIRECT ACCESS TO PHYSICAL THERAPY SERVICES.

(a) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the ''Commission'') shall conduct a study on the feasibility and advisability of allowing medicare fee-for-service beneficiaries direct access to outpatient physical therapy services and physical therapy services furnished as comprehensive rehabilitation facility services.

(b) REPORT.—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Commission determines to be appropriate.

(c) DIRECT ACCESS DEFINED.—The term ''direct access'' means, with respect to outpatient physical therapy services and physical therapy services furnished as comprehensive outpatient rehabilitation facility

services, coverage of and payment for such services in accordance with the provisions of title XVIII of the Social Security Act, except that sections 1835(a)(2), 1861(p), and 1861(cc) of such Act (42 U.S.C. 1395n(a)(2), 1395x(p), and 1395x(cc), respectively) shall be applied—

(1) without regard to any requirement that—

(A) an individual be under the care of (or referred by) a physician; or

(B) services be provided under the supervision of a physician; and

(2) by allowing a physician or a qualified physical therapist to satisfy any requirement for—

(A) certification and recertification; and

(B) establishment and periodic review of a plan of care.

SEC. 348. DEMONSTRATION PROJECT FOR CONSUMER-DIRECTED CHRONIC OUTPATIENT SERVICES.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, the Secretary shall establish demonstration projects (in this section referred to as ''demonstration projects'') under which the Secretary shall evaluate methods that improve the quality of care provided to individuals with chronic conditions and that reduce expenditures that would otherwise be made under the medicare program on behalf of such individuals for such chronic conditions, such methods to include permitting those beneficiaries to direct their own health care needs and services.

(2) INDIVIDUALS WITH CHRONIC CONDITIONS DEFINED.—In this section, the term ''individuals with chronic conditions'' means an individual entitled to benefits under part A of title XVIII of the Social Security Act, and enrolled under part B of such title, but who is not enrolled under part C of such title who is diagnosed as having one or more chronic conditions (as defined by the Secretary), such as diabetes.

(b) DESIGN OF PROJECTS.—

(1) EVALUATION BEFORE IMPLEMENTATION OF PROJECT.—

(A) IN GENERAL.—In establishing the demonstration projects under this section, the Secretary shall evaluate best practices employed by group health plans and practices under State plans for medical assistance under the medicaid program under title XIX of the Social Security Act, as well as best practices in the private sector or other areas, of methods that permit patients to self-direct the provision of personal care services. The Secretary shall evaluate such practices for a 1-year period and, based on such evaluation, shall design the demonstration project.

(B) REQUIREMENT FOR ESTIMATE OF BUDGET NEUTRAL COSTS.—As part of the evaluation under subparagraph (A), the Secretary shall evaluate the costs of furnishing care under the projects. The Secretary may not implement the demonstration projects under this section unless the Secretary determines that the costs of providing care to individuals with chronic conditions under the project will not exceed the costs, in the aggregate, of furnishing care to such individuals under title XVIII of the Social Security Act, that would otherwise be paid without regard to the demonstration projects for the period of the project.

(2) SCOPE OF SERVICES.—The Secretary shall determine the appropriate scope of personal care services that would apply under the demonstration projects.

(c) VOLUNTARY PARTICIPATION.—Participation of providers of services and suppliers, and of individuals with chronic conditions, in the demonstration projects shall be voluntary.

(d) DEMONSTRATION PROJECTS SITES.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall conduct a demonstration project in at least one area that the Secretary determines has a population of individuals entitled to benefits under part A of title XVIII of the Social Security Act, and enrolled under part B of such title, with a rate of incidence of diabetes that significantly exceeds the national average rate of all areas.

(e) EVALUATION AND REPORT.—

(1) EVALUATIONS.—The Secretary shall conduct evaluations of the clinical and cost effectiveness of the demonstration projects.

(2) REPORTS.—Not later than 2 years after the commencement of the demonstration projects, and biannually thereafter, the Secretary shall submit to Congress a report on the evaluation, and shall include in the report the following:

(A) An analysis of the patient outcomes and costs of furnishing care to the individuals with chronic conditions participating in the projects as compared to such outcomes and costs to other individuals for the same health conditions.

(B) Evaluation of patient satisfaction under the demonstration projects.

(C) Such recommendations regarding the extension, expansion, or termination of the projects as the Secretary determines appropriate.

(f) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(g) AUTHORIZATION OF APPROPRIATIONS.—(1) Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

(2) There are authorized to be appropriated from such Trust Fund such sums as may be necessary for the Secretary to enter into contracts with appropriate organizations for the deign, implementation, and evaluation of the demonstration project.

(3) In no case may expenditures under this section exceed the aggregate expenditures that would otherwise have been made for the provision of personal care services.

SEC. 349. MEDICARE CARE MANAGEMENT PERFORMANCE DEMONSTRATION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a pay-for-performance demonstration program with physicians to meet the needs of eligible beneficiaries through the adoption and use of health information technology and evidence-based outcomes measures for—

(A) promoting continuity of care;

(B) helping stabilize medical conditions;

(C) preventing or minimizing acute exacerbations of chronic conditions; and

(D) reducing adverse health outcomes, such as adverse drug interactions related to polypharmacy.

(2) SITES.—The Secretary shall designate no more than 4 sites at which to conduct the demonstration program under this section, of which—

(A) 2 shall be in an urban area;

(B) 1 shall be in a rural area; and

(C) 1 shall be in a State with a medical school with a Department of Geriatrics that manages rural outreach sites and is capable of managing patients with multiple chronic conditions, one of which is dementia.

(3) DURATION.—The Secretary shall conduct the demonstration program under this section for a 3-year period.

(4) CONSULTATION.—In carrying out the demonstration program under this section, the Secretary shall consult with private sector and non-profit groups that are undertaking similar efforts to improve quality and reduce avoidable hospitalizations for chronically ill patients.

(b) PARTICIPATION.—

(1) IN GENERAL.—A physician who provides care for a minimum number of eligible beneficiaries (as specified by the Secretary) may participate in the demonstration program under this section if such physician agrees, to phase-in over the course of the 3-year demonstration period and with the assistance provided under subsection (d)(2)—

(A) the use of health information technology to manage the clinical care of eligible beneficiaries consistent with paragraph (3); and

(B) the electronic reporting of clinical quality and outcomes measures in accordance with requirements established by the Secretary under the demonstration program.

(2) SPECIAL RULE.—In the case of the sites referred to in subparagraphs (B) and (C) of subsection (a)(2), a physician who provides care for a minimum number of beneficiaries with two or more chronic conditions, including dementia (as specified by the Secretary), may participate in the program under this section if such physician agrees to the requirements in subparagraphs (A) and (B) of paragraph (1).

(3) PRACTICE STANDARDS.—Each physician participating in the demonstration program under this section must demonstrate the ability—

(A) to assess each eligible beneficiary for conditions other than chronic conditions, such as impaired cognitive ability and comorbidities, for the purposes of developing care management requirements;

(B) to serve as the primary contact of eligible beneficiaries in accessing items and services for which payment may be made under the medicare program;

(C) to establish and maintain health care information system for such beneficiaries;

(D) to promote continuity of care across providers and settings;

(E) to use evidence-based guidelines and meet such clinical quality and outcome measures as the Secretary shall require;

(F) to promote self-care through the provision of patient education and support for patients or, where appropriate, family caregivers;

(G) when appropriate, to refer such beneficiaries to community service organizations; and

(H) to meet such other complex care management requirements as the Secretary may specify.

The guidelines and measures required under subparagraph (E) shall be designed to take into account beneficiaries with multiple chronic conditions.

(c) PAYMENT METHODOLOGY.—Under the demonstration program under this section the Secretary shall pay a per beneficiary amount to each participating physician who meets or exceeds specific performance standards established by the Secretary with respect to the clinical quality and outcome measures reported under subsection (b)(1)(B). Such amount may vary based on different levels of performance or improvement.

(d) ADMINISTRATION.—

(1) USE OF QUALITY IMPROVEMENT ORGANIZATIONS.—The Secretary shall contract with quality improvement organizations or such other entities as the Secretary deems appropriate to enroll physicians and evaluate their performance under the demonstration program under this section.

(2) TECHNICAL ASSISTANCE.—The Secretary shall require in such contracts that the contractor be responsible for technical assistance and education as needed to physicians

enrolled in the demonstration program under this section for the purpose of aiding their adoption of health information technology, meeting practice standards, and implementing required clinical and outcomes measures.

(e) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary estimates would have been paid if the demonstration program under this section was not implemented.

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(g) REPORT.—Not later than 12 months after the date of completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(h) DEFINITIONS.—In this section:

(1) ELIGIBLE BENEFICIARY.—The term ''eligible beneficiary'' means any individual who—

(A) is entitled to benefits under part A and enrolled for benefits under part B of title XVIII of the Social Security Act and is not enrolled in a plan under part C of such title; and

(B) has one or more chronic medical conditions specified by the Secretary (one of which may be cognitive impairment).

(2) HEALTH INFORMATION TECHNOLOGY.—The term ''health information technology'' means email communication, clinical alerts and reminders, and other information technology that meets such functionality, interoperability, and other standards as prescribed by the Secretary.

SEC. 350. GAO STUDY AND REPORT ON THE PROPAGATION OF CONCIERGE CARE.

(a) STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on concierge care (as defined in paragraph (2)) to determine the extent to which such care—

(A) is used by medicare beneficiaries (as defined in section 1802(b)(5)(A) of the Social Security Act (42 U.S.C. 1395a(b)(5)(A))); and

(B) has impacted upon the access of medicare beneficiaries (as so defined) to items and services for which reimbursement is provided under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) CONCIERGE CARE.—In this section, the term ''concierge care'' means an arrangement under which, as a prerequisite for the provision of a health care item or service to an individual, a physician, practitioner (as described in section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C))), or other individual—

(A) charges a membership fee or another incidental fee to an individual desiring to receive the health care item or service from such physician, practitioner, or other individual; or

(B) requires the individual desiring to receive the health care item or service from such physician, practitioner, or other individual to purchase an item or service.

(b) REPORT.—Not later than the date that is 12 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a)(1) together with such recommendations for legislative or administrative action as the Comptroller General determines to be appropriate.

SEC. 351. DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE.

(a) DEFINITIONS.—In this section:

(1) CHIROPRACTIC SERVICES.—The term ''chiropractic services'' has the meaning given that term by the Secretary for purposes of the demonstration projects, but shall include, at a minimum—

(A) care for neuromusculoskeletal conditions typical among eligible beneficiaries; and

(B) diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided.

(2) DEMONSTRATION PROJECT.—The term ''demonstration project'' means a demonstration project established by the Secretary under subsection (b)(1).

(3) ELIGIBLE BENEFICIARY.—The term ''eligible beneficiary'' means an individual who is enrolled under part B of the medicare program.

(4) MEDICARE PROGRAM.—The term ''medicare program'' means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE.—

(1) ESTABLISHMENT.—The Secretary shall establish demonstration projects in accordance with the provisions of this section for the purpose of evaluating the feasibility and advisability of covering chiropractic services under the medicare program (in addition to the coverage provided for services consisting of treatment by means of manual manipulation of the spine to correct a subluxation described in section 1861(r)(5) of the Social Security Act (42 U.S.C. 1395x(r)(5))).

(2) NO PHYSICIAN APPROVAL REQUIRED.—In establishing the demonstration projects, the Secretary shall ensure that an eligible beneficiary who participates in a demonstration project, including an eligible beneficiary who is enrolled for coverage under a Medicare+Choice plan (or, on and after January 1, 2006, under a Medicare Advantage plan), is not required to receive approval from a physician or other health care provider in order to receive a chiropractic service under a demonstration project.

(3) CONSULTATION.—In establishing the demonstration projects, the Secretary shall consult with chiropractors, organizations representing chiropractors, eligible beneficiaries, and organizations representing eligible beneficiaries.

(4) PARTICIPATION.—Any eligible beneficiary may participate in the demonstration projects on a voluntary basis.

(c) CONDUCT OF DEMONSTRATION PROJECTS.—

(1) DEMONSTRATION SITES.—

(A) SELECTION OF DEMONSTRATION SITES.—The Secretary shall conduct demonstration projects at 4 demonstration sites.

(B) GEOGRAPHIC DIVERSITY.—Of the sites described in subparagraph (A)—

(i) 2 shall be in rural areas; and

(ii) 2 shall be in urban areas.

(C) SITES LOCATED IN HPSAS.—At least 1 site described in clause (i) of subparagraph (B) and at least 1 site described in clause (ii) of such subparagraph shall be located in an area that is designated under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) as a health professional shortage area.

(2) IMPLEMENTATION; DURATION.—

(A) IMPLEMENTATION.—The Secretary shall not implement the demonstration projects before October 1, 2004.

(B) DURATION.—The Secretary shall complete the demonstration projects by the date that is 2 years after the date on which the first demonstration project is implemented.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration projects—

(A) to determine whether eligible beneficiaries who use chiropractic services use a lesser overall amount of items and services for which payment is made under the medicare program than eligible beneficiaries who do not use such services;

(B) to determine the cost of providing payment for chiropractic services under the medicare program;

(C) to determine the satisfaction of eligible beneficiaries participating in the demonstration projects and the quality of care received by such beneficiaries; and

(D) to evaluate such other matters as the Secretary determines is appropriate.

(2) REPORT.—Not later than the date that is 1 year after the date on which the demonstration projects conclude, the Secretary shall submit to Congress a report on the evaluation conducted under paragraph (1) together with such recommendations for legislation or administrative action as the Secretary determines is appropriate.

(e) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of the medicare program to the extent and for the period the Secretary finds necessary to conduct the demonstration projects.

(f) FUNDING.—

(1) DEMONSTRATION PROJECTS.—

(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (2), the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration projects under this section.

(B) LIMITATION.—In conducting the demonstration projects under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under the medicare program do not exceed the amount which the Secretary would have paid under the medicare program if the demonstration projects under this section were not implemented.

(2) EVALUATION AND REPORT.—There are authorized to be appropriated such sums as are necessary for the purpose of developing and submitting the report to Congress under subsection (d).

TITLE IV—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

SEC. 401. DEMONSTRATION PROJECT TO CLARIFY THE DEFINITION OF HOMEBOUND.

(a) DEMONSTRATION PROJECT.—Not later than 180 days after the date of the enactment of this Act, the Secretary shall conduct a 2-year demonstration project under part B of title XVIII of the Social Security Act under which medicare beneficiaries with chronic conditions described in subsection (b) are deemed to be homebound for purposes of receiving home health services under the medicare program.

(b) MEDICARE BENEFICIARY DESCRIBED.—For purposes of subsection (a), a medicare beneficiary is eligible to be deemed to be homebound, without regard to the purpose, frequency, or duration of absences from the home, if—

(1) the beneficiary has been certified by one physician as an individual who has a permanent and severe, disabling condition that is not expected to improve;

(2) the beneficiary is dependent upon assistance from another individual with at least 3 out of the 5 activities of daily living for the rest of the beneficiary's life;

(3) the beneficiary requires skilled nursing services for the rest of the beneficiary's life and the skilled nursing is more than medication management;

(4) an attendant is required to visit the beneficiary on a daily basis to monitor and treat the beneficiary's medical condition or to assist the beneficiary with activities of daily living;

(5) the beneficiary requires technological assistance or the assistance of another person to leave the home; and

(6) the beneficiary does not regularly work in a paid position full-time or part-time outside the home.

(c) DEMONSTRATION PROJECT SITES.—The demonstration project established under this section shall be conducted in 3 States selected by the Secretary to represent the Northeast, Midwest, and Western regions of the United States.

(d) LIMITATION ON NUMBER OF PARTICIPANTS.—The aggregate number of such beneficiaries that may participate in the project may not exceed 15,000.

(e) DATA.—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to medicare beneficiaries that relates to quality of care, patient outcomes, and additional costs, if any, to the medicare program.

(f) REPORT TO CONGRESS.—Not later than 1 year after the date of the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project using the data collected under subsection (e). The report shall include the following:

(1) An examination of whether the provision of home health services to medicare beneficiaries under the project has had any of the following effects:

(A) Has adversely affected the provision of home health services under the medicare program.

(B) Has directly caused an increase of expenditures under the medicare program for the provision of such services that is directly attributable to such clarification.

(2) The specific data evidencing the amount of any increase in expenditures that is directly attributable to the demonstration project (expressed both in absolute dollar terms and as a percentage) above expenditures that would otherwise have been incurred for home health services under the medicare program.

(3) Specific recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency, and purpose of their absences from the home to qualify for home health services without incurring additional costs to the medicare program.

(g) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(h) CONSTRUCTION.—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available to the Secretary under title XI or title XVIII of the Social Security Act for acts prohibited under such titles, including penalties for false certifications for purposes of receipt of items or services under the medicare program.

(i) AUTHORIZATION OF APPROPRIATIONS.—Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

(j) DEFINITIONS.—In this section:

(1) MEDICARE BENEFICIARY.—The term ''medicare beneficiary'' means an individual who is enrolled under part B of title XVIII of the Social Security Act.

(2) HOME HEALTH SERVICES.—The term ''home health services'' has the meaning given such term in section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)).

(3) ACTIVITIES OF DAILY LIVING DEFINED.—The term ''activities of daily living'' means eating, toileting, transferring, bathing, and dressing.

SEC. 402. DEMONSTRATION PROJECT FOR MEDICAL ADULT DAY-CARE SERVICES.

(a) ESTABLISHMENT.—Subject to the succeeding provisions of this section, the Secretary shall establish a demonstration project (in this section referred to as the ''demonstration project'') under which the Secretary shall, as part of a plan of an episode of care for home health services established for a medicare beneficiary, permit a home health agency, directly or under arrangements with a medical adult day-care facility, to provide medical adult day-care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home.

(b) PAYMENT.—

(1) IN GENERAL.—Subject to paragraph (2), the amount of payment for an episode of care for home health services, a portion of which consists of substitute medical adult day-care services, under the demonstration project shall be made at a rate equal to 95 percent of the amount that would otherwise apply for such home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff). In no case may a home health agency, or a medical adult day-care facility under arrangements with a home health agency, separately charge a beneficiary for medical adult day-care services furnished under the plan of care.

(2) ADJUSTMENT IN CASE OF OVERUTILIZATION OF SUBSTITUTE ADULT DAY-CARE SERVICES TO ENSURE BUDGET NEUTRALITY.—The Secretary shall monitor the expenditures under the demonstration project and under title XVIII of the Social Security Act for home health services. If the Secretary estimates that the total expenditures under the demonstration project and under such title XVIII for home health services for a period determined by the Secretary exceed expenditures that would have been made under such title XVIII for home health services for such period if the demonstration project had not been conducted, the Secretary shall adjust the rate of payment to medical adult day-care facilities under paragraph (1) in order to eliminate such excess.

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

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

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

(f) PREFERENCE IN SELECTING AGENCIES.—In selecting home health agencies to participate under the demonstration project, the Secretary shall give preference to those agencies that are currently licensed or certified through common ownership and control to furnish medical adult day-care services.

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

(h) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the clinical and cost-effectiveness of the demonstration project. Not later than 6 months after the completion of the project, the Secretary shall submit to Congress a report on the evaluation, and shall include in the report the following:

(1) An analysis of the patient outcomes and costs of furnishing care to the medicare beneficiaries participating in the project as compared to such outcomes and costs to beneficiaries receiving only home health services for the same health conditions.

(2) Such recommendations regarding the extension, expansion, or termination of the project as the Secretary determines appropriate.

(i) DEFINITIONS.—In this section:

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

(2) MEDICAL ADULT DAY-CARE FACILITY.—The term ''medical adult day-care facility'' means a facility that—

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

(B) is engaged in providing skilled nursing services and other therapeutic services directly or under arrangement with a home health agency;

(C) is licensed and certified by the State in which it operates or meets such standards established by the Secretary to assure quality of care and such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the facility; and

(D) provides medical adult day-care services.

(3) MEDICAL ADULT DAY-CARE SERVICES.—The term ''medical adult day-care services'' means—

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

(B) a program of supervised activities furnished in a group setting in the facility that—

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

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

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

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

SEC. 403. TEMPORARY SUSPENSION OF OASIS REQUIREMENT FOR COLLECTION OF DATA ON NON-MEDICARE AND NON-MEDICAID PATIENTS.

(a) IN GENERAL.—During the period described in subsection (b), the Secretary may

not require, under section 4602(e) of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 467) or otherwise under OASIS, a home health agency to gather or submit information that relates to an individual who is not eligible for benefits under either title XVIII or title XIX of the Social Security Act (such information in this section referred to as ''non-medicare/medicaid OASIS information'').

(b) PERIOD OF SUSPENSION.—The period described in this subsection—

(1) begins on the date of the enactment of this Act; and

(2) ends on the last day of the second month beginning after the date as of which the Secretary has published final regulations regarding the collection and use by the Centers for Medicare & Medicaid Services of non-medicare/medicaid OASIS information following the submission of the report required under subsection (c).

(c) REPORT.—

(1) STUDY.—The Secretary shall conduct a study on how non-medicare/medicaid OASIS information is and can be used by large home health agencies. Such study shall examine—

(A) whether there are unique benefits from the analysis of such information that cannot be derived from other information available to, or collected by, such agencies; and

(B) the value of collecting such information by small home health agencies compared to the administrative burden related to such collection.

In conducting the study the Secretary shall obtain recommendations from quality assessment experts in the use of such information and the necessity of small, as well as large, home health agencies collecting such information.

(2) REPORT.—The Secretary shall submit to Congress a report on the study conducted under paragraph (1) by not later than 18 months after the date of the enactment of this Act.

(d) CONSTRUCTION.—Nothing in this section shall be construed as preventing home health agencies from collecting non-medicare/medicaid OASIS information for their own use.

SEC. 404. MEDPAC STUDY ON MEDICARE MARGINS OF HOME HEALTH AGENCIES.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study of payment margins of home health agencies under the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff). Such study shall examine whether systematic differences in payment margins are related to differences in case mix (as measured by home health resource groups (HHRGs)) among such agencies. The study shall use the partial or full-year cost reports filed by home health agencies.

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

SEC. 405. COVERAGE OF RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTION SERVICES FURNISHED IN THE HOME.

(a) IN GENERAL.—Section 1821(a) (42 U.S.C. 1395i–5(a)) is amended—

(1) in the matter preceding paragraph (1), by inserting ''and for home health services furnished an individual by a religious nonmedical health care institution'' after ''religious nonmedical health care institution''; and

(2) in paragraph (2)—

(A) by striking ''or extended care services'' and inserting '', extended care services, or home health services''; and

(B) by inserting '', or receiving services from a home health agency,'' after ''skilled nursing facility''.

(b) DEFINITION.—Section 1861 (42 U.S.C. 1395x), as amended by section 342, is amended by adding at the end the following new section:

''Extended Care in Religious Nonmedical Health Care Institutions

''(aaa)(1) The term 'home health agency' also includes a religious nonmedical health care institution (as defined in subsection (ss)(1)), but only with respect to items and services ordinarily furnished by such an institution to individuals in their homes, and that are comparable to items and services furnished to individuals by a home health agency that is not religious nonmedical health care institution.

''(2)(A) Subject to subparagraphs (B), payment may be made with respect to services provided by such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations consistent with section 1821.

''(B) Notwithstanding any other provision of this title, payment may not be made under subparagraph (A)—

''(i) in a year insofar as such payments exceed $700,000; and

''(ii) after December 31, 2006.''.

Subtitle B—Graduate Medical Education

SEC. 411. EXCEPTION TO INITIAL RESIDENCY PERIOD FOR GERIATRIC RESIDENCY OR FELLOWSHIP PROGRAMS.

(a) CLARIFICATION OF CONGRESSIONAL INTENT.—Congress intended section 1886(h)(5)(F)(ii) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(F)(ii)), as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272), to provide an exception to the initial residency period for geriatric residency or fellowship programs such that, where a particular approved geriatric training program requires a resident to complete 2 years of training to initially become board eligible in the geriatric specialty, the 2 years spent in the geriatric training program are treated as part of the resident's initial residency period, but are not counted against any limitation on the initial residency period.

(b) INTERIM FINAL REGULATORY AUTHORITY AND EFFECTIVE DATE.—The Secretary shall promulgate interim final regulations consistent with the congressional intent expressed in this section after notice and pending opportunity for public comment to be effective for cost reporting periods beginning on or after October 1, 2003.

SEC. 412. TREATMENT OF VOLUNTEER SUPERVISION.

(a) MORATORIUM ON CHANGES IN TREATMENT.—During the 1-year period beginning on January 1, 2004, for purposes of applying subsections (d)(5)(B) and (h) of section 1886 of the Social Security Act (42 U.S.C. 1395ww), the Secretary shall allow all hospitals to count residents in osteopathic and allopathic family practice programs in existence as of January 1, 2002, who are training at non-hospital sites, without regard to the financial arrangement between the hospital and the teaching physician practicing in the non-hospital site to which the resident has been assigned.

(b) STUDY AND REPORT.—

(1) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study of the appropriateness of alternative payment methodologies under such sections for the costs of training residents in non-hospital settings.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Inspector General shall submit to Congress a report on the study conducted under paragraph (1), together with such recommendations as the Inspector General determines appropriate.

Subtitle C—Chronic Care Improvement

SEC. 421. VOLUNTARY CHRONIC CARE IMPROVEMENT UNDER TRADITIONAL FEE-FOR-SERVICE.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1806 the following new section:

''CHRONIC CARE IMPROVEMENT

''SEC. 1807. (a) IMPLEMENTATION OF CHRONIC CARE IMPROVEMENT PROGRAMS.—

''(1) IN GENERAL.—The Secretary shall provide for the phased-in development, testing, evaluation, and implementation of chronic care improvement programs in accordance with this section. Each such program shall be designed to improve clinical quality and beneficiary satisfaction and achieve spending targets with respect to expenditures under this title for targeted beneficiaries with one or more threshold conditions.

''(2) DEFINITIONS.—For purposes of this section:

''(A) CHRONIC CARE IMPROVEMENT PROGRAM.—The term 'chronic care improvement program' means a program described in paragraph (1) that is offered under an agreement under subsection (b) or (c).

''(B) CHRONIC CARE IMPROVEMENT ORGANIZATION.—The term 'chronic care improvement organization' means an entity that has entered into an agreement under subsection (b) or (c) to provide, directly or through contracts with subcontractors, a chronic care improvement program under this section. Such an entity may be a disease management organization, health insurer, integrated delivery system, physician group practice, a consortium of such entities, or any other legal entity that the Secretary determines appropriate to carry out a chronic care improvement program under this section.

''(C) CARE MANAGEMENT PLAN.—The term 'care management plan' means a plan established under subsection (d) for a participant in a chronic care improvement program.

''(D) THRESHOLD CONDITION.—The term 'threshold condition' means a chronic condition, such as congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), or other diseases or conditions, as selected by the Secretary as appropriate for the establishment of a chronic care improvement program.

''(E) TARGETED BENEFICIARY.—The term 'targeted beneficiary' means, with respect to a chronic care improvement program, an individual who—

''(i) is entitled to benefits under part A and enrolled under part B, but not enrolled in a plan under part C;

''(ii) has one or more threshold conditions covered under such program; and

''(iii) has been identified under subsection (d)(1) as a potential participant in such program.

''(3) CONSTRUCTION.—Nothing in this section shall be construed as—

''(A) expanding the amount, duration, or scope of benefits under this title;

''(B) providing an entitlement to participate in a chronic care improvement program under this section;

''(C) providing for any hearing or appeal rights under section 1869, 1878, or otherwise, with respect to a chronic care improvement program under this section; or

''(D) providing benefits under a chronic care improvement program for which a claim may be submitted to the Secretary by any provider of services or supplier (as defined in section 1861(d)).

''(b) DEVELOPMENTAL PHASE (PHASE I).—

''(1) IN GENERAL.—In carrying out this section, the Secretary shall enter into agreements consistent with subsection (f) with chronic care improvement organizations for the development, testing, and evaluation of chronic care improvement programs using randomized controlled trials. The first such agreement shall be entered into not later than 12 months after the date of the enactment of this section.

''(2) AGREEMENT PERIOD.—The period of an agreement under this subsection shall be for 3 years.

''(3) MINIMUM PARTICIPATION.—

''(A) IN GENERAL.—The Secretary shall enter into agreements under this subsection in a manner so that chronic care improvement programs offered under this section are offered in geographic areas that, in the aggregate, consist of areas in which at least 10 percent of the aggregate number of medicare beneficiaries reside.

''(B) MEDICARE BENEFICIARY DEFINED.—In this paragraph, the term 'medicare beneficiary' means an individual who is entitled to benefits under part A, enrolled under part B, or both, and who resides in the United States.

''(4) SITE SELECTION.—In selecting geographic areas in which agreements are entered into under this subsection, the Secretary shall ensure that each chronic care improvement program is conducted in a geographic area in which at least 10,000 targeted beneficiaries reside among other individuals entitled to benefits under part A, enrolled under part B, or both to serve as a control population.

''(5) INDEPENDENT EVALUATIONS OF PHASE I PROGRAMS.—The Secretary shall contract for an independent evaluation of the programs conducted under this subsection. Such evaluation shall be done by a contractor with knowledge of chronic care management programs and demonstrated experience in the evaluation of such programs. Each evaluation shall include an assessment of the following factors of the programs:

''(A) Quality improvement measures, such as adherence to evidence-based guidelines and rehospitalization rates.

''(B) Beneficiary and provider satisfaction.

''(C) Health outcomes.

''(D) Financial outcomes, including any cost savings to the program under this title.

''(c) EXPANDED IMPLEMENTATION PHASE (PHASE II).—

''(1) IN GENERAL.—With respect to chronic care improvement programs conducted under subsection (b), if the Secretary finds that the results of the independent evaluation conducted under subsection (b)(6) indicate that the conditions specified in paragraph (2) have been met by a program (or components of such program), the Secretary shall enter into agreements consistent with subsection (f) to expand the implementation of the program (or components) to additional geographic areas not covered under the program as conducted under subsection (b), which may include the implementation of the program on a national basis. Such expansion shall begin not earlier than 2 years after the program is implemented under subsection (b) and not later than 6 months after the date of completion of such program.

''(2) CONDITIONS FOR EXPANSION OF PROGRAMS.—The conditions specified in this paragraph are, with respect to a chronic care improvement program conducted under subsection (b) for a threshold condition, that the program is expected to—

''(A) improve the clinical quality of care;

''(B) improve beneficiary satisfaction; and

''(C) achieve targets for savings to the program under this title specified by the Secretary in the agreement within a range determined to be appropriate by the Secretary, subject to the application of budget neutrality with respect to the program and not taking into account any payments by the organization under the agreement under the program for risk under subsection (f)(3)(B).

''(3) INDEPENDENT EVALUATIONS OF PHASE II PROGRAMS.—The Secretary shall carry out evaluations of programs expanded under this subsection as the Secretary determines appropriate. Such evaluations shall be carried out in the similar manner as is provided under subsection (b)(5).

''(d) IDENTIFICATION AND ENROLLMENT OF PROSPECTIVE PROGRAM PARTICIPANTS.—

''(1) IDENTIFICATION OF PROSPECTIVE PROGRAM PARTICIPANTS.—The Secretary shall establish a method for identifying targeted beneficiaries who may benefit from participation in a chronic care improvement program.

''(2) INITIAL CONTACT BY SECRETARY.—The Secretary shall communicate with each targeted beneficiary concerning participation in a chronic care improvement program. Such communication may be made by the Secretary and shall include information on the following:

''(A) A description of the advantages to the beneficiary in participating in a program.

''(B) Notification that the organization offering a program may contact the beneficiary directly concerning such participation.

''(C) Notification that participation in a program is voluntary.

''(D) A description of the method for the beneficiary to participate or for declining to participate and the method for obtaining additional information concerning such participation.

''(3) VOLUNTARY PARTICIPATION.—A targeted beneficiary may participate in a chronic care improvement program on a voluntary basis and may terminate participation at any time.

''(e) CHRONIC CARE IMPROVEMENT PROGRAMS.—

''(1) IN GENERAL.—Each chronic care improvement program shall—

''(A) have a process to screen each targeted beneficiary for conditions other than threshold conditions, such as impaired cognitive ability and co-morbidities, for the purposes of developing an individualized, goal-oriented care management plan under paragraph (2);

''(B) provide each targeted beneficiary participating in the program with such plan; and

''(C) carry out such plan and other chronic care improvement activities in accordance with paragraph (3).

''(2) ELEMENTS OF CARE MANAGEMENT PLANS.—A care management plan for a targeted beneficiary shall be developed with the beneficiary and shall, to the extent appropriate, include the following:

''(A) A designated point of contact responsible for communications with the beneficiary and for facilitating communications with other health care providers under the plan.

''(B) Self-care education for the beneficiary (through approaches such as disease management or medical nutrition therapy) and education for primary caregivers and family members.

''(C) Education for physicians and other providers and collaboration to enhance communication of relevant clinical information.

''(D) The use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment.

''(E) The provision of information about hospice care, pain and palliative care, and end-of-life care.

''(3) CONDUCT OF PROGRAMS.—In carrying out paragraph (1)(C) with respect to a participant, the chronic care improvement organization shall—

''(A) guide the participant in managing the participant's health (including all co-morbidities, relevant health care services, and pharmaceutical needs) and in performing activities as specified under the elements of the care management plan of the participant;

''(B) use decision-support tools such as evidence-based practice guidelines or other criteria as determined by the Secretary; and

''(C) develop a clinical information database to track and monitor each participant across settings and to evaluate outcomes.

''(4) ADDITIONAL RESPONSIBILITIES.—

''(A) OUTCOMES REPORT.—Each chronic care improvement organization offering a chronic care improvement program shall monitor and report to the Secretary, in a manner specified by the Secretary, on health care quality, cost, and outcomes.

''(B) ADDITIONAL REQUIREMENTS.—Each such organization and program shall comply with such additional requirements as the Secretary may specify.

''(5) ACCREDITATION.—The Secretary may provide that chronic care improvement programs and chronic care improvement organizations that are accredited by qualified organizations (as defined by the Secretary) may be deemed to meet such requirements under this section as the Secretary may specify.

''(f) TERMS OF AGREEMENTS.—

''(1) TERMS AND CONDITIONS.—

''(A) IN GENERAL.—An agreement under this section with a chronic care improvement organization shall contain such terms and conditions as the Secretary may specify consistent with this section.

''(B) CLINICAL, QUALITY IMPROVEMENT, AND FINANCIAL REQUIREMENTS.—The Secretary may not enter into an agreement with such an organization under this section for the operation of a chronic care improvement program unless—

''(i) the program and organization meet the requirements of subsection (e) and such clinical, quality improvement, financial, and other requirements as the Secretary deems to be appropriate for the targeted beneficiaries to be served; and

''(ii) the organization demonstrates to the satisfaction of the Secretary that the organization is able to assume financial risk for performance under the agreement (as applied under paragraph (3)(B)) with respect to payments made to the organization under such agreement through available reserves, reinsurance, withholds, or such other means as the Secretary determines appropriate.

''(2) MANNER OF PAYMENT.—Subject to paragraph (3)(B), the payment under an agreement under—

''(A) subsection (b) shall be computed on a per-member per-month basis; or

''(B) subsection (c) may be on a per-member per-month basis or such other basis as the Secretary and organization may agree.

''(3) APPLICATION OF PERFORMANCE STANDARDS.—

''(A) SPECIFICATION OF PERFORMANCE STANDARDS.—Each agreement under this section with a chronic care improvement organization shall specify performance standards for each of the factors specified in subsection (c)(2), including clinical quality and spending targets under this title, against which the performance of the chronic care improvement organization under the agreement is measured.

''(B) ADJUSTMENT OF PAYMENT BASED ON PERFORMANCE.—

''(i) IN GENERAL.—Each such agreement shall provide for adjustments in payment

rates to an organization under the agreement insofar as the Secretary determines that the organization failed to meet the performance standards specified in the agreement under subparagraph (A).

''(ii) FINANCIAL RISK FOR PERFORMANCE.—In the case of an agreement under subsection (b) or (c), the agreement shall provide for a full recovery for any amount by which the fees paid to the organization under the agreement exceed the estimated savings to the programs under this title attributable to implementation of such agreement.

''(4) BUDGET NEUTRAL PAYMENT CONDITION.—Under this section, the Secretary shall ensure that the aggregate sum of medicare program benefit expenditures for beneficiaries participating in chronic care improvement programs and funds paid to chronic care improvement organizations under this section, shall not exceed the medicare program benefit expenditures that the Secretary estimates would have been made for such targeted beneficiaries in the absence of such programs.

''(g) FUNDING.—(1) Subject to paragraph (2), there are appropriated to the Secretary, in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, such sums as may be necessary to provide for agreements with chronic care improvement programs under this section.

''(2) In no case shall the funding under this section exceed $100,000,000 in aggregate increased expenditures under this title (after taking into account any savings attributable to the operation of this section) over the 3-fiscal-year period beginning on October 1, 2003.''.

(b) REPORTS.—The Secretary shall submit to Congress reports on the operation of section 1807 of the Social Security Act, as added by subsection (a), as follows:

(1) Not later than 2 years after the date of the implementation of such section, the Secretary shall submit to Congress an interim report on the scope of implementation of the programs under subsection (b) of such section, the design of the programs, and preliminary cost and quality findings with respect to those programs based on the following measures of the programs:

(A) Quality improvement measures, such as adherence to evidence-based guidelines and rehospitalization rates.

(B) Beneficiary and provider satisfaction.

(C) Health outcomes.

(D) Financial outcomes.

(2) Not later than 3 years and 6 months after the date of the implementation of such section the Secretary shall submit to Congress an update to the report required under paragraph (1) on the results of such programs.

(3) The Secretary shall submit to Congress 2 additional biennial reports on the chronic care improvement programs conducted under such section. The first such report shall be submitted not later than 2 years after the report is submitted under paragraph (2). Each such report shall include information on—

(A) the scope of implementation (in terms of both regions and chronic conditions) of the chronic care improvement programs;

(B) the design of the programs; and

(C) the improvements in health outcomes and financial efficiencies that result from such implementation.

SEC. 422. MEDICARE ADVANTAGE QUALITY IMPROVEMENT PROGRAMS.

(a) IN GENERAL.—Section 1852(e) (42 U.S.C. 1395w–22(e)) is amended—

(1) in the heading, by striking ''ASSURANCE'' and inserting ''IMPROVEMENT'';

(2) by amending paragraphs (1) through (3) to read as follows:

''(1) IN GENERAL.—Each MA organization shall have an ongoing quality improvement program for the purpose of improving the quality of care provided to enrollees in each MA plan offered by such organization (other than an MA private fee-for-service plan or an MSA plan).

''(2) CHRONIC CARE IMPROVEMENT PROGRAMS.—As part of the quality improvement program under paragraph (1), each MA organization shall have a chronic care improvement program. Each chronic care improvement program shall have a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic conditions that meet criteria established by the organization for participation under the program.

''(3) DATA.—

''(A) COLLECTION, ANALYSIS, AND REPORTING.—

''(i) IN GENERAL.—Except as provided in clauses (ii) and (iii) with respect to plans described in such clauses and subject to subparagraph (B), as part of the quality improvement program under paragraph (1), each MA organization shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality.

''(ii) APPLICATION TO MA REGIONAL PLANS.—The Secretary shall establish as appropriate by regulation requirements for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality for MA organizations with respect to MA regional plans. Such requirements may not exceed the requirements under this subparagraph with respect to MA local plans that are preferred provider organization plans.

''(iii) APPLICATION TO PREFERRED PROVIDER ORGANIZATIONS.—Clause (i) shall apply to MA organizations with respect to MA local plans that are preferred provider organization plans only insofar as services are furnished by providers or services, physicians, and other health care practitioners and suppliers that have contracts with such organization to furnish services under such plans.

''(iv) DEFINITION OF PREFERRED PROVIDER ORGANIZATION PLAN.—In this subparagraph, the term 'preferred provider organization plan' means an MA plan that—

''(I) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

''(II) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

''(III) is offered by an organization that is not licensed or organized under State law as a health maintenance organization.

''(B) LIMITATIONS.—

''(i) TYPES OF DATA.—The Secretary shall not collect under subparagraph (A) data on quality, outcomes, and beneficiary satisfaction to facilitate consumer choice and program administration other than the types of data that were collected by the Secretary as of November 1, 2003.

''(ii) CHANGES IN TYPES OF DATA.—Subject to subclause (iii), the Secretary may only change the types of data that are required to be submitted under subparagraph (A) after submitting to Congress a report on the reasons for such changes that was prepared in consultation with MA organizations and private accrediting bodies.

''(iii) CONSTRUCTION.—Nothing in the subsection shall be construed as restricting the ability of the Secretary to carry out the duties under section 1851(d)(4)(D).'';

(3) in paragraph (4)(B), by amending clause (i) to read as follows:

''(i) Paragraphs (1) through (3) of this subsection (relating to quality improvement programs).''; and

(4) by striking paragraph (5).

(b) CONFORMING AMENDMENT.—Section 1852(c)(1)(I) (42 U.S.C. 1395w–22(c)(1)(I)) is amended to read as follows:

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

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on and after January 1, 2006.

SEC. 423. CHRONICALLY ILL MEDICARE BENEFICIARY RESEARCH, DATA, DEMONSTRATION STRATEGY.

(a) DEVELOPMENT OF PLAN.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall develop a plan to improve quality of care and reduce the cost of care for chronically ill medicare beneficiaries.

(b) PLAN REQUIREMENTS.—The plan will utilize existing data and identify data gaps, develop research initiatives, and propose intervention demonstration programs to provide better health care for chronically ill medicare beneficiaries. The plan shall—

(1) integrate existing data sets including, the Medicare Current Beneficiary Survey (MCBS), Minimum Data Set (MDS), Outcome and Assessment Information Set (OASIS), data from Quality Improvement Organizations (QIO), and claims data;

(2) identify any new data needs and a methodology to address new data needs;

(3) plan for the collection of such data in a data warehouse; and

(4) develop a research agenda using such data.

(c) CONSULTATION.—In developing the plan under this section, the Secretary shall consult with experts in the fields of care for the chronically ill (including clinicians).

(d) IMPLEMENTATION.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall implement the plan developed under this section. The Secretary may contract with appropriate entities to implement such plan.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as may be necessary in fiscal years 2004 and 2005 to carry out this section.

Subtitle D—Other Provisions

SEC. 431. IMPROVEMENTS IN NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS TO RESPOND TO CHANGES IN TECHNOLOGY.

(a) NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS.—

(1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y), as amended by sections 948 and 950, is amended—

(A) in the third sentence of subsection (a), by inserting ''consistent with subsection (l)'' after ''the Secretary shall ensure''; and

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

''(l) NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS.—

''(1) FACTORS AND EVIDENCE USED IN MAKING NATIONAL COVERAGE DETERMINATIONS.—The Secretary shall make available to the public the factors considered in making national coverage determinations of whether an item or service is reasonable and necessary. The Secretary shall develop guidance documents to carry out this paragraph in a manner similar to the development of guidance documents under section 701(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 371(h)).

''(2) TIMEFRAME FOR DECISIONS ON REQUESTS FOR NATIONAL COVERAGE DETERMINATIONS.—In

the case of a request for a national coverage determination that—

''(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

''(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 9 months after the date of the request.

''(3) PROCESS FOR PUBLIC COMMENT IN NATIONAL COVERAGE DETERMINATIONS.—

''(A) PERIOD FOR PROPOSED DECISION.—Not later than the end of the 6-month period (or 9-month period for requests described in paragraph (2)(B)) that begins on the date a request for a national coverage determination is made, the Secretary shall make a draft of proposed decision on the request available to the public through the Internet website of the Centers for Medicare & Medicaid Services or other appropriate means.

''(B) 30-DAY PERIOD FOR PUBLIC COMMENT.—Beginning on the date the Secretary makes a draft of the proposed decision available under subparagraph (A), the Secretary shall provide a 30-day period for public comment on such draft.

''(C) 60-DAY PERIOD FOR FINAL DECISION.—Not later than 60 days after the conclusion of the 30-day period referred to under subparagraph (B), the Secretary shall—

''(i) make a final decision on the request;

''(ii) include in such final decision summaries of the public comments received and responses to such comments;

''(iii) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and

''(iv) in the case of a final decision under clause (i) to grant the request for the national coverage determination, the Secretary shall assign a temporary or permanent code (whether existing or unclassified) and implement the coding change.

''(4) CONSULTATION WITH OUTSIDE EXPERTS IN CERTAIN NATIONAL COVERAGE DETERMINATIONS.—With respect to a request for a national coverage determination for which there is not a review by the Medicare Coverage Advisory Committee, the Secretary shall consult with appropriate outside clinical experts.

''(5) LOCAL COVERAGE DETERMINATION PROCESS.—

''(A) PLAN TO PROMOTE CONSISTENCY OF COVERAGE DETERMINATIONS.—The Secretary shall develop a plan to evaluate new local coverage determinations to determine which determinations should be adopted nationally and to what extent greater consistency can be achieved among local coverage determinations.

''(B) CONSULTATION.—The Secretary shall require the fiscal intermediaries or carriers providing services within the same area to consult on all new local coverage determinations within the area.

''(C) DISSEMINATION OF INFORMATION.—The Secretary should serve as a center to disseminate information on local coverage determinations among fiscal intermediaries and carriers to reduce duplication of effort.

''(6) NATIONAL AND LOCAL COVERAGE DETERMINATION DEFINED.—For purposes of this subsection—

''(A) NATIONAL COVERAGE DETERMINATION.—The term 'national coverage determination' means a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under this title.

''(B) LOCAL COVERAGE DETERMINATION.—The term 'local coverage determination' has the meaning given that in section 1869(f)(2)(B).''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to national coverage determinations as of January 1, 2004, and section 1862(l)(5) of the Social Security Act, as added by such paragraph, shall apply to local coverage determinations made on or after July 1, 2004.

(b) MEDICARE COVERAGE OF ROUTINE COSTS ASSOCIATED WITH CERTAIN CLINICAL TRIALS OF CATEGORY A DEVICES.—

(1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y), as amended by subsection (a), is amended by adding at the end the following new subsection:

''(m) COVERAGE OF ROUTINE COSTS ASSOCIATED WITH CERTAIN CLINICAL TRIALS OF CATEGORY A DEVICES.—

''(1) IN GENERAL.—In the case of an individual entitled to benefits under part A, or enrolled under part B, or both who participates in a category A clinical trial, the Secretary shall not exclude under subsection (a)(1) payment for coverage of routine costs of care (as defined by the Secretary) furnished to such individual in the trial.

''(2) CATEGORY A CLINICAL TRIAL.—For purposes of paragraph (1), a 'category A clinical trial' means a trial of a medical device if—

''(A) the trial is of an experimental/investigational (category A) medical device (as defined in regulations under section 405.201(b) of title 42, Code of Federal Regulations (as in effect as of September 1, 2003));

''(B) the trial meets criteria established by the Secretary to ensure that the trial conforms to appropriate scientific and ethical standards; and

''(C) in the case of a trial initiated before January 1, 2010, the device involved in the trial has been determined by the Secretary to be intended for use in the diagnosis, monitoring, or treatment of an immediately life-threatening disease or condition.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to routine costs incurred on and after January 1, 2005, and, as of such date, section 411.15(o) of title 42, Code of Federal Regulations, is superseded to the extent inconsistent with section 1862(m) of the Social Security Act, as added by such paragraph.

(3) RULE OF CONSTRUCTION.—Nothing in the amendment made by paragraph (1) shall be construed as applying to, or affecting, coverage or payment for a nonexperimental/investigational (category B) device.

(c) ISSUANCE OF TEMPORARY NATIONAL CODES.—Not later than July 1, 2004, the Secretary shall implement revised procedures for the issuance of temporary national HCPCS codes under part B of title XVIII of the Social Security Act.

SEC. 432. EXTENSION OF TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

Section 542(c) of BIPA (114 Stat. 2763A–551) is amended by inserting '', and for services furnished during 2005 and 2006'' before the period at the end.

SEC. 433. PAYMENT FOR PANCREATIC ISLET CELL INVESTIGATIONAL TRANSPLANTS FOR MEDICARE BENEFICIARIES IN CLINICAL TRIALS.

(a) CLINICAL TRIAL.—

(1) IN GENERAL.—The Secretary, acting through the National Institute of Diabetes and Digestive and Kidney Disorders, shall conduct a clinical investigation of pancreatic islet cell transplantation which includes medicare beneficiaries.

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as may be necessary to conduct the clinical investigation under paragraph (1).

(b) MEDICARE PAYMENT.—Not earlier than October 1, 2004, the Secretary shall pay for the routine costs as well as transplantation and appropriate related items and services (as described in subsection (c)) in the case of medicare beneficiaries who are participating in a clinical trial described in subsection (a) as if such transplantation were covered under title XVIII of such Act and as would be paid under part A or part B of such title for such beneficiary.

(c) SCOPE OF PAYMENT.—For purposes of subsection (b):

(1) The term ''routine costs'' means reasonable and necessary routine patient care costs (as defined in the Centers for Medicare & Medicaid Services Coverage Issues Manual, section 30–1), including immunosuppressive drugs and other followup care.

(2) The term ''transplantation and appropriate related items and services'' means items and services related to the acquisition and delivery of the pancreatic islet cell transplantation, notwithstanding any national noncoverage determination contained in the Centers for Medicare & Medicaid Services Coverage Issues Manual.

(3) The term ''medicare beneficiary'' means an individual who is entitled to benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title, or both.

(d) CONSTRUCTION.—The provisions of this section shall not be construed—

(1) to permit payment for partial pancreatic tissue or islet cell transplantation under title XVIII of the Social Security Act other than payment as described in subsection (b); or

(2) as authorizing or requiring coverage or payment conveying—

(A) benefits under part A of such title to a beneficiary not entitled to such part A; or

(B) benefits under part B of such title to a beneficiary not enrolled in such part B.

SEC. 434. RESTORATION OF MEDICARE TRUST FUNDS.

(a) DEFINITIONS.—In this section:

(1) CLERICAL ERROR.—The term ''clerical error'' means a failure that occurs on or after April 15, 2001, to have transferred the correct amount from the general fund of the Treasury to a Trust Fund.

(2) TRUST FUND.—The term ''Trust Fund'' means the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t).

(b) CORRECTION OF TRUST FUND HOLDINGS.—

(1) IN GENERAL.—The Secretary of the Treasury shall take the actions described in paragraph (2) with respect to the Trust Fund with the goal being that, after such actions are taken, the holdings of the Trust Fund will replicate, to the extent practicable in the judgment of the Secretary of the Treasury, in consultation with the Secretary, the holdings that would have been held by the Trust Fund if the clerical error involved had not occurred.

(2) OBLIGATIONS ISSUED AND REDEEMED.—The Secretary of the Treasury shall—

(A) issue to the Trust Fund obligations under chapter 31 of title 31, United States Code, that bear issue dates, interest rates, and maturity dates that are the same as those for the obligations that—

(i) would have been issued to the Trust Fund if the clerical error involved had not occurred; or

(ii) were issued to the Trust Fund and were redeemed by reason of the clerical error involved; and

(B) redeem from the Trust Fund obligations that would have been redeemed from

the Trust Fund if the clerical error involved had not occurred.

(c) APPROPRIATION.—There is appropriated to the Trust Fund, out of any money in the Treasury not otherwise appropriated, an amount determined by the Secretary of the Treasury, in consultation with the Secretary, to be equal to the interest income lost by the Trust Fund through the date on which the appropriation is being made as a result of the clerical error involved.

(d) CONGRESSIONAL NOTICE.—In the case of a clerical error that occurs after April 15, 2001, the Secretary of the Treasury, before taking action to correct the error under this section, shall notify the appropriate committees of Congress concerning such error and the actions to be taken under this section in response to such error.

(e) DEADLINE.—With respect to the clerical error that occurred on April 15, 2001, not later than 120 days after the date of the enactment of this Act—

(1) the Secretary of the Treasury shall take the actions under subsection (b)(1); and

(2) the appropriation under subsection (c) shall be made.

SEC. 435. MODIFICATIONS TO MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

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

''(8) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.''.

(b) CONSIDERATION OF EFFICIENT PROVISION OF SERVICES.—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b–6(b)(2)(B)(i)) is amended by inserting ''the efficient provision of'' after ''expenditures for''.

(c) APPLICATION OF DISCLOSURE REQUIREMENTS.—

(1) IN GENERAL.—Section 1805(c)(2)(D) (42 U.S.C. 1395b–6(c)(2)(D)) is amended by adding at the end the following: ''Members of the Commission shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 2004.

(d) ADDITIONAL REPORTS.—

(1) DATA NEEDS AND SOURCES.—The Medicare Payment Advisory Commission shall conduct a study, and submit a report to Congress by not later than June 1, 2004, on the need for current data, and sources of current data available, to determine the solvency and financial circumstances of hospitals and other medicare providers of services.

(2) USE OF TAX-RELATED RETURNS.—Using return information provided under Form 990 of the Internal Revenue Service, the Commission shall submit to Congress, by not later than June 1, 2004, a report on the following:

(A) Investments, endowments, and fundraising of hospitals participating under the medicare program and related foundations.

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

(e) REPRESENTATION OF EXPERTS IN PRESCRIPTION DRUGS.—

(1) IN GENERAL.—Section 1805(c)(2)(B) (42 U.S.C. 1395b–6(c)(2)(B)) is amended by inserting ''experts in the area of pharmaco-economics or prescription drug benefit programs,'' after ''other health professionals,''.

(2) APPOINTMENT.—The Comptroller General of the United States shall ensure that the membership of the Commission complies with the amendment made by paragraph (1) with respect to appointments made on or after the date of the enactment of this Act.

SEC. 436. TECHNICAL AMENDMENTS.

(a) PART A.—(1) Section 1814(a) (42 U.S.C. 1395f(a)) is amended—

(A) by striking the seventh sentence, as added by section 322(a)(1) of BIPA (114 Stat. 2763A–501); and

(B) in paragraph (7)(A)—

(i) in clause (i), by inserting before the comma at the end the following: ''based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness''; and

(ii) in clause (ii), by inserting before the semicolon at the end the following: ''based on such clinical judgment''.

(2) Section 1814(b) (42 U.S.C. 1395f(b)), in the matter preceding paragraph (1), is amended by inserting a comma after ''1813''.

(3) Section 1815(e)(1)(B) (42 U.S.C. 1395g(e)(1)(B)), in the matter preceding clause (i), is amended by striking ''of hospital'' and inserting ''of a hospital''.

(4) Section 1816(c)(2)(B)(ii) (42 U.S.C. 1395h(c)(2)(B)(ii)) is amended—

(A) by striking ''and'' at the end of subclause (III); and

(B) by striking the period at the end of subclause (IV) and inserting '', and''.

(5) Section 1817(k)(3)(A) (42 U.S.C. 1395i(k)(3)(A)) is amended—

(A) in clause (i)(I), by striking the comma at the end and inserting a semicolon; and

(B) in clause (ii), by striking ''the Medicare and medicaid programs'' and inserting ''the programs under this title and title XIX''.

(6) Section 1817(k)(6)(B) (42 U.S.C. 1395i(k)(6)(B)) is amended by striking ''Medicare program under title XVIII'' and inserting ''program under this title''.

(7) Section 1818 (42 U.S.C. 1395i–2) is amended—

(A) in subsection (d)(6)(A) is amended by inserting ''of such Code'' after ''3111(b)''; and

(B) in subsection (g)(2)(B) is amended by striking ''subsection (b).'' and inserting ''subsection (b)''.

(8) Section 1819 (42 U.S.C. 1395i–3) is amended—

(A) in subsection (b)(4)(C)(i), by striking ''at least at least'' and inserting ''at least'';

(B) in subsection (d)(1)(A), by striking ''physical mental'' and inserting ''physical, mental''; and

(C) in subsection (f)(2)(B)(iii), by moving the last sentence 2 ems to the left.

(9) Section 1886(b)(3)(I)(i)(I) (42 U.S.C. 1395ww(b)(3)(I)(i)(I)) is amended by striking ''the the'' and inserting ''the''.

(10) The heading of subsection (mm) of section 1861 (42 U.S.C. 1395x) is amended to read as follows:

''Critical Access Hospital; Critical Access Hospital Services''.

(11) Paragraphs (1) and (2) of section 1861(tt) (42 U.S.C. 1395x(tt)) are each amended by striking ''rural primary care'' and inserting ''critical access''.

(12) Section 1865(b)(3)(B) (42 U.S.C. 1395bb(b)(3)(B)) is amended by striking ''section 1819 and 1861(j)'' and inserting ''sections 1819 and 1861(j)''.

(13) Section 1866(b)(2) (42 U.S.C. 1395cc(b)(2)) is amended by moving subparagraph (D) 2 ems to the left.

(14) Section 1867 (42 U.S.C. 1395dd) is amended—

(A) in the matter following clause (ii) of subsection (d)(1)(B), by striking ''is is'' and inserting ''is'';

(B) in subsection (e)(1)(B), by striking ''a pregnant women'' and inserting ''a pregnant woman''; and

(C) in subsection (e)(2), by striking ''means hospital'' and inserting ''means a hospital''.

(15) Section 1886(g)(3)(B) (42 U.S.C. 1395ww(g)(3)(B)) is amended by striking ''(as defined in subsection (d)(5)(D)(iii)'' and inserting ''(as defined in subsection (d)(5)(D)(iii))''.

(b) PART B.—(1) Section 1833(h)(5)(D) (42 U.S.C. 1395l(h)(5)(D)) is amended by striking ''clinic,,'' and inserting ''clinic,''.

(2) Section 1833(t)(3)(C)(ii) (42 U.S.C. 1395l(t)(3)(C)(ii)) is amended by striking ''clause (iii)'' and inserting ''clause (iv)''.

(3) Section 1861(v)(1)(S)(ii)(III) (42 U.S.C. 1395x(v)(1)(S)(ii)(III)) is amended by striking ''(as defined in section 1886(d)(5)(D)(iii)'' and inserting ''(as defined in section 1886(d)(5)(D)(iii))''.

(4) Section 1834(b)(4)(D)(iv) (42 U.S.C. 1395m(b)(4)(D)(iv)) is amended by striking ''clauses (vi)'' and inserting ''clause (vi)''.

(5) Section 1834(m)(4)(C)(ii)(III) (42 U.S.C. 1395m(m)(4)(C)(ii)(III)) is amended by striking ''1861(aa)(s)'' and inserting ''1861(aa)(2)''.

(6) Section 1838(a)(1) (42 U.S.C. 1395q(a)(1)) is amended by inserting a comma after ''1966''.

(7) The second sentence of section 1839(a)(4) (42 U.S.C. 1395r(a)(4)) is amended by striking ''which will'' and inserting ''will''.

(8) Section 1842(c)(2)(B)(ii) (42 U.S.C. 1395u(c)(2)(B)(ii)) is amended—

(A) by striking ''and'' at the end of subclause (III); and

(B) by striking the period at the end of subclause (IV) and inserting '', and''.

(9) Section 1842(i)(2) (42 U.S.C. 1395u(i)(2)) is amended by striking ''services, a physician'' and inserting ''services, to a physician''.

(10) Section 1848(i)(3)(A) (42 U.S.C. 1395w–4(i)(3)(A)) is amended by striking ''a comparable services'' and inserting ''comparable services''.

(11) Section 1861(s)(2)(K)(i) (42 U.S.C. 1395x(s)(2)(K)(i)) is amended by striking ''; and but'' and inserting '', but''.

(12) Section 1861(aa)(1)(B) (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking '',,'' and inserting a comma.

(13) Section 128(b)(2) of BIPA (114 Stat. 2763A–480) is amended by striking ''Not later that'' and inserting ''Not later than'' each place it appears.

(c) PARTS A AND B.—(1) Section 1812(a)(3) (42 U.S.C. 1395d(a)(3)) is amended—

(A) by striking ''for individuals not'' and inserting ''in the case of individuals not''; and

(B) by striking ''for individuals so'' and inserting ''in the case of individuals so''.

(2)(A) Section 1814(a) (42 U.S.C. 1395f(a)) is amended in the sixth sentence by striking ''leave home,'' and inserting ''leave home and''.

(B) Section 1835(a) (42 U.S.C. 1395n(a)) is amended in the seventh sentence by striking ''leave home,'' and inserting ''leave home and''.

(3) Section 1891(d)(1) (42 U.S.C. 1395bbb(d)(1)) is amended by striking ''subsection (c)(2)(C)(I)'' and inserting ''subsection (c)(2)(C)(i)(I)''.

(4) Section 1861(v) (42 U.S.C. 1395x(v)) is amended by moving paragraph (8) (including clauses (i) through (v) of such paragraph) 2 ems to the left.

(5) Section 1866B(b)(7)(D) (42 U.S.C. 1395cc–2(b)(7)(D)) is amended by striking ''(c)(2)(A)(ii)'' and inserting ''(c)(2)(B)''.

(6) Section 1886(h)(3)(D)(ii)(III) (42 U.S.C. 1395ww(h)(3)(D)(ii)(III)) is amended by striking ''and'' after the comma at the end.

(7) Section 1893(a) (42 U.S.C. 1395ddd(a)) is amended by striking ''Medicare program'' and inserting ''medicare program''.

(8) Section 1896(b)(4) (42 U.S.C. 1395ggg(b)(4)) is amended by striking ''701(f)'' and inserting ''712(f)''.

(d) PART C.—(1) Section 1853 (42 U.S.C. 1395w–23), as amended by section 307 of BIPA (114 Stat. 2763A–558), is amended—

(A) in subsection (a)(3)(C)(ii), by striking ''clause (iii)'' and inserting ''clause (iv)'';

(B) in subsection (a)(3)(C), by redesignating the clause (iii) added by such section 307 as clause (iv); and

(C) in subsection (c)(5), by striking ''(a)(3)(C)(iii)'' and inserting ''(a)(3)(C)(iv)''.

(2) Section 1876 (42 U.S.C. 1395mm) is amended—

(A) in subsection (c)(2)(B), by striking ''signifcant'' and inserting ''significant''; and

(B) in subsection (j)(2), by striking ''this setion'' and inserting ''this section''.

(e) MEDIGAP.—Section 1882 (42 U.S.C. 1395ss) is amended—

(1) in subsection (d)(3)(A)(i)(II), by striking ''plan a medicare supplemental policy'' and inserting ''plan, a medicare supplemental policy'';

(2) in subsection (d)(3)(B)(iii)(II), by striking ''to the best of the issuer or seller's knowledge'' and inserting ''to the best of the issuer's or seller's knowledge'';

(3) in subsection (g)(2)(A), by striking ''medicare supplement policies'' and inserting ''medicare supplemental policies'';

(4) in subsection (p)(2)(B), by striking '', and'' and inserting ''; and''; and

(5) in subsection (s)(3)(A)(iii), by striking ''pre-existing'' and inserting ''preexisting''.

TITLE V—ADMINISTRATIVE IMPROVEMENTS, REGULATORY REDUCTION, AND CONTRACTING REFORM

SEC. 500. ADMINISTRATIVE IMPROVEMENTS WITHIN THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS).

(a) COORDINATED ADMINISTRATION OF MEDICARE PRESCRIPTION DRUG AND MEDICARE ADVANTAGE PROGRAMS.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 421, is amended by inserting after 1807 the following new section:

''PROVISIONS RELATING TO ADMINISTRATION

''SEC. 1808. (a) COORDINATED ADMINISTRATION OF MEDICARE PRESCRIPTION DRUG AND MEDICARE ADVANTAGE PROGRAMS.—

''(1) IN GENERAL.—There is within the Centers for Medicare & Medicaid Services a center to carry out the duties described in paragraph (3).

''(2) DIRECTOR.—Such center shall be headed by a director who shall report directly to the Administrator of the Centers for Medicare & Medicaid Services.

''(3) DUTIES.—The duties described in this paragraph are the following:

''(A) The administration of parts C and D.

''(B) The provision of notice and information under section 1804.

''(C) Such other duties as the Secretary may specify.

''(4) DEADLINE.—The Secretary shall ensure that the center is carrying out the duties described in paragraph (3) by not later than January 1, 2008.''.

(b) MANAGEMENT STAFF FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—Such section is further amended by adding at the end the following new subsection:

''(b) EMPLOYMENT OF MANAGEMENT STAFF.—

''(1) IN GENERAL.—The Secretary may employ, within the Centers for Medicare & Medicaid Services, such individuals as management staff as the Secretary determines to be appropriate. With respect to the administration of parts C and D, such individuals shall include individuals with private sector expertise in negotiations with health benefits plans.

''(2) ELIGIBILITY.—To be eligible for employment under paragraph (1) an individual shall be required to have demonstrated, by their education and experience (either in the public or private sector), superior expertise in at least one of the following areas:

''(A) The review, negotiation, and administration of health care contracts.

''(B) The design of health care benefit plans.

''(C) Actuarial sciences.

''(D) Compliance with health plan contracts.

''(E) Consumer education and decision making.

''(F) Any other area specified by the Secretary that requires specialized management or other expertise.

''(3) RATES OF PAYMENT.—

''(A) PERFORMANCE-RELATED PAY.—Subject to subparagraph (B), the Secretary shall establish the rate of pay for an individual employed under paragraph (1). Such rate shall take into account expertise, experience, and performance.

''(B) LIMITATION.—In no case may the rate of compensation determined under subparagraph (A) exceed the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.''.

(c) REQUIREMENT FOR DEDICATED ACTUARY FOR PRIVATE HEALTH PLANS.—Section 1117(b) (42 U.S.C. 1317(b)) is amended by adding at the end the following new paragraph:

''(3) In the office of the Chief Actuary there shall be an actuary whose duties relate exclusively to the programs under parts C and D of title XVIII and related provisions of such title.''.

(d) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR THE ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) IN GENERAL.—Section 5314 of title 5, United States Code, is amended by adding at the end the following:

''Administrator of the Centers for Medicare & Medicaid Services.''.

(2) CONFORMING AMENDMENT.—Section 5315 of such title is amended by striking ''Administrator of the Health Care Financing Administration.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection take effect on January 1, 2004.

(e) CONFORMING AMENDMENTS RELATING TO HEALTH CARE FINANCING ADMINISTRATION.—

(1) AMENDMENTS TO THE SOCIAL SECURITY ACT.—The Social Security Act is amended—

(A) in section 1117 (42 U.S.C. 1317)—

(i) in the heading to read as follows:

''APPOINTMENT OF THE ADMINISTRATOR AND CHIEF ACTUARY OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES'';

(ii) in subsection (a), by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services''; and

(iii) in subsection (b)(1)—

(I) by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services''; and

(II) by striking ''Administration'' and inserting ''Centers'';

(B) in section 1140(a) (42 U.S.C. 1320b–10(a))—

(i) in paragraph (1), by striking ''Health Care Financing Administration'' both places it appears in the

matter following subparagraph (B) and inserting ''Centers for Medicare & Medicaid Services'';

(ii) in paragraph (1)(A)—

(I) by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services''; and

(II) by striking ''HCFA'' and inserting ''CMS''; and

(iii) in paragraph (1)(B), by striking ''Health Care Financing Administration'' both places it appears and inserting ''Centers for Medicare & Medicaid Services'';

(C) in section 1142(b)(3) (42 U.S.C. 1320b–12(b)(3)), by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services'';

(D) in section 1817(b) (42 U.S.C. 1395i(b))—

(i) by striking ''Health Care Financing Administration'', both in the fifth sentence of the matter preceding paragraph (1) and in the second sentence of the

matter following paragraph (4), and inserting ''Centers for Medicare & Medicaid Services''; and

(ii) by striking ''Chief Actuarial Officer'' in the second sentence of the

matter following paragraph (4) and inserting ''Chief Actuary'';

(E) in section 1841(b) (42 U.S.C. 1395t(b))—

(i) by striking ''Health Care Financing Administration'', both in the fifth sentence of the matter preceding paragraph (1) and in the second sentence of the

matter following paragraph (4), and inserting ''Centers for Medicare & Medicaid Services''; and

(ii) by striking ''Chief Actuarial Officer'' in the second sentence of the

matter following paragraph (4) and inserting ''Chief Actuary'';

(F) in section 1852(a)(5) (42 U.S.C. 1395w–22(a)(5)), by striking ''Health Care Financing Administration'' in the

matter following subparagraph (B) and inserting ''Centers for Medicare & Medicaid Services'';

(G) in section 1853 (42 U.S.C. 1395w–23)—

(i) in subsection (b)(4), by striking ''Health Care Financing Administration'' in the first sentence and inserting ''Centers for Medicare & Medicaid Services''; and

(ii) in subsection (c)(7), by striking ''Health Care Financing Administration'' in the last sentence and inserting ''Centers for Medicare & Medicaid Services'';

(H) in section 1854(a)(5)(A) (42 U.S.C. 1395w–24(a)(5)(A)), by striking ''Health Care Financing Administration''and inserting ''Centers for Medicare & Medicaid Services'';

(I) in section 1857(d)(4)(A)(ii) (42 U.S.C. 1395w–27(d)(4)(A)(ii)), by striking ''Health Care Financing Administration'' and inserting ''Secretary'';

(J) in section 1862(b)(5)(A)(ii) (42 U.S.C. 1395y(b)(5)(A)(ii)), by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services'';

(K) in section 1927(e)(4) (42 U.S.C. 1396r–8(e)(4)), by striking ''HCFA'' and inserting ''The Secretary'';

(L) in section 1927(f)(2) (42 U.S.C. 1396r–8(f)(2)), by striking ''HCFA'' and inserting ''The Secretary''; and

(M) in section 2104(g)(3) (42 U.S.C. 1397dd(g)(3)) by inserting ''or CMS Form 64 or CMS Form 21, as the case may be,'' after ''HCFA Form 64 or HCFA Form 21''

(2) AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.—The Public Health Service Act is amended—

(A) in section 501(d)(18) (42 U.S.C. 290aa(d)(18)), by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services'';

(B) in section 507(b)(6) (42 U.S.C. 290bb(b)(6)), by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services'';

(C) in section 916 (42 U.S.C. 299b–5)—

(i) in subsection (b)(2), by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services''; and

(ii) in subsection (c)(2), by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services'';

(D) in section 921(c)(3)(A) (42 U.S.C. 299c(c)(3)(A)), by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services'';

(E) in section 1318(a)(2) (42 U.S.C. 300e–17(a)(2)), by striking ''Health Care Financing

Administration'' and inserting ''Centers for Medicare & Medicaid Services'';

(F) in section 2102(a)(7) (42 U.S.C. 300aa–2(a)(7)), by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services''; and

(G) in section 2675(a) (42 U.S.C. 300ff–75(a)), by striking ''Health Care Financing Administration'' in the first sentence and inserting ''Centers for Medicare & Medicaid Services''.

(3) AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.—Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended—

(A) in subparagraph (B), by striking ''Health Care Financing Administration'' in the matter preceding clause (i) and inserting ''Centers for Medicare & Medicaid Services''; and

(B) in subparagraph (C)—

(i) by striking ''HEALTH CARE FINANCING ADMINISTRATION'' in the heading and inserting ''CENTERS FOR MEDICARE & MEDICAID SERVICES''; and

(ii) by striking ''Health Care Financing Administration'' in the matter preceding clause (i) and inserting ''Centers for Medicare & Medicaid Services''.

(4) AMENDMENTS TO TITLE 10, UNITED STATES CODE.—Title 10, United States Code, is amended—

(A) in section 1086(d)(4), by striking ''administrator of the Health Care Financing Administration'' in the last sentence and inserting ''Administrator of the Centers for Medicare & Medicaid Services''; and

(B) in section 1095(k)(2), by striking ''Health Care Financing Administration'' in the second sentence and inserting ''Centers for Medicare & Medicaid Services''.

(5) AMENDMENTS TO THE ALZHEIMER'S DISEASE AND RELATED DEMENTIAS SERVICES RESEARCH ACT OF 1992.—The Alzheimer's Disease and Related Dementias Research Act of 1992 (42 U.S.C. 11271 et seq.) is amended—

(A) in the heading of subpart 3 of part D to read as follows:

''Subpart 3—Responsibilities of the Centers for Medicare & Medicaid Services'';

(B) in section 937 (42 U.S.C. 11271)—

(i) in subsection (a), by striking ''National Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services'';

(ii) in subsection (b)(1), by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services'';

(iii) in subsection (b)(2), by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services''; and

(iv) in subsection (c), by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services''; and

(C) in section 938 (42 U.S.C. 11272), by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services''.

(6) MISCELLANEOUS AMENDMENTS.—

(A) REHABILITATION ACT OF 1973.—Section 202(b)(8) of the Rehabilitation Act of 1973 (29 U.S.C. 762(b)(8)) is amended by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services''.

(B) INDIAN HEALTH CARE IMPROVEMENT ACT.—Section 405(d)(1) of the Indian Health Care Improvement Act (25 U.S.C. 1645(d)(1)) is amended by striking ''Health Care Financing Administration'' in the matter preceding subparagraph (A) and inserting ''Centers for Medicare & Medicaid Services''.

(C) INDIVIDUALS WITH DISABILITIES EDUCATION ACT.—Section 644(b)(5) of the Individuals with Disabilities Education Act (20 U.S.C. 1444(b)(5)) is amended by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services''.

(D) THE HOME HEALTH CARE AND ALZHEIMER'S DISEASE AMENDMENTS OF 1990.—Section 302(a)(9) of the Home Health Care and Alzheimer's Disease Amendments of 1990 (42 U.S.C. 242q–1(a)(9)) is amended by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services''.

(E) THE CHILDREN'S HEALTH ACT OF 2000.—Section 2503(a) of the Children's Health Act of 2000 (42 U.S.C. 247b–3a(a)) is amended by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services''.

(F) THE NATIONAL INSTITUTES OF HEALTH REVITALIZATION ACT OF 1993.—Section 1909 of the National Institutes of Health Revitalization Act of 1993 (42 U.S.C. 299a note) is amended by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services''.

(G) THE OMNIBUS BUDGET RECONCILIATION ACT OF 1990.—Section 4359(d) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1395b–3(d)) is amended by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services''.

(H) THE MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000.—Section 104(d)(4) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (42 U.S.C. 1395m note) is amended by striking ''Health Care Financing Administration'' and inserting ''Health Care''.

(7) ADDITIONAL AMENDMENT.—Section 403 of the Act entitled, ''An Act to authorize certain appropriations for the territories of the United States, to amend certain Acts relating thereto, and for other purposes'', enacted October 15, 1977 (48 U.S.C. 1574–1; 48 U.S.C. 1421q–1), is amended by striking ''Health Care Financing Administration'' and inserting ''Centers for Medicare & Medicaid Services''.

Subtitle A—Regulatory Reform

SEC. 501. CONSTRUCTION; DEFINITION OF SUPPLIER.

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

(1) to compromise or affect existing legal remedies for addressing fraud or abuse, whether it be criminal prosecution, civil enforcement, or administrative remedies, including under sections 3729 through 3733 of title 31, United States Code (commonly known as the ''False Claims Act''); or

(2) to prevent or impede the Department of Health and Human Services in any way from its ongoing efforts to eliminate waste, fraud, and abuse in the medicare program.

Furthermore, the consolidation of medicare administrative contracting set forth in this division does not constitute consolidation of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund or reflect any position on that issue.

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

''Supplier

''(d) The term 'supplier' means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title.''.

SEC. 502. ISSUANCE OF REGULATIONS.

(a) REGULAR TIMELINE FOR PUBLICATION OF FINAL RULES.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)) is amended by adding at the end the following new paragraph:

''(3)(A) The Secretary, in consultation with the Director of the Office of Management and Budget, shall establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed regulation or an interim final regulation.

''(B) Such timeline may vary among different regulations based on differences in the complexity of the regulation, the number and scope of comments received, and other relevant factors, but shall not be longer than 3 years except under exceptional circumstances. If the Secretary intends to vary such timeline with respect to the publication of a final regulation, the Secretary shall cause to have published in the Federal Register notice of the different timeline by not later than the timeline previously established with respect to such regulation. Such notice shall include a brief explanation of the justification for such variation.

''(C) In the case of interim final regulations, upon the expiration of the regular timeline established under this paragraph for the publication of a final regulation after opportunity for public comment, the interim final regulation shall not continue in effect unless the Secretary publishes (at the end of the regular timeline and, if applicable, at the end of each succeeding 1-year period) a notice of continuation of the regulation that includes an explanation of why the regular timeline (and any subsequent 1-year extension) was not complied with. If such a notice is published, the regular timeline (or such timeline as previously extended under this paragraph) for publication of the final regulation shall be treated as having been extended for 1 additional year.

''(D) The Secretary shall annually submit to Congress a report that describes the instances in which the Secretary failed to publish a final regulation within the applicable regular timeline under this paragraph and that provides an explanation for such failures.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act. The Secretary shall provide for an appropriate transition to take into account the backlog of previously published interim final regulations.

(b) LIMITATIONS ON NEW MATTER IN FINAL REGULATIONS.—

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

''(4) If the Secretary publishes a final regulation that includes a provision that is not a logical outgrowth of a previously published notice of proposed rulemaking or interim final rule, such provision shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation.''.

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

SEC. 503. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

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

''(e)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall

not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

''(i) such retroactive application is necessary to comply with statutory requirements; or

''(ii) failure to apply the change retroactively would be contrary to the public interest.''.

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

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

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

''(B)(i) Except as provided in clause (ii), a substantive change referred to in subparagraph (A) shall not become effective before the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

''(ii) The Secretary may provide for such a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.

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

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

(c) RELIANCE ON GUIDANCE.—

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

''(2)(A) If—

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

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

''(iii) the guidance was in error;

the provider of services or supplier shall not be subject to any penalty or interest under this title or the provisions of title XI insofar as they relate to this title (including interest under a repayment plan under section 1893 or otherwise) relating to the provision of such items or service or such claim if the provider of services or supplier reasonably relied on such guidance.

''(B) Subparagraph (A) shall not be construed as preventing the recoupment or repayment (without any additional penalty) relating to an overpayment insofar as the overpayment was solely the result of a clerical or technical operational error.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act and shall only apply to a penalty or interest imposed with respect to guidance provided on or after July 24, 2003.

SEC. 504. REPORTS AND STUDIES RELATING TO REGULATORY REFORM.

(a) GAO STUDY ON ADVISORY OPINION AUTHORITY.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to determine the feasibility and appropriateness of establishing in the Secretary authority to provide legally binding advisory opinions on appropriate interpretation and application of regulations to carry out the medicare program under title XVIII of the Social Security Act. Such study shall examine the appropriate timeframe for issuing such advisory opinions, as well as the need for additional staff and funding to provide such opinions.

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

(b) REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.—Section 1871 (42 U.S.C. 1395hh), as amended by section 503(a)(1), is amended by adding at the end the following new subsection:

''(f)(1) Not later than 2 years after the date of the enactment of this subsection, and every 3 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

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

''(A) information from individuals entitled to benefits under part A or enrolled under part B, or both, providers of services, and suppliers and from the Medicare Beneficiary Ombudsman with respect to such areas of inconsistency and conflict; and

''(B) information from medicare contractors that tracks the nature of written and telephone inquiries.

''(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.''.

Subtitle B—Contracting Reform

SEC. 511. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

''CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

''SEC. 1874A. (a) AUTHORITY.—

''(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

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

''(A) the entity has demonstrated capability to carry out such function;

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

''(C) the entity has sufficient assets to financially support the performance of such function; and

''(D) the entity meets such other requirements as the Secretary may impose.

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

''(A) IN GENERAL.—The term 'medicare administrative contractor' means an agency, organization, or other person with a contract under this section.

''(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services or supplier (or class of such providers of services or suppliers), the 'appropriate' medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services or supplier or class of provider of services or supplier.

''(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions (including the function of developing local coverage determinations, as defined in section 1869(f)(2)(B)), provider services functions, and functions relating to services furnished to individuals entitled to benefits under part A or enrolled under part B, or both, as follows:

''(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, suppliers and individuals.

''(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

''(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Providing education and outreach to individuals entitled to benefits under part A or enrolled under part B, or both, and providing assistance to those individuals with specific issues, concerns, or problems.

''(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services or suppliers.

''(E) COMMUNICATION WITH PROVIDERS.—Communicating to providers of services and suppliers any information or instructions furnished to the medicare administrative contractor by the Secretary, and facilitating communication between such providers and suppliers and the Secretary.

''(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions relating to provider education, training, and technical assistance.

''(G) ADDITIONAL FUNCTIONS.—Performing such other functions, including (subject to paragraph (5)) functions under the Medicare Integrity Program under section 1893, as are necessary to carry out the purposes of this title.

''(5) RELATIONSHIP TO MIP CONTRACTS.—

''(A) NONDUPLICATION OF DUTIES.—In entering into contracts under this section, the Secretary shall assure that functions of medicare administrative contractors in carrying out activities under parts A and B do not duplicate activities carried out under a contract entered into under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5)

(relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

''(B) CONSTRUCTION.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

''(6) APPLICATION OF FEDERAL ACQUISITION REGULATION.—Except to the extent inconsistent with a specific requirement of this section, the Federal Acquisition Regulation applies to contracts under this section.

''(b) CONTRACTING REQUIREMENTS.—

''(1) USE OF COMPETITIVE PROCEDURES.—

''(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section, taking into account performance quality as well as price and other factors.

''(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every 5 years.

''(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among medicare administrative contractors consistent with the provisions of this paragraph. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide public notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred, a description of the providers of services and suppliers affected by such transfer, and contact information for the contractors involved).

''(D) INCENTIVES FOR QUALITY.—The Secretary shall provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

''(2) COMPLIANCE WITH REQUIREMENTS.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, quality of services provided, and other matters as the Secretary finds pertinent.

''(3) PERFORMANCE REQUIREMENTS.—

''(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—

''(i) IN GENERAL.—The Secretary shall develop contract performance requirements to carry out the specific requirements applicable under this title to a function described in subsection (a)(4) and shall develop standards for measuring the extent to which a contractor has met such requirements.

''(ii) CONSULTATION.—In developing such performance requirements and standards for measurement, the Secretary shall consult with providers of services, organizations representative of beneficiaries under this title, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements.

''(iii) PUBLICATION OF STANDARDS.—The Secretary shall make such performance requirements and measurement standards available to the public.

''(B) CONSIDERATIONS.—The Secretary shall include, as one of the standards developed under subparagraph (A), provider and beneficiary satisfaction levels.

''(C) INCLUSION IN CONTRACTS.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

''(i) shall reflect the performance requirements published under subparagraph (A), but may include additional performance requirements;

''(ii) shall be used for evaluating contractor performance under the contract; and

''(iii) shall be consistent with the written statement of work provided under the contract.

''(4) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

''(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

''(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

''(5) SURETY BOND.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

''(c) TERMS AND CONDITIONS.—

''(1) IN GENERAL.—A contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

''(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

''(d) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

''(1) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by the individual under this section.

''(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General of the United States) of a certifying officer designated as provided in paragraph (1) of this subsection.

''(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—

''(A) IN GENERAL.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless, in connection with such payment, the medicare administrative contractor acted with reckless disregard of its obligations under its medicare administrative contract or with intent to defraud the United States.

''(B) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code.

''(4) INDEMNIFICATION BY SECRETARY.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (D), in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from or relating directly to the claims administration process under this title, the Secretary may, to the extent the Secretary determines to be appropriate and as specified in the contract with the contractor, indemnify the contractor and such persons.

''(B) CONDITIONS.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the judicial proceeding or by the Secretary to be criminal in nature, fraudulent, or grossly negligent. If indemnification is provided by the Secretary with respect to a contractor before a determination that such costs arose directly from such conduct, the contractor shall reimburse the Secretary for costs of indemnification.

''(C) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

''(D) WRITTEN APPROVAL FOR SETTLEMENTS OR COMPROMISES.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate such settlement or compromise. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement or compromise of a proceeding described in such subparagraph are conditioned upon prior written approval by the Secretary of the final settlement or compromise.

''(E) CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

''(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulation.''.

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act, as inserted by paragraph (1), the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of the enactment of this Act.

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

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

''PROVISIONS RELATING TO THE ADMINISTRATION OF PART A''.

(2) Subsection (a) is amended to read as follows:

''(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.''.

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking ''agreement under this section'' and inserting ''contract under section 1874A that provides for making payments under this part''.

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

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

(A) by striking ''An agreement with an agency or organization under this section'' and inserting ''A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part''; and

(B) by striking ''such agency or organization'' and inserting ''such medicare administrative contractor'' each place it appears.

(7) Subsection (l) is repealed.

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

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

''PROVISIONS RELATING TO THE ADMINISTRATION OF PART B''.

(2) Subsection (a) is amended to read as follows:

''(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.''.

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

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

(ii) in subparagraph (C), by striking ''carriers'' and inserting ''medicare administrative contractors''; and

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

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking ''Each such contract shall provide that the carrier'' and inserting ''The Secretary'';

(ii) by striking ''will'' the first place it appears in each of subparagraphs (A), (B), (F), (G), (H), and (L) and inserting ''shall'';

(iii) in subparagraph (B), in the matter before clause (i), by striking ''to the policyholders and subscribers of the carrier'' and inserting ''to the policyholders and subscribers of the medicare administrative contractor'';

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

(v) in subparagraph (H)—

(I) by striking ''if it makes determinations or payments with respect to physicians' services,'' in the matter preceding clause (i); and

(II) by striking ''carrier'' and inserting ''medicare administrative contractor'' in clause (i);

(vi) by striking subparagraph (I);

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

(viii) in the first sentence, after subparagraph (L), by striking ''and shall contain'' and all that follows through the period; and

(ix) in the seventh sentence, by inserting ''medicare administrative contractor,'' after ''carrier,'';

(D) by striking paragraph (5);

(E) in paragraph (6)(D)(iv), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(F) in paragraph (7), by striking ''the carrier'' and inserting ''the Secretary'' each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)(A), by striking ''contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B),'' and inserting ''contract under section 1874A that provides for making payments under this part'';

(C) in paragraph (3)(A), by striking ''subsection (a)(1)(B)'' and inserting ''section 1874A(a)(3)(B)'';

(D) in paragraph (4), in the matter preceding subparagraph (A), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

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

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

(6) Subsection (g) is amended by striking ''carrier or carriers'' and inserting ''medicare administrative contractor or contractors''.

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking ''Each carrier having an agreement with the Secretary under subsection (a)'' and inserting ''The Secretary''; and

(ii) by striking ''Each such carrier'' and inserting ''The Secretary'';

(B) in paragraph (3)(A)—

(i) by striking ''a carrier having an agreement with the Secretary under subsection (a)'' and inserting ''medicare administrative contractor having a contract under section 1874A that provides for making payments under this part''; and

(ii) by striking ''such carrier'' and inserting ''such contractor'';

(C) in paragraph (3)(B)—

(i) by striking ''a carrier'' and inserting ''a medicare administrative contractor'' each place it appears; and

(ii) by striking ''the carrier'' and inserting ''the contractor'' each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking ''carriers'' and inserting ''medicare administrative contractors'' each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(B) in paragraph (2), by striking ''carrier'' and inserting ''medicare administrative contractor''.

(9) Subsection (p)(3)(A) is amended by striking ''carrier'' and inserting ''medicare administrative contractor''.

(10) Subsection (q)(1)(A) is amended by striking ''carrier''.

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2005, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this Act, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2011.

(2) GENERAL TRANSITION RULES.—

(A) AUTHORITY TO CONTINUE TO ENTER INTO NEW AGREEMENTS AND CONTRACTS AND WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—Prior to October 1, 2005, the Secretary may, consistent with subparagraph (B), continue to enter into agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u). The Secretary may enter into new agreements under section 1816 prior to October 1, 2005, without regard to any of the provider nomination provisions of such section.

(B) APPROPRIATE TRANSITION.—The Secretary shall take such steps as are necessary to provide for an appropriate transition from agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) AUTHORIZING CONTINUATION OF MIP FUNCTIONS UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER TRANSITION CONTRACTS.—Notwithstanding the amendments made by this section, the provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply during the period that begins on the date of the enactment of this Act and ends on October 1, 2011, and any reference in such provisions to an agreement or contract shall be deemed to include a contract under section 1874A of such Act, as inserted by subsection (a)(1), that continues the activities referred to in such provisions.

(e) REFERENCES.—On and after the effective date provided under subsection (d)(1), any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to a medicare administrative contractor (as provided under section 1874A of the Social Security Act).

(f) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(g) REPORTS ON IMPLEMENTATION.—

(1) PLAN FOR IMPLEMENTATION.—By not later than October 1, 2004, the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes the plan for implementation of the amendments made by this section. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2008, that describes the status of implementation of such amendments and that includes a description of the following:

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

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

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

(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.

SEC. 512. REQUIREMENTS FOR INFORMATION SECURITY FOR MEDICARE ADMINISTRATIVE CONTRACTORS.

(a) IN GENERAL.—Section 1874A, as added by section 511(a)(1), is amended by adding at the end the following new subsection:

''(e) REQUIREMENTS FOR INFORMATION SECURITY.—

''(1) DEVELOPMENT OF INFORMATION SECURITY PROGRAM.—A medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall implement a contractor-wide information security program to provide information security for the operation and assets of the contractor with respect to such functions under this title. An information security program under this paragraph shall meet the requirements for information security programs imposed on Federal agencies under paragraphs (1) through (8) of section 3544(b) of title 44, United States Code (other than the requirements under paragraphs (2)(D)(i), (5)(A), and (5)(B) of such section).

''(2) INDEPENDENT AUDITS.—

''(A) PERFORMANCE OF ANNUAL EVALUATIONS.—Each year a medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall undergo an evaluation of the information security of the contractor with respect to such functions under this title. The evaluation shall—

''(i) be performed by an entity that meets such requirements for independence as the Inspector General of the Department of Health and Human Services may establish; and

''(ii) test the effectiveness of information security control techniques of an appropriate subset of the contractor's information systems (as defined in section 3502(8) of title 44, United States Code) relating to such functions under this title and an assessment of compliance with the requirements of this subsection and related information security policies, procedures, standards and guidelines, including policies and procedures as may be prescribed by the Director of the Office of Management and Budget and applicable information security standards promulgated under section 11331 of title 40, United States Code.

''(B) DEADLINE FOR INITIAL EVALUATION.—

''(i) NEW CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that has not previously performed the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) as a fiscal intermediary or carrier under section 1816 or 1842, the first independent evaluation conducted pursuant to subparagraph (A) shall be completed prior to commencing such functions.

''(ii) OTHER CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that is not described in clause (i), the first independent evaluation conducted pursuant to subparagraph (A) shall be completed within 1 year after the date the contractor commences functions referred to in clause (i) under this section.

''(C) REPORTS ON EVALUATIONS.—

''(i) TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The results of independent evaluations under subparagraph (A) shall be submitted promptly to the Inspector General of the Department of Health and Human Services and to the Secretary.

''(ii) TO CONGRESS.—The Inspector General of the Department of Health and Human Services shall submit to Congress annual reports on the results of such evaluations, including assessments of the scope and sufficiency of such evaluations.

''(iii) AGENCY REPORTING.—The Secretary shall address the results of such evaluations in reports required under section 3544(c) of title 44, United States Code.''.

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

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

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

Subtitle C—Education and Outreach

SEC. 521. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1888 the following new section:

''PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

''SEC. 1889. (a) COORDINATION OF EDUCATION FUNDING.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (g), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services and suppliers.''.

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

(3) REPORT.—Not later than October 1, 2004, the Secretary shall submit to Congress a report that includes a description and evaluation of the steps taken to coordinate the funding of provider education under section 1889(a) of the Social Security Act, as added by paragraph (1).

(b) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—

(1) IN GENERAL.—Section 1874A, as added by section 511(a)(1) and as amended by section 512(a), is amended by adding at the end the following new subsection:

''(f) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—The Secretary shall use specific claims payment error rates or similar methodology of medicare administrative contractors in the processing or reviewing of medicare claims in order to give such contractors an incentive to implement effective education and outreach programs for providers of services and suppliers.''.

(2) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(f) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(3) GAO REPORT ON ADEQUACY OF METHODOLOGY.—Not later than October 1, 2004, the Comptroller General of the United States shall submit to Congress and to the Secretary a report on the adequacy of the methodology under section 1874A(f) of the Social Security Act, as added by paragraph (1), and shall include in the report such recommendations as the Comptroller General determines appropriate with respect to the methodology.

(4) REPORT ON USE OF METHODOLOGY IN ASSESSING CONTRACTOR PERFORMANCE.—Not later than October 1, 2004, the Secretary shall submit to Congress a report that describes how the Secretary intends to use such methodology in assessing medicare contractor performance in implementing effective education and outreach programs, including whether to use such methodology as a basis for performance bonuses. The report shall include an analysis of the sources of identified errors and potential changes in systems of contractors and rules of the Secretary that could reduce claims error rates.

(c) PROVISION OF ACCESS TO AND PROMPT RESPONSES FROM MEDICARE ADMINISTRATIVE CONTRACTORS.—

(1) IN GENERAL.—Section 1874A, as added by section 511(a)(1) and as amended by section 512(a) and subsection (b), is further amended by adding at the end the following new subsection:

''(g) COMMUNICATIONS WITH BENEFICIARIES, PROVIDERS OF SERVICES AND SUPPLIERS.—

''(1) COMMUNICATION STRATEGY.—The Secretary shall develop a strategy for communications with individuals entitled to benefits under part A or enrolled under part B, or both, and with providers of services and suppliers under this title.

''(2) RESPONSE TO WRITTEN INQUIRIES.—Each medicare administrative contractor shall, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries of providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, concerning the programs under this title within 45 business days of the date of receipt of such inquiries.

''(3) RESPONSE TO TOLL-FREE LINES.—The Secretary shall ensure that each medicare administrative contractor shall provide, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, a toll-free telephone number at which such individuals, providers of services, and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

''(4) MONITORING OF CONTRACTOR RESPONSES.—

''(A) IN GENERAL.—Each medicare administrative contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

''(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

''(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

''(B) DEVELOPMENT OF STANDARDS.—

''(i) IN GENERAL.—The Secretary shall establish and make public standards to monitor the accuracy, consistency, and timeliness of the information provided in response to written and telephone inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

''(ii) EVALUATION.—In conducting evaluations of individual medicare administrative contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

''(C) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.

''(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this subsection.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect October 1, 2004.

(3) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(g) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(d) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(1) IN GENERAL.—Section 1889, as added by subsection (a), is amended by adding at the end the following new subsections:

''(b) ENHANCED EDUCATION AND TRAINING.—

''(1) ADDITIONAL RESOURCES.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) such sums as may be necessary for fiscal years beginning with fiscal year 2005.

''(2) USE.—The funds made available under paragraph (1) shall be used to increase the conduct by medicare contractors of education and training of providers of services and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses.

''(c) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

''(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall tailor such activities to meet the special needs of small providers of services or suppliers (as defined in paragraph (2)). Such education and training activities for small providers of services and suppliers may include the provision of technical assistance (such as review of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance).

''(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term 'small provider of services or supplier' means—

''(A) a provider of services with fewer than 25 full-time-equivalent employees; or

''(B) a supplier with fewer than 10 full-time-equivalent employees.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(e) REQUIREMENT TO MAINTAIN INTERNET WEBSITES.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsection (d), is further amended by adding at the end the following new subsection:

''(d) INTERNET WEBSITES; FAQS.—The Secretary, and each medicare contractor insofar as it provides services (including claims processing) for providers of services or suppliers, shall maintain an Internet website which—

''(1) provides answers in an easily accessible format to frequently asked questions, and

''(2) includes other published materials of the contractor,

that relate to providers of services and suppliers under the programs under this title (and title XI insofar as it relates to such programs).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(f) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsections (d) and (e), is further amended by adding at the end the following new subsections:

''(e) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION PROGRAM ACTIVITIES.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services or suppliers for the purpose of conducting any type of audit or prepayment review.

''(f) CONSTRUCTION.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor—

''(1) of the screens used for identifying claims that will be subject to medical review; or

''(2) of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

''(g) DEFINITIONS.—For purposes of this section, the term 'medicare contractor' includes the following:

''(1) A medicare administrative contractor with a contract under section 1874A, including a fiscal intermediary with a contract under section 1816 and a carrier with a contract under section 1842.

''(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services or supplier an entity that has no authority under this title or title IX with respect to such activities and such provider of services or supplier.''.

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

SEC. 522. SMALL PROVIDER TECHNICAL ASSISTANCE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the ''demonstration program'') under which technical assistance described in paragraph (2) is made available, upon request and on a voluntary basis, to small providers of services or suppliers in order to improve compliance with the applicable requirements of the programs under medicare program under title XVIII of the Social Security Act (including provisions of title XI of such Act insofar as they relate to such title and are not administered by the Office of the Inspector General of the Department of Health and Human Services).

(2) FORMS OF TECHNICAL ASSISTANCE.—The technical assistance described in this paragraph is—

(A) evaluation and recommendations regarding billing and related systems; and

(B) information and assistance regarding policies and procedures under the medicare program, including coding and reimbursement.

(3) SMALL PROVIDERS OF SERVICES OR SUPPLIERS.—In this section, the term ''small providers of services or suppliers'' means—

(A) a provider of services with fewer than 25 full-time-equivalent employees; or

(B) a supplier with fewer than 10 full-time-equivalent employees.

(b) QUALIFICATION OF CONTRACTORS.—In conducting the demonstration program, the Secretary shall enter into contracts with qualified organizations (such as peer review organizations or entities described in section 1889(g)(2) of the Social Security Act, as inserted by section 521(f)(1)) with appropriate expertise with billing systems of the full range of providers of services and suppliers to provide the technical assistance. In awarding such contracts, the Secretary shall consider any prior investigations of the entity's work by the Inspector General of Department of Health and Human Services or the Comptroller General of the United States.

(c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The technical assistance provided under the demonstration program shall include a direct and in-person examination of billing systems and internal controls of small providers of services or suppliers to determine program compliance and to suggest more efficient or effective means of achieving such compliance.

(d) GAO EVALUATION.—Not later than 2 years after the date the demonstration program is first implemented, the Comptroller General, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct an evaluation of the demonstration program. The evaluation shall include a determination of whether claims error rates are reduced for small providers of services or suppliers who participated in the program and the extent of improper payments made as a result of the demonstration program. The Comptroller General shall submit a report to the Secretary and the Congress on such evaluation and shall include in such report recommendations regarding the continuation or extension of the demonstration program.

(e) FINANCIAL PARTICIPATION BY PROVIDERS.—The provision of technical assistance to a small provider of services or supplier under the demonstration program is conditioned upon the small provider of services or supplier paying an amount estimated (and disclosed in advance of a provider's or supplier's participation in the program) to be equal to 25 percent of the cost of the technical assistance.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, from amounts not otherwise appropriated in the Treasury, such sums as may be necessary to carry out this section.

SEC. 523. MEDICARE BENEFICIARY OMBUDSMAN.

(a) IN GENERAL.—Section 1808, as added and amended by section 500, is amended by adding at the end the following new subsection:

''(c) MEDICARE BENEFICIARY OMBUDSMAN.—

''(1) IN GENERAL.—The Secretary shall appoint within the Department of Health and

Human Services a Medicare Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals entitled to benefits under this title.

''(2) DUTIES.—The Medicare Beneficiary Ombudsman shall—

''(A) receive complaints, grievances, and requests for information submitted by individuals entitled to benefits under part A or enrolled under part B, or both, with respect to any aspect of the medicare program;

''(B) provide assistance with respect to complaints, grievances, and requests referred to in subparagraph (A), including—

''(i) assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, MA organization, or the Secretary;

''(ii) assistance to such individuals with any problems arising from disenrollment from an MA plan under part C; and

''(iii) assistance to such individuals in presenting information under section 1839(i)(4)(C) (relating to income-related premium adjustment; and

''(C) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

''(3) WORKING WITH HEALTH INSURANCE COUNSELING PROGRAMS.—To the extent possible, the Ombudsman shall work with health insurance counseling programs (receiving funding under section 4360 of Omnibus Budget Reconciliation Act of 1990) to facilitate the provision of information to individuals entitled to benefits under part A or enrolled under part B, or both regarding MA plans and changes to those plans. Nothing in this paragraph shall preclude further collaboration between the Ombudsman and such programs.''.

(b) DEADLINE FOR APPOINTMENT.—By not later than 1 year after the date of the enactment of this Act, the Secretary shall appoint the Medicare Beneficiary Ombudsman under section 1808(c) of the Social Security Act, as added by subsection (a).

(c) FUNDING.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund, established under section 1817 of the Social Security Act (42 U.S.C. 1395i), and the Federal Supplementary Medical Insurance Trust Fund, established under section 1841 of such Act (42 U.S.C. 1395t)) to carry out section 1808(c) of such Act (relating to the Medicare Beneficiary Ombudsman), as added by subsection (a), such sums as are necessary for fiscal year 2004 and each succeeding fiscal year.

(d) USE OF CENTRAL, TOLL-FREE NUMBER (1–800–MEDICARE).—

(1) PHONE TRIAGE SYSTEM; LISTING IN MEDICARE HANDBOOK INSTEAD OF OTHER TOLL-FREE NUMBERS.—Section 1804(b) (42 U.S.C. 1395b–2(b)) is amended by adding at the end the following: ''The Secretary shall provide, through the toll-free telephone number 1–800–MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.''.

(2) MONITORING ACCURACY.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study to monitor the accuracy and consistency of information provided to individuals entitled to benefits under part A or enrolled under part B, or both, through the toll-free telephone number 1–800–MEDICARE, including an assessment of whether the information provided is sufficient to answer questions of such individuals. In conducting the study, the Comptroller General shall examine the education and training of the individuals providing information through such number.

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subparagraph (A).

SEC. 524. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the ''demonstration program'') under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to individuals entitled to benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title, or both, regarding the medicare program at the location of existing local offices of the Social Security Administration.

(b) LOCATIONS.—

(1) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to paragraph (2), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by individuals referred to in subsection (a).

(2) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(c) DURATION.—The demonstration program shall be conducted over a 3-year period.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(A) utilization of, and satisfaction of those individuals referred to in subsection (a) with, the assistance provided under the program; and

(B) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local offices of the Social Security Administration.

(2) REPORT.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing medicare specialists at local offices of the Social Security Administration.

SEC. 525. INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT SKILLED NURSING FACILITY BENEFITS.

(a) IN GENERAL.—The Secretary shall provide that in medicare beneficiary notices provided (under section 1806(a) of the Social Security Act, 42 U.S.C. 1395b–7(a)) with respect to the provision of post-hospital extended care services under part A of title XVIII of the Social Security Act, there shall be included information on the number of days of coverage of such services remaining under such part for the medicare beneficiary and spell of illness involved.

(b) EFFECTIVE DATE.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

SEC. 526. INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS.

(a) AVAILABILITY OF DATA.—The Secretary shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program.

(b) INCLUSION OF INFORMATION IN CERTAIN HOSPITAL DISCHARGE PLANS.—

(1) IN GENERAL.—Section 1861(ee)(2)(D) (42 U.S.C. 1395x(ee)(2)(D)) is amended—

(A) by striking ''hospice services'' and inserting ''hospice care and post-hospital extended care services''; and

(B) by inserting before the period at the end the following: ''and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to discharge plans made on or after such date as the Secretary shall specify, but not later than 6 months after the date the Secretary provides for availability of information under subsection (a).

Subtitle D—Appeals and Recovery

SEC. 531. TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) TRANSITION PLAN.—

(1) IN GENERAL.—Not later than April 1, 2004, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) CONTENTS.—The plan shall include information on the following:

(A) WORKLOAD.—The number of such administrative law judges and support staff required now and in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated claims volume, appeals, number of beneficiaries, and statutory changes.

(B) COST PROJECTIONS AND FINANCING.—Funding levels required for fiscal year 2005 and subsequent fiscal years to carry out the functions transferred under the plan.

(C) TRANSITION TIMETABLE.—A timetable for the transition.

(D) REGULATIONS.—The establishment of specific regulations to govern the appeals process.

(E) CASE TRACKING.—The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the medicare program.

(F) FEASIBILITY OF PRECEDENTIAL AUTHORITY.—The feasibility of developing a process to give decisions of the Departmental Appeals Board in the Department of Health and Human Services addressing broad legal issues binding, precedential authority.

(G) ACCESS TO ADMINISTRATIVE LAW JUDGES.—The feasibility of—

(i) filing appeals with administrative law judges electronically; and

(ii) conducting hearings using tele- or video-conference technologies.

(H) INDEPENDENCE OF ADMINISTRATIVE LAW JUDGES.—The steps that should be taken to ensure the independence of administrative law judges consistent with the requirements of subsection (b)(2).

(I) GEOGRAPHIC DISTRIBUTION.—The steps that should be taken to provide for an appropriate geographic distribution of administrative law judges throughout the United States to carry out subsection (b)(3).

(J) HIRING.—The steps that should be taken to hire administrative law judges (and support staff) to carry out subsection (b)(4).

(K) PERFORMANCE STANDARDS.—The appropriateness of establishing performance standards for administrative law judges with respect to timelines for decisions in cases under title XVIII of the Social Security Act taking into account requirements under subsection (b)(2) for the independence of such judges and consistent with the applicable provisions of title 5, United States Code relating to impartiality.

(L) SHARED RESOURCES.—The steps that should be taken to carry out subsection (b)(6) (relating to the arrangements with the Commissioner of Social Security to share office space, support staff, and other resources, with appropriate reimbursement).

(M) TRAINING.—The training that should be provided to administrative law judges with respect to laws and regulations under title XVIII of the Social Security Act.

(3) ADDITIONAL INFORMATION.—The plan may also include recommendations for further congressional action, including modifications to the requirements and deadlines established under section 1869 of the Social Security Act (42 U.S.C. 1395ff) (as amended by this Act).

(4) GAO EVALUATION.—The Comptroller General of the United States shall evaluate the plan and, not later than the date that is 6 months after the date on which the plan is received by the Comptroller General, shall submit to Congress a report on such evaluation.

(b) TRANSFER OF ADJUDICATION AUTHORITY.—

(1) IN GENERAL.—Not earlier than July 1, 2005, and not later than October 1, 2005, the Commissioner of Social Security and the Secretary shall implement the transition plan under subsection (a) and transfer the administrative law judge functions described in such subsection from the Social Security Administration to the Secretary.

(2) ASSURING INDEPENDENCE OF JUDGES.—The Secretary shall assure the independence of administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Centers for Medicare & Medicaid Services and its contractors. In order to assure such independence, the Secretary shall place such judges in an administrative office that is organizationally and functionally separate from such Centers. Such judges shall report to, and be under the general supervision of, the Secretary, but shall not report to, or be subject to supervision by, another officer of the Department of Health and Human Services.

(3) GEOGRAPHIC DISTRIBUTION.—The Secretary shall provide for an appropriate geographic distribution of administrative law judges performing the administrative law judge functions transferred under paragraph (1) throughout the United States to ensure timely access to such judges.

(4) HIRING AUTHORITY.—Subject to the amounts provided in advance in appropriations Acts, the Secretary shall have authority to hire administrative law judges to hear such cases, taking into consideration those judges with expertise in handling medicare appeals and in a manner consistent with paragraph (3), and to hire support staff for such judges.

(5) FINANCING.—Amounts payable under law to the Commissioner for administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund shall become payable to the Secretary for the functions so transferred.

(6) SHARED RESOURCES.—The Secretary shall enter into such arrangements with the Commissioner as may be appropriate with respect to transferred functions of administrative law judges to share office space, support staff, and other resources, with appropriate reimbursement from the Trust Funds described in paragraph (5).

(c) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to ensure timely action on appeals before administrative law judges and the Departmental Appeals Board consistent with section 1869 of the Social Security Act (42 U.S.C. 1395ff) (as amended by this Act), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund, established under section 1817 of the Social Security Act (42 U.S.C. 1395i), and the Federal Supplementary Medical Insurance Trust Fund, established under section 1841 of such Act (42 U.S.C. 1395t)) to the Secretary such sums as are necessary for fiscal year 2005 and each subsequent fiscal year to—

(1) increase the number of administrative law judges (and their staffs) under subsection (b)(4);

(2) improve education and training opportunities for administrative law judges (and their staffs); and

(3) increase the staff of the Departmental Appeals Board.

(d) CONFORMING AMENDMENT.—Section 1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)) is amended by striking ''of the Social Security Administration''.

SEC. 532. PROCESS FOR EXPEDITED ACCESS TO REVIEW.

(a) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

(1) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)) is amended—

(A) in paragraph (1)(A), by inserting '', subject to paragraph (2),'' before ''to judicial review of the Secretary's final decision''; and

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

''(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

''(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or an individual entitled to benefits under part A or enrolled under part B, or both, who has filed an appeal under paragraph (1) (other than an appeal filed under paragraph (1)(F)(i)) may obtain access to judicial review when a review entity (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation for a specific matter in dispute in a case of an appeal.

''(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute, and if such request is accompanied by the documents and materials as the appropriate review entity shall require for purposes of making such determination, such review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the request and such accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.

''(C) ACCESS TO JUDICIAL REVIEW.—

''(i) IN GENERAL.—If the appropriate review entity—

''(I) determines that there are no material issues of fact in dispute and that the only issues to be adjudicated are ones of law or regulation that the Departmental Appeals Board does not have authority to decide; or

''(II) fails to make such determination within the period provided under subparagraph (B),

then the appellant may bring a civil action as described in this subparagraph.

''(ii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in—

''(I) clause (i)(I), within 60 days of the date of the determination described in such clause; or

''(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

''(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the District Court for the District of Columbia.

''(iv) INTEREST ON ANY AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier is granted judicial review pursuant to this paragraph, the amount in controversy (if any) shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services or suppliers under this title.

''(D) REVIEW ENTITY DEFINED.—For purposes of this subsection, the term 'review entity' means an entity of up to three reviewers who are administrative law judges or members of the Departmental Appeals Board selected for purposes of making determinations under this paragraph.''.

(2) CONFORMING AMENDMENT.—Section 1869(b)(1)(F)(ii) (42 U.S.C. 1395ff(b)(1)(F)(ii)) is amended to read as follows:

''(ii) REFERENCE TO EXPEDITED ACCESS TO JUDICIAL REVIEW.—For the provision relating to expedited access to judicial review, see paragraph (2).''.

(b) APPLICATION TO PROVIDER AGREEMENT DETERMINATIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

(1) by inserting ''(A)'' after ''(h)(1)''; and

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

''(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and individuals entitled

to benefits under part A or enrolled under part B, or both, may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.''.

(c) EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.—

(1) TERMINATION AND CERTAIN OTHER IMMEDIATE REMEDIES.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)), as amended by subsection (b), is amended by adding at the end the following new subparagraph:

''(C)(i) The Secretary shall develop and implement a process to expedite proceedings under this subsection in which—

''(I) the remedy of termination of participation has been imposed;

''(II) a remedy described in clause (i) or (iii) of section 1819(h)(2)(B) has been imposed, but only if such remedy has been imposed on an immediate basis; or

''(III) a determination has been made as to a finding of substandard quality of care that results in the loss of approval of a skilled nursing facility's nurse aide training program.

''(ii) Under such process under clause (i), priority shall be provided in cases of termination described in clause (i)(I).

''(iii) Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.''.

(2) WAIVER OF DISAPPROVAL OF NURSE-AIDE TRAINING PROGRAMS.—Sections 1819(f)(2) and section 1919(f)(2) (42 U.S.C. 1395i–3(f)(2) and 1396r(f)(2)) are each amended—

(A) in subparagraph (B)(iii), by striking ''subparagraph (C)'' and inserting ''subparagraphs (C) and (D)''; and

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

''(D) WAIVER OF DISAPPROVAL OF NURSE-AIDE TRAINING PROGRAMS.—Upon application of a nursing facility, the Secretary may waive the application of subparagraph (B)(iii)(I)(c) if the imposition of the civil monetary penalty was not related to the quality of care provided to residents of the facility. Nothing in this subparagraph shall be construed as eliminating any requirement upon a facility to pay a civil monetary penalty described in the preceding sentence.''.

(3) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund, established under section 1817 of the Social Security Act (42 U.S.C. 1395i), and the Federal Supplementary Medical Insurance Trust Fund, established under section 1841 of such Act (42 U.S.C. 1395t)) to the Secretary such additional sums for fiscal year 2004 and each subsequent fiscal year as may be necessary. The purposes for which such amounts are available include increasing the number of administrative law judges (and their staffs) and the appellate level staff at the Departmental Appeals Board of the Department of Health and Human Services and educating such judges and staffs on long-term care issues.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to appeals filed on or after October 1, 2004.

SEC. 533. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE.—

(1) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by section 532(a), is further amended by adding at the end the following new paragraph:

''(3) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE BY PROVIDERS.—A provider of services or supplier may not introduce evidence in any appeal under this section that was not presented at the reconsideration conducted by the qualified independent contractor under subsection (c), unless there is good cause which precluded the introduction of such evidence at or before that reconsideration.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(b) USE OF PATIENTS' MEDICAL RECORDS.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)) is amended by inserting ''(including the medical records of the individual involved)'' after ''clinical experience''.

(c) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

(1) INITIAL DETERMINATIONS AND REDETERMINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)) is amended by adding at the end the following new paragraphs:

''(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS.—With respect to an initial determination insofar as it results in a denial of a claim for benefits—

''(A) the written notice on the determination shall include—

''(i) the reasons for the determination, including whether a local medical review policy or a local coverage determination was used;

''(ii) the procedures for obtaining additional information concerning the determination, including the information described in subparagraph (B); and

''(iii) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination under this section;

''(B) such written notice shall be provided in printed form and written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both; and

''(C) the individual provided such written notice may obtain, upon request, information on the specific provision of the policy, manual, or regulation used in making the redetermination.

''(5) REQUIREMENTS OF NOTICE OF REDETERMINATIONS.—With respect to a redetermination insofar as it results in a denial of a claim for benefits—

''(A) the written notice on the redetermination shall include—

''(i) the specific reasons for the redetermination;

''(ii) as appropriate, a summary of the clinical or scientific evidence used in making the redetermination;

''(iii) a description of the procedures for obtaining additional information concerning the redetermination; and

''(iv) notification of the right to appeal the redetermination and instructions on how to initiate such an appeal under this section;

''(B) such written notice shall be provided in printed form and written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both; and

''(C) the individual provided such written notice may obtain, upon request, information on the specific provision of the policy, manual, or regulation used in making the redetermination.''.

(2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)) is amended—

(A) by inserting ''be written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include (to the extent appropriate)'' after ''in writing,''; and

(B) by inserting ''and a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section'' after ''such decision,''.

(3) APPEALS.—Section 1869(d) (42 U.S.C. 1395ff(d)) is amended—

(A) in the heading, by inserting ''; NOTICE'' after ''SECRETARY''; and

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

''(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include—

''(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

''(B) the procedures for obtaining additional information concerning the decision; and

''(C) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.''.

(4) SUBMISSION OF RECORD FOR APPEAL.—Section 1869(c)(3)(J)(i) (42 U.S.C. 1395ff(c)(3)(J)(i)) is amended by striking ''prepare'' and inserting ''submit'' and by striking ''with respect to'' and all that follows through ''and relevant policies''.

(d) QUALIFIED INDEPENDENT CONTRACTORS.—

(1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(3) (42 U.S.C. 1395ff(c)(3)) is amended—

(A) in subparagraph (A), by striking ''sufficient training and expertise in medical science and legal matters'' and inserting ''sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing''; and

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

''(K) INDEPENDENCE REQUIREMENTS.—

''(i) IN GENERAL.—Subject to clause (ii), a qualified independent contractor shall not conduct any activities in a case unless the entity—

''(I) is not a related party (as defined in subsection (g)(5));

''(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

''(III) does not otherwise have a conflict of interest with such a party.

''(ii) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

''(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional.''.

(2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—Section 1869 (42 U.S.C. 1395ff) is amended—

(A) by amending subsection (c)(3)(D) to read as follows:

''(D) QUALIFICATIONS FOR REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals).''; and

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

''(g) QUALIFICATIONS OF REVIEWERS.—

''(1) IN GENERAL.—In reviewing determinations under this section, a qualified independent contractor shall assure that—

''(A) each individual conducting a review shall meet the qualifications of paragraph (2);

''(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

''(C) in the case of a review by a panel described in subsection (c)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a 'reviewing professional'), a reviewing professional meets the qualifications described in paragraph (4) and, where a claim is regarding the furnishing of treatment by a physician (allopathic or osteopathic) or the provision of items or services by a physician (allopathic or osteopathic), a reviewing professional shall be a physician (allopathic or osteopathic).

''(2) INDEPENDENCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

''(i) not be a related party (as defined in paragraph (5));

''(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

''(iii) not otherwise have a conflict of interest with such a party.

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit an individual, solely on the basis of a participation agreement with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

''(I) the individual is not involved in the provision of items or services in the case under review;

''(II) the fact of such an agreement is disclosed to the Secretary and the individual entitled to benefits under part A or enrolled under part B, or both, or such individual's authorized representative, and neither party objects; and

''(III) the individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

''(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of having such staff privileges if the existence of such privileges is disclosed to the Secretary and such individual (or authorized representative), and neither party objects; or

''(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

For purposes of this paragraph, the term 'participation agreement' means an agreement relating to the provision of health care services by the individual and does not include the provision of services as a reviewer under this subsection.

''(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

''(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be—

''(A) a physician (allopathic or osteopathic) who is appropriately credentialed or licensed in one or more States to deliver health care services and has medical expertise in the field of practice that is appropriate for the items or services at issue; or

''(B) a health care professional who is legally authorized in one or more States (in accordance with State law or the State regulatory mechanism provided by State law) to furnish the health care items or services at issue and has medical expertise in the field of practice that is appropriate for such items or services.

''(5) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a case under this title involving a specific individual entitled to benefits under part A or enrolled under part B, or both, any of the following:

''(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

''(B) The individual (or authorized representative).

''(C) The health care professional that provides the items or services involved in the case.

''(D) The institution at which the items or services (or treatment) involved in the case are provided.

''(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

''(F) Any other party determined under any regulations to have a substantial interest in the case involved.''.

(3) REDUCING MINIMUM NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(4) (42 U.S.C. 1395ff(c)(4)) is amended by striking ''not fewer than 12 qualified independent contractors under this subsection'' and inserting ''with a sufficient number of qualified independent contractors (but not fewer than 4 such contractors) to conduct reconsiderations consistent with the timeframes applicable under this subsection''.

(4) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA (114 Stat. 2763A–534).

(5) TRANSITION.—In applying section 1869(g) of the Social Security Act (as added by paragraph (2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).

SEC. 534. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 511(a)(1) and as amended by sections 912(b), 921(b)(1), and 921(c)(1), is further amended by adding at the end the following new subsection:

''(h) CONDUCT OF PREPAYMENT REVIEW.—

''(1) CONDUCT OF RANDOM PREPAYMENT REVIEW.—

''(A) IN GENERAL.—A medicare administrative contractor may conduct random prepayment review only to develop a contractor-wide or program-wide claims payment error rates or under such additional circumstances as may be provided under regulations, developed in consultation with providers of services and suppliers.

''(B) USE OF STANDARD PROTOCOLS WHEN CONDUCTING PREPAYMENT REVIEWS.—When a medicare administrative contractor conducts a random prepayment review, the contractor may conduct such review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

''(C) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review.

''(D) RANDOM PREPAYMENT REVIEW.—For purposes of this subsection, the term 'random prepayment review' means a demand for the production of records or documentation absent cause with respect to a claim.

''(2) LIMITATIONS ON NON-RANDOM PREPAYMENT REVIEW.—

''(A) LIMITATIONS ON INITIATION OF NON-RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate non-random prepayment review of a provider of services or supplier based on the initial identification by that provider of services or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error under section 1893(f)(3)(A).

''(B) TERMINATION OF NON-RANDOM PREPAYMENT REVIEW.—The Secretary shall issue regulations relating to the termination, including termination dates, of non-random prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) shall take effect 1 year after the date of the enactment of this Act.

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall first issue regulations under section 1874A(h) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of the enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(h)(1)(B) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary shall specify.

(c) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(h) of the Social Security Act, as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

SEC. 535. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1893 (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

''(f) RECOVERY OF OVERPAYMENTS.—

''(1) USE OF REPAYMENT PLANS.—

''(A) IN GENERAL.—If the repayment, within 30 days by a provider of services or supplier, of an overpayment under this title would constitute a hardship (as described in subparagraph (B)), subject to subparagraph (C), upon request of the provider of services or supplier the Secretary shall enter into a plan with the provider of services or supplier for the repayment (through offset or otherwise) of such overpayment over a period of at least 6 months but not longer than 3 years (or not longer than 5 years in the case of extreme hardship, as determined by the Secretary). Interest shall accrue on the balance through the period of repayment. Such plan shall meet terms and conditions determined to be appropriate by the Secretary.

''(B) HARDSHIP.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the repayment of an overpayment (or overpayments) within 30 days is deemed to constitute a hardship if—

''(I) in the case of a provider of services that files cost reports, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services for the cost reporting period covered by the most recently submitted cost report; or

''(II) in the case of another provider of services or supplier, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services or supplier for the previous calendar year.

''(ii) RULE OF APPLICATION.—The Secretary shall establish rules for the application of this subparagraph in the case of a provider of services or supplier that was not paid under this title during the previous year or was paid under this title only during a portion of that year.

''(iii) TREATMENT OF PREVIOUS OVERPAYMENTS.—If a provider of services or supplier has entered into a repayment plan under subparagraph (A) with respect to a specific overpayment amount, such payment amount under the repayment plan shall not be taken into account under clause (i) with respect to subsequent overpayment amounts.

''(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

''(i) the Secretary has reason to suspect that the provider of services or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

''(ii) there is an indication of fraud or abuse committed against the program.

''(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

''(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

''(2) LIMITATION ON RECOUPMENT.—

''(A) IN GENERAL.—In the case of a provider of services or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor on such determination under section 1869(b)(1), the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1869(b)(1) (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

''(B) COLLECTION WITH INTEREST.—Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.

''(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in section 1889(g).

''(3) LIMITATION ON USE OF EXTRAPOLATION.—A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless the Secretary determines that—

''(A) there is a sustained or high level of payment error; or

''(B) documented educational intervention has failed to correct the payment error.

There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations by the Secretary of sustained or high levels of payment errors under this paragraph.

''(4) PROVISION OF SUPPORTING DOCUMENTATION.—In the case of a provider of services or supplier with respect to which amounts were previously overpaid, a medicare contractor may request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

''(5) CONSENT SETTLEMENT REFORMS.—

''(A) IN GENERAL.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

''(B) OPPORTUNITY TO SUBMIT ADDITIONAL INFORMATION BEFORE CONSENT SETTLEMENT OFFER.—Before offering a provider of services or supplier a consent settlement, the Secretary shall—

''(i) communicate to the provider of services or supplier—

''(I) that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment;

''(II) the nature of the problems identified in such evaluation; and

''(III) the steps that the provider of services or supplier should take to address the problems; and

''(ii) provide for a 45-day period during which the provider of services or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

''(C) CONSENT SETTLEMENT OFFER.—The Secretary shall review any additional information furnished by the provider of services or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

''(i) shall provide notice of such determination to the provider of services or supplier, including an explanation of the reason for such determination; and

''(ii) in order to resolve the overpayment, may offer the provider of services or supplier—

''(I) the opportunity for a statistically valid random sample; or

''(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

''(D) CONSENT SETTLEMENT DEFINED.—For purposes of this paragraph, the term 'consent settlement' means an agreement between the Secretary and a provider of services or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services or supplier agrees not to appeal the claims involved.

''(6) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services and suppliers, a process under which the Secretary provides for notice to classes of providers of services and suppliers served by the contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

''(7) PAYMENT AUDITS.—

''(A) WRITTEN NOTICE FOR POST-PAYMENT AUDITS.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services or supplier under this title, the contractor shall provide the provider of services or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

''(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services or supplier under this title, the contractor shall—

''(i) give the provider of services or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services or supplier and permits the development of an appropriate corrective action plan;

''(ii) inform the provider of services or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary);

''(iii) give the provider of services or supplier an opportunity to provide additional information to the contractor; and

''(iv) take into account information provided, on a timely basis, by the provider of services or supplier under clause (iii).

''(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

''(8) STANDARD METHODOLOGY FOR PROBE SAMPLING.—The Secretary shall establish a standard methodology for medicare contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.''.

(b) EFFECTIVE DATES AND DEADLINES.—

(1) USE OF REPAYMENT PLANS.—Section 1893(f)(1) of the Social Security Act, as added by subsection (a), shall apply to requests for repayment plans made after the date of the enactment of this Act.

(2) LIMITATION ON RECOUPMENT.—Section 1893(f)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date of the enactment of this Act.

(3) USE OF EXTRAPOLATION.—Section 1893(f)(3) of the Social Security Act, as added by subsection (a), shall apply to statistically valid random samples initiated after the date that is 1 year after the date of the enactment of this Act.

(4) PROVISION OF SUPPORTING DOCUMENTATION.—Section 1893(f)(4) of the Social Security Act, as added by subsection (a), shall take effect on the date of the enactment of this Act.

(5) CONSENT SETTLEMENT.—Section 1893(f)(5) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of the enactment of this Act.

(6) NOTICE OF OVERUTILIZATION.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish the process for notice of overutilization of billing codes under section 1893A(f)(6) of the Social Security Act, as added by subsection (a).

(7) PAYMENT AUDITS.—Section 1893A(f)(7) of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of the enactment of this Act.

(8) STANDARD FOR ABNORMAL BILLING PATTERNS.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1893(f)(8) of the Social Security Act, as added by subsection (a).

SEC. 536. PROVIDER ENROLLMENT PROCESS; RIGHT OF APPEAL.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) by adding at the end of the heading the following: ''; ENROLLMENT PROCESSES''; and

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

“(j) ENROLLMENT PROCESS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

“(1) ENROLLMENT PROCESS.—

“(A) IN GENERAL.—The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this title.

“(B) DEADLINES.—The Secretary shall establish by regulation procedures under which there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment). The Secretary shall monitor the performance of medicare administrative contractors in meeting the deadlines established under this subparagraph.

“(C) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—The Secretary shall consult with providers of services and suppliers before making changes in the provider enrollment forms required of such providers and suppliers to be eligible to submit claims for which payment may be made under this title.

“(2) HEARING RIGHTS IN CASES OF DENIAL OR NON-RENEWAL.—A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.”.

(b) EFFECTIVE DATES.—

(1) ENROLLMENT PROCESS.—The Secretary shall provide for the establishment of the enrollment process under section 1866(j)(1) of the Social Security Act, as added by subsection (a)(2), within 6 months after the date of the enactment of this Act.

(2) CONSULTATION.—Section 1866(j)(1)(C) of the Social Security Act, as added by subsection (a)(2), shall apply with respect to changes in provider enrollment forms made on or after January 1, 2004.

(3) HEARING RIGHTS.—Section 1866(j)(2) of the Social Security Act, as added by subsection (a)(2), shall apply to denials occurring on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary specifies.

SEC. 537. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS WITHOUT PURSUING APPEALS PROCESS.

(a) CLAIMS.—The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(g) of the Social Security Act, as inserted by section 301(a)(1)) and representatives of providers of services and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

(b) DEADLINE.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first develop the process under subsection (a).

SEC. 538. PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES; ADVANCE BENEFICIARY NOTICES.

(a) IN GENERAL.—Section 1869 (42 U.S.C. 1395ff(b)), as amended by section 533(d)(2)(B), is further amended by adding at the end the following new subsection:

“(h) PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES.—

“(1) ESTABLISHMENT OF PROCESS.—

“(A) IN GENERAL.—With respect to a medicare administrative contractor that has a contract under section 1874A that provides for making payments under this title with respect to physicians’ services (as defined in section 1848(j)(3)), the Secretary shall establish a prior determination process that meets the requirements of this subsection and that shall be applied by such contractor in the case of eligible requesters.

“(B) ELIGIBLE REQUESTER.—For purposes of this subsection, each of the following shall be an eligible requester:

“(i) A participating physician, but only with respect to physicians’ services to be furnished to an individual who is entitled to benefits under this title and who has consented to the physician making the request under this subsection for those physicians’ services.

“(ii) An individual entitled to benefits under this title, but only with respect to a physicians’ service for which the individual receives, from a physician, an advance beneficiary notice under section 1879(a).

“(2) SECRETARIAL FLEXIBILITY.—The Secretary shall establish by regulation reasonable limits on the physicians’ services for which a prior determination of coverage may be requested under this subsection. In establishing such limits, the Secretary may consider the dollar amount involved with respect to the physicians’ service, administrative costs and burdens, and other relevant factors.

“(3) REQUEST FOR PRIOR DETERMINATION.—

“(A) IN GENERAL.—Subject to paragraph (2), under the process established under this subsection an eligible requester may submit to the contractor a request for a determination, before the furnishing of a physicians’ service, as to whether the physicians’ service is covered under this title consistent with the applicable requirements of section 1862(a)(1)(A) (relating to medical necessity).

“(B) ACCOMPANYING DOCUMENTATION.—The Secretary may require that the request be accompanied by a description of the physicians’ service, supporting documentation relating to the medical necessity for the physicians’ service, and any other appropriate documentation. In the case of a request submitted by an eligible requester who is described in paragraph (1)(B)(ii), the Secretary may require that the request also be accompanied by a copy of the advance beneficiary notice involved.

“(4) RESPONSE TO REQUEST.—

“(A) IN GENERAL.—Under such process, the contractor shall provide the eligible requester with written notice of a determination as to whether—

“(i) the physicians’ service is so covered;

“(ii) the physicians’ service is not so covered; or

“(iii) the contractor lacks sufficient information to make a coverage determination with respect to the physicians’ service.

“(B) CONTENTS OF NOTICE FOR CERTAIN DETERMINATIONS.—

“(i) NONCOVERAGE.—If the contractor makes the determination described in subparagraph (A)(ii), the contractor shall include in the notice a brief explanation of the basis for the determination, including on what national or local coverage or noncoverage determination (if any) the determination is based, and a description of any applicable rights under subsection (a).

“(ii) INSUFFICIENT INFORMATION.—If the contractor makes the determination described in subparagraph (A)(iii), the contractor shall include in the notice a description of the additional information required to make the coverage determination.

“(C) DEADLINE TO RESPOND.—Such notice shall be provided within the same time period as the time period applicable to the contractor providing notice of initial determinations on a claim for benefits under subsection (a)(2)(A).

“(D) INFORMING BENEFICIARY IN CASE OF PHYSICIAN REQUEST.—In the case of a request by a participating physician under paragraph (1)(B)(i), the process shall provide that the individual to whom the physicians’ service is proposed to be furnished shall be informed of any determination described in subparagraph (A)(ii) (relating to a determination of noncoverage) and the right (referred to in paragraph (6)(B)) to obtain the physicians’ service and have a claim submitted for the physicians’ service.

“(5) BINDING NATURE OF POSITIVE DETERMINATION.—If the contractor makes the determination described in paragraph (4)(A)(i), such determination shall be binding on the contractor in the absence of fraud or evidence of misrepresentation of facts presented to the contractor.

“(6) LIMITATION ON FURTHER REVIEW.—

“(A) IN GENERAL.—Contractor determinations described in paragraph (4)(A)(ii) or (4)(A)(iii) (relating to pre-service claims) are not subject to further administrative appeal or judicial review under this section or otherwise.

“(B) DECISION NOT TO SEEK PRIOR DETERMINATION OR NEGATIVE DETERMINATION DOES NOT IMPACT RIGHT TO OBTAIN SERVICES, SEEK REIMBURSEMENT, OR APPEAL RIGHTS.—Nothing in this subsection shall be construed as affecting the right of an individual who—

“(i) decides not to seek a prior determination under this subsection with respect to physicians’ services; or

“(ii) seeks such a determination and has received a determination described in paragraph (4)(A)(ii),

from receiving (and submitting a claim for) such physicians’ services and from obtaining administrative or judicial review respecting such claim under the other applicable provisions of this section. Failure to seek a prior determination under this subsection with respect to physicians’ service shall not be taken into account in such administrative or judicial review.

“(C) NO PRIOR DETERMINATION AFTER RECEIPT OF SERVICES.—Once an individual is provided physicians’ services, there shall be no prior determination under this subsection with respect to such physicians’ services.”.

(b) EFFECTIVE DATE; SUNSET; TRANSITION.—

(1) EFFECTIVE DATE.—The Secretary shall establish the prior determination process under the amendment made by subsection (a) in such a manner as to provide for the acceptance of requests for determinations under such process filed not later than 18 months after the date of the enactment of this Act.

(2) SUNSET.—Such prior determination process shall not apply to requests filed after the end of the 5-year period beginning on the first date on which requests for determinations under such process are accepted.

(3) TRANSITION.—During the period in which the amendment made by subsection (a) has become effective but contracts are not provided under section 1874A of the Social Security Act with medicare administrative contractors, any reference in section 1869(g) of such Act (as added by such amendment) to such a contractor is deemed a reference to a fiscal intermediary or carrier with an agreement under section 1816, or contract under section 1842, respectively, of such Act.

(4) LIMITATION ON APPLICATION TO SGR.—For purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)), the amendment made by subsection (a) shall not be considered to be a change in law or regulation.

(c) PROVISIONS RELATING TO ADVANCE BENEFICIARY NOTICES; REPORT ON PRIOR DETERMINATION PROCESS.—

(1) DATA COLLECTION.—The Secretary shall establish a process for the collection of information on the instances in which an advance beneficiary notice (as defined in paragraph (5)) has been provided and on instances in which a beneficiary indicates on such a notice that the beneficiary does not intend to seek to have the item or service that is the subject of the notice furnished.

(2) OUTREACH AND EDUCATION.—The Secretary shall establish a program of outreach and education for beneficiaries and providers of services and other persons on the appropriate use of advance beneficiary notices and coverage policies under the medicare program.

(3) GAO REPORT ON USE OF ADVANCE BENEFICIARY NOTICES.—Not later than 18 months after the date on which section 1869(h) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of advance beneficiary notices under title XVIII of such Act. Such report shall include information concerning the providers of services and other persons that have provided such notices and the response of beneficiaries to such notices.

(4) GAO REPORT ON USE OF PRIOR DETERMINATION PROCESS.—Not later than 36 months after the date on which section 1869(h) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of the prior determination process under such section. Such report shall include—

(A) information concerning—

(i) the number and types of procedures for which a prior determination has been sought;

(ii) determinations made under the process;

(iii) the percentage of beneficiaries prevailing;

(iv) in those cases in which the beneficiaries do not prevail, the reasons why such beneficiaries did not prevail; and

(v) changes in receipt of services resulting from the application of such process;

(B) an evaluation of whether the process was useful for physicians (and other suppliers) and beneficiaries, whether it was timely, and whether the amount of information required was burdensome to physicians and beneficiaries; and

(C) recommendations for improvements or continuation of such process.

(5) ADVANCE BENEFICIARY NOTICE DEFINED.—In this subsection, the term ''advance beneficiary notice'' means a written notice provided under section 1879(a) of the Social Security Act (42 U.S.C. 1395pp(a)) to an individual entitled to benefits under part A or enrolled under part B of title XVIII of such Act before items or services are furnished under such part in cases where a provider of services or other person that would furnish the item or service believes that payment will not be made for some or all of such items or services under such title.

SEC. 539. APPEALS BY PROVIDERS WHEN THERE IS NO OTHER PARTY AVAILABLE.

(a) IN GENERAL.—Section 1870 (42 U.S.C. 1395gg) is amended by adding at the end the following new subsection:

''(h) Notwithstanding subsection (f) or any other provision of law, the Secretary shall permit a provider of services or supplier to appeal any determination of the Secretary under this title relating to services rendered under this title to an individual who subsequently dies if there is no other party available to appeal such determination.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 540. REVISIONS TO APPEALS TIMEFRAMES AND AMOUNTS.

(a) TIMEFRAMES.—Section 1869 (42 U.S.C. 1395ff) is amended—

(1) in subsection (a)(3)(C)(ii), by striking ''30-day period'' each place it appears and inserting ''60-day period''; and

(2) in subsection (c)(3)(C)(i), by striking ''30-day period'' and inserting ''60-day period''.

(b) AMOUNTS.—

(1) IN GENERAL.—Section 1869(b)(1)(E) (42 U.S.C. 1395ff(b)(1)(E)) is amended by adding at the end the following new clause:

''(iii) ADJUSTMENT OF DOLLAR AMOUNTS.—For requests for hearings or judicial review made in a year after 2004, the dollar amounts specified in clause (i) shall be equal to such dollar amounts increased by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount determined under the previous sentence that is not a multiple of $10 shall be rounded to the nearest multiple of $10.''.

(2) CONFORMING AMENDMENTS.—(A) Section 1852(g)(5) (42 U.S.C. 1395w–22(g)(5)) is amended by adding at the end the following: ''The provisions of section 1869(b)(1)(E)(iii) shall apply with respect to dollar amounts specified in the first 2 sentences of this paragraph in the same manner as they apply to the dollar amounts specified in section 1869(b)(1)(E)(i).''.

(B) Section 1876(b)(5)(B) (42 U.S.C. 1395mm(b)(5)(B)) is amended by adding at the end the following: ''The provisions of section 1869(b)(1)(E)(iii) shall apply with respect to dollar amounts specified in the first 2 sentences of this subparagraph in the same manner as they apply to the dollar amounts specified in section 1869(b)(1)(E)(i).''.

SEC. 540A. MEDIATION PROCESS FOR LOCAL COVERAGE DETERMINATIONS.

(a) IN GENERAL.—Section 1869 (42 U.S.C. 1395ff), as amended by section 538(a), is amended by adding at the end the following new subsection:

''(i) MEDIATION PROCESS FOR LOCAL COVERAGE DETERMINATIONS.—

''(1) ESTABLISHMENT OF PROCESS.—The Secretary shall establish a mediation process under this subsection through the use of a physician trained in mediation and employed by the Centers for Medicare & Medicaid Services.

''(2) RESPONSIBILITY OF MEDIATOR.—Under the process established in paragraph (1), such a mediator shall mediate in disputes between groups representing providers of services, suppliers (as defined in section 1861(d)), and the medical director for a medicare administrative contractor whenever the regional administrator (as defined by the Secretary) involved determines that there was a systematic pattern and a large volume of complaints from such groups regarding decisions of such director or there is a complaint from the co-chair of the advisory committee for that contractor to such regional administrator regarding such dispute.''.

(b) INCLUSION IN MAC CONTRACTS.—Section 1874A(b)(3)(A)(i), as added by section 511(a)(1), is amended by adding at the end the following: ''Such requirements shall include specific performance duties expected of a medical director of a medicare administrative contractor, including requirements relating to professional relations and the availability of such director to conduct medical determination activities within the jurisdiction of such a contractor.''.

Subtitle E—Miscellaneous Provisions

SEC. 541. POLICY DEVELOPMENT REGARDING EVALUATION AND MANAGEMENT (E & M) DOCUMENTATION GUIDELINES.

(a) IN GENERAL.—The Secretary may not implement any new or modified documentation guidelines (which for purposes of this section includes clinical examples) for evaluation and management physician services under the title XVIII of the Social Security Act on or after the date of the enactment of this Act unless the Secretary—

(1) has developed the guidelines in collaboration with practicing physicians (including both generalists and specialists) and provided for an assessment of the proposed guidelines by the physician community;

(2) has established a plan that contains specific goals, including a schedule, for improving the use of such guidelines;

(3) has conducted appropriate and representative pilot projects under subsection (b) to test such guidelines;

(4) finds, based on reports submitted under subsection (b)(5) with respect to pilot projects conducted for such or related guidelines, that the objectives described in subsection (c) will be met in the implementation of such guidelines; and

(5) has established, and is implementing, a program to educate physicians on the use of such guidelines and that includes appropriate outreach.

The Secretary shall make changes to the manner in which existing evaluation and management documentation guidelines are implemented to reduce paperwork burdens on physicians.

(b) PILOT PROJECTS TO TEST MODIFIED OR NEW EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES.—

(1) IN GENERAL.—With respect to proposed new or modified documentation guidelines referred to in subsection (a), the Secretary shall conduct under this subsection appropriate and representative pilot projects to test the proposed guidelines.

(2) LENGTH AND CONSULTATION.—Each pilot project under this subsection shall—

(A) be voluntary;

(B) be of sufficient length as determined by the Secretary (but in no case to exceed 1 year) to allow for preparatory physician and medicare contractor education, analysis, and use and assessment of potential evaluation and management guidelines; and

(C) be conducted, in development and throughout the planning and operational stages of the project, in consultation with practicing physicians (including both generalists and specialists).

(3) RANGE OF PILOT PROJECTS.—Of the pilot projects conducted under this subsection with respect to proposed new or modified documentation guidelines—

(A) at least one shall focus on a peer review method by physicians (not employed by a medicare contractor) which evaluates medical record information for claims submitted by physicians identified as statistical outliers relative to codes used for billing purposes for such services;

(B) at least one shall focus on an alternative method to detailed guidelines based on physician documentation of face to face encounter time with a patient;

(C) at least one shall be conducted for services furnished in a rural area and at least one for services furnished outside such an area; and

(D) at least one shall be conducted in a setting where physicians bill under physicians' services in teaching settings and at least one shall be conducted in a setting other than a teaching setting.

(4) STUDY OF IMPACT.—Each pilot project shall examine the effect of the proposed guidelines on—

(A) different types of physician practices, including those with fewer than 10 full-time-equivalent employees (including physicians); and

(B) the costs of physician compliance, including education, implementation, auditing, and monitoring.

(5) REPORT ON PILOT PROJECTS.—Not later than 6 months after the date of completion of pilot projects carried out under this subsection with respect to a proposed guideline described in paragraph (1), the Secretary shall submit to Congress a report on the pilot projects. Each such report shall include a finding by the Secretary of whether the objectives described in subsection (c) will be met in the implementation of such proposed guideline.

(c) OBJECTIVES FOR EVALUATION AND MANAGEMENT GUIDELINES.—The objectives for modified evaluation and management documentation guidelines developed by the Secretary shall be to—

(1) identify clinically relevant documentation needed to code accurately and assess coding levels accurately;

(2) decrease the level of non-clinically pertinent and burdensome documentation time and content in the physician's medical record;

(3) increase accuracy by reviewers; and

(4) educate both physicians and reviewers.

(d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF DOCUMENTATION FOR PHYSICIAN CLAIMS.—

(1) STUDY.—The Secretary shall carry out a study of the matters described in paragraph (2).

(2) MATTERS DESCRIBED.—The matters referred to in paragraph (1) are—

(A) the development of a simpler, alternative system of requirements for documentation accompanying claims for evaluation and management physician services for which payment is made under title XVIII of the Social Security Act; and

(B) consideration of systems other than current coding and documentation requirements for payment for such physician services.

(3) CONSULTATION WITH PRACTICING PHYSICIANS.—In designing and carrying out the study under paragraph (1), the Secretary shall consult with practicing physicians, including physicians who are part of group practices and including both generalists and specialists.

(4) APPLICATION OF HIPAA UNIFORM CODING REQUIREMENTS.—In developing an alternative system under paragraph (2), the Secretary shall consider requirements of administrative simplification under part C of title XI of the Social Security Act.

(5) REPORT TO CONGRESS.—(A) Not later than October 1, 2005, the Secretary shall submit to Congress a report on the results of the study conducted under paragraph (1).

(B) The Medicare Payment Advisory Commission shall conduct an analysis of the results of the study included in the report under subparagraph (A) and shall submit a report on such analysis to Congress.

(e) STUDY ON APPROPRIATE CODING OF CERTAIN EXTENDED OFFICE VISITS.—The Secretary shall conduct a study of the appropriateness of coding in cases of extended office visits in which there is no diagnosis made. Not later than October 1, 2005, the Secretary shall submit a report to Congress on such study and shall include recommendations on how to code appropriately for such visits in a manner that takes into account the amount of time the physician spent with the patient.

(f) DEFINITIONS.—In this section—

(1) the term ''rural area'' has the meaning given that term in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)); and

(2) the term ''teaching settings'' are those settings described in section 415.150 of title 42, Code of Federal Regulations.

SEC. 542. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY AND COVERAGE.

(a) COUNCIL FOR TECHNOLOGY AND INNOVATION.—Section 1868 (42 U.S.C. 1395ee), as amended by section 521(a), is amended by adding at the end the following new subsection:

''(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

''(1) ESTABLISHMENT.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as 'CMS').

''(2) COMPOSITION.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

''(3) DUTIES.—The Council shall coordinate the activities of coverage, coding, and payment processes under this title with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

''(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title.''.

(b) METHODS FOR DETERMINING PAYMENT BASIS FOR NEW LAB TESTS.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following:

''(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2005 (in this paragraph referred to as 'new tests').

''(B) Determinations under subparagraph (A) shall be made only after the Secretary—

''(i) makes available to the public (through an Internet website and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

''(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

''(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

''(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet website and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

''(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet website and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

''(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

''(i) set forth the criteria for making determinations under subparagraph (A); and

''(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

''(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

''(E) For purposes of this paragraph:

''(i) The term 'HCPCS' refers to the Health Care Procedure Coding System.

''(ii) A code shall be considered to be 'substantially revised' if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).''.

(c) GAO STUDY ON IMPROVEMENTS IN EXTERNAL DATA COLLECTION FOR USE IN THE MEDICARE INPATIENT PAYMENT SYSTEM.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study that analyzes which external data can be collected in a shorter timeframe by the Centers for Medicare & Medicaid Services for use in computing payments for inpatient hospital services. The study may include an evaluation of the feasibility and appropriateness of using quarterly samples or special surveys or any other methods. The study shall include an analysis of whether other executive agencies, such as the Bureau of Labor Statistics in the Department of Commerce, are best suited to collect this information.

(2) REPORT.—By not later than October 1, 2004, the Comptroller General shall submit a report to Congress on the study under paragraph (1).

SEC. 543. TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) IN GENERAL.—The Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to medicare secondary payor provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.

(b) REFERENCE LABORATORY SERVICES DESCRIBED.—Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation.

SEC. 544. EMTALA IMPROVEMENTS.

(a) PAYMENT FOR EMTALA-MANDATED SCREENING AND STABILIZATION SERVICES.—

(1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by inserting after subsection (c) the following new subsection:

''(d) For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1867 to an individual who is entitled to benefits under this title, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items and services furnished on or after January 1, 2004.

(b) NOTIFICATION OF PROVIDERS WHEN EMTALA INVESTIGATION CLOSED.—Section 1867(d) (42 U.S.C. 42 U.S.C. 1395dd(d)) is amended by adding at the end the following new paragraph:

''(4) NOTICE UPON CLOSING AN INVESTIGATION.—The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.''.

(c) PRIOR REVIEW BY PEER REVIEW ORGANIZATIONS IN EMTALA CASES INVOLVING TERMINATION OF PARTICIPATION.—

(1) IN GENERAL.—Section 1867(d)(3) (42 U.S.C. 1395dd(d)(3)) is amended—

(A) in the first sentence, by inserting ''or in terminating a hospital's participation under this title'' after ''in imposing sanctions under paragraph (1)''; and

(B) by adding at the end the following new sentences: ''Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this title for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to terminations of participation initiated on or after the date of the enactment of this Act.

SEC. 545. EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP.

(a) ESTABLISHMENT.—The Secretary shall establish a Technical Advisory Group (in this section referred to as the ''Advisory Group'') to review issues related to the Emergency Medical Treatment and Labor Act (EMTALA) and its implementation. In this section, the term ''EMTALA'' refers to the provisions of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

(b) MEMBERSHIP.—The Advisory Group shall be composed of 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services and of which—

(1) 4 shall be representatives of hospitals, including at least one public hospital, that have experience with the application of EMTALA and at least 2 of which have not been cited for EMTALA violations;

(2) 7 shall be practicing physicians drawn from the fields of emergency medicine, cardiology or cardiothoracic surgery, orthopedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;

(3) 2 shall represent patients;

(4) 2 shall be staff involved in EMTALA investigations from different regional offices of the Centers for Medicare & Medicaid Services; and

(5) 1 shall be from a State survey office involved in EMTALA investigations and 1 shall be from a peer review organization, both of whom shall be from areas other than the regions represented under paragraph (4).

In selecting members described in paragraphs (1) through (3), the Secretary shall consider qualified individuals nominated by organizations representing providers and patients.

(c) GENERAL RESPONSIBILITIES.—The Advisory Group—

(1) shall review EMTALA regulations;

(2) may provide advice and recommendations to the Secretary with respect to those regulations and their application to hospitals and physicians;

(3) shall solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and

(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public.

(d) ADMINISTRATIVE MATTERS.—

(1) CHAIRPERSON.—The members of the Advisory Group shall elect a member to serve as chairperson of the Advisory Group for the life of the Advisory Group.

(2) MEETINGS.—The Advisory Group shall first meet at the direction of the Secretary. The Advisory Group shall then meet twice per year and at such other times as the Advisory Group may provide.

(e) TERMINATION.—The Advisory Group shall terminate 30 months after the date of its first meeting.

(f) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary shall establish the Advisory Group notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).

SEC. 546. AUTHORIZING USE OF ARRANGEMENTS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following:

''(D) In extraordinary, exigent, or other non-routine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.

''(E) A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services of a registered professional nurse and are provided non-routinely and so infrequently so that the provision of such services directly would be impracticable and prohibitively expensive.''.

(b) CONFORMING PAYMENT PROVISION.—Section 1814(i) (42 U.S.C. 1395f(i)), as amended by section 212(b), is amended by adding at the end the following new paragraph:

''(5) In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to hospice care provided on or after the date of the enactment of this Act.

SEC. 547. APPLICATION OF OSHA BLOODBORNE PATHOGENS STANDARD TO CERTAIN HOSPITALS.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc), as amended by section 206, is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (T), by striking ''and'' at the end;

(B) in subparagraph (U), by striking the period at the end and inserting '', and''; and

(C) by inserting after subparagraph (U) the following new subparagraph:

''(V) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 (or a State occupational safety and health plan that is approved under 18(b) of such Act), to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated).''; and

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

''(4)(A) A hospital that fails to comply with the requirement of subsection (a)(1)(V) (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

''(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(1)(U) by a hospital that is subject to the provisions of such Act.

''(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.''.

(b) EFFECTIVE DATE.—The amendments made by this subsection (a) shall apply to hospitals as of July 1, 2004.

SEC. 548. BIPA-RELATED TECHNICAL AMENDMENTS AND CORRECTIONS.

(a) TECHNICAL AMENDMENTS RELATING TO ADVISORY COMMITTEE UNDER BIPA SECTION 522.—(1) Subsection (i) of section 1114 (42 U.S.C. 1314)—

(A) is transferred to section 1862 and added at the end of such section; and

(B) is redesignated as subsection (j).

(2) Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the last sentence of subsection (a), by striking ''established under section 1114(f)''; and

(B) in subsection (j), as so transferred and redesignated—

(i) by striking ''under subsection (f)''; and

(ii) by striking ''section 1862(a)(1)'' and inserting ''subsection (a)(1)''.

(b) TERMINOLOGY CORRECTIONS.—(1) Section 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)) is amended—

(A) in subclause (III), by striking ''policy'' and inserting ''determination''; and

(B) in subclause (IV), by striking ''medical review policies'' and inserting ''coverage determinations''.

(2) Section 1852(a)(2)(C) (42 U.S.C. 1395w–22(a)(2)(C)) is amended by striking ''policy''

and ''POLICY'' and inserting ''determination'' each place it appears and ''DETERMINATION'', respectively.

(c) REFERENCE CORRECTIONS.—Section 1869(f)(4) (42 U.S.C. 1395ff(f)(4)) is amended—

(1) in subparagraph (A)(iv), by striking ''subclause (I), (II), or (III)'' and inserting ''clause (i), (ii), or (iii)'';

(2) in subparagraph (B), by striking ''clause (i)(IV)'' and ''clause (i)(III)'' and inserting ''subparagraph (A)(iv)'' and ''subparagraph (A)(iii)'', respectively; and

(3) in subparagraph (C), by striking ''clause (i)'', ''subclause (IV)'' and ''subparagraph (A)'' and inserting ''subparagraph (A)'', ''clause (iv)'' and ''paragraph (1)(A)'', respectively each place it appears.

(d) OTHER CORRECTIONS.—Effective as if included in the enactment of section 221(c) of BIPA, section 1154(e) (42 U.S.C. 1320c–3(e)) is amended by striking paragraph (5).

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

SEC. 549. CONFORMING AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a–7(c)(3)(B)) is amended to read as follows: ''Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of the administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both, the Secretary may, after consulting with the Inspector General of the Department of Health and Human Services, waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.''.

SEC. 550. TREATMENT OF CERTAIN DENTAL CLAIMS.

(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by adding at the end, after the subsection transferred and redesignated by section 548(a), the following new subsection:

''(k)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

''(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.''.

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

SEC. 551. FURNISHING HOSPITALS WITH INFORMATION TO COMPUTE DSH FORMULA.

Beginning not later than 1 year after the date of the enactment of this Act, the Secretary shall arrange to furnish to subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage under such section for that hospital for the current cost reporting year. Such data shall also be furnished to other hospitals which would qualify for additional payments under part A of title XVIII of the Social Security Act on the basis of such data.

SEC. 552. REVISIONS TO REASSIGNMENT PROVISIONS.

(a) IN GENERAL.—Section 1842(b)(6)(A) (42 U.S.C. 1395u(b)(6)(A)) is amended by striking ''or (ii) (where the service was provided in a hospital, critical access hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service,'' and inserting ''or (ii) where the service was provided under a contractual arrangement between such physician or other person and an entity, to the entity if, under the contractual arrangement, the entity submits the bill for the service and the contractual arrangement meets such program integrity and other safeguards as the Secretary may determine to be appropriate,''.

(b) CONFORMING AMENDMENT.—The second sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by striking ''except to an employer or facility as described in clause (A)'' and inserting ''except to an employer or entity as described in subparagraph (A)''.

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

SEC. 553. OTHER PROVISIONS.

(a) GAO REPORTS ON THE PHYSICIAN COMPENSATION.—

(1) SUSTAINABLE GROWTH RATE AND UPDATES.—Not later than 6 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the appropriateness of the updates in the conversion factor under subsection (d)(3) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), including the appropriateness of the sustainable growth rate formula under subsection (f) of such section for 2002 and succeeding years. Such report shall examine the stability and predictability of such updates and rate and alternatives for the use of such rate in the updates.

(2) PHYSICIAN COMPENSATION GENERALLY.—Not later than 12 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on all aspects of physician compensation for services furnished under title XVIII of the Social Security Act, and how those aspects interact and the effect on appropriate compensation for physician services. Such report shall review alternatives for the physician fee schedule under section 1848 of such title (42 U.S.C. 1395w–4).

(b) ANNUAL PUBLICATION OF LIST OF NATIONAL COVERAGE DETERMINATIONS.—The Secretary shall provide, in an appropriate annual publication available to the public, a list of national coverage determinations made under title XVIII of the Social Security Act in the previous year and information on how to get more information with respect to such determinations.

(c) GAO REPORT ON FLEXIBILITY IN APPLYING HOME HEALTH CONDITIONS OF PARTICIPATION TO PATIENTS WHO ARE NOT MEDICARE BENEFICIARIES.—Not later than 6 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the implications if there were flexibility in the application of the medicare conditions of participation for home health agencies with respect to groups or types of patients who are not medicare beneficiaries. The report shall include an analysis of the potential impact of such flexible application on clinical operations and the recipients of such services and an analysis of methods for monitoring the quality of care provided to such recipients.

(d) OIG REPORT ON NOTICES RELATING TO USE OF HOSPITAL LIFETIME RESERVE DAYS.—Not later than 1 year after the date of the enactment of this Act, the Inspector General of the Department of Health and Human Services shall submit a report to Congress on—

(1) the extent to which hospitals provide notice to medicare beneficiaries in accordance with applicable requirements before they use the 60 lifetime reserve days described in section 1812(a)(1) of the Social Security Act (42 U.S.C. 1395d(a)(1)); and

(2) the appropriateness and feasibility of hospitals providing a notice to such beneficiaries before they completely exhaust such lifetime reserve days.

TITLE VI—MEDICAID AND MISCELLANEOUS PROVISIONS

Subtitle A—Medicaid Provisions

SEC. 601. MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

(a) TEMPORARY INCREASE.—Section 1923(f)(3) (42 U.S.C. 1396r–4(f)(3)) is amended—

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

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

''(C) SPECIAL, TEMPORARY INCREASE IN ALLOTMENTS ON A ONE-TIME, NON-CUMULATIVE BASIS.—The DSH allotment for any State (other than a State with a DSH allotment determined under paragraph (5))—

''(i) for fiscal year 2004 is equal to 116 percent of the DSH allotment for the State for fiscal year 2003 under this paragraph, notwithstanding subparagraph (B); and

''(ii) for each succeeding fiscal year is equal to the DSH allotment for the State for fiscal year 2004 or, in the case of fiscal years beginning with the fiscal year specified in subparagraph (D) for that State, the DSH allotment for the State for the previous fiscal year increased by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

''(D) FISCAL YEAR SPECIFIED.—For purposes of subparagraph (C)(ii), the fiscal year specified in this subparagraph for a State is the first fiscal year for which the Secretary estimates that the DSH allotment for that State will equal (or no longer exceed) the DSH allotment for that State under the law as in effect before the date of the enactment of this subparagraph.''.

(b) INCREASE IN FLOOR FOR TREATMENT AS A LOW DSH STATE.—Section 1923(f)(5) (42 U.S.C. 1396r–4(f)(5)) is amended to read as follows:

''(5) SPECIAL RULE FOR LOW DSH STATES.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2000, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2003, is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for the State with respect to—

''(A) fiscal year 2004 shall be the DSH allotment for the State for fiscal year 2003 increased by 16 percent;

''(B) each succeeding fiscal year before fiscal year 2009 shall be the DSH allotment for the State for the previous fiscal year increased by 16 percent; and

''(C) fiscal year 2009 and any subsequent fiscal year, shall be the DSH allotment for

the State for the previous year subject to an increase for inflation as provided in paragraph (3)(A).''.

(c) ALLOTMENT ADJUSTMENT.—Section 1923(f) (42 U.S.C. 1396r–4(f)) is amended—

(1) in paragraph (3)(A), by striking ''The DSH'' and inserting ''Except as provided in paragraph (6), the DSH'';

(2) by redesignating paragraph (6) as paragraph (7); and

(3) by inserting after paragraph (5) the following:

''(6) ALLOTMENT ADJUSTMENT.—Only with respect to fiscal year 2004 or 2005, if a statewide waiver under section 1115 is revoked or terminated before the end of either such fiscal year and there is no DSH allotment for the State, the Secretary shall—

''(A) permit the State whose waiver was revoked or terminated to submit an amendment to its State plan that would describe the methodology to be used by the State (after the effective date of such revocation or termination) to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities (other than State-owned institutions or facilities), on the basis of the proportion of patients served by such hospitals that are low-income patients with special needs; and

''(B) provide for purposes of this subsection for computation of an appropriate DSH allotment for the State for fiscal year 2004 or 2005 (or both) that would not exceed the amount allowed under paragraph (3)(B)(ii) and that does not result in greater expenditures under this title than would have been made if such waiver had not been revoked or terminated.

In determining the amount of an appropriate DSH allotment under subparagraph (B) for a State, the Secretary shall take into account the level of DSH expenditures for the State for the fiscal year preceding the fiscal year in which the waiver commenced.''.

(d) INCREASED REPORTING AND OTHER REQUIREMENTS TO ENSURE THE APPROPRIATE USE OF MEDICAID DSH PAYMENT ADJUSTMENTS.—Section 1923 (42 U.S.C. 1396r–4) is amended by adding at the end the following new subsection:

''(j) ANNUAL REPORTS AND OTHER REQUIREMENTS REGARDING PAYMENT ADJUSTMENTS.—With respect to fiscal year 2004 and each fiscal year thereafter, the Secretary shall require a State, as a condition of receiving a payment under section 1903(a)(1) with respect to a payment adjustment made under this section, to do the following:

''(1) REPORT.—The State shall submit an annual report that includes the following:

''(A) An identification of each disproportionate share hospital that received a payment adjustment under this section for the preceding fiscal year and the amount of the payment adjustment made to such hospital for the preceding fiscal year.

''(B) Such other information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments made under this section for the preceding fiscal year.

''(2) INDEPENDENT CERTIFIED AUDIT.—The State shall annually submit to the Secretary an independent certified audit that verifies each of the following:

''(A) The extent to which hospitals in the State have reduced their uncompensated care costs to reflect the total amount of claimed expenditures made under this section.

''(B) Payments under this section to hospitals that comply with the requirements of subsection (g).

''(C) Only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to individuals described in paragraph (1)(A) of such subsection are included in the calculation of the hospital-specific limits under such subsection.

''(D) The State included all payments under this title, including supplemental payments, in the calculation of such hospital-specific limits.

''(E) The State has separately documented and retained a record of all of its costs under this title, claimed expenditures under this title, uninsured costs in determining payment adjustments under this section, and any payments made on behalf of the uninsured from payment adjustments under this section.''.

(e) CLARIFICATION REGARDING NON-REGULATION OF TRANSFERS.—

(1) IN GENERAL.—Nothing in section 1903(w) of the Social Security Act (42 U.S.C. 1396b(w)) shall be construed by the Secretary as prohibiting a State's use of funds as the non-Federal share of expenditures under title XIX of such Act where such funds are transferred from or certified by a publicly-owned regional medical center located in another State and described in paragraph (2), so long as the Secretary determines that such use of funds is proper and in the interest of the program under title XIX.

(2) CENTER DESCRIBED.—A center described in this paragraph is a publicly-owned regional medical center that—

(A) provides level 1 trauma and burn care services;

(B) provides level 3 neonatal care services;

(C) is obligated to serve all patients, regardless of State of origin;

(D) is located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 States, including the States described in paragraph (1);

(E) serves as a tertiary care provider for patients residing within a 125 mile radius; and

(F) meets the criteria for a disproportionate share hospital under section 1923 of such Act in at least one State other than the one in which the center is located.

(3) EFFECTIVE PERIOD.—This subsection shall apply through December 31, 2005.

SEC. 602. CLARIFICATION OF INCLUSION OF INPATIENT DRUG PRICES CHARGED TO CERTAIN PUBLIC HOSPITALS IN THE BEST PRICE EXEMPTIONS FOR THE MEDICAID DRUG REBATE PROGRAM.

(a) IN GENERAL.—Section 1927(c)(1)(C)(i)(I) (42 U.S.C. 1396r–8(c)(1)(C)(i)(I)) is amended by inserting before the semicolon the following: ''(including inpatient prices charged to hospitals described in section 340B(a)(4)(L) of the Public Health Service Act)''.

(b) ANTI-DIVERSION PROTECTION.—Section 1927(c)(1)(C) (42 U.S.C. 1396r–8(c)(1)(C)) is amended by adding at the end the following:

''(iii) APPLICATION OF AUDITING AND RECORDKEEPING REQUIREMENTS.—With respect to a covered entity described in section 340B(a)(4)(L) of the Public Health Service Act, any drug purchased for inpatient use shall be subject to the auditing and recordkeeping requirements described in section 340B(a)(5)(C) of the Public Health Service Act.''.

SEC. 603. EXTENSION OF MORATORIUM.

(a) IN GENERAL.—Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989, as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993 and section 4758 of the Balanced Budget Act of 1997, is amended—

(1) by striking ''until December 31, 2002'', and

(2) by striking ''Kent Community Hospital Complex in Michigan or.''

(b) EFFECTIVE DATES.—

(1) PERMANENT EXTENSION.—The amendment made by subsection (a)(1) shall take effect as if included in the amendment made by section 4758 of the Balanced Budget Act of 1997.

(2) MODIFICATION.—The amendment made by subsection (a)(2) shall take effect on the date of enactment of this Act.

Subtitle B—Miscellaneous Provisions

SEC. 611. FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS.

(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—

(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary $250,000,000 for each of fiscal years 2005 through 2008 for the purpose of making allotments under this section for payments to eligible providers in States described in paragraph (1) or (2) of subsection (b).

(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

(b) STATE ALLOTMENTS.—

(1) BASED ON PERCENTAGE OF UNDOCUMENTED ALIENS.—

(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $167,000,000 of such amount to make allotments for such fiscal year in accordance with subparagraph (B).

(B) FORMULA.—The amount of the allotment for payments to eligible providers in each State for a fiscal year shall be equal to the product of—

(i) the total amount available for allotments under this paragraph for the fiscal year; and

(ii) the percentage of undocumented aliens residing in the State as compared to the total number of such aliens residing in all States, as determined by the Statistics Division of the Immigration and Naturalization Service, as of January 2003, based on the 2000 decennial census.

(2) BASED ON NUMBER OF UNDOCUMENTED ALIEN APPREHENSION STATES.—

(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $83,000,000 of such amount to make allotments, in addition to amounts allotted under paragraph (1), for such fiscal year for each of the 6 States with the highest number of undocumented alien apprehensions for such fiscal year.

(B) DETERMINATION OF ALLOTMENTS.—The amount of the allotment for each State described in subparagraph (A) for a fiscal year shall be equal to the product of—

(i) the total amount available for allotments under this paragraph for the fiscal year; and

(ii) the percentage of undocumented alien apprehensions in the State in that fiscal year as compared to the total of such apprehensions for all such States for the preceding fiscal year.

(C) DATA.—For purposes of this paragraph, the highest number of undocumented alien apprehensions for a fiscal year shall be based on the apprehension rates for the 4-consecutive-quarter period ending before the beginning of the fiscal year for which information is available for undocumented aliens in such States, as reported by the Department of Homeland Security.

(c) USE OF FUNDS.—

(1) AUTHORITY TO MAKE PAYMENTS.—From the allotments made for a State under subsection (b) for a fiscal year, the Secretary shall pay the amount (subject to the total amount available from such allotments) determined under paragraph (2) directly to eligible providers located in the State for the provision of eligible services to aliens described in paragraph (5) to the extent that

the eligible provider was not otherwise reimbursed (through insurance or otherwise) for such services during that fiscal year.

(2) DETERMINATION OF PAYMENT AMOUNTS.—

(A) IN GENERAL.—Subject to subparagraph (B), the payment amount determined under this paragraph shall be an amount determined by the Secretary that is equal to the lesser of—

(i) the amount that the provider demonstrates was incurred for the provision of such services; or

(ii) amounts determined under a methodology established by the Secretary for purposes of this subsection.

(B) PRO-RATA REDUCTION.—If the amount of funds allotted to a State under subsection (b) for a fiscal year is insufficient to ensure that each eligible provider in that State receives the amount of payment calculated under subparagraph (A), the Secretary shall reduce that amount of payment with respect to each eligible provider to ensure that the entire amount allotted to the State for that fiscal year is paid to such eligible providers.

(3) METHODOLOGY.—In establishing a methodology under paragraph (2)(A)(ii), the Secretary—

(A) may establish different methodologies for types of eligible providers;

(B) may base payments for hospital services on estimated hospital charges, adjusted to estimated cost, through the application of hospital-specific cost-to-charge ratios;

(C) shall provide for the election by a hospital to receive either payments to the hospital for—

(i) hospital and physician services; or

(ii) hospital services and for a portion of the on-call payments made by the hospital to physicians; and

(D) shall make quarterly payments under this section to eligible providers.

If a hospital makes the election under subparagraph (C)(i), the hospital shall pass on payments for services of a physician to the physician and may not charge any administrative or other fee with respect to such payments.

(4) LIMITATION ON USE OF FUNDS.—Payments made to eligible providers in a State from allotments made under subsection (b) for a fiscal year may only be used for costs incurred in providing eligible services to aliens described in paragraph (5).

(5) ALIENS DESCRIBED.—For purposes of paragraphs (1) and (2), aliens described in this paragraph are any of the following:

(A) Undocumented aliens.

(B) Aliens who have been paroled into the United States at a United States port of entry for the purpose of receiving eligible services.

(B) Mexican citizens permitted to enter the United States for not more than 72 hours under the authority of a biometric machine readable border crossing identification card (also referred to as a ''laser visa'') issued in accordance with the requirements of regulations prescribed under section 101(a)(6) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(6)).

(d) APPLICATIONS; ADVANCE PAYMENTS.—

(1) DEADLINE FOR ESTABLISHMENT OF APPLICATION PROCESS.—

(A) IN GENERAL.—Not later than September 1, 2004, the Secretary shall establish a process under which eligible providers located in a State may request payments under subsection (c).

(B) INCLUSION OF MEASURES TO COMBAT FRAUD AND ABUSE.—The Secretary shall include in the process established under subparagraph (A) measures to ensure that inappropriate, excessive, or fraudulent payments are not made from the allotments determined under subsection (b), including certification by the eligible provider of the veracity of the payment request.

(2) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The process established under paragraph (1) may provide for making payments under this section for each quarter of a fiscal year on the basis of advance estimates of expenditures submitted by applicants for such payments and such other investigation as the Secretary may find necessary, and for making reductions or increases in the payments as necessary to adjust for any overpayment or underpayment for prior quarters of such fiscal year.

(e) DEFINITIONS.—In this section:

(1) ELIGIBLE PROVIDER.—The term ''eligible provider'' means a hospital, physician, or provider of ambulance services (including an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization).

(2) ELIGIBLE SERVICES.—The term ''eligible services'' means health care services required by the application of section 1867 of the Social Security Act (42 U.S.C. 1395dd), and related hospital inpatient and outpatient services and ambulance services (as defined by the Secretary).

(3) HOSPITAL.—The term ''hospital'' has the meaning given such term in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)), except that such term shall include a critical access hospital (as defined in section 1861(mm)(1) of such Act (42 U.S.C. 1395x(mm)(1)).

(4) PHYSICIAN.—The term ''physician'' has the meaning given that term in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).

(5) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms ''Indian tribe'' and ''tribal organization'' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(6) STATE.—The term ''State'' means the 50 States and the District of Columbia.

SEC. 612. COMMISSION ON SYSTEMIC INTEROPERABILITY.

(a) ESTABLISHMENT.—The Secretary shall establish a commission to be known as the ''Commission on Systemic Interoperability'' (in this section referred to as the ''Commission'').

(b) DUTIES.—

(1) IN GENERAL.—The Commission shall develop a comprehensive strategy for the adoption and implementation of health care information technology standards, that includes a timeline and prioritization for such adoption and implementation.

(2) CONSIDERATIONS.—In developing the comprehensive health care information technology strategy under paragraph (1), the Commission shall consider—

(A) the costs and benefits of the standards, both financial impact and quality improvement;

(B) the current demand on industry resources to implement this Act and other electronic standards, including HIPAA standards; and

(C) the most cost-effective and efficient means for industry to implement the standards.

(3) NONINTERFERENCE.—In carrying out this section, the Commission shall not interfere with any standards development of adoption processes underway in the private or public sector and shall not replicate activities related to such standards or the national health information infrastructure underway within the Department of Health and Human Services.

(4) REPORT.—Not later than October 31, 2005, the Commission shall submit to the Secretary and to Congress a report describing the strategy developed under paragraph (1), including an analysis of the matters considered under paragraph (2).

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 11 members appointed as follows:

(A) The President shall appoint 3 members, one of whom the President shall designate as Chairperson.

(B) The Majority Leader of the Senate shall appoint 2 members.

(C) The Minority Leader of the Senate shall appoint 2 members.

(D) The Speaker of the House of Representatives shall appoint 2 members.

(E) The Minority Leader of the House of Representatives shall appoint 2 members.

(2) QUALIFICATIONS.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, health plans and integrated delivery systems, reimbursement of health facilities, practicing physicians, practicing pharmacists, and other providers of health services, health care technology and information systems, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

(d) TERMS.—Each member shall be appointed for the life of the Commission.

(e) COMPENSATION.—

(1) RATES OF PAY.—Members shall each be paid at a rate not to exceed the daily equivalent of the rate of basic pay for level IV of the Executive Schedule for each day (including travel time) during which they are engaged in the actual performance of duties vested in the Commission.

(2) PROHIBITION OF COMPENSATION OF FEDERAL EMPLOYEES.—Members of the Commission who are full-time officers or employees of the United States or Members of Congress may not receive additional pay, allowances, or benefits by reason of their service on the Commission.

(3) TRAVEL EXPENSES.—Each member shall receive travel expenses, including per diem in lieu of subsistence, in accordance with applicable provisions under subchapter I of chapter 57 of title 5, United States Code.

(f) QUORUM.—A majority of the members of the Commission shall constitute a quorum but a lesser number may hold hearings.

(g) DIRECTOR AND STAFF OF COMMISSION; EXPERTS AND CONSULTANTS.—

(1) DIRECTOR.—The Commission shall have a Director who shall be appointed by the Chairperson. The Director shall be paid at a rate not to exceed the rate of basic pay for level IV of the Executive Schedule.

(2) STAFF.—With the approval of the Commission, the Director may appoint and fix the pay of such additional personnel as the Director considers appropriate.

(3) APPLICABILITY OF CERTAIN CIVIL SERVICE LAWS.—The Director and staff of the Commission may be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of that title relating to classification and General Schedule pay rates, except that an individual so appointed may not receive pay in excess of level IV of the Executive Schedule.

(4) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the Director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(5) STAFF OF FEDERAL AGENCIES.—Upon request of the Chairperson, the head of any Federal department or agency may detail, on a reimbursable basis, any of the personnel of

that department or agency to the Commission to assist it in carrying out its duties under this Act.

(h) POWERS OF COMMISSION.—

(1) HEARINGS AND SESSIONS.—The Commission may, for the purpose of carrying out this Act, hold hearings, sit and act at times and places, take testimony, and receive evidence as the Commission considers appropriate.

(2) POWERS OF MEMBERS AND AGENTS.—Any member or agent of the Commission may, if authorized by the Commission, take any action which the Commission is authorized to take by this section.

(3) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this Act. Upon request of the Chairperson of the Commission, the head of that department or agency shall furnish that information to the Commission.

(4) GIFTS, BEQUESTS, AND DEVISES.—The Commission may accept, use, and dispose of gifts, bequests, or devises of services or property, both real and personal, for the purpose of aiding or facilitating the work of the Commission. Gifts, bequests, or devises of money and proceeds from sales of other property received as gifts, bequests, or devises shall be deposited in the Treasury and shall be available for disbursement upon order of the Commission. For purposes of Federal income, estate, and gift taxes, property accepted under this subsection shall be considered as a gift, bequest, or devise to the United States.

(5) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the United States.

(6) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission, on a reimbursable basis, the administrative support services necessary for the Commission to carry out its responsibilities under this Act.

(7) CONTRACT AUTHORITY.—The Commission may enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5)).

(i) TERMINATION.—The Commission shall terminate on 30 days after submitting its report pursuant to subsection (b)(3).

(j) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 613. RESEARCH ON OUTCOMES OF HEALTH CARE ITEMS AND SERVICES.

(a) RESEARCH, DEMONSTRATIONS, AND EVALUATIONS.—

(1) IMPROVEMENT OF EFFECTIVENESS AND EFFICIENCY.—

(A) IN GENERAL.—To improve the quality, effectiveness, and efficiency of health care delivered pursuant to the programs established under titles XVIII, XIX, and XXI of the Social Security Act, the Secretary acting through the Director of the Agency for Healthcare Research and Quality (in this section referred to as the ''Director''), shall conduct and support research to meet the priorities and requests for scientific evidence and information identified by such programs with respect to—

(i) the outcomes, comparative clinical effectiveness, and appropriateness of health care items and services (including prescription drugs); and

(ii) strategies for improving the efficiency and effectiveness of such programs, including the ways in which such items and services are organized, managed, and delivered under such programs.

(B) SPECIFICATION.—To respond to priorities and information requests in subparagraph (A), the Secretary may conduct or support, by grant, contract, or interagency agreement, research, demonstrations, evaluations, technology assessments, or other activities, including the provision of technical assistance, scientific expertise, or methodological assistance.

(2) PRIORITIES.—

(A) IN GENERAL.—The Secretary shall establish a process to develop priorities that will guide the research, demonstrations, and evaluation activities undertaken pursuant to this section.

(B) INITIAL LIST.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall establish an initial list of priorities for research related to health care items and services (including prescription drugs).

(C) PROCESS.—In carrying out subparagraph (A), the Secretary—

(i) shall ensure that there is broad and ongoing consultation with relevant stakeholders in identifying the highest priorities for research, demonstrations, and evaluations to support and improve the programs established under titles XVIII, XIX, and XXI of the Social Security Act;

(ii) may include health care items and services which impose a high cost on such programs, as well as those which may be underutilized or overutilized and which may significantly improve the prevention, treatment, or cure of diseases and conditions (including chronic conditions) which impose high direct or indirect costs on patients or society; and

(iii) shall ensure that the research and activities undertaken pursuant to this section are responsive to the specified priorities and are conducted in a timely manner.

(3) EVALUATION AND SYNTHESIS OF SCIENTIFIC EVIDENCE.—

(A) IN GENERAL.—The Secretary shall—

(i) evaluate and synthesize available scientific evidence related to health care items and services (including prescription drugs) identified as priorities in accordance with paragraph (2) with respect to the comparative clinical effectiveness, outcomes, appropriateness, and provision of such items and services (including prescription drugs);

(ii) identify issues for which existing scientific evidence is insufficient with respect to such health care items and services (including prescription drugs);

(iii) disseminate to prescription drug plans and MA–PD plans under part D of title XVIII of the Social Security Act, other health plans, and the public the findings made under clauses (i) and (ii); and

(iv) work in voluntary collaboration with public and private sector entities to facilitate the development of new scientific knowledge regarding health care items and services (including prescription drugs).

(B) INITIAL RESEARCH.—The Secretary shall complete the evaluation and synthesis of the initial research required by the priority list developed under paragraph (2)(B) not later than 18 months after the development of such list.

(C) DISSEMINATION.—

(i) IN GENERAL.—To enhance patient safety and the quality of health care, the Secretary shall make available and disseminate in appropriate formats to prescription drugs plans under part D, and MA–PD plans under part C, of title XVIII of the Social Security Act, other health plans, and the public the evaluations and syntheses prepared pursuant to subparagraph (A) and the findings of research conducted pursuant to paragraph (1). In carrying out this clause the Secretary, in order to facilitate the availability of such evaluations and syntheses or findings at every decision point in the health care system, shall—

(I) present such evaluations and syntheses or findings in a form that is easily understood by the individuals receiving health care items and services (including prescription drugs) under such plans and periodically assess that the requirements of this subclause have been met; and

(II) provide such evaluations and syntheses or findings and other relevant information through easily accessible and searchable electronic mechanisms, and in hard copy formats as appropriate.

(ii) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as—

(I) affecting the authority of the Secretary or the Commissioner of Food and Drugs under the Federal Food, Drug, and Cosmetic Act or the Public Health Service Act; or

(II) conferring any authority referred to in subclause (I) to the Director.

(D) ACCOUNTABILITY.—In carrying out this paragraph, the Secretary shall implement activities in a manner that—

(i) makes publicly available all scientific evidence relied upon and the methodologies employed, provided such evidence and method are not protected from public disclosure by section 1905 of title 18, United States Code, or other applicable law so that the results of the research, analyses, or syntheses can be evaluated or replicated; and

(ii) ensures that any information needs and unresolved issues identified in subparagraph (A)(ii) are taken into account in priority-setting for future research conducted by the Secretary.

(4) CONFIDENTIALITY.—

(A) IN GENERAL.—In making use of administrative, clinical, and program data and information developed or collected with respect to the programs established under titles XVIII, XIX, and XXI of the Social Security Act, for purposes of carrying out the requirements of this section or the activities authorized under title IX of the Public Health Service Act (42 U.S.C. 299 et seq.), such data and information shall be protected in accordance with the confidentiality requirements of title IX of the Public Health Service Act.

(B) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require or permit the disclosure of data provided to the Secretary that is otherwise protected from disclosure under the Federal Food, Drug, and Cosmetic Act, section 1905 of title 18, United States Code, or other applicable law.

(5) EVALUATIONS.—The Secretary shall conduct and support evaluations of the activities carried out under this section to determine the extent to which such activities have had an effect on outcomes and utilization of health care items and services.

(6) IMPROVING INFORMATION AVAILABLE TO HEALTH CARE PROVIDERS, PATIENTS, AND POLICYMAKERS.—Not later than 18 months after the date of enactment of this Act, the Secretary shall identify options that could be undertaken in voluntary collaboration with private and public entities (as appropriate) for the—

(A) provision of more timely information through the programs established under titles XVIII, XIX, and XXI of the Social Security Act, regarding the outcomes and quality of patient care, including clinical and patient-reported outcomes, especially with respect to interventions and conditions for which clinical trials would not be feasible or raise ethical concerns that are difficult to address;

(B) acceleration of the adoption of innovation and quality improvement under such programs; and

(C) development of management tools for the programs established under titles XIX

and XXI of the Social Security Act, and with respect to the programs established under such titles, assess the feasibility of using administrative or claims data, to—

(i) improve oversight by State officials;

(ii) support Federal and State initiatives to improve the quality, safety, and efficiency of services provided under such programs; and

(iii) provide a basis for estimating the fiscal and coverage impact of Federal or State program and policy changes.

(b) RECOMMENDATIONS.—

(1) DISCLAIMER.—In carrying out this section, the Director shall—

(A) not mandate national standards of clinical practice or quality health care standards; and

(B) include in any recommendations resulting from projects funded and published by the Director, a corresponding reference to the prohibition described in subparagraph (A).

(2) REQUIREMENT FOR IMPLEMENTATION.—Research, evaluation, and communication activities performed pursuant to this section shall reflect the principle that clinicians and patients should have the best available evidence upon which to make choices in health care items and services, in providers, and in health care delivery systems, recognizing that patient subpopulations and patient and physician preferences may vary.

(3) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to provide the Director with authority to mandate a national standard or require a specific approach to quality measurement and reporting.

(c) RESEARCH WITH RESPECT TO DISSEMINATION.—The Secretary, acting through the Director, may conduct or support research with respect to improving methods of disseminating information in accordance with subsection (a)(3)(C).

(d) LIMITATION ON CMS.—The Administrator of the Centers for Medicare & Medicaid Services may not use data obtained in accordance with this section to withhold coverage of a prescription drug.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $50,000,000 for fiscal year 2004, and such sums as may be necessary for each fiscal year thereafter.

SEC. 614. HEALTH CARE THAT WORKS FOR ALL AMERICANS: CITIZENS HEALTH CARE WORKING GROUP.

(a) FINDINGS.—Congress finds the following:

(1) In order to improve the health care system, the American public must engage in an informed national public debate to make choices about the services they want covered, what health care coverage they want, and how they are willing to pay for coverage.

(2) More than a trillion dollars annually is spent on the health care system, yet—

(A) 41,000,000 Americans are uninsured;

(B) insured individuals do not always have access to essential, effective services to improve and maintain their health; and

(C) employers, who cover over 170,000,000 Americans, find providing coverage increasingly difficult because of rising costs and double digit premium increases.

(3) Despite increases in medical care spending that are greater than the rate of inflation, population growth, and Gross Domestic Product growth, there has not been a commensurate improvement in our health status as a nation.

(4) Health care costs for even just 1 member of a family can be catastrophic, resulting in medical bills potentially harming the economic stability of the entire family.

(5) Common life occurrences can jeopardize the ability of a family to retain private coverage or jeopardize access to public coverage.

(6) Innovations in health care access, coverage, and quality of care, including the use of technology, have often come from States, local communities, and private sector organizations, but more creative policies could tap this potential.

(7) Despite our Nation's wealth, the health care system does not provide coverage to all Americans who want it.

(b) PURPOSES.—The purposes of this section are—

(1) to provide for a nationwide public debate about improving the health care system to provide every American with the ability to obtain quality, affordable health care coverage; and

(2) to provide for a vote by Congress on the recommendations that result from the debate.

(c) ESTABLISHMENT.—The Secretary, acting through the Agency for Healthcare Research and Quality, shall establish an entity to be known as the Citizens' Health Care Working Group (referred to in this section as the ''Working Group'').

(d) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Working Group shall be composed of 15 members. One member shall be the Secretary. The Comptroller General of the United States shall appoint 14 members.

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of the Working Group shall include—

(i) consumers of health services that represent those individuals who have not had insurance within 2 years of appointment, that have had chronic illnesses, including mental illness, are disabled, and those who receive insurance coverage through medicare and medicaid; and

(ii) individuals with expertise in financing and paying for benefits and access to care, business and labor perspectives, and providers of health care.

The membership shall reflect a broad geographic representation and a balance between urban and rural representatives.

(B) PROHIBITED APPOINTMENTS.—Members of the Working Group shall not include Members of Congress or other elected government officials (Federal, State, or local). Individuals appointed to the Working Group shall not be paid employees or representatives of associations or advocacy organizations involved in the health care system.

(e) PERIOD OF APPOINTMENT.—Members of the Working Group shall be appointed for a life of the Working Group. Any vacancies shall not affect the power and duties of the Working Group but shall be filled in the same manner as the original appointment.

(f) DESIGNATION OF THE CHAIRPERSON.—Not later than 15 days after the date on which all members of the Working Group have been appointed under subsection (d)(1), the Comptroller General shall designate the chairperson of the Working Group.

(g) SUBCOMMITTEES.—The Working Group may establish subcommittees if doing so increases the efficiency of the Working Group in completing its tasks.

(h) DUTIES.—

(1) HEARINGS.—Not later than 90 days after the date of the designation of the chairperson under subsection (f), the Working Group shall hold hearings to examine—

(A) the capacity of the public and private health care systems to expand coverage options;

(B) the cost of health care and the effectiveness of care provided at all stages of disease;

(C) innovative State strategies used to expand health care coverage and lower health care costs;

(D) local community solutions to accessing health care coverage;

(E) efforts to enroll individuals currently eligible for public or private health care coverage;

(F) the role of evidence-based medical practices that can be documented as restoring, maintaining, or improving a patient's health, and the use of technology in supporting providers in improving quality of care and lowering costs; and

(G) strategies to assist purchasers of health care, including consumers, to become more aware of the impact of costs, and to lower the costs of health care.

(2) ADDITIONAL HEARINGS.—The Working Group may hold additional hearings on subjects other than those listed in paragraph (1) so long as such hearings are determined to be necessary by the Working Group in carrying out the purposes of this section. Such additional hearings do not have to be completed within the time period specified in paragraph (1) but shall not delay the other activities of the Working Group under this section.

(3) THE HEALTH REPORT TO THE AMERICAN PEOPLE.—Not later than 90 days after the hearings described in paragraphs (1) and (2) are completed, the Working Group shall prepare and make available to health care consumers through the Internet and other appropriate public channels, a report to be entitled, ''The Health Report to the American People''. Such report shall be understandable to the general public and include—

(A) a summary of—

(i) health care and related services that may be used by individuals throughout their life span;

(ii) the cost of health care services and their medical effectiveness in providing better quality of care for different age groups;

(iii) the source of coverage and payment, including reimbursement, for health care services;

(iv) the reasons people are uninsured or underinsured and the cost to taxpayers, purchasers of health services, and communities when Americans are uninsured or underinsured;

(v) the impact on health care outcomes and costs when individuals are treated in all stages of disease;

(vi) health care cost containment strategies; and

(vii) information on health care needs that need to be addressed;

(B) examples of community strategies to provide health care coverage or access;

(C) information on geographic-specific issues relating to health care;

(D) information concerning the cost of care in different settings, including institutional-based care and home and community-based care;

(E) a summary of ways to finance health care coverage; and

(F) the role of technology in providing future health care including ways to support the information needs of patients and providers.

(4) COMMUNITY MEETINGS.—

(A) IN GENERAL.—Not later than 1 year after the date on which all the members of the Working Group have been appointed under subsection (d)(1) and appropriations are first made available to carry out this section, the Working Group shall initiate health care community meetings throughout the United States (in this paragraph referred to as ''community meetings''). Such community meetings may be geographically or regionally based and shall be completed within 180 days after the initiation of the first meeting.

(B) NUMBER OF MEETINGS.—The Working Group shall hold a sufficient number of community meetings in order to receive information that reflects—

(i) the geographic differences throughout the United States;

(ii) diverse populations; and

(iii) a balance among urban and rural populations.

(C) MEETING REQUIREMENTS.—

(i) FACILITATOR.—A State health officer may be the facilitator at the community meetings.

(ii) ATTENDANCE.—At least 1 member of the Working Group shall attend and serve as chair of each community meeting. Other members may participate through interactive technology.

(iii) TOPICS.—The community meetings shall, at a minimum, address the following questions:

(I) What health care benefits and services should be provided?

(II) How does the American public want health care delivered?

(III) How should health care coverage be financed?

(IV) What trade-offs are the American public willing to make in either benefits or financing to ensure access to affordable, high quality health care coverage and services?

(iv) INTERACTIVE TECHNOLOGY.—The Working Group may encourage public participation in community meetings through interactive technology and other means as determined appropriate by the Working Group.

(D) INTERIM REQUIREMENTS.—Not later than 180 days after the date of completion of the community meetings, the Working Group shall prepare and make available to the public through the Internet and other appropriate public channels, an interim set of recommendations on health care coverage and ways to improve and strengthen the health care system based on the information and preferences expressed at the community meetings. There shall be a 90-day public comment period on such recommendations.

(i) RECOMMENDATIONS.—Not later than 120 days after the expiration of the public comment period described in subsection (h)(4)(D), the Working Group shall submit to Congress and the President a final set of recommendations.

(j) ADMINISTRATION.—

(1) EXECUTIVE DIRECTOR.—There shall be an Executive Director of the Working Group who shall be appointed by the chairperson of the Working Group in consultation with the members of the Working Group.

(2) COMPENSATION.—While serving on the business of the Working Group (including travel time), a member of the Working Group shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the chairperson of the Working Group. For purposes of pay and employment benefits, rights, and privileges, all personnel of the Working Group shall be treated as if they were employees of the Senate.

(3) INFORMATION FROM FEDERAL AGENCIES.—The Working Group may secure directly from any Federal department or agency such information as the Working Group considers necessary to carry out this section. Upon request of the Working Group, the head of such department or agency shall furnish such information.

(4) POSTAL SERVICES.—The Working Group may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(k) DETAIL.—Not more than 10 Federal Government employees employed by the Department of Labor and 10 Federal Government employees employed by the Department of Health and Human Services may be detailed to the Working Group under this section without further reimbursement. Any detail of an employee shall be without interruption or loss of civil service status or privilege.

(l) TEMPORARY AND INTERMITTENT SERVICES.—The chairperson of the Working Group may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(m) ANNUAL REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter during the existence of the Working Group, the Working Group shall report to Congress and make public a detailed description of the expenditures of the Working Group used to carry out its duties under this section.

(n) SUNSET OF WORKING GROUP.—The Working Group shall terminate on the date that is 2 years after the date on which all the members of the Working Group have been appointed under subsection (d)(1) and appropriations are first made available to carry out this section.

(o) ADMINISTRATION REVIEW AND COMMENTS.—Not later than 45 days after receiving the final recommendations of the Working Group under subsection (i), the President shall submit a report to Congress which shall contain—

(1) additional views and comments on such recommendations; and

(2) recommendations for such legislation and administrative actions as the President considers appropriate.

(p) REQUIRED CONGRESSIONAL ACTION.—Not later than 45 days after receiving the report submitted by the President under subsection (o), each committee of jurisdiction of Congress, the Committee on Finance of the Senate, the Committee on Health, Education, Labor, and Pensions of the Senate, the Committee on Ways and Means of the House of Representatives, the Committee on Energy and Commerce of the House of Representatives, Committee on Education and the Workforce of the House of Representatives, shall hold at least 1 hearing on such report and on the final recommendations of the Working Group submitted under subsection (i).

(q) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out this section, other than subsection (h)(3), $3,000,000 for each of fiscal years 2005 and 2006.

(2) HEALTH REPORT TO THE AMERICAN PEOPLE.—There are authorized to be appropriated for the preparation and dissemination of the Health Report to the American People described in subsection (h)(3), such sums as may be necessary for the fiscal year in which the report is required to be submitted.

SEC. 615. FUNDING START-UP ADMINISTRATIVE COSTS FOR MEDICARE REFORM.

(a) IN GENERAL.—There are appropriated to carry out this Act (including the amendments made by this Act), to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund—

(1) not to exceed $1,000,000,000 for the Centers for Medicare & Medicaid Services; and

(2) not to exceed $500,000,000 for the Social Security Administration.

(b) AVAILABILITY.—Amounts provided under subsection (a) shall remain available until September 30, 2005.

(c) APPLICATION.—From amounts provided under subsection (a)(2), the Social Security Administration may reimburse the Internal Revenue Service for expenses in carrying out this Act (and the amendments made by this Act).

(d) TRANSFER.—The President may transfer amounts provided under subsection (a) between the Centers for Medicare & Medicaid Services and the Social Security Administration. Notice of such transfers shall be transmitted within 15 days to the authorizing committees of the House of Representatives and of the Senate.

SEC. 616. HEALTH CARE INFRASTRUCTURE IMPROVEMENT PROGRAM.

Title XVIII is amended by adding at the end the following new section:

''HEALTH CARE INFRASTRUCTURE IMPROVEMENT PROGRAM

''SEC. 1897. (a) ESTABLISHMENT.—The Secretary shall establish a loan program that provides loans to qualifying hospitals for payment of the capital costs of projects described in subsection (d).

''(b) APPLICATION.—No loan may be provided under this section to a qualifying hospital except pursuant to an application that is submitted and approved in a time, manner, and form specified by the Secretary. A loan under this section shall be on such terms and conditions and meet such requirements as the Secretary determines appropriate.

''(c) SELECTION CRITERIA.—

''(1) IN GENERAL.—The Secretary shall establish criteria for selecting among qualifying hospitals that apply for a loan under this section. Such criteria shall consider the extent to which the project for which loan is sought is nationally or regionally significant, in terms of expanding or improving the health care infrastructure of the United States or the region or in terms of the medical benefit that the project will have.

''(2) QUALIFYING HOSPITAL DEFINED.—For purposes of this section, the term 'qualifying hospital' means a hospital that—

''(A) is engaged in research in the causes, prevention, and treatment of cancer; and

''(B) is designated as a cancer center for the National Cancer Institute or is designated by the State as the official cancer institute of the State.

''(d) PROJECTS.—A project described in this subsection is a project of a qualifying hospital that is designed to improve the health care infrastructure of the hospital, including construction, renovation, or other capital improvements.

''(e) STATE AND LOCAL PERMITS.—The provision of a loan under this section with respect to a project shall not—

''(1) relieve any recipient of the loan of any obligation to obtain any required State or local permit or approval with respect to the project;

''(2) limit the right of any unit of State or local government to approve or regulate any rate of return on private equity invested in the project; or

''(3) otherwise supersede any State or local law (including any regulation) applicable to the construction or operation of the project.

''(f) FORGIVENESS OF INDEBTEDNESS.—The Secretary may forgive a loan provided to a qualifying hospital under this section under terms and conditions that are analogous to the loan forgiveness provision for student loans under part D of title IV of the Higher Education Act of 1965 (20 U.S.C. 1087a et seq.), except that the Secretary shall condition such forgiveness on the establishment by the hospital of—

''(A) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to a substantial majority of the residents of a State or region, including residents of rural areas;

''(B) an outreach program for cancer prevention, early diagnosis, and treatment that

provides services to multiple Indian tribes; and

''(C)(i) unique research resources (such as population databases); or

''(ii) an affiliation with an entity that has unique research resources.

''(g) FUNDING.—

''(1) IN GENERAL.—There are appropriated, out of amounts in the Treasury not otherwise appropriated, to carry out this section, $200,000,000, to remain available during the period beginning on July 1, 2004, and ending on September 30, 2008.

''(2) ADMINISTRATIVE COSTS.—From funds made available under paragraph (1), the Secretary may use, for the administration of this section, not more than $2,000,000 for each of fiscal years 2004 through 2008.

''(3) AVAILABILITY.—Amounts appropriated under this section shall be available for obligation on July 1, 2004.

''(h) REPORT TO CONGRESS.—Not later than 4 years after the date of the enactment of this section, the Secretary shall submit to Congress a report on the projects for which loans are provided under this section and a recommendation as to whether the Congress should authorize the Secretary to continue loans under this section beyond fiscal year 2008.''.

By Mrs. CLINTON:

S. 1927. A bill to establish an award program to encourage the development of effective bomb-scanning technology; to the Committee on Commerce, Science, and Transportation.

Mrs. CLINTON. Mr. President, ever since the events of September 11, 2001 awakened this Nation to the very real dangers of the world we live in, we have been struggling to defend ourselves against terrorism. Our aviation system remains a primary target for terrorists, and we must be every vigilant in the fight to keep that system safe. The economic viability, not to mention safety and security, of our country is at stake in that fight.

Nowhere is this more obvious than in New York. Not only did we bear the brunt of the worst terrorist attack in our Nation's history, but we also depend on our airports to fuel our state economy. John F. Kennedy Airport in Queens is the Nation's premier international gateway and contributes approximately $30 billion to the regional economy while employing 35,000 people. LaGuardia Airport, also in Queens, handles over 20 million passengers a year despite having only two 7000-foot runways on 680 acres. Our airports in Albany, Syracuse, Rochester, and Buffalo have seen strong growth in recent years with the arrival of low-cost carriers.

Unfortunately, our economic and physical security remains at risk because we still have not developed a way to effectively scan each piece of passenger luggage for explosives. We have recognized that in the current world environment, we must scan each bag, but technology has not kept up with our needs. The current technology used in most airports in this country is known to have a false-positive rate of approximately 20 percent. This means that machines incorrectly identify 20 percent of all bags going through them as containing explosives, thus slowing down the process considerably as well as costing time and money. Even more dangerous is the false-negative rate of these machines. This number, the percentage of bags going undetected through these machines with bombs inside of them during test runs, should be close to zero. The actual false-negative rate is not publicized for obvious reasons, but it is known to be well above zero.

I am proposing a bill today that seeks to create a major incentive for firms to invent a bomb-scanning technology that actually works. It will award $20 million to any firm that can successfully produce a machine that has a false-positive rate less than 10 percent, a false negative rate less than 2 percent, and is feasible for deployment en masse at our Nation's airports. Although we are currently spending money on researching this technology, that funding is clearly not getting us there fast enough. This new award will help to spur the private sector to develop new technology that will make a major difference in the safety of our aviation system.

By Mr. SARBANES (for himself, Mr. SCHUMER, Ms. STABENOW, Mr. CORZINE, Mr. DURBIN, Mr. KERRY, Ms. MIKULSKI, Mrs. CLINTON, Mr. LEVIN, Mr. LEAHY, Mr. AKAKA, Mr. KENNEDY, Mr. LAUTENBERG, Mr. DAYTON, and Mr. DODD):

S. 1928. A bill to amend the Truth in Lending Act to protect consumers against predatory practices in connection with high cost mortgage transactions, to strengthen the civil remedies available to consumers under existing law, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

Mr. SARBANES. Mr. President, in July of 2001, and continuing through January of the following year, the Committee on Banking, Housing, and Urban Affairs held a series of hearings to shine a bright light on the deceptive and destructive practices of predatory mortgage lenders. At those hearings, the Committee heard from housing experts, community groups, legal advocates, industry representatives and victims of predatory lending in an effort to determine how best to address this terrible problem. Today, I am introducing legislation, the ''Predatory Lending Consumer Protection Act of 2003,'' along with a number of my colleagues, that would begin to address the problems that came to light in those hearings.

Homeownership is the American Dream. Indeed, the Committee has already passed legislation this year that would authorize a new $200 million downpayment assistance program to ensure that more people can achieve this goal.

We have taken this step because homeownership is the best opportunity for most Americans to put down roots and start creating equity for themselves and their families. Homeownership has been the path to building wealth for generations of Americans, wealth that can be tapped to send children to college, pay for a secure retirement, or simply work as a reserve against unexpected emergencies. It has been the key to ensuring stable communities, good schools, and safe streets. Common sense tells us, and the evidence confirms, that homeowners are more engaged citizens and more active in their communities.

Little wonder, then, that so many Americans, young and old, aspire to achieve this dream.

Unhappily, predatory lenders cynically play on these hopes and dreams to cheat people out of their wealth. These lenders target lower income, elderly, and, often, uneducated homeowners for their abusive practices. Study after study has shown that predatory lenders also target minorities, driving a wedge between these families and the hope of a productive life in the economic and financial mainstream of America.

We owe it to these hardworking families to provide protections against these unscrupulous players.

Let me share with you one of the stories we heard at our hearings. Mary Ann Podelco, a widowed waitress from West Virginia, used $19,000 from her husband's life insurance to pay off the balance on her mortgage, thus owning her home free and clear. Before her husband's death, she had never had a checking account or a credit card. She then took out a $11,921 loan for repairs. At the time, her monthly income from Social Security was $458, and her loan payments were more than half this amount. Ms. Podelco, who has a sixth grade education, testified that after her first refinancing, ''I began getting calls from people trying to refinance my mortgage all hours of the day and night.'' Within 2 years, having been advised to refinance seven times—each time seeing high points and fees being financed into her new loan—she owed $64,000, and lost her home to foreclosure.

Ms. Podelco's story is all too typical. Unfortunately, most of the sharp practices used by unscrupulous lenders and brokers, while unethical and clearly abusive, are not illegal. This bill is designed to address that problem by tightening the interest rate and fee triggers that define high cost loans; the bill improves protections for borrowers receiving such loans by prohibiting the financing of exorbitant fees, ''packing'' in of unnecessary and costly products, such as single premium credit insurance, and limiting prepayment penalties. Finally, it protects these consumers' rights to seek redress by prohibiting mandatory arbitration, as the Federal Trade Commission (FTC) proposed unanimously in 2000.We often hear about the importance of improved enforcement as a way to combat this

problem. As the FTC pointed out, mandatory arbitration prevents homeowners from exercising any of their rights to enforce existing law.

We cannot extol the virtues of homeownership, as we so often do, without seeking at the same time to preserve this benefit for so many elderly, minority, and unsophisticated Americans who are the targets of unscrupulous lenders and brokers. This legislation will help achieve this important goal. This bill has been endorsed by the Leadership Conference on Civil Rights, the U.S. Conference of Mayors, the National Council of La Raza, the National Consumer Law Center, ACORN, National Consumer Reinvestment Coalition, Consumer Federation of America, the NAACP, the Self-Help Credit Union, the National Association of Local Housing Finance Agencies, the National Community Development Association, the National Association of Consumer Advocates, and the National League of Cities, among others.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1928

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Predatory Lending Consumer Protection Act of 2003''.

SEC. 2. TRUTH IN LENDING ACT DEFINITIONS.

(a) HIGH COST MORTGAGES.—

(1) IN GENERAL.—The portion of section 103(aa) of the Truth in Lending Act (15 U.S.C. 1602(aa)) that precedes paragraph (2) is amended to read as follows:

''(aa) MORTGAGE REFERRED TO IN THIS SUBSECTION.—

''(1) DEFINITION.—

''(A) IN GENERAL.—A mortgage referred to in this subsection means a consumer credit transaction—

''(i) that is secured by the principal dwelling of the consumer, other than a reverse mortgage transaction; and

''(ii) the terms of which provide that—

''(I) the transaction is secured by a first mortgage on the principal dwelling of the consumer, and the annual percentage rate on the credit, at the consummation of the transaction, will exceed by more than 6 percentage points the yield on Treasury securities having comparable periods of maturity on the 15th day of the month immediately preceding the month in which the application for the extension of credit is received by the creditor;

''(II) the transaction is secured by a junior or subordinate mortgage on the principal dwelling of the consumer, and the annual percentage rate on the credit, at the consummation of the transaction, will exceed by more than 8 percentage points the yield on Treasury securities having comparable periods of maturity on the 15th day of the month immediately preceding the month in which the application for the extension of credit is received by the creditor; or

''(III) the total points and fees payable on the transaction will exceed the greater of 5 percent of the total loan amount, or $1,000, excluding not more than 2 bona fide discount points.

''(B) INTRODUCTORY RATES NOT TAKEN INTO ACCOUNT.—For purposes of subparagraph (A)(ii), the annual percentage rate of interest shall be determined—

''(i) in the case of a fixed-rate loan in which the annual percentage rate will not vary during the term of the loan, as the rate in effect on the date of consummation of the transaction;

''(ii) in the case of a loan in which the rate of interest varies according to an index, or is less than the rate of interest which will apply after the end of an initial or introductory period, by adding the index rate in effect on the date of consummation of the transaction to the maximum margin permitted at any time during the loan agreement; and

''(iii) in the case of any other loan in which the rate may vary at any time during the term of the loan for any reason, by including in the finance charge component of the annual percentage rate—

''(I) the interest charged on the loan at the maximum rate that may be charged during the term of the loan; and

''(II) any other applicable charges that would otherwise be included in accordance with section 106.''.

(2) TECHNICAL AND CONFORMING AMENDMENT.—Section 103(aa)(2) of the Truth in Lending Act (15 U.S.C. 1602(aa)(2)) is amended—

(A) by striking subparagraph (B); and

(B) by redesignating subparagraph (C) as subparagraph (B).

(b) POINTS AND FEES.—Section 103(aa)(4) of the Truth in Lending Act (15 U.S.C. 1602(aa)(4)) is amended—

(1) by striking subparagraph (B) and inserting the following:

''(B) all compensation paid directly or indirectly by a consumer or a creditor to a mortgage broker;'';

(2) by redesignating subparagraph (D) as subparagraph (G); and

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

''(C) each of the charges listed in section 106(e) (except an escrow for future payment of taxes and insurance);

''(D) the cost of all premiums financed by the lender, directly or indirectly, for any credit life, credit disability, credit unemployment or credit property insurance, or any other life or health insurance, or any payments financed by the lender, directly or indirectly, for any debt cancellation or suspension agreement or contract, except that, for purposes of this subparagraph, insurance premiums or debt cancellation or suspension fees calculated and paid on a monthly basis shall not be considered financed by the lender;

''(E) the maximum prepayment penalties that may be charged or collected under the terms of the loan documents;

''(F) all prepayment fees or penalties that are charged to the borrower if the loan refinances a previous loan made by the same creditor or an affiliate of that creditor; and''.

(c) HIGH COST MORTGAGE LENDER.—Section 103(f) of the Truth in Lending Act (15 U.S.C. 1602(f)) is amended by striking the last sentence and inserting ''Any person who originates 2 or more mortgages referred to in subsection (aa) in any 12-month period, any person who originates 1 or more such mortgages through a mortgage broker or acted as a mortgage broker between originators and consumers on more than 5 mortgages referred to in subsection (aa) within the preceding 12-month period, and any creditor-affiliated party shall be considered to be a creditor for purposes of this title.''.

(d) BONA FIDE DISCOUNT POINTS AND BENCHMARK RATE DEFINED.—Section 103 of the Truth in Lending Act (15 U.S.C. 1602) is amended by adding at the end the following:

''(cc) OTHER INTEREST RATE RELATED TERMS.—

''(1) BENCHMARK RATE.—The term 'benchmark rate' means an interest rate that the borrower may reduce by paying bona fide discount points, not to exceed the weekly average yield of United States Treasury securities having a maturity of 5 years, on the 15th day of the month immediately preceding the month in which the loan is made, plus 5 percentage points.

''(2) BONA FIDE DISCOUNT POINTS.—The term 'bona fide discount points' means loan discount points which are—

''(A) knowingly paid by the borrower;

''(B) paid for the express purpose of lowering the benchmark rate;

''(C) in fact reducing the interest rate or time-price differential applicable to the loan from an interest rate which does not exceed the benchmark rate; and

''(D) recouped within the first 4 years of the scheduled loan payments.

''(3) RECOUPMENT.—For purposes of paragraph (2)(D), loan discount points shall be considered to be recouped within the first 4 years of the scheduled loan payments if the reduction in the interest rate that is achieved by the payment of the loan discount points reduces the interest charged on the scheduled payments, such that the dollar amount of savings in payments made by the borrower over the first 4 years is equal to or exceeds the dollar amount of loan discount points paid by the borrower.''.

SEC. 3. AMENDMENTS TO EXISTING REQUIREMENTS FOR HIGH COST CONSUMER MORTGAGES.

(a) ADDITIONAL DISCLOSURES.—Section 129(a)(1) of the Truth in Lending Act (15 U.S.C. 1639(a)(1)) is amended by adding at the end the following:

''(C) 'The interest rate on this loan is much higher than most people pay. This means the chance that you will lose your home is much higher if you do not make all payments under the loan.'.

''(D) 'You may be able to get a loan with a much lower interest rate. Before you sign any papers, you have the right to go see a housing or consumer credit counseling agency, as well as to consult other lenders to find ways to get a cheaper loan.'.

''(E) 'If you are taking out this loan to repay other loans, look to see how many months it will take to pay for this loan and what the total amount is that you will have to pay before this loan is repaid. Even though the total amount you will have to pay each month for this loan may be less than the total amount you are paying each month for those other loans, you may have to pay on this loan for many more months than those other loans which will cost you more money in the end.' ''.

(b) PREPAYMENT PENALTY PROVISIONS.—Section 129(c) of the Truth in Lending Act (15 U.S.C. 1639(c)) is amended to read as follows:

''(c) PREPAYMENT PENALTY PROVISIONS.—

''(1) NO PREPAYMENT PENALTIES AFTER END OF 24-MONTH PERIOD.—A mortgage referred to in section 103(aa) may not contain terms under which a consumer must pay any prepayment penalty for any payment made after the end of the 24-month period beginning on the date the mortgage is consummated.

''(2) NO PREPAYMENT PENALTIES IF MORE THAN 3 PERCENT OF POINTS AND FEES WERE FINANCED.—Subject to subsection (l)(1), a mortgage referred to in section 103(aa) may not contain terms under which a consumer must pay any prepayment penalty for any payment made at or before the end of the 24-month period referred to in paragraph (1) if

the creditor financed points or fees in connection with the consumer credit transaction in an amount equal to or greater than 3 percent of the total amount of credit extended in the transaction.

''(3) LIMITED PREPAYMENT PENALTY FOR EARLY REPAYMENT UNDER CERTAIN CIRCUMSTANCES.—Subject to paragraph (2), the terms of a mortgage referred to in section 103(aa) may contain terms under which a consumer must pay a prepayment penalty for any payment made at or before the end of the 24-month period referred to in paragraph (1) to the extent that the sum of the total amount of points or fees financed by the creditor, if any, in connection with the consumer credit transaction and the total amount payable as a prepayment penalty does not exceed the amount which is equal to 3 percent of the total amount of credit extended in the transaction.

''(4) CONSTRUCTION.—For purposes of this subsection, any method of computing a refund of unearned scheduled interest is a prepayment penalty if it is less favorable to the consumer than the actuarial method (as that term is defined in section 933(d) of the Housing and Community Development Act of 1992).

''(5) PREPAYMENT PENALTY DEFINED.—The term 'prepayment penalty' means any monetary penalty imposed on a consumer for paying all or part of the principal with respect to a consumer credit transaction before the date on which the principal is due.''.

(c) ALL BALLOON PAYMENTS PROHIBITED.—Section 129(e) of the Truth in Lending Act (15 U.S.C. 1639(e)) is amended by striking ''having a term of less than 5 years''.

(d) ASSESSMENT OF ABILITY TO REPAY.—Section 129(h) of the Truth in Lending Act (15 U.S.C. 1639(h)) is amended—

(1) by striking ''CONSUMER.—A creditor'' and inserting ''CONSUMER.—

''(1) PROHIBITION ON PATTERNS AND PRACTICES.—A creditor''; and

(2) by adding at the end the following:

''(2) CASE-BY-CASE ASSESSMENTS OF CONSUMER ABILITY TO PAY REQUIRED.—

''(A) IN GENERAL.—In addition to the prohibition in paragraph (1) on engaging in certain patterns and practices, a creditor may not extend any credit in connection with any mortgage referred to in section 103(aa) unless the creditor has determined, at the time such credit is extended, that 1 or more of the resident obligors, when considered individually and collectively, will be able to make the scheduled payments under the terms of the transaction based on a consideration of the current and expected income, current obligations, employment status, and other financial resources of any such obligor, without taking into account any equity of any such obligor in the dwelling which is the security for the credit.

''(B) REGULATIONS.—The Board shall prescribe, by regulation, the appropriate format for determining the ability of a consumer to make payments and the criteria to be considered in making that determination.

''(C) RESIDENT OBLIGOR.—For purposes of this paragraph, the term 'resident obligor' means an obligor for whom the dwelling securing the extension of credit is, or upon the consummation of the transaction will be, the principal residence.

''(3) VERIFICATION.—The requirements of paragraphs (1) and (2) shall not be deemed to have been met unless any information relied upon by the creditor for purposes of any such paragraph has been verified by the creditor independently of information provided by any resident obligor.''.

(e) REQUIREMENTS RELATING TO HOME IMPROVEMENT CONTRACTS.—Section 129(i) of the Truth in Lending Act (15 U.S.C. 1639(i)) is amended—

(1) by striking ''IMPROVEMENT CONTRACTS.—A creditor'' and inserting ''IMPROVEMENT CONTRACTS.—

''(1) IN GENERAL.—A creditor''; and

(2) by adding at the end the following:

''(2) AFFIRMATIVE CLAIMS AND DEFENSES.—Notwithstanding any other provision of law, any assignee or holder, in any capacity, of a mortgage referred to in section 103(aa) which was made, arranged, or assigned by a person financing home improvements to the dwelling of a consumer shall be subject to all affirmative claims and defenses which the consumer may have against the seller, home improvement contractor, broker, or creditor with respect to such mortgage or home improvements.''.

(f) CLARIFICATION OF RESCISSION RIGHTS.—Section 129(j) of the Truth in Lending Act (15 U.S.C. 1639(j)) is amended to read as follows:

''(j) CONSEQUENCE OF FAILURE TO COMPLY.—

''(1) IN GENERAL.—The consummation of a consumer credit transaction resulting in a mortgage referred to in section 103(aa) shall be treated as a failure to deliver the material disclosures required under this title for the purpose of section 125, if—

''(A) the mortgage contains a provision prohibited by this section or does not contain a provision required by this section; or

''(B) a creditor or other person fails to comply with the provisions of this section, whether by an act or omission, with regard to such mortgage at any time.

''(2) RULE OF APPLICATION.—In any application of section 125 to a mortgage described in section 103(aa) under circumstances described in paragraph (1), paragraphs (2) and (4) of section 125(e) shall not apply or be taken into account.''.

SEC. 4. ADDITIONAL REQUIREMENTS FOR HIGH COST CONSUMER MORTGAGES.

(a) SINGLE PREMIUM CREDIT INSURANCE.—Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended—

(1) by redesignating subsections (k) and (l) as subsections (s) and (t), respectively; and

(2) by inserting after subsection (j), the following:

''(k) SINGLE PREMIUM CREDIT INSURANCE.—

''(1) IN GENERAL.—The terms of a mortgage referred to in section 103(aa) may not require, and no creditor or other person may require or allow in connection with any such mortgage, whether paid directly by the consumer or financed by the consumer through such mortgage—

''(A) the advance collection of a premium, on a single premium basis, for any credit life, credit disability, credit unemployment, or credit property insurance, and any analogous product; or

''(B) the advance collection of a fee for any debt cancellation or suspension agreement or contract.

''(2) RULE OF CONSTRUCTION.—Paragraph (1) shall not be construed as affecting the right of a creditor to collect premium payments on insurance or debt cancellation or suspension fees referred to in paragraph (1) that are calculated and paid on a regular monthly basis, if the insurance transaction is conducted separately from the mortgage transaction, the insurance may be canceled by the consumer at any time, and the insurance policy is automatically canceled upon repayment or other termination of the mortgage referred to in paragraph (1).''.

(b) RESTRICTION ON FINANCING POINTS AND FEES.—Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended by inserting after subsection (k) (as added by subsection (a) of this section) the following:

''(l) RESTRICTION ON FINANCING POINTS AND FEES.—

''(1) LIMIT ON AMOUNT OF POINTS AND FEES THAT MAY BE FINANCED.—Subject to paragraphs (2) and (3) of subsection (c), no creditor may, in connection with the formation or consummation of a mortgage referred to in section 103(aa), finance, directly or indirectly, any portion of the points, fees, or other charges payable to the creditor or any third party in an amount in excess of the greater of 3 percent of the total loan amount or $600.

''(2) PROHIBITION ON FINANCING CERTAIN POINTS, FEES, OR CHARGES.—No creditor may, in connection with the formation or consummation of a mortgage referred to in section 103(aa), finance, directly or indirectly, any of the following fees or other charges payable to the creditor or any third party:

''(A) Any prepayment fee or penalty required to be paid by the consumer in connection with a loan or other extension of credit which is being refinanced by such mortgage if the creditor, with respect to such mortgage, or any affiliate of the creditor, is the creditor with respect to the loan or other extension of credit being refinanced.

''(B) Any points, fees, or other charges required to be paid by the consumer in connection with such mortgage if—

''(i) the mortgage is being entered into in order to refinance an existing mortgage of the consumer that is referred to in section 103(aa); and

''(ii) if the creditor, with respect to such new mortgage, or any affiliate of the creditor, is the creditor with respect to the existing mortgage which is being refinanced.''.

(c) CREDITOR CALL PROVISION.—Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended by inserting after subsection (l) (as added by subsection (b) of this section) the following:

''(m) CREDITOR CALL PROVISION.—

''(1) IN GENERAL.—A mortgage referred to in section 103(aa) may not include terms under which the indebtedness may be accelerated by the creditor, in the sole discretion of the creditor.

''(2) EXCEPTION.—Paragraph (1) shall not apply when repayment of the loan has been accelerated as a result of a bona fide default.''.

(d) PROHIBITION ON ACTIONS ENCOURAGING DEFAULT.—Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended by inserting after subsection (m) (as added by subsection (c) of this section) the following:

''(n) PROHIBITION ON ACTIONS ENCOURAGING DEFAULT.—No creditor may make any statement, take any action, or fail to take any action before or in connection with the formation or consummation of any mortgage referred to in section 103(aa) to refinance all or any portion of an existing loan or other extension of credit, if the statement, action, or failure to act has the effect of encouraging or recommending the consumer to default on the existing loan or other extension of credit at any time before, or in connection with, the closing or any scheduled closing on such mortgage.''.

(e) MODIFICATION OR DEFERRAL FEES.—Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended by inserting after subsection (n) (as added by subsection (d) of this section) the following:

''(o) MODIFICATION OR DEFERRAL FEES.—

''(1) IN GENERAL.—Except as provided in paragraph (2), a creditor may not charge any consumer with respect to a mortgage referred to in section 103(aa) any fee or other charge—

''(A) to modify, renew, extend, or amend such mortgage, or any provision of the terms of the mortgage; or

''(B) to defer any payment otherwise due under the terms of the mortgage.

''(2) EXCEPTION FOR MODIFICATIONS FOR THE BENEFIT OF THE CONSUMER.—Paragraph (1) shall not apply with respect to any fee imposed in connection with any action described in subparagraph (A) or (B) if—

''(A) the action provides a material benefit to the consumer; and

''(B) the amount of the fee or charge does not exceed—

''(i) an amount equal to 0.5 percent of the total loan amount; or

''(ii) in any case in which the total loan amount of the mortgage does not exceed $60,000, an amount in excess of $300.''.

(f) CONSUMER COUNSELING REQUIREMENTS.—Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended by inserting after subsection (o) (as added by subsection (e) of this section) the following:

''(p) CONSUMER COUNSELING REQUIREMENT.—

''(1) IN GENERAL.—A creditor may not extend any credit in the form of a mortgage referred to in section 103(aa) to any consumer, unless the creditor has provided to the consumer, at such time before the consummation of the mortgage and in such manner as the Board shall provide by regulation—

''(A) all warnings and disclosures regarding the risks of the mortgage to the consumer;

''(B) a separate written statement recommending that the consumer take advantage of available home ownership or credit counseling services before agreeing to the terms of any mortgage referred to in section 103(aa); and

''(C) a written statement containing the names, addresses, and telephone numbers of counseling agencies or programs reasonably available to the consumer that have been certified or approved by the Secretary of Housing and Urban Development, a State housing finance authority (as defined in section 1301 of the Financial Institutions Reform, Recovery, and Enforcement Act of 1989), or the agency referred to in subsection (a) or (c) of section 108 with jurisdiction over the creditor as qualified to provide counseling on—

''(i) the advisability of a high cost loan transaction; and

''(ii) the appropriateness of a high cost loan for the consumer.

''(2) COMPLETE AND UPDATED LISTS REQUIRED.—Any failure to provide as complete or updated a list under paragraph (1)(C) as is reasonably possible shall constitute a violation of this section.''.

(g) ARBITRATION.—Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended by inserting after subsection (p) (as added by subsection (f) of this section) the following:

''(q) ARBITRATION.—

''(1) IN GENERAL.—A mortgage referred to in section 103(aa) may not include terms which require arbitration or any other nonjudicial procedure as the method for resolving any controversy or settling any claims arising out of the transaction.

''(2) POST-CONTROVERSY AGREEMENTS.—Subject to paragraph (3), paragraph (1) shall not be construed as limiting the right of the consumer and the creditor to agree to arbitration or any other nonjudicial procedure as the method for resolving any controversy at any time after a dispute or claim under the transaction arises.

''(3) NO WAIVER OF STATUTORY CAUSE OF ACTION.—No provision of any mortgage referred to in section 103(aa) or any agreement between the consumer and the creditor shall be applied or interpreted so as to bar a consumer from bringing an action in an appropriate district court of the United States, or any other court of competent jurisdiction, pursuant to section 130 or any other provision of law, for damages or other relief in connection with any alleged violation of this section, any other provision of this title, or any other Federal law.''.

(h) PROHIBITION ON EVASIONS.—Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended by inserting after subsection (q) (as added by subsection (g) of this section) the following:

''(r) PROHIBITIONS ON EVASIONS, STRUCTURING OF TRANSACTIONS, AND RECIPROCAL ARRANGEMENTS.—

''(1) IN GENERAL.—A creditor may not take any action—

''(A) for the purpose or with the intent to circumvent or evade any requirement of this title, including entering into a reciprocal arrangement with any other creditor or affiliate of another creditor or dividing a transaction into separate parts, for the purpose of evading or circumventing any such requirement; or

''(B) with regard to any other loan or extension of credit for the purpose or with the intent to evade the requirements of this title, including structuring or restructuring a consumer credit transaction as another form of loan, such as a business loan.

''(2) OTHER ACTIONS.—In addition to the actions prohibited under paragraph (1), a creditor may not take any action which the Board determines, by regulation, constitutes a bad faith effort to evade or circumvent any requirement of this section with regard to a consumer credit transaction.

''(3) REGULATIONS.—The Board shall prescribe such regulations as the Board determines to be appropriate to prevent circumvention or evasion of the requirements of this section or to facilitate compliance with the requirements of this section.''.

SEC. 5. AMENDMENTS RELATING TO RIGHT OF RESCISSION.

(a) TIMING OF WAIVER BY CONSUMER.—Section 125(a) of the Truth in Lending Act (15 U.S.C. 1635(a)) is amended—

(1) by striking ''(a) Except as otherwise provided'' and inserting ''(a) RIGHT ESTABLISHED.—

''(1) IN GENERAL.—Except as otherwise provided''; and

(2) by adding at the end the following:

''(2) TIMING OF ELECTION OF WAIVER BY CONSUMER.—No election by a consumer to waive the right established under paragraph (1) to rescind a transaction shall be effective if—

''(A) the waiver was required by the creditor as a condition for the transaction;

''(B) the creditor advised or encouraged the consumer to waive such right of the consumer; or

''(C) the creditor had any discussion with the consumer about a waiver of such right during the period beginning when the consumer provides written acknowledgement of the receipt of the disclosures and the delivery of forms and information required to be provided to the consumer under paragraph (1) and ending at such time as the Board determines, by regulation, to be appropriate.''.

(b) NONCOMPLIANCE WITH REQUIREMENTS AS RECOUPMENT IN FORECLOSURE PROCEEDING.—Section 130(e) of the Truth in Lending Act (15 U.S.C. 1640(e)) is amended by inserting after the second sentence the following: ''This subsection also does not bar a person from asserting a rescission under section 125, in an action to collect the debt as a defense to a judicial or nonjudicial foreclosure after the expiration of the time periods for affirmative actions set forth in this section and section 125.''.

SEC. 6. AMENDMENTS TO CIVIL LIABILITY PROVISIONS.

(a) INCREASE IN AMOUNT OF CIVIL MONEY PENALTIES FOR CERTAIN VIOLATIONS.—Section 130(a) of the Truth in Lending Act (15 U.S.C. 1640(a)) is amended—

(1) in paragraph (2)(A)(iii), by striking ''$2,000'' and inserting ''$10,000''; and

(2) in paragraph (2)(B), by striking ''lesser of $500,000 or 1 percentum of the net worth of the creditor'' and inserting ''the greater of—

''(i) the amount determined by multiplying the maximum amount of liability under subparagraph (A) for such failure to comply in an individual action by the number of members in the certified class; or

''(ii) the amount equal to 2 percent of the net worth of the creditor.''.

(b) STATUTE OF LIMITATIONS EXTENDED FOR SECTION 129 VIOLATIONS.—Section 130(e) of the Truth in Lending Act (15 U.S.C. 1640(e)) (as amended by section 5(b) of this Act) is amended—

(1) in the first sentence, by striking ''Any action'' and inserting ''Except as provided in the subsequent sentence, any action''; and

(2) by inserting after the first sentence the following: ''Any action under this section with respect to any violation of section 129 may be brought in any United States district court, or in any other court of competent jurisdiction, before the end of the 3-year period beginning on the date of the occurrence of the violation.''.

SEC. 7. AMENDMENT TO FAIR CREDIT REPORTING ACT.

Section 623 of the Fair Credit Reporting Act (15 U.S.C. 1681s–2) is amended by adding at the end the following:

''(e) DUTY OF CREDITORS WITH RESPECT TO HIGH COST MORTGAGES.—

''(1) IN GENERAL.—Each creditor who enters into a consumer credit transaction which is a mortgage referred to in section 103(aa), and each successor to such creditor with respect to such transaction, shall report the complete payment history, favorable and unfavorable, of the obligor with respect to such transaction to a consumer reporting agency that compiles and maintains files on consumers on a nationwide basis at least quarterly, or more frequently as required by regulation or in guidelines established by participants in the secondary mortgage market, while such transaction is in effect.

''(2) DEFINITIONS.—For purposes of paragraph (1), the term 'credit' and 'creditor' have the same meanings as in section 103 of the Truth in Lending Act (15 U.S.C. 1602).''.

SEC. 8. REGULATIONS.

The Board of Governors of the Federal Reserve System shall publish regulations implementing this Act and the amendments made by this Act in final form before the end of the 6-month period beginning on the date of enactment of this Act.

By Mr. BROWNBACK (for himself, Mr. ENSIGN, Mr. ENZI, Mr. HAGEL, Mr. INHOFE, Mr. NICKLES, Mr. SANTORUM, and Mr. SESSIONS):

S. 1930. A bill to provide that the approved application under the Federal Food, Drug and Cosmetic Act for the drug commonly known as RU–486 is deemed to have been withdrawn, to provide for the review by the Comptroller General of the United States of the process by which the Food and Drug Administration approved such drug, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. BROWNBACK. Mr. President, I rise today to introduce a very important piece of legislation, the RU–486 Suspension and Review Act of 2003. The abortion drug RU–486 increases in infamy as its lethal nature continues to reveal itself. As my colleagues may remember, in September, RU–486 claimed two more lives, one of whom was an 18-year-old woman. Holly Patterson, a resident of the San Francisco suburb of Livermore, died from an infection caused by fragments of her baby left in

her uterus after she was administered RU–486 at a Planned Parenthood facility. This tragedy underscores the dangerous nature of this drug.

The available data from the U.S. trials of RU–486 raises serious questions in my mind as to whether or not this drug truly is ''safe'' for the women who use it. Women who participated in the U.S. trials of this drug were carefully screened, and only those who were in the most physically ideal condition were accepted. Even so, among these physically ideal participants, troubling results emerged. Two-percent of the women participating hemorrhaged; one-percent had to be hospitalized; several others required surgery to stop the bleeding—some of whom needed blood transfusions; and one woman in Iowa, after losing between one-half to two-thirds of her total blood volume, would have died if she had not undergone emergency surgery. If these side-effects occurred in the most physically ideal candidates, what about those who are not in the physically ideal category? Is this drug ''safe'' for women? I believe medical results suggest it is not.

The bill I am introducing today will require the suspension of the Food and Drug Administration's approval of RU–486. Following this suspension, the General Accounting Office is directed to review the process the FDA used to approve RU–486 and to determine whether the FDA followed its own guidelines. If it is determined that the FDA violated its guidelines, RU–486 will be suspended indefinitely. Monty and Helen Patterson, the parents of Holly Patterson, have expressed their firm support for this legislation and have requested that it be known as ''Holly's Law'' in honor of their daughter whose life was prematurely ended. I ask that their open letter on this subject be printed in the RECORD.

The Food and Drug Administration should not have authorized this dangerous drug. RU–486 is perilous both to the baby and to the woman who uses it. I urgently call on my colleagues in this Chamber to support ''Holly's Law'' to prevent more unnecessary deaths.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

LIVERMORE, CA,
November 20, 2003.

DEAR SIR OR MADAM: The Alameda County Coroner's report has validated what we already believed to be true. Holly has died from an RU–486 chemical induced abortion. There are no quick fixes for a pregnancy or magical pills that will make it go away. Our family, friends and community are all deeply saddened and forever marred by Holly's tragic and preventable death.

Holly lived as an adult by law for only 19 days, yet she became pregnant when she was just 17 years old. We now know that she learned about her pregnancy in the second week of August and was so distraught over her unplanned pregnancy that she sought help for depression from her family doctor on September 10, 2003—the very day that she began the drug induced abortion process.

Holly was a strong, healthy, intelligent and ambitious teenager who fell victim of a process that wholly failed her, beginning with the 24-year-old man who had unprotected sex with her, impregnated her, and then proceeded to facilitate the secrecy that surrounded her pregnancy and abortion. Under this conspiracy of silence, Holly suffered and depended on the safety of the FDA approved pill administered by Planned Parenthood and emergency room treatment by Valley Care Medical Center where she received pain killers for severe cramping and was sent home. On Saturday and Sunday, Holly cried and complained of severe cramping and constipation, and even allowed us to comfort her but could not tell us what she was really going through. On September 17, 2003, she succumbed to septic shock and died while many members of our family waited anxiously, yet expectantly in the Critical Care Unit for her to recover until we were forced behind the curtain when it was clear that she was dying.

And in those last moments of her life feeling utter disbelief and desperation we formed a circle just beyond the curtain and prayed aloud, cried and screamed, ''We love you, Holly'' hoping beyond hope that those words would ring out and save her life. And the other members of our family who drove and flew from all over the country to be by her side did not make it in time to say, ''I love you'' just one last time. Holly was not alone, unloved, unprotected or unsupported; she had a large family who willingly supported her throughout her short life and tragic death.

In the weeks since we buried Holly's body we are now able to recall and share the memories of our daughter's brilliant blue eyes, engaging smile, laughter, unwavering determination and sheer gentle beauty that invoked our natural instinct to protect and love her, but we will never be able to forget those last moments of her life when she was too weak to talk and could barely squeeze our hands in acknowledgement of our words of encouragement. ''We love you, Holly'', ''Just hang in there, the whole family is coming,'' ''You fight this Holly, you can do it.''

Because Holly has died this way, we have educated ourselves about the grave dangers of this drug, become conscious of the current lack of parental notification/consent laws in California and now recognize the critical need for accurate, impartial sources of information and resources for parents, teenagers and young women who want to learn about the real dangers and risks of unplanned pregnancy and abortion and the dire need for a national movement to encourage prevention and open dialogue in the home about unplanned pregnancy and abortion.

We will actively support ''Holly's Law'' in Congress by Reps. DeMint, Bartlett and Senator Brownback to suspend and review the abortion drug RU–486, the Tell-A-Parent (TAP) bill, which requires parental notification laws in California and a campaign to encourage prevention and open dialogue about unplanned pregnancy and abortion in the home.

As parents, we cannot allow our beautiful Holly's horrible death to be in vain. RU–486 has caused serious injury and has been implicated in the deaths of other young women. Now it has killed our daughter. We have learned that the initial trials were rushed and the drug was lumped in and approved with drugs designed for life threatening illnesses such as cancer and AIDS. Pregnancy is a natural process that a woman's body is designed to support and has never been classified as a life threatening illness. We need help to develop a website and provide a place for teenagers and women to report their stories and testimonials of their experience on the serious and adverse affects using RU–486.

The FDA has failed to carry out its mission of ensuring RU–486 is a safe and effective abortion drug regimen. According to the FDA, it is ''responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation.'' Holly has already paid the ultimate price. The RU–486 abortion drug should not be either a Pro Life or Pro Choice issue. The most primary concern here must be the health and welfare of our children and young women. Hopefully, all parents can learn from Holly's horrible death and our loss.

According to Danco Laboratories, the abortion drug's distributor, the RU–486 regimen fails to work 7–8 percent of the time. Over a year ago the FDA received 400 reports of adverse reactions to the drug including several deaths.

Holly is yet another victim who was subject to an unacceptable risk to a drug that has a significant failure rate. And we demand that FDA Commissioner Mark McClellan and Health and Human services Secretary, Tommy Thompson take RU–486 off the market immediately pending an extensive investigation by the Comptroller General of the United States before more parents suffer and women die.

We respectfully request the name of the bill that is to be presented to the House of Representatives, an Act as the ''[RU–486 Approval and Review Act of 2003]'' to be known as ''Holly's Law.'' With actively support a bill that halts the use of the drug that took Holly's young life.

We demand an investigation by the FDA and the California State Health Department as to why abortion clinics like Planned Parenthood are not following FDA approved regulations to administer the drug. We question the purity of the drugs they administer, especially when they are made in foreign countries, such as China.

In addition to the dangers of this drug and its administration, we believe that health care providers such as Valley Medical Center don't appear to be fully prepared to evaluate and treat patients with RU–486 complications in emergency situations. Holly was in the hospital twice and died within 20 minutes before her follow up appointment with Planned Parenthood.

FDA Commissioner Mark McClellan and Health and Human Services Secretary, Tommy Thompson should now have enough evidence to pull this drug from the market. How many more teenagers and young women will have to pay the price with their health or with their life, before the FDA decides to act?

Currently in California, teenage girls under the age of 18 can't get their ears pierced or go on a school trip, but they can have a medical or surgical abortion without parental knowledge or consent. This prevents parents from being able to talk to their children about a pregnancy that would allow them to keep a baby or to be able to follow the abortion process.

The first line of defense for a child is a parent. Kids wouldn't be walking into clinics under a veil of secrey if parents were notified first hand where they could talk to their children about abortion risks. We have now learned that Holly first sought a pregnancy test in the months leading up to her pregnancy while she was still 17 years old. We know now that a parental notification law would have brought Holly's activity to our attention and her needless death could have been prevented if we had been aware and intervened.

We actively support the Tell-A-Parent (TAP) ballot initative sponsored by Life on

The Ballot www.LifeontheBallot.org. With enough petitions, this initiative will be on the 2004 ballot and requires parental notification 48 hours prior to an abortion in California. As parents, we are concerned about the health and welfare of all daughters; we are ''Pro Holly'' and look to our California Senators Barbara Boxer and Dianne Feinstein to support this initiative for the safety and protection of all young women in California.

Finally, we have suffered greatly with the realization that it's not enough to avoid the issue or talk to our children about why we don't want them to be involved in an unplanned pregnancy or abortion, but as parents, we must also talk about the tragic realities of unwanted pregnancy and abortion and reassure both, our daughters and sons that while we don't want this to happen, we will support them. We must focus on prevention and they must be told that they are not alone in this or any other unfortunate circumstances, regardless of the outcome.

We feel strongly that this country needs a national campaign to promote open and frank discussions in the home about unplanned pregnancy and the options that are available to our daughters who find themselves in this unfortunate predicament. We are eager to support such a campaign designed to bring about awareness, encourage parental involvement, and provide accurate information to minors, women, and parents about abstinence, birth control, unplanned pregnancy, abortion, parenting, and adoption options.

While parents would prefer that their daughters abstain from sex and many do, we must deal with the reality that many don't. In addition to unplanned pregnancy, girls can contract HIV and other STIs. As parents we need to prevent unplanned pregnancy instead of relying upon abortion clinics and agencies to educate our children and provide them with inaccurate information. No parent wants to see his or her teenage or college age daughter in the unfortunate situation that Holly was faced with.

We have lost our daughter, Holly, but we can still help to prevent this terrible tragedy from happening in other families. Holly's drive and determination to accomplish her goals gives us strength to pursue these critical issues in her name. Holly's memory and light will live on in our hearts, family, friends and our work. We will actively support the bill to suspend and review ''Holly's Law'' in Congress by Reps. DeMint and Bartlett and Senator Brownback to suspend and review the abortion drug RU–486, the Tell-A-Parent (TAP) bill, which requires parental notification laws in California and a campaign to encourage prevention and open dialogue about unplanned pregnancy and abortion in the home. Please contact us with any questions or requests for support of these very important issues.

Sincerely,

MONTY AND HELEN PATTERSON.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 271—URGING THE PRESIDENT AND THE UNITED STATES DIPLOMATIC CORPS TO DISSUADE MEMBER STATES OF THE UNITED NATIONS FROM SUPPORTING RESOLUTIONS THAT UNFAIRLY CASTIGATE ISRAEL AND TO PROMOTE WITHIN THE UNITED NATIONS GENERAL ASSEMBLY MORE BALANCED AND CONSTRUCTIVE APPROACHES TO RESOLVING CONFLICT IN THE MIDDLE EAST

Mr. COLEMAN (for himself, Mr. CORZINE, Mr. VOINOVICH, and Mr. LAUTENBERG) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 271

Whereas the United Nations General Assembly and United Nations Security Council have over a period of many years engaged in a pattern of introducing and enacting measures and resolutions unfairly castigating and condemning the state of Israel;

Whereas despite the myriad of challenges facing the world community, the United Nations General Assembly has devoted a disproportionate amount of time and resources to castigating Israel;

Whereas during the fifty-seventh session of the United Nations General Assembly, the General Assembly adopted a total of 69 resolutions by roll call vote, 22 of which related to Israel;

Whereas many member states of the United Nations General Assembly continue to engage in a discriminatory campaign against Israel, including enacting on October 21, 2003 a resolution that condemns Israeli security measures without proportional condemnation of terrorist attacks launched against Israel;

Whereas the discriminatory voting patterns in the United Nations have historically been driven by voting blocs and ideological divides originating from Cold War rivalries that are obsolete in the post-Cold War period; and

Whereas in the post-Cold War geopolitical environment, the United States has a special responsibility to promote fair and equitable treatment of all nations in the context of international institutions, including the United Nations: Now, therefore, be it

Resolved, That the Senate urges the President and all members of the United States diplomatic corps—

(1) to dissuade member states of the United Nations from voting in support of General Assembly resolutions that unfairly castigate Israel; and

(2) to promote within the United Nations General Assembly more balanced and constructive approaches to resolving conflict in the Middle East.

Mr. COLEMAN. Mr. President, today I am proud to submit, along with my good friend and colleague Senator CORZINE, a bipartisan resolution dealing with the unfair treatment of Israel at the United Nations.

For too long, Israel has been singled out for castigation by the United Nations General Assembly. Israeli defensive actions are condemned, while terrorism against Israeli civilians goes largely unnoticed. There are whole bodies designed to do nothing but produce anti-Israel materials. There is a Division of Palestinian Rights which sits at the same level in the U.N. organization as a single division for the Americas and Europe, a single division for Asia and the Pacific, and two Africa divisions. Of all the resolutions adopted by rollcall vote at the last session of the UN General Assembly, one-third singled out Israel.

Let me be clear on this point: I do think it is appropriate to help the Palestinian people, and I do share President Bush's vision of two states living side by side in peace.

But for the United Nations to spend so much of its time on this one crisis, with an unbalanced approach, ultimately undermines its ability to contribute constructively to the peace process. To accord the Palestinian people—however serious their problems are the same level of attention as entire continents is inappropriate in a world where there are so many other oppressed groups and nations. Why is there no Division of Tibetan Rights? Why no Division of Chechen Rights?

If you look at the General Assembly voting records, there are too many one-sided resolutions dealing with Israel that pass with only a handful of negative votes—cast by the U.S., Israel, Micronesia, the Marshall Islands, Nauru and Palau. Last Friday, I was pleased to note Australia joined us as well.

The good news is that we are starting to see some progress. A joint U.S.-European-Israeli effort to consolidate seven resolutions on UNRWA into one resolution recently was a good start. The resolution was passed out of the committee by a vote of 109 to 0, albeit with 54 abstentions. True, several superfluous resolutions on UNRWA were also approved by the committee. But this year, it was five resolutions instead of seven.

When the U.S., Europe, and Israel can work together on a resolution dealing with Palestinian refugees—and one that is passed without any negative votes—we get a glimpse of the U.N.'s potential for bringing parties together.

I would be remiss if I did not commend the work of U.S. diplomats, and applaud their increased attention to this issue. This resolution gives them a tool to use with their diplomatic counterparts—a strong statement from the U.S. Senate that we are paying attention to these votes, and that we support a more balanced approach toward the Middle East at the United Nations.

It should be a goal we can all agree upon. By reducing the number of anti-Israel resolutions passed by the General Assembly, the United Nations can live up to the promise of its charter: ''to practice tolerance and live together in peace with one another as good neighbors.''

Mr. CORZINE. Mr. President, today, along with Senators COLEMAN, LAUTENBERG and VOINOVICH, I am submitting a resolution to address a serious and persistent problem: the unfair and inequitable treatment of Israel in the United